

Psychopharmacology for the Clinician

Psychopharmacologie pratique

The information in this column is not intended as a definitive treatment strategy but as a suggested approach for clinicians treating patients with similar histories. Individual cases may vary and should be evaluated carefully before treatment is provided.

Combined antidepressants and CBT for panic disorder with agoraphobia

A 26-year-old woman presents with panic disorder and moderate agoraphobia. She has prominent dizziness, stays close to physical supports when outside (safety behaviour) and panics crossing roads, in case she falls in traffic. Dysthymic disorder is also diagnosed on the basis of chronic, fluctuating low mood and self-esteem, impaired motivation and indecisiveness. Current guidelines recommend cognitive-behavioural therapy (CBT) and antidepressants (SSRIs or venlafaxine) as first-line treatment choices for panic disorder with agoraphobia. However, relapse is more common after antidepressant treatment than after CBT monotherapy. It has been suggested that combining antidepressants with CBT might also reduce long-term treatment efficacy because, for example, medication produces a state-dependent learning context or because it acts as a safety signal that interferes with the success of exposure to feared stimuli. Is antidepressant medication advisable when CBT is available?

Some of the concerns about combining antidepressants with CBT have come from naturalistic studies that track outcomes from CBT in patients who were receiving or not receiving medication at the start of treatment. The major limitation of this approach is that treatment allocation is not randomized and that, although groups may score similarly on standard rating scales, they may not be equivalent. A recent meta-analysis in the Cochrane Library database has provided quantitative informa-

tion from 21 studies on the comparative efficacy of antidepressant monotherapy, cognitive-behavioural monotherapy and combined treatment in patients with panic disorder with agoraphobia. Treatments were compared in the acute phase over 2–4 months, after continuation for several months to maximize recovery and prevent early relapse, and at 6–24 months' posttreatment follow-up. The primary outcome was the relative risk (RR) for categorical measures of overall response. Secondary outcomes included measures of global severity, panic frequency, phobic avoidance, general anxiety, depression and social functioning. In the acute phase, combined therapy was superior both to antidepressant treatment (RR 1.28, 95% confidence interval [CI] 1.08–1.52) and to CBT (RR 1.17, 95% CI 1.05–1.31) on the primary outcome and several secondary outcomes, with these advantages maintained during continuation. At long-term follow-up, combination therapy remained superior to antidepressants alone (RR 1.61, 95% CI 1.23–2.11). Superiority was no longer maintained over CBT alone, but on the other hand, there was no evidence of inferior outcomes for the combination (RR 0.96, 95% CI 0.79–1.16).

On average, if not in all patients, combining treatments is more efficacious while the antidepressant medication is maintained, and there is no strong evidence that this is detrimental to the long-term outcome of CBT if the antidepressant is subsequently withdrawn. With SSRI treatment while awaiting a course of CBT, the present patient had substantial improvements

in panic attacks and in associated and depressive symptoms. Following CBT, she achieved full remission, particularly in terms of her remaining avoidance and use of safety behaviours. In follow-up, she chose not to withdraw from medication, feeling that depressive symptoms had had the worst long-term impact on her life.

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Competing interests: Dr. Coupland has received speaker's fees from Wyeth (venlafaxine) for 2 presentations to family practitioners on the treatment of anxiety (March 2006).

Psychopharmacology for the Clinician columns are usually based on a case report that illustrates a point of interest in clinical psychopharmacology. They are about 500–650 words long and do not include references. Columns can include a bibliography that will be available only at the journal website and can be accessed through a link at the bottom of the column.

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