THE DIAGNOSTIC VALIDITY OF PANIC DISORDER, ANXIETY, DEPRESSION, OR A SEPARATE ENTITY

Thesis
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بسم الله الرحمن الرحيم

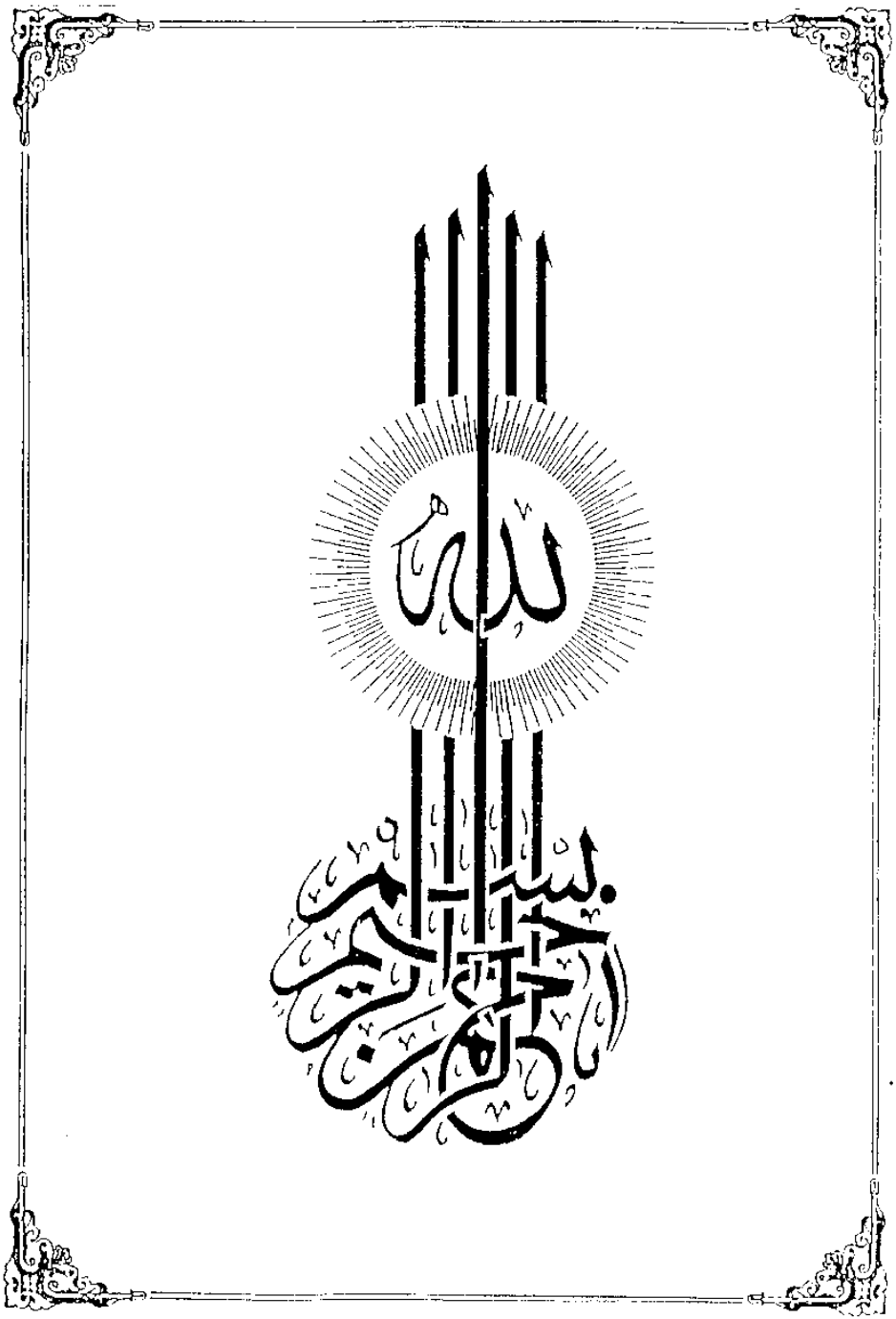
إن الإنسان خلق هلوعا. إذا مسه الشر جزوعا

وإذا مسه الخير منوعا

صدق الله العظيم

سورة المعارج

(آية ١٨، ١٩، ٢٠)



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CONTENTS

INTRODUCTION

INTRODUCTION

Panic disorder is a relatively new diagnostic entity, which previously was included in the broader category of anxiety states. In the last 10 years, the diagnosis has been in wide use, because it is included as a separate disorder in the ICD9 and DSM III.

Patients who are presented with DSM IIIR diagnosis of panic disorder often show a complex mixture of psychopathological symptoms, including panic attacks (spontaneous and situational), anxiety (anticipatory and generalized), phobias (fear and avoidance), depression, dysphoria, and social disability. The casual links among these symptoms remain elusive. Various theories about the pathogenesis of these symtpoms have been advanced to focus on a given symptom being primary, with concurrent symptoms seen as epiphenomena or as secondary or reactive.

Studies of patients suffering from panic attacks have found a high prevalence of depressive symptoms, severe enough to qualify for a secondary diagnosis of depression, while secondary anxiety and panic have been found to occur in a comparable percentage of depressed patients (Deltito et al., 1991).

Although in DSM III panic disorder is classified as one of anxiety disorders, many studies suggest that panic disorder is frequently and systematically associated with major depression. When the longitudinal course of these disorders is examined, a particularly strong relationship between panic and depression emerges. Studies of life-time occurrence of the two conditions shows that they may occur together during the index episode, or they may appear at different times (Brier et al., 1984).

The finding that some antidepressant medications are effective in the treatment of panic attacks has led to speculation regarding the relationship between panic and depression are varients of a single disorder (Johnston et al., 1980), while others have rejected the unitary view point because of the studies supporting a diagnostic distinction between these two disorders (Montjoy and Roth, 1982).

Panic attacks remain to be a focus of controversy.

REVIEW OF LITERATURE

HISTORICAL OVERVIEW

Panic attacks have traditionally been considered as part of the neurotic anxiety syndrome, a conception which dates back to early description of Freud over 90 years ago (Gelder, 1986). Freud description of the symptoms of an anxiety (or, as it is now usually known, panic) attack is closely similar to that incorporated in the current American diagnostic systems DSM III and DSM IIIR (American psychiatric association, 1980 and 1987).

In 1894, Freud described a syndrome of morbid anxiety with anxious expectation as its nuclear symptom and termed it "anxiety neurosis". As described by Freud, anxiety neurosis subsumed two different forms of anxiety: chronic anxiety and anxiety attacks. He said that anxiety neurosis is a chronic form of generalized or free-floating anxiety that could coexist or occur independently from a pattern of anxiety attacks, "which could erupt suddenly into consciousness without being called forth by any train of thought". The mental symptoms of anxiety attacks were well described by Freud, who drew attention to the interplay of two kinds of disturbance. "An anxiety attack may consist of a feeling of anxiety alone, without any associated ideas, or accompanied by the interpretation that is nearest to hand such as ideas of the extinction of life, or a stroke, or the threat of madness, or the feeling of anxiety may have linked to it a disturbance of one or

more of the bodily functions - such as respiration, heart action, vasomotor innervation or glandular activity. From this combination the patient picks out in particular now one, now another factor. He complains of "spasms of the heart", "Difficulty in breathing", outbreaks of "sweating", and such like; and in his description, "the feeling of anxiety often recedes into the background." (Freud, 1894). Freud's description of anxiety neurosis remained essentially unchanged for many years and was incorporated in major medical and psychiatric nosological systems.

A parallel historical development of a syndrome consisting of both chronic anxiety and panic attacks began in 1871 with Da Costa's description of "irritable heart syndrome" (Da Costa, 1871). This syndrome was subsequently assigned several names, including "effort syndrome", "Da Costa's syndrome", "Soldier's heart", "Cardiac neurosis", and "neurocirculatory asthenia" (Wheeler et al., 1950). These disorders were the forerunners of the "anxiety neurosis" described by Feighner and associates (1972), which was marked by "chronic nervousness with recurrent anxiety attacks".

Over years, most psychiatrists shared Freud and Da Costa this view of panic attacks. In the early 1960s it was discovered that panic attacks could be successfully treated with antidepressant medications. These agents produced a remission of panic symptoms before any remission of the

generalized anxiety symptoms (Klein, 1964). This discovery indicated that panic anxiety might represent a disorder distinct from generalized anxiety. DSM III adopted this distinction and included two separate disorders in place of anxiety neurosis : panic disorder and generalized anxiety disorder, and thus, panic disorder considered as a distinct diagnostic entity. However, Kaplan (1979) claims to have invented the term panic disorder (Holemberg, 1987).

EPIDEMIOLOGY

Prevalence of Panic Disorder

Panic disorder is a relatively new diagnosis, and epidemiologic research focused on it has until yet been scant. Lehtinen (1989), considered that existing information about occurrence of panic disorder is ambiguous, with approximate assessment he found that for real panic disorder, the point prevalence could be about 5 per 1000, the six months period prevalence about 10 per 1000 and the life-time prevalence perhaps 20-30 per 1000. Robins et al. (1984), studied the life time prevalence of anxiety disorders, they found it to be at least 10-20%, among these panic disorder constitute 3-8%/ Von Korff et al. (1985), reported that at least 3% of the population had had at least one panic attack during the previous six months, and at least 10% had experienced a panic attack sometimes in their lives.

Prevalence according to age:

The prevalence of panic disorder seems to be smaller in older age groups than in younger persons. Von Korff et al. (1985), in their study showed highest prevalence of panic disorder in the age group of 25-44 years, and a very low prevalence among persons over 65 years of age. They also showed that the disorder usually begins in the age group of 10-29 years. Studies of the age of onset of various anxiety

syndromes present a varied picture with significant differences between simple and social phobias on one hand, and agoraphobia and panic disorder on the other. Simple and social phobias have an earlier age of onset, the incidence being at a maximum in childhood or adolescence, and very low later in life. Agoraphobia and panic disorder show unimodal distribution, the maximum being between 15 and 35 years of age and the average age of onset 26-27 years (Thyer and Parrish, 1985). Both earlier and later onset panic disorder can occur. In a sample of 136 psychiatrically hospitalized children, panic disorder was identified in four boys and three girls. Six had separation anxiety, and four had depressive disorder (Alessi and Magen, 1988).

Prevalence according to sex, marital status and other socio-demographic factors:

National Institute of Mental Health (NIMH) in the U.S.A. are running a project called the epidemiologic catchment area program. Three citites in the U.S.A. have reported their prevalence data (Myer et al., 1984) and (Robins et al., 1984), studies using similar methods have also been conducted in Zurich (Angst and Dobler, 1985), Munich (Wittchen, 1986) and Kangwha Island, Korea (Min and Lee, 1986). The 6-month prevalence of panic disorder varies between 0.6 and 1.5%. Demographic data show a uniform over-presentation of women, and also divorced and separated persons, while there