Prevalence of anxiety disorders among outpatient depressed patients in Thi-qar governorate.

-A. H.Hussien (FICSMpsy, CABMpsy) Thi-qar faculty of medicine, Iraq.

الخلاصة

الهدف من البحث هو دراسة انتشار القلق بين مرضى الاكتئاب الذين يراجعون العيادة الخارجية. تم دراسة 130 حالة مرضية لمرضى الاكتئاب في العيادة الخارجية في مستشفى الناصرية وذلك خلال الفترة مابين العاشر من كانون الثاني والعشرين من شهر حزيران عام 2006. قدمت المقابلة التشخيصية في تشخيص المرضى المأظهرت الدراسة بان أكثر من نصف المرضى كانوا من حالة القلق المصاحب للاكتئاب. إن هذه النتيجة لها أهمية تطبيقية من الناحية العلاجية.

Abstract

The study determined the frequency of anxiety disorders in a large group of depressed outpatients. The Composit International Diagnostic Interview (CIDI) was administered to130 depressed outpatients. More than one-half of the patients met the full criteria for a current anxiety disorder, and more than one-half of the patients with an anxiety disorder had more than one. When partial remissions and anxiety disorder diagnoses classified as "not otherwise specified" were included, two-thirds of the patients had a current anxiety disorder and three-quarters had a lifetime history of an anxiety disorder.The majority of patients with a principal diagnosis of unipolar major depressive disorder have a comorbid anxiety disorder. Because antidepressant medications have differential efficacies for anxiety disorders, knowledge of the presence of a comorbid anxiety disorder in a depressed patient may have treatment implications.

Introduction

Anxiety is commonly found in adults with depressive disorders, both as a symptom and as a comorbid disorder such as generalized anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), or a phobia(1-4).Most of the research examining the frequency of anxiety in depressed patients has focused on symptoms of anxiety. While there are several

reports from epidemiological studies on the frequency of anxiety disorders in individuals with major depressive disorder(5,6), there have been surprisingly few studies of the full range of anxiety disorders in groups of depressed psychiatric patients. Sanderson and colleagues (7) examined anxiety disorder comorbidity among 197 patients with major depressive disorder seen in a center for cognitive therapy. Overall, 41.6% of the depressed patients had a comorbid anxiety disorder, the most frequent of which was generalized anxiety disorder. Some of the results of this study were surprising, e.g., the frequencies of some anxiety disorders, such as posttraumatic stress disorder (PTSD) and simple phobia, were lower than the prevalence rates reported in epidemiological surveys of the US general population. Such studies are very scanty in Iraq .Indeed no published study available till the present time. Researchs indicated that patients with comorbid anxiety and depression exhibited more severe symptoms, impairment, and subjective distress and a more chronic course than those with "pure" disorders (7-10). The US National Comorbidity Survey (3) found elevated rates of co morbid current social phobia (27.1%), simple phobia (24.3%), generalized anxiety disorder (17.2%), and panic disorder (9.9%) in adults with major depression in the community. Reported rates of comorbidity are even higher in clinical samples seen in primary care (4,5)and psychiatric settings (6). The DSM-IV symptom inclusion criteria for major depressive disorder and generalized anxiety disorder overlap, with four of six generalized anxiety disorder symptoms (sleep disturbance, difficulty concentrating, restlessness, and fatigue) also constituting criteria for a diagnosis of major depressive disorder. The frequent occurrence of anxiety syndromes in depressed patients has stimulated a debate over the past 30 years regarding the hierarchical relationship between anxiety and depressive disorders .Moreover,some researchers have questioned the validity of the DSM-IV hierarchical relationship between major depressive disorder and generalized anxiety disorder and suggest that the exclusion criterion should be eliminated (11).The aim of this study is to measure current and lifetime rates of DSM-IV anxiety disorders in a group of

depressed outpatients seen in an outpatient psychiatric practice at Alnasria city-Iraq. The emphasis here is on the frequency of current DSM-IV anxiety disorders. Although we also report lifetime prevalence rates so that the results can be compared with those from studies that exclusively focused on lifetime rates. We report the frequency of each of the 10 DSM-IV anxiety disorders defined by specific inclusion and exclusion criteria.

Methods

The sample comprised 130 patients with DSM-IV diagnosis of unipolar depression. Patients were selected from the main psychiatric outpatient clinic in Al-Nassiria general hospital during the period from 10th January 2006 to 20th June 2006.The first patient to attend the clinic with a clinical diagnosis of unipolar depression and who agreed to participate was eligible for this study. Patients with drug abuse and medical comorbidity were excluded from the study. All participations provided informed written consent. Formal assessment was first conducted to elicit the sociodemographic data including age, sex, marital status, formal education, and employment. The Composit International Diagnostic Interview (CIDI) is a fully structured interview designed to be administered by interviewers who are not clinicians and to generate diagnoses according to the definitions and criteria of both DSM-IV and ICD-10.Two diagnostic raters were used to administer the CIDI. The raters included were, the author of the paper and a clinical psychologist, each of whom has extensive experience administering research diagnostic interviews. Both raters had undergone a training course on the use of CIDI by WHO expert as part of Iraqi mental health survey. "Not otherwise specified" diagnoses were made in two ways. First, these diagnoses were made for patients with clinically significant symptoms that fell below the DSM-IV threshold for the diagnosis of a specific disorder. In such cases we indicated which anxiety disorder the not-otherwise-specified diagnosis was related to (e.g., subthreshold panic disorder, subthreshold PTSD, etc.). The second circumstance in which a patient was given a current not-otherwise-specified diagnosis was when the full

DSM-IV criteria for a disorder had been met in the past, but the symptoms had partially but not completely remitted. Although DSM-IV provides specific guidelines regarding use of a partial-remission specifier only for the mood and substance use disorders, we adopted this specifier for all disorders. For example, someone who met the DSM-IV criteria for PTSD 5 years ago but at the time of the evaluation was bothered by a sub threshold number of criteria would have been diagnosed with the disorder in partial remission. We examined the impact of both methods of making not-otherwise-specified diagnoses on the overall estimate of the frequency of anxiety disorders in depressed patients.

Result

A total of 130 patients presented with a chief complaint of depression and were given a principal diagnosis of unipolar major depressive disorder. The group included 45 men (34.6%) and 85 women (65.40%), who ranged in age from 18 to 76 years (mean=38.4, SD=12.30). More than one-half of the subjects were married (N=82, 63%); the remainder were single (N=28, 21.5%), divorced (N=15, 11.5%), separated (N=1, 0.7%), widowed (N=4,3%). About one-third (N=42, 32.3%) were illitrate, 26.1% (N=34) had less than 6 years-formal education, 40% (N=52) had 6-12 years-formal education, and 1.5% (N=2) had graduated from a 4-year college or university.). More than one-third of the patients had experienced at least one prior episode of major depressive disorder (N=46, 35.4%). The data in table below show the frequency of current and lifetime anxiety disorders in the 130 outpatients with a principal diagnosis of unipolar major depressive disorder. At the time of the evaluation, 61.5% (N=80) of the patients met the criteria for one of the 10 specific anxiety disorders. Including patients with an anxiety disorder in partial remission increased the frequency to 67.6% (N=88). Adding the patients with an anxiety disorder not otherwise specified to this group increased the percentage of patients with at least one current anxiety disorder to 77.6% (N=101). The lifetime frequency of any anxiety disorder (including not-otherwise-specified diagnoses) was 83.0% (N=108).The most frequent

current anxiety disorder was social phobia, diagnosed in 30% of the patients. PTSD was diagnosed in approximately 23% of the patients.The rate of PTSD in this study was higher than those reported by other studies conducted in the western countries (1).This might be in part, explained by the fact that Iraqi people, especially at the time of the study, are experiencing more traumatic events than their counter western people.Panic disorder, specific phobia, and generalized anxiety disorder were each diagnosed in approximately 18%, 11%of the patients respectively. Twenty patients (15.3%) were diagnosed with a disorder in partial remission, and 26 (20%) received a current not-otherwise-specified diagnosis. PTSD was the most frequent partially remitted and subthreshold disorder.Apart from PTSD; rates of other anxiety disorders in this study are nearly in line with the results of other studies.

Rates of Current and lifetime Anxiety Disorders in 130 Outpatients with Major Depressive Disorders

Anxiety Disorders	Current		lifetime	
	N	**%**	**N**	**%**
Meeting full DSM-IV criteria				
Panic disorder without agoraphobia	5	3.8	6	4.6
Panic disorder with agoraphobia	24	18.4	26	20
Agoraphobia without panic disorder	1	0.7	1	0.7
Specific phobia	15	11.5	16	12.3
Social phobia	40	30	43	33
Obsessive-compulsive disorder	12	9.2	20	15.3
Posttraumatic stress disorder	30	23	35	26.9
Acute stress disorder	0	0	3	2.3
Generalized anxiety disorder	15	11.5	15	11.5
Anxiety due to general medical condition	0	0	0	0
Any anxiety disorder	80	61.5	89	68.4
In partial remission				
Panic disorder without agoraphobia	2	1.5	2	1.5
Panic disorder with agoraphobia	2	1.5	2	1.5
Agoraphobia without panic disorder	0	0.0	0	0.0
Specific phobia	0	0.0	0	0.0
Social phobia	0	0.0	0	0.0
Obsessive-compulsive disorder	0	0.0	0	0.0
Posttraumatic stress disorder	16	12.3	16	12.3
Acute stress disorder	0	0.	0	0.0
Generalized anxiety disorder	0	0.0	0	0.0
Anxiety due to general medical condition				
Any anxiety disorder in partial remission	20	15.3	20	15.3
Not otherwise specified				
Subthreshold panic disorder	2	1.5	3	1.5
Subthreshold specific phobia	1	0.7	1	0.7
Subthreshold social phobia	3	2.3	3	2.3
Subthreshold obsessive-compulsive disorder	1	0.7	1	0.7
Subthreshold posttraumatic disorder	10	7.6	10	7.6
Subthreshold generalized anxiety disorder	4	3	5	3.8
Mixed anxiety-depressive disorder	0	0.0	0	0.0
Other anxiety disorder	5	3.8	5	3.8
Any anxiety disorder not otherwise specified	26	20	28	21.5

Discussion

Anxiety disorders are frequent in depressed outpatients. More than one-half of the depressed patients in this study met the full DSM-IV criteria for a specific anxiety disorder; when not-

otherwise-specified diagnoses were included, two-thirds of the depressed patients had an anxiety disorder. Of the depressed patients with an anxiety disorder, one-half had more than one. These results highlight the importance of conducting thorough diagnostic evaluations of outpatients with a chief complaint of depression.

The comorbidity of anxiety disorders among depressed patients can have treatment implications. It is generally believed that all antidepressant medications are approximately equally effective for the treatment of depression. However, these medications are not equally effective in the treatment of anxiety disorders. For example, the serotonin reuptake inhibitors are more effective than tricyclic antidepressants in the treatment of OCD, and monoamine oxidase inhibitors may be more effective than tricyclic antidepressants in treating social phobia(10,12). Several antidepressant medications are indicated for the treatment of certain anxiety disorders, whereas other antidepressants have not been consistently shown to also be effective in treating anxiety disorders. Certain medications have acquired a reputation of being more or less anxiogenic or anxiolytic than others, and pharmaceutical companies have developed promotional campaigns suggesting that some medications are particularly well suited for treating depressed patients with anxious features. While knowledge of the presence of an anxiety disorder in a depressed patient might influence the choice of medication prescribed, there are, in fact, few data to support suggestions that depressed patients with anxious features respond differentially to the range of antidepressant medications.

Awareness of the presence of a comorbid anxiety disorder might also influence the prescription of psychotherapy. For example, cognitive behavior therapy has been demonstrated to be effective in the treatment of all of the specific anxiety disorders. Interpersonal or psychodynamic therapy might also be effective in treating anxiety disorders. If a comorbid anxiety disorder is not appropriately recognized, patients might not receive these potentially effective forms of treatment. To our knowledge, there have been no controlled trials comparing the efficacy of

medications and psychotherapy in the treatment of comorbid anxiety disorders in depressed Iraqi patients. In light of the high prevalence of anxiety disorders among depressed patients, this line of research warrants attention. If one form of treatment proves superior to the other, or if the combination of both treatments produces the greatest improvement, then improved clinical detection of anxiety disorders in depressed patients might improve outcome by virtue of more appropriate treatment planning.The relatively high rate of posttraumatic stress disorder compared with results of other studies highlights the need to conduct further studies ,specialy at the community level, and to develop special program for treatment of such disorder .

References

- Zimmerman ,M.McDermut W, Mattia J, Frequency of Anxiety Disorders in Psychiatric Outpatients With Major Depressive Disorder.Am J Psychiatry 2000;157:1337-1340
- Clayton, PJ. Grove WM, Coryell W, Keller M, Hirschfeld R, Fawcett J: Follow-up and family study of anxious depression. Am J Psychiatry 1991; 148:1512–1517
- Coryell, W. Endicott J, Andreasen NC, Keller MB, Clayton PJ, Hirschfeld RM, Scheftner WA, Winokur G: Depression and panic attacks: the significance of overlap as reflected in follow-up and family study data. Am J Psychiatry 1988; 145:293–300
- Van Valkenburg, C. Akiskal HS, Puzantian V, Rosenthal T: Anxious depressions: clinical, family history, and naturalistic outcome-comparisons with panic and major depressive disorders. J Affect Disord 1984; 6:67–82
- Boyd ,JH. Burke JD, Gruenberg E, Holzer CE, Rae DS, George LK, Karno M, Stoltzman R, McEvoy L, Nestadt G: Exclusion criteria of DSM-III: a study of co-occurrence of hierarchy-free syndromes. Arch Gen Psychiatry 1984; 41:983–989
- Kessler, RC.Stang PE, Wittchen H-U, Ustun TB, Roy-Burne PP, Walters EE: Lifetime panic-depression comorbidity in the National Comorbidity Survey. Arch Gen Psychiatry 1998; 55:801–808

- Sanderson ,WC. Beck AT, Beck J: Syndrome comorbidity in patients with major depression or dysthymia: prevalence and temporal relationships. Am J Psychiatry 1990; 147:1025–1028
- First, MB. Spitzer RL, Gibbon M, Williams JBW: Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I), Administration Booklet. Washington, DC, American Psychiatric Press, 1997
- Mark Hyman Rapaport, Cathryn Clary, Rana Fayyad, and Jean Endicott: Quality-of-Life Impairment in Depressive and Anxiety Disorders . Am J Psychiatry2005; 162:1171-1178
- Goodman, WK. Price LH, Delgado PL, Palumbo J, Krystal JH, Nagy LM, Rasmussen SA, Heninger GR, Charney DS: Specificity of serotonin reuptake inhibitors in the treatment of obsessive-compulsive disorder: comparison of fluvoxamine and desipramine. Arch Gen Psychiatry 1990; 47:577–585
- Mark Zimmerman,Iwona Chelminski: Generalized Anxiety Disorder in Patients With Major Depression: Is DSM-IV's Hierarchy Correct? Am J Psychiatry 2003; 160:504-512,
- Simpson, HB.Schneier FR, Campeas RB, Marshall RD, Fallon BA, Davies S, Klein DF, Liebowitz MR: Imipramine in the treatment of social phobia. J Clin Psychopharmacol 1998; 18:132–135