of cigarettes and changes in cigarette consumption during the course of panic disorder were recorded as well as the impact of these changes on panic symptomatology.

Results: Both rates of smokers (56%) and of ex-smokers (28%) were substantially higher than in the general population (smokers: 27.5%, ex-smokers 15%; values for the general population outside 95% Confidence Intervals). However, a surprisingly high number of patients had succeeded in reducing or quitting cigarette smoking because of their panic disorder, although they experienced little benefit in regard to panic symptoms from doing so.

Conclusions: The motivation for changing smoking habits is high in this population with elevated smoking prevalence and should be taken into consideration by therapists.

Tues-P95

COGNITIONS AND DISABILITIES IN PANIC DISORDER

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Dysfunctional cognitions represent a core element of panic disorder. We investigated the question whether certain cognitions are associated with disabilities in different areas of life.

In a study on the comparison of paroxetine with group-psychotherapy in patients with panic disorder with or without agoraphobia, dysfunctional cognitions were assessed by the Agoraphobic-Cognitions-Questionnaire and psychosocial impairment was evaluated by the Sheehan-Disability-Scale.

Of 100 patients included in the study, 88 cases could be analyzed regarding this question due to complete data. Dysfunctional cognitions showed a significant correlation with disabilities in social relations and family life but not in functioning at work. As suggested in the literature the most frequently reported cognitions were: getting a heart attack (26.1%), the fear of fainting (19.3%), and the fear of dying (19.3%). However, cognitions which were associated with disabilities in daily life were characterized by the fear of loosing social control (doing something stupid ($r = .38$), loosing control ($r = .30$), and becoming crazy ($r = .29$)) and the fear of impairment that would result in dependency on the help of others.

The results suggest that cognitions with an interpersonal aspect have a greater impact on patient's role functioning aspect of quality of life than the cognition of fear of dying. It is concluded that it is advisable to concentrate on these interpersonal cognitions.

Tues-P96

PANIC DISORDER WITH AGORAPHOBIA AND MARITAL AND SEXYAL FUNCTIONALITY

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Background and Objective: Panic disorder with agoraphobia is a complex psychiatric disorder. Possibility of better understanding and treatment of the disorder including estimate of marital and sexual functionality.

Method: Instruments which were administrated: DSM-IV criteria for panic disorder with agoraphobia, Acute Panic Inventory, Self-rating subscale for agoraphobia, Marital-Maudsley questionaire, DSM-IV criteria for sexual dysfunctions. The sample included two groups: 30 patients which filfulled criteria for panic disorder with agoraphobia, and 30 healthy maritaly harmonic pearsons.

Rezults: The study results indicates that patients with panic disorder with agoraphobia are maritally and sexually dysfunction as compared to control maritaly harmonic pearsons. 60.3% of the patients filfulled criteria for one or more sexual dysfunction and none of the control group. In the majority of cases (53.3%) sexual dysfunctions occured secucundarily upon a certain period of satisfactory marital sexual functioning. Sexual desire disorders was the most frequent (46.6%), than sexual arousal disorders (26.7%) and orgazmic disorders (16.6%)

Conclusion: In conclusion the authors suggest integrative treatment for panic disorder with agoraphobia which including marital and psychosexual therapy.

Tues-P97

THE APPLICATION OF THE PANIC AND AGORAPHOBIA SCALE (P & A) IN CLINICAL TRIALS

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Introduction: A new scale for assessing severity in PDA (Panic Disorder with/without Agoraphobia) has been developed: the Panic and Agoraphobia Scale (P & A[1]). The objective of this study was to verify that the scale is sensitive to changes from baseline or to differences between treatments.

Method: Two treatment trials were performed. In the first study, 36 patients with PDA were treated with imipramine (75–150 mg per day) and self-exposure to feared stimuli for eight weeks in an open, prospective trial[2]. In the second trial, 49 outpatients with PDA were randomly assigned to a ten-week treatment protocol of either regular aerobic exercise (running), intake of clomipramine (112.5 mg per day) or placebo pills[3]. Treatment efficacy was measured with the Panic and Agoraphobia Scale (P & A) and other rating scales (e.g. the Hamilton Anxiety Scale and the Clinical Global Impression Scale).

Results: In the first study, treatment success could be demonstrated by a significant decrease of the average P & A severity scores. In the double-blind placebo-controlled trial, the P & A revealed significant differences between both active treatments (running and clomipramine) and placebo, whereas clomipramine was significantly more effective than running.

Conclusions: The new Panic and Agoraphobia Scale (P & A) was shown to be sensitive to changes and to differences between various treatment modalities for PDA.

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