PANIC ATTACK TREATMENT

Step-by-Step Clinician Guide + Client Self-Help Plan

CBT-informed • exposure-focused • practical handouts

Purpose

A concise reference for licensed clinicians treating adults with recurrent panic attacks or panic disorder, plus client-facing exercises that can be used between sessions. Adapt to diagnosis, developmental level, medical status, culture, comorbidities, and scope of practice.

Important clinical safety note

New or atypical chest pain, fainting, severe shortness of breath, neurologic symptoms, substance intoxication/withdrawal, pregnancy-related concerns, or symptoms that may reflect a medical emergency require appropriate medical assessment. Do not assume every episode of racing heart, dizziness, or chest discomfort is panic. Assess suicide/self-harm risk and other acute safety concerns as clinically indicated.

The treatment in one page

Step	Clinician focus	Client task
1	**1. Assess and rule out**	Complete assessment and obtain medical evaluation if needed.
2	**2. Explain the panic cycle**	Draw your personal panic cycle.
3	**3. Track attacks**	Record attacks without judging them.
4	**4. Reappraise catastrophic beliefs**	Write the prediction and test it.
5	**5. Interoceptive exposure**	Practice planned body-sensation exercises.
6	**6. In-vivo exposure**	Approach one avoided situation repeatedly.
7	**7. Drop safety behaviors**	Choose one safety behavior to reduce.
8	**8. Consolidate and prevent relapse**	Create a 30-day maintenance plan.

Step 1 - Assessment and formulation

Assess before beginning exposure. A useful formulation distinguishes the panic attack itself from the fear of panic and the behaviors used to prevent or escape it.

- Panic symptoms: palpitations, sweating, trembling, breathlessness, choking sensations, chest discomfort, nausea, dizziness, chills/heat, tingling, derealization/depersonalization, fear of losing control, fear of dying.
- Pattern: unexpected vs situationally cued attacks; frequency; duration; first episode; recent change in pattern.
- Avoidance/agoraphobia: driving, stores, crowds, exercise, elevators, being alone, travel, waiting in lines, etc.

- Safety behaviors: sitting near exits, carrying medication/water “just in case,” checking pulse/oxygen, reassurance seeking, avoiding caffeine/exercise, leaving situations early.
- Differential/comorbidity: medical causes, substance/medication effects, trauma-related episodes, social anxiety, OCD, illness anxiety, depression, bipolar symptoms, psychosis, ADHD/autism-related overload, sleep problems.
- Measures (optional): Panic Disorder Severity Scale (PDSS) or another validated anxiety/panic measure available in your setting.

Step 2 - Psychoeducation: explain what panic is

Teach the client that panic is an intense false-alarm response. The sensations are real; the feared catastrophe usually is not. Panic becomes self-reinforcing when normal bodily sensations are interpreted as dangerous.

Simple therapist explanation

“Your body is producing an alarm response. The alarm feels dangerous, but feeling danger is different from being in danger. Treatment helps your brain learn that these sensations can rise and fall without catastrophe, and that you do not have to escape them.”

Draw the cycle together: Trigger or sensation → “Something terrible is happening” → anxiety/adrenaline → stronger sensations → escape/safety behavior → temporary relief → stronger fear next time.

Step 3 - Self-monitoring

Ask the client to record enough information to identify patterns without turning monitoring into constant body checking.

Situation	Body sensations	Feared outcome	Fear 0-100	What I did	What actually happened

Clinical target: identify the catastrophic prediction, not merely the trigger.

Step 4 - Cognitive reappraisal

Use collaborative questioning rather than reassurance. The objective is to create beliefs that can be tested during exposure.

- What exactly are you afraid will happen?
- If your heart races, what does that mean to you?
- How many times has this sensation occurred? How many times did the feared catastrophe happen?
- What is another explanation for the sensation?
- What evidence would help us test this belief?

Example

Prediction: “If I feel dizzy in a store, I will faint.” Alternative: “Dizziness is a common anxiety sensation; fainting from panic itself is uncommon. I can test whether dizziness can rise and pass while I remain standing safely.”

Step 5 - Interoceptive exposure

Interoceptive exposure intentionally produces feared physical sensations. It should be planned, consented to, medically appropriate, and framed as a learning experiment rather than a trick to "get rid of anxiety."

Example exercise	Possible sensation	Sample duration	Clinical caution
Run/march in place	racing heart / breathlessness	30-60 sec	Modify for cardiac, respiratory, orthopedic, pregnancy, or other medical concerns.
Spin in a chair	dizziness	20-30 sec	Avoid when vestibular/neurologic/medical concerns are present.
Head between knees then rise	light-headedness	20-30 sec	Use caution with blood-pressure/fainting history.
Breathe through a narrow straw	air hunger	briefly	Do not use with respiratory disease; stop if medically concerning.
Stare at a fixed point / fluorescent area	visual unreality	30-60 sec	Useful when derealization/visual sensations are feared.
Tense muscles	tightness / shaking	30-60 sec	Modify for pain/injury conditions.

Protocol: predict feared outcome → rate fear → do the exercise → remain with the sensation without escape → observe what happens → compare outcome with prediction → repeat. Vary exercises and context to strengthen learning.

Do not over-rely on controlled breathing

Slow breathing can be useful for some clients, especially when hyperventilation is prominent, but it should not become a "rescue" behavior that teaches the client they are safe only if they control their breathing. Exposure-based learning is generally aimed at increasing willingness to experience sensations without catastrophe.

Step 6 - Situational (in-vivo) exposure

Create an exposure hierarchy based on avoided situations and feared outcomes. Choose tasks that are meaningful and repeatable. The goal is new learning: "I can experience anxiety and continue," not perfect calm.

Situation	Prediction	Fear 0-100	Outcome / learning
Stand in a checkout line 5 min	I will panic and need to leave	60	
Drive one exit on highway	I will lose control	70	
Exercise 10 min	My heart rate means danger	75	
Sit away from exit in restaurant	I will be trapped	80	

During exposure, reduce unnecessary reassurance, distraction, escape, or checking. Encourage curiosity: "What does your brain predict? What actually happens?"

Step 7 - Reduce safety behaviors

Safety behaviors prevent disconfirmation of feared beliefs. Identify which behaviors are genuinely medically necessary versus anxiety-driven.

- Always carrying extra medication solely for reassurance

- Repeatedly checking heart rate or oxygen saturation
- Calling someone every time sensations begin
- Only going places with a “safe person”
- Sitting next to exits
- Leaving as soon as anxiety rises
- Avoiding exercise because a fast heartbeat feels dangerous
- Constantly scanning the body for signs of panic

Plan gradual reduction when clinically appropriate. Example: sit one table farther from the exit; delay reassurance seeking by 10 minutes; complete an exposure without pulse checking.

Step 8 - Maintenance and relapse prevention

End treatment by strengthening self-efficacy rather than promising that panic will never return.

- List the client’s original feared predictions and the new evidence learned.
- Continue planned interoceptive and situational exposure for several weeks.
- Identify residual avoidance or subtle safety behaviors.
- Create a response to recurrence: notice → label the false alarm → allow sensations → remain/approach → review what was learned.
- Schedule booster sessions when appropriate.
- If progress is limited, revisit diagnosis, adherence, medical issues, substance use, comorbidity, exposure quality, and hidden safety behaviors.

Suggested 8-session clinician protocol

Session	Primary focus	In-session work	Between-session practice
1	Assessment + formulation	Assess panic, avoidance, safety, medical/differential issues; explain panic cycle.	Panic monitoring record.
2	Catastrophic beliefs	Identify feared meanings of sensations; create testable predictions.	Thought/prediction records.
3	Interoceptive exposure I	Select 2-3 sensation exercises; prediction vs outcome review.	Daily planned interoceptive practice if appropriate.
4	Interoceptive exposure II	Increase variation/intensity; reduce reassurance and safety behaviors.	Repeat exercises in multiple contexts.
5	In-vivo exposure I	Build hierarchy; complete first real-world exposure.	Repeat 3-5 times during week.
6	In-vivo exposure II	More difficult/variable exposures; combine body sensations + situation.	Continue approach practice; reduce safety behaviors.
7	Generalization	Target remaining avoidance, exercise, travel, being alone, crowds, etc.	Independent exposure plan.
8	Relapse prevention	Review learning, residual symptoms, future response plan.	30-day maintenance plan; booster if needed.

CLIENT HANDOUT - What to do when panic starts

1. Name it

“This is a panic alarm. It feels intense, but I have experienced this before and it passes.”

2. Stop fighting the sensations

Notice the heartbeat, dizziness, heat, shaking, or breathlessness. Try to let the sensations be present rather than urgently checking, escaping, or forcing them away.

3. Stay or approach when safe

If the situation itself is safe, remain there instead of immediately escaping. If you are driving or doing something hazardous, follow normal safety procedures first.

4. Test the scary prediction

Ask: “What am I predicting right now?” Then observe what actually happens. Example: “I predict I will faint.” Did I faint? What did I learn?

5. Let the wave rise and fall

Panic sensations can peak and then decrease. Your task is not to make the wave disappear instantly; your task is to learn that you can experience it without catastrophe.

6. Do not reward the alarm

When possible, avoid repeated checking, reassurance seeking, or abandoning the situation solely because anxiety appeared. These behaviors can strengthen the fear cycle.

7. Afterward, write down the learning

Situation: ____ Sensations: ____ Prediction: ____ What actually happened: ____ What I learned: ____

Weekly exposure worksheet

Date	Exposure	Prediction	Fear before	What happened	Learning

When to consider additional or higher-level care

- Symptoms remain severe or disabling despite an adequate CBT/exposure trial.
- The client cannot participate because of severe depression, substance use, unstable medical illness, psychosis, mania, or acute safety concerns.
- There is significant diagnostic uncertainty or frequent emergency presentations.
- Medication evaluation may be appropriate; refer to a qualified prescriber. NICE and other major sources recognize antidepressant medication as an evidence-based option for panic disorder.
- Consider specialty anxiety treatment or more intensive CBT when avoidance/agoraphobia is extensive or progress stalls.

Evidence base and free resources

Centre for Clinical Interventions (Government of Western Australia). When Panic Attacks - Panic Disorder Self-Help Resources. Free sequential CBT workbook, worksheets, and information sheets.
https://www.cci.health.wa.gov.au/resources/looking-after-yourself/panic

NICE. Generalised anxiety disorder and panic disorder in adults: management (CG113). Guideline supporting CBT and stepped-care/self-help approaches for panic disorder.
https://www.nice.org.uk/guidance/cg113

American Psychological Association. Short, intensive cognitive behavioral therapy can ease panic disorder (2025). Overview of contemporary panic-focused CBT and exposure-based treatment.
https://www.apa.org/monitor/2025/11-12/panic-disorder-treatment-progress

American Psychological Association. What Is Exposure Therapy? Patient-friendly description of exposure, including interoceptive exposure for panic.
https://www.apa.org/ptsd-guideline/patients-and-families/exposure-therapy

NHS. Panic disorder. Public-facing overview of symptoms, CBT, medication, and self-help.
https://www.nhs.uk/mental-health/conditions/panic-disorder/

Use of this guide

This document is educational and is not a substitute for individualized diagnosis, medical evaluation, psychotherapy training, supervision, emergency care, or prescribing guidance. Interoceptive exercises must be screened and adapted for medical conditions and client-specific risks.