Coordinated care consisting of cognitive behavioural therapy plus medication improves panic disorder

Roy-Byrne PP, Craske MG, Stein MB, *et al.* A Randomized effectiveness trial of cognitive-behavioral therapy and medication for primary care panic disorder. *Arch Gen Psychiatry* 2005;**62**:290–8.

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Q Is coordinated care consisting of cognitive behavioural therapy plus medication effective for people with panic disorders?

METHODS

Design: Randomised controlled trial.
Allocation: Unconcealed.
Blinding: Open.
Follow up period: Two years.
Setting: Six primary care clinics in the USA; enrolment from March 2000 to March 2002.
Patients: 232 people (mean age of 41.2 years) with panic disorder (DSM-IV) and at least one panic attack in the previous week. Exclusion criteria: receiving psychiatric disability benefits; already seeing a psychiatrist or cognitive behavioural therapist; inability to speak English; or no telephone access.
Intervention: Coordinated care consisting of cognitive behavioural therapy (CBT) plus medication or usual care. CBT consisted of six sessions plus six follow up telephone booster sessions and a patient education video and workbook. A behavioural health specialist delivered CBT and was involved in coordinated care by communicating with both primary care physicians and consultant psychiatrists as necessary. Antidepressant medication was managed by a primary care physician using a medication algorithm and with guidance from a consulting psychiatrist. Usual care consisted of medication delivered by the primary care physician with possible referral to community based mental health resources.
Outcomes: Clinical response (no panic attacks in the past month, minimal anticipatory anxiety about panic, and an agoraphobia subscale score ≤ 10); functional status and health related quality of life (five items from the WHO disability scale and physical and mental health scales of the SF-12); severity of depression (Center for Epidemiologic Studies-Depression (CES-D) scale).
Patient follow up: 93.1% of participants completed the study.

MAIN RESULTS

Coordinated care consisting of CBT plus medication improved clinical response and reduced the severity of depression at 12 months. Functional status and health related quality of life (QOL) outcomes

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depended on the scale used for measurement (see <http://www.ebmmentalhealth.com/supplemental> for table).

CONCLUSIONS

Coordinated care consisting of CBT plus medication improves clinical response and severity of depression in people with panic disorder compared with usual care. The effects on functional status and quality of life are less clear.

NOTES

The WHO disability scale had not been validated for measuring functional status and health related quality of life, so results using this scale should be treated with caution.

Commentary

Panic disorder is prevalent in primary care, however little is known about the efficacy of interventions delivered in this setting. The study by Roy-Byrne *et al* aims to fill this gap in the literature by exploring whether a collaborative care approach could improve for people with panic disorder presenting at primary care clinics in the USA.

The study has several features which increase its validity, such as its large sample size and its pragmatic approach. This approach consisted of using primary care physicians to deliver medication after only brief training, relatively inexperienced therapists to deliver CBT, and participant reports of medication compliance, and the inclusion of an ethnically and socially diverse population with comorbidities (medical conditions and mood or anxiety disorders). Comorbidities are common among people with panic disorder, and exclusion of this important population would have limited the generalisability of the study findings.

The intervention increased clinical response rates compared with usual care, but several points are worth highlighting. CBT was delivered competently and according to the research schedule. However, despite providing physicians with information and medical treatment algorithms, there was no improvement in the delivery of guideline concordant medication compared with the usual care group. Further study is needed to identify barriers to guideline adherence, but one potential contributing factor could have been that participants were required to pay for their medication while CBT was delivered at no cost. The authors did not analyse the effects of associated disorders on treatment outcomes. This is a particularly important issue as comorbid agoraphobia and depression have been associated with poorer outcomes in people with panic disorder.¹

Overall, Roy-Byrne *et al*'s findings support results seen in secondary care settings, where cognitive behaviour therapy plus pharmacotherapy have been shown to improve outcomes in people with anxiety disorders.¹ Importantly, they show that these components can be delivered in a collaborative care package by trained non-specialists and physicians in primary care settings.

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1 Andrews G. Australian and New Zealand clinical practice guidelines for the treatment of panic disorder and agoraphobia. *Aust N Z J Psychiatry* 2003;**37**:641–56.