

Depersonalization and personality in panic disorder

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Abstract

Background: Prevalence and clinical correlates of depersonalization symptoms have been associated with panic disorder. Personality traits might increase the likelihood of experiencing depersonalization symptoms or depersonalization disorder in panic patients.

Aims: The objectives of this study are to establish the prevalence of depersonalization symptoms during the panic attack and in depersonalization disorder and to examine the personality factors associated with the presence of depersonalization in patients with panic disorder.

Methods: The sample comprised 104 consecutive adult outpatients with panic disorder, diagnosed according to the Semistructured Clinical Interview for *DSM-IV* (Axis I/II disorders). Participants were assessed with the Cambridge Depersonalization Scales, the Temperament and Character Inventory, and the Panic and Agoraphobia Scale.

Results: Forty-eight percent of the sample had depersonalization symptoms during the panic attack, whereas 20% of patients had a depersonalization disorder. Women presented more depersonalization disorders than did men ($P = .036$). Patients with panic disorder with depersonalization disorder had a more severe panic disorder ($P = .002$). Logistic regression analysis showed that self-transcendence trait (odds ratio, 1.089; 95% confidence interval, 1.021–1.162; $P = .010$) and severity of panic (odds ratio, 1.056; 95% confidence interval, 1.005–1.110; $P = .032$) were independently associated with depersonalization disorder.

Conclusions: A high prevalence of depersonalization symptoms and depersonalization disorder was confirmed in patients with panic disorder, supporting a dosage effect model for understanding depersonalization pathology. Self-transcendence trait and severity of panic disorder were reported as risk factors for depersonalization disorder.

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1. Introduction

Depersonalization is a common and complex clinical phenomenon in neurology and psychiatry, but it can also be experienced by healthy people under stress, fatigue, or drug-use situations [1]. It is defined as an experience in which the individual feels a sense of unreality and detachment from

him/herself. Very often it is associated with derealization, which consists of an alteration in the perception of one's surroundings such that a sense of the reality of the external world is lost [2]. Patients maintain their judgment that nothing has changed, just their feeling about themselves or about the surroundings. Depersonalization disorder is one of the major dissociative disorders and is characterized by persistent or recurrent episodes of depersonalization symptoms, causes significant distress, and does not occur exclusively during the course of another mental disorder [2]. Depersonalization has been associated with a decreased response to emotional stimuli in the neural regions implicated in the processing of emotion, particularly the subcortical limbic region, as well as an increased response in the inhibitory prefrontal region [3]. A history of traumatic

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experiences, in particular, emotional abuse, has been associated as predisposing factors of depersonalization symptoms [4] and depersonalization disorder compared with healthy controls [5].

The lifetime prevalence of transient depersonalization symptoms in the general population has been reported to be between 26% and 74% [6], and it seems to be sensitive to cultural variation, there being evidence that it is more common among Western cultures [7]. Different community surveys using standardized diagnostic interviews reveal a monthly depersonalization prevalence rate of 1.9% in the UK [1] and Germany [8] and up to 2.4% in a Canadian study [9]. The symptoms can occur in the context of other psychiatric disorders such as depression, bipolar disorder, posttraumatic stress disorder, schizophrenia, substance use, or, particularly, panic disorder [6,10,11].

Depersonalization has often been considered as a nonspecific response to anxiety [12], and some authors have reported that in patients with panic disorder, these symptoms were associated with an earlier age of disease onset, a history of childhood abuse [13], higher prevalence of avoidance behavior, agoraphobia that is more severe [14–16], and high rates of psychiatric comorbidity [15]. However, most of these studies were focused on the prevalence of depersonalization symptoms during the panic attack, which ranges from 7.8% to 82.6% depending on the clinical sample used [6]. Furthermore, studies published to date have some methodological weaknesses, including a lack of standardized diagnostic measures to evaluate in patients with panic disorder not only depersonalization symptoms but also depersonalization disorder.

Although dissociative disorders have shown a strong association with personality disorders, mostly among individuals with cluster B personality disorder [17], there is very little corresponding research on depersonalization disorder. To the best of our knowledge, only one study has specifically investigated the association between depersonalization disorder and personality disorders, reporting that 52% of 117 patients with depersonalization disorder had a personality disorder [18]. The same occurs as regards the dimensional aspect, where depersonalization has been associated in one study with certain personality traits such as the “harm avoidant” temperament dimension, immature defenses, and overconnection and disconnection cognitive schemata [19]. In a study examining the relationship between personality and dissociation in general in both psychiatric patients and healthy subjects, dissociation scores were predicted by the character traits of low self-directedness and high self-transcendence but not by temperament traits [20]. To our knowledge, no studies have examined the association of personality temperament and character traits with depersonalization disorder in patients with panic disorder.

In light of the above, the present study sought to establish the relationship between depersonalization and personality in panic patients. It was hypothesized that patients with depersonalization, either as a symptom during a panic attack

or as a disorder, would present a more severe phenotype of panic disorder, as well as a higher prevalence of personality disorders, high harm avoidance temperament traits, low self-directedness, and high self-transcendence character traits.

2. Methods

2.1. Study design and subjects

Adult patients of both sexes who were diagnosed with panic disorder (with and without agoraphobia) and consecutively seen in the outpatient department of a teaching hospital were eligible to participate in a cross-sectional study. Exclusion criteria were age less than 18 years; presence of severe medical illnesses; neurologic diseases, in particular, seizure disorders; major affective and psychotic disorders; and substance abuse or dependence disorders. The institution’s Ethical Review Board approved all the recruitment and assessment procedures, and written informed consent was obtained from all participants before enrolment in the study.

2.2. Clinical assessment

Sociodemographic data were collected. Participants were diagnosed by 2 senior psychiatrists using the Spanish version of the Structured Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, Axis I disorders (SCID-I) [21] and by 2 clinical psychologists with the Structured Clinical Interview for *DSM-IV* Axis II disorders (SCID-II; First et al, 1997) [22]. Patients were also assessed with Cloninger’s Temperament and Character Inventory (TCI) (Cloninger et al, 1994) [23] and the self-report version of the Panic and Agoraphobia Scale (PAS) (Bandelow et al, 1995) [24]. SCID-II examiners were blind to the results on Axis I, and both SCID-I and SCID-II examiners were blind to the results of the TCI and Cambridge Depersonalization Scale (CDS) (see the succeeding sections). The κ indexes of agreement were 0.65 to 1.00 for SCID-I and 0.49 to 0.95 for SCID-II.

2.3. Instruments

All patients were assessed and diagnosed for current and past psychiatric disorders using the SCID-I [21]. Panic disorder had to be the main Axis I disorder. All patients with panic disorder with the *DSM-IV* depersonalization item of panic attack were selected for the “depersonalization symptoms during the panic attack” group. The SCID-II [22] includes a self-report screening questionnaire, followed by a semistructured clinical interview that allows the assessment of cluster A (paranoid, schizoid, schizotypal), cluster B (antisocial, borderline, histrionic, narcissistic), and cluster C (avoidant, dependent, obsessive-compulsive) personality disorders.

The PAS [24] contains 13 items grouped into 5 subscales: panic attacks, agoraphobia, anticipatory anxiety, disability,

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