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Does prescribing SSRI alone effective to prevent relapse in panic disorder?

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***Abstract*---**Psychological and pharmacological modalities have been proposed by studies to be adapted for treatment of panic disorder. Selective Serotonin Receptor Inhibitors (SSRI), a group of antidepressant is the first-line drug recommended by National Institute for Health and Care Excellence (NICE) and the British Association for Psychopharmacology for their more desired profile of adverse effect over other classes of antidepressants such as tricyclic antidepressants (TCAs) and Monoamine Oxidase Inhibitors (MAOIs). However, the efficacy of SSRI as a monotherapy to prevent relapse in panic disorder has not being widely studied, hence, this review.

***Keywords*---**Panic disorder, SSRI, Relapse.

Introduction

Recurrent panic attacks, persistent fears of more attacks, anxiety over the consequences of the attack, and significant behavioural changes in response to the attacks are all symptoms of panic disorder (PD) (American Psychiatric Association. (2013)). Diagnostic and statistical manual of mental disorders (5th ed.)). The World Federation of Biological Psychiatry (WFSBP) has found that selective serotonin re-uptake inhibitors (SSRIs) are one of the first-line pharmacological treatments for anxiety disorders in a systematic review of 510 randomised controlled trials (RCT) (Bandelow et al., 2012).

A study has shown that the SSRI escitalopram was much more effective and well tolerated than the placebo, which was in line with current guidelines. SSRIs are thought to work in the similar way, inhibiting serotonin absorption in the presynaptic membrane and increasing serotonin levels in the synaptic cleft, but they differ in terms of pharmacological profiles and clinical therapeutic benefits (Du et al., 2021).

Discussion

Although SSRI medication is generally well accepted, restlessness, jitteriness, an increase in anxiety symptoms, sleeplessness, or headache may interfere with treatment compliance during the first few days or weeks of treatment (Bandelow et al., 2012).

Lowering the starting dose of SSRIs can help to reduce overstimulation. Nausea (which is why it's best taken after a meal), headache, tiredness, and dizziness are all possible adverse effects. It may take 2–4 weeks for the anxiolytic effect to manifest (in some cases up to 6 or 8 weeks). Long-term side effects include sexual dysfunction and weight gain (Baldwin et al., 2014).

Studies of double-blind show that taking clomipramine or SSRI for a duration of 12 to 52 weeks results in a higher total treatment response rate. Although a 12-month trial of the acceptability and effectiveness of different SSRIs indicated that fluvoxamine is less likely to produce gaining of weight or sexual side effects, the long-term efficacy and tolerability of different medications is unknown (Perna et al., 2017).

Baldwin & Leonard (2013) mentioned that first-line pharmaceutical or psychological therapies are ineffective to some and previous research has shown treatment choices for people with panic disorder who remain symptomatic after receiving early prescribed interventions are lacking (Perna et al., 2017). The first stage in treating non-responding patients is to make sure the diagnosis is correct, that the patient is following the treatment plan, that the dosage is appropriate, and that the treatment period has been sufficient.

According to the findings of randomised fixed-dose placebo-controlled studies, higher daily doses of some antidepressants may be advantageous. It may be desirable to alternate between proven pharmaceutical and psychosocial treatments too. Unresolved psychological difficulties also reduce the chances of an effective therapeutic response (Baldwin & Leonard, 2013).

Treatment should be continued for at least a few months following remission to avoid relapse as when SSRIs are abruptly stopped, even when tapered carefully, they can trigger a withdrawal symptoms and dizziness, sleeplessness, and flu-like symptoms are common complaints. Continuation of active medicines like fluoxetine, imipramine, paroxetine, sertraline or venlafaxine for up to six months has a significant advantage over switching to placebo in patients who have responded to previous acute treatment but the ideal period to continue treatment, however, is unknown (Andrisano et al., 2013)

In addition to pharmacological treatment for panic disorder, psychotherapy as a first- line has a lot of evidence to back it up. The Canadian Psychological Association claimed that the potency of psychotherapy effects for anxiety disorders is equivalent to or superior to that of medication in a few meta-analyses of psychological treatments for anxiety disorders.

Furthermore, several Clinical Practice Guidelines (CPG) regarded psychological therapy as the first step in treatment for anxiety disorders, owing to the risk of getting negative effects associated with medications due to poor patient compliance (Hunsley et al., 2014). Only if psychological treatments have been evaluated thoroughly, availably made, and provided by appropriately competent and supervised therapists is this significant (Katzman et al., 2014).

Two forms of psychological treatments for anxiety disorders available include Cognitive Behavioural Therapy (CBT) and Relaxation Therapy (RT) (Abdul Khaiyom et al., 2019). CBT was determined to be the majority explored treatment and is recommended as the current standard of excellence of psychotherapy in a meta-analytic evaluation by David et al., 2019. (2018). Nonetheless, this patient was not offered any form of psychotherapy and could be due to a number of reasons.

Conclusion

In summary, prescribing SSRI alone has its own benefits and risk, and should always be monitored to ensure the efficacy in order to prevent relapse. From a review of the literatures, CBT treatment was identified as one of the preferred psychological interventions to be combined with for individuals with panic disorder. This, however, should be described in detail by the treating physician in order to determine the appropriate therapy option for this patient.

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