

Depersonalization in Panic Disorder: A Clinical Study

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Panic disorder (PD) has been hypothesized to be a heterogeneous entity, with distinct clinical subgroups. The presence of depersonalization during panic attacks may distinguish a specific subgroup of PD. We sought to analyze the differential features of a subgroup of PD patients with depersonalization. A total of 274 patients with PD were assessed and divided into 2 groups according to the presence or absence of depersonalization. The Structured Clinical Interview for DSM-III-R (SCID-UP-R) was used to assess PD and comorbid disorders. The clinical scales administered included the Hamilton Anxiety and Depression Rating Scale (HARS and HDRS), the Marks and Mathews Fears and Phobia Scale, Panic-Associated Symptom

Scale (PASS), and a panic attack symptoms inventory. A total of 66 patients (24.1%) exhibited depersonalization during the attacks. Patients with depersonalization appeared to be younger and had an earlier age at onset. PD was more severe in the depersonalization group (greater number of attacks, worse level of functioning, and higher scores on most self-rating scales). Also, depersonalization patients showed more comorbidity with specific phobia. Our results support the view that PD with depersonalization may be considered a distinct and more severe subcategory of PD.

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MORE THAN 30 years after Klein's description¹ of panic disorder (PD), it has been suggested that PD may be a heterogeneous entity with the coexistence of various clinical subgroups.²⁻⁵ Several authors have favored a possible typification of PD based on the predominant symptoms. Thus, some have differentiated among PD with cardiorespiratory symptoms,⁶ vestibular symptoms,⁷ gastrointestinal symptoms,⁶⁻⁸ and depersonalization/derealization.⁹

Roth¹⁰ formulated the "phobic anxiety–depersonalization syndrome," which may be regarded as a special subtype of PD where depersonalization is the most prominent feature. Depersonalization is a common symptom of panic attacks.¹¹ Its frequency during panic attacks has been documented to vary from 7.7% to 69% of patients with PD.¹¹⁻²⁰ Cassano et al.⁹ reported that their depersonalization subgroup corresponded to more severe forms of PD, with an earlier age at onset, more avoidance behavior and agoraphobia, and a higher rate of comorbidity with other psychiatric disorders—such as obsessive-compulsive disorder (OCD) and generalized anxiety disorder (GAD).

In the present study, we sought to determine the differential characteristics of 2 subgroups of a

sample of 274 patients with PD on the basis of the presence or absence of depersonalization during the attacks. A comparative analysis between the 2 groups (depersonalization group and non-depersonalization group) was conducted.

METHOD

Subjects

The study sample was a series of 274 patients over 16 years old, both men and women, with PD. All subjects were outpatients of the Department of Psychiatry at La Alianza General Hospital, and they were consecutively selected as they were referred from either the emergency room or other medical departments. This center is part of the area's most important health management organization. The study lasted 4 years, beginning with the creation of this unit (March 1, 1991 to February 28, 1995). Of 3,206 patients examined at the unit during the assessment period, 8.5% (274) presented with PD. Of this sample, 76.4% were women. Their mean age at the time of the interview was 44.1 years (range, 16 to 77). Single people constituted 20.8% of the group, while 69.0% were married, 3.3% were separated or divorced, and 6.9% were widowed. The mean age at onset of PD was 35.9 years (range, 10 to 76) and the duration of PD was 8.2 years (range, 0.1 to 57.9). Subjects were excluded from the study if PD was clearly secondary to another medical pathology or associated with organic brain disorders by DSM-III-R criteria. In patients over 60, a final diagnosis was delayed until other medical causes could be ruled out. Thyroid tests were performed on all patients, as well as an ECG, a chest x-ray, and a neurological examination.

Procedure

The clinical assessment was conducted by 2 experienced interviewers, a psychiatrist (J.S.) or a clinical psychologist (J.C.), following DSM-III-R criteria.²¹ The Structured Clinical Interview for DSM-III-R, Upjohn Version Revised (SCID-UP-R) was used for axis I diagnoses.²² Patients were interviewed and assessed at their initial presentation of PD or upon recurrence of panic attacks after asymptomatic periods. At presentation, all patients were suffering from panic attacks.

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They were referred by other medical specialists or from the hospital's emergency room, with a total of 90.7% of subjects having had a previous medical consultation. Most were not under a specific treatment for the PD, and 67.6% had received benzodiazepines as the initial medication. A total of 40.7% of the patients had a prior psychiatric consultation at any time. The presence of comorbid psychiatric disorder was also studied using DSM-III-R criteria. Owing to the reduced number of patients within some diagnostic categories, diagnostic groups were formed for drug dependencies (including alcoholism and other drug dependence) and eating disorders (including anorexia and bulimia nervosa). For the same reason, the diagnoses of schizophrenia (1 case), bipolar disorder (4 cases), and somatization disorder also were not included as comorbid disorders. Diagnostic reliability was checked by 2 independent evaluators in a group of 30 patients, obtaining a κ coefficient of .8 for axis I diagnoses.

The Family History-Research Diagnostic Criteria (FH-RDC) interview²³ in the Spanish version was used to assess the family history.²⁴ Patients or their first-degree relatives were the source of information for assessing psychiatric family histories. As the FH-RDC interview does not include anxiety disorders, an open question on the PD family history was added. To assess the severity of PD, the clinical evaluation at the first visit included the Hamilton Anxiety and Depression Rating Scales (HARS and HDRS),²⁵⁻²⁶ Global Assessment of Functioning Scale (GAF),²¹ Marks and Mathews Fears and Phobia Scale,²⁷ and Panic-Associated Symptom Scale (PASS).²⁸ This latter questionnaire contains 5 subscales that assess situational panic attacks, unexpected panic attacks, limited panic attacks, anticipatory anxiety, and phobias.

In addition, we used a 14-item Inventory of Panic Attack Symptoms (ISAP) based on DSM-III-R symptoms. This self-administered inventory uses a 4-point Likert scale to assess the severity of symptoms (0 = nonexistent; 1 = mild; 2 = moderate; and 3 = severe).²⁹ Patients over 60 years of age (or under 60 whenever cognitive deterioration was suspected) also completed the Spanish version³⁰ of the Mini-Mental State Examination.³¹

Depersonalization was considered to be present when it was a symptom of the panic attack only in the current presentation (not lifetime). Patients did not have a depersonalization syndrome apart from the attacks, and the main causes of depersonalization were ruled out (other psychiatric disorders or disorders due to medical condition or substance use). When an "organic" etiology was suspected, an electroencephalogram and an examination by a neurologist were performed. Assessment of depersonalization was made using the depersonalization item of the SCID, with the DSM-III-R definition. It should be noted that depersonalization was the most prominent panic attack symptom reported by most patients when it was present. In addition, we used the ISAP scale to rate the severity of depersonalization.

The research protocol was approved by the Alianza Hospital Ethics Committee. Written consent to participate in the study was obtained from the subjects after they were thoroughly informed about the research details.

Data Analysis

Patients with PD were divided into 2 groups according to the presence of depersonalization. Student's *t* test for continuous variables and a chi-square test (χ^2) for categorical variables (with Yates' correction or Fisher's exact test when necessary)

were used, and differences were considered significant at a *P* level less than .05. The odds ratio (OR) was obtained by logistic regression analysis with a confidence interval (CI) of 95%. Data analyses were performed with the SPSS software package.³²

RESULTS

The most common symptoms reported by the 274 patients were palpitations (85.0%), shortness of breath (72.6%), fear of dying (65.7%), dizziness (62.8%), trembling (56.6%), chest pain (56.2%), faintness (53.6%), sweating (51.8%), paresthesias or tingling sensation (48.9%), and hot flushes (46.0%). Only 66 patients (24.1%) reported depersonalization.

The depersonalization group was significantly younger ($P < .001$). Both groups were similar by gender. The age at PD onset was lower in the depersonalization group. With respect to the duration of illness, family history of psychiatric disorders, and number of consultations with the general practitioner or the psychiatrist, no differences were found between the groups (Table 1).

Overall, patients with depersonalization panic attacks displayed a more severe disorder than patients without depersonalization (Table 2). The number of attacks over the past month was higher in depersonalization patients. In this group of patients, scores were significantly higher on the HARS and HDRS, and on the blood phobia and agoraphobia subscales of the Marks-Mathews scale. Likewise, anticipatory anxiety, agoraphobia, and spontaneous, situational, and limited panic attacks

Table 1. Sociodemographic Characteristics, Family History, and Other Data in the Two PD Patient Groups

Parameter	Non-Depersonalization (n = 208)	Depersonalization (n = 66)	Significance
Female (n)	164 (75.2%)	54 (24.8%)	
Current age (yr)*	45.3 ± 16.2	40.5 ± 12.8	<i>t</i> = 2.5, <i>P</i> < .05
Educational level (yr)*	8.7 ± 3.5	9.4 ± 3.3	
Age at panic onset (yr)*	37.4 ± 15.3	31.2 ± 12.4	<i>t</i> = 3.4, <i>P</i> < .001
Course (yr)*	7.8 ± 9.3	10.7 ± 10.6	
Family history (n)			
Alcoholism	17 (8.2%)	7 (7.6%)	
Depression	40 (19.2%)	18 (27.3%)	
Schizophrenia	3 (1.4%)	0 (0.0%)	
PD	40 (19.2%)	18 (27.3%)	
Medical visits (n)	191 (91.8%)	59 (89.4%)	
Psychiatric visits (n)	76 (36.5%)	31 (47.0%)	

*Mean ± SD.

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