Managing Anxiety Disorders in primary care

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Preface

Anxiety disorders are among the commonest mental health conditions and are highly prevalent among patients in primary care. These conditions have a negative impact on people’s wellbeing and quality of life and can be disabling and costly to both the patient and the healthcare system. Anxiety can also interfere with the management of people’s physical health and may be associated with worsening outcomes for coexisting chronic physical disorders.

Despite the prevalence of anxiety disorders, many patients remain undiagnosed and untreated, although patients with unrecognised anxiety disorders tend to be high users of both primary and secondary care medical services. Individuals experiencing underlying anxiety may present with multiple somatic complaints and co-morbid disorders or may attend recurrently with unexplained physical symptoms. If anxiety remains undetected, they will not receive appropriate treatment and may also undergo unnecessary, potentially dangerous, and costly investigations.

Making a diagnosis of anxiety can be challenging in primary care. But when anxiety disorders are identified, patients can be offered effective treatments, which include self-help, psychological therapy and medication, and this can transform people’s lives.

This book aims to improve the recognition and treatment of anxiety disorders in primary care. It provides an overview of the commonest anxiety disorders seen in primary care, including how to recognise each disorder, make the diagnosis, explain the condition to patients, and the different management options. It also includes practical case studies to illustrate how different types of anxiety may present in primary care, and how GPs might begin to assess and manage patients with these conditions.

Cognitive behavioural therapy (CBT) is, in many cases, the most effective treatment for anxiety disorders. This book also includes a brief CBT framework for making sense of each anxiety disorder using a five-areas CBT framework, and
an overview of some simple 10 minute CBT strategies for coping with anxiety that can be used to encourage self-care and promote wellbeing.

Further details, including how to access online video-based training and educational DVDs for management of anxiety disorders using 10 minute CBT, can be found on our website: www.10minuteCBT.co.uk.

Lee David
### Abbreviations

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<th>Description</th>
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<td>Acceptance and commitment therapy</td>
</tr>
<tr>
<td>ADHD</td>
<td>Attention deficit hyperactivity disorder</td>
</tr>
<tr>
<td>BDD</td>
<td>Body dysmorphic disorder</td>
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<tr>
<td>CBT</td>
<td>Cognitive behavioural therapy</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>CR</td>
<td>Cognitive restructuring</td>
</tr>
<tr>
<td>DBT</td>
<td>Dialectical behaviour therapy</td>
</tr>
<tr>
<td>EMDR</td>
<td>Eye movement desensitisation and reprocessing</td>
</tr>
<tr>
<td>ERP</td>
<td>Exposure and response prevention</td>
</tr>
<tr>
<td>GAD</td>
<td>Generalised anxiety disorder</td>
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<tr>
<td>GAD-2</td>
<td>Two-item GAD assessment</td>
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<td>GAD-7</td>
<td>Seven-item GAD assessment</td>
</tr>
<tr>
<td>HADS</td>
<td>Hospital Anxiety and Depression Scale</td>
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<tr>
<td>LSAS</td>
<td>Liebowitz Social Anxiety Scale</td>
</tr>
<tr>
<td>MAOI</td>
<td>Monoamine oxidase inhibitor</td>
</tr>
<tr>
<td>MBCT</td>
<td>Mindfulness-based cognitive therapy</td>
</tr>
<tr>
<td>Mini-SPIN</td>
<td>Mini-Social Phobia Inventory</td>
</tr>
<tr>
<td>MUS</td>
<td>Medically unexplained symptoms</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
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<tr>
<td>OCD</td>
<td>Obsessive–compulsive disorder</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-traumatic stress disorder</td>
</tr>
<tr>
<td>SAM</td>
<td>Situationally accessible memory</td>
</tr>
<tr>
<td>SNRI</td>
<td>Selective serotonin and noradrenaline reuptake inhibitor</td>
</tr>
<tr>
<td>SSRI</td>
<td>Selective serotonin reuptake inhibitor</td>
</tr>
<tr>
<td>TCA</td>
<td>Tricyclic antidepressant</td>
</tr>
<tr>
<td>TSQ</td>
<td>Trauma Screening Questionnaire</td>
</tr>
<tr>
<td>VAM</td>
<td>Verbally accessible memory</td>
</tr>
<tr>
<td>Y-BOCS</td>
<td>Yale–Brown Obsessive Compulsive Scale</td>
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Chapter 6
Panic disorder

Panic disorder quick reference guide

<table>
<thead>
<tr>
<th>What is panic disorder?</th>
<th>Recurrent, short-lived episodes of intense fear or anxiety which arise unexpectedly and are associated with intense physical symptoms including palpitations, breathlessness and chest pain or tightness. Catastrophic misinterpretations of bodily symptoms, such as thoughts about having a heart attack or suffocation, lead to rapidly escalating anxiety symptoms as a vicious cycle.</th>
</tr>
</thead>
<tbody>
<tr>
<td>How common is it?</td>
<td>Prevalence is 1.7% in the UK. Panic disorder affects around 7% of patients attending primary care.</td>
</tr>
<tr>
<td>Risk factors</td>
<td>More common in women, in people with a family history of panic disorder and with coexisting physical health conditions causing cardiac and gastrointestinal symptoms. Panic attacks may also be triggered by stressful life events.</td>
</tr>
<tr>
<td>Co-morbid conditions</td>
<td>Panic disorder commonly occurs in association with other anxiety disorders, depression, suicidal behaviour and substance use disorders, including nicotine dependence. Around one-third of people with panic disorder also have agoraphobia. It is also associated with chronic physical health conditions including mitral valve prolapse, migraine and hypertension.</td>
</tr>
<tr>
<td>Usual course</td>
<td>Typically begins with occasional panic attacks which gradually increase in frequency and eventually lead to a pattern of recurrent anxiety and widespread avoidance. It is particularly likely to become a chronic and relapsing condition when associated with agoraphobia.</td>
</tr>
<tr>
<td>Common presentations</td>
<td>Patients with panic disorder may be high users of health services and may present in primary care and emergency settings with severe somatic symptoms such as chest pain, which mimic those of serious physical illness and may lead to the disorder being unrecognised.</td>
</tr>
<tr>
<td>How to make the diagnosis</td>
<td>Diagnosis in primary care is largely clinical. Screening with GAD-2 questions does not specifically ask about symptoms of panic but may also identify people with panic disorder.</td>
</tr>
<tr>
<td>What else could it be?</td>
<td>Where appropriate, rule out underlying physical causes for symptoms of panic, including side-effects of prescribed medication. Routine physical investigation is not required if there is a typical history of panic disorder. The differential diagnosis also includes other anxiety disorders such as social anxiety and PTSD, or substance misuse.</td>
</tr>
</tbody>
</table>
Chapter 6 - Panic disorder

Self-management strategies
Provide clear and accurate explanations of an individual’s feared symptoms that arise during a panic attack. Use graded exposure, breathing techniques to reduce hyperventilation and distraction to manage panic symptoms.

Treatment of panic disorder
First-line treatment is with 7–14 sessions of individual CBT, which is more effective than drug therapy. Guided self-help may be offered in mild–moderate cases. SSRIs are first-line choice of medication.

When to refer
Refer to specialist mental health services if the person continues to experience significant symptoms after treatment with two interventions (any combination of psychological intervention, medication or bibliotherapy).

Risk of relapse
Relapse rates after stopping medication are between 55% and 77% but may be reduced in patients with chronic or relapsing symptoms using maintenance therapy. Relapse rates are lower after CBT.

Follow-up
Chronic relapsing cases will require long-term follow-up and monitoring. Drug therapy should be continued for 6–12 months, after which the dose can be tapered.

CBT framework for panic disorder

6.1 Introduction

Panic disorder is common and can be a severe and disabling illness which involves repeated, short-lived and sudden bursts of intense fear and anxiety, which are highly distressing. Patients with panic disorder have a high use of medical services, an impaired social and work life, and a reduced quality of life overall.
6.2 What is panic disorder?

Panic disorder is characterised by recurring, unpredictable panic attacks, usually associated with worry about having another attack, and a significant change in behaviour related to the episodes. The first panic attack may be associated with a stressful situation or experience, but gradually the attacks become dissociated and occur ‘out of the blue’.

A panic attack is defined as a discrete episode of intense subjective fear. The symptoms arise rapidly and usually peak within 10 minutes and can last for 20–40 minutes but will rarely persist beyond one hour. Patients often develop a fear of experiencing further panic attacks. During a panic attack, sufferers experience intense anxiety-related physical symptoms such as chest pain and tightness, rapid heart rate, hyperventilation, sweating, shaking and gastrointestinal symptoms.

Around two-thirds of patients with panic disorder also experience agoraphobia, defined as fear in places or situations from which escape might be difficult, such as in crowded shops or trains (see Chapter 7). Experiencing panic attacks without meeting the ICD-10 criteria for panic disorder (Box 6.1) is also common, but these attacks can still have a significant effect on quality of life and ability to function in daily life.

---

**Box 6.1 Diagnostic criteria for panic disorder**

**Panic attacks:**
- Discrete episodes of intense fear
- Episodes arise rapidly and peak within 10 minutes, usually lasing for around 20–40 minutes
- Accompanied by intense anxiety-related physical symptoms such as palpitations, chest pain, sweating, trembling, shortness of breath, dry mouth, numbness, dizziness or light-headedness
- Associated with catastrophic fears, such as choking, having a heart attack or imminent death

**Panic disorder:**
- Recurrent panic attacks which arise unpredictably or ‘out of the blue’ without a specific trigger
- Persistent fear of having another panic attack leads to marked avoidance behaviour
- Significant impairment in important areas of functioning
- Symptoms are not caused by substance misuse, medical conditions or other psychiatric disorders
6.3 Epidemiology

Panic disorder has a prevalence of approximately 1.7% in the UK and affects about 7% of patients attending primary care. Panic attacks are even more common, and as many as 13% of the population are likely to experience a panic attack at some stage in their life.

The prevalence of panic disorder is also affected by the presence or absence of agoraphobic symptoms (see Box 6.2).

Panic disorder most commonly develops in the third decade, although it may develop at any time of life. It is 2–3 times more common in women than in men. It is also more common in patients presenting with cardiac and gastrointestinal symptoms. In the USA, up to 25% of patients presenting to emergency departments with chest pain may meet criteria for panic disorder.

### Box 6.2: Prevalence of panic disorder with and without agoraphobia

<table>
<thead>
<tr>
<th></th>
<th>12-month prevalence</th>
<th>Lifetime prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic disorder without agoraphobia</td>
<td>1.5%</td>
<td>4%</td>
</tr>
<tr>
<td>Panic disorder with agoraphobia</td>
<td>0.5%</td>
<td>1%</td>
</tr>
</tbody>
</table>

6.4 Aetiology

Panic disorder is 2–3 times more common in women. Factors that may be associated with its development include:

- genetic factors: the risk of panic disorder increases around 5-fold among first-degree relatives, and twin studies suggest a strong familial component
- biochemical theories: these involve a possible abnormality of neurotransmitter function leading to increased sensitivity of the autonomic nervous system in response to stress
- environment: major life events or life stresses increase background anxiety and may trigger the onset of panic attacks
- physical health conditions: panic disorder is more common in patients presenting with cardiac and gastrointestinal symptoms.

6.5 CBT model of panic disorder

In a CBT model, panic attacks are viewed as spiralling levels of anxiety associated with catastrophic misinterpretations of harmless, often anxiety-related, bodily symptoms (Box 6.3). The patient incorrectly interprets these
### Box 6.3

**Catastrophic misinterpretations in panic disorder**

<table>
<thead>
<tr>
<th>Physiological change</th>
<th>Physical symptom experienced by patient</th>
<th>Examples of catastrophic thoughts and fears</th>
<th>Examples of associated ‘safety behaviour’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid heart rate</td>
<td>Palpitations and muscular chest pain</td>
<td>Maybe I’m having a heart attack</td>
<td>Resting to avoid heart rate getting faster</td>
</tr>
<tr>
<td>Muscle tension in chest wall</td>
<td></td>
<td>I’m going to collapse and die!</td>
<td>Calling an ambulance or presenting to A&amp;E</td>
</tr>
<tr>
<td>Hyperventilation</td>
<td>Feeling short of breath, chest feels tight</td>
<td>I can’t get enough air. I’m going to suffocate!</td>
<td>Trying to take deeper breaths, leading to worsened tightness and discomfort</td>
</tr>
<tr>
<td></td>
<td>Tingling around mouth and in hands</td>
<td>I’m going to collapse or faint!</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Light-headed and dizzy</td>
<td>Maybe I’m having a stroke!</td>
<td></td>
</tr>
<tr>
<td>Reduced saliva</td>
<td>Dry mouth and tightness in throat; globus</td>
<td>I’ve got a lump in my throat</td>
<td>Repeated swallowing as a checking behaviour (makes it even harder to swallow)</td>
</tr>
<tr>
<td>production</td>
<td></td>
<td>I’m choking!</td>
<td></td>
</tr>
<tr>
<td>Reduced concentration</td>
<td>Racing thoughts, forgetfulness</td>
<td>I’m losing control</td>
<td>Attempts to control thoughts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maybe I’m going crazy</td>
<td>Avoiding challenging tasks</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Escape from a situation whenever anxiety arises (leads to reduced confidence and limits daily function)</td>
</tr>
<tr>
<td>Anticipation and fear of panic attacks</td>
<td>Increased background anxiety levels</td>
<td>I’m terrified of having another panic attack</td>
<td>Trying to mentally suppress fears (leads to paradoxical increase in worry thoughts) Avoidance of public places or only going with someone with whom we feel safe</td>
</tr>
<tr>
<td></td>
<td>General sense of apprehension and fear</td>
<td>I must try not to get anxious!</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>I might make a fool of myself in public</td>
<td></td>
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</tbody>
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physical experiences as indicating imminent disaster such as a heart attack, suffocation or going mad. The anxiety that develops in response to these fears results in further symptoms, such as an increasingly rapid heartbeat, dizziness or difficulty concentrating, which are further misinterpreted, rapidly increasing anxiety as a vicious cycle.

Behavioural reactions to feelings of anxiety and panic act to further reinforce fears and compound the problem over time (Figure 6.1). Typical behaviour associated with panic disorder includes avoidance of or ‘escape’ from feared situations and reassurance-seeking. ‘Safety behaviours’ designed to protect the person from their most feared outcome include sitting near exits in public places, avoiding exercise, staying near other people or opening the window to ‘get more air’.

**Figure 6.1** CBT model of panic disorder.
6.6 Co-morbidity

Mental health conditions

Panic disorder is highly co-morbid with other anxiety, mood and substance use disorders, including nicotine dependence. There is a significant association with depression, with lifetime prevalence rates as high as 50–60%. There also appears to be a higher risk of suicide attempts than in the general population.

Around one-third of people with panic disorder have coexistent agoraphobia. This is more common in women and is associated with greater severity and a chronic relapsing course with poorer outcomes from therapy. Social anxiety disorder may also coexist and is diagnosed where the situations avoided are predominantly social and interactive in nature (see Chapter 9).

Physical health conditions

Panic disorder is also associated with chronic medical conditions including mitral valve prolapse, migraine and hypertension, although the cause of the association is not yet clear. It can also coexist with independent physical disorders, which may complicate the clinical picture, especially where these disorders affect cardiac or respiratory function.

6.7 Course and prognosis of panic disorder

Panic disorder typically begins with occasional panic attacks which gradually increase in frequency and eventually lead to a pattern of recurrent anxiety and widespread avoidance. In the longer term, panic disorder can become a chronic and relapsing condition, particularly when associated with agoraphobia.

CBT and antidepressant medication are both effective for panic disorder, although some individuals with good initial treatment responses may develop recurrent symptoms following remission. This may be higher amongst people with marked agoraphobic avoidance. Rates of relapse of panic disorder after stopping medication are estimated to be between 55% and 77%. Relapse may be lower after successful completion of CBT, particularly if people are offered maintenance therapy.

6.8 Presentation of panic disorder

Patients with panic disorder may present with anxiety or with physical symptoms that arise as part of a panic attack. They may be high users of health services with frequent attendances in primary care and emergency settings with severe somatic symptoms, such as chest pain, which mimic those of serious physical illness, and this may lead to the disorder being unrecognised.
Panic attacks which arise unexpectedly and without any obvious triggering situation or event are characteristic of panic disorder without agoraphobia. Those that arise in a predictable way as a follow-on to a given anxiety-provoking situation or event usually reflect a phobia, such as agoraphobia or social phobia.

Case example 6.1: Nisha

How might panic disorder present?

Nisha, a 22-year-old first-year university student, attends the surgery. She describes waking in the middle of the night with a pounding heart, hot flushes and difficulty breathing. The episode came on suddenly and unexpectedly, and the symptoms subsided after a few minutes. Over the last few months, she has been feeling more anxious and has experienced similar episodes in the daytime, at varying levels of intensity. As she approaches her end of year exams, the episodes have become more common and more severe. She is now worried that she might be on the verge of a “nervous breakdown” and describes being overly aware of her “fast breathing and pounding heart”.

Her greatest fear during the episode was that she was about to suffocate and collapse, because her chest felt so tight. She has been avoiding going to lectures and has been staying with her boyfriend due to increasing fears about sleeping alone. Her university studies have been suffering and it has been harder than usual to concentrate on her work. She also admits to sometimes drinking excessive alcohol to try to prevent the episodes at night.

Her GP uses the information that Nisha gives during the consultation to complete a brief CBT framework for Nisha’s experience during a recent panic attack:
GP management of panic disorder begins with recognition and an initial assessment of the condition. The role also includes the provision of support and information, and in collaboratively making initial decisions about management. This may include providing advice about lifestyle changes, making decisions about prescribing medication, and making referrals for psychological interventions or specialist services. A stepped care approach to management is often recommended.

Making the diagnosis

Screening and diagnostic tools
NICE guidelines suggest that there is insufficient evidence to recommend any screening tool for the diagnosis of panic disorder and recommend that clinicians rely largely on consultation skills to elicit the key information.

For screening, use of the two GAD-2 questions may help to identify patients with panic disorder (see Chapter 2). GAD-7 was designed for assessment of generalised anxiety disorder but there is evidence that it is also sensitive in detecting panic-related symptoms and could be used as part of a broader assessment of anxiety. However, it does not specifically ask about panic symptoms.

Case example 6.1: contd

Thoughts
Am I having a nervous breakdown?
I’m going to suffocate or collapse

Feelings
Anxious and panicky

Behaviour
Avoiding going to lectures
Staying with boyfriend to avoid being alone
Drinking excess alcohol

Physical symptoms
Difficulty breathing
Tight chest
Pounding heart
Hot flushes
Difficulty concentrating

With this history, Nisha’s GP strongly suspects that the episodes are due to panic disorder and goes on to carry out a more thorough assessment with this condition in mind.
The Panic Disorder Severity Scale (PDSS) is a 7-item measure assessing the frequency, avoidance, degree of distress, and functional impairment of panic attacks but is relatively long to complete in the primary care setting.

**Discussing panic symptoms**

Some patients with panic disorder will be aware that their symptoms are likely to be due to anxiety. Others will present with somatic symptoms that they fear are due to an underlying physical health condition and may be more resistant to accepting the diagnosis of panic disorder. Some useful questions for asking about anxiety in patients presenting with somatic symptoms are shown in Box 6.4.

**Ruling out underlying physical causes**

An important role of primary care is to look for underlying physical causes for symptoms of panic. This might include ruling out hyperthyroidism and investigation of physical symptoms such as chest pain, palpitations, dizziness or shortness of breath.

Many drugs can also trigger panic attacks, including prescribed medication such as SSRIs, or withdrawal from medication such as benzodiazepines or zopiclone, or withdrawal from alcohol, or even just caffeine and nicotine. Illegal substances, particularly stimulants, can also be associated with panic symptoms.

Whilst it is important not to miss likely physical causes, it is not necessary to routinely investigate or refer a patient presenting with typical symptoms of panic

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**Box 6.4**

**Starting to talk about panic attacks**

- Reflect back when you notice that a patient seems anxious or panicky about their symptoms: “This symptom seems to be worrying you a lot…”
- Identify which symptom(s) are giving rise to high levels of anxiety: “Which is the most severe symptom or the one that worries you the most…”?
- Ask for a specific example: “Can you give me an example of a time that you started to feel tight in your chest? Where were you and what were you doing?”
- Identify the person’s fears and health beliefs at the time of a panic attack: “What went through your mind when you were experiencing the chest pain? What was the worst thing that it might be?”
- Tentatively explore whether they had considered the possibility of anxiety: “Do you think that anxiety or panic might be a cause of your symptoms? How do you feel about this possibility?”
- Ask about avoidance and the functional impact of panic attacks: “How much are the symptoms affecting your life? Are you avoiding any situations to stop yourself getting them?”
disorder. Over-investigation or unnecessary referrals can make it difficult for patients with panic disorder to accept an emotional disorder as an explanation for their symptoms.

**What else to consider**

The differential diagnosis should include physical and mental health conditions that can cause acute episodes of anxiety or symptoms which mimic anxiety (Box 6.5).

**Initial assessment**

The initial assessment should explore the nature and frequency of the panic attacks, whether they are spontaneous or associated with specific triggers and whether agoraphobia has developed. Asking questions using a CBT framework can be very helpful when later explaining the condition to patients, as it is easy to highlight the vicious cycles of panic using this model (Box 6.6).

It is helpful to explore the specific fears held by each patient about the meaning of their physical symptoms, particularly what they fear most when the panic attack is at its height. This can help to identify the most relevant explanations about the nature of anxiety and how it may be affecting this individual. Remember that the process of recalling thoughts and feelings during a panicky episode can trigger further anxiety in some people. The discussion should therefore be carried out sensitively, whilst remaining vigilant to possible increased anxiety or distress in the patient during the discussion.

It is also important to assess for the presence of co-morbid conditions such as depression or substance misuse.

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**Box 6.5**

**Differential diagnosis for panic disorder**

- Physical health conditions mimicking or triggering panic attacks: e.g. cardiac or respiratory conditions, hyperthyroidism
- Substance misuse: symptoms caused by the effects of substance use or as a result of withdrawal
- Agoraphobia: panic attacks are predictable and associated with specific situations from which escape may be difficult
- Social anxiety: symptoms are provoked specifically by anticipated and actual exposure to social and performance situations and are associated with a fear of embarrassment or negative evaluation by others
- PTSD: episodes of acute anxiety or panic triggered by trauma-related cues following a traumatic experience
Initial management in primary care

The next step is to offer treatment in primary care. The choice of treatment should be made through a process of shared decision-making with the patient. Psychological therapy, medication and self-help have all been shown to be effective for panic disorder. Self-help strategies can also be used as an adjunct to other treatments.

Explaining panic disorder

One of the most important goals for management of panic disorder in primary care is to provide explanations which help people to better understand the nature of anxiety and the ‘fight or flight response’ (Chapter 1), ideally using a CBT framework to make the explanation clearer. In panic disorder, fear leads
to a vicious cycle of rapidly spiralling anxiety. This can be markedly reduced by giving clear and credible explanations about the cause of the person’s most feared physical symptoms during a panic attack.

Explanations should be tailored to address the person’s specific concerns. For example, someone fearing fainting or collapse may benefit from learning that blood pressure typically rises during a panic attack, so they are highly unlikely to faint, and that the feeling of dizziness actually stems from a combination of hyperventilation and feeling disorientated. Someone fearing choking may benefit from an explanation of what choking is, and a practical experiment of how the throat can feel very tight after repeated swallowing (ask the patient to swallow five times rapidly to demonstrate this).

**Self-help strategies**

Self-help strategies can be particularly helpful for people with mild to moderate panic disorder. These include:

- providing written information about panic disorder and how it affects people
- highlighting relevant self-help books and websites based on CBT principles
- providing information about local and national support groups for anxiety
- lifestyle modification: physical exercise, reducing caffeine intake, smoking cessation and improving sleep habits may all be beneficial.

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**Box 6.7**

**Explanation of a panic attack**

In panic attacks, people experience very intense bouts of anxiety that come on extremely quickly, when they feel under threat. It involves a physical reaction known as the fight or flight response, where the body starts preparing to cope with potential danger. This creates powerful physical sensations. You might notice that you are breathing more quickly and deeply to get more oxygen into the system and that your heart is racing as it pumps more blood around your body to help your muscles prepare to fight or run. The muscles of your chest wall tense up and are working harder, which leads to pain in your chest.

In panic attacks, people usually find these symptoms very frightening, which leads to further anxiety and more physical symptoms as a vicious cycle.

However, although it can feel very unpleasant, remember that symptoms of anxiety are not harmful or dangerous. Try to accept what is happening and do not run away from the situation. If you wait, the fear will pass. Concentrate on exhaling slowly or using ‘square breathing’ to reduce hyperventilation. Distraction can also be helpful. Focus on your surroundings or carry out a mental exercise, check your phone or count backwards from 100 until your symptoms begin to improve.
10 minute CBT strategies for panic disorder

These brief interventions can be used to encourage positive self-management and reduce unhelpful ways of coping during a panic attack.

Cognitive defusion. Cognitive ‘defusion’ involves learning to disconnect or distance ourselves from negative or unhelpful thoughts, and to recognise them as simply words and ideas, rather than absolute facts. It involves a process of pausing, stepping back and observing what is happening in our mind and body. This can be a helpful way to ‘unhook’ from fearful or catastrophic thoughts about the meaning of physical symptoms in panic attacks. The process of becoming less ‘fused’ with thoughts leads to a thought becoming less believable and allows the person to consider alternative perspectives.

Using defusion is often more helpful in a time-pressed GP consultation than attempts to persuade or convince the person that a thought is unhelpful or inaccurate. Strategies to encourage cognitive defusion include:

- labelling thoughts: “That sounds like a really scary thought…”
- reflecting back: “It sounds like you were thinking that the pain might be due to a heart attack, and that was a very scary idea…”
- writing it down: seeing our thoughts as written words on paper allows us the opportunity to step back and view them from a different perspective
- using the sky and the clouds metaphor: “Look up at the sky and watch the clouds moving slowly across it. Your mind is the sky, the clouds are your thoughts. Clouds come and go, and the weather may change, but the sky is constant and still. If we wait, a cloud, or a difficult thought can pass, allowing the sun to shine through again.”

Graded exposure. It is often helpful to encourage patients with panic disorder to gradually reduce avoidance of feared situations, using a brief form of graded exposure. This should be carried out in very small steps, setting ‘micro-goals’ for making change. The patient can be encouraged to carry this out whilst also

**Box 6.8**

**Steps for graded exposure**

1. Make a list of a variety of situations that are being avoided due to anxiety or panic
2. Choose one of the easiest or least anxiety-provoking situations to try first, breaking it down into much smaller steps if needed
3. Aim to complete the task and remain in the situation despite feeling anxious; it can be helpful to plan strategies for coping with any anxiety that arises, e.g. breathing exercises or distraction
4. Try out the task and repeat it until it is more easily achievable without the use of any safety behaviours
5. Repeat with a slightly more challenging experience
using some form of CBT-based self-help material, such as a book or website, which will enable the patient to take the lead in this process.

**Behavioural activation.** Using brief behavioural activation strategies to increase participation in any meaningful or enjoyable activities, with a goal of improving general wellbeing and mood, can also be extremely important.

**Reducing hyperventilation.** Using breathing techniques can help to reduce hyperventilation during a panic attack. These should be practised several times each day when the individual is not feeling anxious, so that they will be more easily recalled and used in a panicky situation. Techniques include:

- square breathing (*Figure 6.2*): breathe in for a slow count of 4, hold for 4, breathe out slowly for 4 and hold again for 4; repeat this process for 4 minutes
- slow exhale (*Figure 6.3*): breathe out as slowly as possible, creating a gentle audible sighing sound, while counting upwards in your head to as high a number as possible, inhale and then repeat the slow exhale
- vigorous exercise such as a brisk walk or jog, or running up and down the stairs, provides distraction and will reduce symptoms arising from hyperventilation.

**Distraction.** Distraction can be a useful strategy to help reduce anxiety at the peak of a panic attack, enabling the individual to remain in the situation and leading to a reduced anxiety over time. It involves shifting attention away from...
catastrophic thoughts and fears, by paying attention to something else. To be effective in a panic attack, the activity needs to engage the mind when anxiety levels are very high, and therefore should not be overly complex or difficult. However, distraction techniques should not be overused as they can become counterproductive if used as a method of avoiding feared situations.

Examples of distraction activities include:
- counting backwards or in sevens or simple mental arithmetic
- focusing on the immediate environment: mentally describe the sights, sounds, smells around you or count the objects that can be seen
- simple puzzles, crosswords, word searches or sudoku; drawing a diagram or picture
- raising activity levels – going for a short walk or running up and down the stairs
- electronic distraction: sending an email or a text message, or using an app or game on the phone (note – this should be used with caution as it has a particularly high risk of leading to avoidance).

Treatment of panic disorder in primary care

**Psychological therapy**

CBT is the first-line treatment for panic disorder and is more effective than medication. It usually involves between 7 and 14 weekly one-to-one sessions, with the process of therapy rarely lasting longer than 4 months. Briefer CBT (i.e. less than 7 sessions) may also be used in combination with structured self-help materials in mild–moderate cases.

Importantly, research does not currently support the use of relaxation techniques such as progressive muscle relaxation as part of CBT for panic disorder. Relaxation strategies are ineffective and may even inadvertently increase anxiety as they may detract from the patient’s ability to tolerate the anxiety and some patients may use them as safety behaviours.

Factors which may lead to poorer outcomes from CBT include a younger age of onset, longer duration of the disorder, poor motivation and individuals with high levels of social dysfunction or avoidance.

Core components of CBT for panic disorder are shown in Box 6.9.

**Drug treatment**

Drug therapy is less effective than CBT but may be helpful in some cases. First-line treatment is usually with an SSRI licensed for panic disorder, such as sertraline, citalopram, escitalopram or paroxetine.

Initiation and monitoring of drug therapy should follow recommended guidelines, which are summarised in Chapter 3. Medication should be continued for 6–12 months after the optimal dose is reached, after which the dose can be tapered.
## Box 6.9

### Core components of CBT for panic disorder

| **Psychoeducation** | - Understanding the panic model and the CBT approach to panic disorder  
- Education that panic symptoms are not dangerous but reflect the body’s automatic response to danger  
- The role of avoidance in maintaining the problem |
|---------------------|-------------------------------------------------------------------------------------------------------------------|
| **Cognitive restructuring (CR)** | - Discussion and verbal processing to help the patient identify and restructure the thoughts that arise during a panic attack  
- CR can be used to address unhelpful thinking styles such as over-estimation of danger or catastrophising about anxiety-related physical symptoms through:  
  - learning to treat the thought as a hypothesis or theory  
  - looking at evidence for and against the thought being accurate  
  - identifying a balanced, alternative conclusion based on the evidence  
- CR may also involve looking for alternative thoughts that promote coping behaviour and reduce avoidance of feared situations |
| **Graded exposure** | - Repeated graded exposure to situations that are being avoided due to anxiety or panic, building up through a gradually increasing hierarchy of difficulty  
- The patient remains in the situation until anxiety symptoms have subsided (habitation), leading to tolerance and eventual resolution of the anxiety  
- Patient must not carry out any safety behaviours, avoidance or distraction from the source of the anxiety  
- Interoceptive exposure involves doing physical exercises to provoke panic symptoms (e.g. deliberately hyperventilating, or spinning a chair to recreate dizziness)  
- *In vivo* exposure involves facing the real-life situations that provoke panic attacks  
- Imaginal exposure involves imagining being in a panic-provoking situation and visualising coping with it |
| **Core beliefs** | Some patients may need to address underlying core beliefs that lead to increased anxiety and tendency to panic (e.g. “I must be in control all the time”) |
| **Relapse prevention** | Review what has been learned, identify potentially difficult situations that may trigger an attack and identify strategies to prevent future attacks or to manage their anxiety should a panic attack occur |
At the end of treatment, withdraw the SSRI gradually, as dictated by patient preference, and monitor for relapse for as long as is appropriate to the individual.

If there is no improvement after a 12-week course of SSRI medication, or an SSRI is not suitable, consider trial of an alternative SSRI or a TCA such as imipramine or clomipramine. Alternatives include an SNRI such as venlafaxine, or an anticonvulsant such as gabapentin or sodium valproate.

Benzodiazepines, sedative antihistamines and antipsychotics are not recommended for panic disorder and should be avoided. Propranolol has also been shown to lack efficacy in panic disorder and may even contribute to its maintenance as a safety behaviour and should therefore be avoided in most cases. Where possible, ‘as required’ medication should also be avoided, which can worsen anxiety by reinforcing fears about the dangers of panic attacks.

If there is insufficient response to medication, then consider psychological treatment, if this has not previously been tried.

**When to change treatments**

After around 12 weeks of first-line therapy, an assessment of the effectiveness of the initial treatment should be made, and a decision made whether to continue or consider an alternative intervention if there is insufficient improvement. This might involve changing to an alternative SSRI, trying a different class of antidepressant medication or offering psychological therapy if it has not so far been tried. Conversely, medication may be offered to patients who have not improved after undergoing psychological therapy.

**When to refer**

Offer referral to specialist mental health services if the person continues to experience significant symptoms after treatment with two interventions (any combination of psychological intervention, medication, or bibliotherapy), or in severe cases where there are concerns about a risk of self-harm or neglect, or significant functional impairment.

Specialist mental health services should conduct a thorough, holistic reassessment of the individual, their environment and social circumstances. Care should be based on the individual's circumstances and shared decisions made. Management options at this stage include:

- CBT with an experienced therapist, if not offered already, including home-based CBT if attendance at clinic is difficult, e.g. due to agoraphobic symptoms
- structured problem-solving
- alternative options for medication
- assessment for and treatment of co-morbid mental health conditions
- day support to relieve carers and family members
- referral to tertiary centres for advice, assessment or management in severe cases.
## Summary of primary care management of panic disorder

<table>
<thead>
<tr>
<th>Stepped care approach</th>
<th>What to offer</th>
<th>What does this involve?</th>
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</table>
| **Initial presentations of mild to moderate panic disorder** | Explain the diagnosis and the person’s feared symptoms | • Give clear and accurate explanations of the patient’s feared symptoms and how these symptoms can arise as a consequence of a panic attack  
• Use the CBT framework and the fight or flight response to increase understanding of the nature of anxiety and its effect on the body |
| **10 minute CBT advice about managing anxiety** | | • Discuss the role of graded exposure to reduce avoidance to feared situations  
• Use brief behavioural activation to increase participation in any meaningful or enjoyable activities  
• Reduce hyperventilation using strategies such as ‘square breathing’ and slow exhalation  
• Use distraction to help reduce anxiety during a panic attack, enabling the individual to remain in the situation and leading to reduced anxiety over time |
| **Signpost to self-help resources** | Provide information about CBT-based books and websites for understanding and managing anxiety |
| **Moderate panic disorder or lack of response to initial measures** | CBT is the most effective treatment for panic disorder and should be first-line choice of treatment | **First-line:**  
refer for primary care psychological therapy  
• Less severe cases: low intensity CBT involving guided self-help or group-based CBT  
• More severe cases: 7–14 sessions of individual CBT over a maximum of 4 months |
| **Second-line:** pharmacological treatment | | • Initial choice of drug treatment for panic disorder is an SSRI licensed for panic disorder such as sertraline, citalopram, escitalopram or paroxetine; therapy should be continued for 6–12 months and can then be tapered  
• Maintenance therapy may reduce the risk of relapse  
• Second-line therapy could involve a TCA (imipramine or clomipramine), SNRI or anticonvulsants (gabapentin or sodium valproate)  
• Benzodiazepines, sedative antihistamines and antipsychotics should be avoided  
• Where possible, avoid ‘as required’ medication as this may act as a safety behaviour and worsen panic |
| **Severe or complex problem or lack of response to primary care treatment** | Refer to specialist services | • Refer if the person continues to experience significant symptoms after treatment with two interventions (any combination of psychological intervention, medication or bibliotherapy), or in severe cases of significant functional impairment or a risk of self-harm or neglect |
6.10 Monitoring and follow-up

Patients with panic disorder should undergo regular review in primary care, particularly in the early stages of starting medication. Individuals receiving self-help interventions should be offered regular review every 4–8 weeks so that progress can be monitored, and alternative interventions considered if appropriate.

Follow standard guidelines for monitoring during initiation and maintenance of antidepressant medication (see Chapter 3). There is a risk of relapse after discontinuation of drug therapy, which may be reduced using maintenance therapy in patients with recurrent or relapsing symptoms.

Case example 6.2: Richard

**Diagnosis of panic disorder**

Richard is 38 years old and presents to the surgery for the second time in 4 weeks with sudden-onset chest pain, rapid heart rate, sweating, dizziness and shortness of breath. He works in a high-pressure job in a large bank and the attacks have worsened recently when his new boss has been putting him under pressure to achieve higher targets.

He worries about having these episodes in public and other places where getting help would be difficult. He has stopped driving his car and is avoiding crowded areas for fear of bringing on further attacks. He never goes anywhere without his mobile phone, in case he needs to call his wife for help. Past medical history is unremarkable and cardiac investigations have always been completely normal.

Dr Khan has never met the patient previously, so he starts by taking a full history, carrying out a physical examination and reviewing the medical record including all letters from emergency services and hospital letters. The GP is aware that Richard seems very anxious and agitated, and reflects this back with empathy during their conversation, whilst exploring Richards fears and health beliefs: “You seem very anxious… This must be very frightening… What is the most frightening part for you? What is the worst thing that might happen?”

Richard explains that when he experiences these episodes, he believes that he is going to faint, which he describes as both embarrassing and dangerous, saying, “I could never return to work if I fainted in front of my boss. And what if it gets so bad that I stop breathing? I could suffocate!”

Dr Khan uses labelling to highlight Richard’s catastrophic fearful thoughts: “It sounds like you were having a lot of very frightening thoughts. You were thinking that you might faint or even stop breathing or suffocate…? That sounds very scary…”

He also asks Richard to describe the physical sensations that are making him anxious, using non-judgemental language, by asking: “Can you tell me the physical sensations that you are having that make you feel like you might faint or stop breathing…”
**Case example 6.2: contd**

Dr Khan uses a CBT framework to write down Richard’s experiences:

**Thoughts**
- I’m going to faint
- I could never return to work if I fainted in front of my boss
- I might stop breathing or suffocate

**Feelings**
- Anxious and agitated
- Panicky
- Embarrassed

**Behaviour**
- Stopped driving
- Avoids crowded areas
- Takes mobile phone for reassurance

**Physical symptoms**
- Chest pain, rapid heart rate
- Sweating, dizziness and shortness of breath
- Tight chest and light-headedness

**Environment**
- High pressured job in a bank; new boss and higher targets

Dr Khan notices that Richard seems to be getting anxious when talking about his feared physical symptoms. So, he shows Richard how to carry out a brief ‘square breathing’ exercise. By concentrating on this, Richard is able to reduce his anxiety levels and engage more fully in the discussion again.

The GP explains that he believes Richard is experiencing panic attacks, saying: “You have described experiencing a very severe tightness in your chest and a feeling of light-headedness. That physical sensation led to thoughts that you might faint or suffocate.”

Dr Khan then gives a credible physiological explanation for Richard’s symptoms: “An alternative explanation for your symptoms is that they are due to severe anxiety. It’s possible that this was a panic attack. When you have high levels of anxiety, your body releases the chemical adrenaline, which triggers the fight or flight response as it prepares for possible danger. So you start to breathe faster and deeper, and can ‘hyperventilate’ causing tightness and discomfort in the muscles of your chest wall. This over-breathing can also make you feel light-headed, although you are actually far less likely to faint because your blood pressure rises during periods of anxiety…”

Dr Khan explains that the most effective treatment for panic disorder is CBT but that medication may also be an option in some cases. He gives Richard a leaflet about panic disorder and invites him to return for a follow-up consultation to discuss the treatment options.
6.11 Summary and key points

- Panic disorder is characterised by recurrent episodes of intense fear and highly distressing somatic symptoms.
- Individuals with panic disorder make catastrophic misinterpretations about the risks of harmless, anxiety-related physical symptoms, leading to rapidly escalating anxiety as a vicious cycle.
- Avoidance or safety behaviours maintain the disorder over time and lead to significant functional impairment.
- Assessment of panic disorder involves clinical interview and there is no recommended specific screening tool, although HADS or GAD-7 may be helpful to monitor background levels of anxiety.
- Underlying physical causes should be ruled out when clinically indicated, including physical health conditions, prescribed or over-the-counter medications, and illicit substances.
- Psychoeducation involves providing a credible alternative medical explanation for an individual’s specific feared physical symptoms that arise during a panic attack.
- CBT is the most effective treatment for panic disorder, and is associated with a lower risk of relapse after successful treatment than antidepressants.
- Relaxation training is not recommended in panic disorder and may even worsen long-term anxiety by reinforcing fears about the dangers of panic attacks and acting as a form of safety behaviour.
- SSRI antidepressants are first-line medication for panic disorder; other drug treatments include SNRI antidepressants and tricyclics. Benzodiazepines and beta blockers are not recommended.

6.12 Panic disorder resources

- Centre for Clinical Interventions: www.cci.health.wa.gov.au/Resources/For-Clinicians/Panic
- Northumberland, Tyne & Wear NHS Foundation Trust Self Help leaflets: https://web.ntw.nhs.uk/selfhelp/leaflets/Panic%20A4%202016%20FINAL.pdf