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Panic Disorders in Saudi Patients

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ABSTRACT

Panic attacks are defined as discrete episodes of apprehension or fear accompanied by at least four (from a list of eleven) symptoms of somatized anxiety such as dyspnoea, palpitation, chest pain and faintness. Panic disorder is defined as the occurrence of at least three panic attacks in three weeks in the absence of a life threatening situation or the coexistence of other psychiatric disorder.

The disorder usually invites costly work-ups and multiple consultations due to the wide range of highly variable symptoms typically found in panic disorder. In one series (Sheehan et al., 1980) all patients with panic disorder had previously consulted a physician, 70% had consulted more than 10 physicians and 95% had consulted a psychiatrist for relief. This article presents the prevalence of the condition at Al Jubail industrial City in Saudi Arabia as well as the various epidemiological and psychological factors related to it.

INTRODUCTION

Panic attacks are defined as discrete episodes of apprehension or fear accompanied by at least four (from a list of eleven) symptoms of somatized anxiety such as dyspnoea, palpitation, chest pain, and faintness. Panic disorder is defined by the occurrence of at least three panic attacks in three weeks in the absence of a life threatening situation or the coexistence of other psychiatric disorders.

The disorder usually invites costly work-ups and multiple consultations due to the wide range of highly variable symptoms typically found in panic disorder. In one series (Sheehan **et al.,** 1980), patients with panic disorder had previously consulted a physician, 70% had consulted more than 10 physicians and 95% had consulted a psychiatrist for relief.

This article presents the prevalence of the condition in Saudis at Al-Jubail industrial city as well as the various epidemiological and psychological factors related to it.

MATERIAL AND METHOD

All psychiatric records during the year 1982 were reviewed in this retrospective study for the symptoms that define the panic attacks. All the assessments were carried out by the same psychiatrist, using a structured interview. Patients were defined as having panic attacks if they experience discrete periods of apprehension or fear associated with at least four of the symptoms listed in table (1). Patients defined as such were then grouped according to age with demonstration of relative distribution in relation to sex. The frequency of occurrence of panic attacks, if any, and the duration of the illness were determined as well as the number of times the patient was seen in the last three months before being examined by the psychiatrist. Psychiatric diagnosis as well as the associated physical condition, if any, are also presented.

RESULTS

Among a total of 1032 cases referred to the psychiatrist during the period specified 47 cases fit the description of panic attacks. The disorder seems to be a disorder of adulthood as most of the cases were in the age group 20 – 40 years old. The disorder is commoner in Saudi males. The frequency of occurrence of each of the symptoms of panic attacks are listed in table (2). Cardiovascular symptoms (palipitation, chest pain or discomfort or choking sensation) are almost seen in every case. Fear of dying, "going crazy" or losing self-control

are also very common, though it is not associated with every case or reported by all the patients. Trembling is also common, and to a lesser extent sweating and dizziness or feeling unsteady. Eight cases had a history of illness more than three years, one of them actually for ten years or more. However, the majority of cases had a duration of one year or less. Over one third of our series were seen for these symptoms three times in the last three months before being seen by the psychiatrist.

The main precipitants are summarized in table (3). Exit phenomenon, pressures at work, marital and family problems are the main precipitants. No known precipitant was found in 18 cases.

Associated psychiatric conditions are shown in table (4). Three cut of the series had clear agoraphobic symptoms. Another developed car driving phobia as the first attack accompanied a car accident. These four cases had a duration of illness of three years or more. Seven of our cases have associated symptoms of depression with additional six cases associated with bereavement reaction. The physical conditions that associated or precipitated panic attacks are shown in table (5).

TABLE I

Symptoms of Panic Attacks

1	Dyspnoea
2	Palpitations
3	Chest Pain or discomfort
4	Choking or smothering sensations
5	Dizziness, vertigo or unsteady feelings
6	Feeling of unreality
7	Paresthesias
8	Hot and cold flushes
9	Sweating
10	Faintness
11	Trembling
12	Fear of dying, "going crazy" or losing self-control

TABLE II

The Frequency of the Symptoms of the Panic attacks.

	Symptoms	No.
1	Dyspnoea	40
2	Palpitations	45
3	Chest Pain or discomfort	46
4	Choking or smothering sensations	43
5	Dizziness, vertigo or unsteady feelings	23
6	Feeling of unreality	4
7	Paresthesias	4
8	Hot and cold flushes	7
9	Sweating	22
10	Faintness	20
11	Trembling	30
12	Fear of dying, going crazy or losing self-control	37

TABLE III

The Main Precipitant of the Attacks.

Precipitant	Frequency among Cases
Exit phenomenon	8
Pressures at work	6
Family or marital problems	5
External appearance	2
Car accident	1
Donation of blood	1
Major financial loss	2
Migration (internal or external)	2
Examination	1
Military service	2
Unknown	18

TABLE IV

Associated Psychiatric Conditions

Psychiatric Condition	No.
Depressive Neurosis	7
Bereavement Reaction	6
Agoraphobia	3
Other phobia	1

TABLE V

Associated Physical Conditions

Physical Condition	No.
Barlow's syndrome	1
Mitral incompetence	1
Hypertension	1
Asthmatic bronchitis	1
Irritable colon	1
Gastritis	1

DISCUSSION

Forty seven of all the patients referred to Al-Huwaylat hospital for psychiatric treatment in a year were having symptoms of panic attacks. These represent 4% of all referrals for psychiatric assessment in our out-patient clinic. The number of cases referred to other specialists (e.g. Cardiology and internal medicine) could probably increase that percent. Epidemiologically, our results are in full agreement with Snaith (1983); in considering panic attacks as a disease of late adolescence or early adulthood, however, over 70% of the patients in our series were males. This is surprising as the study of Hagnell (1966) as well as Sheehan **et al.** (1981) described 80% of those affected are women. It is possible that the male predominance in this industrial area may have contributed to that sex preference. It is also noticeable

that patients who develop panic symptoms have the least tendency towards somatization. Somatization and hysterionic behaviour in Saudi females may represent another way of channelling anxiety and tension and also tend to push them toward internal medicine clinics.

Panic disorder is not separated as a separate item in international classification of mental diseases.

The DSM-III excludes the presence of a physical illness or another mental disorder. It also indicates that the disorder is not associated with agoraphobia. This is difficult to understand as panic attacks are mentioned at other sites of DSM-III and in association with agoraphobia. The symptoms of panic attacks are difficult to differentiate from generalized anxiety disorder. Whether panic attacks represent a separate entity or is a part of a spectrum of anxiety disorders waits to be seen.

A disturbance of mood was seen clearly in seven of our series. An additional six patients with bereavement reaction showed a depressed mood. The relationship of panic attacks to mood disorder need further understanding. Early reporters drew attention to the chronic nature of the disorder (Sheehan et al., 1980); however, thirty one of the cases seen in our series developed the disorder recently (less than a year). The rest of our cases had a disorder for more than a year, and half of the latter group had the disorder for more than three years. The increased awareness by the psychiatrist of the condition might have increased the possibility of early diagnosis and management. It is noted in our study that the first panic attacks are precipitated by psychosocial stresses in twenty nine out of forty seven cases. Eighteen cases (38%) had no such a precipitant for the attacks. However, there is no essential difference in the clinical presentation between the two groups. There was no difference in our series in clinical picture among cases occurring alone or associated with a physical disorder (e.g. prolapsed mitral valve) or a psychiatric condition like depression or agoraphobia.

The panic disorder in all cases responded to the same treatment, though additional behavioural treatment was needed in patients with phobia. These results raise doubts over the value of the exclusive nature of the definitions of panic in DSM-III. Various hypotheses have been advocated including biological, behavioural, and developmental. Current research suggests that panic is a state of autonomic dysfunction in which an initial abnormal sympathetic response is followed by a parasympathetic reaction (Katerndahl, 1982). The sequence of symptoms observed in patients with panic attacks support this theory.

Kaplan (1979) believes that thyroid releasing hormone (TRH) acts centrally through the hypothalamus and limbic system to trigger similar autonomic response. The true aetiology of panic may be a combination of factors (Katerdahl, 1982). Lactate, for example, may be a stressful stimulus that triggers the autonomic response. On the other hand any fear will cause a certain degree of hyperventilation, which adds the symptoms of hypokalaemia to the syndrome. Although several different disorders are associated with panic attacks, the attacks are probably mediated similarly regardless of the disease producing it. This biochemical mechanism may well be an inborn response to a variety of stimuli. Individuals may therefore be biologically predisposed to respond to stressfull life events or endocrine alterations with the development of panic symptoms. Once this occurs even minor stress may elicit the pathologic panic response. The effect of various antidepressants in the management of panic disorder lend further support to the above hypothesis.

The importance of diagnosing panic attacks and disorder lies in the recent advances in its treatment. Until recently, the treatment for this condition was disappointing (Sheehan et al., 1980). Marks (1966) concentrated on the behavioural treatment of the avoidance behaviour habits that are late complications of the panic attacks. However, direct exposure and other behavioural treatment now appear to be

taking on a secondary role to medication (Sheehan **et al.,** 1981). Recent studies demonstrate that three classes of medication are effective for relieving panic attacks; namely the monoamine oxidase inhibitors "Phenelzine", the tricyclic antidepressants "imipramine and desipramine" and the tetracyclic agents "Maprotiline" (Gonzaler 1982; Sheehan **et al.,** 1980; Zitrin, 1978).

Finally, it is hoped that the increased physician awareness of the condition will result in the reduction of the crippling complications of panic disorder; namely avoidance reaction and phobia. It is also hoped that recently introduced medication will increase our capability of successful treatment.

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الموجـــــــز

اضطراب الفزع عند المرضى السعوديين

تعرف نوبات الرعب بأنها نوبات محددة من الفزع أو الخوف مصحوبة باربعة أعراض على الأقل (من قائمة بها احدى عشر عرضا) للقلق الجسمانى كصعوبة التنفس والنبض المسموع وآلام الصدر والاغماء . ويجب لتشخيص اضطراب الفزع أن تحدث ثلاث نوبات فى ثلاث أسابيع دون وجود موقف مهدد فى الحياة وفى غياب اضطراب نفسى آخر .

ويتطلب هذا الاضطراب استشارات متعددة وتقييما مكلفا بسبب المدى الواسع لأغراضه المتعددة . وفى احدى الدراسات (شـــيهان وآخرون ، ١٩٨٢) كان جميع المرضى قد استشاروا طبيبا واستشار ٧٠٪ منهم اكثر من عشرة أطباء ولجأ ٩٥٪ منهم الى طبيب نفسى .

ويعرض المقال انتشار هذا الاضطراب فى مدينة جوبيل الصناعية فى المملكة العربيـــة الســـعودية وكذلك العوامل البيئية والســـيكولوجية المرتبطة به .

ABSTRAIT

Les Troubles de Panique Chez les Patients Seoudiens.

Les attaques de panique sont definies par des épisodes discrètes d'appréhension ou de peur accompagnée de 4 au moin (d'une liste de

cnze) symptomes d'anxiété somatisée comme la dyspné, les palpitations, les douleurs de poitrine, les évanouissements.

Les troubles de paniques sont définis par l'occurence d'au moin 3 attaques en 3 semaines, en l'abscence de situation endangerant la vie ou d'autre troubles psychiatriques.

Ces troubles sont souvent la cause de multiples consultations, et de beaucoup de dépense, et ceci est due à la grande variabilité des symptomes appartenant typiquement aux troubles de panique.

Dans une serie (Sheehan et al., 1980) tous les patients de troubles de panique avaient consulté un médecin, 70% avaient consulté plus de 10 médecins, et 95% avaient consulté un psychiatre pour le traitement.

Cet article montre la prévalence de cette condition dans la cité industrielle à Jubail, en Arabie Seoudite, ainsi que les facteurs épidemiologiques et psychologiques ayant rapport à elle.