PhD Thesis – Abstract

THE ROLE OF CLIENT-CENTRED PSYCHOTHERAPY IN THE MANAGEMENT OF PANIC DISORDER

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Key words: panic disorder, client centered psychotherapy, treatment management, selective serotonin re-uptake inhibitors, social functioning.

I. GENERAL PART

Panic disorder has a twelve-month prevalence of 2.7% and a lifetime prevalence of 4.7%, with higher incidence in females (Kessler et al, 2005). The essential feature of panic disorder, according to DSM-IV (American Psychiatric Association), is the presence of recurrent, unexpected panic attacks. There is no specification of the precise frequency of panic attacks to fulfill the criteria for panic disorder in DSM-IV. At least one of the attacks has to be followed by one month or more of the following: persistent concern about having another attack, worry about the consequences of having an attack or a significant change in behaviour. There may also be unfocused anxiety present between the attacks.

Panic disorder is generally considered to be a chronic condition; although most patients improve, few seem to achieve full remission (Keller et al 1994, Roy-Byrne and Cowley 1994/95, Pollack and Otto 1997). It is estimated that only one third of the patients remain in full remission, the others have a chronic evolution (episodic course or persistent course) (Katschnig et al 1995). The course and outcome of panic disorder are influenced by many factors. Women are twice likely to have recurrence of the disease, after remission (Yonkers et al 1998).

Panic disorder patients experience severe social and health consequences, which are comparable in severity and sometimes bigger than those seen in depressed patients. Social and marital functions were significantly impaired, and panic disorder was associated with financial dependency. Panic disorder patients subjectively experienced poor physical and emotional health. There was an increased risk of suicide, alcohol and drug abuse, as well as use of psychotropic medication (such as tranquillizers) (Markowitz et al 1989). These patients appear to be more severely impaired than patients with other anxiety disorders. Disability in relation to work is also extensive. Panic disorder patients are more likely to be unemployed or to earn less than “normal” people who do the same jobs. Therefore, understanding the extent to which panic disorder affects patients” lives as a whole is a key issue when it comes to treatment.

Several psychopharmacological agents are available for the treatment of panic disorder, among them the selective serotonin reuptake inhibitors (SSRIs) are the first-line drugs. Their efficacy has been proven in many controlled studies, and they are considered to be first-line drugs for this disorder. Psychotherapy has proven to be effective and client centred therapy is one method to be considered.

II. OBJECTIVES AND METHOD OF THE STUDY

2.1. Objective

The main objective: the comparative evaluation of two groups of patients with panic disorder, along 48 weeks, one of them treated with SSRI and the other one with SSRI and client centred therapy. Secondary objectives:

- The global evaluation of therapy.
- The evaluation of the social and professional functioning.


2.2. Methodological background
Prospective study of patients diagnosed with panic disorder, treated only with SSRI (group A) and with SSRI and client centred therapy (group B). The study was 48 weeks long, between February 2004-February 2006.

2.3. Inclusion criteria
- Diagnostic of panic disorder with/without agoraphobia according to DSM-IV
- Age of 18 at least
- Able to understand the instructions from the scales and to accept psychotherapy.
- COVI score at least 9 at screening
- CGI-S score at least 4 la at screening.

2.4. Exclusion criteria:
- Without important co-morbidities, or therapeutic-controlled co-morbidities.
- Without psychiatric co-morbidities.
- No substances dependency in the last 6 months.

2.5. Recorded characteristics
- Age: 20-29 years, 30-39 years and 40-49 years;
- Residence: rural, urban;
- Educational background: elementary, college, university.
- Alcohol consumption: abstinence, occasionally (1-2 times/week), chronic (more than 3 times/week).
- Years from the beginning of the disorder.

2.6. Scales of evaluation
- COVI scale
- Panic and Agoraphobia Scale (PAS).
- Panic and Agoraphobia Scale-patient questionnaire.
- Clinical Global Impression Severity Scale.
- Index of anxiety R-IMA-36.
- Sheehan Disability Scale (SDS).

2.7. Study design
The subjects were evaluated along seven visits S0, S4, S8 within 4 weeks, and S12, S24, S36 and S48 within 12 weeks.
Visit S0- after signing the inform consent:
- Inclusion and exclusion criteria
- Medical history
- Psychiatric history
- Previous treatments
- Demographic data
- Employment
- Level of education
- Residence: rural/urban
- Clinic general examination
- COVI
- PAS
- PAS-patient questionnaire
- R-IMA-36
- CGI-S
- SDS
Visits S4-S48:
- Maintaining the inform consent
- COVI
- PAS
- PAS-patient questionnaire
- R-IMA-36
- CGI-S
- SDS
- Possible adverse events
- Paroxetine treatment
- Alprazolam treatment
- Participation in the therapy sessions for the group B patients.

The results were processed separately for each group, related to the recorded characteristics, and comparative, looking for the evolution in time of the scores on all the scales, at each visit

2.8. Study groups

Group A:
- 41 patients: 15 male and 26 de female
- Age 21-49 years, with an average mean of 33.5+-7.1
- Treatment with paroxetine 20-40 mg/day for 48 weeks
- Treatment with alprazolam, 0.25-0.50mg/day for a short period
- No psychotherapy.

Group B:
- 30 patients: 9 males and 21 females
- Age 24-43 years with an average mean of 33+-6.6
- Treatment with paroxetine 20-40 mg/day for 36 weeks
- Treatment with alprazolam, 0.25-0.50mg/day for a short period
- Client centred psychotherapy for 48 weeks.

III. RESULTS AND DISCUSSIONS

The patients” age from both groups is situated between 30-39, namely 53% from group B and 44% from group A. Group A (treated only with SSRI) has a uniform distribution, while 86% from group B patients (treated with SSRI and client centred therapy) are under 39 years of age. The sex distribution was the same in both groups; the share of female is almost double.

Regarding the level of instruction, in group A prevail the patients which graduated from high-school, and in the other group the university graduated patients.

The majority of both groups (95% from A and 100% from B) have urban residence, the disorder has a history of at least 5 years in both groups. In general, there were no significant differences regarding the demography of both groups.

3.1. Comparative evolution of the groups

COVI scale

The COVI scores have a descendent trend for both groups, demonstrating the symptoms’ remission and treatment’s efficacy (Fig. nr. 1). The scores were almost equal in the beginning of the study – 13.1 for group A and 12.82 for group B. At a global assessment, group A has a more constant evolution along the 48 study weeks, with a slower rhythm in the first 24 weeks; the B group has a marked improvement of the panic symptoms in the first 24 weeks, the majority of the patients have similar scores as the normal people at week 36. This demonstrates that client centred therapy had an important role in the therapeutic management of panic disorder.
Fig. nr. 1. COVI score evolution in the two groups

In a comparative study from 2001, Teusch shows that both treatment methods are effective in diminishing both panic and anxiety and avoidance behaviour. The differences between the two groups consisted from the personality scales: the degree of autonomy was bigger in the patients with combined treatment (SSRI and client centred therapy), the patients felt more independent, less stressed, with fewer somatic complaints (Teusch and al. 2001).

PAS scale

The scores on this scale have a more constant evolution for group A; the most important changes for all the patients are in the first 12 weeks of treatment, when the symptoms have a significant improvement (50%) and then the rhythm decreases.

The symptoms” diminishing is bigger between week 12-24 for group B, the scores average improving by 26.6% (only by 20% for group A), and between week 36-48 for group A (Fig. nr. 2).

Fig. nr. 2. PAS score evolution in the two groups

In general, both groups have a clear improvement of panic symptoms along the study; in group A the improvement rhythm is constant and the treatment efficacy is better if the period of administration is at least 12 months (Ballenger, 2004). The evolution of group B patients is more rapid, at week 36 they have normal PAS scores; the psychotherapy is helping them to master the anxiety symptoms and the avoidance behaviour.
**PAS-patient questionnaire**

For all the patients the scores on this scale are dropping by 50% in the first 12 weeks.

For the group B patients the improvement of the symptoms is by 53% between weeks 12-24, and for group A is 33%. In the next 12 weeks the difference is the same (50% for the group A and 69% for the group B), the role of client centred therapy is shown in the fact that the patients feel more social accepted, more independent in all the activities out their secure environment, with fewer somatic complaints (Mitte, 2005). In the last 12 weeks the ratio changes: 75% for group A and 30% for group B (Fig. nr. 3).

**Fig. nr. 3.** PAS patient questionnaire score evolution in the two groups

**R-IMA-36 scale**

In general, the group A has a more constant evolution along the 48 weeks; for this patients the scores’ average drops in the first 12 weeks by 30%, while in group B it drops by 50%. The intensity of panic attacks and of the somatic complaints continues to diminish for these patients by 50% in the next 12 weeks, but for the group A the decrease is only by 31%. Between week 24-36 the difference is the same (50% for group A and 65% for group B), the therapeutical intervention has an important role in the disappearance of panic attacks and agoraphobia (Mitte, 2005). In the last 12 weeks the R-IMA-36 score diminishes by 50% for both groups (Fig.4).

**Fig. nr. 4.** R-IMA-36 evolution in the two groups
PGI-S
Panic disorder is a chronic disorder which needs treatment, but, under these conditions, its prognosis is good (Andersch and Hetta, 2003). The clinical global assessment shows the symptoms’ improvement in both groups, with a descendent course for all patients (Fig. nr. 5).

![Fig. nr. 5. CGI-S score evolution in the two groups](image)

In general, both groups have a similar evolution in the 48 study weeks. For all the patients the scores drop by 50% in the first 12 weeks, more for the group B, proving that client centred therapy is favourable. In the last 12 weeks group A has a better improvement (33% and group B only 23%). The group B patients have a more rapid course, they report the disappearance of panic attacks and the avoidance behaviour and the somatic complaints (Teusch, 2001).

SDS
The evaluation of the social, professional and familial impact of the disorder on the SDS shows the improvement of these items in both groups (Fig.6).

![Fig. nr. 6. SDS score evolution in the two groups](image)

We see that the level of disability decreases, so the social functioning is increasing in both groups the first 12 weeks, by 33% for the A patients and by 45% for the patients benefiting from therapy. The same course is seen in the next 24 weeks; in the last 12 weeks the rhythm is more rapid for group A-37% and only 30% for group B.
Both groups show an improvement of the social functioning in the 48 study weeks, improvement which is more rapid in group B patients. The rapid recovery is important because the specific panic disorders disabilities are related to the quality of life decreasing (Rubin and al. 2000). A cost/efficacy study in two groups of panic disorder patients treated one group with monotherapy (SSRI or psychotherapy) and the other with combined therapy showed that monotherapy is more effective in the acute phase, and the combined treatment in the long-term treatment (McHugh and al. 2007).

IV. CONCLUSIONS
1. The symptoms” improvement (both panic attacks and anxiety) of the group B patients from group B were more rapid. The considerable differences between the two groups, in the group B favour, support the scales” conclusions, proving the superiority of the combined therapy in the treatment of panic disorder.
2. Patients treated with SSRI and client centred therapy have a rapid improvement of the social functioning.
3. In the management of panic disorder it has to be considered the association of psychotherapy and pharmacotherapy, because the therapeutic response is quicker and the time of administration of SSRI is shorter.
4. The superiority of combined therapy regarding patients” functionality suggests that in the therapeutic management of panic disorder we have to consider beyond the clinical efficacy, the improvement of the social and familial functioning.
5. Panic disorder responded both to the SSRI treatment and to the combined therapy.
6. Regarding the global social functioning, we see a balance between familial and social dysfunction in both groups, with an important impact on quality of life.
7. Patients” functioning is a basic aspect to evaluate, and it is an important marker for adequate therapeutic intervention in panic disorder.

V. REFERENCES


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