

COMORBIDITY OF PANIC DISORDER WITH DEPRESSION: CLINICAL IMPLICATIONS

Felicia Romosan, Liana Dehelean, Monica Ienciu

ABSTRACT

Objective: The objective of the study is to evaluate the comorbidity rate of panic disorder with depression and the impact of the comorbid state on illness course and on patients' level of functioning.

Method: 47 patients with panic disorder (18 with concomitant depression and 29 without) were studied over a 3 years period. At the admission and the end of the study the patients were assessed using HAM-A and HAM-D scales. At the end of the study were also applied the Psychiatric State Rating Scale and a questionnaire designed by the authors for assessing the patients' level of functioning.

Results: strong comorbidity was found between panic disorder and depression (38.3%). Comorbidity was associated with increased symptom severity both at the index and final assessment. At the end of the study patients without comorbidity presented higher rates of remission than patients with depression (41.4% vs.33.3%). No differences related to the presence/absence of comorbidity was found in regard to the social, professional and family functioning of patients.

Conclusions: the association of depression as a comorbid state with panic disorder leads to an increased severity of symptoms of panic disorder; the evolution of patients with comorbid depression is not less favorable compared with the panic group without depression.

Key Words: panic disorders, comorbidity, depression

INTRODUCTION

The frequent association between panic disorders and depression is extensively documented in both clinical and epidemiological studies and it is considered to be more of a common phenomenon than an exception.

In panic disorders, as in other anxiety disorders, depression can be episodic or persistent, concurrent or not with the anxious episode; can be of medium or high severity, with or without endogenous features. The type of relationship between the two disorders is complex and not sufficiently elucidated to the present.

The prevalence of depression as comorbid state is differently evaluated in various studies by diverse authors: between 20% and 73%.¹⁻⁶ A great number of studies indicate that this specific comorbidity determines: increased symptom severity,⁶⁻⁸ a unfavourable outcome or a more chronic illness⁹⁻¹¹, increased suicide risk,^{12,13} decreased professional and social functioning¹⁴⁻¹⁶ and also a reduced therapeutic

response and compliance^{5,17} as compared to non comorbid cases. Panic disorder and depression are considered chronic illnesses that require long-term therapeutic management. The important consequences that can possibly emerge in individuals presenting both types of disorders inflict the need for an early diagnosis of the comorbid state and a complex therapeutic approach.

Our study, comprising a period of three years, was aimed at assessing the comorbidity rate of panic disorders and depression, the impact of the comorbid state on the illness course and patient's social, professional and family functioning. The study has investigated a group of 47 patients with a diagnosis of panic disorders, with or without agoraphobia, who were subjected to a routine treatment.

INSTRUMENTS AND METHODS

The study was performed on a group of 47 patients, hospitalized in the Timisoara Psychiatric Clinic and Timisoara Day Care Center during 1999, selected according to the DSM-IV criteria for panic disorders (with or without agoraphobia) and depression. Cases with primary depression, severe personality disorder, a history of affective and non-affective psychosis, alcohol and drugs dependence, somatic illnesses that could explain the symptoms were excluded from the

Psychiatric Clinic
Victor Babes University of Medicine and Pharmacy Timisoara

Correspondence to:
Felicia Romosan, Timisoara Psychiatric Clinic, 21 I. Vacarescu Str.,
Tel.+40 256/193859

study. The study has lasted for 3 years: during this time the patients were assessed at the beginning (when entering the study) and at the end of the study period. For the initial evaluation (upon entering the study) the structured interview for anxious disorders ADIS-R (Anxiety Disorders Interview Schedule Revised – Di Nardo)¹⁸ was used. Complementary data regarding clinical aspects, illness course and comorbidity were obtained from the patients' observation charts and history. The psychopathological state was assessed using the Hamilton Scale for Anxiety (HAM-A) and the Hamilton Scale for Depression (HAM-D, the 17 items version). The scales were applied to each patient two times: upon entering and on leaving the study.

For the final evaluation the Psychiatric Status Rating Scale – PSR – Keller¹⁹ was also used, a scale that defines specific criteria for panic symptoms and agoraphobia on 6 levels of intensity and for remission states (complete remission – a score =2; incomplete remission – a score = 3). The time criterion for remission states considered in our study was 6 months.

At the end of the study the professional, social and family functioning level of patients was also assessed, using a questionnaire designed by the author, in order to analyze the above-mentioned area, assigning scores to each level of functioning (1 – no impairment of functioning; 4 – maximum impairment of functioning) and calculating a global score (1-3 – no impairment; 4-6 – minimal impairment; 7-9 – medium impairment; 10-12 – maximum impairment).

The presence or absence of depression was used as a criteria to separate patients in two distinct groups, the results obtained for each group with the previously mentioned scales were discussed comparatively. Patients from both groups have followed during the study a routine treatment, continuous or intermittent, including benzodiazepines and antidepressants (tricyclic or selective serotonin reuptake inhibitors).

The statistic processing of data was realized using the T test (Student) for dependent samples (evaluation of statistical significance in the differences of means for each sample at the beginning and at the end of the study) and the T test (Student) for independent samples (evaluation of statistical significance in the differences of means between the two samples at the end of the study).

RESULTS

Specific traits for patient - samples:

From the 47 patients with panic disorders selected, 38.3% (18 patients) presented concomitant depression at the index (baseline) evaluation (group I); the rest (61.7% - 29 patients) had no concurrent depression or previous depressive episodes.

The proportion of patients with extensive or limited agoraphobia was similar in the two samples (72.2% versus 68.3%). In both groups, women were prevailing (66.6% and 62.0%), most of them being married (72.2% and 68.3% respectively). The average age upon entering the study was of 35.2 years for group I (ages between 20-53) and 37.3 for group II (ages between 22-55); the average duration of the illness was of 9.6 years for group I and 7.3 years for group II.

The severity of symptoms:

At the final assessment, a significant reduction in the mean anxiety and depression scores (on HAM-A and HAM-D scales) compared to the index evaluation has been observed for the both groups. The reduction was greater in the non-depressive group (Tab. 1).

By comparison, both at initial and at final evaluation, the comorbid group presented higher scores on anxiety (HAM-A: 22.7 vs.19.5, $p = 0.01$ at index evaluation and 9.1 vs.5.5, $p = 0.001$ at final evaluation) and depression scales (HAM-D: 14.9 vs.9.9, $p < 0.01$ at index evaluation and 5.3 vs.3.1, $p = 0.02$ at final evaluation).

Course model

Three years after entering the study, a higher proportion of patients with panic disorder but no comorbid depression presented complete (41.37%) or partial remission (17.24%) compared with the comorbid patients (33.3% and 11.1% respectively).

During the study, patients presented an episodic course model with a fluctuant level of symptomatology, with asymptomatic periods and relapses of various lengths; no characteristic course pattern could be discerned.

The assessment of global and area functioning was realized at the end of the study. From the obtained data, it results: a medium impairment (a total score

Table 1. Mean scores on Hamilton scales for anxiety and depression (HAM-A and HAM-D) in the two assessment moments

	Means for scores on HAM-A Scale at assessment moment:				Means for scores on HAM-D Scale at assessment moment:			
	Index	Final	t	Statistic sig.	Index	Final	t	p
Group I N = 18	22.67±4.05	9.11±5.31	11.98	$p < 0.01$	14.89±4.1	5.28±3.75	11.43	$p < 0.01$
Group II N = 29	19.48±4.9	5.48±4.34	15.25	$p < 0.01$	9.98±2.22	3.14±2.66	11.48	$p < 0.01$

<10) for patients in both groups, with no significant differences for each functioning area (Tab. 2).

Table 2. Mean scores for global functioning levels.

Functioning area	Group I	Group II	t	p
Professional	2.16 ± 0.85	2.03 ± 1.08	0.43	0.66
Social	3.94 ± 0.99	3.44 ± 1.21	1.45	0.15
Family	2.88 ± 0.79	1.55 ± 0.63	1.35	0.18
Global	8.94 ± 2.34	7.03 ± 2.54	1.58	0.1

In both samples, a predominance of cases with no or minimal impairment (50% in group I and 58.6% in the second group) has been noted, followed by patients with medium impairments (38.8% vs. 34.5%). There is a slight difference between the number of cases with severe impairment, with a greater number of patients in group I presenting severe impairments (11.1% vs. 6.9%). On functioning areas, higher levels of impairments were observed to occur in the social and professional functioning of patients in both samples.

DISCUSSIONS

The comorbidity rate for depression resulting from our study (38.29%) is concordant with the rates reported by Noyes¹⁰, Cowley²⁹ and Katshnig²⁰ and is lower than the ones reported by studies in which there was no distinction between primary and secondary disorders in selecting the cases or in epidemiological studies. The comorbidity rates resulting from clinical studies are not representative for morbidity in the general population, as they already involve a selection of cases with higher severity and chronicity.

The clinical state of most patients with or without depression has improved significantly during the study period. The proportion of cases in remission at final evaluation was higher in both samples than the rates reported in several studies.^{10,22,14} Three years after the baseline evaluation, 33.33% of patients in group I and 41.37% of patients in group II presented no more symptoms; 11.11% and 17.24% respectively presented minimal symptomatology and only 10.34% of patients in group II presented the same level of increased symptomatology during the whole period of study. These results are concordant with the ones published by Katshnig²⁰, O'Rourke¹⁷ and Scheibe²³. The divergences between the remission rates reported in literature (20-72%) can be explained by the use of various criteria by different authors in defining the remission state, its duration and the differences in the global study period. For example, studies defining remission by the absence of any perturbations on Diagnosis Axis I for a period of 6 or 12 months have

reported much lower rates of remission than studies which defined remission by including also cases with minimal symptoms or which considered the period necessary for considering remission to be of one month. Comorbidity with depression has increased the severity of anxious symptoms (HAM-A) at index and final evaluation moments, suggesting a less favourable course for patients with comorbidity, as compared with patients without depression. If we take into consideration other aspects, like the average severity of symptoms at the final evaluation, similar remission rates and the non significant differences in global functioning levels between patients in the two groups, the evolution of patients in the comorbid group does not seem to be worse than the one of patients without depression.

The results of our study are in concordance with other studies reporting a favorable course for cases with persistent symptomatology^{24,25} and with studies presenting a favorable course for comorbid groups.²⁵⁻²⁷

In conclusion, with all its limits (small number of cases, no intermediary evaluations, no evaluation of patient's compliance), our study presents a number of results that enable us to make several observations: the association of depression as a comorbid state at variable time intervals from the onset of panic disorder contributes to an increased severity of this disorder; the course of studied cases was fluctuant, with a tendency towards chronicity, but favorable overall; though the proportion of cases presenting complete remission at final evaluation was relatively low (especially in the comorbid group), the general severity of symptoms and global functioning impairment was of medium intensity. Hence, we can conclude that the evolution of patients with comorbid depression is comparable with the one of patients without comorbidity. Taking into consideration the fact that both disorders (panic disorder and depression) can coexist in a patient, it is especially important to early detect (diagnose) the comorbid state and to design a complex therapeutic approach, in order to reduce the level of functional impairment and increase the life quality of patients.

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