Original Article

Impact of Personality Disorder on the Treatment Response of Panic Disorder Patients

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Background: Most clinicians tend to believe that the occurrence of the anxiety disorder in comorbidity with a personality disorder often leads to longer treatment, worsens the prognosis, and thus increasing treatment costs. The study is designed to compare the short-term effectiveness of pharmacotherapy in patients suffering with panic disorder with and without personality disorder.

Subjects & Methods: We compare the efficacy of 6th week therapeutic program and 6th week follow up in patients suffering with panic disorder and/or agoraphobia and comorbid personality disorder (29 patients) and panic disorder and/or agoraphobia without personality disorder (31 patients). Diagnosis was done according to the DSMIV diagnostic criteria, Patients were treated with psychopharmacs. They were regularly assessed in week 0, 2, 4, 6 and 12 by an independent reviewer on the CGI (Clinical Global Improvement) for severity and change, PDSS (Panic Disorder Severity Scale), HAMA (Hamilton Anxiety Rating Scale), SDS (Sheehan Disability Scale), HDRS (Hamilton Depression Rating Scale), and in self-assessments BAI (Beck Anxiety Inventory) and BDI (Beck Depression Inventory).

Results: pharmacotherapy proved to be an effective treatment of patients suffering with panic disorder and/or agoraphobia with or without comorbid personality disorder. The 12th week treatment efficacy in the patients with panic disorder without personality disorder had been showed significantly better compared with the group with panic disorder comorbid with personality disorder in CGI and specific inventory for panic disorder-PDSS. Also the scores in depression inventories HDRS and BDI showed significantly higher decrease during the treatment comparing with group without personality disorder. But the treatment effect between groups did not differ in objective anxiety scale HAMA, and subjective anxiety scale BAI.

Conclusion: Personality disorder in panic disorder patients is related to a smaller decrease of specific panic symptomatology during treatment than in patients without personality disorders. Nevertheless a significant decrease in symptomatology occurs in personality disorder patients as well.

Keywords: Panic disorder, Treatment response personality disorder, Impact of personality.

Abbreviations:

PDSS: Panic Disorder Severity Scale
DSMIV: Diagnostic and statistical manual of mental disorders
PAF: Personality assessment form.
HAMA: Hamilton Anxiety Rating Scale
SDS: Sheehan Disability Scale
HDRS: Hamilton Depression Rating Scale
BAI: Beck Anxiety Inventory
BDI: Beck Depression Inventory
SSRI: Selective Serotinine Reuptake Inhibitor
SNRI: Selective Norepinephine Reuptake Inhibitor
CGI: Clinical Global impression

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INTRODUCTION

Personality disorders are relatively frequent in the general population. Their prevalence ranges from 10 to 13% (Lenzenweger, et al. 1997). Among outpatient psychiatric popul-ation, 30-50% suffer with personality disorders (Koenigsberg, et al. 1985) and about 15% of inpatients come to health care facilities because of problems related primarily to their personality disorders; up to half of the remaining inpatients suffer with comorbid personality disorder (Loranger, 1990).

A diagnosis of personality disorder often evokes images of troublesome, difficult work with little hope for success, and correspondingly affects the therapist's conscious or unconscious attitudes from the very beginning of his relationship with the patient. These attitude are often negative and moralizing (Tyrer and Davidson, 2000). Personality disorders rarely occur separately and are often related to other health problems, such as depressive states, anxiety disorders, eating disorders, alcohol and drug abuse, promiscuity; injury, infectious diseases etc. Most clinicians tend to believe that the occurrence of these problems in tandem with a personality disorder often leads to longer treatment, worsens the prognosis, and thus increases treatment costs. However, the latest overview of empirical psychotherapeutic studies of personality disorders shows that, despite of the myth

of untreatability, treatment is relatively effective (Perry and Bond, 2000). The authors have carried out a meta-analysis of 22 studies showing that significant positive changes during active treatment are 2-4 times higher than in control group without an active treatment. In four studies with the treatment outcome criterion of full remission, 52% of patients met this criterion after 1.3 years of treatment. Although the improvement is not as fast and substantial as in anxiety disorders or depressions, there is still a significant reduction in the patients' suffering and improvement in their adaptation in life. Nonetheless, this analysis does not answer the clinically relevant question: Does a comorbid personality disorder influence the effectiveness of treatment of a disorder on axis I?

According to most clinicians, treatment of a panic disorder with a comorbid personality disorder is more difficult, and achieving remission is less likely than in patients without a comorbid personality disorder. Unfortunately, there are no studies confirming this. Approximately half of all panic patients also suffer a comorbid personality disorder. Prevailing personality disorders include histrionic, narcissistic, avoidant, dependent, and borderline.

The aim of our study is to compare the efficacy of treatment of panic disorder patients suffering with a comorbid personality disorder with the treatment of panic disorder patients without a comorbid personality disorder.

- The null hypothesis assumed that treating panic disorder patients with a comorbid personality disorder would be as effective in the parameters of alleviating of psychopathology as treating anxiety disorder patients without a comorbid personality disorder.

- An alternative hypothesis suggested that the treatment of patients with panic disorder and comorbid personality disorder would be less effective than the treatment of panic disorder patients without a comorbid personality disorder (In the sense of a smaller decrease in psychopathology and poorer social adaptation).

Further we assumed partial alternative hypotheses:

- That, besides panic disorder, personality disorder patients will more frequently suffer from other comorbid disorders, such as depressions, social phobia, generalised anxiety disorder, or eating disorders.

- That, we would identify a larger disproportion between objective and subjective assessment scales and a greater impact on work adaptation in these patients, as compared to panic disorder patients without personality disorders.

METHOD

Patient group

So far, 60 patients who met the following admission criteria have been included into the study (31 with panic disorders without comorbid personality disorders and 29 with panic and comorbid personality disorders):

1. DSMIV diagnostic criteria for panic disorder or panic disorder with agoraphobia (Am. Psych-Assoc, 1994).
2. Age 18 - 45 years.
3. Signed informed consent of the study.

The exclusion criteria were following:

a) The presence of a major depressive episode: DSMIV criteria for a major depressive episode, dysthymia and minor depressive episodes were not reasons for exclusion from the study.
b) Organic mental disorder.
c) Psychotic disorder in the person's history.
e) Drug addiction.
f) Serious somatic illness.
g) Pregnancy and lactation in women.
h) Suicidality.

The inclusion and exclusion criteria of the study were confirmed by two independent experts.

Assessment:

After study enrolment, patients were assessed during the first two days of attendance at the outpatient clinic before the beginning of treatment. The assessment focused on psychopathology and was carried out by psychiatric rating scales in the second, fourth and sixth week, and in a brief follow up six weeks after the end of treatment (Table 1).

a) **Objective:** to assess the degree of psychopathology, we used the following objective psychological methods and rating scales:

- ***PAF*** (Personality assessment form) the PAF was developed by Shea, et al. (1987) to assess DSM-III personality disorders. The scale consists of descriptive paragraphs emphasizing salient features of each of the 11 DSM-111 axis II personality disorders. Ratings of the extent to which the features described are characteristic of the patient's long-term personality functioning were made for each disorder on a 6-point rating scale, ranging from 1= not at all to 6= to an extreme degree, a response option of "No information or insufficient data" is also provided. Ratings on the Personality Assessment Form were made on the basis of information obtained during the clinical interview and specific probe questions targeted at relevant features of axis II personality disorder.

- ***CGI*** (Clinical Global Impression): global assessment of the degree of psychopathology. The source of data is an as complete as possible collection of information about the patient's behaviour (Guy, 1976).

- ***PDSS*** (Panic Disorder Severity Scale). Was developed as a simple, standardized tool for assessing holistic severity in panic disorder. The scale comprises seven items that probe the following dimensions of panic disorder and associated symptoms: frequency of panic attacks, distress during the attack, anticipatory worry, agoraphobic fear, avoidance interoceptive fear, and impairment in work, and social functioning. (Shear, et al. 1997).

- ***HAMA*** (Hamilton Anxiety Rating Scale): a structured questionnaire for adult patients diagnosed with anxiety neurosis. Its purpose is to monitor changes during therapy; the source of data is the patient's verbal and non-verbal behaviour during examination (Hamilton, 1959).

- ***SDS*** (Sheehan Disability Scale): 10-point analogue scale on which, after talking with the therapist, the patients indicate the degree to which their work, social and family life are affected.

- ***HDRS*** (Hamilton Depression Rating Scale): 21-item instrument for assessing depression (Hamilton, 1967).

b) **Subjective:**

- ***BAI*** (Beck Anxiety Inventory): self-rating scale with 21 anxiety indicators (Beck, et al. 1985).

- ***BDI*** (Beck Depression Inventory): self-rating scale with 21 depression indicators (Beck, et al. 1961).

Treatment approaches:
Patients were treated with SSRI The medication of the first choice was paroxetine in doses of 10mg during the first week and 20mg during the second week. In the fourth week there was a possibility to double the dose in case of insufficient effectiveness. If no results occurred by the end of the fourth week, paroxetine was replaced by another SSRI If a patient had used paroxetine in the past, another SSRI or SNRI was applied. If patients used anxiolytics, their dose was gradually tapered.

Table 1: Timetable of the rating scales administration:

Assessment tool	Week 0	Week 2	Week 4	Week 6	Week 12
DSMIV	X				
PAF	X				
CGI-severity	X	X	X	X	X
CGI-improvement		X	X	X	X
PDSS	X	X	X	X	X
HAMA	X	X	X	X	X
SDS	X				X
HDRS	X				X
BAI	X	X	X	X	X
BDI	X				X

PDSS :Panic Disorder Severity Scale.
DSMIV :Diagnostic and statistical manual of mental disorders.
PAF :Personality assessment form.
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RESULTS

Description of the patient group:
Sixty patients were included into the study - 14 men and 46 women. Twenty-nine patients met the criteria for personality disorders as assessed by PAF for the patients' characteristics see (Table 2). There were no statistically significant differences between the group of panic disorder patients suffering from a comorbid personality disorder and the panic disorder patients without comorbid personality disorder neither in terms of demographic characteristics such as age, sex, marital status, or the number of current comorbid disorders (see Table 2), nor in the average scores of psychopathology rating scales of CGI, PDSS, HAMA, SDS, HDRS, BAI and BDI (see Table 4) (t-tests: n.s.). The most common personality disorder of patients admitted for panic disorders with or without agoraphobia was a dependent personality disorder (41.4%) and histrionic personality disorder (27.6%). Comorbidity of other mental disorders in both groups was relatively high: 58.6% of panic disorder and personality disorder patients were currently suffering from another disorder (most frequently GAD 27.6% and social phobia 20.7%), as were 45.2% of panic disorder patients without a diagnosed personality disorder (most frequently social phobia 25.8% and GAD 16.1%). Although the percentage of current comorbid disorders is higher among patients with personality disorders, the difference between the groups does not reach statistical significance (chi2: n.s.). Our hypothesis that personality disorder patient groups would significantly more often suffer from another comorbid anxiety disorder was not confirmed.

Table 2: Description of the patients:

	Panic Disorder With Personality Disorder	Panic Disorder Without Personality Disorder	Statistics
Age	33.10 + 7.77	35.39 + 9.61	t-test:n.s.
Sex (Male:Female)	7:22	7:24	Chi²: n.s.
Marital Status (SingIe:Married:Divorced/ Widowed)	11:13:5	14 :16 :1	Chi²: n.s.
Personality Disorder	100%	0	
• Histrionic	8 (27.6%)		
• Narcissistic	4 (13.8%)		
• Avoidant	3 (10.3%)		
• Dependent	12 (41.4%)		
• Borderline	2 (6.9%)		
Comorbidity-current disorders	17 (58.6%)	14 (45.2%)	Chi': n.s.
• Dysthmia/mixed anxiety and depressive disorder	3 (10.3%)	0	
• Social Phobia	6 (20.7%)	8 (25.8%)	
• GAD	8 (27.6%)	5 (16.1%)	
• Eating Disorder	1 (3.5%)	1 (3.2%)	
• Somatization Disorder/ neurasthenia	3 (10.3%)	0	
• Clustrophobia	0	2 (6.5%)	

Treatment:

Pharmacotherapy was more variable, although the basic procedure was set up identically. The average doses of antidepressant medication and adjuvant therapy with anxiolytics are given in (Table 3). In order to compare the antidepressants we calculated the doses of individual drugs to the equivalents of an antidepressant (Paroxetine 20mg = citalopram 20mg or fluoxetin 20mg or sertralin 50mg or fluvoxamin 50mg or escitalopram 10mg or venlafaxin 75mg), or an anxiolytic (Alprazolam 0.75mg = clonazepam 0.5mg or diazepam 15mg or oxazepam 20mg). The average dose of an antidepressant calculated to an equivalent was significantly higher in the group of comorbid disorder patients than in the group without a comorbid personality disorder. The average dose of the equivalent of an anxiolytic is far lower in patients without personality dis¬orders; however, considering the small number of such medicated patients and significant standard deviation, the difference does not reach a level of significance.

Table 3: Average dose of medication according to the equivalent of an antidepressants, and anxiolytics:

	Panic Disorder With Personality Disorder	Panic Disorder Without Personality Disorder	Statistics
Anxiolytics patients without: patients with	10:19	5:26	Chi2: n.s.
Average equivalent dose of antidepressant (paroxetine) in the group of all patients	30.34+10.57	19.35+15.59	t-test: $p < 0.05$
Average equivalent dose of antidepressant (paroxetine) on one medicated patient	33.84+10.24	31.59+12.02	t-test: n.s.
Average equivalent dose of anxiolytic (alprazolam) in the group of all patients	0.52+0.75	0.13+0.22	t-test: p=n.s.
Average equivalent dose of anxiolytic (alprazolam) of one medicated patient	1.51+0.99	0.83+0.58	t-test: n.s.

Rating scales:

GGI – severity

In the beginning, there were not significant differences in severity scores of clinical global impression scale in both groups (4.59+0.56 in group of patients with personality disorders versus 4.55+0.55 in group without personality disorders). Severity scores in both groups dropped significantly in both groups during the treatment (Sixth week 2.59+0.83 in group with personality disorders, versus 1.94+0.53 in the other group). The difference - between the groups after two weeks of treatment is not significant. From the fourth week onwards, significant differences between the groups began to occur both $p<0.05$, this difference was evident both in the 6th ($p<0.05$) and in the 12th week of assessment ($p<0.01$) (see Table 4). According to the CGI-severity score, the treatment of panic disorder patients leads to an improvement in both groups of patients (With and without comorbid personality disorder). From the fourth week, the effectiveness of the treatment is significantly higher for patients without personality disorder than for patients with a personality disorder; this difference persists until the 12th week of assessment.

PDSS

PDSS is an instrument for specific assessment of the severity of a panic disorder. It is the most sensitive instru¬ment for this disorder. In both groups of patients with or without personality disorder there was a significant decrease in total scores during 12-week study period (from 17.45+3.11, and 17.29+2.93 respectively, to 8.0+4.07, and 5.23+2.82 respectively). The difference between the groups is statistically significant in the 4th

and 12th week of the study :p<0.05, in favour of a more significant decrease in the group without personality disorders. However, in the 6th week of the study the difference is not significant (Table 4). The results suggest that after the termination of the treatment in the 6th week of the study, when the decrease of panic and agoraphobic symptomatology was similar in both groups, further improvement occurs in the group of patients without a personality disorder, while among per¬sonality disorder patients this tendency is less significant. The results show that one of the differences in treating panic disorder patients with a personality disorder, as compared with patients who do not suffer from personality disorders, might be the patient's ability to continue the change already started.

HAMA

In the objective rating scale intended for measuring overall symptoms of anxiety (not solely focused on panic and agoraphobic symptomatology), both clinically and statistically significant decrease of total scores occurred (from 23.72 + 4.12 in the personality disorders group and 24.65 + 5.06 in the group without personality disorders at the beginning of the study to scores of 11.41 + 5.34 and 9.94 + 4.55, respectively, in the 12th week of the study). However, no significant difference was found between two patient groups (Table 4). The results show that the treatment of non-specific symptomatology of anxiety was as effective in personality disorder patients as in patients without personality disorders. It should be noted that the study was explicitly focused on panic disorder and agoraphobia and not other anxiety symptoms. Moreover, treatment is not designed for the treatment of personality disorders. It seems that there is no difference in the effectiveness of treatment between personality disorder patients and those who do not suffer from this disorder

SDS

At the beginning there were no significant differences between the groups in the evaluation of social and family handicaps on the SDS scale. However, there was a difference in profession/work item (see Table 4). On the average, patients evaluated their degree of impairment in work as strongly affected (7.41+1.86 in personality disorder patients and 6.29+1.77 in patients without per¬sonality disorders). Impairment in social and family life was evaluated as moderate. During treatment there was a significant decrease in all of three rating scale items, the impairment mostly perceived as mild or very mild. In the 12th week of the study there is a significant difference between the groups in terms of work impairment evaluation, P<0.01. The group without personality disorders had lower impairment scores (Table 4). The results show that in both groups perceived impairment in the area of occupation/work/ profession, social and family life dropped significantly. The only difference between the groups before and after the treatment is how they perceive the work impairment that is corresponding with our clinical experience -even after the treatment, personality disorder patients have difficulties with occupational adaptation. This area remains frustrating for them, despite the fact their psychopathology has decreased significantly. On the contrary, in patients without personality disorders the decrease in psychopathology and overall improvement leads to a parallel increase in self-confidence in the professional area. HDRS

An objective assessment of symptoms of depression with this standard scale shows mild depression symptoms- at the beginning of the treatment, with virtually no difference between the groups (14.14+3.89 in personality disorder patients versus 14,0+4.31 in the other group). In both groups there is a decrease of depression score during treatment (10.59+4.37 among personality disorder patients versus 6.61+3.16 in the other group). A significant difference between groups occurred after 12 weeks of the study, when patients without personality disorders showed a larger decrease in HDRS scores than personality disorder patients P<0.05 (see Table 4). It seems that even though the study was not focused on treating depression symptoms, these were alleviated in both groups during the treatment. We do not know why there is a smaller decrease of depression among personality disorder patients. According to the results we assume that it might be related to the smaller decrease in panic and agoraphobic symptomatology (Measured by PDSS) and lower self-confidence in abilities to adapt oneself professionally (As measured SDS)

BAI

Time path of BAI scores - general subjective scale for anxiety symptoms is similar to those of HAMA. The scores of both groups at the beginning are similar (22.93 + 6.39 in the personality disorders group versus 26.1 + 8.67 in the group without personality disorders), and during treatment a significant reduction of psychopathology occurs in both groups (sixth week: 15.83 + 6.22 versus 16.84 + 7.31). The pattern of symptom decrease is very similar in both groups; no significant difference was found in either of the study visit (Table 4). Subjective evaluation of a wide range of anxiety symptoms in BDI rating scale confirms these acquired data. Panic disorder patients with or without personality disorders are improving rapidly during a short-term treatment programme; and if we do not focus on the specific symptoms for which they were admitted and treated, the changes are to be similar.

BDI

The Beck Depression Inventory is designed for evaluating subjective depression symptoms. Similarly to the objective scale for depression (HRDS), there was no difference in depression symptoms at the beginning of the treatment (15.41 + 6.21 among personality disorder patients versus 13.26 + 6.1 in the second group). Average scores in both groups agree with mild depression. According to our hypothesis we

expected a disproportion between the HRDS and BDI assessment: personality disorder patients overrating individual symp-toms. This did not prove to be the case; there is no significant difference between the groups on either the objective or subjective scales. At the end of the treatment there is a significant difference between the groups in the 12th week, p<0.05 (see Table 4). We understand this finding similarly to HDRS and SDS results, patients finished the treatment and most of them started to work; those suffering from personality disorders had lower self-confidence in their adaptability at work than patients without personality disorders.

Table 4: Changes of psychopathology during the treatment:

		Panic Disorder with Personality Disorder (n=29)	Panic Disorder without personality Disorder (n=31)	Statistics (Mann-Whitney test)
CGI-Severity	0.week	4.59+0.55	4.55+0.55	n.s.
	2.week	3.86+0.53	3.48+0.83	n.s.
	4.week	3.17+0.87	2.55+0.6	P<0.05
	6.week	2.59+0.83	1.94+0.53	P<0.05
	12.week	2.48+0.82	1.78+0.68	P<0.01
PDSS	O.week	17.45+3.11	17.29+2.93	n.s.
	2.week	15.48+4.02	13.87+3.65	n.s.
	4.week	12.34+3.97	9.42+3.52	P<0.05
	6.week	8.48+3.12	6.84+2.64	n.s.
	12.week	8.0+4.07	5.23+2.82	P<0.05
HAMA	0.week	23.72+4.12	24.65+5.06	n.s.
	2.week	20.79+5.61	19.39+6.03	n.s.
	4.week	16.52+6.25	14.45+5.86	n.s.
	6.week	12.48+4.65	10.19+4.31	n.s.
	12.week	11.41+5.34	9.94+4.55	n.s.
SDS	0.week			
• Work		7.41+1.86	6.29+1.77	P<0.05
• Social activities		5+2.13	4.94+1.94	n.s.
• Family		4+2.97	2.97+1.22	n.s.
SDS	12.week			
• Work		3.9+1.82	2.32+0.92	P<0.01
• Social activities		3.14+1.64	2.39+1.15	n.s.
• Family		2.76+1.64	1.94+0.77	n.s.
HDRS	0.week	14.14 + 3.89	14 + 4.31	n.s.
	12.week	10.59 + 4 31	6.61+3.16	P<0.05
BAI	0.week	22.93 + 6.39	26.1+8.67	n.s.
	2.week	20.62 + 6.29	20.81+9.93	n.s.
	4.week	18.52 + 6.82	17.19 + 7.48	n.s.
	6.week	15.83 + 6.22	16.84 + 7.31	n.s.
	12.week	15.83 + 6.21	14.68 + 6.57	n.s.
BD1	0.week	15.41+6.21	13.26 + 6.1	n.s.
	12.week	12.72 + 6.14	6.48 + 3.67	P<0.05

DISCUSSION

Referring back to our hypotheses, the study has shown that neither the null hypothesis nor the alternative hypothesis is completely valid; in other words, both are partly valid. The treatment of panic disorder patients with a comorbid personality disorder was as effective in alleviating anxiety symptomatology as was treatment for panic disorder patients without a comorbid personality disorder.

On the other hand, treatment of patients without personality disorders was significantly more effective for specific panic and agoraphobic symptomatology (Target of the study) than it was for patients with personality disorders. In personality disorder patients there was a smaller decrease in symptomatology; patients evaluated themselves as less socially adapted in the area of work and profession.

Another hypothesis - that in addition to panic disorder, personality disorder patients would more frequently suffer from other comorbid disorders - was not confirmed. In both groups we found frequent comorbidity, most often with social phobia and generalised anxiety disorder. If we had chosen different selection criteria, we might have found significant comorbidity with a depression disorder. However, our aim was to evaluate the therapeutic effectiveness for a panic disorder and we did not include patients with stronger comorbid depres¬sion.

Surprisingly we did not find any prominent disproportion between the objective and subjective measures of rating scales between group of personality disorder patients and group of patients without personality disorders. We expected that the objective scales would show similar results and the subjective scales would show significantly higher scores among personality disorder patients. There was not found any difference between the groups; average total scores of BAI rating scale are lower in personality disorder patients than in the other group. However, regarding the SDS rating scale of social handicaps (Item “Work”). In the beginning of the study, patients from both groups evaluated their work adaptation similarly; at the end of treatment, patients without personality disorders perceived their work adaptation as being significantly better.

It seems that our results may reflect reality to a certain degree. Follow up evaluation performed six weeks after the end of therapeutic programme showed worsening of some of the patients with personality disorder (CGI - improvement to 1 and 2 in 69% after six weeks and in 62.1% after 12 weeks); in the group without personality disorders there was a further increase in the number of improvements (In 80.6% after six weeks and in 90.3% after 12 weeks).

Perry and Bond (2000) claim that, despite of earlier assumptions about untreatability; treatment of personality disorders is relatively effective. In all studies they reviewed the improvement in personality disorder patients was not as pronounced as in patients without personality disorders, and the effect of therapy varied for different types of personalitydisorders. The greatest changes were observed in various symptoms, while social adaptation, problems in interpersonal relationships and individual personality traits were influenced by treatment very slowly. Our findings in the group of personality dis¬order patients with or without agoraphobia show similar result - treatment is successful, although significantly less in some parameters (In our case, specific panic and agoraphobia symptomatology, depression symptoms and work adaptation) than among patients without personality disorders.

CONCLUSIONS

Our study showed that, personality disorder in panic disorder patients is related to a smaller decrease of specific panic and agoraphobic symptomatology during treatment than in patients without personality disorders. Nevertheless, a significant decrease in symptomatology occurs in personality disorder patients as well. And a large proportion of them is with significant overall improvement. However, they are less able to continue with improvements after the end of the treatment and improvement in their self-confidence to manage their work situation is not the same as for patients without personality disorders.

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الملخص العربى

تأثير اضطرابات الشخصية على الاستجابة للعلاج في مرض اضطراب الهلع

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أستاذ مساعد الأمراض النفسية (كلية الطب-جامعة المنصورة)

يعتقد الكثيرون أن اضطرابات القلق النفسى ومن أكثرها شيوعاً اضطراب الهلع والمصحوب باضطراب الشخصية يستغرق وقتاً أطول فى العلاج وأن نتائج العلاج لكونه مصحوباً باضطراب الشخصية تكون غير مرضية مما يؤثر بالسالب على المستقبل المرضى لهؤلاء المرضى. وتهدف هذه الدراسة إلى مقارنة مدى تأثير العلاج الدوائي على مجموعة من مرض اضطراب الهلع المصحوب باضطراب الشخصية مع مجموعة أخرى من مرضى الهلع الغير مصحوب باضطراب الشخصية.

ولقد أظهرت النتائج أن العلاج الدوائي له تأثير ايجابى وفعال فى علاج اضطراب الهلع سواء كان مصحوباً أو غير مصحوب باضطرابات الشخصية. ولوحظ بداية من الأسبوع الثاني عشر للعلاج أن درجة ومعدل التحسن من حيث الانطباع الإكلينيكي العام وأعراض الهلع نفسه، وأعراض القلق والاكتئاب المصاحب، وكذلك الاندماج الأسرى الوظيفي كانت أكثر وذو دلالة إحصائية أعلى فى مرض اضطراب الهلع الغير مصحوب باضطراب الشخصية عنه فى مجموعة مرضى الهلع المصحوب باضطراب الشخصية. واستنتجت الدراسة أن سبب هذه الفروق يرجع إلى عدم قدرة مرضى الهلع المصحوب باضطرابات الشخصية على الاستمرارية فى التحسن الذى بدأ بالفعل مع العلاج والتكيف الوظيفي والأسرى مما يصيبهم بالإحباط برغم التحسن الواضح فى الأعراض وذلك بسب اضطرابات الشخصية الموجودة لديهم خاصة أن معظم هذه الإضرابات كانت من نوع اضطرابات الشخصية الإعتمادى واضطرابات الشخصية الهستيري فى هذه المجموعة.