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PSYCHOLOGICAL FEATURES IN PANIC DISORDER

A comparison with major depression

Yasmin A. Almeida[1], Antonio E. Nardi[2]

ABSTRACT - *Objective*: We aim to evaluate the psychodymanic model for panic disorder (PD) formulated by Shear et al. (1993), comparing PD patients and major depression (MD) patients. *Method*: We evaluated these parameters in open interviews in 10 PD patients and 10 patients with MD (DSM-IV). The data were recorded on videotape and were examined by 5 diagnostic blind appraisers. *Results*: The data allowed a comparative analysis that underscores the existence of a psychological model for PD vs MD: 1) the protracted symbiotic phase of development and the existence of problems with separation in PD patients; 2) patients with MD tended to have a particularly negative impression of relationship with the first objects; furthermore, they had remarkable experiences of loss; and 3) while the PD patients tended to be shy and inhibited in childhood, especially showing a clear difficulty in expressing aggressiveness, the depressed patients tended to disclose an impulsive aggressiveness from infancy to adulthood. *Conclusion:* Exposure to parental behaviours that augment fearfulness may result in disturbances in object relations and persistence of conflicts between dependence and independence may predispose to anxiety symptoms and fears of PD.

KEY WORDS: panic attack, psychology, psychopathology, psychotherapy.

Características psicológicas no transtorno de pânico: comparação com depressão maior

RESUMO - *Objetivo*: Avaliar o modelo psicodinâmico para o transtorno de pânico (TP) proposto por Shear e col. (1993), comparando pacientes com TP e pacientes com depressão maior (DM). *Metodo*: Os parâmetros psicodinâmicos foram obtidos através de entrevista aberta com 10 pacientes com TP e 10 pacientes com MD (DSM-IV). As entrevistas foram gravadas em videotape e examinadas por 5 avaliadores sem conhecimento do diagnóstico. *Resultados*: Os dados permitiram uma análise comparativa demonstrando a existência de modelo psicológico para o TP vs DM: 1) uma fase simbiótica de desenvolvimento prolongada e a existência de problemas de separação em pacientes com TP; 2) os pacientes com DM tendem a ter impressão particularmente negativa com os primeiros objetos, principalmente associados a experiências marcantes de perda; e 3) enquanto os pacientes com TP tendem à timidez e inibição na infância, especialmente demonstrando clara dificuldade em expressar agressividade, os pacientes com DM tendem a demonstrar agressividade impulsiva da infância à vida adulta. *Conclusão*: A exposição aos comportamentos paternais que aumentam a insegurança podem resultar em distúrbios nas relações objetais e persistência de conflitos entre dependência e independência, predispondo aos sintomas ansiosos e medos do TP.

PALAVRAS-CHAVE: ataque de pânico, psicologia, psicopatologia, psicoterapia.

Panic disorder (PD) is a common and potentially debilitating anxiety disorder that can adversely affect patients' personal, social, work, and academic lives[1]. The discrimination of PD as a diagnosis entity was anticipated by some phenomenological descriptions[2-4]. Psychological aspects are currently having their efficiency subjected to questioning due to the lack of controlled studies as a result of methodological limitation[5]. Biological foundations for the etiology of PD have considered psychological factors as a second rated participant[6]. Nevertheless, existing evidences question this proposition and signals to the need of reconsidering psychotherapeutic approach in PD[7]. For instance, PD patients respond well to psychopharmacotherapy but responses are also good to non-pharmacological treatments[8,9]. Other types of psychotherapy using research techniques, such as focal psychotherapy[10] and client-centered psychotherapy[11]

Institute of Psychiatry, Federal University of Rio de Janeiro, Rio de Janeiro RJ, Brasil: [1]Psychiatrist; [2]Associate Professor. This research was supported by the Brazilian Council for Scientific and Technological Development (CNPq) grant 300500/93-9.

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Yasmin A. Almeida, MD - Institute of Psychiatry, Federal University of Rio de Janeiro - R. Visconde de Pirajá, 407 / 702 - 22410-003 Rio de Janeiro RJ -Brazil. FAX: 5521-2523-6839 - E-mail: aenardi@novanet.com.br

also have had their efficiency confirmed with the behavior-cognitive therapy[12] and recent trial[13] of brief psychodynamic psychotherapy. However, in a small percentage of cases (10-20%), PD is refractory to the combination of drugs and psychotherapy, at correct dosages and during adequate time[14]. Refractoriness, residual disabilities and defects that follow all forms of treatment and the problems posed by patient selection, the placebo responders[15] and high drop-out rates have received insufficient attention[16].

From the psychopathological point of view, the relationship between PD and agoraphobia has not yet been established, nor has with depression[1,17]. The psychological, behavioural and psychodynamic aspects of these disorders should continue to receive due attention both in clinical management and scientific investigation[14]. Some data suggest a 'psychologic vulnerability' to PD. During chilhood, PD patients often presented separation anxiety[18], cronic anxiety[19], social anxiety and difficulties in managing their own angry feelings or criticism from others[20]. Oral personality traits or neuroticism which includes self-doubt, interpersonal sensitiviness, dependency and emocional instability have been recognized as triggering factors to PD and agoraphobia[19,21,22]. They seem to represent vulnerability at least to maintenance or recorrence of PD.

Psychological factors have rarely been systematically studied in PD. One of the most important studies concerning this subject was performed by Shear et al.[23], where a psychodynamic model was designed based on opened interviews carried on with nine patients which fulfilled the DSM-III-R PD criteria. Six common characteristics were considered: 1) psychologically meaningful stressors associated with frustration and resentment preceded the onset of panic; 2) patients perceived their parents as controlling, demanding, frightening, temperamental and critical; 3) patients have difficulty in acknowledging their angry feelings, aggression was prominent and uncomfortable; 4) patients described themselves as frightful, nervous or shy as children; 5) most described feelings of inadequacy or self-reproach (low self-esteem); and 6) their spouses were characterized as passive, kind and nonaggressive. In order to enable scientific outcome studies of psychological treatment, certain preliminary research is required, as a set of reliable diagnoses that also recognize psychological factors may be developed[23]. We appraised some psychological features in PD patients in contrast with patients with major depression (MD). The data from interviews with PD and MD patients were compared and discussed based in Shear et al.[23] psychodynamic formulation for PD.

METHOD

Twenty patients were randomly selected at the Institute of Psychiatry of the Federal University of Rio de Janeiro. Participants were men and women, aged between 18 and 60, who met criteria for PD, with or without agoraphobia, or MD, both determined by the Structured Clinical Interview[24] for DSM-IV[25]. The 10 PD patients needed to have a minimum of 4 panic attacks, at least 1 unexpected, during the 4 weeks before the interview. The 10 MD patients had current moderate MD episode but all had a recurrent subtype and the presence of PD or panic attacks were excluding criteria. Pregnant or nursing women were excluded from participation. Patients who met DSM-IV criteria for bipolar disorder, obsessive-compulsive disorder, schizophrenia, delusional or psychotic disorders, organic brain syndrome, severe personality disorder, epilepsy, or substance abuse or dependence (during the previous year) were also excluded. Patients with comorbid dysthymia and generalized anxiety disorder could be included if the PD or the recurrent MD disorder were judged to be the principal diagnosis. Other reasons for exclusion included unstable medical conditions; concomitant treatment with any psychotropic drug or psychotherapy during one-month before the interview; use of any regular antipsychotic, antidepressant, regular benzodiazepine or nonbenzodiazepine anxiolytic medication within 4 weeks, or fluoxetine within 5 weeks of the interview; or the presence of suicidal risk.

After complete description of the objective of the interview to the subjects, written informed consent was obtained. The protocol complying with the principles laid down in the Declaration of Helsinki was approved by our local Ethics Committee.

The interviews lasted in average 60 minutes and were documented in videotape and were later put into transcripts for further analysis and discussion. The interviews were all done by the same psychiatrist (YAA) and were open, but systematically covered the six subjects proposed by Shear et al.[23]. For reliability control purposes, the interviews were submitted to five diagnostic blind appraisers, all post-graduated medical doctors with more than 12 years of psychotherapeutic experience. Only a full agreement among all the appraisers was considered as a psychologic feature for any of the groups.

Age differences were compared using Student-t test and gender differences using χ^2 with Yates correction. The psychological features were compared with the Fisher exact-test.

RESULTS

The ten PD patients with agoraphobia interviewed were seven women and three men with a mean (± SD) age of 35.6 (± 12.5) years. The ten MD group were six women and four men with a mean (± SD) age of 37.3 ± 9.8 years. The gender differences between the groups was not statistically significant (χ^2 with Yates correction= 0.57, p=0.987).

Table 1. Summary of psychological features comparing panic disorder with agoraphobia (n=10) and major depression (n=10) with full agreement among the five blind appraisers.

	Panic Disorder	Major Depression
Parents	In 7 cases, the relationship with the parents was positive, having an exaggerated dependency on the mother, with extension of the symbiotic relationship in 6 of these cases. In 2 cases, the relationship with parents was described as negative.	In 8 cases, the relationship was described as being negative with both parents, in most cases. In 3 of these cases, relationship with the mother was good whereas with the father it was very bad. In 2 cases there was premature loss of the mother, in 2 cases there was severe illness of the mother. In 3 cases, the mother considered having an abortion when pregnant with the patient.
Childhood	Shyness, inhibition, fears, tendency to insecurity and lack of initiative in 6 cases. Portrait of specific phobia in 3 cases. Presence of separation anxiety to a certain degree in every case, better characterized in 6 cases. Impulsiveness and low self-esteem in 1 case.	Aggressiveness and impulsiveness in 5 cases, aggressiveness without impulsiveness, with feelings of inferiority in 2 cases.
Object-choice	Docility, passiveness and placidity in 8 cases, and in 3 of these cases partner was unavailable.	Passiveness of partner in 7 cases. Patient adopts a dominating [master] attitude within relationship in 8 cases. Insensibility and aggressiveness of partner in 2 cases.
Triggering factor	Presence of psychologically significant triggering event in 9 cases, being obvious in 4 cases and indirectly attested in 5 cases.	Presence of triggering events clearly mentioned in 7 cases. Common significance involved loss.
Self-esteem	Low in 9 cases.	Low in 9 cases.
Agressiveness	Constriction of aggressiveness manifestations in 9 cases, with exaggerated docility in 4 cases.	Clearly aggressive personality in 7 cases, with impulsiveness in 6 cases.

The results were separeted by diagnosis and main psychological features. They are summarized in Table 1.

Seven PD patients described their relationship with the parents as being positive, having an exaggerated dependency on the mother, with extension of the symbiotic relationship in six of these cases ($p= 0.023$). Fathers were characterized as being fragile and kind. In two cases, relationship with parents was described as negative: one parent was considered to be rejecting or coercive and the other parent to be remiss (neglectful). In only one case the mother, fragile and kind, have a good relationship with the patient, whereas the father presented characteristics compatible with a mild personality disorder (borderline).

Eight patients with MD described their relationship with parents as being negative with both parents, in most cases. In three of these cases, relationship with the mother was good whereas with the father it was very bad. In two cases there was premature loss of the mother, in two other cases there was severe illness of the mother. In three cases, the mother considered having an abortion when pregnant with the patient.

Shyness, inhibition, frights, tendency to insecurity and lack of initiative in six PD patients during childhood ($p= 0.047$). There was a portrait of specific phobia in three cases. Presence of separation anxiety to a certain degree in every case, better characterized in six cases. Impulsiveness and low self-esteem were detected in one case.

Aggressiveness and impulsiveness were detected

during childhood in five patients with MD. Aggressiveness without impulsiveness but with feelings of inferiority was detected in two cases.

Docility, passiveness and placidity were detected in eight PD patients (p= 0.039), and in three of these cases partner were unavailable. Unavailability was the most significant characteristic in two cases, in one case due to cruelty and in the other case due to the person being previously compromised.

Passiveness of partner was detected in seven patients with MD. Eight patients with MD adopt a dominating (master) attitude within their relationships. Insensibility and aggressiveness of partner were detected in two cases.

Presence of psychologically significant triggering event was detected in nine PD patients (p= 0.029), being obvious in four cases and indirectly attested in five cases. Common significance involved separation, *latu sensu.*

The presence of triggering events clearly mentioned in seven MD patients. Common significance involved loss.

The self-esteem was low in nine PD patients. It was detected an unstable balance of self-esteem through maintenance of the symbiotic situation throughout life. It was also low in nine MD patients (p= 0.906). There was an unstable balance of self-esteem through conscious use of aggressiveness in objective (actual) reality.

There was a constriction of aggressiveness manifestations in nine PD patients, with exaggerated docility in four cases. Aggressiveness with impulsiveness together with a history of dystocia (difficult delivery) was detected in one case with hyperactivity during childhood. Distinctive inhibited aggressiveness, only demonstrated indirectly through unconscious ambivalence directed towards the first objects (parents).

There was a clearly aggressive personality in seven MD patients (Fisher exact test, p= 0.031), with impulsiveness in six cases. It was detected a proper handling of aggressiveness, without excesses or denials (disavowals), in three cases.

DISCUSSION

Although our study has a small sample size, our results from the interviews with PD patients were phenomenologically coinciding with those of Shear et al.[23]. Previous reviews of the literature concerning the subject indicated the existence of similar phenomena descriptions with no connection traced between the different theoretical lines of psychological orientation[5,26].

PD patients showed a tendency of having had a positive relationship with their first objects (mother or substitute), characterized by the extension of the symbiotic phase (stage) – beyond the considered normal time, according to the descriptions included in Mahler´s psychology of development[27]. The tendency to establish intimate emotional ties with special individuals – stronger and wiser – is a basic component of the human nature[28,29]. This tendency lasts throughout the individual's life with the purpose of self-preservation. However, in this half-sample we speculate that the object (mother) behaved as the fragile element in the mother-child couple, causing an inversion of the attachment function. This kind of inversion would be highly responsible for the generation of anxiety, inhibited behavior and non-manifested anger[28,29]. The inversion is characterized by the mother's failure in playing the role of the stronger or wiser person in the attachment link, disturbing the child's normal development.

The tendency to maintain a symbiotic link continues throughout life, manifesting itself in the patients' object-choices[5,29]. Therefore, it seemed more operative here to appraise the type of relationship rather than to value the type of the object's personality, as had been done by Shear et al.[23]. PD patients tend to choose amiable partners which, however, do not represent a solid foundation (individual circumstances are variable), repeating the maternal pattern with a relationship generally of the symbiotic type. The existence of symbiosis in the mother-child relationship is absolutely normal; attention is brought to the extension of this type of link and its further repetition in the object-choices. The role of the symbiotic aspects also can be seen in a study where unconscious pregnancy fantasies were outlined as an underlying dynamic organizer to the panic experience in some patients with PD[7].

Our sample of PD patients do not manifest themselves openly aggressive, as opposed to the impulsive aggressive tendency observed in MD patients. In general, PD patients proved to be frightful children, while MD patients were frightless children. Besides, MD patients use their aggressiveness as a way of balancing their self-esteem which shows up in their dominating (master) attitude assumed in regard to their spouses, whereas panic stricken patients have a tendency of balancing their self-esteem through the maintenance of the symbiotic link from which they obtain their solace (refuge). This mechanism does not seem to be a viable or practical alternative for depressed patients, be it due to their intrinsically aggressive characteristics or to the marking nega-

tive trait of their relationship profile with their first objects.

It has been described some panic-focused psychodynamic treatment for PD[5,13]. These reports outlined psychoanalytic concepts that were employed to develop a complementary approach to PD, including the idea of unconscious mental life and the existence of defense mechanisms, compromise formations, the pleasure principle, and the transference. There are some evidences suggesting that psychotherapy works by changing the functioning of the brain because neither gene expression nor the anatomy or physiology of the brain is static: genetics and environment are in constant interaction with one another. For a full understanding of any mental illness, psychological aspects must be incorporated[30].

The MD disorder sample had a negative evaluation of the relationship they had with their parents. They had been frightless, impulsive and aggressive during their childhood and this pattern is still present in their adult behavior. The dominating (master) attitude towards their spouses was a marking factor in the object-choice. Self-esteem is low even outside the depressive event, and its balance is mainly possible through the possibility of using aggressiveness in actual (objective) reality.

Structured video-taped interviews and agreement among well-trained blind appraisers in trials comparing different diagnosis groups and with specific scales could identify specific psychological features and increase the knowledge about PD pacients improving our approach for biological and psychological treatment.

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