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S36. Panic, anxiety and its treatment

WORLDWIDE PROGRAM ON RECOGNITION AND TREATMENT OF PANIC DISORDER

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In 1989, as part of my presidency of the World Psychiatric Association, I initiated a new program of Presidential educational projects. I felt that one of the first projects should be a task force to assess the status of panic anxiety and its treatments.

This symposium is part of the report of the Task Force chaired by Gerald Klerman, M.D. and Robert Hirschfeld, M.D. In it, we review the clinical and epidemiologic findings regarding panic, anxiety, particularly as to the validity of the diagnostic concepts, the evidence for efficacy and safety of current treatments the available knowledge regarding current clinical practices in relation to research findings and public health needs, and the implication of these findings for clinical practice and public policy. We identify areas for future research and then make recommendations to the World Psychiatric Association regarding future educational research programs.

Clinical and Diagnostic Features of Panic Anxiety and Panic Disorders

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Clinical descriptions of panic disorder have existed for several hundred years. However, panic disorder did not become a part of the DSM until 1980 and has only recently been included in the ICD. Although both of these systems have the same diagnostic criteria of panic disorder and agoraphobia, they differ in concept. The ICD-10 regards agoraphobia as an extreme type of phobia whereas the DSM-IV considers agoraphobia as secondary to panic disorder. Panic disorder requires spontaneous, unexpected panic attacks with typical age of onset in late adolescence and early adulthood. Women are affected twice as frequently as men. Panic disorder has a high rate of comorbidity with other anxiety disorders, depression, and personality disorders.

COGNITIVE THERAPY FOR PANIC DISORDER

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Patients with panic disorder are fearful of the physical symptoms of anxiety and this fear increases and prolongs their anxiety. Cognitive therapy designed to reduce this fear is an effective treatment for panic disorder. Controlled clinical trials indicate that its immediate effect is similar in magnitude to that of imipramine, and there is some evidence that its effects may be better maintained than that of drug treatment. Cognitive therapy is, however, more time consuming and complex than pharmacotherapy.

Results of a controlled trial of cognitive therapy, non-specific psychological treatment and drug therapy, carried out in Oxford will be summarized before considering evidence from other controlled trials. This body of work will be reviewed with regard to the outcome at the end of treatment and at follow-up of cognitive therapy, non-specific psychological treatment, and pharmacotherapy. Drop out rates from each kind of treatment will be reviewed, and conclusions will be drawn about the role of cognitive therapy for panic disorder in everyday clinical practice, and about needs for future research.

THE TREATMENTS OF PANIC DISORDERS

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Panic disorder is a treatable condition - at least in the short-term. Numerous studies have shown that pharmacological treatments, especially the classical tricyclic antidepressants, the monoaminooxidase-inhibitors and certain benzodiazepines can effectively control the condition over a period of several weeks. The relatively high percentage of patients who show a symptomatic course after terminating such short-term pharmacological treatments has become a challenge to both biologically and psychologically orientated researchers. It could be shown that a carefully tailored slow reduction of psychotropic medication leads less frequently to a re-occurrence of symptoms. In a long-term follow-up study of patients who had received short-term treatment with psychotropics only 20% had a persistent chronic symptomatic course 4 years after the end of treatment, with another 50% presenting with waxing and waning symptomatology and 30% remaining completely healthy. Psychologically orientated researchers have shown that psychological treatments - cognitive therapy for panic attacks, exposure in vivo for agoraphobia - are not only efficacious in the short-term but that the effect of these treatments persists over several years of follow-up. Sample sizes are still small in these studies and there are some open questions about comparability with psychopharmacological trials. In the future, the question of a possible heterogeneity of what is called panic disorder both in terms of etiology and treatability should be given more consideration in order to be able to identify sub-populations who are more likely to respond to one treatment or to the other.

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