



Relationship between atypical depression and social anxiety disorder



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ABSTRACT

In this study, we aimed to investigate the effects of atypical and non-atypical depression comorbidity on the clinical characteristics and course of social anxiety disorder (SAD). A total of 247 patients with SAD were enrolled: 145 patients with a current depressive episode (unipolar or bipolar) with atypical features, 43 patients with a current depressive episode with non-atypical features and 25 patients without a lifetime history of depressive episodes were compared regarding sociodemographic and clinical features, comorbidity rates, and severity of SAD, depression and functional impairment. Thirty four patients with a past but not current history of major depressive episodes were excluded from the comparisons. 77.1% of current depressive episodes were associated with atypical features. Age at onset of SAD and age at initial major depressive episode were lower in the group with atypical depression than in the group with non-atypical depression. History of suicide attempts and bipolar disorder comorbidity was more common in the atypical depression group as well. Atypical depression group has higher SAD and depression severity and lower functionality than group with non-atypical depression. Our results indicate that the presence of atypical depression is associated with more severe symptoms and more impairment in functioning in patients with SAD.

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1. Introduction

Social anxiety disorder (SAD) is common in the general population with a lifetime prevalence of 10–15% and a 1-year prevalence of 5–10% (Kessler et al., 1994, 2005; Stein, 2006; Acarturk et al., 2008; Ohayon and Schatzberg, 2010).

SAD and major depressive disorder (MDD) are closely associated with each other; the frequency of comorbid MDD in patients with SAD is reported to be between 35% and 74.5% (Stein et al., 1990; Van Ameringen et al., 1991; Perugi et al., 1999, 2001; Koyuncu et al., 2014) whereas the frequency of comorbid SAD in patients with MDD is reported to be approximately 20–30% (Alpert et al., 1997; Kessler et al., 1999; Brown et al., 2001; Rush et al., 2005). Furthermore, SAD was found to be a predictor for the subsequent development of MDD (Weiller et al., 1996; Kessler et al., 1999; Stein et al., 2001; Bittner et al., 2004; Beesdo et al., 2007; Ohayon and Schatzberg, 2010). In addition, SAD was found to be associated with severity and persistence of comorbid mood disorders (Kessler et al., 1999; Stein et al., 2001).

Atypical depression was defined as a subgroup of MDD in DSM-IV (American Psychiatric Association: APA, 1994). According to the DSM-IV, the main criterion of atypical depression is the presence of mood reactivity in combination with at least two of four secondary criteria (hypersomnia, increased appetite or weight gain, leaden paralysis, and interpersonal rejection sensitivity). In community samples, it was suggested that 15–29% of patients with MDD had atypical depression and this rate corresponded to a 1-year prevalence of approximately 1–4% in the community (Thase, 2007). Considerably similar estimates were reported in the studies performed with clinical samples: atypical depression was encountered in 18–36% of patients with MDD (Thase, 2007).

It was reported that female gender was more common in patients with atypical MD episodes compared to patients with non-atypical MD episodes (Thase et al., 1991; Asnis et al., 1995; Benazzi, 1999a, 1999b; Agosti and Stewart, 2001; Angst et al., 2002; Posternak and Zimmerman, 2002a; Matza et al., 2003; Novick et al., 2005; Thase, 2007, 2009; Blanco et al., 2012). Overall, patients with atypical depression have an earlier age of onset compared to the patients with non-atypical depression (Thase et al., 1991; Horwath et al., 1992; Benazzi, 1999b; Angst et al., 2002; Posternak and Zimmerman, 2002a; Matza et al., 2003; Novick et al., 2005; Thase, 2007, 2009; Blanco et al., 2012). In addition to these,

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it was reported that depression with atypical features is associated with longer disease duration (Thase et al., 1991; Angst et al., 2002; Posternak and Zimmerman, 2002a), more depressive recurrences (Horwath et al., 1992; Blanco et al., 2012), more chronic disease course (McGinn et al., 1996; Benazzi, 1999b; Posternak and Zimmerman, 2002a; Angst et al., 2002; Thase, 2007, 2009; Stewart et al., 2009), more suicidality (Horwath et al., 1992; Matza et al., 2003; Blanco et al., 2012) and more severe symptoms (Novick et al., 2005; Thase, 2009; Blanco et al., 2012).

The presence of atypical depression was found to be associated with the presence of more comorbid diagnoses (Alpert et al., 1997; Novick et al., 2005; Thase, 2009; Blanco et al., 2012). There are also studies reporting that atypical depression is associated with SAD as a highly comorbid condition (Perugi et al., 1998; Sullivan et al., 1998; Parker et al., 2002; Angst et al., 2002; Matza et al., 2003; Blanco et al., 2012). Posternak and Zimmerman (2002a) have reported that SAD comorbidity in atypical MD group was significantly higher than in non-atypical MD group. Although many studies have found an association between SAD and atypical depression, it must be acknowledged that these findings are not unequivocal. For example, in a pharmacological trial, Schneier et al. (2003) found atypical depression in only three patients (14.3%), although 18 (85.7%) fulfilled the criterion for interpersonal rejection sensitivity. They concluded that the overlap of social anxiety disorder with atypical features of depression may primarily be due to the shared feature of rejection sensitivity.

Additionally, in a study performed with 129 SAD patients, the group with generalized SAD had higher rates of atypical depression than the group with non-generalized SAD (Mannuzza et al., 1995). In another study performed with adult patients with MDD, atypical depression was significantly higher in the group with SAD+avoidant personality disorder compared to the group with SAD without avoidant personality disorder (Alpert et al., 1997).

This association between atypical MD and SAD might be related to the common features which have a role in both disorders. Interpersonal rejection sensitivity is defined as a cognitive–affective processing disposition to anxiously expect, readily perceive and overreact to social rejection (Feldman and Downey, 1994). Interpersonal rejection sensitivity is seen as a common feature of both SAD (Liebowitz et al., 1985) and depression with atypical features (APA, 1994). This feature may represent an underlying personality trait of individuals with SAD and especially with the generalized subtype of SAD (Harb et al., 2002). In atypical depression, the primacy of mood reactivity in relation to the other diagnostic criteria has been questioned and reformulated definitions of atypical depression arguing for the primacy of rejection sensitivity as against mood reactivity have been suggested (Parker, 2007). Although it was reported that when major depression existed in the presence of a comorbid anxiety disorder, the likelihood of presenting with atypical features doubled (Posternak and Zimmerman, 2002b), this common feature of atypical depression and SAD helps explaining the question of why to study SAD specifically with atypical depression, rather than anxiety disorders more generally.

To the best of our knowledge, there is no study in SAD patients investigating the effects of comorbid atypical depression or non-atypical depression on clinical characteristics of SAD in detail. In this study, our aim is to investigate the effects of the presence of major depression (unipolar or bipolar) with or without current atypical features on the clinical characteristics of SAD. It would be important to know about any differences in clinical characteristics between SAD patients with atypical versus non-atypical depression also because of possible treatment implications. For example, interpersonal rejection sensitivity may be a focus for psychotherapy in SAD patients with atypical depression. Additionally, there are reports of differential response to different classes of antidepressant medications in treating subgroups of patients with

MDD with atypical features (Zisook et al., 1985; Quitkin et al., 1991). Therefore, such discrimination may provide information to guide selecting an effective antidepressant medication for the patients according to their comorbidity profile.

2. Methods

Two hundred forty seven patients with a primary diagnosis of SAD presenting to the Outpatient Clinic of the Psychiatry Department between November 2008 and June 2011 were included in this study. The outpatient unit, although a general psychiatry clinic, is known for its expertise in treatment of SAD in Istanbul. As part of a routine assessment protocol of our unit, an interview was performed with all of the patients by using the Structured Clinical Interview for DSM-IV/Clinical Version (SCID-I/CV) (First et al., 1997). Diagnoses of SAD and all comorbid disorders were made according to SCID-I/CV interview. SAD was considered as the primary diagnosis when clinicians' judgment were accordant with patient reports declaring that their main problems are related to SAD and that they had applied for receiving treatment for SAD. Patients who applied consecutively to receive treatment for SAD and whose diagnosis of SAD was confirmed were invited to participate. Patients who agreed to participate in the study and signed informed consent were enrolled. This study adheres to the Declaration of Helsinki.

The inclusion criteria were as follows: 1) being between 18 and 65 years of age, 2) diagnosis of generalized type social anxiety disorder according to SCID-I/CV interview, and 3) not using any psychotropic drugs within the last month prior to the study enrollment. Since we were investigating the effects of current depression, we excluded patients on psychotropic medications because their potential confounding has effects on our findings. Patients with schizophrenia or related psychotic disorders or organic mental syndromes were also excluded from the study.

In our study, DSM-IV (APA, 1994) criteria were used to evaluate the presence of atypical features in the patients meeting criteria for a current depressive episode (unipolar or bipolar) according to SCID-I/CV. Accordingly, patients whose depressive symptoms included mood reactivity plus at least two of four other DSM-IV symptoms of atypical depression were considered as having comorbid atypical depression. Patients with MD who did not have mood reactivity or who did have mood reactivity but have less than two secondary symptoms of atypical depression were considered to have non-atypical depression. Current depressive episode with atypical features and with non-atypical features was found in 145 and 43 patients, respectively. Thirty four patients who had a history of major depressive episodes but who were not currently depressed were excluded from the comparisons because they were not homogenous in terms of depressive episode types (most of them reported both atypical and non-atypical episodes) and because the difficulties of determining the type of episodes reliably correct in a retrospective fashion. There were no current or past depressive episodes in 25 patients and they were considered as a control group to allow analyzing whether both groups of patients with depression differ significantly from patients without a history of depression.

Diagnoses were made at the first interview and the aforementioned assessments were performed at the second interview. In addition, a sociodemographical and clinical data form (including information about age of onset of SAD, age of onset of first depressive episode, age of first treatment contact, history of suicidal attempts etc.) was filled out by the study clinicians who are trained and experienced in using SCID and rating scales. All SAD patients were assessed by using Liebowitz Social Anxiety Scale (LSAS) (Liebowitz, 1987), Beck Depression Inventory (BDI) (Beck et al., 1961), and Global Assessment of Functioning Scale (GAF) (APA, 1994).

LSAS was developed to assess the range of social interaction and performance situations in which SAD patients exhibited fear and/or avoidance behaviors. Assessment is performed on a 0–3 Likert scale by considering the level of fear and the severity of avoidance. Total score is obtained by summing the scores for fear and avoidance. Reliability and validity study of the Turkish version was performed by Soykan et al. (2003). Clinician administered version of the LSAS was used.

The BDI was developed by Beck et al. (1961) to measure the cognitive, emotional and physical symptoms of depression. It is a self-rating scale including 21 symptom categories. Rating is performed between 0 and 3 scores. The maximum score is 63. Higher total scores indicate more severe depressive symptoms. Validity and reliability study of the Turkish version was performed by Hisli (1988).

In accordance with the purpose of our study, 145 patients with a current depressive episode with atypical features, 43 patients with a current depressive episode with non-atypical features and 25 patients without lifetime depressive episodes were grouped and named as the atypical MD group, the non-atypical MD group and the non-MD group, respectively. The groups were compared with respect to sociodemographical and clinical characteristics, comorbidity rates and the rating scale scores.

Statistical analysis was performed by using the SPSS version 11.0. The χ^2 test or Fisher's exact test was used to compare categorical variables. One-way ANOVA was used to assess data obtained from the scales and Scheffe Test was used for post-hoc assessment. Significance value was considered as 0.05.

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