

Recognising and managing panic disorder and agoraphobia

Why is this important?

Each year, between one and two per cent of the Australian population is affected by panic disorder [1]. Panic attacks are sudden-onset episodes of severe anxiety coupled with symptoms of the flight or fight response – palpitations, trembling, shortness of breath, sweating – in situations where there is no real danger. Panic disorder is characterised by recurrent panic attacks, fear of physical or emotional collapse during an attack and worry about future attacks. Many people with panic disorder avoid situations in which they imagine help would not be available, or escape possible, should they have an attack. This avoidance is known as agoraphobia. These conditions usually begin in young adults between the ages of 15 and 30, and are twice as likely to be experienced by women as men.

Despite panic disorder and agoraphobia being significant causes of disability, most people (61

per cent) experiencing one or both of these conditions do not seek or receive any professional treatment. Of those who do receive some form of care, more than a third receive treatment for which there is no evidence of effectiveness in their particular circumstances [1].

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Best available evidence

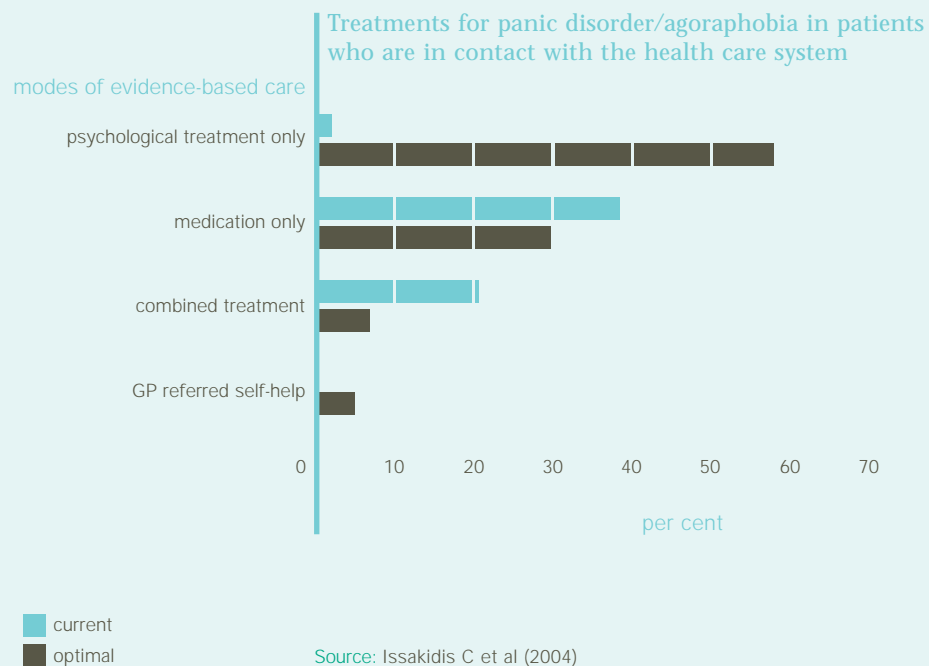
The optimal treatment package for panic disorders places emphasis on CBT as a first-line treatment for the majority of people [2]. CBT offers the prospect of a sustained benefit once the patient is no longer receiving active treatment. It can be delivered individually or as a group treatment for six to eight persons of varying levels of severity. Typically, a total of about seven hours of group therapy is required per person. Not every patient with panic disorder/agoraphobia benefits equally from CBT. In fact, for every three patients who receive CBT, only one will achieve a significant improvement. In other words, the number needed to treat (NNT) for CBT is three.

Those receiving medication as a first-line treatment would see the treating clinician an average of five times per year [2]. Treatment guidelines recommend either selective serotonin reuptake inhibitors (SSRIs) or tricyclic

antidepressants (TCAs) as the optimal pharmacological treatments for most anxiety disorders, with the NNT being six in both cases, i.e. six patients being treated for one to achieve a favourable outcome [2]. SSRIs have fewer side effects than TCAs, but are more expensive.

Just under half of those people with panic disorder/agoraphobia have a mild form of the disorder and many would be helped by self-help books and patient treatment manuals that doctors can work through with their patients (see 'Resources').

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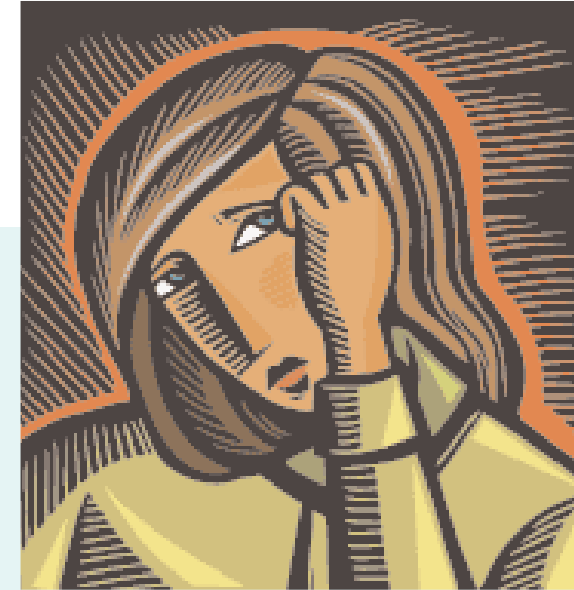


Current practice

Only two per cent of patients receive CBT as a sole form of therapy, yet evidence suggests that 60 per cent of patients should be receiving this form of care [3].

Currently, 39 per cent of patients receive medication as the only form of therapy, but according to best evidence, the figure should be closer to 30 per cent. This applies equally to patients with mild, as well as moderate/severe, forms of the disorder [3].

About 20 per cent of patients are receiving a combination of psychological and medication therapy. According to best evidence, approximately 14 per cent of patients with moderate/severe disorders should be receiving combined treatment [3].



Implications

- Only two out of every five people experiencing panic disorder and/or agoraphobia seek professional help. Those not seeking help often have the mistaken belief that therapy is ineffective or that their symptoms are caused by a physical health problem. There is also an unwillingness to acknowledge that they have a mental illness.
- Best estimates from clinical trials suggest that providing evidence-based care to all those people experiencing panic disorder and/or agoraphobia would halve the level of disability at an increase of only 40 per cent over current expenditure.
- Applying evidence-based care to the management of anxiety disorders would involve more consultations by psychiatrists and clinical psychologists, and more support for general practitioners to provide psychological care.

- Currently, many patients cannot access or afford CBT. In addition, severe symptoms can sometimes act as a deterrent to commencing CBT. In this regard, combination treatment of CBT and medication provides a powerful incentive for certain patients to receive treatment.

Resources

- Andrews G et al, (2003) *The Treatment of Anxiety Disorders: Clinician Guides and Patient Manuals. Second Edition*, Cambridge University Press
- Page A (2002) *Don't Panic: Anxiety, Phobias & Tension*, ACP, Sydney
- Website: www.aforanxiety.com

References

- 1 Andrews G, Henderson S, Hall W (2001) Prevalence, comorbidity, disability and service utilisation. Overview of the Australian National Mental Health Survey. *Br J Psychiatry* 178: 145–153
- 2 The Royal Australian and New Zealand College of Psychiatrists (2002) *Clinical Practice Guidelines for Panic Disorder and Agoraphobia*. RANZCP, Melbourne
- 3 Issakidis C et al (2004) Modelling the population cost-effectiveness of current and evidence-based optimal treatment for anxiety disorders. *Psychol Med* 34:19–35