

GSN0606 Clinical Correlation: Panic Disorder

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Historical Perspective of Panic Disorder

Panic disorders were not considered a unique diagnosis until the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders’ (DSM-III) published criteria in 1980 (Roth, 1997). Prior to that time, diagnosing panic disorder was not standard practice in psychiatry. Fear and anxiety were described as symptoms, Freudian psychologist focus was on understanding the dynamics of the disease. Panic disorder symptoms were described by Freud, as part of other psychiatric diseases, as early 1885. The symptoms for diagnosis of panic disorder rarely occur alone and often occur in patients with other problems such as depression, fear of social situations and phobias.

Definition

Angere, a Latin word, is the root word for anxiety and it means “to choke or strangle”. Panic disorder is classified as a type of anxiety disorder. A certain level of anxiety, arousal, and stress reactions are essential for survival of humans. Pathological anxiety is excessive or inappropriate arousal that is characterized by feelings of apprehension, uncertainty, and fear. The reaction is often not attributable to a real or appropriate threat and paralyzes the individual into inaction or withdrawal. Anxiety disorders may be caused by combinations of psychological, physical, and genetic conditions and treatment is generally quite effective. Anxiety can be a symptom with other psychologic or medical problems such as depression, phobias, posttraumatic stress disorder, substance abuse, thyroid disease, heart disease. Valente (1996) listed medical conditions and drugs, prescription, otc and illegal, with anxiety as a common component see Table 1 Medical Conditions and Drugs with Common Anxiety Components.

Cardiovascular Conditions	Endocrine Conditions	Immunologic Conditions
Arrythmia	Hyperadrenalism	Anaphylaxis
Cardiomyopathies	Hypocalcemia	Systemic lupus
CAD	Hypothyroidism	HIV
CHF	Cushing’s Syndrome	
Mitral Valve Prolapse		
Myocardial infarction		
Neurologic Conditions	Secreting Tumors	Respiratory Conditions
Akathisia	Carcinoid	Asthma
Encephalopathy	Pheochromocytoma	COPD
Essential tremor		Pulmonary Embolism
Multiple sclerosis	Other	
Restless legs syndrome	Peptic Ulcer Disease	
Temporal Lobe Epilepsy		

Drugs and Medications with Common Anxiety Component

Alcohol	Aminophylline	Amphetamines	Anticholinergics
Antihypertensive	TB agents	Cycloserine	Caffeine
Cocaine	Digitalis (toxicity)	Dopamine	Ephedrine
Epinephrine	Hallucinogens	Levodopa	Lidocaine
Marijuana	Methylphenidate	MSG	Neuroleptics
NSAIDS	Nicotine	Nicotinic Acid	Phenylephrine
Phenylpropanolamine	Procarbazine	Pseudoephedrine	Salicylates
Sedative hypnotics (use/withdrawal)	SSRIs	Theophylline	Thyroid Preparations

Table 1 Medical Conditions and Drugs with Common Anxiety Components.

Anxiety disorders are common psychiatric conditions in the USA, for the general population there is a 25% lifetime risk for an anxiety disorder. Women are twice as likely to have PD as men. The most common age range for women was 30 to 44 years. Anxiety disorder affect more than 23 million American and as many as 25% of all Americans experience intense anxiety at sometime in their lives. Disorders run in families and genetic or biological factors play a role in most forms of anxiety. Panic disorders tend to begin in late adolescence and peak at around 25 years of age. Women have twice the risk of anxiety disorders as mean and that may be due to hormonal factors, cultural pressure and greater tendency to report anxiety to physicians.

Early research, 1980, determined a frequency of 5.9% of the population in an epidemiologic catchment area had panic attacks at some time in their life with 1.4% having more than three spontaneous attacks in less than a three week period. Prevalence was about one-third of lifetime prevalence . A repeat survey in 1990-92 was conducted , National Co-morbidity Survey, using structured interviews keyed to the revised DSM-III, the findings found a lifetime prevalence of 3.5% , almost twice the rate of the 1980 ECA study.

Some diagnosis go together with panic disorder. Depression or a major grief episode was four times more likely in people with panic attacks, drug abuse or dependence three times more likely, alcohol abuse or dependence two times. Sixty-seven percent of PD patients had at least one other major psychiatric disorder with a propensity to develop depression 23% and agoraphobia 21% in next 12 months. In a study were 55 pd patients were re-interviewed at 15 to 60 months, 43% had a least three panic-free months during follow-up but only 10% were completely asymptomatic. Co-morbid agoraphobia, major depression and Axis II disorders at intake were unfavorable prognostics signs.

In the veteran health care population, panic disorder is most often present in patients with depression, substance abuse and alcohol abuse. Anxiety and panic attacks also occur in older veterans with chronic pulmonary disease. Panic attacks are fairly common among younger women but is not usually the principal reason for seeking care. (Roth, 1997)

Pathogenesis

There is a complex relationship with panic attacks and stressors. Some patients never have panic attacks at home where they feel secure. Outside home the anxiety mounts and panic attacks occur with high anxiety. Some patients get panic attacks while relaxing or even sleeping. Panic attacks occur during Stage 2 or beginning Stage 3 sleep which is different from nightmares or night terrors which occur during REM sleep or late Stage 3 and Stage 4 sleep.

Factors that increase the risk of anxiety disorders may be related to a person's genetics, biochemistry, environment, and psychologic profile. Literature suggest a biological vulnerability to stress that makes them more susceptible to environmental stimuli. Panic attacks have been conceptually described at the neurochemical level, the level of specific brain systems and the psychological level. These are not independent levels since neurotransmitters are concentrated at different levels in different brain systems and thoughts ultimately depend on neural activity.

Biochemical factors include abnormalities in the brain. Panic disorders are associated with the amygdala, a part of the brain that regulates fear, memory, and emotion and coordinates them with heart rate, blood pressure, and other physical responses to stressful event. Exposure to certain food or chemicals, perfume, hair sprays, may cause a panic attack. Some studies have found that people with anxiety disorders, especially children, are hypersensitive to high levels of carbon dioxide which can occur in crowded spaces i.e. airplanes, elevators, crowded cars.

About 20-25% patients with close relatives with panic disorder will experience the disorders. Researchers have identified a gene associated with personality traits that include anxiety, anger, hostility, impulsiveness, pessimism, and depression. The gene reduces amounts of a protein that transports serotonin and those affecting dopamine appear to cause a syndrome which is important in maintaining positive emotions. Genetic mutations that affect other neurotransmitter have been shown to cause a syndrome that includes headaches, anxiety, and depression.

Psychodynamic theorists propose that panic disorder is caused by unresolved dependence vs. independence in early childhood. One study showed that young adults who experienced childhood anxiety live with their parents until later in their mid-twenties. They may perceive their parents as frightening and extremely controlling however studies did not show that there was any more inconsistent, neglectful or abusive parenting than average unless they also had agoraphobia, and there was less parental affection.

There is evidence of some biological propensity for specific fears that can be triggered and perpetuated after a single first exposure. Alcohol use increases risk of panic disorder significantly (Roth, 1997, Merika & Fenton, 1996). Smoking has been shown to have a causal effect in panic attacks with a three time greater risk of panic attack and panic disorders (Denoon & Meszaros, 1999).

Profile of Panic Disorder

Increased risk of suicide has been identified for panic disorders. Studies indicate that 25-30% of people with panic disorder have suicidal thoughts and 18% have actually attempted suicide. Adolescent girls with panic disorder have nearly three times the risk of suicide as those without anxiety disorders.

People with panic disorder perceive their own health and emotional well being as poor and seek medical care more frequently than the general population. Anxiety may trigger acute events such as asthma, chest pain or abnormal heart rhythms particularly ventricular fibrillation. One study showed that 25-60% of patients seeing a doctor for heart problems/chest pain had a panic disorder. Another study showed that people with anxiety are more likely to develop high blood pressure. Studies have shown that patients with panic disorders have a higher rate of sudden death from cardiac events. It is not clear whether the psychologic disorder preceded the physical symptoms and no hard evidence that treating anxiety alone will benefit the patient's physical health. There is evidence that untreated anxiety leads to a greater risk of severe depression and self-medication with alcohol or drugs.

Clinical Presentation of Panic Disorder

A diagnosis of panic disorder may be with or without agoraphobia according to DSM-IV. The diagnosis is determined based on the number of panic attacks, the period of time involved, the number of symptoms, the unexpectedness of the attack, the residual anxiety and elimination of organic factors in initiating or maintaining the attack.

Most patients with anxiety do not meet the criteria for a primary anxiety disorder. The DSM-IV identifies nine primary anxiety disorders. Uphold and Graham(1999) describe four categories for anxiety in a primary care setting:

1. Anxiety in response to psychosocial or physical stressors, adjustment disorder with anxious mood. Patient is anxious for a good reason, but anxiety is excessive. High prevalence in outpatient settings and should be suspected in patient who have a major psychosocial stressor like divorce or serious physical illness.
2. Anxiety due to a general medical condition is distinguished by the fact that the anxiety can be directly linked physiologically to the medical conditions. Cardiovascular conditions that have anxiety as a symptom are: congestive heart failure, coronary artery disease, pulmonary emboli, and arrhythmias. Endocrine disorders with anxiety symptoms are hyper/hypothyroidism, hypoglycemia, Cushing's syndrome. Metabolic disorders include Vitamin B12 deficiency and porphyria. Neurological disorders include metastatic neoplasms in the brain, temporal lobe epilepsy, and encephalitis. Respiratory conditions with anxiety are chronic obstructive pulmonary disease, asthma and pneumonia.
3. Substance-induced anxiety disorder may be related to drugs or toxins. Examples of medications that may create anxiety are: stimulants, bronchodilators, anticholinergics, insulin, thyroid medications, antihistamines, corticosteroids, antihypertensives, anticonvulsants, antipsychotics, and antidepressants. Non-medication substances that cause anxiety are alcohol, caffeine, cannabis, cocaine, hallucinogens, inhalants, gasoline, paint, insecticides, and carbon monoxide. Withdrawal from use of some of the drugs that cause anxiety can also cause anxiety; alcohol, cocaine, sedatives, hypnotics, anxiolytics.
4. Anxiety associated with another psychiatric condition such as depression and alcoholism is not uncommon. It is difficult to distinguish an anxiety disorder and a depressive illness. The overlapping symptoms of these include sleep and appetite disturbances, difficulty concentrating, irritability, fatigue. There is a high comorbidity of alcohol and anxiety and it

would be prudent to screen patients with symptoms of anxiety to screen for alcohol use, abuse, or dependence. .

Panic disorder is described by the frequency, intensity and number of attacks in a short period of time. A panic attack is described as sudden, unexpected, attacks of anxiety or terror with at least four physiological symptoms which reach maximum intensity in ten minutes and which last fifteen to thirty minutes. The residual effect, fear of another attack, may last much longer. Attacks may occur spontaneously or they may be triggered by a particular situation. Limited-symptom attacks are those that have only one or two of the physical symptoms such as dizziness or pounding heart. This may be a residual effect or a precursor to a major panic attack. Organic factors such as amphetamine, caffeine intoxication hyperthyroidism, mitral valve prolapse, must be ruled out as initiating or maintaining cause before the symptoms are defined as panic attack.

Agoraphobia often accompanies panic disorder. Agoraphobia is defined as fear of being in places or situations from which escape might be difficult or embarrassing or in which help might not be available in the event of suddenly developing symptoms that could be incapacitating or extremely embarrassing. Panic disorder with agoraphobia according to DSM-IV meets the criteria for panic disorder but additionally has a fear of being in places or situations from which escape might be difficult or embarrassing or in which help might not be available in event of a panic attack. Cases are included that have persistent avoidance behavior originated during an active phase of panic disorder even if the person denies that the behavior is related to fear of having a panic attack. As a result of fear, the person restricts travel, needs a companion or endures situations despite intense anxiety. Common agoraphobic situations include being outside the home alone, being in crowds, standing in line, being on a bridge, and traveling by car, bus, train. Agoraphobic avoidance is classified in five levels: 1. Mild some avoidance or endurance with distress but relatively normal life-style; i.e. travels unaccompanied when necessary such as to work or to shop; otherwise avoids traveling alone. 2. Moderate avoidance results in constricted lifestyle; the person is able to leave the house alone but not to go more than a few miles unaccompanied. 3. Severe avoidance results in being nearly or completely housebound or unable to leave the house unaccompanied. 4. Partial remission no current agoraphobic avoidance but some agoraphobic avoidance during the past six month. 5. Full remission, no current agoraphobic avoidance and none during the past six months.

The presence of physiological symptoms without any physical symptoms reasons are important distinguishing factors. The number of symptoms reported determines the severity of the attack; four or more symptoms is considered a “panic attack”, less than four symptoms is considered a limited symptoms attack - not a full scale panic attack. . The symptoms develop suddenly and increase in intensity within ten minutes of awareness of the first symptom.

The classic physiological symptoms reported with panic disorder are:

- shortness of breath (dyspnea) or smothering sensations
- dizziness, unsteady feelings, or faintness
- palpitations or accelerated heart rate (tachycardia)
- trembling or shaking
- sweating
- choking
- nausea or abdominal distress
- depersonalization or derealization
- numbness or flushes (hot flashes) or chills
- tingling sensations (paresthesias)

Definitions

The diagnosis of Panic Disorder is closely tied to specific definitions of events. The DSM-IV diagnostic factors include frequency, intensity and number of physiological symptoms. During an attack there is intense fear or discomfort with a combination of physiological symptoms . The definitions for the events required by DSM-IV include:

- Panic attacks - discrete periods of intense fear or discomfort.
- Unexpected occurrence - did not occur immediately before or on exposure to a situation

that almost always causes anxiety; was not triggered by situations in which the person was the focus of others' attention.

- Time/Frequency of Attacks - four attacks have occurred within a four-week period
- Residual effect - one or more attacks have been followed by a period of a least a month of persistent fear

of having another attack

Agoraphobia which is fear of being in places or situations from which escape might be difficult or embarrassing or in which help might not be available in the event of suddenly developing symptoms that could be incapacitating or extremely embarrassing.

When panic attacks occur only in social situations it may be considered to overlap social phobia, performance situations like driving a car. It is important to determine whether PD is the correct diagnosis and should include evaluation for anxiety disorders especially depression, alcohol or substance abuse. Agoraphobia must be distinguished from avoidances of social situations (social phobia), single situations phobia (riding an elevator), obsessive-compulsive (dirt fear) or situations associated with past severe stressors (PTSD).

Diagnosis/Evaluation

The DSM-IV criteria for panic disorder are very specific and a review before obtaining a history and doing a physical exam may be helpful. DSM-IV criteria for diagnosis of Panic Disorder are:

1. One or more panic attacks have occurred that were unexpected and not triggered by a known situation where person was focus of others' attention.
2. Four attacks within a four-week period or at least one attack followed by at least of a month of persistent fear of another attack.
3. Development of at least four (4) of the defined symptoms in at least one of the attacks.
4. Symptoms developed suddenly and increased in intensity within ten minutes.
5. Organic factors have been eliminated as causes.

Severity of panic attacks has five levels according to DSM-IV:

1. Mild is considered all attacks have limited number of symptoms, fewer than four, or there has been no more than one attack in the past month.
2. Moderate is when attacks for the past month have been between mild and severe, more than one attack and fewer than 8, less than four symptoms per attack.
3. Severe is when there have been at least eight panic attacks.
4. Partial remission the condition is between "in full remission" and Mild attacks .
5. Full remission is when during the past six months, there have been no panic or limited symptom attacks.

Subtypes of panic disorder per DSM-IV:

Panic disorder without agoraphobia meets criteria for panic disorder and an absence of agoraphobia as defined by DSM-IV.

Panic Disorder with agoraphobia - meets criteria for Panic Disorder and has agoraphobia - needs to specify current severity of agoraphobic avoidance and current severity of panic attacks.

Agoraphobia without history of panic disorder - meets criteria for agoraphobia which is fear of being in places or situations from which escape might be difficult or embarrassing or in which help might not be available in the event of suddenly developing symptoms that could be incapacitating or extremely embarrassing. Examples of symptoms include dizziness, falling, depersonalization, derealization, loss of bladder or bowel control, vomiting or cardiac distress. Person restricts travel or needs a companion when away from home or endures situation despite intense anxiety. Common situations include being outside the home alone, being in crowd or standing in lines, being on a bridge and traveling in a bus, train or care. Has never met criteria for Panic Disorder.

History is important to determine the onset and duration in distinguishing whether the attacks are acute or chronic. It is essential to determine if there is a trigger to the attacks; a specific event or situation that precedes the attack. Determine if the feelings of anxiety are interfering with the activities of daily living including going to work, school or participating in leisure activities. Determine what specific psychological and physiological symptoms of anxiety they have and how many. Medication and dietary intake history is essential to determine if there are any contributing factors to the anxiety. (caffeine, alcohol, drugs). Medical history is important and should be reviewed for presence of any medical conditions associated with anxiety. Psychiatric history of patient and family is important to obtain a thorough history and physical are essential with special attention to occurrences of anxiety and contributing factors such as family history, excessive use of stimulants (caffeine, alcohol, substance), recent life changes and stressful events. Anxiety attacks can mimic or accompany certain physical conditions. The physical symptoms of mitral valve prolapse and paroxysmal supraventricular tachycardia are the same as those expected in panic attacks and panic often accompanies these problems. Women with heart events are much more likely to be misdiagnosed as having an anxiety attack than a man with similar symptoms. Asthma and panic attacks have similar symptoms. Other medical conditions with anxiety-like symptoms include epilepsy, hypoglycemia, adrenal gland tumors, hyperthyroidism, menopause. Drugs for thyroid, high

blood pressure, diabetes and withdrawal from drugs especially those used for sleep may cause similar symptoms.

Excessive use of caffeine, amphetamines as well as alcohol withdrawal may cause panic attack symptoms.

Differential Diagnosis:

Anxiety as a primary psychiatric disorder.

Anxiety as a response to psychological or physical stressors.

Anxiety due to a medical condition.

Substance induced anxiety.

Anxiety associated with other psychiatric disorders.

Diagnostic Test:

Clinicians can use a variety of test to determine causes, type, severity and frequency of anxiety. Two test include the Beck Anxiety inventory which is self-administered and the Hamilton Anxiety Rate Scale and Anxiety disorders interview schedule.

Physiological measurement of the autonomic nervous system functions can gauge severity of a person's response to anxiety. These include heart rate, blood pressure, muscle tension and respiratory rate. Diagnostic test would be those necessary to rule out underlying medical conditions. Test might include laboratory studies of thyroid function, adrenal function and hematologic function. This would be the usual screening laboratory of : CBC with differential, Full chemistry (Kodak, Chem12), Drug screen or levels. Cardiac testing would be electrocardiogram and review of labs. Pulmonary function might include arterial blood gases, chest radiography, and pulmonary function testing. If there is suspicion of metastatic malignancy or neurological involvement, CAT scan as indicated.

Treatment Options for Panic Disorder

Once a diagnosis is made, determine if treatment in primary care is appropriate. If the primary anxiety disorder meets the DSM-IV criteria it is best managed by a specialist. In general patients with anxiety related to adjustment to psychosocial or physical stressor, due to medical conditions and those related to substance induced can be managed by primary care. Anxiety associated with a psychiatric disorder are best referred to psychiatry service.

Anxiety disorders require treatment because it is futile to try to talk oneself out of this disorder just as it would be to attempt to talk oneself out of a heart or stomach problem. Most disorders respond well to treatment with

the most effective approach being a combination of cognitive-behavior therapy (CBT) and medication. The effects of CBT are relatively short-lived and most anxiety disorders are chronic and often recur after treatments.

Women are at a much higher risk of recurrence than men; some studies show that 30-82% of people treated with panic disorders have a recurrence of attacks at an average of nine months after successful short-term therapy.

Ideal treatment is a single drug and cognitive-behavior therapy. Drug classes for use as anti-anxiety drugs include benzodiazepines and antidepressants especially selective serotonin-reuptake inhibitors (SSRIs). Anxiety disorders are chronic, therefore, drug therapy may be needed for years. The most effective treatments are usually combinations of drugs and behavioral techniques.

Pharmacotherapy for panic attacks include serotonin-reuptake inhibitors (SSRIs), tricyclic antidepressants, and Benzodiazepines.

The antidepressant category of Serotonin-reuptake inhibitors (SSRIs) primarily are used because they have a better sideeffect profile than the TCA antidepressants. The literature does not indicate that they work better than the TCA. SSRI are newer drugs that target mechanism for elevating serotonin and other neurotransmitters.

Fluvoxamine (Prozac)	Sertraline (Zoloft)
Venlafaxine (Effexor)	Nefazodone (Serzone)

SSRI can cause agitation, nausea, sexual dysfunction delay or loss of orgasm, low sexual drive. Taking a supervised drug holiday on weekend may be sufficient to improve sexual function. During early treatment there may be a small amount of weight loss but it is generally regained. Monitor closely if there are any preexisting heart conditions.

The older class of antidepressants are the tricyclic antidepressants (TCA's).

Imipramine or Desipramine (Tofranil, Janimine) 150-300 mg/day. Takes 2-3 weeks to respond

TCAs should be avoided or patients should be closely supervised if they have a history of seizures, cardiac problems, closed-angle glaucoma and urinary retention or obstruction.

Benzodiazepines have been standard treatment for most anxiety disorders they reinforce a chemical in the brain that inhibits nerve-cell excitability. There is a moderate high risk of dependence and addiction with benzodiazepines. The

recommendation is to use benzodiazepines for a short period of time, two - three weeks until the antidepressants reach effective levels. Benzodiazepines have to be weaned slowly especially Xanax.

Alprazolam (Xanax) Alprazolam 0.5-2 mg/day TID or QID
Expect rapid response but may have depression and potential for addiction

Clonazepam (Klonopin)

Benzodiazepines cause daytime drowsiness and hung-over feelings. Respiratory problems may be exacerbated. They also stimulate eating and cause weight gain. They interact with cimetidine (Tagamet) and antihistamines and are potentially dangerous when combined with alcohol. Overdoses are serious although rarely fatal. Elderly patients should be started at one half the dose prescribed for younger people. There may be a higher risk for falls in older people and more car accidents. They should not be used by pregnant women.

Benzodiazepines lose their effectiveness over time with continued use at the same dose. Dependence is a common problem and can occur with as little as three months of use. There may be rebound symptoms such as sleep disturbances and increased anxiety when the drugs are discontinued. Additionally some patients may experience withdrawal symptoms such as stomach distress, sweating, insomnia that may last as long as three weeks.

MAO Inhibitors are the drug of last choice. They have many drug interactions and food restrictions. They can be used if other antidepressants are ineffective.

Phenelzine (Nardil) 30-75 mg/day. More side effects and requires diet restrictions. Effective with broad spectrum of patients. Takes 4-6 weeks to reach effective response level.

Tranlycpromine (Parnate)

MAOIs commonly cause weight gain, drowsiness, dizziness, sexual dysfunction, insomnia. They can cause birth defects and should not be taken by pregnant women. Hypertension can be brought on by eating food with a high tyramine content (cheese, red wine, vermouth, dried meats and fish, canned figs, fava beans. MAOIs have serious interaction with certain drugs including over-the-counter cough medication and decongestants. Fatal reactions have been reported with SSRIs and MAOIs were taken at the same time.

Antidepressants have a long delay, two to four weeks, before they are effective. They may initially cause an increase in anxiety. About a third of patients stop the drug before it reaches a therapeutic level. A combination of

the anti-anxiety drugs alprazolam (Xanax) or clonazepam (Konopin) are sometimes used to avoid the initial anxiety symptoms and to hasten control of the panic symptoms. Then the Xanax can be withdrawn to decrease the addictive risk and the antidepressant continued for long term effects with little risk of abuse.

The new class of drugs for generalized anxiety Azapirone, Buspirone (BuSpar) is not useful for panic attacks. Beta-blockers are used to control the cardiac symptoms associated with panic attacks. Propranolol (Inderal) and atenolol (Tenormin) block the nerves that stimulate the heart to beat faster; they affect only the physiologic symptoms are most useful for phobias, particularly performance anxiety. Pagoclone is a new drug known as a gamma amino butyric acid (GABA) receptor modulator. It is showing promise in trials by reducing panic attacks with few side effects.

Careful explanation of the disease and symptoms as a normal and useful manifestation of the fight/flight response (all that is needed in 10% of patients). SSRI and TCA at very low dose. SSRI are better tolerated and safer but more expensive than TCA. SSRI for long-term control with results not seen for 3-4 weeks when therapeutic blood levels are achieved. Continue medications for at least 6 months and then decrease medication slowly. Monitoring for at least a year with monthly to every three month visits due to the high rate of recurrent (80%).

Cognitive-Behavioral Therapy

Combining medications (SSRIs) and cognitive-behavioral therapies (CBT) is the best treatment option for panic disorders. The goal is to regain control of reactions to stress and stimuli and reduce the feeling of helplessness. Treatment usually takes from 12-20 weeks and many require continued treatment to prevent relapse.

Cognitive therapy works on the principle that thoughts that produce and maintain anxiety can be recognized objectively and altered and change the persons response and eliminate the anxiety reaction. The patient must learn to recognize anxious reactions and thoughts when begin to occur and control the automatic reactions. The patient must learn to understand their automatic reactions to the anxiety creating events and substitute new ways of coping with the feared stimuli. New actions must be developed and practiced that are based on reasonable expectations. A small study compared cognitive therapy with emotional supportive therapy, after two months 70% of the cognitive therapy patients were free of panic attacks. Techniques used in this method include keeping a diary of repetitive

thinking events, using an audio tape to “over-expose” the patient to repetitive thoughts, self-observation to reduce unrealistic ideas, i.e. perfectionism, an restructure thought.

Systematic Desensitization - breaks the link between the anxiety-provoking stimulus and the response. Treatment requires that the patient gradually confront the object of fear. Three main elements in the process: relaxation training, list composed by the patient that prioritizes anxiety-inducing situations by degree of fear; desensitization procedure itself- emphasizes a relaxed approach and allows the patient to gradually confront the sources of anxiety, confronting each item on list beginning with the least stressful.

Exposure and Response Treatment purposefully generates anxiety by repeatedly. The patient experiences the anxiety over and over until the event loses its effect. Two methods are used: flooding and graduated exposure. Flooding is long periods of exposure and graduated lets the patient control the amount of exposure by length and frequency .

Breathing Retraining - Panic disorder patients often experience hyperventilation which expels too much carbon dioxide resulting in chest pain, dizziness, tingling of mouth and fingers, muscle cramps an fainting. By teaching practiced measured controlled breathing at the beginning of a panic attack, patients may be able to prevent full attacks. Used in conjunction with other treatments.

Treatment Plan

Education of the patient and the family is the first and most important step in treatment of panic disorders. There must be a supportive, caring approach that has a calming effect and reassurance that the person is not “crazy”.

Pharmacotherapy is generally required in two phases, immediate control of effects of the attacks and long term management or prevention. Details of pharmacolotherapy follow the plan. Blood level for drug , kidney and liver function should be monitored as appropriate for each drug.

Medical management of conditions that is the underlying cause of anxiety.

Substance induced anxiety requires review of medication use and consideration of changing to a class of drugs with less anxiety producing effects. Provide counseling or detoxification programs if the substance is not prescribed for management of a co-morbid medical condition.

Psychiatric referral for management of primary problem for anxiety associated with a psychiatric condition .

Followup depends on the level of counseling that is involved in the office and the need for pharmacotherapy monitoring. Weekly counseling sessions are usual in the community. Monitoring of patients every 2-3 weeks for drug levels until a stable dose is established and the symptoms are relieved. These patients may require long term use of benzodiazepams and antidepressants and should be continue to have monitoring to assure that the condition remains controlled.

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Case Study

Problem Identification

1. What information in this patient's case is consistent with the diagnosis of panic disorder?