Managing panic disorder and generalised anxiety disorder

Panic disorder and generalised anxiety disorder are common and cause significant distress and disability to affected patients. Both of these conditions are treatable, and with appropriate care patients can return to baseline functioning.

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GPs frequently see patients with panic disorder and generalised anxiety disorder (GAD) in their surgeries. The 12-month prevalences of panic disorder and GAD are 2.6% and 2.7%, respectively. It is important for GPs to diagnose and educate affected patients, as well as direct them to suitable self-help resources. Patients with complicated presentations may require medication and psychological referral.[1]

Diagnosis

Panic disorder

The essential feature of panic disorder is the presence of recurrent, unexpected panic attacks (two or more in the previous month). A panic attack is a discrete period of severe anxiety that peaks within 10 minutes. For a diagnosis of panic disorder to be made, the attacks should be followed by at least one month of persistent concern about having another attack, worry about the possible implications or consequences of the attacks, or a significant behavioural change related to the attacks. Agoraphobia is fear and avoidance of places (e.g. crowded areas) that may lead to panic or panic-like symptoms.

Generalised anxiety disorder

The hallmark of GAD is excessive anxiety and worry about a variety of different themes, occurring more days than not for a period of at least six months. For a diagnosis of GAD to be made, the individual finds it difficult to control the worry and it must be accompanied by at least three of the following: restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension and disturbed sleep.

The focus of the anxiety and worry in patients

IN SUMMARY

- **Panic disorder and generalised anxiety disorder are common and debilitating conditions.**
- **Patients with anxiety disorders require an accurate diagnosis and thorough education regarding the nature of their disorder.**
- **A stepwise approach to the management and treatment of panic disorder and generalised anxiety disorder is ideal.**
- **Cognitive behavioural therapy (CBT), including group CBT, individual CBT or clinician-assisted computerised CBT, is the treatment of choice for patients with these anxiety disorders.**
- **Pharmacotherapy in the form of selective serotonin reuptake inhibitors or tricyclic antidepressants can also have a useful role in these patients.**
- **Both panic disorder and generalised anxiety disorder are treatable, and with appropriate care affected patients can return to baseline functioning.**

with GAD is not confined to features of another disorder, such as being embarrassed in public (as in social phobia) or having panic attacks (as in panic disorder). Although patients with GAD may not always say their worry is excessive, they will be distressed by it, have difficulty controlling it or it will impair their functioning (e.g. work, social life and attention).[2]

Presentation

Patients with panic disorder and GAD present in any number of ways. They may present with generalised distress and seek help in managing this. Alternatively, patients may describe anxiety specifically or a particular diagnosis that they have researched on the internet. More often that not, however, patients will present with concerns about the symptoms of the disorder (e.g. anxiety, fatigue, poor concentration and difficulty relaxing).

Patients with panic disorder frequently fear the physical symptoms of anxiety (e.g. racing heart). Patients often misinterpret their symptoms as being harmful and may present with fears such as having a heart attack or stroke, going crazy or dying.[3,4] Patients may believe they are at imminent risk during a panic attack and may have a history of calling the ambulance service or going to the emergency department. Patients with anxiety problems may frequently re-present seeking reassurance that they do not have a serious medical condition. Although reassurance reduces anxiety at the time, it is only short lived. Ultimately, patients will benefit most from empathic education regarding the nature of their condition.

Patients with GAD worry about everyday concerns (e.g. health, family and work) like most people do, but the intensity, duration or frequency of the worry is out of proportion to the actual likelihood or impact of the feared event. Patients with GAD often make the proverbial 'mountain out of a molehill' and frequently report feeling under pressure and stressed.

The challenge for GPs is to identify the problem as an anxiety disorder and then correctly identify which anxiety disorder is at hand. The key to understanding anxiety disorders is identifying what it is the patient fears – for example, with panic disorder it will be the physical symptoms themselves, whereas with GAD it will be the process of worrying (e.g. it is intrusive and difficult to control)

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or the content of the worry (e.g. fearing being sacked for a minor mistake). Panic attacks can occur in all the anxiety disorders if the anxiety becomes high enough; however, in all anxiety disorders except panic disorder, the antecedent to the panic attack is usually readily identified (e.g. a spider for someone with arachnophobia).

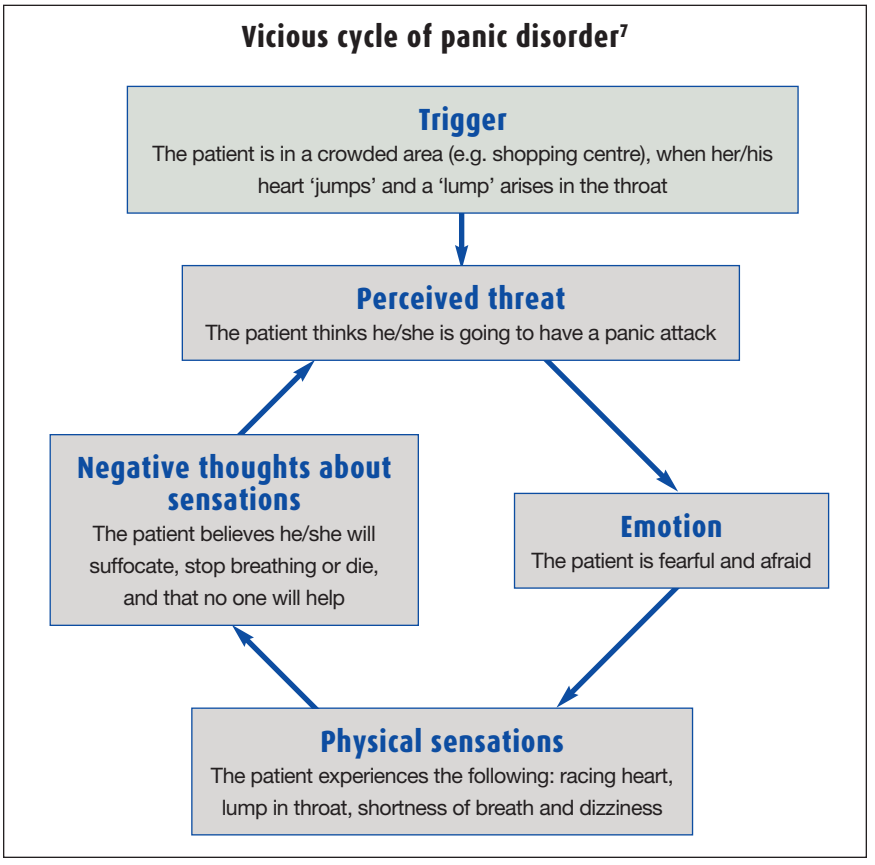
Causes and maintaining factors

Patients benefit from GPs explaining the causes and maintaining factors of anxiety disorders. Often patients have their own ideas about these factors, and it is helpful to provide accurate information from the outset.

Anxiety disorders tend to run in families, and panic and GAD are no exception. Panic disorder and GAD have a strong familial basis, although specific genetic linkages are currently unknown.[5,6] Individuals may also be more vulnerable to anxiety due to traumatic experiences, their temperament, anxious caregivers and a chaotic childhood.

The cognitive behavioural model of panic disorder explains how panic is maintained. Patients experience physical sensations of anxiety and find these sensations threatening, which results in more anxiety and an ever worsening cycle that peaks with a panic attack (see the flowchart on page 44).[7]

Panic attacks become associated with certain situations and this can result in avoidance and thus agoraphobia. The feared situations can then become triggers for increased anxiety thus feeding into the cycle in the flowchart on page 44. Because of the beliefs that patients hold, they develop



an elaborate set of avoidance and safety-seeking behaviours that ultimately maintain the problem. These behaviours can include always having a mobile phone with them, never leaving their 'comfort zone' by themselves or always carrying a benzodiazepine tablet in their purse or bag. These behaviours maintain the anxiety by preventing individuals from finding out that their symptoms, although unpleasant, are transient and benign.

The cognitive behavioural model of GAD focuses not on the content of the worry, but rather on the worry itself.[8] People with GAD often have a combination of positive and negative beliefs about worry that keep them worrying. Patients describe the phenomenon of being unable to stop their worrying despite the distress it causes or the seeming senselessness of their worry. This might be explained by positive beliefs such as 'worry helps me be prepared', 'worry helps me solve problems' or 'worry keeps me safe'. The other side of the problem may be fears like 'worry will drive me insane', 'worry wears me out', 'my worries are highly likely to occur' or 'worry will harm my health'. These opposing sets of beliefs will result in increasing agitation for patients as they try to sort out their mental processes. Subsequently patients will again develop a complex set of avoidance and safety-seeking behaviours such as avoiding things that trigger their worry (e.g. watching the news, making decisions, answering the phone, interacting with family), or chronically seeking reassurance. This avoidance maintains the patient's worry.

Differential diagnoses

There is significant comorbidity with all the anxiety disorders, partly as a result of the disorder and partly as a result of a concomitant mental disorder. It is important to screen patients for other mental disorders, in particular the most common ones, such as depression and substance misuse. Co-occurring anxiety disorders such as obsessive compulsive disorder, hypochrondiasis and social phobia may also be present in these patients.

Suicidal ideation can also occur in patients with anxiety disorders, especially at times when the anxiety is at its worst and there is a perception of helplessness and hopelessness. GPs should ask patients gently but directly if they have thoughts or urges to harm or kill themselves.

It is extremely important not to miss potential physical causes of the anxiety problem. Panic disorder in particular can be a presentation of mitral valve prolapse or a cardiac arrhythmia such as paroxysmal atrial fibrillation or Wolff-Parkinson-White syndrome.

Both panic disorder and GAD can be the first presentation of an underlying thyroid problem, in particular thyrotoxicosis or hypothyroidism, or may even be a presentation of an underlying substance abuse problem such as alcoholism or amphetamine abuse. It is important to rule out simple benign causes such as excess caffeine intake because the physical effects of excess caffeine can often mimic the sensations associated with anxiety.

Treatment and management

The treatment and management of panic disorder and GAD can take a stepwise approach (see the flowchart on page 45).[9] In the first instance, an accurate and empathic diagnosis in itself can be therapeutic, although it is essential that patients feel it is not 'all in their head'.

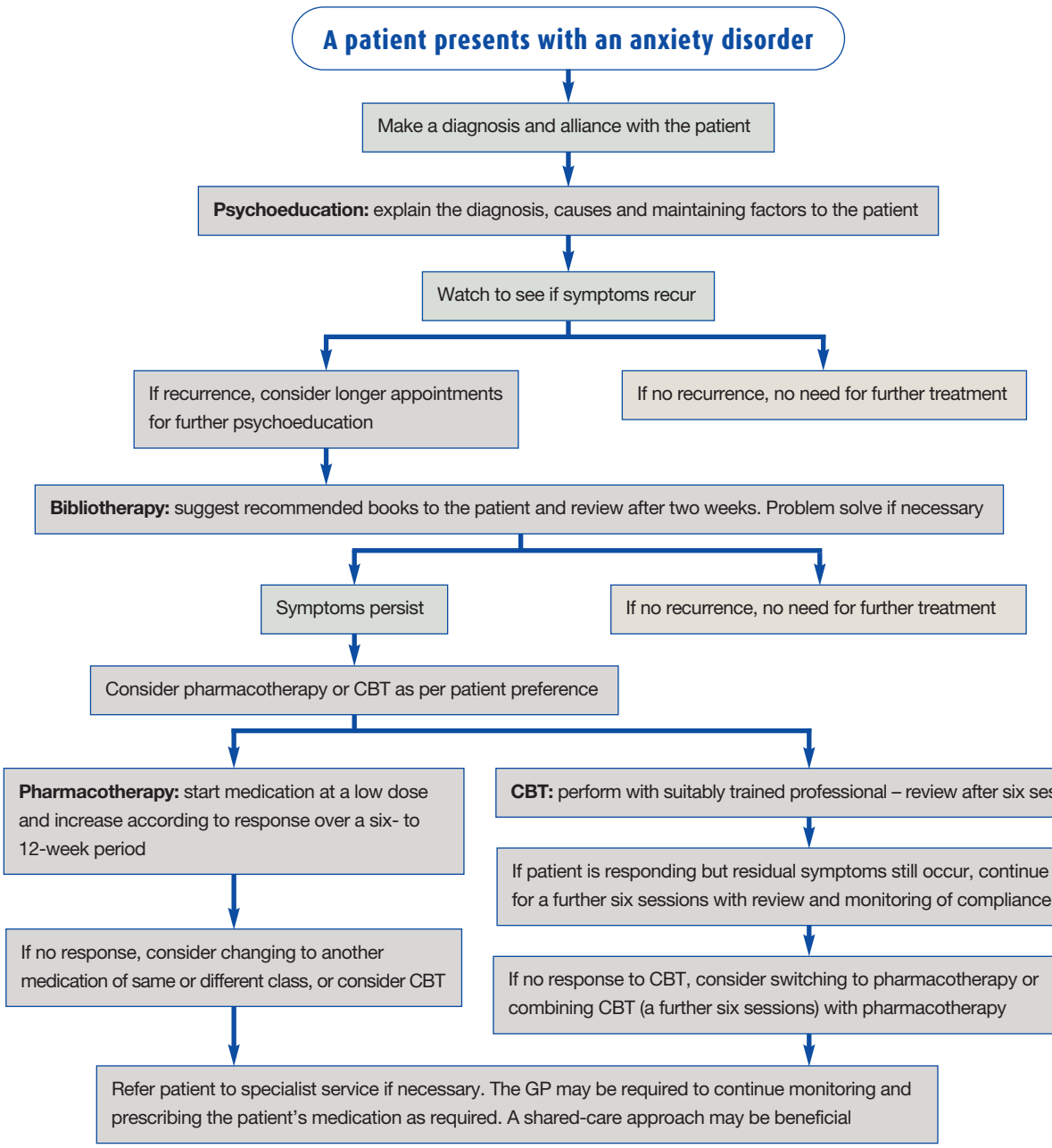
It is best to walk patients through the diagnostic criteria and describe how their symptoms fit. A discussion of the causes and maintaining factors of the disorder may also be beneficial; this may involve explaining the flowchart on this page to patients with panic disorder. Patients may require a double appointment at a later

date to facilitate discussion with time for questions.

Websites such as those of the Centre for Clinical Interventions and the Clinical Research Unit for Anxiety and Depression (CRUfAD; see the box on page 46) can be beneficial to GPs to provide accurate education and guidance to patients regarding self-management.

Treatment thereafter will depend on a joint decision between the patient and the GP. Problem severity, patient preference and treatment cost and availability will also guide decision making. There is good evidence to support the use of bibliotherapy

Proposed step-care model for a patient with an anxiety disorder[9]



ABBREVIATION: CBT = cognitive behavioural therapy.

Patient resources for generalised anxiety disorder and panic disorder

Websites

Clinical Research Unit for Anxiety and Depression (CRUfAD)
www.crufad.com

VirtualClinic
www.virtualclinic.org.au

Centre for Clinical Interventions
www.cci.health.wa.gov.au

Mental Health First Aid
www.mhfa.com.au

Books

Lampe L. Take control of your worry. Sydney: Simon & Schuster; 2005.

Page A. Don't panic: anxiety, phobias and tension. Sydney: Media 21 Publishing; 2002.

Meditation CDs

Meditation CDs by Dr Sarah Edelman. See the following website for more details: www.holisticpage.com.au/_Sarah_Edelman.php

and self-help, cognitive behavioural therapy (CBT) and pharmacotherapy.[10,11]

Bibliotherapy and self-help

Within the context of the GP surgery, bibliotherapy is the easiest treatment to provide. Patients who are motivated and have a standard education should be able to make use of these resources. Recommended books for patients are included in the box on this page. It is best to ask patients regularly about their reading and answer questions as they arise.

Arousal reduction strategies such as breathing exercises and relaxation training are also useful. They do not treat the underlying maintaining factors, but they are practical and can be implemented quickly. Getting patients to slow their breathing rate to three seconds in and three seconds out can help manage panic attacks that occur in consultations. Good resources for patients are readily available online including a series of meditation CDs (see the box on this page). The Mental Health First Aid website (see the box on this page) is also useful for more practical tips on managing panic attacks. Treatments incorporating mindfulness and meditation are becoming increasingly popular; however, there is currently insufficient evidence to suggest they are effective.

Cognitive behavioural therapy

CBT is the treatment of choice for patients with panic disorder and GAD. There is some evidence that combining selective serotonin reuptake inhibitors (SSRIs) with CBT is more effective than either therapy alone, although there are some inconsistencies in study findings.[12,13] CBT for panic disorder leads to large treatment effect sizes with response rates of 70 to 80%, whereas CBT for GAD yields medium to large treatment effect sizes and response rates of 50 to 60%.[14,15] These gains appear to be maintained over a year.[16]

There is an increasing variety of forms of CBT available, such as group CBT, individual CBT and clinician-assisted computerised CBT (CaCCBT). One of the difficulties with CBT is the relative dearth of suitably trained clinicians outside metropolitan areas. CaCCBT is an attempt to address this problem.[17] To date there have been promising results for internet-based treatment of panic disorder, but this form of treatment is still in its infancy and requires further evaluation.[18,19] (Online programs are available on the Centre for Clinical Interventions and VirtualClinic websites; see the box on this page.)

Of paramount importance is that CBT is administered by a suitably qualified professional (ideally by a specialist clinical psychologist or psychiatrist) who uses a standardised protocol and receives regular supervision. CBT appears to be more cost effective than other forms of treatment.

Pharmacotherapy

As a rule, benzodiazepines are not recommended in patients with anxiety disorders because of their addictive potential and the resurgence in symptoms after cessation of treatment. However, they can prove useful in the ultra short term to provide fast relief of extreme distress.

Panic disorder

If pharmacotherapy is considered for the treatment of panic disorder, there is evidence for efficacy of SSRI antidepressants, although there is no evidence to favour one over the other. As for treatment of depression, patients should start at the lowest available dose of antidepressant and then increase the dose gradually according to response over a period of six to 12 weeks. There are some negative reports in the literature, and overall treatment response with SSRIs is around 50%. Discontinuation after a year of therapy results in a relapse rate of approximately 30 to 40% of patients who responded initially, and about 25% of all patients taking SSRIs will cease their use due to side effects.[12]

There is also evidence for the use of tricyclic antidepressants (TCAs); however, this evidence is at times conflicting. Overall, clomipramine and imipramine are generally as effective as CBT. Again, there is a risk of relapse on treatment cessation of these drugs of approximately 40% and relapses tend to occur in the first six months post cessation.[12]

Generalised anxiety disorder

In general there is little difference in efficacy between the various medications in the treatment of GAD. Overall the SSRIs, TCAs and venlafaxine all appear to be efficacious and reasonably tolerated, but there is a high relapse rate after cessation.[20]

There is some evidence to suggest that the newer serotonin noradrenaline reuptake inhibitors (SNRIs) may be effective, but the level of evidence is not yet sufficient to recommend routine use.

Benzodiazepines, and in particular diazepam, show large treatment effect sizes, but their effects are short lived and there are significant complications on cessation even after a brief treatment session. These complications include withdrawal syndrome, increase in the primary anxiety symptoms and seizures in the case of the short-acting benzodiazepines.[21] Buspirone also appears to be effective but less so than the benzodiazepines, and it is associated with significant relapse upon cessation.[22]

Conclusion

Panic disorder and GAD are common and debilitating anxiety disorders. It is important for GPs to diagnose and educate affected patients about their condition and rapidly guide them to helpful resources such as self-help books and websites, prescribe medication and refer them as needed. MT

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