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THE IMPACT OF COMORBID MOOD AND PERSONALITY DISORDERS IN THE COGNITIVE-BEHAVIORAL TREATMENT OF PANIC DISORDER

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ABSTRACT. *The present review examined the effect of comorbid major depressive disorder and personality disorder on the outcome of cognitive-behavioral interventions for panic disorder. Panic disorder patients often present with these comorbid conditions, but for the most part, treatment studies have paid little attention to them. Most studies on the effects of comorbidity on treatment outcome address pharmacological treatment. However, there is a growing literature on the effect of additional disorders on the outcome of cognitive-behavioral interventions for panic disorder. Findings from the studies of comorbidity with depression are equivocal, possibly reflecting inconsistencies in measurement methodology across studies. However, personality psychopathology was found to exert a detrimental effect on the outcome of cognitive-behavioral treatment for panic disorder. Further research is necessary to elucidate the impact of these concurrent conditions on cognitive-behavioral treatment for panic disorder. It is suggested that studies utilizing cognitive-behavioral treatment routinely examine the influence of comorbid conditions on treatment outcome.* © *2000 Elsevier Science Ltd.*

OVER THE PAST decade, tremendous strides have been made in the treatment of anxiety disorders. Both pharmacological and cognitive-behavioral therapies have demonstrated efficacy (Barlow & Lehman, 1996; Lydiard, Brawman-Mintzer, & Ballenger, 1996). Specific intervention strategies for different disorders have increased precision of treatment. This has been particularly evident in the cognitive-behavioral treatment (CBT) of panic disorder, where strategies focus on particular characteristics of the disorder (Clum, Clum, & Surls, 1993; Otto & Gould, 1996).

CBT for panic disorder has been highly successful in reducing frequency of panic attacks, severity of symptoms, and the dysfunction associated with panic disorder. CBT interventions have been shown to be among the most efficacious psychological treat-

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ments for panic disorder (Chambless & Gillis, 1993). In addition, CBT has been shown to be as efficacious, if not more efficacious, than pharmacological treatment (Clum et al., 1993; Gould, Otto, & Pollack, 1995). This is an important issue given the cost-effectiveness of CBT and its avoidance of the risks, side effects, and discontinuation difficulties associated with some pharmacological treatments for panic disorder (Gould et al., 1995).

Results of controlled studies of CBT for panic disorder have been promising. Craske (1996), in a review of 14 studies of panic disorder with limited or no agoraphobic avoidance, reported that 71% of patients were panic-free after treatment. Furthermore, 82% were free of panic at a 2-year follow-up. Chambless and Gillis (1993) performed a meta-analysis of 14 studies of CBT for panic disorder. Consistently large effect sizes were reported (range, 1.00–1.73 at follow-up), especially when cognitive restructuring and exposure techniques were integrated. Clum et al. (1993) examined 29 controlled studies of either CBT, medication, or combination treatment for panic disorder. They concluded that CBT, incorporating both exposure and cognitive coping techniques, was the most efficacious treatment strategy, followed by combined CBT and medication treatment. Medication administered as a sole treatment was associated with smaller effect sizes than cognitive-behavioral treatment alone or in combination with medication.

Gould et al. (1995) conducted a meta-analytic examination of 43 controlled studies of the treatment of panic disorder. Of the 76 treatment interventions performed in these studies, those utilizing CBT yielded the highest mean effect size, with a value of 0.68; significantly greater than the effect sizes for pharmacological and combination treatments, 0.47 and 0.56, respectively. Furthermore, CBT was strongest when it included both interoceptive exposure (i.e., identifying and confronting internal fear cues) and cognitive restructuring. Attrition rates were also lowest in CBT interventions (5.6%) when compared with either pharmacotherapy alone (19.8%) or pharmacotherapy in combination with CBT (22.0%). Finally, CBT was estimated to be more cost-effective than treatment with high-dose alprazolam or fluoxetine after 1 year of treatment.

Clearly, CBT for panic disorder has demonstrated considerable efficacy. However, outcome has been less promising when more stringent criteria for treatment response are applied. For example, D. M. Clark et al. (1994) reported that a significantly greater percentage of cognitive therapy patients were panic-free (85%) at 15-month follow-up than patients receiving either imipramine (60%) or applied relaxation (47%). However, only 70% of cognitive therapy patients, 45% of imipramine patients, and 32% of applied relaxation patients met the more stringent criteria for high end-state functioning (i.e., no panic attacks in the past month and a low score on a clinician's rating of symptom severity) at 15-month follow-up. Craske, Brown, and Barlow (1991) also reported that fewer patients met criteria for high end-state functioning than for frequency of panic attacks at 24-month follow-up. Whereas 86.7% were found to be panic-free, only 53.3% met criteria for high end-state functioning. Brown and Barlow (1995) examined long-term outcome for 63 patients with panic disorder. At 24-month follow-up, 74.6% of patients were considered panic-free. However, only 47.6% were considered to be functioning at a high end-state level and were not receiving further panic treatment.

These results suggest that, despite a number of positive outcomes, many patients do not improve sufficiently with CBT interventions for panic disorder. As a result, investigators have begun to examine variables that may predict poor treatment response (e.g., Brown & Barlow, 1995). One variable that has been suggested to affect treat-