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Cognitive Behavioral Treatment of Panic Disorder and Agoraphobia in a Multiethnic Urban Outpatient Clinic: Initial Presentation and Treatment Outcome

Steven Friedman, Jeffrey W. Braunstein, and Beth Halpern
State University of New York Downstate Medical Center

Few studies examine the effectiveness of panic control treatment across diverse ethnic groups. In this paper we present data on 40 patients (African American, n = 24; Caucasian, n = 16) with panic disorder and comorbid agoraphobia who presented at an anxiety disorder clinic in an inner-city area. On initial assessment both groups were similar on psychometric measures, and both groups moderately improved with treatment though significant residual symptoms remained. We illustrate, through case examples, a variety of clinical issues that need to be addressed when providing treatment to multiethnic African American clients with panic disorder and agoraphobia.

Despite the increase in panic disorder (PD) research, little attention has been paid to exploring the generalizability of these findings to other cultural groups; for example, little research has been conducted on these issues in the African American population (Neal & Turner, 1991). This lack of research is especially disturbing given the high rates of PD in African American populations (Eaton, Kessler, Wittchen, & Magee, 1994; Friedman, Paradis, & Hatch, 1994; Horwath, Johnson, Hornig, & Weissman, 1993; Regier et al., 1984). The effectiveness of specific cognitive-behavioral psychotherapy procedures involving exposure-based interventions has been well documented by a number of studies (Barlow, Gorman, Shear, & Woods, 2000; Gould, Otto, & Pollack, 1995) and has been endorsed by the NIH Panic Consensus Statement as effective therapy for PD (Wolfe & Maser, 1994). Several existing studies support the generalizability of these treatments to real-world settings (Sanderson, Raue, & Wetzler, 1998; Wade, Treat, & Smart, 1998). Despite the plethora of past research on PD, outcome research has failed to adequately study the influence of cross-cultural factors on the cognitive behavioral treatment (CBT) of PD. In this paper we present the results of a naturalistic treatment provided to African American and Caucasian patients who presented to an anxiety disorders clinic in an inner-city area. We also provide some clinical guidelines that we have found helpful in treating minority (primarily African American and Caribbean American) patients with panic disorder and agoraphobia (PDA).

As reviewed by Zoellner, Feeny, Fitzgibbons, and Foa (1999), research to date on treatment outcome and ethnicity has focused on broad patterns of mental health usage and efficacy in the general population rather than specific disorders or treatment outcome. Previous research has indicated that in comparison to other ethnic groups African Americans were more likely to seek treatment but terminated treatment earlier (Sue, 1977; Sue, Fujino, Hu, Takeuchi, & Zane, 1991).

In one of the first studies to examine cross-cultural factors in the treatment of PDA, Chambless and Williams (1995) examined pretreatment severity and outcome for African Americans and Caucasian patients who received CBT for PDA. They found African American patients demonstrated more phobic symptoms than Caucasian patients on both self-report and behavioral assessment measures. CBT utilizing time-limited, therapist-assisted in-vivo exposure to environmental panic triggers, but not interoceptive cues or systemic cognitive therapy, was effective for both groups, though Caucasians showed significantly more improvement on most outcome measures. In their study, African American patients were of lower socioeconomic status, and this factor may have influenced treatment outcome.

More recently, Carter, Sbrocco, Gore, Marin, and Lewis (2003) published the only randomized clinical trial of panic control treatment for African Americans. They assigned 25 African American women, of high socioeconomic status and recruited by advertisement, diagnosed with PD to either treatment or wait-list control. Treatment was provided in groups. At pretreatment both

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Continuing Education Quiz located on pp. 337–338.

groups were similarly depressed and anxious. After active treatment, in contrast to wait-list, there was a significant reduction in panic frequency, avoidance behavior, state and trait anxiety, and anxiety sensitivity. The authors reported that their overall effect size was comparable to previously published studies on the use of interoceptive exposure with Caucasians.

Zoellner et al. (1999) reported the response of African American and Caucasian women to CBT for posttraumatic stress disorder. They found in their treatment—consisting of nine individual sessions (twice weekly) utilizing prolonged exposure, stress-inoculation, or a combination of the two treatments—that African American and Caucasian women did not differ on pretreatment measures, dropout rates, or overall treatment efficacy. We recently reported the results of our group (Friedman et al., 2003) in providing exposure and ritual prevention in a multiethnic sample of patients with OCD. We found few pretreatment or posttreatment differences between African American and Caucasians with OCD.

The purpose of this paper is to present clinical data on the efficacy of CBT for the treatment of PD in African American and Caucasian adults in a naturalistic setting. Analysis included possible differences in initial symptom presentation, comorbidity, and ratings on standardized self-report questionnaires. We hypothesized a significant decrease in symptomatology for all participants across treatment. Based on our previous research on OCD (Friedman et al., 2003) and research by Carter et al. (2003) on PDA, we also hypothesized that there would be no difference in treatment outcome as a function of ethnicity. Based on the present study we present some clinical guidelines, illustrated through cases, that we have found helpful when treating African American and Caribbean American patients with PD.

Method

Setting

Patients presented for treatment at the Anxiety Disorders Clinic of the State University of New York at Brooklyn, a community mental health clinic serving primarily African American and Caribbean American patients. Over the years, the clinic has gained a good reputation in the community, and it has seen a steady increase in the number of African Americans with anxiety disorders who present for treatment. Patients were treated by doctoral-level staff (psychology interns and senior psychiatry residents), nearly all of whom were Caucasians trained in CBT, who were closely supervised throughout the study. Supervision consisted of weekly 1-hour sessions of individual supervision for each staff member as well as a weekly 90-minute case conference. Those patients with current substance abuse problems, as defined by active substance dependency or abuse within the past year, were referred elsewhere. Similarly, patients who were actively suicidal were referred elsewhere. Patients had no concurrent organic or intellectual impairment and English was their primary language. None of the patients reported here were seen as part of a research protocol.

Participants

All initial evaluations were reviewed, and only those cases in which the initial interviewer, the treating therapist, and the clinic director concurred on a *DSM-IV* (Brown, DiNardo, & Barlow, 1994; American Psychiatric Association, 1994) diagnosis of PD with or without agoraphobia were used for this study. Patients received treatment between 1995 and 1999. A total of 40 patients (African American $n=24$; Caucasian $n=16$) with a primary diagnosis of PD with or without agoraphobia were included in this study. Ethnicity was determined by self-identification of group membership as either African American or Caucasian. Patients with Hispanic surnames or who identified themselves as Hispanic were excluded from this study. Since there are cultural differences between African American and Caribbean American immigrants, we opted not to include data from our Caribbean American patients. The number of Caribbean Americans with PD was too small to allow for multiple statistical comparisons.

Thirty-four patients were diagnosed with PD with agoraphobia and 6 patients were diagnosed with PD alone. A significant difference was found between African American and Caucasian participants (PD alone vs. PDA), with more African American patients receiving a primary diagnosis of PDA than Caucasians (Cramer's $V=.372$; $p<.05$). Regarding secondary Axis I diagnoses, 75% (30/40) of participants were diagnosed with a secondary Axis I diagnosis: generalized anxiety disorder ($n=13$), posttraumatic stress disorder ($n=5$), obsessive-compulsive disorder ($n=3$), major depression ($n=3$), social phobia ($n=2$), hypochondriasis ($n=2$), and dysthymia ($n=2$). Forty percent (16/40) of patients were diagnosed with a third Axis I diagnosis: generalized anxiety disorder ($n=5$), posttraumatic stress disorder ($n=3$), major depression ($n=5$), social phobia ($n=1$), dysthymia ($n=1$), and bipolar disorder ($n=1$). No significant differences were found as a function of ethnicity for secondary diagnosis: 63% (10/16) of Caucasian patients were diagnosed with a secondary Axis I diagnosis compared with 83% (20/24) of African American patients ($\chi^2=2.22$, *ns*). In addition, 31.3% (5/16) of Caucasian patients were diagnosed with a third Axis I diagnosis compared with 45.8% (11/24) of African American patients ($\chi^2=.85$, *ns*). Table 1 provides