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Naturalistic manner of benzodiazepine use and cognitive behavioral therapy outcome in panic disorder with agoraphobia

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Abstract

Benzodiazepines (BZs) are commonly used in conjunction with cognitive behavioral therapy (CBT) in the treatment of panic disorder with agoraphobia (PDA). However, empirical evidence provides little support for the utility of this combined treatment approach over CBT alone. Westra and Stewart [Clin. Psychol. Rev. 18 (1998) 307] have proposed that prn or as-needed use of BZs may inhibit positive CBT outcome to a greater extent than regularly scheduled BZ use. Using a naturalistic design, the present study investigated the impact of manner of BZ use on treatment outcome from CBT in 43 patients with PDA. Among various BZ parameters (chronicity, frequency, dose, and frequency of prn use), prn use of BZs for coping with anxiety symptoms was a significant negative predictor of degree of change in both anxiety sensitivity and anxious arousal from pre- to post-CBT. Although no significant between-group differences were evident in pre-treatment symptomatology, unmedicated subjects demonstrated the most positive overall CBT outcome, while prn BZ users evidenced the fewest gains. Regular BZ users were generally not significantly differentiated from unmedicated subjects in CBT outcome and both tended to obtain post-treatment scores in the nonclinical range. Implications of these findings for clinical management of BZ use throughout CBT for PDA are discussed.

Keywords: Benzodiazepines (BZs); Cognitive behavioral therapy (CBT); Panic disorder

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1. Introduction

Both pharmacotherapy and cognitive behavioral therapy (CBT) have demonstrated efficacy in the treatment of panic disorder with agoraphobia (PDA; for a review see Schmidt, 1999). Among medication treatments for anxiety, benzodiazepines (BZs) continue to be one of the most common, with 60% of PDA patients taking either BZs alone or a BZ in combination with an antidepressant (Otto, 1999; Otto, Pollack, Penava, & Zucker, 1999). Although little evidence favors using BZs as a sole treatment for optimal long-term management of anxiety (Westra & Stewart, 1998), some researchers advocate supplementing CBT with BZs, arguing that a combination treatment may be superior to either treatment alone (e.g., Hegel, Ravaris, & Ahles, 1994; Roy-Byrne & Swinson, 1991).

Although the rationale of using BZs to enhance the probability and breadth of CBT exposure activities seems reasonable, a growing body of empirical findings converge in finding no clear evidence for the utility of BZs as an adjunct to CBT (Clum, Clum, & Surls, 1993; Gould, Otto, & Pollack, 1996; Marks et al., 1993; Schmidt, 1999). For the most part, short-term evaluations of combined BZ/CBT treatment have failed to demonstrate superior efficacy over CBT alone on a broad range of outcome measures (Gelertner et al., 1991; see also Clum et al., 1993 for a review). In considering diazepam for example, there is some limited evidence of diazepam enhancing exposure if administered well before exposure exercises, versus immediately before (Marks, Viswanathan, Lipsedge, & Gardner, 1972). However, although these two methods of diazepam administration may differ in efficacy, even waning diazepam effects have been found in other studies to be equivalent to exposure alone (Hafner & Marks, 1976). Wardle et al. (1994) also conclude that there was no evidence that the outcome of the behavior therapy was significantly affected by concurrent diazepam treatment. In considering alprazolam, a multi-site, well-controlled study by Marks et al. (1993) reported that alprazolam/exposure was significantly better than placebo/exposure on only 1 out of 34 comparisons up to 8 weeks of treatment, and subsequently on none. Long-term follow-up studies consistently fail to support the superior efficacy of combined BZ/CBT treatment. These studies find either no incremental utility of adding BZs to exposure treatment (Wardle et al., 1994), or loss of gains upon drug discontinuation (Marks et al., 1993) and higher relapse rates at follow-up relative to CBT alone (Otto, Pollack, & Sabatino, 1996).

Although controlled research trials suggest that combined BZ/CBT treatment protocols are less effective for long-term positive adjustment, these findings may be of limited practical utility since the majority of anxious individuals referred for CBT to tertiary treatment centers are already using some type of anxiolytic medication (Wardle, 1990), very commonly BZs (Otto, 1999). And since most patients have difficulty discontinuing BZs due to withdrawal symptoms (Griffith & Weerts, 1997), it is not often possible to provide patients