A Comparative Clinical and Psychometric Study of Phobic, Depressssive and Anxiety Disorders

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74 Phobic patients recruited from an outpatient psychiatric clinic in Saudi Arabia diagnosed according to DSM - III - R were assessed for anxiety, depression and personality. Two control groups, one with major depression (n = 18) and one with generalized anxiety (n = 24) were similarly assessed. Results showed that agoraphobic patients with panic attacks were significantly older (P <0.01) than those with social phobia.

Males predominate social phobia diagnoses than females. Phobic patients were significantly less depressed than patients with major depressive disorders. The implications of these findings are discussed.

(Egypt.J. Psychiat.,1992,15:45-52).

Introduction

Schapiro and associates (1970) found that patients with symptoms of agoraphobia are more vulnerable to affective disorders.

It has been recognized for many years that depression frequently occurs in patients with panic-agoraphobia syndromes (Stein et al.,: 1990).

Sir Martin Roth, (1972) in an early description of the "phobic anxiety - depersonalization syndrome", recognized that more than half of such patients experienced variable degrees of depression.

The literature is rather devoid of studies examining the lifetime relationship between major depression and social phobia and this certainly applies to the study of affective illness in patients with social phobia (Liebowitz et al., 1989).

Reports that imipramine and phenelzine prevent panic attacks and improve agoraphobia suggest the possibility that agoraphobia and / or panic disorder might be a clinical manifestation of underlying depression (Marks, 1983).

To test this hypothesis, dexamethazone suppression tests were performed in some agoraphobics and some patients with panic disorders. The results suggest that agoraphobia and / or panic attacks and endogenous depression are separate disorders and that the antipanic properties of imipramine and phenelzine are separate from their antidepressant action (Curtis et al.,: 1982).

Bowen and Kohout (1979) found a high incidence of affective disorders in the relatives of agoraphobics.

In early childhood, separation - anxiety may lead to school phobia which, in some cases, may be a depressive equivalent (Wolpert, 1981).

West and Ally (1959) described what they termed atypical depression. It was based largely on a chronic condition in which fatigue, bodily complaints, and phobic anxiety were the prominent symptoms. The classical endogenous symptoms were infrequent.

Various authors have suggested that all agoraphobics, if carefully questioned, would report symptoms of a full blown depressive syndrome (Curtis, et al., 1982).

Statistical inquiries confirm that mild phobic symptoms are common in depressive illness. Likewise, depressive symptoms are common among agoraphobic patients (Bowen and Kohout, 1979).

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Marks (1969) found that half of his social phobics gave a history of depression or anxiety outside the feared situation.

The aim of this work is to compare the level of depression and anxiety in different groups of phobic patients as well as comparing them with a group of anxious patients and depressive patients.

Subjects and Method

(1) All phobic patients who presented to the outpatient psychiatric clinic of one of the biggest private hospital in Jeddah, Saudi Arabia, within six months (from the 1st of January to the 30th of June 1991), were diagnosed by two senior psychiatrists (M. D. qualified) according to DSM-III-R) (1987).

Frequency of the type of phobic disorders was as follows:

(a) 44 patients were diagnosed social phobia (30 males and 14 females) with mean age 24.38±5.66.

(b) 16 patients were diagnosed agoraphobia with panic attack (6 males and 10 females) with mean age 34.5± 13.12.

(c) 14 patients with the diagnosis of agoraphobia (6 males and 8 females) with mean age 26.4±4.22.

(2) two Control groups:

(a) Major depression group. 18 patients (10 males and 8 females) with mean age 37.13±3.42.

(b) Generalized anxiety group. 24 patients (16 males and 12 females) with mean age 30.27+8.1.

All the patients were subjected to psychometric assessment including:

(a) Beck's Questionnaire for Depression.

(b) Taylor's Questionnaire for Anxiety.

(c) E. P. Q. (Eysenk's Personality Questionnaire).

Results

From the tables we can see that there are significant difference between the age of agoraphobic patients with panic attack and social phobic patients.

There is no significant difference as regards marital status between different groups of phobia.

As regards sex distribution, females were commoner in agoraphobic patients with or without panic attacks. Social phobic patients were mainly men.

As regards psychometric results there was a significant difference between phobic patients and patients with major depression on Beck's questionnaire for depression.

There was no significant difference between phobic patients and the control groups on Taylor's questionnaire for anxiety.

Discussion

From our results Our agoraphobic patients, as shown in the results had a mean age 26.4±4.22 while social phobia had a mean age 24.38±5.66 and the difference was not significant. Agoraphobic patients with panic attacks group had a mean age 34.5±13.12. This is nearly the same as that found by Okasha (1977),

Table 1

Comparison Between the Age, Sex, and Marital Status of Phobic Patients

	Social Phobia Vs. Agoraphobia		Social Phobia Vs. Agoraphobia and Panic		Agoraphobia with and Without Panic	
	t	p	t	p	t	p
Age	1	N. S.	4.091	<0.01	1.34	N. S.
Sex	1.691	< 0.1	2.193	<0.05	0.299	N. S.
Marital	1.231	N.S.	0.792	N. S.	0.321	N. S.

Table 2
Comparison Between Psychometric Results of Social Phobics, Depressive and Anxious Patients

	Social Phobics (44 Patients)	Depression 18	t	p	Anxiety 15	t	p
Taylor's Q	34.64±6.15	31.36±6.74	1.823	<0.1	31.53±7.25	0.075	N. S.
Beck's Q	52.75±19.63	73.41±22.05	3.567	<0.01	52.79±16.1	0.185	N. S.
E. P. Q. P	5.09±2.5	12.71±6.16	4.18	<.001	5.53±3.24	0.450	N. S.
N	18.55±4.38	18.43±4.3	0.097	N.	19.27±3.4	0.72	N. S.
E	4.5±2.8	11.5±4.82	7.015	<0.01	8±4.89	2.33	<0.05
L	4.36±2.35	5.57±1.59	2.624	<0.05	5.4±4.42	0.514	N. S.
C	13.45±3.89	13.67±3.94	0.198	N. S.	12.79±4.06	0.71	N. S.

Table 3
Comparison Between Psychometric Results of Agoraphobic with Panic Attacks, Anxious and Depressive Patients

	Agoraphobia (16 Patients)	Depression (18 Patients)	t	p	Anxiety (28 Patients)	t	p
Taylor's Q	33.67±8.16	31.36±6.74	0.641	N. S.	31.53+7.25	0.884	N.
Beck's Q	60±16.07	73.41±22.05	1.945	<0.1	52.79±16.1	1.397	N.
E. P. Q. P	7.25±4.32	12.71±6.16	2.15	<. 05	5.53±3.24	1.46	N.
N	19±1.58	18 43±4.3	0.486	N. S.	19.27±3.4	0.293	N.
E	3.5±3.27	11.5±4.82	3.98	<.001	8±4.89	1.88	N.
L	6.75±3.11	5.57±1.59	0.907	N. S.	5.4±4.42	1.17	N.
C	13.75±5.63	13.67±3.94	0.05	N. S	12.79±4.06	0.638	N.

who reported that the mean age of those seeking treatment was about 32 years in agoraphobics and 27 years in social phobia.

Also agoraphobia was found by Snaith (1968) to have its onset in the patients, late teens or early twenties, although it may be first manifested much later in life.

Social phobias are characteristically associated with adolescence (Abe and Masui, 1981). Moran and Andrews (1989) reported that there is consistent evidence that phobic patients come for treatment some seven to ten years after the onset of the disorder.

As regards sex distribution our sample was composed of more female patients suffering from agoraphobia with or without panic attacks, while social

Table 4

Comparison Between Agoraphobic Panic Attacks Depressive, and Anxious Patients

	Agoraphobia (16 Patients)	Depression (18 Patients)	t	p	Anxiety (28 Patients)	t	p
Taylor's Q	34±5.52	31.36±6.74	0.89	N. S.	31.53±7.25	0.86	N. S.
Beck's Q	47.75±10.01	73.41±22.05	3.33	<.01	52.79±16.1	1.046	N. S.
E. P. Q. P	8.75±4.92	12.71±6.16	1.47	N. S.	5.53±3.24	2.473	<0.05
N	13±2	18.43±4.3	4.233	<0.01	19.27±3.4	6.217	<0.01
E	5.2±2.16	11.5±4.82	2.586	<0.05	8±4.89	5.132	<0.01
L	5.6±1.36	5.57±1.59	0.673	N. S.	5.4±4.42	0.161	N. S.
C	14.4±8.815	13.67±3.94	0.323	N. S	12.79±4.06	0.634	N. S.

Table 5

Comparison Between Psychometric Results of Different Types of Phobic Patients

	Social Phobia Vs. Agoraphobia and Panic attack		Social Phobia Vs. Agoraphobia		Agoraphobia With and Without Panic attack	
	t	p	t	p	t	p
Taylor's Q for Anxiety	0.33	N.S.	0.27	N. S.	0.85	N. S.
Beck's Q for Depression	1.04	N. S.	0.89	N. S.	1.83	N. S.
E. P. Q. P	1.48	N. B.	2.15	P<0.05	0.62	N. S.
N	5.66	P<0.001	4.66	P<0.001	6.52	<0.001
E	0.76	N. S.	0.70	N. S.	1.16	N. S.
L	2.11	<0.05	1.72	N. S	1.02	N. S.
C	0.15	N. S.	0.323	N. S.	0.17	N. S.

phobic patients were mainly men.

Agoraphobia is more commonly diagnosed in women than in men; the sex ratio of social phobia is unknown (Nemiah, 1981-a). Abe and Masui (1981) found that the fear of talking and psychogenic frequency of micturition were more prevalent in boys than in girls in adolescence. Other fears and phobias were found more prevalent in girls (Agras et al., 1969). Fodor (1974) suggested that agoraphobia may be considered as a caricature of the female role in the western society. She holds that socialization, sex - role stereotyping, and sex - role conflict are responsible for the development of agoraphobia in women. Agoraphobia develops because patients in infancy were reinforced for stereotypical female behaviour (i.e.; helplessness and dependency). Fodor's sex-role theory of agoraphobia is in keeping with the finding that most agoraphobics are females.

Our result that social phobics are more males than females is different from other researches. In Maudsley Hospital (in London) 60% of the patients of social phobia were women (Thorley and

Stern, 1974 Absents Rek).

Our results are the same as that of Amies, Gelder, and Shaw (1983) who found that the patients complaining of social phobia are of a younger age; a greater proportion were men and they were of higher social class.

The symptoms of social phobia include an unreasonable anxiety experienced by a person when in the company of other people. It is accompanied by a desire to avoid the situations in which it is experienced (Amies et al., 1983). They complain of a fear of being criticized in certain social situations which they therefore tend to avoid (Taylor, 1966). These social situations include playing games, speaking to strangers or persons in authority and working with other people for fear of making mistakes (Marks, 1969).

In the Saudi Arabian Society as well as in many Arab societies, women are still playing a minimal role in social life. The main responsibilities are carried out by the man. He is the one who has to go to work, talk to persons in authority or to attend social gatherings.

Women can avoid easily all these situations. So men complained and asked for treatment more than women in our sample of social phobia.

As regards depression level as measured by Beck's Questionnaire for depression there was a significant difference between phobic patients in any group and patients with major depression.

Our results are against those of other authors who have suggested that all agoraphobics, if carefully questioned, would report symptoms of a fullblown depressive syndrome (Curtis et al., 1982).

Statistical inquiries confirm that mild phobic symptoms are common in depressive symptoms. Equally depressive symptoms are common among agoraphobic patients (Bowen, and Kohout, 1979).

But still we are in agreement with the work of Mathews et al., (1981):

This can be explained by

(1) In some cases of depression, at the beginning of the attack, ideas occur which can not be recognized as part of the picture of psychotic depression. They seem to be neurotic obsessions, phobias, what the patient call unclean thoughts. They are followed by discouraging ideas which acquire more and more prominence (Beck, 1974).

(2) The depressive symptoms that are commonly present in agoraphobia appear usually to be an understandable psychological reaction to the distress and disability caused by the phobic anxiety, although in a few cases, depression seems to have occurred without such obvious cause (Mendel and Klein, 1969).

A mild element of depression may be added to the phobic symptoms when the patient finds himself weak and helpless and can not master his phobia (Nemiah, 1981-a).

From all of the above we can deduce that although some phobic patients can manifest mild element of depression, phobia and major depression are different diagnostic categories.

From our results we can notice that there was no significant difference between patients with phobias (Agoraphobia with and without panic attacks and social phobia) and the control groups (patients with major depression and anxiety) on Taylor's scale for anxiety.

Also there is no significant difference between patients with phobias and those with anxiety on Beck's questionnaire for depression.

These results are going along with many researchers. Emmel Kamp (1982) reported that there is conforming overlap between social phobia, agoraphobia and anxiety states. He added that the actual clinical diagnosis depends on the predominant features in a particular patient.

Roth, et al., (1972) reported that statistical inquiries confirm that mild phobic symptoms are common in anxiety states and no clear separation of anxiety and phobic states has been achieved by these methods.

Hallam (1978) concluded also that agoraphobia is not a central feature of a phobic syndrome, but rather a variable feature of patients with neurotic anxieties.

However, Mathews et al., (1981) in their discussion of this statement, stated that Hallam failed to take account of another criterion that has been employed (since the days of Kraepelin) in deciding whether a group of symptoms can be regarded as cohering together sufficiently to constitute a syndrome. The decision requires a study of the condition over many years and not merely an analysis of the information available at the time when the diagnosis is made.

Munby and Johnston (1980) followed agoraphobic patients for up to nine years and stated that whatever the relation of anxiety states and agoraphobia at the time of onset, it appears that once agoraphobia has developed, it remains the same condition.

The anxiety neurotics suffer from a general fear of dying rather than from fear a of a specific object. Their anxieties are of a free floating form, whereas the phobic's fears center on a specific object or group of related objects, and subside when the object is removed. This is why phobic patients carefully avoid the anxiety arousing object or situation (Marks, 1969).

On E. P. Q., our phobic patients reported high neuroticism and low extroversion which is conforment with the work of Marks (1969) who said that the psychological tests show a similar tendency between social phobia and agoraphobia to neuroticism and introversion.

We can then conclude that

(a) Phobias are a separate diagnostic entity.

(b) From the affective point of view they are nearer to anxiety but different from major depression.

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Une Comparaison entre les Troubles Phobiques, Dépressifs et Anxieux: Une Etude Psychométrique

74 patients phobiques, venant en consultation psychiatrique externe en Arabie Séoudite, et diagnostiqués selon le DSM III-R, ont fait l'objet d'une investigation concernant le profil de personnalité ainsi que la présence de symptômes anxieux ou dépressifs. Deux groupes controls, l'un portant le diagnostic de dépression majeur (n=18), l'autre d'anxiété généralisé (n=24), ont été également évaluer.Les résultats ont montré que les patients agoraphobes étaient plus agés que ceux atteint de phobie sociale et que dans ce dernier groupe la prédominance des hommes était marquée. Les implications de ces résultats sont discuttées.

مقارنه بين إضطرابات الرهاب، الاكتئاب والقلق دراسة قياسية نفسيه

أجريت هذه الدراسة على ٧٤ مريضاً باضطربات الرهاب والاكتئاب الجسيم والخوف، وقد أجريت القياسات النفسيه لتشمل مقياس للقلق ومقياس الإكتئاب ومقياس للشخصيه.

وقد أظهرت النتائج أن مرضى رهاب الأماكن المفتوحه مع نوبات الهلع أكبر سناً من مرضى الرهاب الاجتماعى، وقد زادت نسبه الذكور فى فئة الرهاب الاجتماعى عن الإناث، كما أن مرضى الرهاب كانوا أقل اكتئاباً من مرض الاكتئاب مما قد يشير إلى أن هاتين الفئتين التشخصيتين مختلفتين تركيباً، وتناقش الدراسه التطبيقات المختلفه للنتائج.