Panic, Self-Disorder, and EASE Research: Methodological Considerations

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Madeira et al. [1] report high levels of EASE-measured self-disorders in a sample of chronic, treatment-resistant, panic disorder (PD) patients without a comorbid diagnosis ($n = 47$) and compared to population-drawn controls ($n = 47$). They motivate their study by considering self-disorders as a potentially “transdiagnostic” phenotype and seem basically to show that their patient group exhibits self-disorder scores on a similar level as that reported in schizophrenia spectrum patients [2–6]. Our commentary is prompted by a concern about the potential confusion the study [1] may bring about in this research field.

Instead of perceiving self-disorders as a transdiagnostic feature, as the authors seem to do, it is perhaps more appropriate to consider anxiety and panic as transdiagnostic features. DSM-5 explicitly states: “Panic disorder infrequently occurs in clinical settings in the absence of other psychopathology” [7]. Several studies have shown that PD patients show comorbidity in 80% of cases and that the PD diagnosis massively increases the odds ratio ($OR = 35.66$) for comorbid psychosis [8]. In other words, the sample in Madeira et al. [1] is peculiar with regard to the total absence of comorbidity. Another crucial issue concerns the diagnostic assessment of this sample. If the motivation of the study was to explore the presence of self-disorders beyond the schizophrenia spectrum, then a systematic and comprehensive, in-depth psychopathological research assessment of the study population, fo-

cusing also on schizotypal traits, would be necessary. For example, one study demonstrated that healthy subjects with few schizotypal traits (not warranting a clinical diagnosis) score higher on self-disorders than healthy subjects completely free of schizotypal features [9]. In the study by Madeira et al. [1], diagnoses were allocated by treating clinicians, using the MINI, and the patients were not diagnosed by a thorough in-depth psychopathological research assessment. In fact, European clinicians practically never use the diagnosis of schizotypal disorder with the few exceptions of university clinics with a long track record of research on schizophrenia spectrum disorders [10]. The use of the MINI is not a safeguard – on the contrary, as is explicitly stated in the MINI 5.0.0 manual (July 1, 2006): “This program is not designed or intended to be used in the place of a full medical and psychiatric evaluation by a qualified licensed physician-psychiatrist.” Moreover, the MINI does not address personality disorders, including DSM schizotypal disorder. Thus, with respect to the sample, we are left with a group of chronic patients, whose diagnostic profile is basically unclear and who were certainly not screened for schizotypal features. If we look at the self-disorders scored in this sample, it is peculiar that none of the patients was found to be psychotic or schizotypic, given the fact that all experiential schizotypal items are present in the EASE and several patients had first-rank symptoms (EASE item 1.7.3) or delusional I-split (EASE item 2.7.4).

The second major issue is the conduct of the EASE interviews in this study. When applying the EASE, the authors refrained from inquiring into past life history in order to remain diagnostically blind (something which, in our experience, is simply not possible). Their approach is therefore inconsistent with the nature of the EASE interview as indicated in the manual [11] – here EASE items are required to be evaluated contextually (i.e., including life and illness history, other experiences, and interpersonal relations), and furthermore, the question of trait versus state features cannot be settled without a temporal assessment, i.e., without exploring the patient's history. In other words, the study's EASE interviews fail to satisfy basic tenets of the phenomenological interviewing approach, which is indispensable in order to faithfully explore disorders of subjectivity [12–14]. A related methodological problem is the lack of certification in the use of EASE, which according to the current standard involves participation in the Introductory EASE course, followed by the Advanced EASE course and reliability training (for details, see www.easenet.dk). In our own experience, achieving reliable ratings in this difficult domain of psychopathology requires a long, arduous training of several months. Additionally, the study was not preceded by a formalized reliability study, and the authors do not offer interrater reliability kappa values for the EASE.

The next point we wish to address is the comparability of their scores with those of other EASE studies. In addition to the problems already mentioned, making such

comparisons basically impossible, the authors used all subtypes of the main EASE items, giving a total of 94 items, in their analysis. By contrast, the other EASE studies have, in their data analysis, collapsed subtypes into main EASE items, resulting in a total of 57 items. Thus, the finding of Madeira et al. [1] of the mean total EASE score of 17.94 in PD patients is not comparable to the total EASE scores identified in the other EASE studies [2–4].

Finally, the authors claim that certain, rarely scored items of the EASE with intuitive psychopathological affinity to schizophrenia may still be considered as relatively specific to the schizophrenia spectrum because of their rare occurrence in their PD sample. However, such a claim can only be made if there is a control group of patients with schizophrenia spectrum disorders. For example, the EASE item “confusion with specular image” (item 4.2) was found in less than 10% of their PD sample and in only 3% of our own clinical sample [4], testifying to the item's rarity in both samples. This illustrates that to ascertain item specificity one cannot focus solely on the frequency of an item but must study relevant comparison groups.

We hope that this comment may be helpful in highlighting certain important, but also basic, methodological issues that need attention in the phenomenological research on self-disorders. Otherwise, we fear that the notion of self-disorders will become trivialized into banality, as, for example, is already happening by transforming the EASE into a self-rating questionnaire [15].

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