A Systematic Study of Axis-II Diagnosis and Coping Style in Panic Disorder

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The dynamic formulation in psychiatric patients has been reconsidered recently. The proposed axis of defense mechanisms in the DSM-IV represents an attempt to include these data in systematic psychiatric assessment. In this study 20 patients with the diagnosis of panic disorder with or without agoraphobia were submitted to Axis II diagnosis for personality disorders according to DSM-III-R. Panic patients and age and sex matched non - patient controls completed the Arabic version of DSQ-40 for defense style. Results of this study showed that the common Axis II diagnoses in this sample of panic disorder patients are obsessive compulsive and dependent PDs. The pattern of defense style differed significantly between panic patients and non-patient group. Panic patients used less mature (less adaptive) coping style. The significance of findings to the understanding of patients with panic disorder and the implications for therapy are discussed.

(Egypt. J. Psychiat.,1997, 20: 215-220).

INTRODUCTION

The "either-or" polarization of psychodynamic and biological, a trend in contemporary psychiatry, has been increasingly disappointing to those who view clinical work as an optimal integration of mind and brain. Much of this polarization arises from failure to appreciate the complex relationships between psychosocial and neuro-physiological factors in the etiology and pathogenesis of psychiatric disorders (Gabbard, 1992). To assume, as we all do, that biochemical processes underlie mental activity and behavior, does not imply that they are causal agents but rather constitute mediating mechanisms. They are influenced by the information inputs we receive from our body and environment, and by the subjective meaning of that information for us (Lipowski, 1989). Kandel (1983), in a series of experiments with the marine snail Aplysia, convincingly demonstrated that the functional effectiveness of synaptic connections can be altered by learning experiences connected with the environment, specifically, through regulation of gene expression. He concluded: "It is only in so far as our words produce changes in each others brain that psychotherapeutic interventions produce changes in patients' minds. From this perspective the biological and psychological approaches are joined".

Since the creation of panic disorder as a separate diagnostic category by the authors of DSM-III, the etiology of panic was postulated to be a neurophysiological defect. This model was influential in stimulating neuro-biological research efforts that has led to identification of medications that are effective in ameliorating panic symptoms (Shear et al., 1993). The brief effective treatment for panic episodes with either medication or cognitive behavioral interventions supported the enthusiasm for short-term focused treatments. However, reports of high levels of functional impair-

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ment (Markowitz et al., 1989), residual symptoms (Katon et al., 1987) and persistent long-term symptoms (Noyes et al. 1989), has challenged this enthusiasm.

In the same direction, Andrews et al. (1990) considered panic a neurotic symptom and suggested that predisposing personality factors provide the best explanation for the development of neurotic symptoms and they claimed that "good" treatment should involve not just resolution of symptoms but also improvement in the vulnerability factors that appear to be central to these disorders. The reintroduction of psychodynamic perspective is useful in guiding research strategies to identify traits which predispose to panic and in designing treatments to address such traits (Shear et al., 1993).

The current availability of operationalized rating instruments have facilitated the systematic assessment of psychodynamic factors (Busch et al., 1995). The proposed axis of defense mechanisms (coping styles) in the DMS-IV (APA, 1994) represents an attempt to include these data in systematic psychiatric assessment.

SUBJECTS AND METHODS

20 new patients recruited from the outpatient clinic (Suez-Canal University Hospitals) with the predominant diagnosis of panic disorder according to DSM-III-R. All patients were diagnosed using the structured clinical interview for DSM-III-R (Spitzer et al., 1990). There was no age or sex restriction. The only exclusion criterion was any significant active medical illness. Twenty age and sex matched (non-patient control) sample was recruited from the community through personal communication.

1. Patient and non-patient groups completed the Arabic version of defense-style questionnaire (Soliman, 1996). Comparison between the two groups in all items of DSQ was carried using Mann-Whitney test. Logistic regression analysis for predictor variables (defenses) was performed
2. Patient group was submitted for Axis-II diagnosis using the Arabic version of SCID-II (Omar et al., 1992) for DSM-III-R personality disorders.

RESULTS

Demographic data are presented in table (1), differences between panic patients and controls on the use of defense mechanisms are presented in table (2). Panic patients scored significantly higher on the defense of idealization and significantly lower on the defense of anticipation. Three mechanisms; displacement, somatization and passive aggression, were utilized frequently but not significantly by panic patients. They did not score significantly higher than controls on the defense of reaction formation. Results of logistic regression analysis of predictor variables (defenses) are presented in table (3), $R^2 = 40.5\%$.

Highly significant variation ($P<0.001$) is noticed on defenses of anticipation and reaction formation (used more by non-patient group) on one hand and displacement on the other hand (used more by panic patients). Idealization also predicts variation significantly ($P<0.05$) (used more by panic patients). Somatization and passive aggression, although used more frequently by panic patients, yet their predicative value did not reach statistical significance.

Table (4) shows Axis II diagnosis in panic patients, which are presented in

descending order of frequency. The most frequent diagnoses were obsessive compulsive PD (10 cases, 50%), dependent PD (6 cases, 30%) and narcissistic PD (5 cases, 25%). 9 Subjects fulfilled the diagnostic criteria of multiple PDs (2 or more threshold PD diagnoses) and 6 subjects had no Axis-II PD diagnosis.

Table 1
Demographic Data and Diagnosis

	Control	Cases
Sex	F:9 (45%) M:11 (55%)	F : 9 (45%) M:11 (55%)
Age (years)	34.2± 12.9	36.9 ± 10.9
Marital Status		Single : 8 (40%) Married : 12 (60%)
Education		* R & W: 4 (20%) Diploma : 8 (40%)
Employment		Unemployment : 5 (25%) Engineer : 5 (25%) Government : 2 (0%) Teacher : 2 (10%) Student : 3 (15%) Secretary: 1 (5%) Driver : 1 (5%) Labourer: 1 (5%)
Diagnosis		PD with agoraphobia : 3 (15%) PD without agoraphobia : 17 (85%)

Table 2
Defense Mechanisms Ratings{Mean (SD)} of Patients with Panic Disorder and Non-Patient Controls

Defenses	Patients	Non-patients	M.-Whitney Z	P
Mature				
Anticipation	11.4(4.0)	13.5 (3.4)	2.04	< 0.05
Neurotic				
Idealization	10.0 (3.7)	8.0 (2.9)	1.96	< 0.05
Reaction Formation	8.7 (2.6)	9.8 (3.4)	0.89	> 0.05
Immature				
Displacement	9.2 (3.5)	8.1 (2.7)	1.84	> 0.05
Somatization	11.9 (3.6)	9.5 (4.7	1.64	> 0.05
Passive Aggression	8.5 (2.9)	7.0 (3.6)	1.51	> 0.05

Table 3
Logistic Regression Analysis for Prediction of Defense Mechanisms in Panic Disorder Patients

Predicator Variable	B-coefficient	P-value	Adjusted OR
Anticipation	0.569	<0.01	1.8
Displacement	- 0.32	<0.01	1.4
Reaction Formation	0.353	<0.01	1.4
Idealization	- 0.240	< 0.05	1.3
Somatization	- 0.22	>0.05	1.3
Passive Aggression	- 0.155	>0.05	1.2
Suppression	0.035	> 0.05	1.03
Sublimation	- 0.02	> 0.05	1.02

N.B.: $R^2 = 40.5\%$
(-) Cases use more than non-cases.

Table 4
Principle Axis II Diagnoses in Panic Disorder Patients *

Personality Disorder	Threshold No	Threshold %
Obsessive compulsive	10	50
Dependent	6	30
Narcissistic	5	25
Self - defeating	4	20
Paranoid	4	20
Histrionic	2	10
Avoidant	0	0
Passive aggressive	0	0
Schizotypal	0	0
Schizoid	0	0
Borderline	0	0
Antisocial	0	0

* Nine subjects had 2 or more PD diagnosis (Multiple PDs). Six subjects did not have any Axis - II Diagnosis.

DISCUSSION

Obsessive-compulsive and dependent personality disorders are the most common Axis-II diagnoses in this study. They are included under cluster C of personality disorders classification. Sub-

jects under this category are described as anxious and fearful. This constitutional fearfulness formed part of Shear et al. (1993) psychodynamic model. These authors propose a relationship between neurophysiological vulnerability to panic and constitutional fearfulness, in conjunction with parental failure to modulate this fearfulness. Bowlby (1973) views that the fearfulness of panic patients with or without agoraphobia results from a chronically impaired sense of safety, due, in large part, to insecure attachment. David Barlow (1991) proposed another model that focuses on the importance of a learned sense of uncontrollability in the pathogenesis of panic. Shear et al (1993) provided the mechanisms for impairment in development of a sense of controllability. They suggested that avoidance of real life experiments impairs learning about predictability of threats. This explanation is supported by the finding in this study that panic patients utilized the mechanism of anticipation significantly less than non-patient group. This leads to interference with realistic self confidence in coping with threats. The resulting lowered sense of safety affects internalized objects to the point that there is a weak self and powerful others.The significant use of the mechanism of idealization by panic patients in this study supported also this view point. This creates the vulnerability to separation or to feeling trapped that appears to characterize these patients.

Bond et al (1983) found that subjects self ratings of their defenses factored into styles that could be ranked in a hierarchy from mal-adaptive to adaptive. The proposed defensive scale for further study in the DSM-IV sixth Axis (APA,1994) adopted the same concept. In this study significant difference on the level of adaptation between panic patients and non-patients was confirmed. The significant use of anticipation by non-patients placed them on the 1st high adaptive level according to DSM-IV defense levels. On the other hand panic patients utilized idealization significantly and used displacement, somatization and passive aggression frequently than controls. This places them on the levels 2,3 and 6 on the hierarchy (less adaptive). These results replicated the findings of another Egyptian study by Soliman (1997) who used the same tool in her study of defense style in patients with major depressive disorder. In comparison to normal controls, she found that patients used immature (less adaptive) defenses while control used more mature (adaptive) ones. In accordance with this study, Pollock and Andrews (1989) and Busch et al (1995) reported the use of immature and neurotic (less adaptive) mechanisms by panic patients. However, the pattern of these defenses were not the same in the three studies. The different use of individual defense mechanisms in the same diagnosis was supported by Bond and Vaillant (1986) who reported the lack of clear relationship between defense style as measured by the questionnaire and DSM-III diagnosis. Their findings supported the view of Karasu and Skodol (1980) who advocated a sixth axis for DSM-III to offer discriminating information about the psychodynamics that help in describing heterogenous features of the same disorder.

Information about constitutional predisposition and defense style (coping or adaptive level) in conjunction with clinical data can broaden our understanding of panic patients and help in planning treatments that would augment current symptom-focused treatments, and provide further relief of residual symptoms and protect against future exacerbation of active panic disorder.

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Etude Systhématique des Axis - II et des Systèmes de défense du désorder de Panique

La formulation dynamique de la psychiatrie fut prise récemment en considération. L'axe proposé des méchanismes de défense du IDS - IV (DSM-IV) est une tentative d'ajouter ces données à l'évaluation systématique des désordres psychiatriques. Il s'agit, dans cette étude, de 20 patients dont le diagnostique est le désordre panique avec et sans agoraphobie. Ceux-ci ont subi le diagnostique pour le désordre personnel : Axis II appartenant à IDS -III-R (DSM - III - R.)

Les Patients du panique et d'atures patients semblables en âge, en sex et en nombre ont subi la version arabe du QSD - 40 pour le système de défense.

Les résultats de cette étude ont montré que les diagnostiques communs Axis-II de cet échantillon de patients de désordre panique sont des personnalités compulsives obsessives et dépendantes.

Le système de défense differt d'une façon significative entre les patients de panique et les personnes normales.

دراسة تصنيفية للمحور التشخيصى الثانى والاسلوب الدفاعى (التكيفى) لدى مرضى اضطراب الرهاب

تم مؤخراً إعادة الاهتمام بالصياغة الدينامية المرضى النفسيين. ويعتبر المحور المفترض لميكانيزمات الدفاع فى التقسيم الأمريكى الرابع للاضطرابات الطبية النفسية محاوله لاضافه هذه المعطيات للتقييم التصنيفى للاضطرابات الطبية النفسية. وقد تم إخضاع عينة مكونة من عشرين مريضا ومريضة باضطراب الرهاب للتصنيف المحورى الثانى لتحديد نوع اضطرابات الشخصية لهؤلاء المرضى حسب التقسيم الأمريكى المعدل الثالث للاضطرابات الطبية النفسية . وقد أكملت العينة المرضية مع عينة سوية متطابقة بالنسبة للعدد والسن والنوع النسخة العربية لاستبار الاسلوب الدفاعى . ولقد أظهرت نتائج هذا البحث أن الشخصية الوسواسية القهرية والشخصية الاعتمادية تمثلان أعلى نسبة فى هذه العينة لمرضى اضطراب الرهاب. ولقد اختلف نمط الاسلوب الدفاعى (التكيفى) عند المرضى عنه عند الأسوياء حيث استخدم المرضى أساليب دفاعية غير ناضجة (غير متكيفة) مقارنة بالاسوياء ولقد تمت مناقشة دلالة هذه النتائج وتطبيقاتها العلاجية .