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Panic and avoidance in panic disorder with agoraphobia: Clinical relevance of change in different aspects of the disorder

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Abstract

Different aspects of change were examined in 62 patients who fulfilled the DSM-IV criteria for a primary diagnosis of panic disorder with agoraphobia of moderate to severe magnitude, and who were treated with 16 sessions of behavioral therapy. The treatment resulted in substantial effects on panic attacks and agoraphobic avoidance. Panic-free status only differentiated the patients regarding mood at pre- and post-treatment. Changes in panic and avoidance were related to each other, but change in avoidance was more related to change in negative affect. Change in quality of life (QOL) was also more associated with change in avoidance at post-treatment. At follow-up change in QOL was more related to change in panic than change in avoidance.

Keywords: Exposure in vivo; Cognitive-behavior therapy; Negative affect; Quality of life

1. Introduction

Panic disorder with agoraphobia (PDA) is a pervasive disorder that has far reaching implications for the individual. It is also one of the most well-researched disorders regarding the efficacy of psychological treatment. It is an area where significant contributions to the field of established efficacious treatments have come from the cognitive-behavioral tradition. But it is also an area of competing assertions regarding necessary and sufficient treatment components.

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This clinical disorder was initially conceptualized as a phobia, as implied by the name agoraphobia. Accordingly, the earlier treatment formulations were centered on in vivo exposure to external conditioned anxiety-evoking stimuli. These behavioral treatments have gained strong empirical support (Shapiro, Pollard, & Carmin, 1993). Since the revision of DSM-III, where panic attacks were given primacy in the clinical picture and the agoraphobic avoidance was considered secondary, the treatment focus has shifted to the task of eliminating these attacks (Barlow, 2002).

The causal role of panic attacks for agoraphobic avoidance has been an area of continuous controversy. However, there seems to be a general consensus that in clinical samples the agoraphobic avoidance develops following panic attacks or panic-like sensations. It is generally recognized that it is uncommon in clinical samples to find agoraphobic avoidance not preceded by panic attacks or limited symptom attacks (Craske, DeCola, Sachs, & Pontillo, 2003). While the etiological relationship between panic attacks and agoraphobic avoidance may not bear any necessary implication for treatment, the relative importance of these phenomena in maintaining the disorder could be regarded as more crucial. However, the presence of recurring panic attacks, per se, does not seem to be closely linked to agoraphobia, and neither severity nor frequency of panic attacks has been found predictive of agoraphobic severity (Cox, Endler & Swinson, 1995). The level of avoidance of agoraphobic situations is more accurately predicted by the anticipatory anxiety surrounding panic attacks (Craske, Rapee, & Barlow, 1988). It seems as if the expectation of panic attacks and of their consequences appears to be more critical in predicting agoraphobia than the quality or quantity of the panic attacks. In a longitudinal study, it was found that panic expectancy was predominantly influenced by a trait-like expectancy component, but uninfluenced by the previous day's experienced anxiety (Rodebaugh, Curran, & Chambless, 2002). Cox et al. (1995) found that the more severe group, not only was more avoidant of agoraphobic situations, but the patients also reported more general anxiety related to novel or ambiguous situations. Apart from that, they also scored higher on measures of depressed mood and state anxiety, which suggests that agoraphobic severity is associated with more clinical distress.

While the diagnostically distinguishing features of PDA focus exclusively on panic attacks and phobic avoidance, agoraphobic patients have been noted to show generally more severe impairment and a markedly higher co-morbidity rate for depression than do other phobias (Wittchen & Essau, 1991). Generally a high co-morbidity with other anxiety disorders and mood disorders is reported within this population (Brown, Anthony, & Barlow, 1995). They are consistently found to suffer from a plethora of clinical problems (Chambless, 1985) and the remission rates are lower and relapse rates are higher for PDA than panic disorder (Keller et al., 1994).

The well-established cognitive-behavioral treatments for panic disorder have frequently focused on subjects with minimal or no agoraphobia, thereby limiting their scope to the patients within a less serious spectrum of the disorder (Barlow, 2002). This not only raises serious questions about the generalization of these treatments over the full spectrum of panic disorder, but it also means that research has been focusing on the part of the patient spectrum, subsumed under the category panic disorder, which shows a lesser degree of general impairment.

The generalization of treatment methods focusing on ameliorating panic attacks, over the full spectrum of panic disorder, rests on the hypothesis that controlling panic attacks