

Interpersonal Fears among Patients with Panic Disorder with Agoraphobia

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Abstract. To study the role of catastrophic interpersonal cognitions in panic disorder with or without agoraphobia, a questionnaire listing such items – the Interpersonal Panic Fear Questionnaire (IPFQ) – was constructed and administered to English and Norwegian samples. The results of the factor analysis indicated a three-factor structure of interpersonal fears: fear of negative evaluation, fear of being trapped and separated from safe persons and places, and fear of being neglected. The corresponding three IPFQ scales had satisfactory internal consistency and sensitivity to change following therapeutic intervention, discriminated well between diagnostic groups, and correlated moderately with measures of other dimensions of panic disorder and agoraphobia. The construct validity of the interpersonal fears was further supported by mostly significant relationships between the IPFQ scales and a measure of agoraphobic avoidance, when the contribution of intrapersonal (physical, loss of control) fears was controlled.

Keywords: Panic disorder with agoraphobia, interpersonal fears, measurement.

Introduction

Fears of incapacitating events happening to the person's mind or body (hereafter described as intrapersonal fears) are given the status of important maintaining factors in the cognitive model of panic disorder (Clark et al., 1994). However, several authors have noted that interpersonal fears may also play a prominent role in panic disorder, and perhaps more particularly in

Reprint requests to Asle Hoffart, Research Institute, Modum Bad, N-3370 Vikersund, Norway. E-mail: asle.hoffart@modum-bad.no An extended version and a copy of the instrument (IPFQ) are also available online in the table of contents for this issue: http://journals.cambridge.org/jid_BCP.

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those with agoraphobia (for review see Hackmann, 1998). If further evidence showed that such interpersonal concerns are prominent in panic disorder with (or without) agoraphobia, it could stimulate a degree of theoretical expansion and reformulation. In addition, it would be clinically useful to have a questionnaire that measured interpersonal fears, if these contribute to avoidance. To study the role of catastrophic interpersonal cognitions in panic disorder, we constructed a questionnaire listing such items and administered it to English and Norwegian samples.

Method

Participants

English sample. Four groups of participants were recruited and interviewed for DSM-IV diagnoses in Oxford, England. The panic disorder without agoraphobia group consisted of 11 outpatients (9 female, 2 male), mean age 35.1 years ($SD = 7.6$). The panic disorder with agoraphobia group consisted of 22 outpatients (16 female, 6 male), mean age 37.8 years ($SD = 14.5$). None of the panic disorder patients met criteria for social phobia. The social phobia control group consisted of 33 outpatients (15 female, 18 male), mean age 29.1 years ($SD = 6.7$). None of them met criteria for panic disorder or agoraphobia without a history of panic disorder. The non-patient control group consisted of 28 (20 female, 8 male) nonmedical volunteers with no current or past psychiatric disorder, mean age 37.9 years ($SD = 12.8$), who were recruited from local offices and colleges.

Norwegian sample. Two different sub-samples of inpatients hospitalized at Modum Bad, Vikersund, Norway were included in the present study. Sub-sample 1 consisted of participants in an inpatient treatment program primarily for patients suffering from panic disorder/agoraphobia and personality related problems. Among the 160 patients included, 10 patients (7 female, 3 male) with mean age 42.7 years ($SD = 9.2$) met the criteria for panic disorder without agoraphobia, 109 patients (80 female, 29 men) with mean age 41.2 years ($SD = 9.0$) met the criteria for panic disorder with agoraphobia. These 119 patients could have a comorbid diagnosis of social phobia, but unfortunately were not further evaluated with regard to a social phobia diagnosis. Thirty-six patients (19 female, 17 male) with mean age 38.8 years ($SD = 8.6$) met the criteria for social phobia and not for panic disorder with or without agoraphobia. Five patients (2 female, 3 male) with mean age 45.0 years ($SD = 10.0$) had a somatoform disorder and neither panic disorder/agoraphobia nor social phobia. Sub-sample 2 consisted of patients admitted to a program for social phobia and/or avoidant personality disorder. Only those meeting the criteria for social phobia and not for panic disorder/agoraphobia were included in Sub-sample 2. Nine patients (6 female, 3 male; mean age 36.8 years, $SD = 10.1$) with social phobia and not with panic disorder/agoraphobia were included.

Treatment

The patients in the Norwegian Sub-sample 1 were treated in a program with two phases, one 5-week panic/agoraphobia-focused part based on the cognitive model of panic disorder (Clark et al., 1994), and one 6-week personality-focused part based on Young's (1990) schema-focused approach.

Measures

The self-report Mobility Inventory for Agoraphobia (MI; Chambless, Caputo, Jasin, Gracely and Williams, 1985) measures agoraphobic avoidance of a range of situations, both when the patients are alone (MI-AAL) and when they are accompanied (MI-ACC). The self-report Body Sensations Questionnaire (BSQ; Chambless, Caputo, Brigh and Gallagher, 1984) measures fear of body sensations associated with high arousal. The self-report Agoraphobic Cognitions Questionnaire (ACQ; Chambless et al., 1984) addresses beliefs about the possible catastrophic physical and loss of control consequences of panic attacks (e.g. heart attack, going crazy).

The selection of the 25 items of the Interpersonal Panic Fear Questionnaire (IPFQ) was based on the authors' experiences during therapy of patients with panic disorder and/or agoraphobia and on the second author's investigations of the contents of intrusive images as they occur during panic attacks in a public place (Day, Holmes and Hackmann, 2004). The IPFQ was constructed in the format of the ACQ, so that subjects were asked to rate both how often each thought occurs (1–5 scale) and how much they believe in each thought (0–100%) when nervous or frightened in a public place.

Procedure

The patients in the Norwegian Sub-sample 1 completed the IPFQ, MI, ACQ, and BSQ within the first week after intake (pretreatment), at the shift of phases (midtreatment), and at discharge (posttreatment). The other participants of this study completed the IPFQ before or at the start of treatment.

Results

A factor analysis of the scores on the 25 IPFQ items for the pooled sample of 263 participants produced four factors with eigenvalue above one. The scree-test indicated that the plot of eigenvalues started to level off at the third factor. The items loading on the third and the fourth factor had similar content, including fear of being trapped, being separated from safe persons and places, and kept in hospital by force. This suggested that these two factors could be combined. These considerations led to the decision to use a three-factor solution. Nine items were omitted because they loaded on more than one factor. In the final solution, comprising 16 items, the first factor accounted for 50.2% of the variance, the second for 12.9%, and the third for 7.1%. The 6 items loading on the first factor concern fear of negative evaluation, the 6 items loading on the second factor concern fear of being trapped and separated from safe persons and places, and the 4 items loading on the third factor concern fear of being neglected (see Table 1).

Three scales were constructed corresponding to the three-factor solution. There were no significant ($p < .05$) relationships between the scales and the age and sex of the participants. The Cronbach's *alpha* of the scales ranged from .86 to .92. To examine the concurrent validity of the scales, the scores for patients with panic disorder without agoraphobia, patients with panic disorder with agoraphobia, patients with social phobia and the normal controls were compared. One-way ANOVAs revealed main effects on all three scales, $F(3, 254) = 17.5$ for the negative evaluation scale, $F(3, 254) = 14.5$ for the being trapped/separated scale, and $F(3, 254) = 12.1$ for the being neglected scale. Bonferroni post hoc tests revealed that the

Table 1. Varimax rotated factor loadings of the Interpersonal Panic Fear Questionnaire Items ($N = 263$)

Thought	Factor		
	I	II	III
Look foolish	.87	–	–
Attract attention	.84	–	–
People think I am weird/strange	.84	–	–
Make a scene in front of others	.75	.34	–
People think I am mad, drunk or drugged	.73	.33	–
People laugh at me	.69	–	–
Trapped or stuck	–	.77	–
Kept in hospital by force	–	.77	–
Stuck in an unreal, unfamiliar world	.34	.74	–
Taken to hospital against will	–	.73	–
Separated from those who need me	–	.70	.40
Never get home	–	.70	–
No one will help me	.30	.33	.72
No one care about what happens to me	–	.35	.71
Abandoned	–	.35	.71
People ignore me	.35	–	.67

Note: Loadings $< .30$ are not included in the table.

three patient groups scored higher than normal controls on all three scales. In line with our expectations, panic with agoraphobia patients scored higher than social phobia patients except on the fear of negative evaluation scale. There were no significant differences between panic disorder patients with and without agoraphobia, although there was a trend ($p = .10$) for those with agoraphobia to score higher on the fear of negative evaluation scale. Separate analyses of the English and the Norwegian samples and of men and women indicated similar patterns of findings. To examine the convergent validity, the correlations between the IPFQ scales and established measures of central dimensions of panic disorder and agoraphobia in the Norwegian Sub-sample 1 were investigated. The IPFQ scales correlated moderately to strongly (from .30 to .69) with each other and with the MI-AAL, the BSQ, and the ACQ scales. Sensitivity to change was evidenced by repeated measures ANOVAs across pre-, mid-, and post-treatment in the Norwegian Sub-sample 1 yielding significant changes on all three scales. Finally, to assess the independent contribution from the interpersonal fears to agoraphobic avoidance among the patients with panic disorder with and without agoraphobia in the Norwegian Sub-sample 1, the MI-AAL scores were used as dependent variable, and the ACQ physical and control scales were included in the first block of independent variables. Both physical fear, $\beta = .24$, $t(114) = 2.29$, $p < .05$, and loss of control fear, $\beta = .22$, $t(114) = 2.13$, $p < .05$, contributed to avoidance. Then, the IPFQ scales were included, first one at a time, in a second block. Fear of negative evaluation contributed significantly, $\beta = .36$, $t(113) = 3.04$, $p < .01$, as did fear of being neglected, $\beta = .25$, $t(113) = 2.57$, $p < .05$, whereas only a statistical trend was evident for fear of being trapped/separated, $\beta = .18$, $t(113) = 1.74$, $p < .09$. When all three IPFQ scales were included in the second block, only fear of negative evaluation contributed significantly to avoidance, $\beta = .29$, $t(111) = 2.36$, $p < .05$.

Discussion

The results of this study suggest that there are interpersonal fears among patients with panic disorder, particularly those with significant agoraphobia. These interpersonal fears are linked to the degree of agoraphobic avoidance, even when the influence of intrapersonal fears are controlled for. This suggests that interpersonal fears may contribute to initiate and/or maintain agoraphobic avoidance.

The results of the factor analysis indicated a three-factor structure of interpersonal fears of patients with panic disorder with agoraphobia. We do not know whether we have covered all aspects of the construct. The moderate to high intercorrelations across the interpersonal and intrapersonal fears may indicate the existence of a common catastrophic fear factor. The three IPFQ scales had satisfactory internal consistencies and sensitivity to change following an empirically supported therapeutic intervention. The IPFQ scales discriminated between diagnostic groups. The findings support the hypothesis that high fear of negative evaluation and social anxiety are overlapping features in panic disorder with agoraphobia and social phobia. The convergent validity of the IPFQ scales was supported by moderate correlations with measures of other central dimensions of panic disorder and agoraphobia.

Weaknesses of this study were that the reliability of the diagnostics was not systematically examined, and that the presence of co-morbid diagnoses was not assessed in a large proportion of the Norwegian patients. In the Norwegian group, the high scores in the panic with agoraphobia group for fear of negative evaluation could have been due to un-diagnosed social phobia. However, a similar pattern of results was obtained in the English sample, where social phobia was an exclusion criterion. Future studies should address the psychometric properties of the IPFQ in various samples and the potential role of interpersonal fears in the maintenance of panic disorder and agoraphobia.

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