



INTRODUCTION TO PANIC ATTACKS

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HISTORY OF THE CONCEPT OF PANIC ATTACK

These outcomes were astounding in light of predominating hypothesis: chlorpromazine helped normal schizophrenics whose insane indications apparently came about because of great uneasiness, yet it neglected to help an atypical gathering of schizophrenics who were exceptionally restless, yet who were not maniacal. As proof for the energizer impacts gathered, Klein and his partners attempted to treat a gathering of profoundly restless inpatients who had been diagnosed as "schizophrenic" however who displayed not hallucinations or fantasies. Sadly, imipramine did not constrict fancies or mind flights, yet it did assuage depressive manifestations in schizophrenic patients, and its temperament enhancing impacts were remarkably sensational in patients experiencing serious gloom. Klein was concentrating on imipramine, another medication orchestrated by a minor adjustment in the substance structure of the "real sedative" chlorpromazine. Notwithstanding, in the wake of taking imipramine for a few weeks, the patients kept up that the medication was incapable on the grounds that it neglected to weaken their ceaseless nervousness. Scientists trusted that imipramine, in the same way as chlorpromazine, would help individuals with schizophrenia, whose insane side effects were around then accepted to result from unnecessary tension. Klein's choice to endorse imipramine for these atypical schizophrenics was conceived of dissatisfaction. Before taking imipramine, these patients had been racing to the nursing station a few times each day, frightened, and shouting that they were passing on. Not just had they neglected to react to tranquilizers and to psychotherapy, their uneasiness was not diminished by chlorpromazine. In spite of their cases of absence of change, patients were no more encountering these frightening scenes of all of a sudden feeling on the verge of death.

Klein's involvement with imipramine not just spurred his qualification in the middle of frenzy and nervousness, it additionally drove him to infer that agoraphobia was mainly an outcome of fits of anxiety. In this way, contemplated Klein, generally as bacterial pneumonia does not lie on a continuum of seriousness with the basic icy, frenzy is not just a serious type of customary nervousness. Bacterial pneumonia and the basic chilly are respiratory issue that impart numerous side effects, and in spite of the fact that the previous may be mixed up for a serious type of the recent, anti-toxins are powerful against bacterial pneumonia yet are futile against the normal cool. In light of these perceptions, Klein gathered that imipramine was successful against intense fits of anxiety, yet not against interminable uneasiness. Klein contemplated that the impacts of imipramine would have neither rhyme nor reason if frenzy were

simply a compelling manifestation of nervousness. The "schizophrenic" patients who initially reacted to imipramine would now be diagnosed as having "frenzy issue with agoraphobia" on the grounds that they frightfully dodged numerous exercises notwithstanding having fits of anxiety. For instance, individuals with agoraphobia regularly frenzy while in packed stores, yet gathered stores don't inexorably trigger alarm with the same consistency that snakes trigger freeze in individuals with snake fear. Boost bound frenzies allude to the sudden surge of serious dread experienced by individuals with particular fears (e. of creatures, of statures) when they experience, or suspect experiencing, their dreaded article. These scenes are like spontaneous assaults aside from that the panicker is mindful of the outer precipitant and is more averse to confound the assaults as an indication of approaching craziness. Spontaneous fits of anxiety are sudden, startling surges of dread joined by extreme (particularly cardiorespiratory) manifestations. Spontaneous" does not suggest "uncaused"; it suggests just the nonattendance of outer triggers, not the unlucky deficiency of neurobiological dysregulation. Spontaneous frenzies are much the same as different conditions in pharmaceutical that emit without obvious outside incitement, in the same way as paroxysmal tachycardia, headache, and vertigo (i. Spontaneous frenzies are frequently joined by calamitous considerations that one is going to kick the bucket, "go insane," or lose restraint.

One sort was described by rehashed spontaneous fits of anxiety (frenzy issue), and the other was portrayed by constant elevated amounts of uneasiness that did not emit into fits of anxiety (summed up tension issue. This imperative change recognized the agreement view among American psychopathologists that albeit some individuals with frenzy issue don't broadly stay away from circumstances and exercises, when individuals do create agoraphobia, their evasion quite often grows as a result of frenzy issue. In the reexamined form of DSM-III (DSM-III-R), which showed up in 1987, frenzy issue was coded as either frenzy issue without agoraphobia or frenzy issue with agoraphobia. social fear, significant depressive issue), DSM-IV characterizes fits of anxiety independently from frenzy issue. Since examination has shown that spontaneous fits of anxiety periodically happen in individuals with different issue (e. That is, repetitive spontaneous frenzies are inadequate for the analysis of frenzy issue: the individual must likewise adjust his or her life to suit the assaults, add to a constant trepidation of the assaults, or both.

At long last, situationally inclined fits of anxiety are activated by experiences with dreaded situational jolts, however are not perpetually activated by such experiences. Situationally bound (signaled) fits of anxiety are activated by an experience with a dreaded (phobic) boost or in foresight of such an experience. For instance, an individual with a trepidation of driving autos will have a tendency to experience fits of anxiety more frequently while driving than while doing different things, yet driving does not constantly cause alarms. DSM-IV recognizes three sorts of fit of anxiety that are more or less identical to Klein's spontaneous, boost bound, and situationally inclined frenzies. To qualify as a fit of anxiety, a scene of sudden-onset dread must be joined by no less than four of the accompanying indications: (1) palpitations, beating heart, or quickened heart rate; (2) sweating; (3) trembling or shaking; (4) vibes of shortness of breath or covering; (5) inclination of gagging; (6) midsection agony or uneasiness; (7) sickness or stomach trouble; (8) inclination tipsy, temperamental, bleary eyed, or weak; (9) derealization (emotions of illusion) or depersonalization (being disconnected from oneself); (10)fear of losing control or going insane; (11) alarm of kicking the bucket.

ASSESSING PANIC ATTACKS

Examination recommends that atypically extreme, and along these lines noteworthy, assaults are regularly depicted as "common," and patients frequently overestimate the recurrence and seriousness of their assaults when gotten some information about them days or weeks after the fact. Most research on spontaneous fits of anxiety has been in light of the patients' review report toward oneself. Surely, most research facility examine on frenzy includes assaults incited by natural difficulties (see underneath. To bypass this issue, clinical analysts now have patients prospectively screen toward oneself their assaults and record them in organized journals intended for this reason soon after the assault happens. All things considered, around 20 unforeseen assaults have been recorded while patients were experiencing different appraisals while wired for psychophysiology evaluations. These recorded scenes have shown that frenzies do, in reality, start sharply, as patients say, and are checked by expansions in heart rate, skin conductance (i. Patients are frequently asked to review their latest, most extreme, or most run of the mill assault, and afterward show the vicinity and seriousness of the DSM side effects on some scale. Since excellent fits of anxiety happen unusually, they have seldom been caught in the psychophysiology research center.

PANIC ATTACK VARIANTS

Examinations between commonplace panickers and nonfearful panickers on variables, for example, time of onset, normal number of side effects every assault, span of turmoil, depressive, agoraphobic indications, et cetera demonstrate that the two gatherings are about undefined aside from the way that average panickers experience fear amid their assaults, while nonfearful panickers don't. Amid the mid-1980s, analysts noted that around 33% of the youthful grown-up (nonclinical)population reported having encountered a "fit of anxiety" amid the earlier year. Nonfearful frenzy demonstrates that sudden hurries of autonomic manifestations are not equal to fits of anxiety, in this manner raising the likelihood that an individual's translation of the indications as debilitating may incompletely figure out if they encounter the scene as startling. Analysts have depicted the apparently oxymoronic state of nonfearful fits of anxiety among cardiology patients looking for help for unexplained midsection torment. These people grumble of sudden surges of substantial indications indistinguishable to those of fits of anxiety, however don't encounter dreadful musings about up and coming passing et cetera.

It is exceptionally surprising for an individual with frenzy issue to have just nighttime alarms, yet the individuals who experience nighttime frenzies have a tendency to experience more daytime frenzies also. Since nighttime assaults develop amid non-REM (fast eye-development) rest, they are infrequently gone before by dreams (which happen amid REM rest. Around 5% of school understudies report having had a nighttime alarm eventually in their lives, and around 69% of frenzy issue patients have had no less than one nighttime alarm. One plausibility is that physiological abnormalities waken the individual who then frenzies in light of confounding indications like shortness of breath, dashing heart, et cetera. An alternate probability is that the psychobiological substrate of the feeling of dread does, undoubtedly, start while the individual is resting, reliable with patients' reports that they arose effectively amidst trepidation. Nighttime (or slumber) frenzies are described by unexpected arousing, dread, and extreme physiological arousal. Besides, night fear start with a blood-turning sour shout, yet the individual who encounters a night dread seldom recollects the scene, and effortlessly comes back

to rest. Interestingly, nighttime panickers clearly recollect their assaults, and frequently encounter trouble coming back to rest. There are likenesses and contrasts between nighttime frenzies and night fear (otherwise called payor nocturnus in youngsters and incubus in grown-ups).

THE DEVELOPMENT OF PANIC DISORDER AND AGORAPHOBIA

Avoiders and nonavoiders don't contrast in their time of onset or term of frenzy issue, and there are few contrasts in the seriousness of the assaults themselves: agoraphobic panickers don't appear to have more awful assaults than nonagoraphobic panickers. A few panickers get to be agoraphobic inside days of their first assault; others get to be progressively agoraphobic over weeks, months, and years; and still others never get to be agoraphobic. Indicators of agoraphobic shirking incorporate desires of panicking in specific circumstances, saw negative results of frenzy, apprehensions of kicking the bucket or going insane amid assaults, and absence of trust in one's capacity to adapt to frenzy. Specialists have concentrated on what variables foresee which panickers create agoraphobia by contrasting panickers and without agoraphobia. Intermittent fits of anxiety are not extraordinary in the overall public, yet in the event that people get to be steadily dreadful of them or change their lives in light of them, frenzy issue is diagnosed. Fits of anxiety typically begin in late pre-adulthood or in right on time adulthood; they infrequently start before adolescence or late in life. The larger part of individuals who create agoraphobia do as such as an outcome of their apprehension of fits of anxiety. They ordinarily develop amid times of life stretch, for example, after the passing of a friend or family member, in foresight of a significant life occasion (e. It is exceptionally strange for somebody to wind up agoraphobic without first having had fits of anxiety. Infrequently, clinicians experience individuals who seem to have agoraphobia without a background marked by frenzy.

EPIDEMIOLOGY

The ECA information demonstrated that the yearly commonness rate of DSM-HI frenzy issue (without agoraphobia) was 1. Frenzy issue was most normal among individuals matured 30 to 44 years, and minimum regular in individuals more established than 65 years of age. The ECA group reported yearly predominance rates for DSM-III agoraphobia of 5. Shockingly, be that as it may, the ECA group reported that just 7% of the subjects diagnosed with agoraphobia additionally had frenzy issue. Individuals with frenzy issue looked for the administrations of psychological well-being experts more than individuals with whatever other issue, including liquor abuse and schizophrenia. Meeting more than 18,000 American grown-ups, the Epidemiologic Catchment Area (ECA) group tried to focus the pervasiveness and rate of frenzy issue and other mental issue. Consequent reconsideration of the "agoraphobia without frenzy" cases emphatically proposed that the ECA group had accidentally characterized numerous instances of particular fears (e. This outcome was drastically at difference with the perceptions of clinicians who once in a while see agoraphobics without frenzy issue. of flying, driving, intersection spans) as occurrences of agoraphobia. 1% in ladies and 1.

The ECA group found that 20% of individuals with frenzy issue reported having endeavored suicide eventually in their lives. By the by, the vicinity of frenzy issue in an individual with, say, sadness gives no ensure that the individual won't endeavor suicide. This finding was astounding in light of the fact that frenzy patients regularly dread biting the dust

amidst their assaults, and most studies on patients with the issue show that they are not at high hazard for endeavoring suicide. The NCS group likewise found that those with short of what a secondary school instruction were more than 10 times as prone to have frenzy issue as the individuals who had moved on from school. Since salary level, dissimilar to instruction, was inconsequential to hazard for frenzy issue, the NCS group proposed that lower cognitive capacity may be connected to frenzy. The National Comorbidity Survey (NCS), an across the country DSM-III-R appraisal of mental issue, uncovered a lifetime pervasiveness rate for frenzy issue of 3. schizophrenia, liquor addiction, misery) may have been the premise for the evident association between frenzy issue and suicide endeavors.

BIOLOGICAL ASPECTS OF PANIC

Organic test tests produce extreme substantial sensations, and instigate fits of anxiety significantly more frequently in frenzy patients than in patients with different issue or in sound subjects. They are intended to push particular neurobiological frameworks, and if frenzy happens, then brokenness in the anxiety framework may constitute a helplessness to characteristically happening fits of anxiety. Anyhow exorbitant ventilation is a typical backup of fits of anxiety and can intensify the indications connected with frenzy. In this way, hyperventilation does not appear to cause fits of anxiety, yet it does appear to strengthen assaults that do happen. Then again, most consequent exploration demonstrates that frenzy patients are typically not endless hyperventilators. A motivation behind this examination is to distinguish strategies that will dependably start assaults in the research facility that firmly look like spontaneous fits of anxiety.

Predictable with this probability, oral (or imbued) yohimbine challenges, which fortify noradrenergic action, produce freeze in around 63% of frenzy patients and in around 7% of control subjects. Imbuement of sodium lactate events freeze in around 67% of frenzy patients, however in just around 13% of sound control subjects. Contention continues about whether the reaction of frenzy patients contrasts subjectively from that of control subjects. That is, the reactivity of frenzy patients is regularly not more prominent than that of control subjects (i. Case in point, alarm patients frequently are a bigger number of on edge and more physiologically excited than control subjects before the imbuement starts. A few psychopathologists accept that dysregulation in the noradrenergic framework is included in the genesis of fits of anxiety. In any case, fits of anxiety happening in light of organic difficulties have been deciphered in two central ways. Fits of anxiety are portrayed by indications demonstrative of huge autonomic arousal connected with norepinephrine surges, accordingly suggesting a precariousness in the noradrenergic framework. One understanding holds that difficulties specifically induce freeze by intensifying a neurobiological brokenness. This theory stems somewhat from the phenomenology of frenzy itself.

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PSYCHOLOGICAL ASPECTS OF PANIC

An alternate perspective holds that fits of anxiety happen in light of the fact that people cataclysmically misjudge certain favorable real sensations as harbingers of inevitable mental or physical catastrophe. For frenzy qua frenzy to happen, the individual must respond to these substantial sensations with dread. As per mental scholars, frenzy issue is in huge part a "dread of trepidation" itself. Introductory fits of anxiety create certain substantial sensations (e. Reacting to one's own particular substantial sensations as though they were phobic boosts, panickers exacerbate these indications, and consequently enhance their dread. Mental scholars hold that physiological indications are deficient to deliver the experience of frenzy. As indicated by this perspective, disastrous misinterpretations of real sensations are vital for a fit of anxiety to happen. Along these lines, an individual may misjudge palpitations as a looming heart assault, get to be more on edge, and subsequently strengthening these sensations until they finish into a fit of anxiety. One perspective holds that Pavlovian interoceptive molding figures being developed of frenzy issue. Also, just those individuals who fear these indications will meet all requirements for frenzy issue.

Characteristic nervousness alludes to an inclination to respond frightfully to an extensive variety of potential stressors, while uneasiness affectability alludes to the particular propensity to respond dreadfully to substantial sensations connected with tension. Verifiable in the alarm of-dread understandings of frenzy is the idea that individuals inclined to experience fits of anxiety methodology arousal-related data uniquely in contrast to do individuals who are not inclined to experience fits of anxiety. Tension affectability is an individual contrast variable that may constitute a cognitive danger element for frenzy issue. Individuals who hold mixed up convictions about quick heartbeats, wooziness, et cetera are apparently more probable than other individuals to respond dreadfully when these sensations happen. Essentially, individuals with lifted scores on the Anxiety Sensitivity Index (ASI)~a survey measure of this variable~respond much the same as frenzy patients to natural difficulties (e. That is, individuals with frenzy issue appear described by cognitive inclinations supporting the elucidation of risk. These studies suggest that a frightful reaction to test is a marker for the dread of manifestations as opposed to a marker for frenzy issue as such. carbon dioxide inward breath) regardless of the possibility that they have no history of fits of anxiety or frenzy issue. Longitudinal exploration shows that individuals with hoisted ASI scores are at improved danger for creating frenzy and other uneasiness issue. A third approach underscores that not everybody is just as liable to react dreadfully to their own real sensations.

At long last, different studies have demonstrated that frenzy patients show better memory for words related than nervousness and danger. In one investigation, alarm patients displayed deferred color naming for words identified with dread (e. Defers in color naming happen when the significance of the statement catches the subject's consideration in spite of the subject's push

to go to the shade of the saying. Alarm patients are likewise portrayed by attentional predispositions favoring danger, as revealed by their reactions on "enthusiastic Stroop" undertakings. This memory inclination for risk seems improved when patients are in a condition of physiological arousal. Taken together, these outcomes recommend that danger related material may have special access to cognizant mentation in these patients. In these assignments, subjects are indicated expressions of positive, unbiased, and negative enthusiastic criticalness, and are asked to name the shades in which the words show up (on a PC screen) while disregarding the implications of the words. These studies propose that frenzy issue is described by inclinations for specifically going to risk prompts.

PSYCHOPHARMACOLOGIC TREATMENTS FOR PANIC

The impacts of imipramine are potentiated by joining it with presentation in vivo, a conduct treatment technique. Patients require not be discouraged for this medication to conflict with frenzy. As noted prior, the tricyclic energizer, imipramine, was the first compound indicated compelling against fits of anxiety. Albeit controlled research on the treatment of frenzy issue with SSRIs has just as of late started, the accord among psychopharmacologists is that SSRIs are the medication treatment of decision for frenzy issue. To be sure, the study reporting the most great confirmation for the pharmacologic treatment of frenzy issue tried the SSRI fluvoxamine. In addition, end of these mixes regularly brings about the reappearance of fits of anxiety, and now and again these bounce back frenzies are more extreme than the assaults that had been happening before the patient started taking alprazolam. High-intensity benzodiazepines, for example, alprazolam, have been utilized to treat frenzy issue. Some confirmation recommends that frenzy patients with agoraphobia who experience generally successful in vivo presentation medicines do more regrettable at subsequent on the off chance that they had been taking alprazolam than if they had been taking placebo. Their reactions are less unpleasant, and these prescriptions start to apply their antipanic impacts inside days of beginning treatment rather than imipramine, which regularly takes weeks before profits start to show up. Initially grew as antidepressants, SSRIs, for example, fluoxetine, have been as of late utilized as antipanic operators. The specific serotonin reuptake inhibitors (SSRIs) have been generally recommended for some psychiatric conditions as of late. Lamentably, a significant minority of frenzy patients neglect to endure the reactions of imipramine, which incorporate expanded heart rate and unsteadiness. Disservices of these mixes incorporate their ability to instigate pharmacologic and mental reliance; alarm patients frequently think that it hard to stop taking alprazolam.

PSYCHOLOGICAL TREATMENTS FOR PANIC

Patients are taught to inhale by utilizing their belly as opposed to simply their upper midsection, and are taught to inhale at an agreeable pace as opposed to wheezing for air and compounding the situation. Early sessions generally are intended to decrease the persistent's nervousness affectability by giving the patient essential data about fits of anxiety that balances the understanding's catastrophizing propensities. They are taught to inhale through the nose, not the mouth, as an extra method for balancing hyperventilation. Patients are taught a strategy called connected unwinding as an alternate method for overseeing indications. These incorporate respiratory control techniques for balancing patients' inclinations to hyperventilate amid fits of anxiety (and consequently exacerbating them. For instance, one methodology accentuates that

fits of anxiety reflect a versatile, developed battle or-flight reaction that flames at wrong times. This strategy first includes showing them how to strained and unwind distinctive muscle bunches in the center and to recognize indications of strain. A few clinicians next train patients to utilize indication (or frenzy) administration systems.

Pretty much as the alarm of-dread speculation propelled the improvement of interoceptive presentation, so has the disastrous distortion theory enlivened cognitive methods for discrediting persistent's convictions about the destructiveness of real sensations. Interoceptive presentation alludes to graduated, organized prompting of dreaded substantial sensations done in a manner to lessen the persistent's dread of the sensations. Motivated by the idea that fits of anxiety are much the same as molded reactions to the phobic jolts of one's own substantial sensations, clinicians structure interoceptive presentation works out. On the off chance that, for instance, a patient theorizes that unsteadiness drives one to fall, the advisor may have the patient hyperventilate while sitting and afterward have the patient remain up rapidly. These convictions are dealt with as exploratory speculations, and specialists work with patients to assess the proof for and against their calamitous theories and noncatastrophic option understandings of real sensations. The fundamental thought behind these trials is that patients regularly take part in unobtrusive evasion conduct amidst fits of anxiety that keeps their disastrous convictions from being tried and negated. The disappointment of the patient to crumple disconfirms the disastrous theory while affirming the noncatastrophic option that serious dizziness may create instability

Regardless of the fact that a patient leaves the dreaded circumstance, no enduring worsening of alarm appears to happen if the patient reenters the circumstances soon subsequently. Most early mental research on the treatment of frenzy issue and agoraphobia focused on the decrease of alarm and evasion through introduction treatments. Despite the fact that it was once accepted that leaving a dreaded circumstance amidst a frenzy would naturally exacerbate the quiet's trepidation and shirking, ensuing exploration has shown that this is not so much genuine. genuine living) introduction practices whereby they work on entering already dodged circumstances and participating in beforehand kept away from exercises. It is not crucial that the specialist go with the patient on these raids, yet for very avoidant patients, it is frequently useful. Albeit in vivo presentation does not specifically target alarm, disastrous misinterpretations, et cetera, it has been demonstrated to lessen (yet not generally to dispose of) fits of anxiety. Accordingly, patients are urged to embrace in vivo (i. The boss objective is to guarantee that patients consistently work on participating in dreaded exercises.

In reality, the rates of patients who are frenzy free at posttreatment are equivalent and regularly higher than the rates of frenzy free patients who get prescription. Also, rates of backslide are lower after cognitive-conduct treatment than after medication treatment, most likely in light of the fact that patients have adapted not to respond frightfully to substantial sensations and have consequently figured out how not to let apprehension winding into frenzy. In addition, cost-viability examinations have affirmed that cognitive-behavioral treatment for frenzy is not just in any event as viable in the fleeting as medication treatment, it is less costly in the long haul, and it doesn't create symptoms or pharmacologic reliance. This methodology kills fits of anxiety in roughly 80% to 90% of patients, and most hold their additions at subsequent meet-ups of 1 to 2 years posttreatment.

CONCLUSIONS

Most information show that surges of sensations don't create the enthusiastic sensation of frenzy unless the individual responds to them as undermining jolts. Taken together, the information recommend that frenzy issue involves anomalies in both science and insight. More probable, a few diverse organic anomalies deliver the vibes that patients dread. noradrenergic overreactivity, carbon dioxide touchiness), it is unrealistic that one physiologic reason is the wellspring of sensations in all patients. Albeit most specialists concur that fits of anxiety constitute enthusiastic phenomena different from uneasiness, there is no agreement about their reason.

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