PANIC ATTACKS AND MEDICATION

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Abstract – Panic attacks can interfere greatly with a patient's social, professional and personal life. The first-line treatment is usually a combination of psychotherapy and medication. Medication broadly addresses two time horizons. In the short-run, benzodiazepines or benzodiazepine-like drugs reduces anxiety within twenty minutes to an hour, which is too long to treat an acute panic attack biologically, but which gives the patient a greater sense of control over the feelings of anxiety, which can in turn reduce anxiety and panic attacks. In the medium- to long-run, antidepressants with effectiveness on serotonergic pathways reduce or eliminate anxiety and the occurrence of panic attacks in the majority of patients. The group of selective serotonin reuptake inhibitors (SSRIs) is probably the best researched and clinically most widely used family of antidepressants for cases of anxiety and panic attack disorders.

Keywords: panic attack, medication, psychiatry

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Introduction

Panic attacks have a sudden onset. Often there is the sense of losing control, physically as well as psychologically. A panic attack leads into a vicious cycle, where the anxiety of losing even further control makes the panic attack worse. Breathing is often rapid and shallow, which further contributes to the panic attack by altering the blood gas levels.

Panic attacks seem to occur out of the blue. However, a more thorough psychotherapeutic investigation often leads to underlying thoughts, emotions and remembered situations that can trigger or maintain anxiety and panic attacks. In most cases of panic attacks and anxiety, patients themselves often have the sense that something in their life is out of sync. Maybe a job is not what it was expected to be, or it has lost meaning altogether, or a relationship to a significant other, particularly a romantic relationship, has become difficult or collapsed. Anxiety usually arises from interpersonal issues, which in some cases can also go back to the parent - child relationship. Early losses of a parent or emotionally chaotic family interactions can often be found in patients with anxiety and panic attacks. While psychotherapy is the preferred long-term treatment, medication nevertheless has a place in reducing symptoms rapidly and working effectively against the symptoms in the medium- and long-term.

Medication as a psychological tool

The sudden onset seems to require medication that is taken preemptively. However, this is often not the case. Many patients report that merely having a tablet of an anxiolytic, such as lorazepam or alprazolam in their pocket and immediately available, effectively prevents panic attacks and reduces the need for medication. (1) The knowledge that one has something that helps quickly, can make one less anxious about becoming anxious. (2)

Antidepressants in the medium- to long-term

In the medium- to long-term usually an antidepressant with anti-anxiety properties is used, particularly substances from the group of selective serotonin reuptake inhibitors (SSRIs). They are generally held to be non-addictive and their side-effect profiles, especially of the newer ones, are usually relatively benign. The serotonin syndrome, a potentially fatal side-effect, can occur in some drug combinations, but is otherwise a very rare occurrence. The most dangerous combination with monoamine-oxidase (MAO) inhibitors, a functional group of antidepressants, is more an academic consideration, because the latter should not be used anymore in treating anxiety.

Antidepressant plus Benzodiazepine

The usual strategy is to prescribe an anxiolytic, such as lorazepam or alprazolam, as a fast-acting substance. Lorazepam in the sublingual form, placed underneath the tongue, often works the fastest, although the maximum effect can take as long as the oral form. Parallel to the benzodiazepine for the short-run, a longer-term medication with an SSRI can be started, which can take several weeks to show an effect. But SSRIs are usually quite effective in reducing panic attacks and anxiety, while, unlike the benzodiazepines, they are considered to be non-addictive. Sometimes a switch to another SSRI may be necessary, but one should not switch unless an SSRI has been tried for six to eight weeks at a higher dose.

Other Antidepressants

Other antidepressants which directly influence also the norepinephrine transmitter system, such as the serotonin-norepinephrine reuptake inhibitor (SNRI) Venlafaxine (Effexor®), are probably better avoided in treating panic attacks because they can make them worse in the early phase of treatment. However, sometimes if two or three SSRIs have not worked satisfactorily, one may have to resort to different functional groups or even combinations.

Going slow on the antidepressant

In the case of an SNRI, it usually helps to start on a very low dose, such as 37.5mg Venlafaxine or even half of that, and then go up in small increments (37.mg in the beginning and 75mg later) as soon as any side effects have disappeared. This approach should also be used with the SSRIs. A quarter tablet may be required in the beginning to get the patient used to the medication. Starting too high or going up too fast can lead to more side effects and anxiety in the beginning, which understandably lowers the patient's motivation to take the medication.

The power of information and communication

In any case, it helps greatly to provide the patient with a brief overview of the medication available, including its uses and potential side effects, and how the medication woks. It should especially be mentioned that with some antidepressants, particularly the SNRIs, such as venlafaxine, and less often the SSRI sertraline, anxiety can actually increase in the first couple days or even the first week (sometimes this lasts for up to two weeks, rarely longer than that).

The patient will feel more comfortable with and trusting towards the prescriber, and compliance increases.

One should not discourage a patient from seeking out helpful information on the internet, but steer him or her to content with scientific foundations, such as can be found on Medline, which is run by the National Institutes of Health, or the websites on mental health issues operated by larger teaching hospitals. At the least, the prescriber should also keep up to date on the available medication and how it works. Being able to build confidence in the prescriber's knowledge and skills is important for a patient with anxiety and panic attacks.

Pregabalin and Gabapentin

Pregabalin, an anticonvulsant, which like gabapentin is used in the management of chronic pain, has demonstrated its effectiveness against the symptoms of anxiety in a number of studies. (1–3) Clinically, it is often combined with an antidepressant, such as an SSRI or SNRI, although combinations with second generation antipsychotics or other medication can be considered. The side effect profile is usually good, especially relative to the benzodiazepines with their risk or tolerance and dependency when used over several weeks or months and relative to second generation antipsychotics with their metabolic and other side effects.

Second Generation Antipsychotics

Second generation antipsychotics are not the firts line shoice when it comes to anxiety, especially so when it comes to panic attacks. Reasons are that they are less specific from a neurobiological perspective and have a more adverse side effect profile. However, their effects on the dopamine system may help against anxiety due to interconnectedness of the srotonergic and the dopaminergic systems. (1)

In more severe conditions of anxiety, especially if it presents itself with agitation, second generation antipsychotics can be a worthwhile add-on. However, one should have an eye on possible interactions and wiegh off the higher likelihood of severe side effects, such as tardive dyskinesia, against the added benefit from the medication.

SSRIs and SNRIs generally should be considered a better long term solution than antipsychotics, if only because of the more serious and more frequent side effects patients experience on antipsychotics, which in several cases necessitates a switch in medication, and not infrequently one away from the group of antipsychotics as a whole. However, in a number

of cases the use of second generation antipsychotics seem justified, particularly if the symptoms are of a kind or intensity which antidepressants do not deal with adequately.

Psychotherapy

Medication should always be used in combination with some form of psychotherapy.(2–8) The reasons are manifold, but overall it has shown to increase and maintain the effectiveness of medication and the compliance.

There are a number of psychotherapeutic approaches that have been applied to the treatment of panic attacks, including conginitive behavioral therapy (CBT), psychodynamic psychotherapy, mindfulness training, interpersonal psychotherapy (IPT), and others with considerable success. Ther therapies with the best empirical trac record are the first four.

Since communication plays an important role in the successful treatment of panic attacks, the author has developed communication-focused therapy (CFT), which works directly with the communication processes that underlie virtually all psychotehrapeutic approaches. (6) A specific approach to panic attacks has also been developed within the CFT framework. (7)

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