WIPPF PROFILE IN PATIENTS WITH ANXIETY DISORDERS

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A person suffering from one of the anxiety disorders usually feels intense and irrational fear, as if something dreadful is about to happen. The person is not out of contact with reality; the dreadful feeling does not render the person incapable of coping with daily life. Instead, this feeling makes the person miserable. The feeling is common to the anxiety disorders and that is what brings anxiety disorders into a class (Stein, Young, 1998).

A special type of anxiety disorders is the anxiety due to a general medical condition (AGMC). This type of anxiety is judged to be a direct psychological consequence of a specific medical condition. This determination is based on history, laboratory or physical examination. Another type of anxiety is generalized anxiety disorder, characterized by exacerbated anxiety and worry (apprehensive expectation), shown for more days in at least 6 months, related to several events or activities (such as work or school performance). It seems very difficult for this person to control his/her worry. Anxiety and worry are associated with 3 or more of the following 6 symptoms:

- disquiet;
- asthenia;
- difficulties in concentration or blank mind;
- irritability;
- muscular tension;
- sleep disorders (difficulty to fall asleep, to maintain sleep sate or unsatisfying (insufficient) sleep);

Patients suffering from a cardiovascular disease usually develop several types of anxiety disorders (panic attacks, specific phobias, social phobia, acute stress disorders and even PTSD). A special type of anxiety disorder is the anxiety about the ill. The link between anxiety and cardiovascular disease shows with several types of patients. **The first** is a patient whose problem is mainly anxiety associated with somatic symptoms that suggest heart disease. **A second** is a patient who is healthy and not anxious but who develops symptoms that are interpreted as being due to heart disease. **A third** is a patient with minor heart disease that is complicated by major anxiety, and **a fourth** is a patient with major heart disease who develop secondary anxiety (Rosenman, 1988). Despite the importance and implications in medical domain, anxiety against the ill is still ignored in research work.

According to medical and psychological literature, out that 60% of the patients with major CVD develop anxiety due to the cardiovascular condition. There are no recent data regarding the long-term evolution of anxiety after the cardiac treatment (medication, PTCA, surgery). 12% of patients hospitalized in psychiatric institutes suffer from generalized anxiety disorder, according to their diagnosis (GAD) (DSM IV).

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Research hypotheses:

In the psychotherapeutic practice we led, we noticed a difference between WIPF profiles of AGMC cardiovascular patients and WIPF profiles of patients diagnosed with GAD without other somatic disease. The aim of the present study is to demonstrate the existence of specific profiles with the two patient groups (cardiovascular patients with AGMC and patients with GAD), profiles which determine different methods of psychotherapeutic approach. These profiles are extremely useful in therapeutic work, as they reveal primary or secondary over/under developed capacities, as well as types of reaction to conflict for the two specific groups.

Subject characteristics:

The subjects of our study are 60 cardiovascular patients hospitalized at the Heart Institute with ischaemic heart disease and 50 patients hospitalized at the University Psychiatric Clinic for anxiety disorders. Out of these subjects were selected 20 patients with CVD and AGCM and 18 patients with GAD, which represented the study groups.
G1= 20 patients with CVD and AGCM, hospitalized at the Heart Institute with ischaemic heart disease, 11 men and 9 women, average age 49.
G2= 18 patients with GAD, hospitalized at the University Psychiatric clinic, 10 men and 8 women, average age 34.

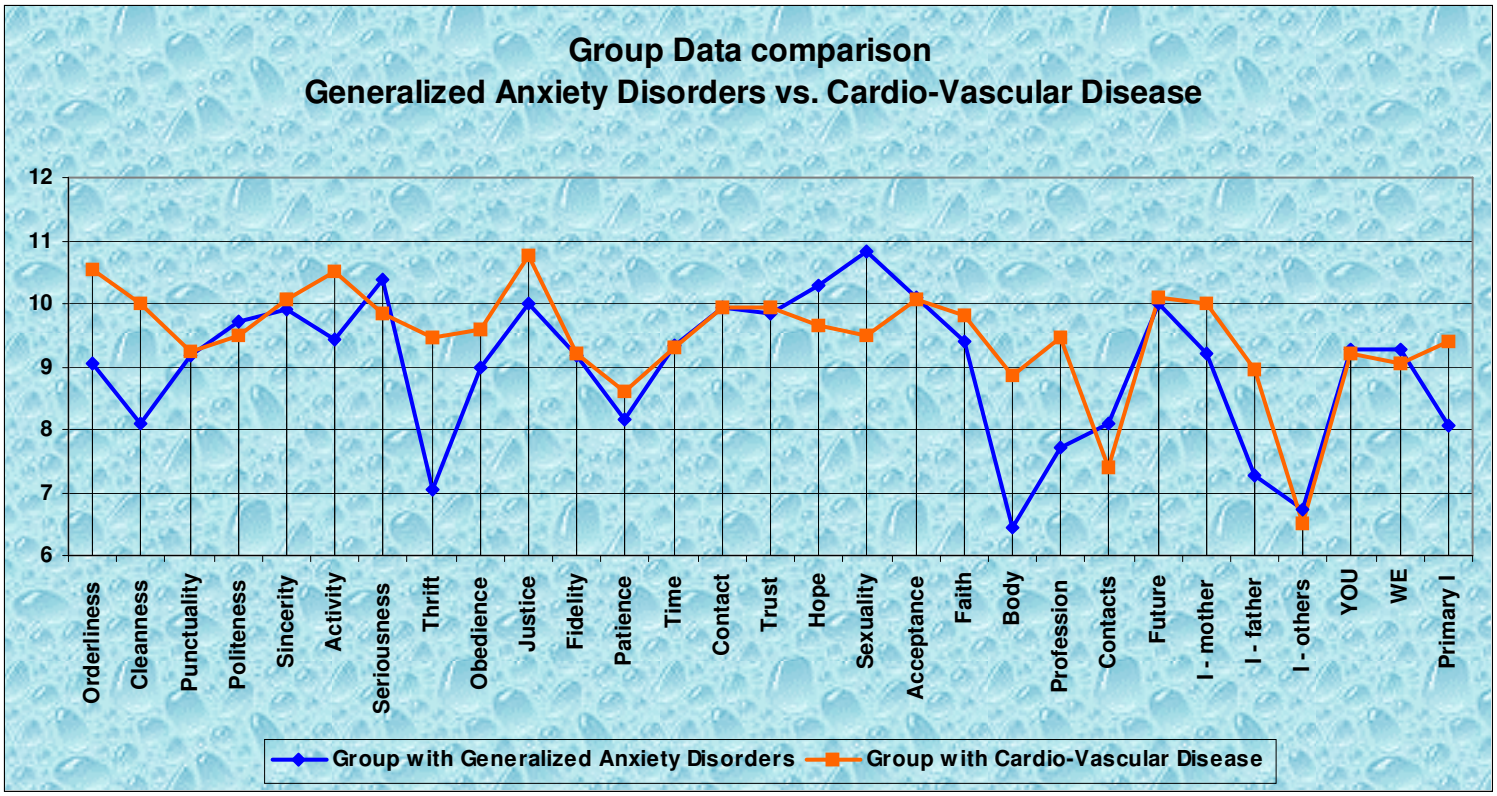
Measures:

Two scale type were used for anxiety disorders:

* State Trait Anxiety Inventory (STAI) to evaluate the level of anxiety as a state and as a personality trait.
* Hamilton Anxiety Scale (HAM-A) to evaluate the patients' type of anxiety.
Experimental groups were formed based on the results of the two inventories.
Then, WIPF was conducted to sow differences between the profiles of patients with CVD and AGMC and patients with GAD.
Questionnaires were filled-in during hospitalization and for CV patients, before surgery for coronary artery by-pass graft (CABG).

Results:

Significant differences showed up between profiles of the two patient groups (Graphic 1.1.).



Graphic 1.1

There is a significant difference between CV patients and GAD patients on p=0.09 (Table 1.1.).

Significance level		Generalized Anxiety Disorder		Cardio-Vascular Disease
		Group	Female	Male
Cardio-Vascular Disease	Group	0,09		
	Female		0,04	0,4
Generalized Anxiety Disorder	Male		0,8	0,2

Legend:

P <= 0,05

P <= 0,1

P = NS

Table 1.1. Significance level in comparison between the groups.

Statistically significant differences between the above-mentioned groups are due to the scales of secondary capacities, reaction to conflict and the model dimension (Table 1.2.).

Secondary capacities	
Orderliness	0,01
Cleanness	0,01
Punctuality	0,7
Politeness	0,7
Sincerity	0,8
Activity	0,1
Seriousness	0,6
Thrift	0,02
Obedience	0,2
Justice	0,2
Fidelity	0,8

Primary capacities	
Patience	0,6
Time	0,7
Contacts	0,7
Trust	0,9
Hope	0,5
Sexuality	0,04
Acceptance	0,6
Faith	0,8

Conflict reaction	
Body	0,01
Activity	0,04
Contacts	0,5
Future	0,9

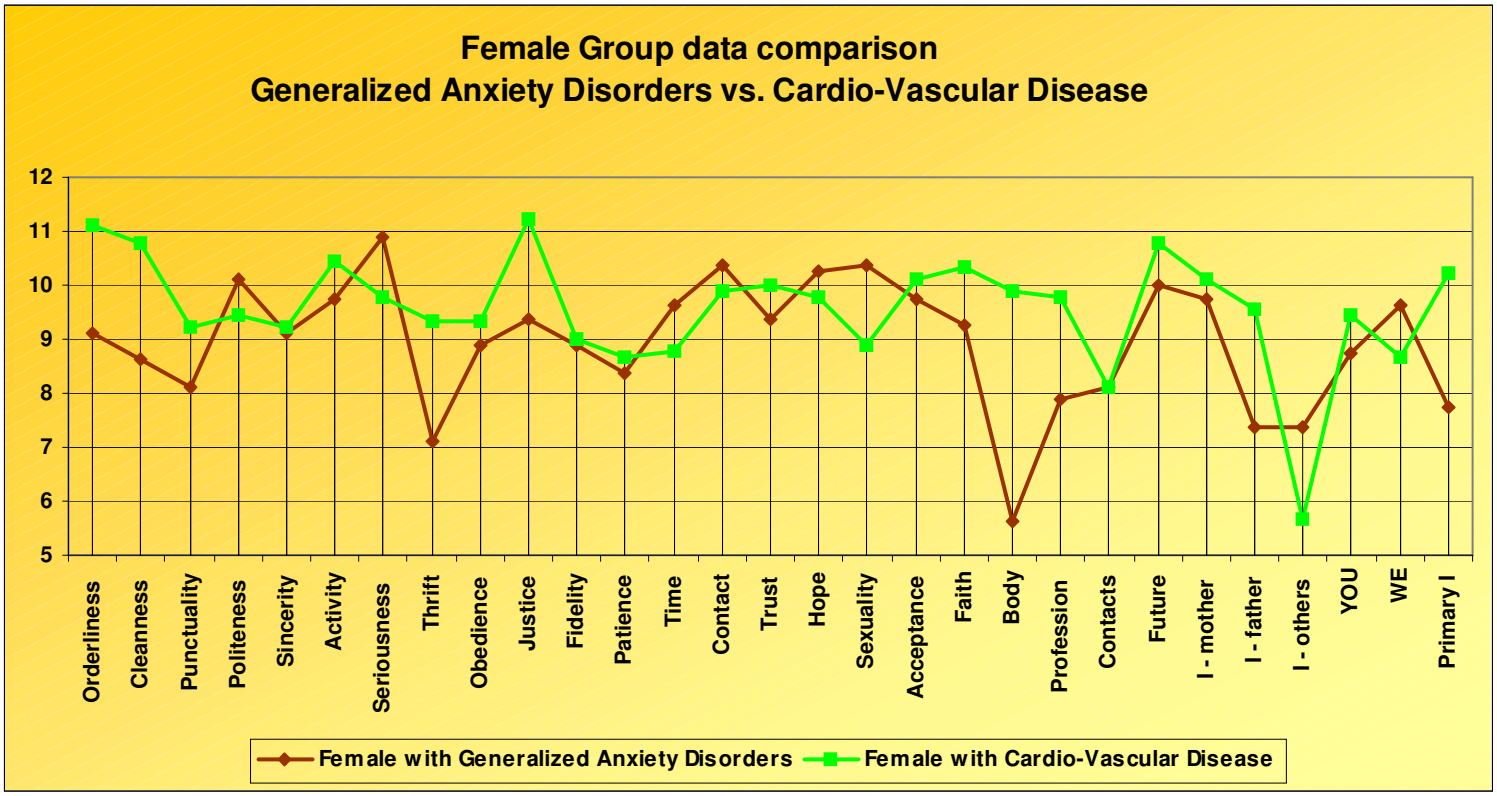
Model dimension	
I – mother	0,2
I – father	0,02
I – others	0,9
You	0,7
We	0,9
Primary I	0,04

Legend:

p <= 0,01 | p <= 0,05 | p <= 0,1 | P = NS

Table 1.2. Significance level for WIPF scales in comparison between groups

Statistic analysis became deeper as we searched for the origin of the differences we found. Thus, patient groups were divided according to sex and comparisons were made between female with CVD and female with GAD, between male with CVD and male with GAD. Comparison between averages resulted, according to sex, led to the conclusion that significant differences appear only for female profiles (Graphic 2.1.), while males with CVD and males GAD showed similar profiles (without any statistically significant differences). There is a significant difference between the graphics representing the two female groups on p=0.04 (Table 1.1.).



Graphic 2.1

Statistically significant differences between profile scales for the two female groups appear for scales: orderliness, cleanness, thrift, justice, sexuality, body/senses, activity, Primary I (Table 2.1.)

Secondary capacities	
Orderliness	0,04
Cleanness	0,04
Punctuality	0,2
Politeness	0,5
Sincerity	0,9
Activity	0,4
Seriousness	0,2
Thrift	0,08
Obedience	0,7
Justice	0,02
Fidelity	0,8

Primary capacities	
Patience	0,7
Time	0,4
Contacts	0,6
Trust	0,4
Hope	0,6
Sexuality	0,1
Acceptance	0,6
Faith	0,3

Conflict reaction	
Body	0,001
Activity	0,1
Contacts	0,9
Future	0,3

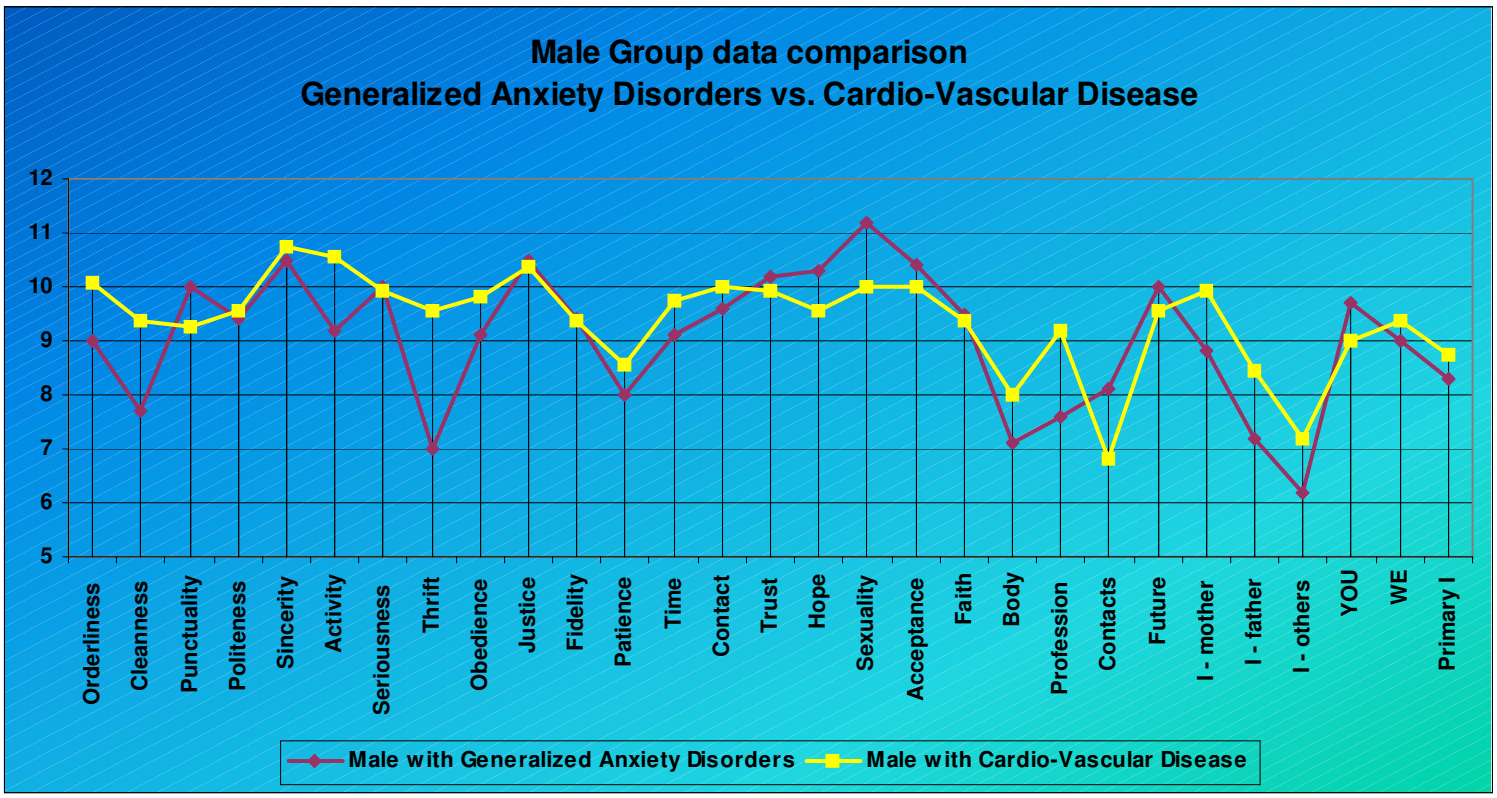
Model dimension	
I - mother	0,8
I - father	0,2
I - others	0,2
You	0,6
We	0,3
Primary I	0,07

Legend:

p <= 0,01 p <= 0,05 p <= 0,1 p = NS

Table 2.1. Significance level for WIPF scales in comparison between female groups

There are no significant differences for the male profiles of the two study groups (Graphic 2.2.).



Graphic 2.2.

A comparison between profiles inside groups (the results of the females with CVD with the results of males with CVD, the results of females with GAD with the results of males with GAD) reveals a difference between profiles, but the difference is not statistically important.

Another statistical analysis was based upon WIPF scales: secondary capacities, primary capacities, reaction to conflict and model dimension. The comparisons were made between groups, on sex criteria, and led to significant differences between the two groups and between the female groups, according to secondary capacities (Table 3.1.)

Significance level			Generalized Anxiety Disorder Group											
			Secondary Capacities			Primary Capacities			Conflict Reaction			Model Dimension		
			Group	Female	Male	Group	Female	Male	Group	Female	Male	Group	Female	Male
Cardio-Vascular Disease Group	Secondary Capacities	Group	0,047											
		Female		0,052										
		Male			0,112									
	Primary Capacities	Group				0,686								
		Female					0,736							
		Male						0,703						
	Conflict Reaction	Group							0,384					
		Female								0,161				
		Male									0,840			
	Model Dimension	Group										0,439		
		Female											0,555	
		Male												0,399

Legend:

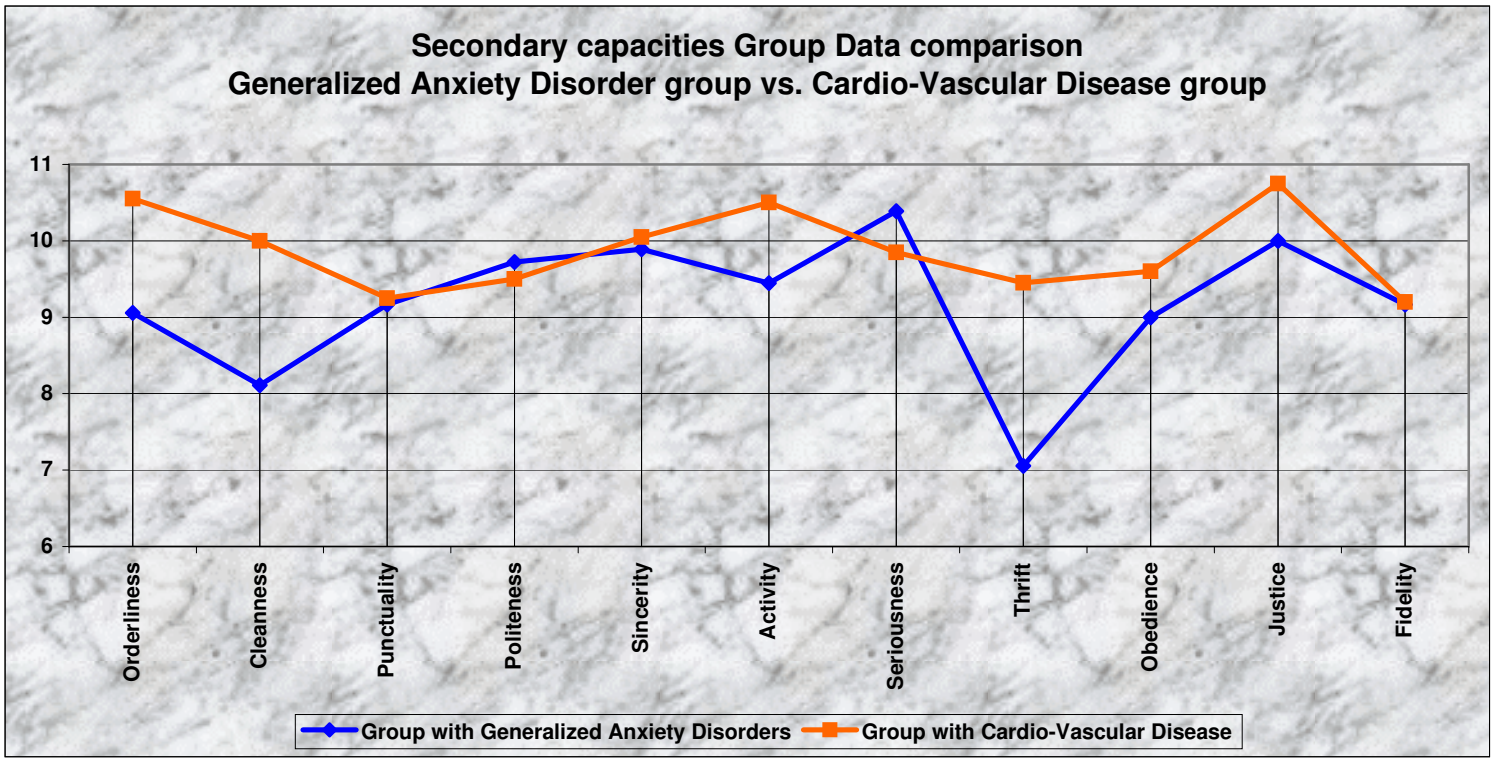
P <= 0,05

p <= 0,1

p = NS

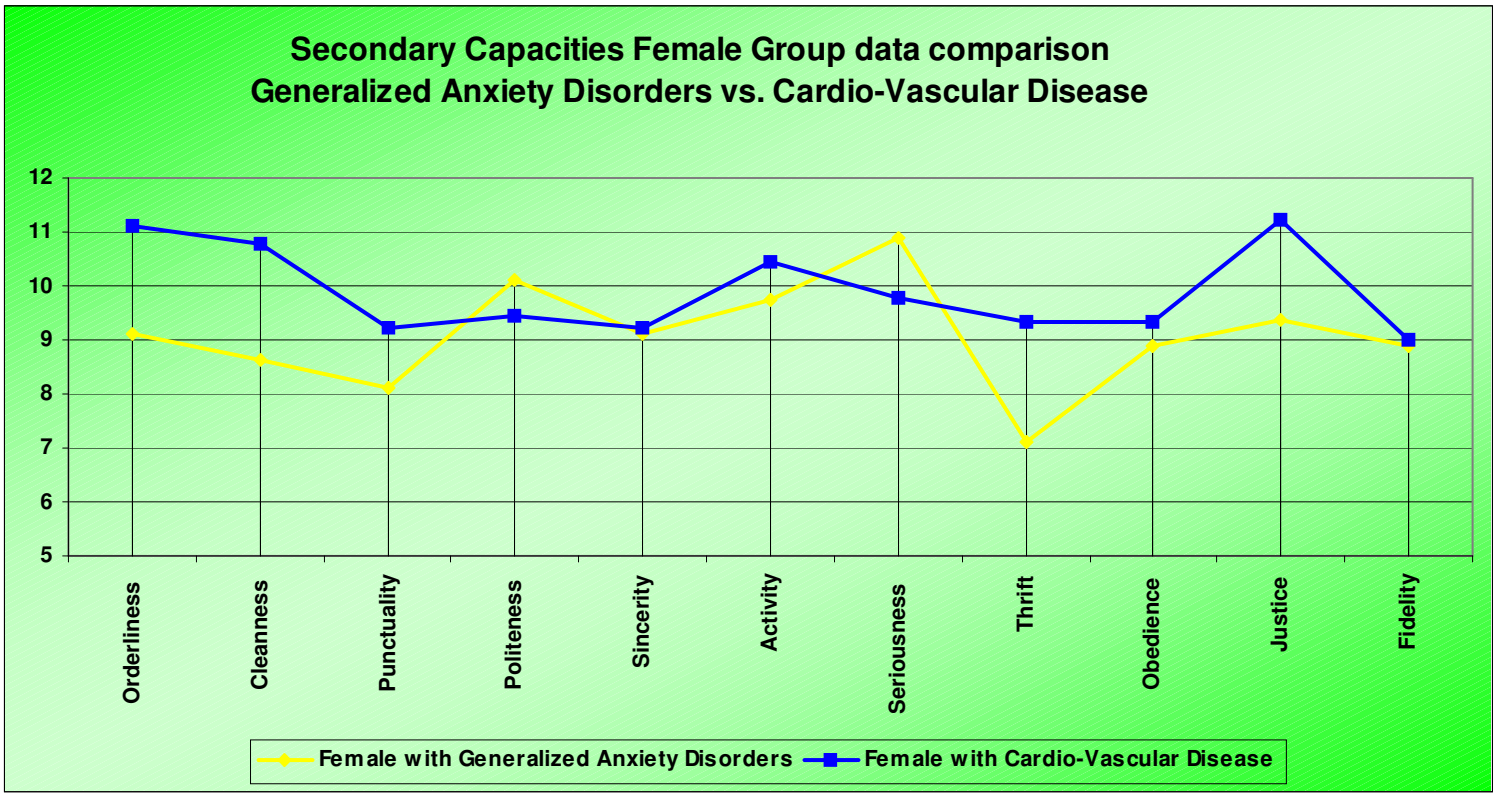
Table 3.1. Significance level in comparison between WIPF scales.

The results of the study only reveal statistical differences between the groups – subject of the study – for secondary capacities (Graphic 3.1.). Significant differences between groups only appear on orderliness, cleanness, activity and thrift.



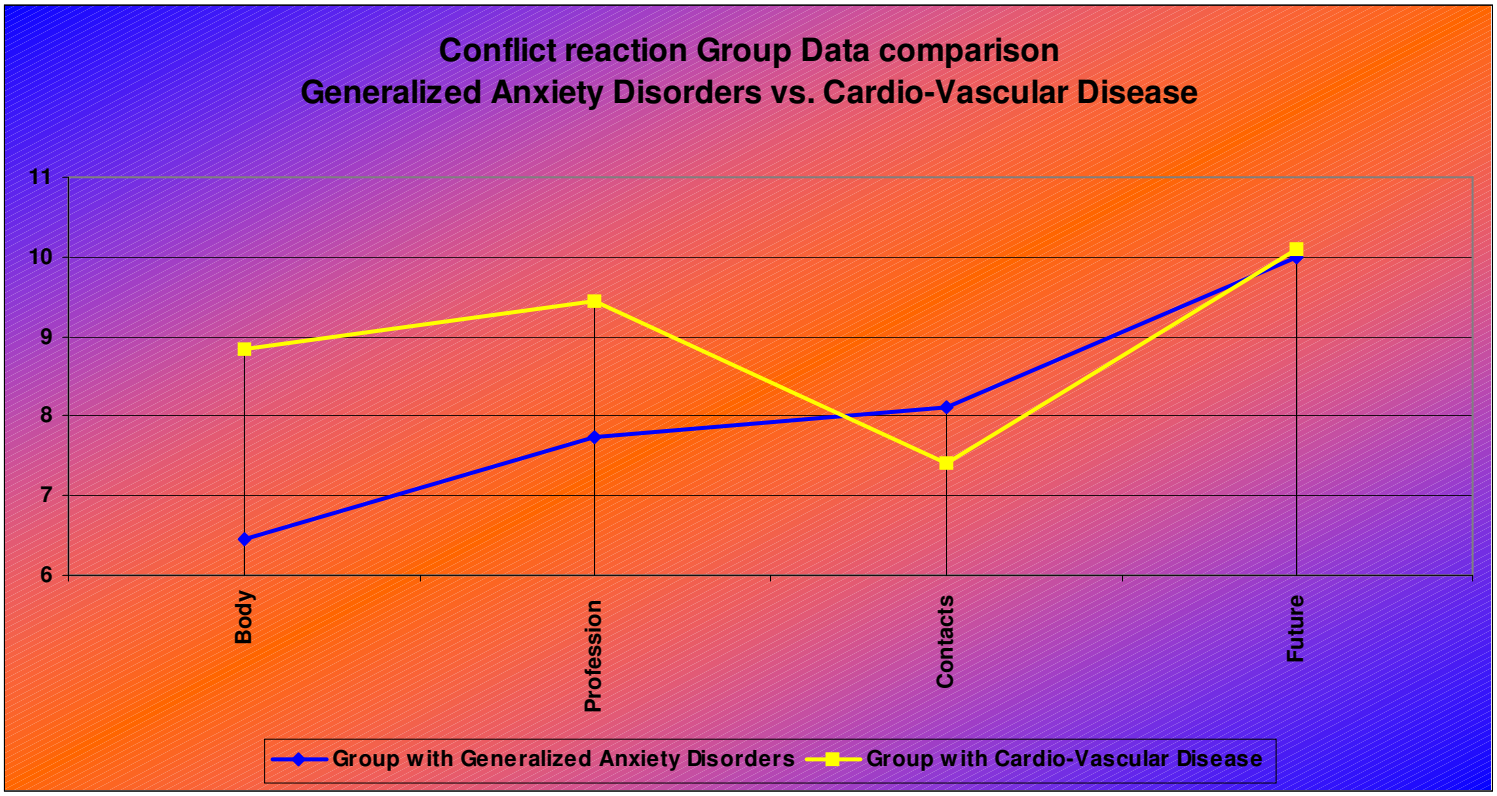
Graphic 3.1.

The same statistically significant differences appear for females in case of secondary capacities scales (orderliness, cleanness, thrift). Moreover, with females, the justice scale is also significant, as differences between CVD females and GAD females are rather important (Graphic 3.2.).

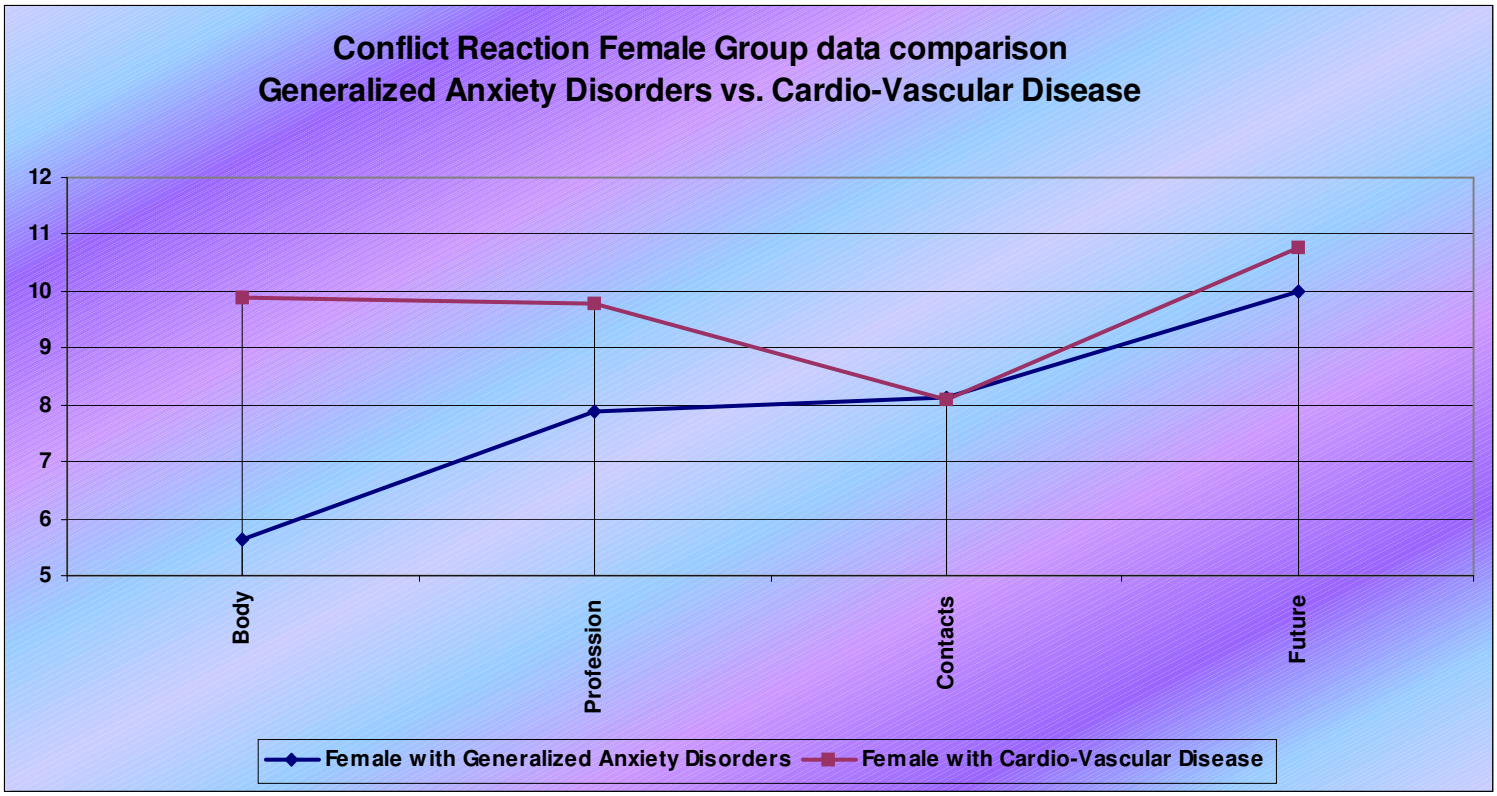


Graphic 3.2.

Even if as a whole, reactions to conflict are not statistically different for the 2 groups of study (p=0.3), a more detailed data analysis reveals the existence of statistically significant differences when it comes to group comparison by body/senses and profession/activity scales (Graphic 4.1.)

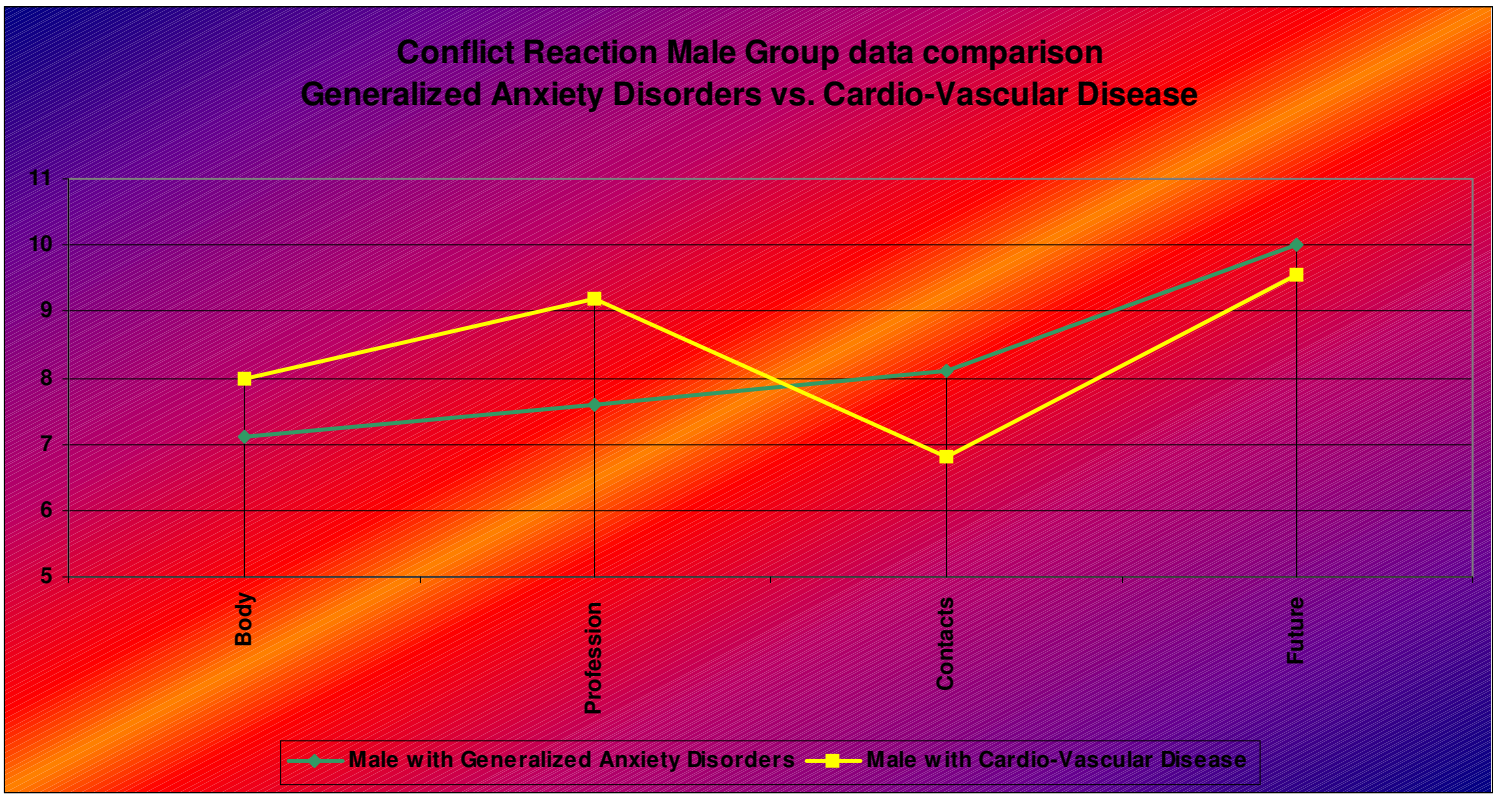


Graphic 4.1.



Graphic 4.2.

Reactions to conflict are different for the 2 experiment female groups (Graphic 4.2), while for men, they are of no significance (Graphic 4.3.).



Graphic 4.3.

Discussions and conclusions:

The aim of the present study was to reveal the existence of significant differences between WIPF profile of cardiovascular patients with cardiac anxiety and the profile of patients suffering from generalized anxiety disorder. The subjects of the study have been 20 CVD patients with cardiac anxiety (9 females and 11 males) and 18 GAD patients (8 females and 10 males).

The comparison of profiles of the two groups led to medium-leveled results. Profiles reveal tendencies to oversize several secondary capacities with CVD patients (tidiness, activity, justice) and the primary capacity – sexuality – with GAD patients. When it comes to the reaction to conflict, the profiles prove a stronger tendency of CVD patients to psychosomatic disorders as compared to GAD patients. Also, GAD patients show a weaker professional efficiency than CVD patients do. On the contact level, CVD patients show a stronger tendency to redraw from social life as compared to GAD patients. Both types of patients follow the same defense mechanism in case of conflict, that is finding a shelter in fantasy. The model dimensions for the two groups of study are alike and characterized by a relationship with tendencies of dependence on mother, by a small amount of alternative models (I – others) and medium-leveled YOU and WE scales. There are differences between groups regarding the relationship with the father – CVD patients seem to have a better I-father relationship than GAD patients do. CVD patients feel more secure with their "Primary I" than GAD patients.

Comparisons between WIPF profiles of the two patient groups proved statistically significant differences between profiles, mainly caused by secondary capacity scales – tidiness, cleanness, activity and economic sense and by the scales of reaction to conflict – body/senses and profession/activity. Some significant differences are produced by other dimensions, such as: tenderness/sexuality (primary capacities) and I-father and Primary I (model dimensions).
These differences show that CVD patients have oversized secondary capacities: tidiness and activity (level 11), more developed as compared to those of GAD patients. The secondary capacities (orderliness and thrift) are not oversized with neither of the groups, but the differences between the types of patients are statistically significant.

The analysis of the results, based on sex criterion, revealed differences between CV females and GAD females and no differences in case of males. Also, CVD females have more severe tidiness, cleanness, economic sense and justice scales than GAD females. The graphics show that most of secondary capacities of CVD females are higher scaled than for GAD females, while for primary capacities, GAD females are higher leveled on the graphic than CVD females, except for confidence and trust/sense. For CVD patients, conflicts are projected on body/senses and profession dimensions (tendency to overreact) and at this point, there are significant differences between the two groups. Both types of patients show tendency to hide in imagination in case of conflict.

As far as males are concerned, CVD patients profile describes higher values than that of GAD patients for secondary capacities, but with no statistically significant differences. CVD males show tendencies to oversize tidiness, sincerity, activity and justice scales. Primary capacities scales have similar profiles for the two male groups, with tendency to oversize contacts, confidence, sexuality and acceptance. In case of conflict, CVD males seem to choose to redraw from the social life and hide in the imaginary, while GAD patients tend to hide in their work, in activities or imagination. Model dimension scales show a good relationship with the mother both for CVD and for GAD patients (with the latter's even dependence on the mother).

We noticed significant differences between the two groups on the relation with the father scale, where CV patients seem to have better relationships than GAD patients do. We also noticed statistically significant differences between the two groups on the Primary I scale, which is underdeveloped with GAD patients (uncertain Primary I).

The conclusion we reached is that there are statistically significant differences between WIPF profiles of CVD patients as compared with those of GAD patients and these differences are especially pregnant with females. It is useful to know these differences in psychotherapeutic work with these patients, as models and directions of psychotherapy need to be specified for each psychological profile.

As compared to Hamilton or STAI scales, useful for anxiety disorders diagnosis, WIPF is a more human inventory, and, at the same time, more useful in psychotherapy – it separates primary and secondary capacities, it reveals the ways of reaction to conflict and gives the opportunity to understand the present behavior of the patient knowing the model dimensions the patient followed ever since his/her childhood. WIPF opens important directions in psychotherapy, which other scales or questionnaires do not provide.

The present study also has several **future aims**:

- extending the research to a larger number of patients, so as to see if the differences observed up to now are maintained;
- evaluation of patients' personality so as to learn whether or not premorbid personality influences anxious reactions to the disease;
- extending the research to healthy subjects, so as to have a healthy population sample.

Even if we proved the existence of a specific profile of patients suffering from anxiety disorders, we should not forget that each and every patient has his/her own individuality and psychotherapy should focus on the patient.