August 2008

# Panic attacks: Can they really be stopped?

John C. Thomas
*Liberty University*, jcthomas2@liberty.edu

# Panic Attacks: Can They Really Be Stopped?

John C. Thomas

"It was the most frightening experience of my life. I thought I was having a heart attack. Imagine a pastor collapsing on the platform in front of his congregation! The doctor assured me that my heart was fine; he told me that it was a panic attack. As a minister of the Gospel, I cannot have panic attacks! Perhaps other people can have attacks, but not me. I have preached against worry, urged my congregation to trust God, and rebuked those who live in fear instead of faith. If people knew that I had panic attacks, they would never look at me in the same way."

These are the words of a distraught and disillusioned pastor of a large conservative church. Pastor Dirk, as he was affectionately called, was loved by his congregation, respected in the community, and considered a great orator. Dirk's presence evinced a confident and capable man whose drivenness awarded him many successes. His childhood, however, was anything but polished. Dirk's father was an alcoholic; his parents separated and eventually divorced when he was 11. Yet it was not those wounds that prompted Dirk to seek counseling. Since the initial episode, his panic attacks became more frequent… ambushing him at "inopportune times." Sometimes they lasted only a few minutes, but other times he experienced terrifying panic for nearly 15 minutes.

The panic "consumed" him. In a haze of disbelief, Dirk muttered, "I feel like I'm coming apart." Indeed, Dirk's life and ministry were in shambles. No matter how hard he tried, he could not rid himself of the panic. Like most victims, he began to avoid places that he associated with panic, but that was not always possible since many attacks occurred during service or in a church meeting—at those times he simply had to grin and bear it. More and more, however, he limited his activities to his home, becoming increasingly agoraphobic.

Some people would have sought counseling long before nearly a year of panic attacks, but Dirk had to reach the end of his rope. Dirk did not hold a favorable view of counseling, believing that God's Word was sufficient for every problem. Now he was face-to-face with an experience that appeared to contradict that belief. In his eyes, his faith was failing him; his panic attacks continued despite his best spiritual interventions to rid them.

Ultimately, his first obstacle was to accept medication to treat panic, which he finally took at the request of his wife. Though the medication provided some relief, it failed to eliminate the symptoms. After much pressure from his doctor and wife, he agreed to counseling.

**An Arousing Alarm**

"Frightening experience"… "heart attack"… "consumed"… "coming apart." The words Dirk used to describe his panic attacks speak of the terror that stalks those who have them. In fact, panic attacks are quite common. Up to 10% of otherwise healthy people experience an isolated attack annually (Collaborative Psychiatric Epidemiology Survey, 2007). Approximately 3% meet criteria for panic disorder in their lifetime (Kessler et al., 1994). Clearly, their prevalence necessitates that counselors understand both panic attack and panic disorder. In this article, we will use Pastor Dirk's story to illustrate key points about panic and strategies used to treat them.

*First of all, Dirk experienced a discrete period of rapidly mounting intense fear that overwhelmed him*. Like being aroused from a sound sleep by a blaring alarm clock, panic attacks demand attention. In fact, Dirk's doctor called panic "fear on steroids." Even the roots of the word "panic" reveal its intensity. Pan, the mythological Greek god of woods and fields, would let out a blood-curdling scream so intense that many who heard it died of fright. This reaction became known as "panic," after the irate god (Barlow & Durand, 2005).

Like Dirk, many who experience attacks believe they are having a heart attack. Panic attacks can vary widely in intensity, duration, frequency, number, and accompanying sensations. Repeated and unprovoked attacks may indicate a panic disorder, but panic attacks are associated with other anxiety disorders as well. For example, people with phobias may experience attacks upon exposure to the feared trigger.

*Second, panic attacks overtake the entire body.* They are born out of a sudden onset of fear with little or no provoking stimulus. The body releases significant adrenaline into the bloodstream, which yields the fight-or-flight response characterized by increased heart rate, rapid breathing (hyperventilation), and sweating. Because strenuous activity rarely ensues, the hyperventilation reduces carbon dioxide in the lungs and blood. The pH in the blood changes, which produces symptoms such as tingling or numbness, dizziness, lightheadedness, and choking.

*Third, Dirk's abrupt attack developed without warning.* An "unexpected" (uncued) attack ambushed him for no reason. In contrast, some attacks are "situationally bound" (cued) by particular situations that trigger them. As Dirk's condition worsened, certain situations guaranteed an attack. A "situationally predisposed" panic attack means that although a person is prone to have an attack, it is not guaranteed. Situationally predisposed and unexpected type attacks are typical of individuals diagnosed with panic disorder, whereas situationally bound attacks are common in phobias.

*Fourth, the attacks were indescribably frightening to Dirk, as they are to virtually everyone who has them*. People with panic attacks are not necessarily anxious all of the time. Yet, given the fact that people feel they are losing control and knowing that it can happen at any time, avoiding panic attacks becomes a priority.

Accordingly, once people have a panic attack, they worry about its reoccurrence; such worry is known as "fear the fear." The fear might be rooted in being humiliated, losing control, or feeling helpless. Such fear can lead to a very limited life, leaving a lasting residue of dread and disability. Like Dirk, people often avoid things that might trigger an attack that can lead to a diagnosis of ***agoraphobia*.** They stop doing the things they used to do and going to the places they used to go. Dirk limited his activities as much as possible to the home or endured with significant distress situations he associated with the fear of having an attack. One panic attack can so traumatize people that they are haunted by it for the rest of their lives.

**Triggering the Alarm**

Research indicates that panic is born, reared, and perpetuated by a combination of physiological and cognitive factors. Predisposing factors can be grouped into three categories that follow the "Triple Vulnerability" theory of anxiety (Barlow, 2002).

The first category deals with **biological factors**. Some individuals are genetically wired toward panic (Comer, 2003) and vulnerable due to it being a familial disorder (Rush, Feldman-Koffler, Weissenburger, Giles, Roffwarg & Orsulak, 1995). Certain inborn traits, such as neuroticism, pessimism, behavioral inhibition, and being high-strung, are also linked with panic. Additionally, research indicates that sodium lactate, carbon dioxide, caffeine, vigorous exercise, and hyperventiliation can produce panic attacks. Drugs, such as marijuana, can provoke attacks

in people. Neurologically, panic attacks are linked with the locus cereleus region of the brain, where norepinephrine is highly active.

**Generalized psychological factors** deal with early life experiences that relate to gaining a sense of control over the world. In families with strong attachments, children develop stronger self-efficacy, which is a person's perceived ability and control over outcome. A sense of control markedly lessens anxiety and panic (Barlow, 2002). By contrast, poor attachment can create anxiety and diminish a child's sense of master and control. Well-meaning, but smothering, parents who limit their children from venturing out destroy self-efficacy.

In short, anxious families produce anxious children who come to believe that certain events are outside of their control. Typically, these anxious children will either seek control where none is possible or surrender to helplessness (Chorpita & Barlow, 1998). The perceived level of control is evident in a person's danger-laden beliefs. People will avoid places associated with panic because they do not believe they can act effectively and exercise behavioral and cognitive control. Anxiety in general makes panic more likely and panic can actually breed more panic. Likewise, stressful life events such as a marriage, losing a job, moving, or financial problems can trigger a panic attack.

Third, **specific psychological factors** are linked with panic. Some people are taught that certain things are dangerous (e.g., dogs). Panic can occur when a person associates certain things with particular internal and/or external cues. Psychologically, a person who perceives threat and interprets sensations as indicative of catastrophic outcomes will provoke more sensations, producing a downward cycle. A final psychological factor, exposure, occurs as a direct result of exposure to the feared trigger, such as seeing a dog. These panic attacks are usually short-lived and self-limiting, as they will subside once the trigger is no longer present.

**Turning Off and Tuning Down the Alarm**

Though some people overcome panic by riding out the attacks, many others, like Dirk, need outside assistance. Often the first intervention is pharmacological. Certain antidepressants (e.g., paroxetine, sertraline) are prescribed to break the cycle of attack, anticipation, and anxiety. Benzodiazepines (e.g., diazepam, lorazepam, alprazolam, clonazepam) may be taken at the onset of an attack or in anticipation of a challenging situation, but pose risk of abuse and addiction

with continued use. Of course, simply knowing that medication is close by might be enough to prevent an attack. Unlike antidepressants, benzodiazepines do not treat the cause of the attacks. Research indicates that 80% of people receive some relief and between 40 to 60% achieve nearly full recovery using medication. Unfortunately, symptoms commonly return if the medication is discontinued.

Dirk's panic attacks stopped in part due to cognitive-behavioral counseling. In the treatment of panic attacks, a variety of cognitive and behavioral techniques are used. Like most disorders, it helps to learn the early signs of an attack in order to try to obviate them. Focusing on the reduction of responsiveness to internal and external stressors and learning sound coping skills are effective. Clients must also learn that a panic attack poses no physical danger.

Thus, they must learn to embrace, not fight, their symptoms. Some attacks can be paradoxically managed, in part, by telling oneself that it is only a panic attack, and it will run its course and soon be over. A suggested technique is saying the words "stop it!" and then focusing on deep abdominal breathing to slow respiration and relax the muscles.

Some counselors use a technique known as Symptom Induction/Interoceptive Desensitization in which attacks are induced in a controlled environment in order to help the client learn how to deal with them (Barlow & Craske, 2000). Importantly, the exercises should mimic the most frightening symptoms of a panic attack using the induction cycle for each symptom and be repeated three to five times per day. This technique often takes weeks or even months to be effective.

Another helpful skill is developing a healthy lifestyle. A healthy diet is critical for many reasons and plays a role in controlling anxiety. Avoiding unhealthy food and including certain foods, such as bananas, turkey, and carbohydrates that create serotonin in the brain, work to limit anxiety. One should also limit caffeine, smoking, and alcohol, and get adequate rest and exercise.

Most importantly, one should strengthen the Christian disciplines. Even though the word *meditation* is unnerving to many conservative believers because of its association with New Age, the regular use of Christian meditation helps reduce panic (cf 1 Peter 5:7). Giving up a hapless fight against panic by adopting Paul's embrace of weakness (1 Corinthians 2:1-5; 2 Corinthians 12:7-10; Philippians 4:10-14) paradoxically allows God to become our strength in an arena

where we have none. Not only can panic be controlled, but the long-term spiritual fruits of such an approach can be quite significant.

Perhaps the most problematic aspect of panic for Christians is that it calls their faith into question. Many reason that if God is sovereign over the future, then being anxious about the future indicates a lack of trust. Some Christians will continue to fight this assessment by arguing with God and themselves that they trust completely or, at least, well enough. Others will embrace the fact that trust-building is an ongoing challenge of any relationship, embracing God's grace and acceptance apart from our fallen humanity and learning to grow in faith and trust as a result of God's unending love poured out unto all sinners who are saved by His grace. Panic might then be seen as the crisis that led to the entry to a deeper, loving, grace-based walk with God—one that sheds the impossible demands of legalistic religion.

Moreover, a non-shaming church community can dramatically impact the treatment of panic. A judgmental and shaming church practically condemns the believer to suffer through this trouble alone. A church that mirrors the unconditional love of the Father can allow panic sufferers to be honest with themselves and others about their struggles, and together, the community of believers can add the necessary strength to overcome any problem.

Clearly a mark of Christian maturity is less worry, but becoming enveloped in the shame of being "less than Christian" compounds the problem. Accordingly, counselors must get to the underlying issues that perpetuate the panic while controlling the bleeding of shame. Establishing and building up Christian-based coping skills can help sufferers deal with their sensitivity to anxiety and panic.

**Conclusion**

To live is to experience fear and anxiety. It is our response to both that can determine whether a problem ensues. A regular response of panic can dramatically limit a person's risk-taking and initiative. People become anchored in fear rather than faith. Christians are particularly prone to added anxiety because of the biblical directives to not worry.

As Christian counselors, our call is to help people not just glorify God, but also enjoy Him and experience pleasure in Him. When panic blocks people's ability to experience the

fullness of God, we must help them incarnate the truths of Scripture in the everyday existence of their lives.

John C. Thomas, Ph.D., Ph.D., is the Program Director in the Center for Counseling and Family Studies at Liberty University in Lynchburg, Virginia. He also owns Source One Strategies (SOS), an organizational consulting business. Dr. Thomas is co-author of *What's Good About Feeling Bad?* by Tyndale. He and Denise, his wife of 23 years, conduct marriage enrichment retreats and have two children.

**References**

Barlow, D.H. (2002). *Anxiety and its Disorders.* New York: Guilford.

Barlow, D.H., & Craske, M.G. (2000). *Mastery of your Anxiety and Panic* (3rd ed.). Albany, NY: Psychological Corporation.

Barlow, D.H., & Durand, V. Mark (2005). *Abnormal Psychology: An Integrative Approach* (4th ed.). Belmont, CA: Thomson Wadsworth.

*Collaborative Psychiatric Epidemiology Survey.* (2007). Retrieved June 17, 2008, from http://www.icpsr.umich.edu/cocoon/cpes/cpes/DX_PANIC_ATTACK/V08476/var.xml.

Kessler, R.C., McGonagle, K.A., Zho, S., Nelson, C.B., Hughes, M., Eshleman, S., et al. (1994). Lifetime and 12-month Prevalence of DSM-III-R Psychiatric Disorders in the United States: Results from the National Comorbidity Survey. *Archives of General Psychiatry*, 51, 8-19.

Reed, V., & Wittchen, H.U. (1998). DSM-IV Panic Attacks and Panic Disorder in a Community Sample of Adolescents and Young Adults: How Specific are Panic Attacks? *Journal of Psychiatric Research*, 32, 335-345.

Rush, A.J., Feldman-Koffler, F., Weissenburger, J.E., Giles, D.E., Roffwarg, H.P., & Orsulak, P.J. (1995). Depression Spectrum Disease with and without Depression in First-degree Relatives. *Journal of Affective Disorders*, 35, 131-138.