What treatments do patients with panic disorder and agoraphobia get?

Received: 7 September 1994 / Accepted: 3 February 1995

Abstract In a retrospective study 100 patients with DSM-III-R/ICD-10 panic disorder and agoraphobia (PDA) were interviewed about the psychopharmacological, psychological and 'alternative' treatments they had received in the course of their illness. Patients gave global statements about how satisfied they were with the various treatments they had experienced. Many patients received treatments that have never been investigated under controlled conditions. The most common drug treatments, in descending order, were: 48% benzodiazepines, 42% tricyclic antidepressants, 32% herbal preparations, 29% neuroleptics, 7% selective serotonin reuptake inhibitors and 6% beta blockers. Of the drug prescriptions, 63% were according to international standards. Of the neuroleptics, two-thirds (63.3%) were prescribed by non-psychiatric physicians, and only one-third by psychiatrists (33.3%). Tricyclic antidepressants were prescribed more often by psychiatrists (64.7%) than by non-psychiatrists (31.4%). Among psychological treatments, autogenic training (43% of the patients) and psychodynamic therapy (33%) were used far more frequently than behavioural/cognitive therapy (20%). These results confirm the underutilisation of available effective treatments for panic disorder (e.g. tricyclic antidepressants or behavioural therapy) and the overutilisation of treatments without proven efficacy (e.g. herbal preparations or autogenic training). Patients were most satisfied with treatments that have been proven effective in controlled studies. Among drug treatments, benzodiazepines, selective serotonin inhibitors and tricyclic antidepressants were favoured (mean on a 0–4 scale indicating effectiveness: 2.6, 2.6 and 2.4). Neuroleptics (1.4), beta-blockers (1.0) and herbal preparations (0.9) were not rated highly effective by the patients. Among psychological treatments, patients were more satisfied with behavioural/cognitive therapy (2.6) than with psychodynamic therapies (1.5).

Satisfaction with autogenic training was very low (1.0). Results have to be interpreted very carefully, because many factors could not be controlled in the study: proper recollection of the applied treatments, adequate duration and dosage of the drugs, compliance of drug intake, availability of psychological treatments, adequate duration of psychological treatments, qualification level of therapists, treatment combinations and other factors. The results may have been influenced by the fact that most respondents were recruited from an outpatient anxiety-disorders unit.

Key words Panic disorder • Agoraphobia • Drug treatment • Psychological treatment

Introduction

Many studies have shown the efficacy of certain pharmacological and psychological treatments in panic disorder and agoraphobia (PDA). Only the results of studies involving a control group should be considered when judging the efficacy of a treatment. Most authors agree that a high placebo response rate is common in panic disorder (Rosenberg et al. 1991; see Clark et al. 1994 for an alternative view). Among the drugs that have reliably proven effective against PDA in many controlled studies are benzodiazepines, such as alprazolam (Ballenger et al. 1988), tricyclic antidepressants, such as imipramine (CNCPS 1992) or clomipramine (Johnston et al. 1988), irreversible MAO inhibitors, such as phenelzine (Sheehan et al. 1980), and selective serotonin reuptake inhibitors, such as fluvoxamine (Black et al. 1993). For other drugs proof of efficacy is less consistent. Efficacy of neuroleptics in anxiety neuroses has been shown in many older studies in the 1970s and 1980s (e.g. Laakmann et al. 1988), but few studies have used patient samples comparable with the DSM-III and DSM-III-R definitions of panic disorder. It remains unclear whether treatment with beta-blockers, such as propranolol, is as effective as standard treatments (Munjack et al. 1989; Ravaris et al. 1991). For herbal preparations (e.g. Piper methysticum and Hypericum perfora-
Among psychological treatments, cognitive/behavioural therapies have consistently shown efficacy in PDA (Barlow 1994; Clark 1994). Within the group of behaviourally orientated therapies, techniques that use in vivo exposure to feared situations have shown the best results (Marks 1987; Grawe et al. 1994). Efficacy was also proven for cognitive therapy that focuses directly on panic attacks (Clark 1994). The only study investigating psychodynamic treatment of panic disorder is a study comparing a combination of psychodynamic therapy and exposure with pure psychodynamic therapy. The combination was found to be superior (Hoffart and Martinsen 1990). Presently, the efficacy of psychodynamic treatment in panic disorder is regarded as unproven (National Institute of Health 1991). Hypnosis has been shown to be effective in two of four existing anxiety studies (Marks et al. 1968; Grawe et al. 1994), but studies involving DSM-defined panic-disorder patients are lacking. In Germany 'autogenic training', a self-applied relaxation technique, is very common. No controlled studies on the treatment of PDA with autogenic training exist. Psychotherapy research showed that results with autogenic training in other psychological disorders were insufficient (Grawe et al. 1994). Progressive relaxation was found to be less effective than exposure therapy (Marks et al. 1983) Biofeedback methods were found to be effective in two of three control comparisons conducted with anxiety patients (not defined by DSM), but the effects seemed to be unspecific (Grawe et al. 1994).

Controlled comparisons of pharmacological with psychological treatments of PDA are rare. Superiority of psychological treatments was found in two studies (Marks et al. 1983, 1993). Superiority of drug treatment was found in two studies (Klein et al. 1987, Black et al. 1993). No difference was found between drugs and psychological therapy in three studies (Telch et al. 1985; Mavissakalian and Michelson 1986a; Klosko et al. 1990).

In one follow-up study comparing drugs and exposure therapy (Marks et al. 1993), exposure was more effective after treatment termination than alprazolam. In two studies no difference was found between drug and psychological therapy upon follow-up (Marks et al. 1983; Mavissakalian and Michelson 1986b). In order to obtain a survey of pharmacological and psychological methods applied in patients with PDA, a field study was conducted by interviewing PDA patients to find out which therapy methods had been applied and what experiences the patients had had with these methods.

### Subjects and methods

Patients fulfilling criteria of DSM-III-R and DSM-JV Panic Disorder and/or Agoraphobia (300.21, 300.01 and 300.22) or ICD-10 Agoraphobia and/or Panic Disorder (F40.00, F40.01 and F41.0) were included in the study. Patients had either a current episode of PDA or were in a state of remission. Severity of PDA was measured with the Hamilton Anxiety Scale (HAMA; Hamilton 1969) and the Panic and Agoraphobia Scale (P & A; Bandelow 1995). The mean HAMA score was 23.93 (± 10.29) and the mean P & A score was 23.38 (± 9.99) in the psychiatrist-rated version and 22.96 (± 10.89) in the self-rating. The mean duration of PDA was 4.75 years (SD 5.5 years). Most subjects (n = 90) had been clients of the outpatient anxiety-disorders unit at the University of Göttingen and were contacted by mail to participate in the investigation. Ten subjects were hospitalised because of PDA at the time in two psychiatric clinics and two departments for inpatient psychotherapy. Of 207 patients who were contacted, 100 agreed to participate, 83 did not participate and 24 had moved and were not traceable.

Patients were interviewed in person with a structured interview concerning the whole range of pharmacological and psychological treatments they had received for PDA in their illness history. Acute panic-attack treatments with parenteral, sublingual or oral benzodiazepines were not analysed because of low case number. Patients with comorbid conditions requiring neuroleptics were not included in the study. Only treatments that were well remembered by the patients were analysed. Drug treatments that were given either in a subclinical dose or not long enough to be effective were excluded. For tricyclic antidepressants, selective serotonin inhibitors (SSRIs) and monoamine oxidase inhibitors (MAOIs) only treatments with a minimum duration of 4 weeks' continuous intake were evaluated. For benzodiazepines, neuroleptics and herbal preparations a minimum-intake duration of 1 week was required. Of 241 drug treatments reported by the patients, 28 were not evaluable because of these criteria. For outpatient psychological treatments a minimum treatment duration of 8 weeks was necessary for inclusion. For inpatient treatment in a psychotherapy unit a minimum duration of 4 weeks was required. Five psychological treatments out of 103 had to be excluded because of insufficient duration.

Patients stated that it usually took a long time from the first onset of symptoms until the adequate diagnosis 'PDA' was made by a physician (on average 3.76 years; SD 5.17 years). Patients had to indicate their satisfaction with a certain therapy by responding to the statement, 'This therapy has been very helpful against my fears' on a 5-point Likert scale (from 0 = 'not true' to 4 = 'true'). As the scale was assumed to be of ordinal rank level, the central tendency ("mean") of these answers was taken as a "saturation index". Central tendencies were compared with Mann-Whitney's U test. Statistical analyses were performed with the Statistical Analysis System (SAS 6.08), SAS Institute, Heidelberg.

Finally, 54 patients who had received both drugs (not including herbal preparations) and psychological treatment in the course of their illness had to indicate which kind of treatment had helped most in the course of their illness. Only one answer was possible to this question.

### Results

#### Application of treatments

Table 1 shows the percentages of patients who received particular treatment modalities at least once in the course of their illness. Four percent of patients had received no treatment at all before the interview.

<table>
<thead>
<tr>
<th>Treatment modality</th>
<th>Application (%)</th>
<th>Satisfaction mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs</td>
<td>88</td>
<td>2.6 (1.1)</td>
</tr>
<tr>
<td>Individual psychotherapy</td>
<td>58</td>
<td>1.8 (1.1)</td>
</tr>
<tr>
<td>Relaxation techniques</td>
<td>54</td>
<td>1.2 (1.1)</td>
</tr>
<tr>
<td>Inpatient treatment</td>
<td>38</td>
<td>2.0 (1.5)</td>
</tr>
<tr>
<td>Group psychotherapy</td>
<td>28</td>
<td>1.3 (1.1)</td>
</tr>
<tr>
<td>&quot;Alternative treatments&quot;</td>
<td>7</td>
<td>2.1 (1.2)</td>
</tr>
</tbody>
</table>

### Table 1 Application of different treatment modalities and satisfaction index