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A Comparison of Panic Disorder and Generalized Anxiety Disorder in an Arab Culture

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ABSTRACT

This study was conducted with the aim of examining clinical characterisrics of paiiic disorder compared to those of generalized anxiety disorder as encountered in an Arab culture (Saudi Arabia). 33 consecutive referrals diagnosed as patiic disorder (N = 20) or generalized anxiety disorder (N = 13) were subjected to a structured interview as well as psychometric evaluation.

Findings generally support the diagnostic validity of patiic disorder and its distinction from generalized anxiety disorder. Besides the typical dramatic episodic attacks the pattern in patierits with panic disorder showed more intense anxiety, more prominent somatic symptoms, more preoccupation with ideas about illness arid dying arid possibly ati overall episodic course of illness. Among associated features, depression and hypochondriasis were particularly prominent.

INTRODUCTION

Panic attacks have traditionally been considered as part of the neurotic anxiety syndrome, a conception which dates back to early descriptions of Freud over 90 years ago *(Gelder,* 1986). Recently, *it* has been suggested that such attacks characterize a distinct form of anxiety disorders. This new distinction has particularly materialized in the DSM-III *(American Psychiatric Association, 1980),* in which a "Panic Disorder" and a "Generalized Anxiety Disorder" are separately described in terms of operationalized diagnostic criteria. Interest in this nosological issue has directly stemmed from pharmacotherapeutic research indicating that panic anxiety is moderated specifically by tricyclic drugs and by monoamine oxidase inhibitors in contrast to

chronic generalized anxiety which responds to benzodiazepines ***(Typrer, 1984: Nemiah, 1985).*** This has been followed by an increasing number of research studies along different lines, including descriptive, genetic, treatment and neurobiological lines, all attempting to test the diagnostic validity of panic disorder and identify its distinct origin ***(Breier, 1985).***

Descriptively, distinction has largely been based on the acute and dramatic attack pattern in panic anxiety compared with the more persistent and less dramatic pattern of anxiety in generalized anxiety disorder. In addition, studies indicate significantly more frequent somatic symptoms particularly respiratory symptoms, palpitation and sweating among panic attack patients ***(Hoen-Saric, 1982: Anderson, 1984).*** These patients also show more preoccupation with ideas about illness and dying ***(Hibbert. 1985),*** and tend to be hypochondrical ***(Noyes*** et al., ***1986).***

Genetic and family studies provide strong evidence that panic disorder, but not generalized anxiety disorder, has high familial prevalence and genetic transmission ***(Breier et al., 1985).*** It is questionable, however, whether such results indicate a distinct disorder and not a difference in genetic loading representing a severe degree of the same syndrome ***(Gelder, 1986).***

Within the last few years the extraordinary amount of research on panic disorder has shown a marked focusing on its biological features ***(Ballenger, 1986).*** Different hypotheses have been offered and investigated to uncover the biological mechanisms underlying this disorder. Three main hypotheses attempt to explain its symptoms in relation to: 1) hyperventilation, 2) a peripheral; or 3) a central noradrenergic overactivity ***(Hibbert, 1984; Gelder, 1986).*** The increasing concern, however, is directed to a central theory suggesting paroxysmal noradrenergic overactivity mechanisms involving the locus cerulus ***(Nurnber and Coccaro, 1982;*** Ballenger, ***1986).*** Research utilizing newly emerging tools such as PET claims significant results in favour of this hypothesis ***(Reiman*** et ***al., 1986).***

Studies exploring the psychological mechanisms involved in panic disorder are apparently still minimal compared to those concerned with the biological mechanisms. At a pharmacological level some illuminating results have been obtained from studies probing

cognitive aspects of this disorder *(Hibbert, 1984: Gelder, 1986)*, and they possibly contribute to the identification of its distinct pattern of disturbance. At a dynamic level clinical observations and studies have indicated a highly possible link between separation and loss experiences in childhood and anxiety in adult life in general *(Bowlby, 1977; Nemiah, 1985)*. An investigation of this aspect by Raskin *et* al. *(1982)* revealed no significant differences between panic disorder and generalized anxiety disorder patients as regards separation or loss experiences. However, panic disorder patients reported more gross disturbances in their childhood environment.

Besides the distinction between panic disorder and generalized anxiety disorder an equally important line of research is concerned with the relation of panic disorder to depression. Several observations and studies have indicated an apparent overlap between panic disorder and depression seen in clinical symptoms, family history, and treatment response *(Ballenger, 1986)*. Clinically, the concomitant occurrence of symptoms of anxiety and panic with episodes of major depression is well documented. In addition, studies have indicated that a significantly high proportion of patients with panic attacks have a history of major depression or go on to develop a depressive syndrome *(Breier et al., 1985)*.

Evidence from genetic and family studies indicate that depressive illness is significantly more in relatives of patients with panic disorder than in general population or other anxiety disorders *(Liberkmart et al., 1983)*. Such findings, in addition to the therapeutic response of panic disorder to antidepressants have led investigators to suggest that panic disorder is a clinical manifestation of underlying depression or a form of atypical depression *(Curtis et al., 1982; Breier, 1985)*. It has also been suggested that a common pathophysiological process underlies both disorders *(Liberman, 1983)*, and that panic and depressive symptoms are phenotypic expressions of a single biological diathesis *(Breier, 1985)*.

An overall evaluation of literature indicates that the issue of panic disorder still raises much debate and stimulates a considerable amount of research. It is noticed, however, that almost all available research has been conducted in Western Cultures. Little information is available about this disorder in other cultures. This study has been planned to examine clinical characteristics of panic disorder

compared to those of generalized anxiety disorders as encountered in an Arab Culture.

MATERIAL AND METHODS

The sample consisted of 33 consecutive referrals to a psychiatric outpatient clinic in Saudia Arabia who were diagnosed as having panic disorder (N = 20) or generalized anxiety disorder (N = 13). Diagnosis was based on DSM-III criteria. It was made by an experienced psychiatrist and was substantiated by a second psychiatrist through the detailed psychobiograms of patients.

Besides the full initial psychobiograms all patients were subjected to:

1. A structured interview eliciting informations about:
   a) Symptom profile including various psychological and physical symptoms of anxiety.
   b) Associated manifestations.
   c) Duration and course of illness.
   d) Relevant past and family history in terms of similar disorders or other neurotic or psychotic disorders.
   e) Relevant personal history in terms of childhood loss or separation from parents or grossly disturbed family life.
   f) Precipitating stresses in terms of loss or separation from significant attachment figures or grossly disturbed family or work life.

2. The Middlesex test as a tool providing a quantitative evaluation of anxiety, phobia obsessiveness, somatization, depression and hysteria.

All patients were interviewed and tested by the same psychiatrist. Statistically, Chi-square tests were used to evaluate significant differences among frequency data while t-test (Fisher's Formula) was used to evaluate the significance of differences in relations to means.

RESULTS

Mean age for panic disorder group was 27.5 ± 6.5 in generalized anxiety disorder group. The majority of patients in both groups were males (70% of panic disorder group and 80% of generalized anxiety disorder group). The majority of panic disorder patients were married (70%), while the rest were single (25%) or divorced (5%). In generalized anxiety disorder the higher percentage were single (46.4%), while relatively less were married (38.4%) or divorced (15%).

Patients with generalized anxiety disorder reported a significantly longer duration of illness than panic disorder patients (Mean ± **S.D.** = 16.35 ± 16.33 months and 5.85 ± 11.15 months respectively; $p < 0.05$).

In generalized anxiety disorder the reported anxiety was more or less persistent and generally less severe, while patients with panic disorder typically reported the acute and dramatic attack pattern with variable degrees of anticipatory anxiety inbetween. The frequency of reported attacks ranged between 1-3/week in 75% of cases while the rest reported daily attacks. Duration of attacks ranged between a few minutes to less than one hour in 65% of cases, from one to two hours in 30% of cases and more than two hours in only one case (5%).

Table (I) shows that the great majority of somatic or psychological symptoms of anxiety were reported more frequently by patients with panic disorder. This **is** particularly prominent in most somatic (autonomic and skeletal) symptoms. However, the differences were statistically significant in relation to **5** symptoms (chocking sensation, dizziness, faintness or syncope, parasthesia and muscle tension). In addition, one psychological symptom (Fear of death) was significantly more frequent among panic disorder patients. Three psychological symptoms (apprehensive fear, tension and restlessness and impatience) were relatively more frequent among patients with generalized anxiety disorder but differences did not amount to a statistically significant level.

Information provided by patients as regards past or family history was not sufficient for an accurate and reliable identification of specific diagnostic labels in most cases. Differentiation could reliably be made between similar disorders and globaly other neurotic **or** psychotic disorders. **As** seen in table (II) no psychotic disorders could be identified in past or family history of all patients.

Table I: Symptoms Reported by Patients with Panic Disorder or Generalized Anxiety Disorder Compared

Symptoms	Panic Disorder (N = 20) N	%	Gen. anx. Disorder (N = 13) N	%
A. Physical (autonomic & skeletal):				
. Dyspnea	19	95	12	92.3
. Palpitations	20	100	12	92.3
. Chest Pain	16	80	10	76.9
. Chocking Sensation*	18	90	1	7.7
. Dizziness**	19	95	8	61.5
. Sweating	15	75	5	38.5
. Parasthesia**	17	85	6	46.2
. Hot or cold flushes	14	70	9	62.2
. Faintness or syncope*	12	60	1	7.7
. Dry mouth	18	90	9	69.2
. Lump in throat	12	60	9	69.2
. Anorexia	12	60	8	61.5
. Nausea ± vomiting	10	50	5	46.2
. Abdominal pain	7	35	5	38.5
. Urinary frequency	12	60	4	30.8
. Tremours	18	90	9	69.2
. Headache	16	80	8	61.5
. Muscle tension**	16	80	5	38.5
. Weakness	17	85	9	69.2
B. Psychological				
. Fear, apprehension	16	80	12	92.3
. Tension, restlessness	18	90	13	100.0
. Impatience	18	90	12	92.3
. Worry	19	95	12	92.3
. Bad expectations	16	80	7	53.8
. Irritability	19	95	12	92.3
. Poor concentration	17	85	12	92.3
. Insomnia	19	95	10	76.9
. Nightmares	12	50	5	38.5
. Fear of death*	18	90	4	30.8
. Fear of going crazy	9	45	5	38.5
. Fear of loosing control	12	60	4	30.8
. Feeling of unreality	3	15	-	-

Table XI: Relevant History Data

Symptoms	Panic Disorder (N = 20) N	%	Gen. anx. Disorder (N = 13) N	%
Past history				
. Same disorder*	9	45	3	23.1
. Other neurotic disorders	1	5	1	7.7
. Psychotic disorders	-	-	-	-
Family history				
. Same disorder	1	5	-	-
. Other neurotic disorders	7	35	3	23.1
. Psychotic disorder	-	-	-	-
Personal history				
. Separation (from parents)	3	15	2	15.4
. Death (one or both parents)	3	15	4	30.8
. Grossly disturbed family life	5	25	1	7.7
Precipitating stress				
. Significant separation	3	15	2	15.4
. Death of a significant person	3	15	4	30.8
. Grossly disturbed, family or work life	5	25	1	7.7

* $P < 0.05$ (Chi-square analysis).

As regards "other neurotic disorders", patients usually described mixed neurotic depressive and anxiety manifestations which could not be reliably differentiated further. Table II shows that significantly more patients with panic disorder reported past episodes of the same disorder. Of the 9 patients 5 reported **a single previous episode while 4 reported recurrent yearly** episodes each lasting a few months. Other explored data of past and family histories, personal history and precipitating stresses do not indicate significant differences.

Among associated features (Table III) hypochondriasis was significantly more frequent in patients with panic **disorder.**

Differences as regards other features did not amount to a statistically significant level.

Table III: Associated Features

Symptoms	Panic Disorder (N= 20) N	%	Gen. anx. Disorder (N = 13) N	%
. Depressed mood	18	90	10	76.9
. Phobia	1	5	4	30.8
. Obsessions	-	-	2	15.4
. Hypochondriasis*	12	60	1	7.7
. Hysterical	1	5	-	-
. Depersonalization	1	5	-	-
. Psychosexual dysfunction	-	-	2	15.4
. Substance abuse	-	-	1	7.7
. Psychosomatic disorder	2**	10	1**	7.7

* P < 0.01
** Irritable bowel syndrome

Results of the Middlesex test (Table IV) indicate generally higher mean scores in patients with panic disorder. This is particularly prominent in anxiety and psychosomatic (somatization) categories in which differences are statistically significant.

Table IV: Results of Middlesex Test

	Mean Score	
	Panic Disorder (N = 20)	Gen. anx. Disorder (N = 13)
. Anxiety*	11.1	7.8
. Phobia	7.3	6.4
. Obsessions	9.9	9.1
. Psychosomatic*	10.0	6.4
. Depression	9.5	8.7
. Hysteria	7.1	7.0

* $P < 0.05$ (t-test, Fisher's Formula).

DISCUSSION

Results of this study apparently support the distinction made in DSM-III between panic disorder and generalized anxiety disorder. Patients fulfilling criteria for panic disorder were clearly identifiable and could be distinguished from patients meeting criteria for "Generalized Anxiety Disorder", though the latter may not be as well defined and differentiated as noticed by other investigators *(Breier* et al., *1985).*

The clinical characteristics of the two disorders, as encountered in this study, are generally consistent with those operationally described in DSM-III. An exception, however, is the higher ratio of males (70%) in panic disorder compared to the higher ratio of females indicated in DSM-III as well as various studies of panic disorders *(Liberman et* al., *1983).* In a previous study conducted on panic disorder in the same center by *El-Etribi el al. (1984),* a similar higher male ratio (70%) was encountered. This was interpreted by the authors as being due to the predominance of population in the newly evolving industrial community served. We tend to agree with this interpretation.

As noticed in other studies, the main distinguishing criterion was typically the dramatic attack pattern of panic anxiety compared to the more or less persistent and less dramatic pattern in generalized anxiety disorder. Also, as noticed before *(Hoehen-Saric, 1982)*, symptoms of anxiety reported by panic disorder patients indicate more intensity or severity particularly in relation to the attacks. The significantly higher mean score on anxiety in Middlesex test (Table V) is probably a good index in this respect.

As observed in other studies *(Anderson* et al., *1984)* the reported duration of illness in this study indicates that generalized anxiety disorder tends to be more chronic. On the other hand, however, data from past history (Table II) indicate that panic disorder tends to be more recurrent in separate or discrete episodes.

As regards presenting symptoms, several studies have stressed the prominence of physical or somatic symptoms of anxiety in panic disorder. *Hoehen-Saric (1982)* suggested that patients with panic disorder can be distinguished from those with generalized anxiety disorder primarily by the type of somatic symptoms generally Associated with anxiety. In his study headache, palpitation, perspiration, hot flushes and respiratory symptoms were the significantly more frequent symptoms in panic disorder patients. However, in another study *Hibbert (1984)* the significant somatic symptoms were breathlessness, palpitation and sweating, while in the study of *Anderson et* al. *(1984)* the list of significant symptoms included palpitation, chest pain, sweating, dyspnea, light headedness, dizziness, blurred vision and weakness.

In this study, most somatic symptoms of anxiety are more frequently reported by patients with panic disorder (Table I). Of these, however, symptoms which showed statistical significance are only 5 and include dizziness, chocking sensation, parasthesia, faintness or syncope and muscle tension. These patients, somatic (particularly autonomic) symptoms of anxiety are generally prominent and more frequent than in patients diagnosed as generalized anxiety disorder. However, the variability of specific somatic symptoms found significantly more frequent in different studies does not apparently support the suggestion that patients with panic disorder may be differentiated primarily on the basis of certain somatic symptoms.

Among psychological symptoms, fear of death was significantly more frequent in patients with panic disorder (Table I). This, together with the significantly higher frequency of associated hypochondriasis (Table III) generally support the findings of ***Hibbert (1985)*** who, in addition to somatic symptoms, stresses the significance of symptoms indicating preoccupation with ideas about illness and dying in panic disorder patients. Our findings regards hypochondriasis are also in agreement with those of ***Noyes et*** al. ***(1986)*** who reached the conclusion that: "Hypochondriasis appears to be a prominent feature of panic disorder....and responds to treatment of the primary conditions".

As regards the possible psychopathological role of childhood experience, a study by *Raskin et* al. ***(1982)*** showed no significant differences between patients with panic disorder as regards separation or loss experiences. However, panic disorder patients reported more gross disturbances in their childhood environment. Similar trends **can** be noticed in table II. The table also indicates that the role of equivalent experiences in precipitating the disorder in adult life matches the same trends. These findings probably point to the psychopathological role of such experiences in predisposing for anxiety disorders in general. When matters come to the differentiation between different patterns of disorder, the qualitative aspects of such experiences are probably more significant than their incidence. **Also,** this issue is further complicated by the fact that other disorders, particularly depression, are implicated in relation to such childhood experiences *(Tannant et* al., *1982)*, which is another important point to be considered in planning and evaluating research concerned with this aspect.

As regards the highly possible special relation between panic disorder and depression ***(Breier*** et ***al.***, *1985)*, this study has not involved a systematic or specially focused assessment of this aspect. Results related to this aspect are those indicating that associated manifest depressive features were encountered in 90% of patients with panic disorder (Table III). This percentage is high and is higher than that of patients with generalized anxiety disorder (76%), though the difference is not statistically significant. It is well documented by many studies that depression is highly associated with anxiety disorders and this relationship appears to be particularly strong in the case of panic disorder ***(Breier et*** al., ***1985).*** Some studies of panic

disorder reported associated depression in as much as **64%** of patients while other studies of depressive patients reported panic attacks in 29% of their sample ***(Slavrakaki*** arid ***Vargo, 1986).*** Other longitudinal studies identified temporally independent episodes of panic disorder and depression occurring in the same patient in up to 75% and ***68%*** of their studied samples. ***(Breier et*** al., ***1985).*** The nature of depression related to panic disorder (whether primary or secondary, a mere association or an essential part of the disorder) is still highly debatable ***(Stavrakaki*** and ***Vargo. 1985)*** and is still subject to many investigations, including clinical and neurobiological investigation ***(Curtis et*** al., ***1982; Liberman et al., 1953).***

From our clinical impressions the qualitative rather than quantitative aspects of depression related to panic disorder are probably the more differentiating factors. This quality is probably closer to that encountered in depressive illness or major depression rather than neurotic or dysthmic type or level of depression. This point is probably favoured by results of genetic and family studies ***(Liberman, 1983),*** and some neurobiological studies ***(Roy-Byrne et*** al., ***1986).*** Further investigation including not only neurobiological but also qualitative clinical and psychological aspect may help in illuminating which issue in the future.

CONCLUSIONS

Findings of this study which was conducted in a non-western culture tend to support the diagnostic validity of panic disorder and its distinction from generalized anxiety disorder. In our opinion, the findings, together with other findings in literature, also indicate that this clinical distinction is not primarily based on the frequency of some symptoms such as certain somatic symptoms as suggested by some investigators. It is more comprehensibly based on the collective pattern of the disorder in which the different clinical criteria are integrated. Thus the differentiating pattern in panic disorder as encountered in this study includes among its features the typical episodic attacks, acuity and intensity of symptoms, prominence of somatic symptoms and preoccupation with ideas about illness and dying, associated features, particularly depression and hypochondriasis and possibly an overall episodic course of illness. On the other hand, the pattern in generalized anxiety disorder may not be as well defined but symptoms of anxiety are more or less

persistent, less dramatic and intense, with less frequent somatization and possibly a more chronic course. These differentiated criteria are not inclusive but represent some main findings in this study.

Inspite of these findings as well as other findings in the literature supporting the distinction, further research is definitely still required in order to have it established as a justifiable and meaningful differentiation rather than a mere unnecessary fragmentation of existing nosology. However, in addition to the highly emphasized neurobiological aspects observed in current research concerned with these disorders, we believe that more attention should be directed to their possible psychological mechanisms. This may help in reaching more sound and integrative rather than partial and reductionistic facts.

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'UNE COMPARAISON ENTKE LE DESOKDRE DE PANIQUE ET CELUI D'ANGOISSE GENERALIZE DANS UNE CULTURE AKABE `

ABSTRAIT

Cette etude ete conduite dans le but d'examiner les caracteristiques cliniques du desordre de panique comparativement a ceux du desordre d'angoisse generalise, et ceci dans le context d'une culture arabe (Arabie Seoudite).

33 patients diagnostiques comme souffrant de desordre de panique (N=20) ou de desordre d'angoisse generalise (N=13) ont ete assujetti à un interview structure, ainsi qu'a une evaluation psychometrique.

Les resultats de cettc etude soutiennent la validité diagnostique du desorde de panique ainsi que sa distinction du desordre d'angoisse generalise. A part les attaques episodiques, dramatiques typique, les malades souffrant de desordre de panique presentent avec une angoisse plus intense, des symptome somatiques plus prononces, plus de preoccupation avec des idée de maladie et de mort ainsi qu'une rnarche de la maladie plutot épisodique. Parmi les caracteristiques associees, la depression de l'hypochondire etaient particulierement saillant.

الموجز

مقارنة بين اضطراب الفزع واضطراب القلق العام فى احدى الثقافات العربية

أجريت هذه الدراسة بهدف فحص الخواص الاكلينيكية لاضطراب الفزع مقارنه باضطراب القلق العام كما تتجلى فى احدى الثقافات العربية (المملكة العربية السعودية) ولقد أجريت مقابلة منظمه لثلاث وثلاثين مريضا شخصت حالتهم اضطراب الفزع (العدد = ٢٠) أو اضطراب القلق العام (العدد = ١٣) وتم تقييمهم بالقياس النفسى وتدعم النتائج بوجه عام صلاحية تشخيص اضطراب الفزع وتميزه عن اضطراب القلق العام بالاضافة الى النوبات التى تأتى فى صورة متقطعة بشكل دراماتيكى فى اضطراب الفزع يتميز القلق فى هذه الحالات بالشدة ووجود الأعراض الجسمية الظاهرة والأنشغال المسبق بأفكار عن المرض والموت وربما يتميز المرض عموما بطبيعة متقطعة ومن بين الأعراض المصاحبة يبدو الاكتئاب والهيبوكوندريا واضحين بصورة خاصة.