Panic-Focused Psychodynamic Psychotherapy for Panic Disorder

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Q: What is panic-focused psychodynamic psychotherapy?

A: Panic-focused psychodynamic psychotherapy (PFPP) is a manualized treatment for panic disorder. Treatment consists of two sessions per week for a duration of 12 weeks. PFPP focuses on identifying a stressful life event preceding the onset of panic disorder symptoms and exploring the meaning (both conscious and unconscious) that event has for the patient. Intrapsychic conflicts from childhood and conflicts arising from sexual urges are examined during this treatment to increase emotional awareness and foster resolution (Milrod et al., 1997).

Q: What is the theoretical model underlying PFPP?

A: This treatment approach is based on Sigmund Freud's notion of anxiety neurosis wherein he postulated that anxiety functions to alert the ego of emerging and unacceptable unconscious wishes (Freud, 1936). Proponents of the treatment note that the principal benefit of this approach is resolution of intrapsychic conflicts, which should result in better long-term outcomes than treatments focusing on relief of the overt symptoms (Milrod et al., 1997). The goal of this psychotherapy is to target and foster resolution of these conflicts with the secondary benefit of symptom relief. Treatment is divided into three phases: identifying the meaning of panic symptoms, identifying core conflicts underlying panic disorder, and termination (Milrod et al., 1997).

Q: Is PFPP recommended as a treatment for panic disorder in the Military Health System (MHS)?

A: There is no VA/DoD clinical practice guideline (CPG) on the treatment of panic disorder.

The MHS relies on the VA/DoD CPGs to inform best clinical practices. In the absence of an official VA/DoD recommendation, clinicians should look to CPGs and authoritative reviews published by other recognized organizations and may rely on knowledge of the literature and clinical judgement.

Q: Do other authoritative reviews recommend PFPP as a treatment for panic disorder?

A: Yes, the practice guidelines of one other organization recommend PFPP as a treatment for panic disorder.

Other recognized organizations publish CPGs or conduct systematic reviews and evidence syntheses on psychological health topics using grading systems similar to the VA/DoD CPGs. These include the American Psychiatric Association, American Psychological Association, and the United Kingdom's National Institute for Health and Care Excellence. Additionally, Cochrane is an international network that conducts high-quality reviews of healthcare interventions.

- The American Psychiatric Association's Practice Guideline for the Treatment of Patients with Panic Disorder recommends cognitive behavioral therapy as an initial treatment choice unless patients prefer a psychodynamically-oriented therapy (American Psychiatric Association [APA], 2009). Under

those circumstances, PFPP may be considered as an initial or adjunct treatment, with the caution that the research base is more limited than that of CBT with fewer randomized controlled trials.

Q: Is there any recent research on PFPP as a treatment for panic disorder?

A: We identified three secondary analyses of previously conducted randomized controlled trials (RCTs) that examined factors impacting treatment effectiveness of PFPP. Svensson et al. (2021) used data from a doubly-randomized controlled preference trial in which patients were randomly assigned to their preferred treatment (PFPP or a type of cognitive therapy called panic control treatment [PCT]), PFPP intervention, PCT intervention, or waitlist control (Sandell et al., 2015). All three experimental conditions were superior to waitlist at post-treatment and follow-up with regards to panic symptoms. PCT was superior to PFPP during treatment, but the inverse was true at follow-up. Nilsson et al. (2021) examined the impact of treatment termination on panic disorder symptoms for patients randomized to PFPP or PCT using the same dataset that Svensson et al. (2021) derived from Sandell et al. (2015). The researchers found that those randomized to PFPP were more likely to experience an increase in symptoms as termination approached and these differences persisted at the 12-month follow-up.

Keefe et al. (2021) examined patient-level moderators that contributed to dropout from panic-focused treatment. This was a secondary analysis of a trial conducted in 2016, wherein 201 patients diagnosed with panic disorder were randomized to receive PFPP, CBT, or applied relaxation training (ART; Milrod et al., 2016). The original study was conducted at two sites, and the authors reported that there were significant site-by-treatment interactions that complicated interpretation of the results. At one study site, patients improved at similar rates across the treatments and no significant differences were found between groups on the primary outcome measure. At the other study site, CBT and ART groups demonstrated significantly better outcomes at treatment termination compared to the PFPP group. CBT was effective across sites, but PFPP was less consistent. The secondary analysis found that predictors of dropout across treatments were unemployment and higher psychosocial disability, while those with higher anxiety sensitivity were more likely to complete treatment (Keefe et al., 2021). Patients who had experienced childhood sexual abuse were more likely to drop out of ART; women were more likely to drop out of PFPP; and session two expectancies and patient-rated alliance predicted dropout only in CBT.

Q: What conclusions can be drawn about the use of PFPP as a treatment for panic disorder in the MHS?

A: The DoD does not have a clinical practice guideline for panic disorder. The APA's guideline recommends CBT as an initial treatment of choice for panic disorder. PFPP is only recommended in consideration of patient preferences due to a limited research base. An updated review of the literature supports APA's recommendation as research on the comparative effectiveness of PFPP remains mixed.

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