TREATING PANIC DISORDER

A Quick Reference Guide

Based on *Practice Guideline for the Treatment of Patients With Panic Disorder,* originally published in May 1998. A guideline watch, summarizing significant developments in the scientific literature since publication of this guideline, may be available in the Psychiatric Practice section of the APA web site at www.psych.org.

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Introduction

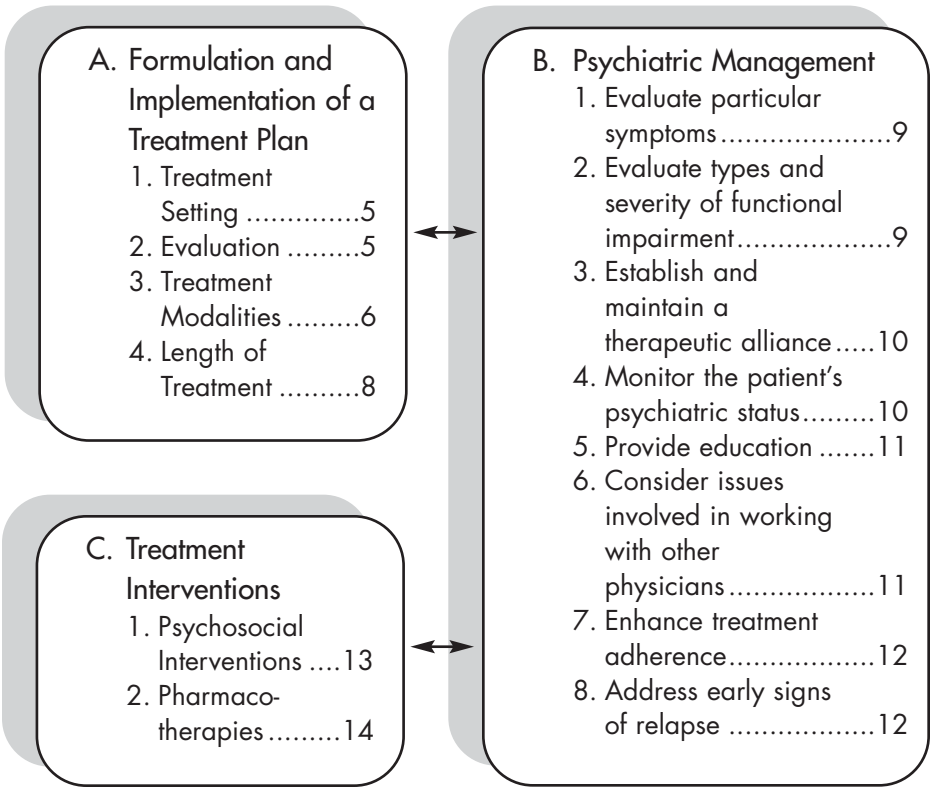
"Treating Patients With Panic Disorder: A Quick Reference Guide" is a summary and synopsis of the American Psychiatric Association's *Practice Guideline for the Treatment of Patients With Panic Disorder,* which was originally published in *The American Journal of Psychiatry* in May 1998 and is available through American Psychiatric Publishing, Inc. The Quick Reference Guide is not designed to stand on its own and should be used in conjunction with the full text of the Practice Guideline. Algorithms illustrating the treatment of panic disorder are included.

Statement of Intent

The Practice Guidelines and the Quick Reference Guides are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and practice patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available.

The development of the APA Practice Guidelines and Quick Reference Guides has not been financially supported by any commercial organization.

OUTLINE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A. Formulation and Implementation of a Treatment Plan

1. Treatment Setting

Outpatient treatment is indicated for most patients.

Consider hospitalization for the following indications:
- Comorbid depression, especially in patients who are at risk of suicide attempts
- Comorbid substance use disorders, especially in patients who require detoxification

2. Evaluation

Perform a comprehensive general medical and psychiatric evaluation.
- Follow principles of APA's *Practice Guideline for the Psychiatric Evaluation of Adults.*
- Determine whether diagnosis of panic disorder is warranted.
- Assess for comorbid psychiatric or general medical conditions.
- Consider general medical conditions and substance or medication use as causes of panic symptoms, especially in patients with new onset of symptoms.
- Perform indicated diagnostic studies and laboratory tests.

3. Treatment Modalities

Consider efficacy, risks and benefits, costs, and patient preference in choice of modality.

- Panic-focused cognitive behavior therapy (CBT) and medications have both been shown to be effective treatments for panic disorder.
- There is no evidence for superiority of either CBT or medications. Rather, choice of modality is mainly determined by weighing advantages and disadvantages (see Appendix A in this guide, p. 16).
- Psychodynamic or other psychotherapies may be the treatment of choice for some patients.
- Combined psychosocial and pharmacological treatments may have advantages over either modality alone.

Choose treatment modalities to be used in conjunction with psychiatric management.
See section C (p. 13) for more detail about specific modalities.

Psychotherapies

- Panic-focused CBT is generally administered in weekly sessions for approximately 12 weeks.
- CBT approaches can be conducted in group formats.
- Psychodynamic psychotherapy may be useful in reducing symptoms or maladaptive behaviors in patients with complicating comorbid Axis I and Axis II conditions.
- Consider employing family and supportive therapy along with other psychosocial and pharmacological treatments.
- Sessions that include significant others help to relieve stress on families and may facilitate adherence.
- Psychotherapies and other psychosocial treatments in conjunction with psychiatric management may also help address certain comorbid disorders or environmental or psychosocial stressors.

Antidepressant medications

- Tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs), and monoamine oxidase inhibitors (MAOIs) generally take 4 to 6 weeks to become effective for panic disorder.
- Because of their side effects and the need for dietary restrictions, MAOIs are generally reserved for patients who do not respond to other treatments.
- With all antidepressants, use doses approximately half of those given to depressed patients at the beginning of treatment because of possible hypersensitivity.
- Increase to a full therapeutic dose over subsequent days and weeks and as tolerated by the patient.

Benzodiazepines (for early symptom control)

- In combination with other treatment modalities, benzodiazepines are useful during initial treatment for more urgent relief of disabling anticipatory anxiety and panic attacks.
- Weigh the potential benefits of benzodiazepines against the following risks:
  - The patient may misattribute the entire treatment response to initial administration of the benzodiazepine and have difficulty with benzodiazepine discontinuation.
  - Anxiety relief may reduce motivation to engage in CBT.
  - Some patients experience withdrawal reactions upon discontinuation, even after relatively brief periods of benzodiazepine treatment.
- To counteract these risks, reassure the patient that definitive treatment takes a few weeks.
- To prevent development of high steady-state benzodiazepine levels and the risk of dependency, avoid unnecessarily high doses.

4. Length of Treatment

When determining length of treatment, consider the following:

- Successful treatment in the acute phase is indicated by markedly fewer and less intense panic attacks, less worry about panic attacks, and minimal or no phobic avoidance.
- With either CBT or antipanic medication, the acute phase of treatment lasts approximately 12 weeks.
- Some improvement is likely with either medication or CBT within 6 to 8 weeks (although full response may take longer).
- If there is no improvement within 6 to 8 weeks with a particular treatment, reevaluate the diagnosis and consider the need for a different treatment or the need for a combined treatment approach.
- If response to medication or CBT is not as expected, or if there are repeated relapses, evaluate for possible addition of a psychodynamic or other psychosocial intervention.
- After CBT treatment during the acute phase, decrease visit frequency and eventually discontinue treatment within several months.
- After 12 to 18 months, discontinuation of medication can be attempted with close follow-up.
- In case of relapse, resume the treatment that had proven effective.

B. Psychiatric Management

1. Evaluate particular symptoms.

- Promote patient perception that the psychiatrist accurately understands the patient's individual experience of panic.
- Be aware that a particular constellation of symptoms and other problems may influence treatment.
- Encourage the patient to self-monitor (e.g., by maintaining a daily diary) the frequency and nature of panic attacks plus the relationship between panic and internal and external stimuli.

2. Evaluate types and severity of functional impairment.

- Monitor anticipatory anxiety in addition to panic attacks.
- Assess the extent of phobic avoidance, which may determine the degree of impairment.
- Encourage the patient to define a desirable level of functioning.

3. Establish and maintain a therapeutic alliance.

- Support the patient's efforts to confront phobic avoidance.
- Assure the patient of therapist availability in case of emergencies to counteract patient's sensitivity to separations.
- Be attuned and responsive to transference and countertransference phenomena.

4. Monitor the patient's psychiatric status.

- Note that different elements of panic disorder often resolve at different times.
- Continue to monitor the status of all presenting symptoms.
- Monitor the success of the treatment plan on an ongoing basis.
- Attend to the possibility of emergent depression.
- Address any contributing comorbid psychiatric conditions.

5. Provide education.

Provide initial and ongoing education to the patient.

- Educate the patient about the disorder, its clinical course, and its complications.
- Emphasize that panic disorder is a real illness requiring support and treatment.
- Reassure the patient that panic attacks reflect real physiological events, but that the attacks themselves are not acutely dangerous or life threatening.

When appropriate, provide education to the family.

- Provide family members and significant others with information similar to that given to the patient.
- Help the family understand that attacks are terrifying to the patient and that panic disorder is debilitating if untreated.

6. Consider issues involved in working with other physicians.

Educate nonpsychiatric physicians who are also treating the patient.

- Recognize that a variety of general medical physicians may be involved because patients are often convinced that attacks are a manifestation of serious medical abnormalities.
- Educate other physicians as necessary about the ability of panic attacks to masquerade as many other general medical conditions.

Intervene as necessary to ensure that the patient continues to receive an appropriate level of medical care from the primary care physician and medical specialists.

7. Enhance treatment adherence.

Be aware that treatment (e.g., taking medication, confronting phobic stimuli) may initially increase anxiety and lead to nonadherence.

Conduct treatment in a supportive manner.

Discuss the patient's fears and provide reassurance, nonpunitive acceptance, and educational measures.

Consider enlisting the assistance of family members in improving the patient's adherence.

For persistent nonadherence, consider a psychodynamic treatment approach to address possible unconscious resistance.

8. Address early signs of relapse.

Respond to exacerbations that occur during treatment.
- Reassure the patient that fluctuations in symptoms can occur during treatment.
- Evaluate whether changes in the treatment plan are warranted.

Respond to relapses that occur after treatment ends.
Instruct patients that it is important to reinitiate treatment quickly to avoid the onset of complications such as phobic avoidance.

C. Treatment Interventions

1. Psychosocial Interventions

Cognitive behavior therapy

CBT may include the following components:

- Psychoeducation
  - Identify and name the patient's symptoms.
  - Provide a direct explanation of the basis for the symptoms.
  - Outline a plan for treatment.
- Continuous monitoring of panic attacks and anxious cognitions
- Daily anxiety-management techniques (e.g., abdominal breathing retraining) to reduce physiological reactivity
- Cognitive restructuring
  - Help the patient identify distorted thinking about sensations (e.g., overestimation of probability of negative consequence and other catastrophic thinking).
  - Encourage the patient to consider the evidence and think of alternative possible outcomes.
- Exposure to fear cues
  - Cues may be internal or environmental.
  - Direct the patient to identify a hierarchy of fear-evoking situations.
  - Encourage the patient to confront feared situations on a regular (usually daily) basis until the fear has attenuated.

Psychodynamic and other psychotherapies

- Psychodynamic and other psychotherapies may be the treatment of choice for some patients.
- The goal of psychodynamic psychotherapy is to elucidate and resolve conflicts and unconscious processes that may be causing or increasing vulnerability to the occurrence of panic symptoms.
- Use the therapeutic relationship to focus on unconscious symptom determinants.
- Place symptoms in the context of the patient's developmental history and current relationships and realities.

1. Psychosocial Interventions *(continued)*

Patient support groups

- Support groups may give patients the opportunity to recognize that their experiences with panic disorder are not unique and to share coping strategies.
- Such groups may complement other therapies but cannot substitute for effective treatment.

2. Pharmacotherapies

Selective serotonin reuptake inhibitors

- For many patients, SSRIs provide the most favorable balance of efficacy versus adverse effects.
- Response usually takes at least 4 weeks; for some patients, full response takes 8 to 12 weeks.
- Taper SSRIs (except for fluoxetine) over several weeks if discontinuing them after prolonged use.

Tricyclic antidepressants

- TCAs may be suboptimal in suicidal patients because overdose may be fatal.
- A common strategy is to start with 10 mg/day (of imipramine or equivalent) and titrate upward gradually (because of the possibility of initial stimulant response).
- Maintain an initial target dosage of 100 mg/day for 4 weeks; if no response or inadequate response, increase to a total of 300 mg/day as needed.
- Wait at least 6 weeks after initiation of TCA treatment (with at least 2 of those weeks at full dose) before deciding whether a TCA is effective.

Benzodiazepines

- Benzodiazepines may be used preferentially in situations in which very rapid control of symptoms is critical (e.g., the patient is about to quit school, lose a job, or require hospitalization).
- An effective dosage of alprazolam may be 1 to 2 mg/day, although many patients require 5 to 6 mg/day (in divided doses from two to four times per day); other benzodiazepines are effective at equivalent dosages.
- Even after 6 to 8 weeks of treatment, withdrawal symptoms and symptom rebound commonly occur when benzodiazepines are discontined. Yet there is little dose escalation with long-term use.
- To discontinue, taper very slowly, probably over 2 to 4 months and at rates no greater than 10% of the dose per week.
- Benzodiazepine use is generally contraindicated for patients with a history of substance use disorder.

Monoamine oxidase inhibitors

- The commonly held belief that MAOIs are more potent antipanic agents than TCAs has never been convincingly proved.
- Although MAOIs are effective, they are generally reserved for patients who do not respond to other treatments. This is due to the risk of hypertensive crises, necessary dietary restrictions, and other side effects.

Other antidepressants

Limited data support the use of venlafaxine and nefazodone but not bupropion.

APPENDIX A. Advantages and Disadvantages of Treatment Modalities

Modality	Advantages	Disadvantages
Psychotherapies		
Panic-focused CBT	• Minimal side effects compared with pharmacotherapies • No risk of physiological dependency	• Patient must be willing to do "homework" (e.g., breathing exercises, recording of anxious cognitions) and confront feared situations • Lack of availability in some regions
Other psychotherapies (e.g., psychodynamic psychotherapy, family therapy)	• May be the treatment of choice for some patients (e.g., those with prominent personality disorder or psychological conflicts)	• Efficacy is less well studied compared with CBT
Pharmacotherapies		
SSRIs	• Ready availability • Fewer serious adverse side effects compared with TCAs and MAOIs • No potential for the physiological dependency associated with benzodiazepines	• Sexual side effects • Cost may be higher compared with other medication classes
TCAs	• Ready availability • Tolerated by most patients, although generally not as well as SSRIs, venlafaxine, or nefazodone • No potential for the physiological dependency associated with benzodiazepines	• Risks of cardiovascular and anticholinergic side effects (especially for the elderly or patients with general medical problems) • Suboptimal for suicidal patients because overdose may be fatal
Benzodiazepines	• Ready availability • Rapid control of symptoms	• Risk of tolerance, dependence, and withdrawal symptoms • In elderly, risk of confusion and falls
MAOIs	• Ready availability • No potential for the physiological dependency associated with benzodiazepines	• Risk of hypertensive crises • Dietary restrictions • Other adverse side effects • Suboptimal for suicidal patients because overdose may be fatal
Other antidepressants	• Ready availability • For some patients, a more tolerable side effect profile than other classes of antidepressants • No potential for the physiological dependency associated with benzodiazepines	• Limited data support the use of venlafaxine and nefazodone • There is general consensus that bupropion is not effective for panic symptoms