The frequency of agoraphobia and the comorbidity of major depressive disorder in panic disorder

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Abstract

Background and objectives: Panic disorder (PD) is a common disabling psychiatric condition that has a considerable impact on the quality of life. This study was done to estimate the frequency of agoraphobia and the comorbidity of major depressive disorder (MDD) in PD, with related sex difference.

Methods: A cross sectional descriptive study, was done on patients who consulted a private psychiatric clinic for features of PD, in Erbil city from August 2009 to August 2010. A convenient sample of 118 patients, 73 females and 45 males, having PD with or without agoraphobia were taken after giving their informed verbal consent. All patients were checked for the presence of MDD. The diagnoses were done clinically, and then checked according to the diagnostic and statistical manual of mental disorders, 4th edition, text revision (DSM-IV-TR).

Results: Mean age of PD with or without agoraphobia was 31.1 years. Female to male ratio was 1.6/1. Mean age at onset was 26.3 years. Mean duration of illness was 4.4 years. Patients having PD without Agoraphobia were 81.4%, while having PD with agoraphobia were 18.6% in which the males (20%) affected more than females (17.8%). The comorbidity rate of MDD (mild to severe degree) in PD was 61% with higher males (68.9%) than females (57.5%).

Conclusion: The majority of patients with PD in our sample had a comorbid MDD. Early detection and management of PD is necessary to reduce complications and improve their quality of life.

Keywords: Panic disorder, agoraphobia, comorbidity, depression

Introduction

Panic disorder (PD) is a common disabling psychiatric illness that has a considerable impact on the quality of life. It impairs the social, family and working lives of sufferers at a time when they should make the greatest contribution to society. It leads to over-utilization of medical facilities in futile efforts to find a physical cause for their symptoms. Frequent comorbid psychiatric conditions, most notably depression and other anxiety disorders complicate the clinical presentation, exacerbating individual disability and increasing the economic burden to society. PD has a life time prevalence of 1.5-4% of population, but it is often undiagnosed and untreated. The longer length of time from onset of panic to first treatment is associated with higher rates of comorbidity at first psychiatric treatment contact and less favorable treatment outcomes. Panic attack is the hallmark of PD. It is a feeling of overwhelming fear that can be defined as a specific, discrete type of anxiety, characterized by an abrupt onset and rapid crescendo peak of prominent autonomic symptoms, often seeming to come 'out of the blue.' While to describe the state as PD, it must include panic attacks, anticipatory anxiety for at least one month about the possibility of having a panic attack, phobic symptoms and functional disability in daily life.

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The frequency of agoraphobia and the comorbidity...  

Methods

Aims of the study:

1- To estimate the frequency of agoraphobia in PD and the related sex difference.
2- To estimate the comorbidity rate of MDD in PD and the related sex difference.

Methods

A cross sectional descriptive study was collected from patients who consulted a private psychiatric clinic for features of PD, in Erbil city from August 2009 to August 2010. A convenient sample of 118 patients, 73 females and 45 males, having PD with or without agoraphobia were enrolled in this study after taking their informed verbal consent. All patients were checked for the presence of MDD. The diagnoses of PD without agoraphobia, PD with agoraphobia and MDD were done clinically by a specialist psychiatrist according to the diagnostic criteria for PD without agoraphobia, PD with agoraphobia and MDD depending on the diagnostic and statistical manual of mental disorders, 4th edition, text revision (DSM-IV-TR). The patients with MDD were classified to Mild, Moderate, Severe without psychotic features and Severe with psychotic features MDD according to the DSM-IV-TR. Patients with primary depression, normal bereavement, history of manic or hypomanic episodes, history of schizophrenia and the related disorders, alcohol and drug dependence, and any physical illness were excluded from the study. All informations including data concerning age, sex, marital status, occupation, age of onset and duration of illness of...
PD were taken through a direct interview. Statistical analyses in form of range, mean and standard deviation were applied by using Microsoft excel program.

**Results**

The Range of age of PD with or without agoraphobia was 34 years (17-51), with a Mean of 31.1 years ± SD 7.6. The female to male ratio was 1.6 / 1. Married patients were 78%. Regarding occupation; 84.4% of the males were employed, while 74% of the females were housewives. The Range of age of onset of PD with or without agoraphobia was 31 years (16 - 47), with a Mean of 26.3 years ± SD 6.3, while the Range of duration of illness was 7.3 years (0.2 - 7.5), with a Mean of 4.4 years ± SD 2.1. Patients having PD without Agoraphobia were 81.4%, while having PD with agoraphobia were 18.6%. The men (20%) were more likely than women (17.8%) to have PD with agoraphobia Table (1). The comorbidity rate of MDD in PD with or without agoraphobia was 61%; Mild MDD was 21.2%, Moderate MDD was 33.9% and Severe without psychotic features MDD was 5.9%. comorbidity was higher in males (68.9%) than females (57.5%), as shown in Table (2).

**Table 1:** Distribution of PD with or without Agoraphobia according to age group and sex.

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>PD without Agoraphobia Male No. (%)</th>
<th>Female No. (%)</th>
<th>PD with Agoraphobia Male No. (%)</th>
<th>Female No. (%)</th>
<th>Total PD Male No. (%)</th>
<th>Female No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-24</td>
<td>11(24.4)</td>
<td>17(23.3)</td>
<td>2(4.4)</td>
<td>4(5.5)</td>
<td>13(28.9)</td>
<td>21(28.8)</td>
</tr>
<tr>
<td>25-34</td>
<td>17(37.8)</td>
<td>29(39.7)</td>
<td>6(13.3)</td>
<td>8(11)</td>
<td>23(51.1)</td>
<td>37(50.7)</td>
</tr>
<tr>
<td>35-44</td>
<td>7(15.6)</td>
<td>12(16.4)</td>
<td>1(2.2)</td>
<td>1(1.4)</td>
<td>8(17.8)</td>
<td>13(17.8)</td>
</tr>
<tr>
<td>45-54</td>
<td>1(2.2)</td>
<td>2(2.7)</td>
<td>0(0.0)</td>
<td>0(0.0)</td>
<td>1(2.2)</td>
<td>2(2.7)</td>
</tr>
<tr>
<td>Total</td>
<td>36(80)</td>
<td>60(82.2)</td>
<td>9(20)</td>
<td>13(17.8)</td>
<td>45(100)</td>
<td>73(100)</td>
</tr>
</tbody>
</table>

**Table 2:** Distribution of MDD in PD according to sex.

<table>
<thead>
<tr>
<th>Sex</th>
<th>Mild MDD No. (%)</th>
<th>Moderate MDD No. (%)</th>
<th>Severe MDD without psychotic features No. (%)</th>
<th>Severe MDD with psychotic features No. (%)</th>
<th>Total MDD in PD No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>11(24.4)</td>
<td>17(37.8)</td>
<td>3(6.7)</td>
<td>0(0.0)</td>
<td>31(68.9)</td>
</tr>
<tr>
<td>Female</td>
<td>14(19.2)</td>
<td>23(31.5)</td>
<td>4(5.5)</td>
<td>0(0.0)</td>
<td>42(57.5)</td>
</tr>
<tr>
<td>Total</td>
<td>25(21.2)</td>
<td>40(33.9)</td>
<td>7(5.9)</td>
<td>0(0.0)</td>
<td>72(61.0)</td>
</tr>
</tbody>
</table>
This lower rate of PD with agoraphobia in our study was 18.6%, which is lower than what was shown by Yates study who reported that one-third to one-half of patients with PD also met the criteria for agoraphobia. 

This lower rate of PD with agoraphobia in our study may be related to the stronger social network and support in our society than in the western countries, which may have a positive impact against the development of agoraphobia. In this study women were less likely than men to have PD with agoraphobia (17.8% versus 20%) , this result disagrees with Yonkers et al study who found that women were more likely to have PD with agoraphobia (85% versus 75%). This difference may be related to that the females in our study were mostly housewives (74%) who are mostly homebound hence, they are less likely to develop anxiety and panic attack outside the home environment. In addition, Turgeon et al study showed lower agoraphobic avoidance behavior in men of western countries to be associated with their alcohol use, which is used less by men in our society. In this study the comorbidity rate of MDD in PD with or without agoraphobia was 61%, in the form of Mild (21.2%), Moderate (33.9%) or Severe without psychotic features MDD (5.9%), while no cases were found having Severe with psychotic features MDD . This comorbidity rate (61%) is concordant with Felicia et al study in 2003 (38.29%) 31, and Kessler et al study national comorbidity survey in 1998 (43.4%) 14, with Rief et al study in 2004 (47.4%), 34 and with Miriam et al study, that this comorbidity may reach up to 65%. In our study the comorbidity rate was relatively high, patients in our society as opposed to western countries, usually consult the psychiatrists at later stage of the illness after consulting many physicians and doing
many investigations searching for an organic cause for their symptoms, and this may lead to the development of more comorbidity and complications. Comorbidity rate was higher in males (68.9%) than females (57.5%), which was concordant with Goodwin et al study in 2004 who showed that the risk was about 2-2.5 more in males than females.  

**Conclusion**

The majority of patients with PD in our sample had a comorbid MDD. Therefore, early detection and management of PD is required to reduce the complications and improve patient’s quality of life.

**References**