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Somatic panic-attack equivalents in a community sample of Rwandan widows who survived the 1994 genocide

Athanase Hagengimana, Devon Hinton*, Bruce Bird, Mark Pollack, Roger K. Pitman

Department of Psychiatry, Harvard Medical School, Massachusetts General Hospital, Boston, MA, USA

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Abstract

The present study is the first to attempt to determine rates of panic attacks, especially 'somatically focused' panic attacks, panic disorder, symptoms of post-traumatic stress disorder (PTSD), and depression levels in a population of Rwandans traumatized by the 1994 genocide. The following measures were utilized: the Rwandan Panic-Disorder Survey (RPDS); the Beck Depression Inventory (BDI); the Harvard Trauma Questionnaire (HTQ); and the PTSD Checklist (PCL). Forty of 100 Rwandan widows suffered somatically focused panic attacks during the previous 4 weeks. Thirty-five (87%) of those having panic attacks suffered panic disorder, making the rate of panic disorder for the entire sample 35%. Rwandan widows with panic attacks had greater psychopathology on all measures. Somatically focused panic-attack subtypes seem to constitute a key response to trauma in the Rwandan population. Future studies of traumatized non-Western populations should carefully assess not only somatoform disorder but also somatically focused panic attacks.

Keywords: Panic disorder; Stress disorders, post-traumatic; Depression; Rwanda; Holocaust

1. Introduction

> …But the fact is that most of the massacres were carried out using more basic weapons: machetes, knives, axes, hoes, hammers, spears, bludgeons or clubs studded with nails (known as *ntampongano* or 'without pity'). I don't need to dwell on the horror of these deaths, the frightful noise of skulls being smashed in, the sound of bodies falling on top of each other. Every Rwandan still has these sounds etched in their memory, and will for a long time: the screams of people being killed, the groans of the dying and, perhaps worst of all, the unbearable silence of death which still hangs over the mass graves [Sibomana, 1999].

Rwandans endured one of the worst genocides of the 20th century. In 100 days in 1994, almost one million people perished, one seventh of the country's population (Keane, 1995; Taylor, 1999). Tutsi were slaughtered, raped, terrorized and maimed by the Hutu majority (Gourevitch, 1998; Keane, 1995; Sibomana, 1999). Death occurred by decapitation, clubbing, starvation and drowning, among other methods. Then, after the war and subsequent displacement to the camps, large num-

*Corresponding author. Revere Counseling Center, 265 Beach Street, Revere, MA 02151, USA. Tel.: +1-617-738-9055; fax: +1-781-286-5636.
E-mail address: devon_hinton@hms.harvard.edu (D. Hinton).

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bers of people died of illness; for instance, 50 000 Rwandans died of cholera and exhaustion in a 2-week period while many suffered starvation (Sibomana, 1999). To this day, Hutus and Tutsis remain in a state of hypervigilance and trepidation, keenly aware that genocidal hostilities between the two ethnic groups might occur again.

Given the degree of trauma experienced by the Rwandan population, surprisingly few studies have assessed levels of psychopathology. One investigation of children and adolescents (Dyregrov et al., 2000) documented an extreme degree of traumatic exposure, with 79% of those surveyed scoring over 17 on the Impact of Event Scale (Horowitz et al., 1979), suggestive of post-traumatic stress disorder (PTSD). The General Health Questionnaire (Goldberg and Williams, 1988) scores of Rwandan adults surveyed in a refugee camp suggested that 50% suffered severe mental disorder (de Jong et al., 2000).

Several recent investigations emphasize the importance of recognizing panic disorder in trauma victims (Falsetti et al., 1995; Falsetti and Ballenger, 1998; Falsetti and Resnick, 1997; Hinton et al., 2000, 2001a). Dr Hagengimana, who is one of only two psychiatrists in Rwanda, has observed that the Rwandan reaction to trauma is often somatic and not infrequently involves panic symptoms. Even when a Rwandan has an attack that is triggered by a trauma cue or accompanied by a flashback, often the main focus of concern is acute bodily dysfunction. Just as somatoform disorder is prevalent among certain cultural groups in response to trauma (Escobar et al., 1992), unique, somatically focused panic attacks also appear to occur with frequency. *Ataques de nervios* in Hispanic populations, often constituting panic attacks, would seem to be one example (Guarnaccia, 1993; Guarnaccia et al., 1996; Guarnaccia and Rogler, 1999; Norris et al., 2001). A study of Khmer refugees demonstrated that headache-, dizziness- and gastrointestinal-focused panic attacks occurred frequently (Hinton et al., 2000). Another study documented high rates of dizziness- and headache-focused panic attacks among Vietnamese refugees (Hinton et al., 2001a).

The present investigation evaluated the hypothesis that Rwandan holocaust survivors frequently experience the sudden appearance of somatic symptoms that form part of a panic attack. The present study classified these attacks according to the somatic focus. Additionally, rates of panic attacks and panic disorder, as well as levels of PTSD and depressive symptomatology, were assessed.

2. Methods

2.1. Participants

One hundred members of a Rwandan Widows' Association who had lost a husband during the genocide but who were not currently receiving mental health services were randomly invited to participate. Almost without exception, widows in Rwanda join these village-based organizations. Each of the widows in the sample had lost her husband during the genocide. Each met DSM-IV PTSD criterion A.1 (i.e. a traumatic event capable of causing PTSD). None had sustained head injury with loss of consciousness. The average age was 29 (range 18–50); and the average number of children was 2.2 (range 0–5). The average educational level was fifth grade and 65% were literate. None of the women had remarried, in large part due to the low ratio of males to females in the country, as a result of the targeted execution of males during the genocide. The women in the sample typically survived through financial assistance provided by the husband's family (e.g. the use of land), the widow's own family and self-employment: 90% of the widows in the sample made a living from agriculture (e.g. growing beans) and animal husbandry, whereas 10% worked in small trade at the market. No international financial help was presently available to the widows. The survey was conducted in 2001, 7 years after the genocide. Each participant received education about the potential meaning of her symptoms, and if deemed appropriate, referral to a local mental health clinic.

2.2. Procedures

Questionnaires were administered by Rwandan mental health workers with college degrees and at least 3 years' experience who were trained in the