HANDI Making non-drug interventions easier to find and use

Cognitive behavioural therapy: Panic disorder

Intervention

Cognitive behavioural therapy (CBT), which is a multimodal psychotherapy. Specific techniques used in CBT for panic disorder include psychoeducation, breathing retraining, progressive muscle relaxation, cognitive restructuring, behavioural experiments, interoceptive exposure and in vivo exposure.

CBT is recommended as first-line therapy for panic disorder. It can be used alone or in conjunction with pharmacotherapy.

Indication

Panic disorder affects approximately 10% of general practice patients

Panic disorder in adults, with or without agoraphobia.

Physical symptoms of a panic attack include a racing heart, palpitations, chest pain or tightness, shortness of breath, feeling faint, sweats, blurred vision, pins and needles in limb peripheries and/or around the mouth, butterflies in the stomach, and 'jelly legs'. Panic disorder involves recurrent and sometimes unexpected attacks.

A panic attack is also characterised by worry about the consequences, such as a loss of control or social humiliation. During an attack, sufferers often report a poor ability to concentrate and may have feelings of unreality.

Panic attacks can lead to agoraphobic avoidance of places where escape is difficult or embarrassing or where help is not available.

The number needed to treat (NNT) with CBT for panic disorder is three.

Availability

CBT may be provided by GPs or other mental health professionals (eg mental health nurses, psychologists, occupational therapists, accredited mental health social workers). Ideally, GPs should be familiar with the areas of expertise of their local network to ensure an appropriate referral.

GPs can provide the appropriate psychoeducation even if they do not use all of the CBT techniques recommended for management of attacks including agoraphobic avoidance. This involves describing the symptoms related to the adrenaline fuelled 'fight or flight' response, and how this can be misinterpreted if a person does not flee or fight.

CBT is increasingly becoming available online (eg mindspot.org.au). This option is more effective if supported by a 'coach' such as a GP or another mental health professional.

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Description

The cognitive component of CBT helps patients to understand how the way they think about their symptoms affects their experience. For example, being fearful of the symptoms can create a feedback loop, increasing the length and intensity of the 'fight or flight' response and continuing the length and severity of the panic attack. Conversely, challenging these thoughts can lead to control of panic and/or agoraphobia.

The behavioural component may involve exercises to induce symptoms as a teaching and mastery tool. An example is getting a patient to hyperventilate (a form of interoceptive exposure) to induce symptoms. This can be undertaken during a consultation or the patient may undertake this as part of their 'homework'.

The behavioural component often also involves patients gradually challenging themselves within triggering situations while giving them skills to manage their panic (in vivo exposure).

Face-to-face therapy is generally limited to 5–10 sessions of 1 hour (often weekly) over a maximum of 4 months. Sessions may be delivered individually or within a group.

Patients can expect to be asked to undertake homework and to monitor their symptoms. Weekly sessions provide a chance to review the progress of homework exercises. The frequency and severity of panic attacks are monitored by the patient and are a guide to progress.

Tips and challenges

CBT can be used at any stage in the development of panic disorder. Even long-term agoraphobia may respond to CBT.

Online delivery of treatment with clinician support may be a preferred and cost-effective option for some patients. For examples, see mindspot.org.au and this way up (choose the panic module).

Treatment strategies may also involve family members to help maximise the patient's consistency with recommended interventions.

Patients don't need a referral from a GP to see an accredited mental health social worker, occupational therapist or psychologist; however, a Mental Health Treatment Plan from a GP is needed to claim rebates from Medicare or to use the Access to Allied Psychological Services (ATAPS) program. Medicare rebates are available for individual or group sessions with these professionals.

Grading

NHMRC Level I evidence.

Training

Accredited mental health training is available from The General Practice Mental Health Standards Collaboration (GPMHSC).

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References

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Pompoli A, Furukawa TA, Imai H, Tajika A, Efthimiou O, Salanti G. Psychological therapies for panic disorder with or without agoraphobia in adults: A network meta-analysis. Cochrane Database Syst Rev 2016. doi: 10.1002/14651858.CD011004.pub2.

Consumer resources

Several online resources about panic attack can be accessed through mindhealthconnect.

Beyondblue panic disorder factsheet: https://www.beyondblue.org.au/the-facts/anxiety/types-of-anxiety/panic-disorder

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