Letters to the Editor

Comments on the APA Panic Disorder Guideline

TO THE EDITOR: I found the American Psychiatric Association's "Practice Guideline for the Treatment of Patients With Panic Disorder"(1) surprisingly disappointing in two regards. 1) There was no mention of the speculative etiology of panic disorder. Is it psychologically rooted, and if so, how does it differ psychodynamically from anxiety disorder? Or is it, as I believe, organically determined? 2) I have been using clonazepam extensively in the treatment of patients with panic disorder for the past 15 years, with 100% efficacy (this includes patients previously resistant to monoamine oxidase inhibitors and tricyclic antidepressants, as well as long-term sufferers) and absolutely no tendency toward addiction (despite using it with a large homeless population that included a high percentage of drug addicts).

REFERENCE

1. American Psychiatric Association: Practice Guideline for the Treatment of Patients With Panic Disorder. Am J Psychiatry 1998; 155(May suppl)

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TO THE EDITOR: In the excellent and well-documented "Practice Guideline for the Treatment of Patients With Panic Disorder," it is stated on pages 3, 10, and 21 that studies comparing the efficacy of combined antipanic medication and cognitive behavioral therapy with the efficacy of either modality alone have produced conflicting results. In the case of conflicting results of randomized controlled trials, meta-analysis can be used to clarify the findings.

Recently, we published a meta-analysis that included 106 short-term outcome studies of 5,011 patients with panic disorder with or without agoraphobia (1). In this meta-analysis, the efficacy of psychopharmacological, cognitive behavioral, and combination treatments was compared. According to this study, for agoraphobic avoidance, the combination of antidepressants with exposure in vivo was significantly more effective (mean Cohen's d=2.47, SD=0.82) than all other treatments evaluated (high-potency benzodiazepines: mean d=1.00, SD=0.59; antidepressants: mean d=1.02, SD=0.44; psychological panic management: mean d=0.91, SD=0.54; exposure in vivo: mean d=1.38, SD=0.84; the combination of psychological panic management with exposure in vivo: mean d=1.22, SD=0.60). With regard to panic, exposure in vivo alone was not effective. When the various treatment conditions were compared, no differences concerning panic attacks were found.

From a second meta-analysis of 68 follow-up studies of 1,346 patients with panic disorder with or without agoraphobia (2), it was concluded that overall, short-term treatment gains were maintained during the follow-up period (mean duration=62 weeks, SD=89 weeks). Again, the combination of antidepressants and exposure in vivo was associated with the largest effect size for agoraphobic avoidance (mean Cohen's d=3.60, SD=0.74). At follow-up, the combination condition was significantly superior to most other treatment options.

On the basis of these data, it could be argued that use of the combination of antidepressants and exposure in vivo can be recommended more broadly, rather than just for patients with severe agoraphobia or an incomplete response.

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2. Bakker A, van Balkom AJLM, Spinhoven PH, Blaauw BMJW, van Dyck R: Follow-up on the treatment of panic disorder with or without agoraphobia: a quantitative review. J Nerv Ment Dis (in press)

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TO THE EDITOR: On behalf of the American Psychoanalytic Association and its members, we are registering our association's grave concerns about the "Practice Guideline for the Treatment of Patients With Panic Disorder." We consider this document to be seriously flawed in its failure to recognize psychodynamic psychotherapy and psychoanalysis as effective and primary forms of treatment for severe anxiety disorders. It is the position of our association that these treatments should be fully included in any adequate description of treatment options for any patient with anxiety or panic symptoms. Since the American Psychoanalytic Association is listed among the "organizations that submitted comments," we expect that our serious reservations about these particular guidelines will be published in a subsequent issue of *The American Journal of Psychiatry*.

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TO THE EDITOR: The "Practice Guideline for the Treatment of Patients With Panic Disorder" makes a strong case for the value of systematic short-term studies of psychopharmacological and cognitive behavioral treatment approaches. The long-term outcome of treatments, however, is not carefully addressed. The potential value of psychodynamic treatments is minimized, ostensibly because of the lack of systematic studies.

Although the Guideline describes panic disorder as potentially having a recurring or chronic course, it also suggests that short-term interventions can bring remission. The cursory review of long-term outcome of cognitive behavioral treatment contained in the Guideline implies continued good results at follow-up.

A review of long-term outcome studies of specific treatment interventions for panic disorder revealed several meth-

odological problems in studies in which follow-up outcome was assessed (1). The sparse available data suggest that there is limited evidence for long-term maintenance of short-term treatment gains in the absence of continued treatment. This is a significant issue for patients with panic disorder, not only because of their subjective distress but also because of their high utilization of medical and psychiatric services.

The Guideline describes different categories of evidence that are required in order to credibly draw therapeutic conclusions, oftentimes making broad recommendations with few systematic data and at other points minimizing data because they were not systematically collected. A "coding system" for recommendations is included, but no systematic criteria are presented for determining what is recommended with "substantial" (level I) or "moderate" (level II) clinical confidence or "on the basis of individual circumstances" (level III). Although the Guideline appears to make a presumption that randomized, controlled treatment trials are most valuable for making such determinations, this standard of evidence is variably applied.

For example, "educating family members and enlisting their help when appropriate" is recommended at level I when there are few data to support this. The tone of the Guideline with regard to psychodynamic treatments implies that the absence of systematic studies is equivalent to lack of therapeutic efficacy, noting in one section that psychotherapy other than cognitive behavioral therapy may be considered at level III. The many published case reports of successful psychodynamic treatment are minimized as evidence by being described as "reports of isolated cases rather than systematic consecutive case series," whereas in the psychopharmacology section, a series of four cases of patients treated with venlafaxine suggests that this medication "may be effective and well tolerated."

The Guideline refers to panic disorder as a discrete, free-standing disorder while noting the high degree of "comorbidity." Alternatively, panic disorder can be viewed as one element in a variety of symptoms that tend to occur together, embedded in a characterological matrix. The latter model requires a broader-based rather than a focused treatment model, to reduce vulnerability to panic.

It is not clear to what extent the recommended treatments mirror those performed in the community and to what extent the patients treated in the studies cited are similar to patients in the community. In randomized, controlled trials, many patients are not studied because of exclusion criteria. Hence, the Guideline may not apply to many typical patients seen in naturalistic settings. Importantly, there is no discussion of appropriate training for individuals who administer the various treatments.

In conclusion, much more extensive testing of a variety of treatments, particularly over the long term, is required before the recommendations made in the Guideline can be established.

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1. Milrod BL, Busch FN: The long-term outcome of treatments for panic disorder: a review of the literature. J Nerv Ment Dis 1996; 184:723–730

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BARBARA L. MILROD, M.D.
GLEN O. GABBARD, M.D.

Drs. Gorman, Shear, McIntyre, and Zarin Reply

TO THE EDITOR: We are pleased to be able to respond to the four thoughtful letters regarding the "Practice Guideline for the Treatment of Patients With Panic Disorder." These letters reflect the reality that American Psychiatric Association practice guidelines are very important for the field and warrant very careful attention and feedback from our profession. We appreciate all the responses—agreement and disagreement—that we have received. Such continued feedback improves the guidelines and the developmental process. In the course of preparing the Guideline for panic disorder, we solicited the input of more than 650 individuals and organizations and were pleased to receive many comments, all of which were carefully considered. In addition, we had several lengthy conferences with clinicians representing the psychoanalytic point of view and made several modifications in the Guideline to incorporate their suggestions. First, it is important to note that this is a practice guideline for panic disorder, not anxiety disorders in general. Given that, we acknowledge that no treatment guideline ever incorporates the ideas of all clinicians or investigators, but we struggled to strike a reasonable balance. We were indeed guided by the principle that rigorous clinical studies are the standard by which the effectiveness of all medical interventions should be judged. In addition, we attempted to incorporate suggestions based on clinical wisdom, as long as they were clearly identified as lacking backing from rigorous studies.

Dr. Fintzy asks why we did not indulge in etiologic speculation. Although it took much forbearance, since many of the Guideline committee members have spent years laboring to elucidate the "cause(s)" of panic disorder, treatment guidelines are not the place to make causal judgments. We are grateful to Dr. Fintzy for his comment about benzodiazepines; although many concerns have been raised about the use of benzodiazepines for the treatment of anxiety disorders, they are clearly effective for many patients.

We are sorry that the two reviews mentioned by Dr. van Balkom and Dr. van Dyck were not available to us in time to be included in our considerations. Although meta-analyses are always subject to technical objections, these reviews do suggest that combination treatment may offer patients with panic disorder an advantage over monotherapy, although not all studies substantiate this finding. As we suggest in the Guideline, this is an important area for further investigation. We thank Drs. van Balkom and van Dyck for their kind comments about the Guideline in general.

We admit that we are disappointed by the reactions to the Guideline of our colleagues from the American Psychoanalytic Association. As we note above, this Guideline reflects a careful review of existing scientific treatment studies and a long and often arduous process in which we tried to identify areas of clinical consensus; especially in those areas where there are major gaps in the research literature. We did not find a body of literature indicating that a scientific evaluation of the treatment of panic disorder with psychoanalytic therapies has been undertaken. We believe it is a universally acknowledged principle of medicine that interventions for illness are best supported by rigorous scientific study, as has clearly been the case for medication and cognitive behavioral therapies for panic disorder. Nevertheless, the Guideline does not in any way suggest that psychodynamic treatments are ineffective, and at many points it suggests that clinicians have found it to be efficacious. One of the co-chairs of the Guideline committee is a faculty member of the Columbia University Center for Psychoanalytic Training and Research, and

both co-chairs are supporters of psychoanalytic research and treatment. We hope that by the time new practice guidelines are formulated, studies evaluating the effectiveness of psychoanalytic therapies for panic disorder will have been published.

There are six points that can be addressed in the letter of Drs. Busch, Milrod, and Gabbard. 1) We agree that more long-term studies of panic disorder are urgently needed and make that suggestion on page 26. There is, however, already a substantial literature on this problem (e.g., 1–3) in addition to the paper by Drs. Milrod and Busch that they cite. Exactly how the lack of long-term studies bears on the issue of acute treatment effects, however, is not clear to us. 2) It should be noted that the ratings of the recommendations is a statement of clinical confidence and, as these authors noted, is not always correlated with the ratings of evidence in the literature. 3) We strongly disagree that the "tone" or any other aspect of the Guideline in any way implies that psychoanalytic treatments "lack...therapeutic efficacy." We agree, however, that there is no way to compensate for the lack of rigorous scientific treatment studies. 4) It seems a quibble to object to our comment that venlafaxine may be effective. It is a member of a class of medications that have been shown to be effective for panic disorder, and therefore we feel it is reasonable to suggest that it "may be effective" as well. This does not seem to be the same as saying that psychoanalytic psychotherapies are effective for panic disorder on the basis of case reports, given that they do not belong to a class of interventions that has documented efficacy. 5) We certainly hope that Drs. Busch, Milrod, and Gabbard do not believe that a treatment guideline for panic disorder is the place to rehearse the debate about the validity of DSM-IV categories. Indeed, the Guideline is written under the assumption that panic disorder is an illness that the psychiatrist has already diagnosed using the criteria of DSM-IV. 6) It is well-known that necessary exclusion criteria in clinical trials rarify the sample of patients enrolled. This clearly imposes the risk of lack of representation of community samples. Again, however, it is unclear what bearing this has on the recommendations given in the Guideline. Treatment guidelines must obviously offer recommendations based on the available scientific literature and acknowledge, as the panic Guideline does at many points, that individual clinicians must tailor treatment to individual patients. Is there evidence that psychoanalytic therapies are as effective as, or superior to, medication or cognitive behavioral therapies in the "community"? We are hopeful that the American Psychiatric Association's Practice Research Network will contribute to the growth of evidence from the community to help with this and many other areas where rigorous studies are not available or are inadequate.

The "Practice Guideline for the Treatment of Patients With Panic Disorder" recommends that there is substantial scientific evidence for the effectiveness of medication and of cognitive behavioral psychotherapy. We believe that this conclusion is obvious and, given the current state of scientific investigation, unassailable. We think it is very important to note that the Guideline clearly states that the published evidence indicates that a form of psychotherapy, namely, cognitive behavioral therapy, is effective, and as effective as medication, for the treatment of patients with panic disorder. In addition, the Guideline addresses the use of other interventions, including psychodynamic psychotherapy, for patients with panic disorder.

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Reprints of letters to the Editor are not available.

Correction

The correct title for the letter by Kevin J. Black, M.D., et al. (Sept. 1998 issue, pp. 1298–1299) should be "Preventing Contractures in Neuroleptic Malignant Syndrome and Dystonia."