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Multidimensional assessment of the Panic–Agoraphobic Spectrum: Reliability and validity of the Spanish version of the PAS-SR

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Abstract

The present study reports on the psychometric properties of the adaptation into Spanish of the Panic–Agoraphobic Spectrum Self-Report (PAS-SR). Drawing on a dimensional and longitudinal perspective of psychopathology, the PAS-SR was designed to measure a wide array of lifetime Panic–Agoraphobic features. Participants included outpatients with a DSM-IV-TR diagnosis of panic disorder ($n = 26$) or major depression ($n = 28$), and a normal control group ($n = 41$). Internal consistency and test-retest reliability were excellent for the total score, and moderate to excellent for most domains. Significant and high correlations between PAS-SR scores and instruments measuring similar constructs indicated good concurrent validity. The findings support the discriminant validity of the questionnaire. Patients with a diagnosis of panic disorder attained higher scores than normal controls on all domains, and displayed higher scores than patients with major depression on five of the eight domains.

Keywords: Panic–Agoraphobic Spectrum; validity; reliability; panic disorders

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1. Introduction

The present study focusses on the adaptation into Spanish and on the validation of the Panic–Agoraphobic Spectrum Self-Report (PAS-SR; Cassano et al., 1997; Shear et al., 2002). The PAS-SR was designed to assess the lifetime presence of the typical symptoms for a panic disorder with or without agoraphobia – i.e., the DSM-IV (APA, 2000) or ICD (WHO, 1992) diagnostic criteria – as well as a range of clinical features associated to the panic–agoraphobic phenomenology. The latter includes, specifically: atypical symptoms (i.e., symptoms not listed among DSM-IV or ICD criteria for panic and agoraphobic disorders), manifestations of separation anxiety, vulnerability to stressful events, reactivity to substances and medication, anxious expectation, illness-related phobia, and tendency to reassurance seeking. Therefore, the term Panic–Agoraphobic ''spectrum'' refers not only to the most prominent symptoms of panic disorders, but also to other features related to the core conditions which are not commonly included in standard assessment tools, as they do not belong to the diagnostic criteria established in the prevailing classification systems.

The lifetime prevalence of atypical and subclinical panic symptomatology – i.e., symptoms that do not reach the diagnostic threshold – has been found to be far high, especially in community and primary care samples (Olfson et al., 1996; Weissman, 1988; Weissman, Klerman, Markowitz, & Ouellette, 1989). Besides their high prevalence, such conditions have been found to be associated with a high level of impairment, increased medical morbidity and psychiatric comorbidity, and increased use of health care facilities and mental health services, even when they occur isolated (Katon, 1989; Klerman, Weissman, Ouellette, Johnson, & Greenwald, 1991; Leon, Portera, & Weissman, 1995; Olfson et al., 1996; Weissman, 1988; Weissman et al., 1989).

Moreover, subclinical presentations of panic as well as other significant clinical features (in particular, hypochondriasis, subtle anxiety and avoidance patterns, anxious expectation, generalized anxiety, or interpersonal dependence) may be present as prodromal, residual and/or co-morbid symptoms either of the corresponding major disease (i.e., the panic disorder in this case) or of other DSM Axis I disorders, affecting the presentation, course and response to treatment of the major conditions (Bouvard, Mollard, Guerin, & Cottraux, 1997; Ehlers, 1995; Faravelli, Paterniti, & Scarpato, 1995; Fava, Grandi, & Canestrani, 1988; Fava, Grandi, Rafanelli, & Canestrani, 1992; Fava, Zielezny, Savron, & Grandi, 1995; Feske et al., 2000; Frank et al., 2000, 2002; Kilic, Noshirvani, Basoglu, & Marks, 1997; Perugi et al., 1998; Teusch & Bohme, 1997).

As Cassano and colleagues have argued (Cassano et al., 1997; Shear et al., 2002), failure to recognize and attend to such features may hinder the advancement in understanding, and therefore, preventing and treating mental disorders. In the meantime, the challenge of caring for patients with atypical and subtle conditions continues to be uncertain, given the lack of current agreement