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TEMPERAMENT DIMENSIONS AND LONG TERM INCAPACITY IN PANIC DISORDER PATIENTS

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The objective of our study is to test the relationship of temperament types as defined by Cloninger and the long term incapacity in panic disorder patients. The dimensions of personality proposed by Cloninger are: 4 temperament dimensions: Novelty Seeking (NS), Harm Avoidance (HA), Persistence (P), and Reward Dependence (RD), and 3 character dimensions: Self Directness (SD), Cooperativness and Self Transcendence (ST). A group of 46 panic disorder patients (DSM-IV and ICD-10 criteria) were assessed at baseline, with the Tridimensional Personality Questionnaire (Cloninger RC et cols., 1993), among other psychopathological measures (self-rating scales: SCL-90, HADS, Agoraphobic Cognitions Questionnaire; Body Sensations Questionnaire; and psychiatric rating scales for depression and anxiety (Hamilton Scales) and CGI). After a period of six months with appropriate drug treatment (Clomipramine or Fluvoxamine according to a naturalistic protocol of treatment) patients were re-assessed, among other measures, with the Scheean Disability Scale. Using a stepwise regression model we found a significant relationship between pre treatment scores on two components of the TPQ sub scales of harm avoidance (anticipatory worry) and novelty seeking (a excessive approach of cues of reward) and the global severity of incapacity at follow-up (familiar, social and work incapacity) (β = 3.388 and 1.608, respectively for $P < 0.001$). Social incapacity after treatment is also predicted by a high reward dependence and a low persistence before treatment (β = 2.214 and −0.409 respectively for $P <$ 001). The temperament dimension harm avoidance is the best predictor of long-term residual incapacity in panic patients in all areas of functional assessment: familiar, interpersonal and working behaviour.

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INTERPERSONAL PROBLEMS AND PSYCHOSOCIAL DISABILITIES IN PANIC DISORDER

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Difficulties in relation with partners or friends and poor psychosocial functioning have been found to be associated with a poor prognosis in patients with panic disorder. In order to further clarify the role of social adaptation and interpersonal problems for the course of panic disorder 100 DSM IV panic disorder outpatients with or without agoraphobia who participated in a clinical trial were studied (62% women, mean age 33.6 ± 8.3 years, agoraphobia 80.4%). All patients received pharmacological treatment with paroxetine (20–60 mg/d) and half of them were randomized to additional group psychotherapy, including elements of cognitive and interpersonal therapy. Duration of treatment was 6 months. Interpersonal problems were assessed by means of the Inventory of Interpersonal Problems (Horowitz et al. 1994), disabilities were recorded with the help of the Sheehan Disability Scale. At baseline higher severity if illness (CGI) was associated with increased social disabilities ($p < 0.01$) and specific interpersonal problems like being overly introverted, subassertive and nurturant ($p < 0.05$). Significant improvements were found in the main outcome criteria (panic attacks and disabilities) in both treatment groups after 24 weeks but there were no significant differences between the treatment groups. Responders and non-responders did not differ in any baseline variables including interpersonal problems and disabilities. However, at follow up non-responders (CGI) were more frequently overly introverted and socially avoidant than responders ($p < 0.01$). In order to investigate the prognostic ability of psychosocial disabilities and interpersonal problems in the long course of the disease follow up data will be analyzed two years after the end of treatment. Treatment for panic disorder including an interpersonal approach deals with the importance of interpersonal conflicts and may protect the patients from relapse in the course of the disease.

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CATASTROPHIC COGNITIONS AND AVOIDANCE BEHAVIOR IN PANIC DISORDER PATIENTS

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Introduction: The purpose of the present study was to further explore the influence of catastrophic cognitions on avoidance behaviour in panic disorder (PD) patients.

Method: The Mobility Inventory (MI), the Agoraphobic-Cognition-Questionnaire (ACQ) and the Beck Depression Inventory (BDI) were administered to 71 consecutive out-patients who received a DSM-III-R diagnosis of PD with or without agoraphobia.

Results: The average age of the total sample was 34.5 years. 62 (87%) received a diagnosis of PD with agoraphobia, 46 (65%) were women. The average value of the ACQ was 2.01 (SD 0.55), of the MI-AAL (avoidance alone) 2.1 (SD 0.97) and of the BDI 17 (SD 9.4). Inter-correlations of the scores of the MI-AAL, the ACQ and the BDI showed one significant correlation (between ACQ and MI-AAL). In a multiple regression analysis (MI-AAL as dependent variable) only ACQ turned out to have a significant influence (β = .27, $p < 0.05$).

Discussion: The pattern of our results support previous findings (e.g. as shown in a study with anxiety disordered people by Warren et al. 1989) that intensity of catastrophic cognitions are associated with extend of agoraphobic avoidance. In contrast to other studies (e.g. Chambless et al. 1984), we found neighter significant correlations between BDI and the ACQ nor between BDI and avoidance behaviour.

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PANIC DISORDER AND CIGARETTE SMOKING BEHAVIOUR

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Objective: The purpose of this study was to assess the cigarette smoking behaviour of panic disorder patients as well as the way panic disorder affects the habits of cigarette smokers and how changes in cigarette smoking in turn affect panic symptoms.

Method: 102 consecutive panic disorder patients attending the panic disorder clinic at the Department of Psychiatry at the University of Vienna with a DSM-III-R diagnosis of panic disorder with or without agoraphobia answered the questions of a specially designed structured clinical interview regarding their smoking habits and their association to panic disorder. Onset, duration, daily numbers

of cigarettes and changes in cigarette consumption during the course of panic disorder were recorded as well as the impact of these changes on panic symptomatology.

Results: Both rates of smokers (56%) and of ex-smokers (28%) were substantially higher than in the general population (smokers: 27.5%, ex-smokers 15%; values for the general population outside 95% Confidence Intervals). However, a surprisingly high number of patients had succeeded in reducing or quitting cigarette smoking because of their panic disorder, although they experienced little benefit in regard to panic symptoms from doing so.

Conclusions: The motivation for changing smoking habits is high in this population with elevated smoking prevalence and should be taken into consideration by therapists.

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COGNITIONS AND DISABILITIES IN PANIC DISORDER

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Dysfunctional cognitions represent a core element of panic disorder. We investigated the question whether certain cognitions are associated with disabilities in different areas of life.

In a study on the comparison of paroxetine with group-psychotherapy in patients with panic disorder with or without agoraphobia, dysfunctional cognitions were assessed by the Agoraphobic-Cognitions-Questionnaire and psychosocial impairment was evaluated by the Sheehan-Disability-Scale.

Of 100 patients included in the study, 88 cases could be analyzed regarding this question due to complete data. Dysfunctional cognitions showed a significant correlation with disabilities in social relations and family life but not in functioning at work. As suggested in the literature the most frequently reported cognitions were: getting a heart attack (26.1%), the fear of fainting (19.3%), and the fear of dying (19.3%). However, cognitions which were associated with disabilities in daily life were characterized by the fear of loosing social control (doing something stupid ($r = .38$), loosing control ($r = .30$), and becoming crazy ($r = .29$)) and the fear of impairment that would result in dependency on the help of others.

The results suggest that cognitions with an interpersonal aspect have a greater impact on patient's role functioning aspect of quality of life than the cognition of fear of dying. It is concluded that it is advisable to concentrate on these interpersonal cognitions.

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PANIC DISORDER WITH AGORAPHOBIA AND MARITAL AND SEXYAL FUNCTIONALITY

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Background and Objective: Panic disorder with agoraphobia is a complex psychiatric disorder. Possibility of better understanding and treatment of the disorder including estimate of marital and sexual functionality.

Method: Instruments which were administrated: DSM-IV criteria for panic disorder with agoraphobia, Acute Panic Inventory, Self-rating subscale for agoraphobia, Marital-Maudsley questionaire, DSM-IV criteria for sexual dysfunctions. The sample included two groups: 30 patients which filfulled criteria for panic disorder with agoraphobia, and 30 healthy maritaly harmonic pearsons.

Rezults: The study results indicates that patients with panic disorder with agoraphobia are maritally and sexually dysfunction as compared to control maritaly harmonic pearsons. 60.3% of the patients filfulled criteria for one or more sexual dysfunction and none of the control group. In the majority of cases (53.3%) sexual dysfunctions occured secucundarily upon a certain period of satisfactory marital sexual functioning. Sexual desire disorders was the most frequent (46.6%), than sexual arousal disorders (26.7%) and orgazmic disorders (16.6%)

Conclusion: In conclusion the authors suggest integrative treatment for panic disorder with agoraphobia which including marital and psychosexual therapy.

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THE APPLICATION OF THE PANIC AND AGORAPHOBIA SCALE (P & A) IN CLINICAL TRIALS

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Introduction: A new scale for assessing severity in PDA (Panic Disorder with/without Agoraphobia) has been developed: the Panic and Agoraphobia Scale (P & A[1]). The objective of this study was to verify that the scale is sensitive to changes from baseline or to differences between treatments.

Method: Two treatment trials were performed. In the first study, 36 patients with PDA were treated with imipramine (75–150 mg per day) and self-exposure to feared stimuli for eight weeks in an open, prospective trial[2]. In the second trial, 49 outpatients with PDA were randomly assigned to a ten-week treatment protocol of either regular aerobic exercise (running), intake of clomipramine (112.5 mg per day) or placebo pills[3]. Treatment efficacy was measured with the Panic and Agoraphobia Scale (P & A) and other rating scales (e.g. the Hamilton Anxiety Scale and the Clinical Global Impression Scale).

Results: In the first study, treatment success could be demonstrated by a significant decrease of the average P & A severity scores. In the double-blind placebo-controlled trial, the P & A revealed significant differences between both active treatments (running and clomipramine) and placebo, whereas clomipramine was significantly more effective than running.

Conclusions: The new Panic and Agoraphobia Scale (P & A) was shown to be sensitive to changes and to differences between various treatment modalities for PDA.

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