

Case Report

DIAGNOSIS OF PANIC DISORDER IN PATIENTS WITH RECURRENT PANIC DISORDER AFTER A TRAUMATIC EVENT: CASE REPORT

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ABSTRACT

Background: Panic disorder is a condition where sudden anxiety attacks occur and are accompanied by feelings of depression. Symptoms of panic disorder include the emergence of repeated and unexpected panic attacks. These vulnerability factors include genetics, neurobiological factors, events during childhood, and personality. Panic disorders that occur after trauma are seen as reminders of the trauma. A history of previous trauma and a history of vulnerability in some patients can trigger a greater incidence of panic disorder.

Objective: To describe diagnosis of panic disorder in patient with recurrent panic disorder after a traumatic event

Case Description: A 42-year-old male visited the Psychiatric Clinic complaining of frequent panic over the past three years. The patient experienced fear, shortness of breath, palpitations, cold sweats, and feeling dazed when in crowds. This happened after the patient had witnessed a stabbing incident in front of his house. The patient was diagnosed with a panic disorder. Panic disorder is characterized by sudden, repeated, and unexpected anxiety attacks. Risk factors include genetics, neurobiology, childhood events, and personality. Panic disorders that occur after trauma are considered reminders of trauma. The patient showed clinical improvement after receiving therapy and medication. The symptoms must be carefully assessed to obtain an accurate diagnosis. This study provides an overview of differentiating panic disorder from phobias and PTSD as well as identifying appropriate diagnoses.

Conclusion: The diagnosis of panic disorder needs to be done correctly so that the therapy is provided accordingly.

Keywords: panic disorder, phobia, agoraphobia, PTSD, diagnosis

INTRODUCTION

Panic disorder is characterized by sudden, repeated, and unexpected anxiety attacks. Panic attacks involve intense anxiety reactions accompanied by physical symptoms, such as palpitations, difficulty breathing, profuse sweating, feelings of weakness, and dizziness.^[1] Panic disorder is the most frequent emergency department case among anxiety disorder; it has a high prevalence, ranking below social anxiety disorder, post-traumatic stress disorder (PTSD), and generalized anxiety disorder (GAD).^[1-5] A panic disorder that occurs after trauma is considered a reminder of a traumatic event. Trauma and vulnerability history in the same patient will trigger more panic disorder events. Repeated exposure to trauma possibly develops into PTSD.^[2-4,7]

CASE DESCRIPTION

Patient Information

Mr. H, a 42-year-old male school principal, visited the Psychiatric Clinic at Dr. Sardjito General Hospital complaining of feeling tense when using public transportation. This was triggered by the patient's traumatic experience three years prior. Patient's consent

for publication was collected by signing a written form during the hospital visit.

Clinical Manifestations 2013

The patient experienced symptoms of frequent fear, anxiety, restlessness, and difficulty sleeping after witnessing a stabbing incident in front of his house. There was one moment when the patient was blanking and could not complete the teaching that day. The patient felt confused, panicked, trembling, shortness of breath, and feeling like he was going to feel faint when starting speaking in front of the class. At any time, the patient speaks in front of a crowd, and feels insecure, scared, palpable, shortness of breath, and cold sweat. These symptoms resolved independently. This made the patient feel incompetent and decided to stop teaching, leading meetings, or speaking publicly for some time.

The patient's condition was unstable. He often heard screams, as if stabbing had occurred. During an attack, the patient experienced an immense amount of fear as if he was going to die. This occurred repeatedly and lasted for 10 minutes. The patient feared that his heart would suddenly stop. The world felt unreal and strange, as if his soul was lifted from his body. These symptoms would occur

anytime and anywhere, up to three times a day, at home, or at school.

Prior to the incident, the patient was motivated and active in the community. However, since the incident, the patient has withdrawn from society and is afraid of being crowded. The patient preferred to attend Friday prayer in the last row, even though he used to lead the prayer. The patient also felt scared when left alone at home. Due to the disability from all these symptoms, the patient decided to visit the Psychiatry Clinic at Dr. Sardjito General Hospital. After the complaints had improved, the patient performed normal activities.

Clinical Manifestations 2014

The patient experienced increasing symptoms, such as feeling tense, anxious, shortness of breath, and cold sweats when interacting socially, for example, while attending a prayer or meeting. These symptoms include frequent involuntary blinking of the eyes and facial movement. They were being mocked by the students, which made the patient feel offended. The patient complained of frequent dizziness. The patient sought treatment at the Psychiatric and Neurological Clinic at Dr. Sardjito General Hospital. After therapy, the patient's symptoms improved.

Clinical Manifestations 2015

Physical and mental symptoms worsened again, including involuntary facial muscle movements. He felt ashamed of meeting other people and of having a mental illness. The patient was also afraid of experiencing more panic attacks. The patient had difficulty sleeping to the point where his mother was asked to accompany him. This limited his activity and caused significant distress and disability. The patient returned for treatment at the Psychiatric and Neurological clinic of Dr. Sardjito General Hospital.

Clinical Manifestations 2016

During follow-up, the patient stated that the symptoms had improved. The patient was able to function socially. At this point, the patient was able to lead the prayers and meetings. However, sometimes, the patient still felt tense when using public transportation. This symptom resolved after the patient prayed and had deep breaths. The patient reported a 20% reduction in symptoms.

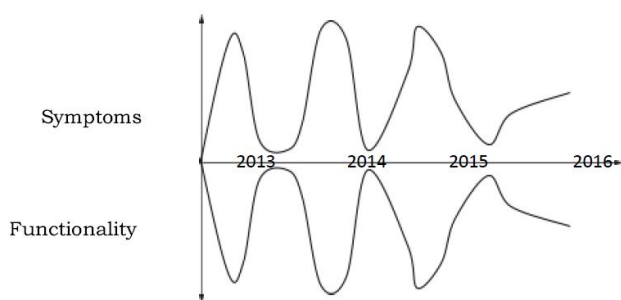


Figure 1. Symptoms Progression

Diagnostic Assessment

During the mental status examination, the patient's impression was appropriate for his age, adequate self-care, and realistic thought forms. The patient exhibited a preoccupation with panic symptoms, anxious affect, and anxious mood. There were no perceptual disturbances, and the patient demonstrated a level III insight. Blood pressure was 146/90 mmHg. The other physical examination results were normal.

Psychiatric support examinations were carried out, including (1) graphic tests (Draw A Person Test, Baum Test, House Tree Person Test), which were interpreted by our psychologist as anxious, depressive, dependent, poor social relation, the need for recognition, with conclusions of anxiety and depression; (2) Hamilton Depression Rating Scale, which obtained a score of 16 (medium); (3) Hamilton Anxiety Rating Scale, which obtained a result of 20 (mild); (4) Woodworth obtained the following results: emotes: 112; Psych. obsession: 96; Schz. tendenz: 90; Paran. tendenz: 60; Depr. hypocho: 208; Epil impulse: 74; Instab. emotion: 104; Antis. Tendenz: 52. (5) Eysenck obtained N = 16, I = 10 and L = 2.



Figure 2. Drawing test

Therapeutic Intervention

The patient was initially administered 20 mg fluoxetine every 24 h and alprazolam (0.5 mg) every 12 h. After the improvement, the doses were gradually reduced.

DISCUSSION

The patient had no history of physical illness, seizures, or trauma. The patient's blood pressure was elevated. The results of the supportive examinations were normal. Hyperthyroidism or other organic causes were ruled out.^[8,9]

This patient did not have a history of psychoactive substances, such as alcohol or drugs, that could alter the central nervous system. No traces of needle injections were found during physical examination, and the patient did not smoke cigarettes. Mental disorders due to the use of psychoactive substances (F1) were ruled out.^[1,8,9]

The patient exhibited prominent symptoms of anxiety, including unreasonable fear and physical tension. Cognitive symptoms included brain fog, restlessness, confusion, fear of going insane, difficulty in self-control, and hypervigilance. Behavioral symptoms include avoidance of people and society. These symptoms interfered with his daily lives, indicating an anxiety disorder.^[8-9]

Panic disorder is a complex anxiety disorder characterized by periods of intense, uncontrollable fear, accompanied by cardiorespiratory, autonomic, and gastrointestinal symptoms. Somatic symptoms may be expressed as fight or flight responses. Panic disorder is one of the most studied anxiety disorders.^[1,10]

Diagnostic criteria for panic disorder according to the DSM V require the presence of recurring symptoms. The symptoms were mostly physical, and only three were cognitive. This differentiates panic disorder from other anxiety disorders, in which the object of fear is not always directed at a person's body signals.^[1,9,10]

Panic disorder has several categories, namely panic disorder without agoraphobia, panic disorder with agoraphobia, and agoraphobia without a history of panic disorder.^[11,12] In panic disorder, symptoms vary between difficulty breathing, nausea, chest pain, feeling choked, and suffocating as if going to die.^[13,14] Panic attacks occur unexpectedly, with a symptom-free period between attacks.^[15-16] A diagnosis of panic disorder is made for at least one month.^[1,8,9]

The patient showed symptoms of agoraphobia from avoiding situations in which a panic attack could be dangerous or embarrassing. Patients did not want to leave their houses and withdrew socially. These symptoms add to panic disorder symptoms, and the patient can be diagnosed with Panic Disorder with Agoraphobia.^[3,4,8]

Posttraumatic stress disorder was another differential diagnosis. After the patient witnessed a stabbing incident, they often heard hysterical screams. This creates extreme fear, horror, helplessness, hypervigilance, and exaggerated startle responses. However, the patient did not experience flashbacks or re-experiencing the event. PTSD has been ruled out.^[17-19]

Another differential diagnosis is GAD. Patients experience three or more of the following: impatience, fatigue, difficulty concentrating, irritability, muscle tension, and sleep disturbances.^[3,4] Even though there were symptoms of anxiety about the future, the patient's anxiety was limited to the fear of a panic attack. Thus, GAD was ruled out.^[2-4]

The patient experienced repeated panic attacks annually because of his vulnerability aggravated by witnessing a stabbing incident. Mild trauma can lead to panic disorders and PTSD [20]. Identifying the definite cause and trigger of trauma is necessary to prevent recurrence.

CONCLUSION

The diagnosis of panic disorder needs to be performed correctly for therapy to be provided accordingly. Proper therapy can facilitate complete remission. Identifying the triggers is important for reducing recurrence.

LIMITATIONS

This study lacked objective measurements regarding the improvement of symptoms due to the patient's occupation

and distance to the hospital, limiting the frequency of psychiatric evaluation.

CONFLICT OF INTEREST

The author has no conflicts of interest to declare.

AUTHOR CONTRIBUTION

AFK was the doctor who treated the patient and was responsible for writing this case. AFK was also responsible for the conceptualization, data curation, analysis, investigation, and writing of the original draft.

LIST OF ABBREVIATIONS

GAD: General Anxiety Disorder; PTSD: Post-Traumatic Stress Disorder; OCD: Obsessive-compulsive disorder.

REFERENCES

1. American Psychiatric Association, 2013, Diagnostic and Statistic Manual of Mental Disorders, DSM-5, 5th ed. Washington, DC, American Psychiatric Publishing.
2. An I, Bang M, Lee SH. 2021 .The interaction effect of early trauma exposure and a diagnosis of panic disorder on cortical thickness. *J Affect Disord.* 1;286:259-266. doi: 10.1016/j.jad.2021.03.008. Epub 2021 Mar 8. PMID: 33752040.
3. Anika Wiltgen, Consuelo Arbona, Leslie Frankel, B. Christopher Frueh. 2015. Interpersonal trauma, attachment insecurity and anxiety in an inpatient psychiatric population. *Journal of Anxiety Disorders*, Volume 35, Pages 82-87, ISSN 0887-6185, <https://doi.org/10.1016/j.janxdis.2015.07.010>.
4. Berenz EC, York TP, Bing-Canar H, Amstadter AB, Mezuk B, Gardner CO, Roberson-Nay R. 2019. Time course of panic disorder and posttraumatic stress disorder onsets. *Soc Psychiatry Psychiatr Epidemiol.*54(5):639-647. doi: 10.1007/s00127-018-1559-1. Epub 2018 Jul 12. PMID: 30003310; PMCID: PMC6509003.
5. Cackovic C, Nazir S, Marwaha R. Panic Disorder. In: StatPearls. Treasure Island (FL): StatPearls Publishing. 2021.<http://www.ncbi.nlm.nih.gov/books/NBK430973/>
6. Sawchuk CN, Roy-Byrne P, Noonan C, Craner JR, Goldberg J, Manson S, Buchwald D; AI-SUPERPPF Team. Panic attacks and panic disorder in the American Indian community. *J Anxiety Disord.* 2017 May;48:6-12. doi: 10.1016/j.janxdis.2016.10.004. Epub 2016 Oct 5. PMID: 27720578; PMCID: PMC5380607.
7. Woodward, E.C., Viana, A.G., Raines, E.M. et al. 2018. The Role of Anxiety Sensitivity in the Relationship Between Emotion Dysregulation and Internalizing Psychopathology Among Trauma-Exposed Inpatient Adolescents. *Cogn Ther Res* 42, 823-831 . <https://doi.org/10.1007/s10608-018-9943-4>
8. Depkes RI., 1993. Pedoman dan Penggolongan Diagnosis Gangguan Jiwa. Edisi ketiga. Jakarta.
9. Kaplan HI., Sadock BJ., 2022. Sinopsis Psikiatri Ilmu Pengetahuan Perilaku Psikiatri Klinis. Edisi 12 Jilid 1.
10. Foldes-Busque G, Fleet RP, Denis I, Poitras J, Chauny JM, Diodati JG, Marchand A. 2015 . Nonfearful Panic Attacks in Patients With Noncardiac Chest Pain. *Psychosomatics* 56(5):513-20.
11. Schrader C, Ross A. 2021 . A Review of PTSD and Current Treatment Strategies. *Mo Med.* 118(6):546-551. PMID: 34924624; PMCID: PMC8672952.
12. Meuret AE, Kroll J, Ritz T. 2017 . Panic Disorder Comorbidity with Medical Conditions and Treatment Implications. *Annu Rev Clin Psychol.* doi: 10.1146/annurev-clinpsy-021815-093044. Epub 2017 Mar 27. PMID: 28375724.

13. Muriel A. Hagenaaers, Agnes van Minnen, Cees A.L. Hoogduin, Marc Verbraak. 2009. A transdiagnostic comparison of trauma and panic memories in PTSD, panic disorder, and healthy controls, *Journal of Behavior Therapy and Experimental Psychiatry*, Volume 40, Issue 3, Pages 412-422, ISSN 0005-7916, <https://doi.org/10.1016/j.jbtep.2009.04.001>.
14. Peter P Roy-Byrne. (2022). Panic disorder in adults: Epidemiology, clinical manifestations, and diagnosis. UpToDate. Retrieved February 22, 2024. From <https://www.uptodate.com/contents/panic-disorder-in-adults-epidemiology-clinical-manifestations-and-diagnosis#references>
15. Cackovic C, Nazir S, Marwaha R. 2021. Panic Disorder. In: StatPearls. Treasure Island (FL): StatPearls Publishing. <http://www.ncbi.nlm.nih.gov/books/NBK430973/>
16. Kim HJ, Kim JE, Lee SH. 2021 . Early Trauma Is Associated With Suicidal Ideation in Patients With Panic Disorder. *J Nerv Ment Dis.* 1;209(10):734-742. doi: 10.1097/NMD.0000000000001368. PMID: 33993182.
17. Shasha T, Dolgin MJ, Tzur Bitan D, Somer E. 2018 . Incidence and Clinical Features of Panic Related Posttraumatic Stress. *J Nerv Ment Dis.* 206(7):501-506. doi: 10.1097/NMD.0000000000000845. PMID: 29965877.
18. Schrader C, Ross A. 2021 . A Review of PTSD and Current Treatment Strategies. *Mo Med.* 118(6):546-551. PMID: 34924624; PMCID: PMC8672952.
19. Sivolap YP. 2017. Panic disorder: clinical phenomena and treatment options. *Zh Nevrol Psikiatr Im S S Korsakova,* 117(4):112-116.
20. Ruud A. Jongedijk, Michiel F. van Vreeswijk, Jeroen W. Knipscheer, Rolf J. Kleber & Paul A. Boelen (2023) The Relevance of Trauma and Re-experiencing in PTSD, Mood, and Anxiety Disorders, *Journal of Loss and Trauma*, 28:4, 404-420, DOI: 10.1080/15325024.2022.2116782