

Pharmacotherapy for panic disorder: Clinical experience vs the literature

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Despite published evidence to the contrary, adding a benzodiazepine to an SSRI may benefit certain panic disorder patients

Clinical experiences sometimes contradict the psychiatric literature. For example, some of my patients with panic disorder (PD) benefit from adding benzodiazepines to selective serotonin reuptake inhibitors (SSRIs). However, 2 double-blind studies show that adding benzodiazepines to SSRIs does not help PD patients.^{1,2} Why are my patients different from those in the studies? Some of my patients may have been misusing benzodiazepines or were psychologically habituated to them, but I doubt that explains all of the improvement I observed.

A more relevant reason for the different responses seen in my patients and those in the 2 studies may be differences in the populations involved. For example, many of my PD patients had not responded to SSRIs alone. In contrast, none of the patients in the studies had been unresponsive to SSRIs.

Also, unlike patients in the studies, many of my patients with PD have severe psychiatric comorbidity—they also may have a diagnosis of schizophrenia, bipolar disorder, schizoaffective disorder, or depression. Comorbidity may affect the severity of PD and treatment response. For example, PD with recurrent comorbid depression has been shown to be more difficult to treat, suggesting the need for “combination treatment with SSRI and benzodiazepines or with pharmacotherapy and cognitive-behavior therapy.”³

I am not suggesting that benzodiazepines should be added to SSRIs for every patient with PD and severe comorbidity. Some of my patients with PD and comorbid psychiatric disorders do quite well

with SSRIs alone. I suggest that patients who do not respond to SSRIs may benefit from adjunctive benzodiazepines. Severe comorbidity may suggest the need for adding benzodiazepines; the lack of response to high doses of SSRIs also may be a determining factor.

References

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Disclosure: Dr Wilf reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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