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The clinical impact of mood disorder comorbidity on social anxiety disorder

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Abstract

Background: High comorbidity rates of mood disorders have been reported in patients with social anxiety disorder (SAD). Our study aims to identify the frequency of comorbid Axis I disorders in patients with SAD and to investigate the impact of psychiatric comorbidity on SAD.
Methods: The study included 247 patients with SAD. Thirty eight patients with bipolar depression (SAD-BD), 150 patients with major depressive disorder (SAD-MDD) and 25 patients who do not have any mood disorder comorbidity (SAD-NOMD) were compared.
Results: Around 90% of SAD patients had at least one comorbid disorder. Comorbidity rates of lifetime MDD and BD were 74.5% and 15.4%, respectively. There was no comorbidity in the SAD-NOMD group. Atypical depression, total number of depressive episodes and rate of PTSD comorbidity were higher in SAD-BD than in SAD-MDD. Additionally, OCD comorbidity was higher in SAD-BD than in SAD-NOMD. SAD-MDD group had higher social anxiety severity than SAD-NOMD.
Conclusions: Mood disorder comorbidity might be associated with increased severity and decreased functionality in patients with SAD.

1. Introduction

It is reported that annual prevalence of social anxiety disorder (SAD) is about 5–10% while lifetime prevalence is about 10–15% in general population [1–5]. Epidemiological studies have established that psychiatric comorbidity, particularly mood disorders, was frequent in SAD patients [1,5–10]. However, there is a scarcity of research on clinical samples and there might be great variance among the rates. According to the previous studies, the mood disorders comorbidity rates in SAD patients are 35–70% for major depressive disorder (MDD) [11–14], and 3–21% for bipolar disorder [12–14].

SAD comorbidity is also frequent in patients with mood disorders. The prevalence of SAD comorbidity in MDD patients is reported to be 22–29.3% [7,15–17]. The presence of SAD is found to be a predictor for the subsequent development of MDD [1,7,18–21].

SAD comorbidity in bipolar patients is reported to be between 7.8% and 47.2% [7,22–30]. Kessler and colleagues (1999) showed an association between bipolar disorder (odds ratio: 5.9) and SAD comorbidity [7]. Also, SAD was found to be related with severity and persistence of comorbid mood disorder [7,19].

There are also studies that point to the association between SAD and bipolar disorder. It was reported that 18 of 32 SAD patients prescribed with a monoamin oxidase inhibitor benefited and hypomanic symptoms appeared in fourteen of those eighteen patients. In the study, it was speculated that a group of SAD patients might be within the bipolar spectrum and bipolar characteristics might appear with antidepressant treatment [31]. Because the increased rate of hypomanic shifts in MDD patients with SAD comorbidity as a result of antidepressant medication, an

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association between bipolar disorder and SAD was mentioned [32].

There are a limited number of studies investigating the clinical effects of mood disorder comorbidity on the course of disorder in patients with SAD. Bipolar disorder comorbidity was reported to be associated with severity and generalization of the social phobia symptoms, multiple comorbidity, and alcohol abuse in SAD patients [14]. The same study found that panic disorder with agoraphobia and obsessive compulsive disorder (OCD) comorbidity, functional impairment, phobic avoidance and overall severity scores of Liebowitz Social Phobic Disorders Rating Scale, Severity (LSPDRS) are higher in SAD patients with bipolar disorder or MDD comorbidity than in SAD patients with no mood disorder comorbidity. In general, bipolar disorder comorbidity has more negative effects than MDD comorbidity even though both have negative effects.

The aim of the present study is to identify the Axis I comorbidity rates in SAD patients and to examine the effects of current unipolar and bipolar depression on the clinical picture of SAD. Another aim is to test the hypothesis that symptomatology and course of the disorder would be significantly different in SAD patients with comorbid major depression or bipolar disorder than in patients without comorbid mood disorders. The groups of SAD patients were as follows: SAD with current major depressive disorder (SAD-MDD), SAD with bipolar disorder, current depressive episode (SAD-BD) and SAD without a history of mood disorder (SAD-non-mood disorder) (SAD-NOMD). The three groups were compared in terms of sociodemographic characteristics, symptom severity, course of illness and presence of other comorbid axis I disorders.

2. Materials and methods

A total of 247 consecutive SAD (generalized type) patients from the Outpatient Clinic of the Psychiatry Department of Bahat Group Hospitals (Bahat Hospital: 51 patients, Bati Bahat Hospital: 196 patients) were interviewed with the Structured Clinical Interview for DSM-IV/Clinical Version (SCID-I/CV) [33] between November 2008 and June 2011. These patients applied to the hospital through web searches and personal recommendations and referrals to the principal investigator (A.K.) who specifically works with SAD patients. SAD was the primary diagnosis for all of the patients and none of them reported using a psychotropic medication for the last month.

A total of 184 patients were diagnosed with a comorbid MDD by using SCID-I/CV (74.5%). One hundred fifty patients had current MDD and 34 patients without a current episode had a history of MDD. Of thirty eight patients diagnosed with bipolar disorder (%15.4), five were diagnosed with bipolar II disorder (%2) and 33 patients who had hypomania while taking antidepressants had a diagnosis of bipolar disorder not otherwise specified (BDNOS) (13.4%). Patients received BDNOS diagnosis when hypomania appeared under antidepressant medication however there was insufficient evidence to determine whether the mood symptoms were primary or due to medication [34]. In 25 of 247 SAD patients there was no current or past mood disorder. At the time of assessment, all patients in the SAD-BD group were currently in a depressive episode of BD.

The first interview was conducted to make diagnoses and the second interview was conducted to make the assessments. In order to gather information on demographic and clinical characteristics of the patients (e.g. age of onset of SAD and depressive episode, presence of depressive episode markers like atypical features, history of suicide attempt), an interview form developed by the investigators was utilized.

All SAD patients were assessed with Liebowitz Social Anxiety Scale (LSAS) [35], Beck Depression Inventory (BDI) [36], and Global Assessment of Functioning Scale (GAF).

2.1. Liebowitz Social Anxiety Scale (LSAS)

LSAS was developed to assess and rate the fear and avoidance levels that individuals have in situations of social interaction and social performance [35]. LSAS is a 24-item, 4-point Likert-type scale that measures fear and avoidance of social situations over the past week. It is administered by a clinician. A total score is calculated by summing all of the fear and avoidance ratings. Soykan and colleagues established the reliability and validity of the Turkish version of LSAS [37].

2.2. Beck Depression Inventory (BDI)

BDI is a self-rating scale that measures somatic, emotional and cognitive symptoms of depression with 21 items [36]. On a Likert-scale from 0 to 3, the possible maximum score is 63. Higher scores indicate more severe depression symptoms. Turkish version of the BDI was shown to be a reliable and valid instrument for the assessment of depression [38].

Atypicality in depression, psychotic features and the diagnosis at the beginning age of SAD were assessed according to DSM-IV criteria [39].

In the study, 38 patients with comorbid bipolar depression were grouped as SAD-BD, 150 patients diagnosed with current MDD comorbidity were grouped as SAD-MDD and 25 patients who did not have any comorbid mood disorders were grouped as SAD-NOMD. Patients with schizophrenia and related psychotic disorders or organic mental syndromes were excluded from the study. The groups were compared to each other in terms of sociodemographic and clinical features. Written informed consent was received from all patients to participate in the study.

Statistical analyses were performed by the Statistical Package for Social Sciences (SPSS) version 11.0 (SPSS, Chicago, IL). The Fisher exact test/χ^2 test was used to compare categorical variables. One-way ANOVA was