

How to **treat**

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PANIC DISORDER

Introduction

PANIC attacks visit with a shocking suddenness, alarming severity and terrifying portent. Of all the anxiety disorders, individuals with panic disorder are most likely to seek medical and psychological help.

Of most concern is the possibility of serious physical illness. There are common and important comorbidities that need to be excluded.

The next most urgent need is for information on how to treat panic

attacks. For both patient and GP, understanding what causes panic attacks to persist is one of the most important factors in understanding how to treat them. From this understanding can come the motivation

and the courage to confront panic disorder and regain function.

Effective treatments are available but assertive follow-up is required to achieve a good functional and symptomatic outcome.

inside

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The author



DR LISA A LAMPE, senior lecturer, discipline of psychological medicine, University of Sydney; consultant psychiatrist, CADE clinic, Royal North Shore Hospital, St Leonards; and senior staff specialist (academic), Hornsby Kuring-gai Health Service, Hornsby, NSW.

What is panic disorder?

THE primary experience in panic disorder is the panic attack. A panic attack is defined in the *DSM-IV* as:

A discrete period in which there is the sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. During these attacks, symptoms such as shortness of breath, palpitations, chest pain or discomfort, choking or smothering sensations, and fear of 'going crazy' or losing control are present.

A persistent concern about panic attacks, whether they occur or not, is what defines panic disorder. When a person also avoids a range of situations for fear of panic attacks, the diagnosis becomes panic disorder with agoraphobia.

Differential diagnosis

Panic attacks may occur in any anxiety disorder if fear and anxiety levels are high enough. Hence recurrent panic attacks of themselves are not enough to make the diagnosis. The attributions around the attacks must be elicited.

In panic disorder the key cognitions concern fears that the physical symptoms experienced during the panic attack reflect a serious underlying physical (or mental) pathology. These beliefs are what drive the person's fears that panic attacks may lead to serious illness or death, or cause them to lose control or go insane.

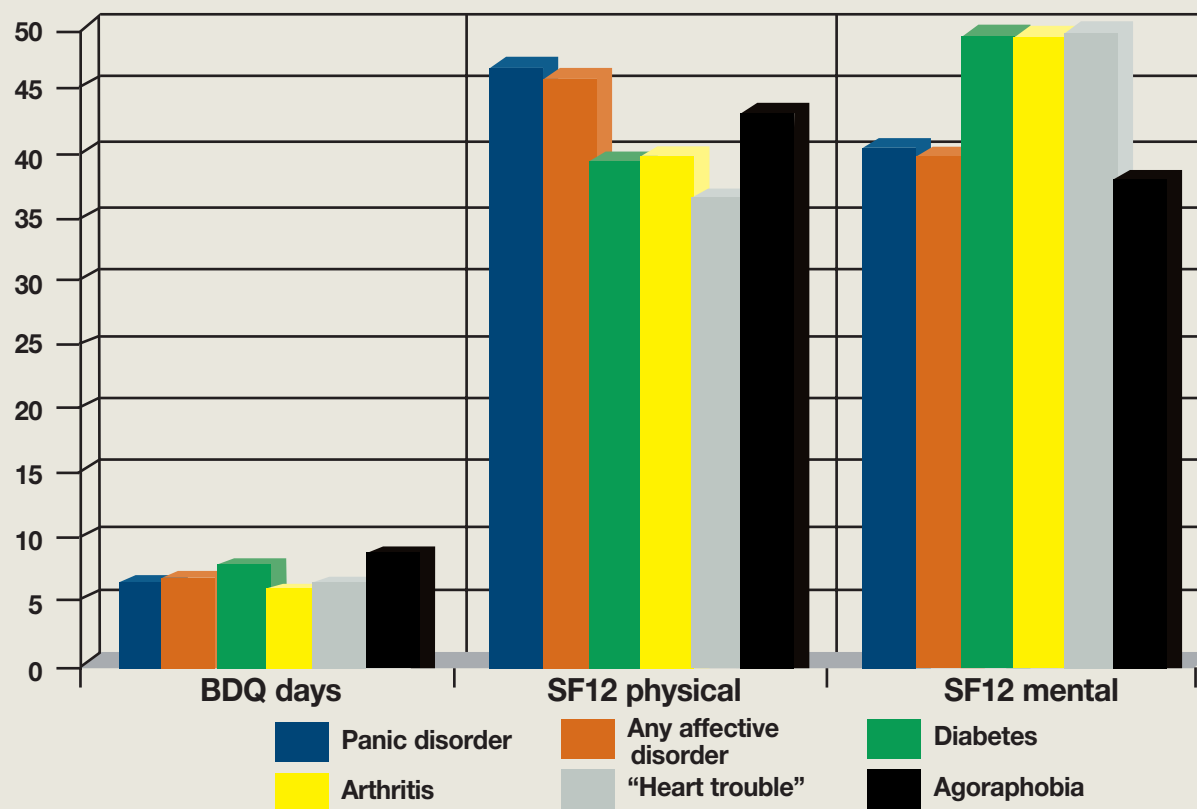
In this way panic disorder is differentiated from a social anxiety disorder, in which the principal fears associated with any panic attacks are that they are embarrassing or will result in negative evaluation from others. In obsessive compulsive disorder (OCD), panic attacks may result from high levels of anxiety after confronting a feared situation (eg, germs, being unable to return to check something). In generalised anxiety disorder (GAD) a panic attack may arise from a bout of intense worry. The panic attacks themselves are rarely anxiety provoking in OCD or GAD.

Epidemiology

Panic attacks are common. In the US National Comorbidity Survey Replication (NCS-R) study, 28.3% of respondents reported ever having had a panic attack.¹ These data also indicate that only a relatively small proportion of people go on to develop panic disorder or agoraphobia (12-month prevalence estimates were 11.2% for panic attacks, 2.8% for panic disorder, and 0.8% for agoraphobia [with panic attacks or panic disorder]). Available Australian data are comparable.

Women are affected 2-3 times as commonly as men. Some data also suggest the

Figure 1: Comparative burden of disease. Adapted from Andrews G et al. *British Journal of Psychiatry* 1998; 173:123-131.



BDQ days = number of days in the last month where the person had to cut down on their usual activities because of the condition in question, based on the "Brief Disability Questionnaire" – higher scores represent more impairment. SF12 is the score on the Medical Outcomes Study Short-Form 12 scale – higher scores represent less impairment on this scale.

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7% of general practice attendees might meet criteria for panic disorder at any given time.

Course and age at onset

Panic disorder develops typically in the late teens and 20s, with a spread between about 15 and 35-40 years. The median age at onset is younger than that for affective disorders and, according to NCS-R data, 75% of those with panic disorder or agoraphobia have developed the illness by age 40.

Studies have shown that perhaps half of those with panic disorder experience an extended period of panic attacks and heightened anxiety before the onset of panic disorder, while half experience a relatively abrupt onset. Many individuals will be able to recall their first panic attack, and, anecdotally, many occur in the context of minor medical illness (eg, a cold or flu), drug use or a hangover, or when travelling away from home.

Once established, agoraphobia is unlikely to remit spontaneously, although panic disorder without agoraphobia has a better outcome. The Harvard/Brown Anxiety Disorders Research Program followed patients with a range of anxiety disorders for 12 years after their index episode. Overall, patients with anxiety were much less likely than those with depression to experience a period of recovery (defined as even a single period of eight consecutive weeks with minimal symptoms) over the 12 years.

The odds of a period of recovery for patients diagnosed with agoraphobia were only 0.48; those with

panic alone had a 0.82 probability of at least one period of recovery (compared with an estimate of 0.73 for major depression). Patients with agoraphobia averaged 78% of the 12-year period symptomatic from their illness.

Aetiology

Risk factors for panic disorder have a strong biological basis. Heritable factors appear to account for about 40% of the variance, and environmental factors outside the family for about 50%. Current biological theories concern abnormalities of neural systems for assessing and responding to threat and anxiety, including hypersensitivity or poor regulation of anxiety responses. As yet this is not easily measurable.

More identifiable risk factors include a high neuroticism factor, also known as negative affectivity, which can be understood as a general sensitivity and reactivity, and is a risk factor shared with depression and other anxiety disorders. A family history of panic disorder is also a risk factor.

A trait-like cognitive factor termed 'anxiety sensitivity', while probably not specific for panic disorder, has nevertheless been shown to be a risk factor for panic attacks and the persistence of panic disorder. Anxiety sensitivity is the 'fear of fear'. Individuals with high anxiety sensitivity fear being in a state of arousal, and attribute threat to associated somatic symptoms of arousal. They are particularly likely to notice somatic sensations and to respond to them anxiously. Anxiety sensitivity is also associated with increased alcohol use in patients with panic disorder.

Comorbidity

Panic disorder is a highly comorbid condition. Other anxiety disorders are common, with major depression and substance abuse (especially of alcohol) representing other significant comorbidities. Panic disorder has been observed as a common comorbid condition in individuals with bipolar affective disorder, type I, with a lifetime prevalence of panic disorder in this group of about 20%.

An association with cigarette smoking that is not seen in other anxiety disorders has been observed, with the proportion of people with panic disorder who smoke being about twice the community rate. There appears to be some bidirectionality of causation. Smokers who believe that cigarettes help manage their moods appear more likely to fear the cognitive and physical aspects of panic attacks and may have more hypervigilance around physical sensations. They are also likely to be more anxious about smoking cessation.

Suicide

Epidemiological and clinical studies have reported an association between panic attacks and panic disorder, and suicidal ideation and attempts. It now appears that the increased risk of suicidal behaviour is associated with comorbidities, especially major depression. Therefore, as part of the risk assessment in panic disorder, depression should be screened for and assertively treated.

'Out of the blue' or predictable?

Although the *DSM-IV* specifies "recurrent unexpected

panic attacks" for a diagnosis of panic disorder, there is widespread agreement that, with the exception of the initial panic attack, this is not the most frequent experience of panic disorder. After panic disorder has become established it is unusual not to be able to identify cues, although individuals themselves may be unaware of these cues until they are assisted to gain more insight into their own illness, and specifically, into their cognitions around their experience of panic symptoms.

Cues may be subtle, such as a missed heartbeat, a change in temperature or being under time pressure, and so the individual may not be consciously aware of them.

Nocturnal panic attacks

Nocturnal panic attacks are common, with estimates that they are experienced by 30-70% of people with panic disorder. The weight of evidence suggests that nocturnal panic attacks do not represent a distinct or more severe variant of panic disorder. Current thinking is that the anxiety sensitivity and increased arousal that underlie panic disorder also contribute to nocturnal panic attacks.

In the same way that a person can be woken by a variety of internal and external stimuli (eg, a noise in the house, overheating, needing to void), sensations associated with panic may also occur and cause a fearful waking (eg, respiratory irregularities, missed heartbeats, temperature changes). Because of the association of fear with such physical sensations, the individual will wake in fright. Nocturnal panic attacks respond to treatments undertaken in the waking state.

Does panic disorder progress to agoraphobia?

It has long been the view that the panic spectrum begins with a panic attack and may progress to panic disorder and then to agoraphobia. However, several lines of evidence now suggest that this is unlikely to be correct.

Epidemiological studies have always identified a small proportion of people with agoraphobia without panic disorder. It was usually assumed that these individuals must have such a high level of avoidance that they no longer feared or experienced panic attacks and hence did not meet criteria for panic disorder. However, recent studies have examined the incidence of panic disorder and agoraphobia, using either follow-up or prospective methods, and found that either disorder may precede the other, and present as a risk factor for the other.

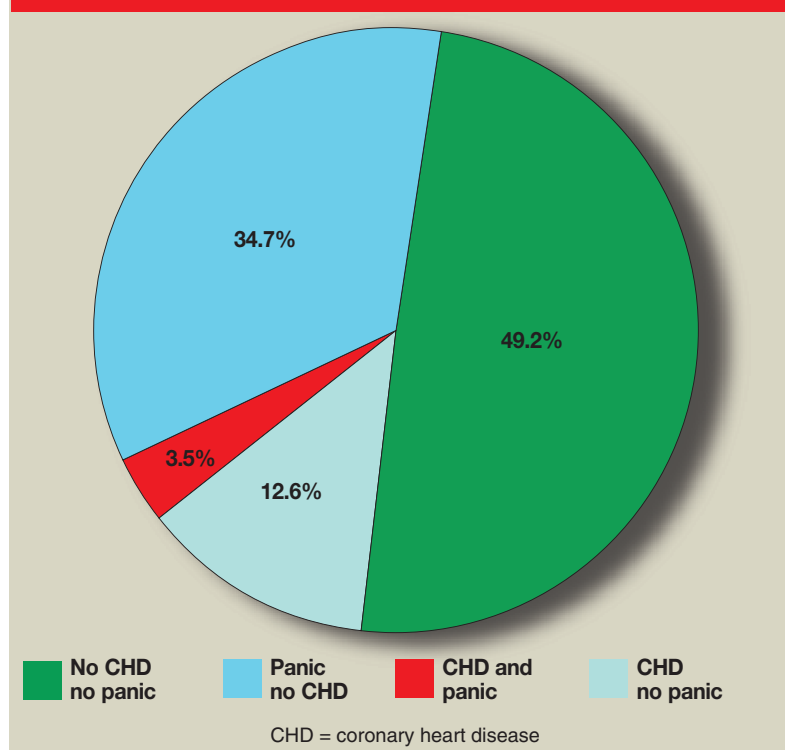
Association of panic disorder with physical illness

ANXIETY disorders, particularly panic/agoraphobia and post-traumatic stress disorder are strongly associated with physical illness. People with panic disorder share with those with other anxiety disorders a greater likelihood of chronic pain, musculoskeletal conditions and respiratory illness.

It has been postulated that panic disorder may actually develop secondary to these conditions through the vulnerability factor of anxiety sensitivity. Panic/agoraphobia shows a uniquely strong association with vascular disease. People with panic disorder are not only more likely to fear they have cardiovascular disease, but are also more likely to actually experience it.

Each year many people present to emergency departments and cardiologists because of chest pain. It has been estimated that up to 60% of this group might actually have panic disorder, and that for the great majority of those who would meet the criteria for panic disorder, there is in fact no cardiac disease identifiable, their chest pain being attributable to panic disorder or a non-cardiac physical problem. However, a small proportion of people who present with chest pain are found to have panic disorder and coronary heart disease (CHD). One recent study which examined the overlap between chest pain, CHD and panic disorder found that most people who presented with chest pain did not meet the criteria for either CHD or panic disorder; the next most common diagnosis was of panic disorder without CHD; a smaller number had CHD but not

Figure 2: Diagnoses for 200 consecutive cardiology clinic attenders for investigation of chest pain.³



panic disorder, and a very small proportion had both panic disorder and CHD (figure 2).

Studies indicate that there is a higher proportion of younger patients and female patients amongst those who present with chest pain who are found to have panic disorder and that this group is more likely to report the persistence of chest pain or tachycardia over time irrespective of a diagnosis of CHD. A poorer outcome of panic disorder has

been identified in association with such ongoing somatic concerns, together with avoidance related to fears around panic. Chronic panic disorder may thus be associated with persistent physical complaints and disability. Soberingly, one study found that only 10% of patients with persistent panic disorder at 12-month follow-up had had effective anti-panic medication and none had been referred for cognitive behaviour therapy (CBT).³

The take-home messages are that panic disorder is a likely diagnosis in individuals who present with chest pain, perhaps especially if they are young or female, that it can become chronic if not treated, but that there is a minority (male and female) who will have both CHD and panic disorder requiring treatment.

Does panic disorder lead to heart disease? Large prospective studies have shown an increased risk of sudden cardiac death in both men and women with phobic anxiety. Several large to very large prospective studies have now shown that panic attacks are an independent risk factor for CHD, after controlling for confounders such as diabetes, smoking and obesity.

People with panic disorder were more likely to be female, overweight, smokers, to have a history of depression and to have existing cardiovascular disease. Increases of 2-4 times in the risk of CHD were evident for the panic disorder group after controlling for other risk factors. The increased risk applies to both men and women. This risk may be increased further when there is an additional history of depression.

The take-home messages are that it is important to ensure effective treatment of panic disorder and that, at the very least, panic attacks might be considered as a marker of increased risk for cardiovascular disease and lead to closer monitoring of cardiovascular status, including other risk factors.

Investigation

BECAUSE of the demonstrated association with cardiovascular and other illness, a thorough physical assessment, including physical examination and indicated investigations, is warranted in patients presenting for the first time. After significant physical illness has been excluded, both doctor and patient can be less concerned about this possibility. In practice, patients themselves are rarely completely reassured. Persistent somatic symptoms should be reassessed at reasonable intervals so as not to miss an emerging problem.

In view of the emerging evidence about the risk of cardiovascular disease, it would seem prudent to investigate cardiac status and check for risk factors in patients presenting with panic attacks, particularly when these have become chronic.

In some cases the anxiety level of the patient and/or doctor may suggest that referral to a specialist for assessment could be helpful. If the specialist concurs with the GP's assessment that the problems do not appear to have a basis in medical illness, this strengthens the alternative hypothesis — that the patient's symptoms are indicative of anxiety rather than serious physical illness.

Assessment

MOST patients with panic disorder will seek medical help, and the most frequently consulted health professional is the GP. Most patients are likely to present with somatic concerns that they are highly anxious about.

The types of symptoms that are most worrying are those which, to the individual, most closely resemble the symptoms of serious medical conditions. Hence, chest pain, shortness of breath, trouble swallowing, dizziness and difficulty thinking clearly feature prominently. Panic disorder could be said to be 'the great mimic' of the 21st century.

The history of onset is useful to know. Many patients will remember their first panic attack; however, a clear precipitant is not

Steps in assessment

1. Consider the diagnosis of panic disorder ± agoraphobia
2. Assess the range of symptoms experienced in somatic, cognitive and behavioural domains
3. Exclude other anxiety disorder diagnoses as being responsible for the patient's chief complaint of panic attacks
4. Identify comorbid psychological conditions, especially depression and alcohol misuse
5. Baseline physical examination
6. Exclude medical causes of panic attacks; investigate and refer as appropriate

always evident. Given what is known about vulnerability factors, it is helpful to enquire about anxious temperament, symptoms of anxiety in childhood, anxiety sensitivity and any family history.

If a patient has none of these vulnerability factors and no past history of anxiety — particularly if they are

aged over about 35 at first presentation — an alternative cause of the panics should be suspected. This may be psychiatric (eg, depression) or organic (alcohol, drugs, thyroid dysfunction, medication side effect).

There are many rarer causes of symptoms resembling panic attacks, which may be suggested by other

somatic symptoms not typical of panic disorder (eg, sudden flushing and headache) (see Author's case study, right).

Symptoms

Somatic symptoms

Ask the patient about the symptoms that trouble them, enquiring about the range of symptoms known to occur during panic attacks.

Cognitive symptoms

Ask about the most feared symptoms and why they are so worrying. To establish the diagnosis of panic disorder it must be demonstrated that the patient fears the panic attacks themselves or the consequences of the attacks (eg, that they will have a heart attack or stroke, lose control and drive off the road or into

another vehicle, go insane).

Behavioural symptoms

Ask about any avoidance: "Is there anything you avoid doing because of your anxiety?" To tap into more subtle forms of avoidance (eg, the person can go to the supermarket but only if their spouse comes with them), I also like to ask: "Is there anything you are not able to do in the way that you would like to be able to do it?" If there is significant avoidance of situations, agoraphobia is added to the diagnosis.

Comorbidities

It is important to screen for common comorbidities, including depression, alcohol use disorders and other anxiety disorders, especially as these may impact adversely on outcome if untreated.

Author's case study

A 65-year-old woman was referred with a 20-year history of globus hystericus that began after her husband's death from oesophageal carcinoma.

She described a recent worsening of her problem, with acute exacerbations when she was anxious but probably an overall deterioration, resulting in her only being able to eat very slowly and causing anxiety and embarrassment.

The history indicated a sense of food sticking at a particular point, and she could only swallow small amounts and sometimes regurgitated.

Investigation confirmed oesophageal carcinoma.

Management

THE basis of management is that the doctor presents to the patient an alternative hypothesis to explain their symptoms (figure 3).

Clearly, for the patient there is a lot at stake — they believe they could be seriously damaged or even die if the cause of their symptoms is in fact a serious illness that is not identified and treated. Therefore we have to be able to present a good argument to counter this.

The approach I use most often is based on risk-management principles. I list the investigations and opinions the patient has had and the illnesses that are thereby excluded. I then suggest that all the most serious illnesses have been excluded and only very rare and unlikely causes that do not match their symptoms well are left. This leaves anxiety at the top of the list as a possible cause.

I ask whether they would be willing for the next two months to try an approach that targets the anxiety, adding that if this does nothing to improve their symptoms I would be happy to revisit the idea of further investigations. I then go on to provide more information about how anxiety can be such a good mimic of serious medical illness.

If this approach is successful, the patient may now be more willing to consider treatment targeted at the anxiety. I ask for a period of two months because, no matter what approach to treatment is taken, it is likely to take this long to make a difference.

Treatment options include pharmacotherapeutic and psychological interventions. Both are now well established.

Pharmacotherapy

The efficacy of the tricyclic antidepressant imipramine in treating panic disorder was established not long after its efficacy in treating depression was shown. Evidence that the monoamine oxidase inhibitors were effective soon followed. Level I evidence of efficacy is now available for all available classes of antidepressants (see table 1).

Patients with panic disorder are extremely sensitive to side effects. This is a function of the high levels of anxiety sensitivity associated with panic — patients fear the meaning and consequences of somatic symptoms, not the symptoms themselves.

This is easily demonstrated by discussing with patients how they would react if they caught the flu and developed aches and pains, dizziness, weakness, headache and cough. Would they be anxious? Most patients will say “no” quite readily. Yet such symptoms may be as severe as those experienced with



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panic attacks.

One can then explore with the patient, using Socratic dialogue, why they would *not* be anxious. Patients will realise that it is the *meaning* they ascribe to symptoms, along with their expectations about course and prognosis, that influences whether or not they worry. So with a flu, they know it’s “just the flu”, that it will be self-limited, go away over a week or two and they will be well again in its wake. Hence, there is no anxiety.

So the likely experience of side effects with medication is best addressed by full and frank disclosure and appropriate reassurance that the common side effects are not dangerous. I prefer this approach to the routine use of adjuvant benzodiazepines and find the latter rarely necessary in practice.

Choice of antidepressant is best guided by long-term tolerability, as the anxiolytic and anti-panic action of this class of medication is independent of sedation. Choice will also be guided by potential interactions with other medications the patient may be taking, by patient preference, and by doctor preference. Many doctors have their own clinical preferences or are more familiar with particular antidepressants.

Based on clinical experience, the most appropriate course of action is to start a patient on half the minimum-strength dose and increase up to the minimum therapeutic dose over the next few days to a week, as tolerated. For most SSRIs the minimum therapeutic dose will be the minimum-strength tablet, but for those with a broad dose range it may be a little higher.

Taking a bit longer to reach a therapeutic dose is far preferable to an aversive experience in starting the medication. The latter could easily lead the patient to refuse to go any further, and cause lingering doubt as to whether there is an insur-

mountable sensitivity to the medication and whether it might have been effective.

There is scant evidence for a dose-response relationship in anxiety. What limited evidence does exist concerns only paroxetine and fluoxetine. However, it is now realised that, on average, anxiety disorders take much longer than major depression to respond.

Current recommendations suggest that 12 weeks represents an adequate trial of an antidepressant when treating anxiety disorders.⁴ This can be a difficult wait for an anxious patient and a doctor anxious to see the patient experience some relief. It requires a confident and calm approach by the GP.

Of course, each patient is an individual, and for some people the therapeutic dose will be higher. Unfortunately there is no way of identifying these individuals in advance. Hence, good clinical practice takes guidelines into account, but maintains some room for individual variation.

In practice, if there has been no response at all by six weeks, and the patient remains highly distressed but is tolerating the antidepressant, it is not unreasonable to increase the dose on the chance that this patient may require more than the minimum. One would then persist with this dose for another six weeks.

If some response becomes evident by 12 weeks, it is reasonable to continue with the same dose and monitor progress: one would expect to see continuing improvement. If improvement plateaus without achieving remission, it is reasonable to increase the dose again and review over the next 6-12 weeks.

If a patient has shown no response by 12 weeks, the evidence suggests that increasing the dose is unlikely to help. At this stage consideration should be given to changing to another antidepressant, or adding CBT if this has not

Figure 3: Cognitive model of panic disorder.

Patient’s hypothesis:

Serious illness → symptoms → anxiety

Doctor’s hypothesis:

Serious illness ≠ symptoms ← anxiety

Table 1: Evidence basis for treatment of panic disorder with or without agoraphobia

Level Ia evidence of efficacy (evidence from meta-analysis of RCTs)

- SSRIs (all)
- Tricyclic antidepressants: imipramine, clomipramine
- Benzodiazepines: alprazolam, clonazepam, diazepam, lorazepam
- Cognitive behaviour therapy

Level Ib evidence of efficacy (evidence from at least one RCT)

- Serotonin and noradrenaline reuptake inhibitor: venlafaxine
- Noradrenaline reuptake inhibitor: reboxetine
- Noradrenergic and specific serotonergic antidepressant: mirtazapine
- Reversible inhibitor of monoamine oxidase type A: moclobemide

Level Ib evidence of lack of efficacy

- Beta blocker: propranolol
- Azapirone: buspirone

Level IV evidence of lack of efficacy

- Antihistamines
- Antipsychotics

been done. With anxiety disorders it is not unreasonable to try a different medication from the same class, as there may be a differential response.

For a patient established on an effective antidepressant there is limited evidence regarding how long treatment should be continued. Studies do show significantly reduced relapse rates compared with placebo when antidepressant medication is continued for periods of six months or more.

Importantly, studies in panic disorder and other anxiety disorders show response rates that continue to increase over long periods — up to 12 months in studies that have continued for this long. When a decision is made to stop antidepressants, clinical recommendations are that this be done as a slow taper over about three months. This avoids any risk of rebound and allows time to make an adjustment. Unfortunately, relapse rates on cessation are high.

There is a limited role for benzodiazepines in panic disorder. Although there is level I evidence for efficacy in the acute treatment of panic, benzodiazepines are not recommended as first-line or long-term therapy.

Benzodiazepines are not routinely necessary on starting an SSRI. One problem with using them in this way, particularly with the more potent and shorter-acting benzodiazepines, is that patients may very quickly develop a

psychological dependence even before any physical dependence. As noted above, while panic attacks are indeed unpleasant, the greater part of the unpleasantness comes from the associated ‘fear of fear’. After advice and explanation, many patients can manage the wait for symptoms to improve.

However, if there is intolerable and perhaps protracted distress, benzodiazepines may be indicated. Ensure that there is a timetable in place at the beginning of treatment for their early discontinuation. The other role for benzodiazepines is in patients for whom no other treatments have worked, and when there is significant distress and disability.

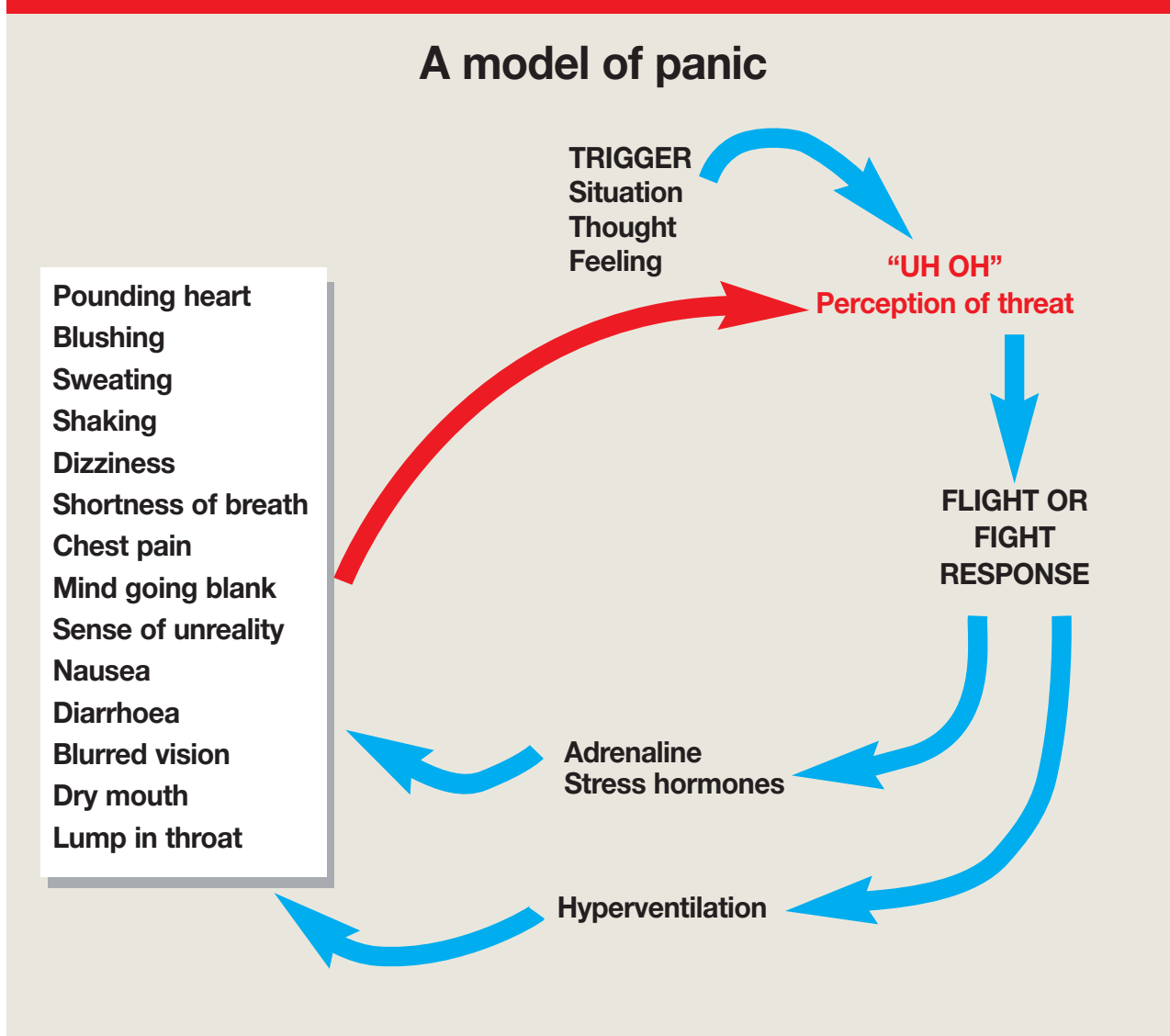
Current evidence fails to provide evidence of efficacy for propranolol, antihistamines or antipsychotics.

Cognitive behaviour therapy

CBT also has a robust treatment literature in panic disorder. The maintenance of treatment effects is much better after CBT than after a course of medication.

Psychoeducation includes an explanation of how anxiety can cause such a wide range of physical symptoms, and how similar these may seem to serious physical illnesses. The ‘flight or fight’ model, incorporating information about the release and effects of adrenaline, is often presented at this junct-

Figure 4: A simple model of anxiety using everyday language can be part of psychoeducation about panic



ture (figure 4).

Negative investigations can be reframed as ‘good news’ confirming that serious illnesses appear very unlikely (note that they really cannot be totally excluded, and the individual does need to live with a degree of uncertainty, as do we all).

The rationale for available treatments is also discussed. Many patients are perplexed that they are being offered antidepressants when anxiety is the main problem. With respect to CBT, the concept of facing something you fear until the fear is overcome is the fundamental principle and can be illustrated with reference to everyday life – for example, learning to drive or learning to ride a bike.

It is also important to acknowledge the very natural tendency to avoid something that is unpleasant or anxiety provoking, but unfortunately, sometimes things that appear

sensible on the surface are in fact not helpful (eg, we now know that the best treatment for many physical injuries is mobilisation and not complete rest).

Cognitive techniques focus on identifying alternative and more likely explanations of physical symptoms than the typically catastrophic interpretations made by people with panic disorder. The concept here is ‘When you hear hoof beats, think of horses and not zebras’.

The model in figure 3 is presented and discussed in detail. The availability of negative investigation results is again helpful in supporting the alternative hypothesis. The essential uncertainty of life can also be discussed.

A good everyday analogy (for patients not excessively fearful of driving) is that of driving a car. It is quite possible that any of us may have an accident at any time, but

it generally does not stop us driving. We have managed to cope with the uncertainty using a range of strategies such as not dwelling on the risk, convincing ourselves that we are better than average drivers, and driving the safest car we can afford.

Behavioural strategies essentially focus on learning to tolerate the physical sensations. Because people with panic disorder tend to have a high level of anxiety sensitivity, they are particularly likely to notice and worry about somatic symptoms. Many patients spend a great deal of time monitoring their bodies, on the principle that catching an illness early is more likely to result in survival.

Monitoring is thus a type of ‘safety behaviour’ — the term used to refer to a strategy designed to prevent or reduce the effect of the feared consequence. Other safety behaviours commonly seen in panic

Myths about drug treatment of panic

Myth	Reality
Warning patients about side effects will cause them to experience them through suggestibility, so better not to tell them	Patients will read about side effects from the package insert or on the Internet. Without your education that the side effects are not dangerous they will be more likely to discontinue medication, and the therapeutic alliance may be irreparably damaged as well
High doses of antidepressants are needed compared with depression	There is no good evidence that dose escalation achieves a better outcome
Patients should begin to respond within two weeks	Response is likely to take at least six weeks
A more sedating antidepressant is the best choice for highly anxious patients	Anxiolytic action is independent of sedation. The best antidepressant is the one that works and that the patient can live with for the next six months plus
When starting SSRIs, they should be combined with a benzodiazepine	With appropriate education about side effects, and slow dose titration, this is not necessary in most cases

disorder include carrying water, carrying benzodiazepines ‘just in case’, and not travelling too far from home or from the doctor or hospital. Hence, behavioural strategies must also include relinquishing of safety behaviours.

When avoidance is a significant issue, the diagnosis will include agoraphobia. In this case, exposure to feared situations is an important element of treatment. This is usually carried out in a ‘graded’ way, that is, step-by-step, starting with the less anxiety-provoking situations.

Patients are asked to generate a list of all the situations they avoid, including cases of subtle avoidance (eg, going to the cinema only if they can sit in an aisle seat and near the exit; going to the local deli but not the supermarket).

They are then asked to assign a difficulty rating to each situation. This is referred to as a ‘subjective units of distress’ (SUDs) rating. A scale of 1-10 is often used, and anchor points are given (zero is no anxiety at all, 3 is mild, 5 is moderate, 8 is severe, and 10 is the worst ever). Graded exposure then might begin with situations rated 4-5, and these steps are repeated frequently until they can be accomplished with a SUDs

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Components of good-quality CBT for panic disorder

Psychoeducation

- About panic disorder
- About why this person developed panic disorder and why it is still a problem (sharing of the cognitive hypothesis model with the patient)
- About what treatments are available and how they work
- About what will be involved in CBT

Cognitive therapy

- Presenting the alternative hypothesis regarding the meaning of symptoms (see figure 3)
- Cognitive challenging regarding likelihood of serious illness, alternative interpretations of symptoms
- Developing better tolerance of uncertainty

Behaviour therapy

- Exposure to feared/avoided situations
- Exposure to internal sensations of panic (interoceptive exposure)
- Relinquishing safety behaviours

CBT = cognitive behaviour therapy

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rating of 3 or less. It is then time to move on to steps at the next level of difficulty.

To be effective, exposure must be undertaken frequently, repeatedly, without any 'as needed' medication, and the individual must remain in the situation, confronting their anxieties, until they can feel their anxiety levels diminishing. Ideally, exposure tasks are also undertaken without using safety behaviours. Even if these are not all relinquished at the start of treatment, they must be phased out and eventually eliminated if full recovery is to be achieved.

Another element of exposure involves exposure to uncertainty. That is, tolerating the physical symptoms without immediately seeking relief from them or reassurance that they are not dangerous. Advice to maintain the focus of attention on the task at hand, whatever it may be, and not on monitoring the body constantly can be helpful.

Deliberate exposure to worrying somatic symptoms, known as interoceptive exposure, is now an important part of exposure therapy. CBT that incorporates interoceptive exposure is most effective. In the office, patients are asked to engage in a series of activities designed to produce a range of somatic sensations similar to those experienced during panic attacks. These activities might include step-ups (to increase the heart rate), spinning around (to cause dizziness or feeling off balance) and hyperventilation (see Andrews et al. [2003] for a full description).⁵

The patient then identifies those that are most like their worrying panic symptoms, arranges these in order of anxiety caused, then begins to practise them daily, starting with the least anxiety provoking. Outcome of CBT is linked to successfully lowering the anxiety associated with physical symptoms.

Hyperventilation control is no longer routinely taught as an 'anxiety management' strategy. It was realised that the original goal of CBT, to achieve 'control' over panic, did not address the *fear* of panic, and left the patient vulnerable to catastrophic reactions if anxiety recurred in the future — a prospect that was highly likely.

In addition, breathing-control strategies themselves can become safety behaviours. It is now realised that reducing the perceived cost of the feared outcome is the most effective aspect of CBT for all the anxiety disorders.

Combined CBT and pharmacotherapy

Despite recent meta-analyses, the question of whether the combination of CBT and pharmacotherapy is more effective than either treatment alone remains unresolved. Importantly, the overall effect sizes for CBT and antidepressants alone or together are high. Given the greater maintenance of gains after CBT, it would seem that as many patients as possible should be offered this type of therapy, but it can be done in combination with medication or sequentially.

Deliberate exposure to worrying somatic symptoms, known as interoceptive exposure, is now an important part of exposure therapy.

Conclusion

PANIC disorders, with and without agoraphobia, are common conditions with a significant associated morbidity and disability. Comorbidities with depression and alcohol abuse are common and important.

Effective treatments are available. The outcome for panic disorder is generally very good, and recovery is highly likely with appropriate treatment. Agoraphobia is somewhat more difficult to treat, but good functional recovery is achievable for many patients.

By understanding the core cognitions of panic disorder, the GP can provide high-quality psychoeducation that is in itself the beginning of effective treatment. By understanding the components of CBT for panic, the GP can ensure that patients are receiving effective therapy when this is outsourced to other professionals, such as psychologists.

References

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Online resource

Clinical Research Unit for Anxiety and Depression: www.crufad.org

GP's contribution



DR FRANCES BLACK
Wahroonga, NSW

Case scenarios and questions for the author

My patient is a 30-year-old woman who lives alone and is unable to work. She is on the maximum dose of an antidepressant. As she has difficulty leaving home, are there some online help programs she can access? There was a recent write-up to say that online programs work well in psychiatry. Could you please advise about these?

Online programs can be effective but unless they are used in conjunction with therapist support (by phone, face to face or possibly email) there is a very high drop-out rate.

I also have a salesman patient who has recently



developed panic attacks that have made it difficult to cross bridges. This is impinging on his ability to

do his job. He is not keen on medication and has heard that working in a group with others with panic disorders works well. Would you agree? Is there evidence to support this and how does it compare with individual CBT instruction?

Group treatment can be as effective as individual CBT. It has the advantage of providing peer support.

Could you explain 'panic surfing' please?

Also referred to as 'riding the panic wave' it refers to being aware of an episode of panic and tolerating it; avoiding cognitive catastrophising about it and choosing not to escape, distract oneself or take medica-

tion to relieve it. It is part of the exposure process.

Although you indicate that breathing control is no longer regarded as helpful, does it still have a place in reducing background anxiety in those who suffer panic? If yes what instructions would you give?

If used as a type of relaxation strategy or as part of a mindfulness practice it can indeed be helpful. It sometimes is also helpful in assisting an individual to calm down sufficiently to be able to think clearly enough to apply the strategies they're learning. So the most important instruction would be to practise it regularly rather than relying on it as a means of controlling panic attacks.



How to Treat Quiz

Panic disorder — 26 September 2008

INSTRUCTIONS

Complete this quiz online and fill in the GP evaluation form to earn 2 CPD or PDP points. We no longer accept quizzes by post or fax.

The mark required to obtain points is 80%. Please note that some questions have more than one correct answer.

ONLINE ONLY

www.australiandoctor.com.au/cpd/ for immediate feedback

1. Which TWO statements about the definition and differential diagnosis of panic disorder are correct?

- a) Panic disorder may be simply defined as experiencing recurrent panic attacks
- b) In panic disorder the key cognitions concern fears that the physical symptoms of the panic attacks reflect serious underlying pathology
- c) In panic disorder the principal fears associated with panic attacks are that they will result in negative evaluation by others
- d) Panic disorder with agoraphobia occurs when a person avoids a range of situations out of fear over panic attacks

2. Which THREE statements about the epidemiology of panic disorder are correct?

- a) Panic attacks are common, with about one-quarter of respondents in a major US study reporting ever having had a panic attack
- b) Women and men are equally likely to experience panic disorder
- c) Most people with panic disorder develop the condition before age 40
- d) About 7% of general practice attendees might meet criteria for panic disorder at any given time

3. Pauline, 23, presents with a 12-month history of symptoms consistent with recurrent panic attacks. She admits that, like her mother, she has "always been a bit of a worrier". Which TWO statements about risk factors and natural history of panic disorder are correct?

- a) Risk factors for panic disorder have a strong biological basis, with heritable factors accounting for about 40% of the variance
- b) Nocturnal panic attacks represent a more severe variant of panic disorder

- c) In panic disorder it is usually possible to identify cues for the panic attacks
- d) The natural history of the panic spectrum is that it begins with a panic attack and progresses to panic disorder and then to agoraphobia

4. Pauline is worried that a heart problem might be causing her symptoms. Which THREE statements about the association of panic disorder with physical illness and other psychiatric disorders are correct?

- a) Panic disorder is commonly associated with other anxiety disorders, major depression and substance abuse
- b) People with panic disorder have a greater likelihood of chronic pain and respiratory illness
- c) Several studies have shown that panic attacks are not an independent risk factor for coronary heart disease (CHD)
- d) Studies have shown a 2-4-fold increased risk of CHD in people with panic disorder

5. Which TWO statements about assessing patients with symptoms of panic attacks are correct?

- a) It is useful to enquire about vulnerability factors for panic attacks, such as anxious temperament
- b) In a patient with no past history of anxiety and no particular vulnerability factors, an alternative cause of the panic attacks should be suspected
- c) Physical examination is not required in patients presenting for the first time with panic attacks, provided their symptoms are clearly consistent with panic disorder
- d) In patients with longstanding panic attacks, reassessment of persistent symptoms is discouraged, as this will only

worsen the anxiety symptoms

6. Pauline's physical examination is normal and baseline investigations do not reveal any physical cause for her symptoms. Which TWO statements about the management of panic disorder are correct?

- a) In patients with panic disorder it is essential that depression is screened for and treated
- b) The basis of managing panic disorder is to present an alternative hypothesis to the patient, ie, that their symptoms indicate anxiety rather than serious physical illness
- c) Warning patients about side effects of medication will cause them to experience them through suggestibility, so it is better not to tell them
- d) The combination of cognitive behaviour therapy (CBT) and pharmacotherapy is proven to be more effective than either treatment alone

7. You present Pauline with the 'alternative hypothesis' that anxiety is the cause of her symptoms and discuss both pharmacological and psychological treatment options. Which THREE statements about use of pharmacotherapy to manage panic disorder are correct?

- a) There is level I evidence of efficacy for all available classes of antidepressants
- b) Benzodiazepines are not recommended as first-line or long-term therapy
- c) Beta blockers, in particular propranolol, have been found to be effective
- d) There is currently no evidence of efficacy for antihistamines or antipsychotics

8. After discussion with Pauline, you decide to trial an antidepressant. Which TWO statements about use of antidepressants in

panic disorder are correct?

- a) A more sedating antidepressant is the best choice for highly anxious patients
- b) When starting an antidepressant for panic disorder, it is most appropriate to start with half the minimum-strength dose of the antidepressant
- c) When started for panic disorder, SSRIs should routinely be combined with a benzodiazepine
- d) Twelve weeks represents an adequate trial of an antidepressant when treating anxiety disorders

9. Which TWO statements about pharmacotherapy for panic disorder are correct?

- a) High doses of antidepressants are needed compared with depression
- b) If a patient with panic disorder fails to respond to one medication in a class, there is no point trying another medication from the same class
- c) Relapse rates are significantly reduced compared with placebo when antidepressant medication is continued for six months or more
- d) When a decision is made to stop antidepressants, this should be done as a slow taper over about three months

10. Which THREE statements about psychological therapy for panic disorder are correct?

- a) Hyperventilation control is an essential part of the treatment for panic disorder
- b) CBT that incorporates interoceptive exposure is most effective
- c) In agoraphobia graded exposure to feared situations is an important element of treatment
- d) The maintenance of treatment effects is much better after CBT than after a course of medication

CPD QUIZ UPDATE

The RACGP now requires that a brief GP evaluation form be completed with every quiz to obtain category 2 CPD or PDP points for the 2008-10 triennium. You can complete this online along with the quiz at www.australiandoctor.com.au. Because this is a requirement, we are no longer able to accept the quiz by post or fax. However, we have included the quiz questions here for those who like to prepare the answers before completing the quiz online.

NEXT WEEK The next How to Treat takes a look at irritable bowel syndrome, a complex clinical condition that is associated with significant morbidity and reduced quality of life. The authors are **Dr Rebecca Burgell**, gastroenterology registrar, and **Dr Sanjay Nandurkar**, head of gastroenterology, Box Hill Hospital, Box Hill, Victoria.

Australian Doctor
Education.

HOW TO TREAT Editor: **Dr Wendy Morgan**
Co-ordinator: **Julian McAllan**
Quiz: **Dr Wendy Morgan**