Panic Disorder: Personality Profile and Comorbidity in a Sample of Egyptian Patients

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Abstract:

Panic disorder with or without agoraphobia is a common mental disorder, with severe handicapping consequences. Etiology is not exactly known. The objective of this work is to probe the etiology or more accurately the early psychopathology of persons with panic disorder (P.D). The Method: of this work was to study thirty patients with (P.D),.collected from psychiatric out patient clinic in general hospital and thirty normal individuals matched with the first group as regards gender, age and social class. Comparison was done as regards their personality traits and mental symptoms psychometrically and other clinical relevant data. Our results: revealed that PD patients have more prevalent family history of PD and other mental disorders. Also they have more early separation anxiety disorder and more losses during their early life and more life events prior to their onset of PD. Traits of avoidant personality disorder and dependant personality disorder were also evident in PD group. Results: were discussed with their implication on treatment of PD.

Introduction:

Panic attack is defined as severe fear or discomfort associated with at least four somatic or cognitive symptoms indicating the intense unexpected fear (DSM-IV).Agoraphobia is the most consequent of panic disorder, hence the classification of panic disorder with agoraphobia and panic disorder without agoraphobia **(Shear 1993& Kesler et al, 2006).**

Lifetime prevalence of panic disorder is 1.5 to 5%. Women are 2 to 3 times more likely to be affected than man **(Kesler et al, 2006).**

Comorbidity is nearly a rule in panic disorder, ninety one percent of patients with panic disorder and 84 percent with agoraphobia have at least one other psychiatric disorder common conditions are major depressive disorder, other anxiety disorders; personality disorders and substance abuse disorder **(Facett 1992, Keller and Hanks 1993, Kaplan and Sadock, 1998).** Comorbidity increases the rate of seeking medical help and increases the consumption of medication especially when panic disorder is associated with depression or social phobia **(Maggee et al, 1996).** As regards the etiology of panic disorder it is still obscure; research in the biological basis of panic disorder has produced a range of findings. Most of these researches has taken place in the area of using biological stimulants to induce panic attacks in patients with panic disorder. The autonomic nervous system of some patients have reported to exhibit increased sympathetic tone to respond excessively to moderate stimuli. However these studies have been inconsistent in their findings. The major neurotransmitter systems that have been implicated are those for norepinephrine, serotonin and GABA. The totality of the biological data has led to focuses on the brain stem particularly the nor adrenergic neurons of the locus ceruleas and the serotonergic neurons of the median

raphe nucleus (**Johnson et al, 1995 & Spiegel and Bruce, 1997).**

On the other hand, there were many studies of psychodynamic and personality structure of panic patients searching for etiology of this obscure disorder, the success of the cognitive behavior therapy to the panic disorder give support to these theories. Behavioral theories gave a model of learned response or classical conditioning. A linkage between the sensation of minor somatic symptoms such as palpitation and the generation of panic attack can be reinforced repeatedly to induce panic disorder. Although panic attacks are correlated neurophysiolgically with the locus ceruleas, the onset is generally related to environmental or psychological factors. Patients with panic disorder have higher life incidents of life events particularly loses compared with control subjects. Separation anxiety early in life in patients with panic disorder was reported in many studies **(Kenady et al, 1992).** Little research was done as regards personality profile of patients with panic disorder that in our opinion may contribute to at least their high response to mild stimuli by panic attacks, that is why in this study we focuses on this point.

Objective of the Study:

- Estimation of the comorbid disorders in a sample of Egyptian patients with panic disorder (PD).
- The study of personality profile of this group of panic disorder.

Subjects and Methods:

Thirty patients with panic disorder with and without agoraphobia from psychiatry clinic in general hospital in Cairo. Both sexes were included.

At the same time 30 persons who are volunteers with no medical or mental disorders and matched with both age and sex were recruited in this study.

A – Patient Group: (group 1)

All patients were diagnosed according to DSM-IV criteria twenty of them were diagnosed as panic disorder with agoraphobia and ten without agoraphobia. Age range was between 18 & 30 years, they were of low to middle social class and different educational level.

B – Control Group (Group II)

All persons were seen by two psychiatrists to exclude any mental disorders and also asked and examined physically to exclude any physical disorder. Age, sex, socioeconomic and educational levels were selected to match with patients group.

Methods :

1. Both groups were subjected to the following :
2. Detailed psychiatric assessment .
3. Complete medical examination.

Interview by two senior psychiatrists.
To diagnose the comorbid disorders using the DSM-IV criteria.
4- Beck Depression inventory **(Beck 1988).**

5- Social anxiety scale **(Mattick &Clarke 1989).**

6- Structured Clinical Interview for diagnosis adult personality disorders **(SCID II) Spitzer etal (1990).** This test evaluates adult personality disorders. The items are answered as Yes or No: Yes indicates presence of the personality trait and No means absence of the trait. According to the diagnostic index of the summary score sheet which indicates the extent to which trait of personality disorders have been met .

Statistical analysis of the results of the two groups were done to find any significant difference between both grousp.

Results:

Our results showed that both groups are matched as regards gender, age, marital status and occupation (Table 1), (Table 2) showed that family history of mental disorders, PD. Past history of other mental disorder and early life events of early losses in patient's life were also significant in patient group. Table (3) showed that patient's group have significant scores on Beck Depression scale, social interactions scale and suicidal ideation scale. SCID II inventory showed in (table 4) that patient group have higher scores on avoidant personality and dependant personality. Associated mental disorders were more frequent in patient's group as shown in (table 5).

Table (1):Sociodemographic data of both groups

	Patient group N= 30	Control group N= 30	P
Gender			
Female	12	11	NS
Male	18	19	
Age (means ± SD)	22.3 ± 3.9	24.7 ± 5.5	NS
Marital Statues			
Married	5	7	NS
Single	24	23	
Divorced	1	-	
Occupation			
Professionals	5	6	NS
Unemployed	5	6	
Skilled Worked	15	13	
Students	5	5	

Table (2): Significant clinical data of both groups

	Patient group N= 30	Control group N= 30	P
Family history of significant mental disorder	8 = 26.6%	2 = 6.6%	0.01*
Family History of PD	4 = 13.3%	0 = 0 %	0.001*
Past History of Other Mental Disorder	5 = 16.6%	0 = 0 %	0.001*
Early loss of Parent	7 = 23.3%	2 = 6.6 %	0.001*
Significant Life Event Prior to Illness	10 = 33.3	0 = 0%	0.001*

*** Statistically significant**

Table (3): Beck Depression Inventory and Social Interaction Anxiety Scale and Suicidal Ideation

	Patient group	Control group	P
	Mean ± SD	Mean ± SD	
Beck Depression Scale	15.2 ± 5.2	7.8 ± 5.1	0.001*
Social Interaction Anxiety Scale	45.1 ± 14	17.2 ± 9	0.001*
Suicidal Ideation (N)	18 = 60 %	0 = 0%	0.001*

*** Statistically significant**

Table (4): Estimation of Number of Patients and Normal Having High Personality Disorder Traits on SCID II

	Patient group N= 30		Control group N = 30		P
	No	%	No	%	
Avoidant Personality	8	26.6	2	0.6	0.01*
Dependent Personality	22	73.3	3	10	0.001*
Obsessive Personality	1	3.3	4	13.3	0.05>
Passive Aggressive P	2	6.6	1	3.3	0.05>
Paranoid P	1	3.3	1	3.3	0.05>
Schizotypal P	0	0	0	0	0.05>
Schizoid P	0	0	1	3.3	0.05>
Histrionic P	1	3.3	2	6.6	0.05>
Narcissistic P	0	0	0	0	0.05>
Borderline P	1	3.3	0	0	0.05>
Antisocial P	0	0	0	0	0.05>

*** Statistically significant**

Table (5): Estimation of diagnosable associated clinical disorders in patient's group

	No	%
Substance Abuse Disorder	20	66.6
Major Depressive Episode	8	26.6
Dysthymia	17	56.6
Social Phobia	10	33.3
Simple Phobia	2	0.06
Schizophrenia	1	0.03
Other Psychotic Disorder	1	0.03

Discussion

Our study was interested in the probing of the lives of panic disordered patients as represented by their personality profile. This was based on the early psychodynamic theory that adopt the pathology of PD as a result of early life experiences and conflicts that later on result in abnormal personality structure vulnerable to PD **(Kleiner & Marshal, 1987, Bush et al, 1991 & Bush et al, 1995)).**

Our study revealed that both avoidant and dependant personality disorders were the most common personality disorders in the group of PD patients. This is in agreement with the psychodynamic formulation that suggest that individuals prone to PD have a fearful dependency on significant others which is derived from a biochemical vulnerability or traumatic and or ambivalent relationships with early care givers that broadly affects their psychological functioning **(Kagan et al, 1990).**

They have a sense of inadequacy and their attachment feeling of insecure. They feel they must depend on others to provide a sense of safety leading to sedation to be experienced. Many patients with panic disorder dread becoming angry at people they love and are frightened that their anger will damage these relationships. A vicious circle of fearful dependency anger and anxiety can develop often triggered by stressors such as interpersonal loss **(Milord et al, 2004).** Accordingly this is consistent for the treatment of PD with techniques based on psychodynamic psychotherapy with its different techniques and also the combinations of these techniques with the well known psychopharmacological measures. Similarly techniques based on cognitive and behavior therapy could benefit from these results. Treatment of complications or consequence as of PD is very important. Our results showed that they are high, so they will find the treatment of PD and quality of life of patient, so the treatment should be comprehensive including PD associated drug substance abuse for example and should tackle these points from both psychodynamics, other psychotherapeutic and psychopharmacological theories.

References

American psychiatric Association (1994): Bock. AT. And Garbin M G. (1988) Psychometric proper ties of the Beck depression Tnertory: twenty five yeas of evaluation clinical. Psychology review 8/77.- 1000

Bush FN, Cooper, AM, Klerman, GL (1991): Neurophysiological, cognitive behavioral and psychoanalytic approaches to panic disorder: toward an integration psychoanalytic inquiry . 11:316-32

Bush, FN, Shear, MR. Cooper, AM (1995): An Empirical study of defense mechanisms in panic disorder. J.Nerv,Men Dis.183 :299-303.

Diagnostic and statistical manual of mental disorders 4th editions Washington Dc: American Psychiatric Association

Fawcett. J. (1992): Suicide risk factors in depressive disorder and panic disorder. J. cling psychiatry 53 (Supp) : 9

Johnson J MR, Lydiard R B, and Ballenger, J C. (1995): Panic disorder pathophysiolgy and drug treatment 49: . 329

Johnson J. MR., Lydird RB. BallengerJC. (1995): Panic Disorder: Pathophysiology and drug Treatment, 49:329

Kagan, J, Reznick JS, Snidman N (1990): Organisms of panic disorder in Ballenger J(ed). Neurobiology of panic disorder. Willey New York.

Keller, MB., Hanks Dl. (1993). Life time Prevalence of panic disorder, Neuropsychopharmacology. Biol. psychiatry , 17. 551

Kenday, J. Fried, L., Kramer HC., Taylor, CB. (1992): Psychological precursor of panic attacks. B.J of psychiatry : , 160 : 668

Kennedy J Fried, l Kramer HC Taylor, C. B. (1992): Psychological precursors panic attacks B J psychology

Kessler, RC., Waltot Chiu, AM,et al (2006): The epidemiology of panic attacks, panic disorder and agoraphobia in the national comorbidity survey replication.

Kleiner L and Marshall WL. (1987): The role of interpersonal problems in the development of agoraphobia with panic attacks. J. Anxiety disorder 1 : 313-23

Maggee, W.J., Eaton, W.W., Witchen, McGonag, et al (1996): Agoraphobia, simple phobia, social phobia in national comorbidity survey, Arch, Gen. Psychiatry 53 :159.

Milrod, B. Leon, A.C., Shear, M.K. (2004): Can interpersonal loss precipitate panic disorder? Am.J. psychiatry, 161:758-59

Myrick , H. and Brady. K. (2003) Editorial review: Current review of the comorbidity of affective anxiety and substance use disorders.

Shear, MK. (1993): Panic disorder with and without agoraphobia eds.) Psychiatry Senders Philadelphia .

Spiegel. DA. Brace T.T., (1997): Benzodiazepines and exposure based cognitive behaviour therapies for panic disorder conclusions from comorbid trials A M J. Psychiatry 154 , 773

Spiegel. DA Brace T.J. (1987): Benzodiazepines and Exposure Based Cognitive Behaviour Therapeutic for Panic Disorder . Conlusion from comorbid trails .Am.J. Psychiatry , 154, 773

Spitzer , R.L Williams, J. B ; First M. B (1990): Starred clinical interview for DSM TTT . Personality Disorders (SCID) TT Version 10 Washington American Psychiatric Press

Watanabe N., Churchill, R., and Furukama, TA. (2002): combination of psychotherapy and benzodiazepines versus either therapy alone no panic disorder "a systematic review"

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