SUICIDAL BEHAVIOUR AND PANIC DISORDER

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***Rezumat**: Tulburarea de panică (TP), este una dintre cele mai frecvente tulburări anxioase, întâlnite în practica psihiatrică și generală. TP prezintă un interes major pentru cercetători datorită ratei crescute de apariție în populația generală, a impactului asupra calității vieții, a costurilor sociale, evoluției cronice și a tentativelor de sinucidere. Riscul tentativelor suicidare este mai mare decât în populația generală(7% versus 1%) fiind similar cu cel întâlnit în tulburarea depresivă majoră necomplicată. (7,9%).În studiul nostru riscul suicidar a fost de 3%. Tratamentul farmacologic și psihoterapeutic fiind relativ bine cunoscut, este importantă identificarea grupelor de risc în populația generală. Se impune elaborarea unor programe educaționale în vederea reducerii tentativelor suicidare, a automedicației, a consumului de alcool, îmbunătățindu-se astfel evoluția. Anxietatea este unul dintre cele mai frecvent întâlnite simptome în practica medicală, manifestată prin tulburare de panică, care a devenit un interes major în rândul oamenilor de știință din cauza ratei crescute de apariție în populație, a impactului asupra calității vieții, și a tentativelor de sinucidere. Un factor foarte important este identificarea populației cu risc înalt, cursul și prognosticul care variază în rândul pacienților, factorii de risc asociați cu debutul sau recăderea, rolul lor în cursul bolii sau influența asupra gravității acesteia. Programele de educație pentru populația generală sunt necesare, deoarece este bine cunoscut faptul că pacienții cu tulburare de panică tind să utilizeze auto-medicație și alcool în încercarea de a-și reduce simptomele fără ajutor medical, provocând tentative suicidare. În ceea ce privește tratamentul, există probleme legate de terapie, durata tratamentului, modul în care menținem remiterea și care sunt cele mai bune metode de prevenire.*
***Cuvinte cheie**: anxietate, tulburare de panică, comportament suicidar.*

***Abstract**:Panic disorder(PD), a particular manifestation of anxiety, is one of the most frequently encountered disorders both in psychiatric and general practice. PD has raised a great interest among scientists due to the increased rate of occurrence in the population, the impact on quality of life, social costs, chronic outcome, suicide attempts .The risk of suicide attempts is greater than in general population (7% to 1%), being similar to that of uncomplicated major depression (7,9%). Our study revealed a risk of suicide of 3%.Pharmacological and psychotherapeutic treatment being relatively well known, is particularly important the identification of a high-risk population,of risk factors associated with the onset or relapse, and their influence on the severity of the disorder.Educational programs for the general population are needed to reduce suicide attempts, self-medication, alcohol -consumption in order to improve PD's outcome.*
***Keywords**: anxiety, panic disorder, suicidal attempts*

Anxiety is one of the most frequently encountered symptoms both in psychiatric and in general practice, panic disorder being one particular manifestation of anxiety. Until not so long ago, panic disorder has been a neglected condition, but during recent decades it became a topic of great interest among scientists because of the following conditions:

a) one in every 75 individuals in the world suffer from panic disorder during some time in his life;

b) the disorder has a significant impact on the sufferer's quality of life, interfering with his social, marital and occupational functioning;

c) the condition may become chronic;

d) the disease has a considerable social cost.

In this context, the panic disorder represents a major concern of psychiatrist and psychologists around the world.

The ICD10 (1) diagnostic criteria of the panic disorder are following:

A. Recurrent panic attacks, that are not consistently associated with a specific situation or object, and often occurring spontaneously (i.e. the episodes are unpredictable). The panic attacks are not associated with marked exertion or with exposure to dangerous or life-threatening situations.

B. A panic attack is characterized by all of the following:

(a) it is a discrete episode of intense fear or discomfort;

(b) it starts abruptly;

(c) it reaches a crescendo within a few minutes and lasts at least some minutes;

(d) at least four symptoms must be present from the list below, one of which must be from items 1 to 14:

Autonomic arousal symptoms

(1) Palpitations or pounding heart, or accelerated heart rate.

(2) Sweating.

(3) Trembling or shaking.

(4) Dry mouth (not due to medication or dehydration).

Symptoms concerning chest and abdomen

(5) Difficulty breathing.

(6) Feeling of choking.

(7) Chest pain or discomfort.

(8) Nausea or abdominal distress (e.g. churning in stomach).

Symptoms concerning brain and mind

(9) Feeling dizzy, unsteady, faint or light-headed.

(10) Feelings that objects are unreal (derealization), or that one's self is distant or "not really here" (depersonalization).

(11) Fear of losing control, going crazy, or passing out.

(12) Fear of dying.

General symptoms

(13) Hot flushes or cold chills.

(14) Numbness or tingling sensations.

C. Most commonly used exclusion criteria: not due to a physical disorder, organic mental disorder, or other mental disorders such as schizophrenia and related disorders, affective disorders, or somatoform disorders.(1)

In panic disorder the risk of suicide attempts is greater than in general population (7% to 1%)being similar to that of uncomplicated major depression (7,9%). Other studies however indicate a 20% risk in panic disorder suicide (2,3,4,5).

The rate of suicide is significantly increased in the case of association of panic disorder with major depression, alcohol and/or drug abuse and personality disorders (borderline, antisocial, histrionic, avoidance and passive-aggressive). (2)

The best predictors of suicidal ideation are the following items:

- a perception of life as chaotic and/or empty,
- affective instability,
- frequency of panic attacks,
- female sex
- self destructive behaviour (other than suicide attempts).(6)

This study sought to determine the prevalence of suicidal ideation and suicide attempts amongpatients with panic disorder hospitalized in the Psychiatry Department of Arad between 2009-2012.

The diagnostic of panic attacks with or without agoraphobia were based on the DSM-IV(7) and ICD10 criteria(1) with the help of which the co-morbid states have been evaluated too.

Our research is based on the study of 65 subjects (52 females and 13 men); the mean age was 33.5 years. For realizing the objective of the epidemiological study, a 16-item standard protocol was developed. The protocol assessed such variables as age, sex, marital status, length of illness and socio - economic status.

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The protocol assessed such variables as age, sex, marital status, length of illness and socio-economic status. Alcohol and drug histories, medical emergency room presentations, self-destructive behaviour

(other than suicide attempts), affective instability perceptions of life as chaotic and/or empty and suicide attempts were rated as either present or absent.

The severity of death fears degree of suicidal ideation and severity of any suicide attempts was also rated.

Finally, self-reported frequency of panic attacks per months was included.

Certain items (thoughts of death, severity of suicidal ideation, history of suicide attempt, and severity of suicide attempt) were reviewed by a second rater for reliability estimations, in order to examine the hypotheses.

The severity of the suicide risk was estimated according to:

A) presence of thoughts of death: Infrequently, less than once a month, 2-3 times a week, almost daily;

B) Severity of suicidal ideation: never, infrequently/no risk, frequently/no risk, frequently/at some risk, frequently/severe risk;

C) History of suicide attempt: yes, no;

D) Severity of suicide attempt: very insignificant, very significant.

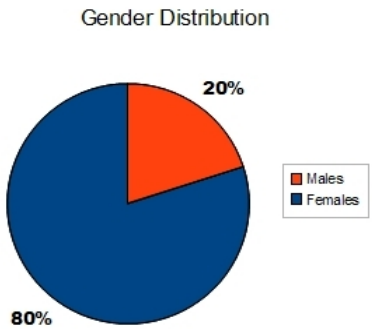

Figure 1

Our study revealed the predominance of females (53) compared to males (12) – 80% vs. 20%

Age	Males	Females
15-24	7	13
25-34	1	7
35-44	-	28
45-54	5	4

Figure 2

The mean age of the patients with panic disorder was 33.5.

Panic attack (N=65)	Mean values for the Hamilton anxiety scale
Panic attack with agoraphobia (N=36)	13.14 ± 4.89
Panic attack without agoraphobia (N=29)	8.69 ± 4.64
Panic attack with agoraphobia and secondary depression (N=21)	14.11 ± 5.88
Panic attack without agoraphobia but with secondary depression (N=9)	9.28 ± 4.07
Panic attack with agoraphobia and personality disorder (N=16)	14.19 ± 4.10
Panic attack without agoraphobia but with personality disorder (N=5)	9.48 ± 4.81
Panic attack with agoraphobia, secondary depression and personality disorder (N=9)	14.39 ± 5.98
Panic attack without agoraphobia, secondary depression and personality disorder (N=2)	9.67 ± 4.98

Figure 3

The severity of anxiety depending on the associated comorbidities and personality disorders:

Our study revealed a risk of suicide of 3.0% (two patients).

The frequency of suicide and of suicide attempts in panic disorder are due to: increased use of psychoactive medications, emergency room visits for emotional problems and a decrease in overall quality of life.

Since 1980, when the disorder was first described as a separate, self-standing entity, a lot of knowledge and clinical expertise have been accumulated and, more important, treatment schedules specific to the disorder have been developed, allowing patients to benefit from adequate therapy.(8,9)

Cognitive-behavior therapy (10,11,12) and medication (tricyclics, SSRIs, MAOIs and benzodiazepines), separately and in different combinations, have unequivocally proven their efficacy in panic disorder.

The most widely used behavioral technique is exposure, its efficacy having been demonstrated in the reduction of both anticipatory anxiety and of agoraphobia. Cognitive therapy, developed more recently, blocks panic attacks. Complex cognitive-behavioral methods seem to be the most efficacious.

None of the drug groups used has been proven tobe better than the rest, since all have both advantage and disadvantage:

-Tricyclics, for instance, can be prescribed in a single dose to be taken in the evening before going tobed, but improvements can only appear 6 to 12 weeks later, and in most cases side effects are difficult to tolerate.

-MAOIs also have several potential side effects and are accompanied by severe dietary restrictions.

SSRIs develop fewer side effects and are safer than tricyclics, owing to their lower toxicity giving rise to a reduced mortality rate in overdose; as is the case of tricyclics, however, clinical improvement only becomes apparent after 6 to 12 weeks of treatment.

Benzodiazepines act faster (one to two weeks); they have a significant effect on anticipatory anxiety, they are more easily tolerated by patients, but due to their short duration of action, the administration of several daily doses is required, and they produce dependence and withdrawal syndrome.

Comorbidity of panic disorder with depressive disorder, posttraumatic stress disorder, bipolar affective disorder, other types of anxiety, anorexia or bulimia nervosa, personality disorder and alcohol or drug abuse should be considered, as they require adequate concomitant treatment.

Panic disorder is curable, and in most cases, therapy leads to a spectacular improvement of the symptoms and to the individual's social and professional rehabilitation, followed by reintegration into the family and society.

Whenthe disorder becomes chronic, social and marital dysfunction may occur as well. The impairment of quality of life may be prevented or significantly diminished by early diagnosis and implementation of correct treatment.

In spite of the fact that interest awakened by panic disorder is still growing and with all the optimism triggered by the successes obtained in its study, the disease has not been fully understood so far.

As we would expect in a relatively young area of research, some questions still remain unanswered, while each discovery gives rise to new questions which create new perspectives for future research.

Theconclusions of our study are:

1. The identification of a high-risk population – although the age of onset of the disorder is well known, the literature containslittle information about predisposing factors. Another interesting subject to explore is that of isolated panic attacks.

2. The course and prognosis of the disorder – panic disorder has a fluctuation evolution, varying across patients and over time within the same individual; risk factors associated with onset or relapse, their role in the course of the disease or their influence on its severity have not yet been clarified

3. Education programs for the general population – it is well known that patients with panic disorder tend to use self-medication and alcohol in an attempt to reduce their symptoms without medical help.

4. Standardization of diagnostic and research methods

5. Treatment – there are still unresolved issues: what are the optimum criteria for choosing therapy, what is the ideal duration of treatment, how do we maintain remission, and what are the best methods of prevention.

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