

Impact of panic disorder on quality of life among veterans in a primary care pilot study

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Abstract

Panic disorder is a debilitating and costly mental health condition which commonly presents in primary care settings; however, little is known about the impact of panic disorder on quality of life and health utility valuations among Veterans in primary care. A cross-sectional investigation of quality of life was conducted in a sample of 21 Veterans with panic disorder in a VA primary care clinic. Health utilities were determined using an algorithm based upon the Medical Outcomes Study Short-Form 36 Health Survey (SF-36). Veterans in the current sample reported significantly greater impairment on all eight of the SF-36 subscales in comparison to published norms. Veterans with panic and comorbid mood disorders reported significantly greater impairment on the Vitality, Social Functioning, and Mental Health subscales, while Veterans with panic and comorbid anxiety disorders reported significantly greater impairment on the Physical Functioning and Bodily pain subscales. Health utilities for the current sample were comparable to previous reports of Veterans with PTSD and depression, as well as health utilities of persons with chronic pulmonary disease and irritable bowel syndrome. The findings from this study highlight the devastating nature of panic disorder and reflect the need for increased attention to the identification and treatment of panic disorder in VA primary care settings.

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1. Background

Panic disorder occurs in approximately 2.7% of individuals in a given year [1], with prevalence rates among Veterans reaching as high as 6.1–8.3% [2,3]. Among Veterans seeking care in Veterans Affairs (VA) hospitals,

panic disorder has been related to increased mental health comorbidity [4], increased utilization of health care services and antidepressant medication [3], risk for suicide attempts [2], and suicide completion [5].

Due to the similarities between common panic symptoms (e.g., heart palpitations, shortness of breath, trembling, & dizziness) and the symptoms of certain physical disorders such as heart failure and stroke, the majority of individuals with panic disorder initially pursue care in medical settings [6,7]. In fact, panic disorder accounts for the highest rates of medical service utilization among the anxiety disorders, particularly in cardiology, emergency medicine, and primary care settings [8]. Furthermore, the economic burden of panic disorder is substantial, with overall costs (direct and indirect) per 1 million inhabitants ranging from \$241.7 to \$287.6 billion in 2005 US dollars [9]. For these reasons, increased attention should be focused on documenting the impairment of individuals with panic disorder in medical settings such as primary care clinics in order to highlight the individual and societal burden of panic disorder in this setting.

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One method of accomplishing this is to evaluate quality of life impairment among individuals with panic disorder in primary care settings. The assessment of quality of life not only provides a more complete evaluation of the impact of a psychiatric condition on individuals' lives than does focusing on symptomatology alone [10,11], it can also inform resource allocation and treatment delivery in primary care settings. Formal quality of life assessments are central to documenting disease burden and evaluating the benefits of a particular treatment in cost-effectiveness studies, which are used by policy makers to guide treatment recommendations at a system level. Quality of life may be assessed in a number of ways, including the objective assessment of individuals' functional impairment by an independent evaluator [12] or the subjective assessment of individuals' own perceptions of the quality of their lives [13].

Subjective, self-report quality of life assessments provide information about individuals' perceived functioning across multiple life domains, but do not consider personal preferences for various domains. Instead, self-report quality of life assessments assume that each area of functioning is of equal importance to the respondent. As a result, these assessments do not indicate the extent to which individuals' self-reported levels of functioning are deemed personally satisfactory. This limitation has been addressed in health economics by using standard econometrics to derive preferences from the general population for a range of possible health states (each of which include a number of domains such as physical functioning, social functioning, psychological well-being, and pain) that are commonly assessed by quality of life measures [14,15]. These researchers have published preference-weighted algorithms that can be applied to data from self-report quality of life assessments in order to generate an estimate of health state desirability, termed *health utility*. This metric allows researchers to determine desirability estimates of health states, which can be compared across disorders. These estimates are then used to document relative disease burden for the purpose of advocating for allocation of resources to highly burdensome conditions.

1.1. Study purpose

The goal of the current study was to elucidate the impact of panic disorder on quality of life and health utility valuations in a pilot sample of 21 Veterans in a VA primary care clinic. Given previous research indicating that civilians with panic disorder show substantial impairments in quality of life [16,17], it was hypothesized that Veterans with panic disorder would report significantly greater impairment in quality of life in comparison to general population norms and civilian outpatients. We also hypothesized that the presence of a comorbid mood disorder would have an even greater negative impact on quality of life than panic disorder alone. An additional aim of this study was to assess the health utility valuations of Veterans with panic disorder and to

compare these scores to previously reported scores from other medical and psychiatric populations. Among Veterans, health utility has been estimated for PTSD [18] and depression [19]; however, to our knowledge, no study to date has documented the health utility valuations of panic disorder in VA primary care settings. It was anticipated that the health utility valuation of Veterans with panic disorder would be similar to that of Veterans with PTSD [18] and depression [19], as well as individuals with serious physical disorders such as back pain and chronic obstructive pulmonary disease [16].

2. Methods

2.1. Participants and procedure

The sample consisted of 21 Veterans enrolled in a pilot study testing the efficacy of a brief cognitive-behavioral therapy for panic disorder in VA primary care clinics. The participants were primarily male (86%) and racially diverse (38.1% Caucasian, 33.3% African American, 14.3% Hispanic, 14.3% other). Veterans ranged in age from 31 to 58 years ($M=46.3$, $SD=9.1$), and were generally well educated (35% college graduate, 45% some college, 15% high school graduate, 5% some high school). To be eligible for participation in the study, Veterans had to meet *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* criteria for panic disorder with or without agoraphobia and report having at least one panic attack within the past month. Additionally, Veterans could not be currently receiving mental health treatment for anxiety at the time of enrollment. Veterans were allowed to continue taking psychotropic medications provided their dosage was stable for the four weeks prior to enrollment. Exclusion criteria included current substance dependence, mania, psychotic symptoms, severe depression (that would interfere with participation in therapy) or bipolar disorder, panic attacks related only to specific phobias, and certain medical conditions that mimic anxiety (e.g., cardiovascular disease, hyperthyroidism).

Patients were recruited via physician referrals and advertisements posted in clinic waiting areas. All methods and procedures were approved by the local Institutional Review Board and Research and Development Committee, and all participants provided informed consent. The data for the current study were obtained from baseline clinical interviews and self-report assessments. In accordance with inclusion criteria, all participants ($n=21$) met *DSM-IV* (APA, 1994) criteria for panic disorder with agoraphobia (67%, $n=14$) or without agoraphobia (33%, $n=7$) at the baseline clinical interview. Sixty-two percent ($n=13$) of the sample met criteria for a mood disorder, of which Major Depressive Disorder ($n=10$) was the most common diagnosis; 57% ($n=12$) met criteria for at least one comorbid anxiety disorder, of which Generalized Anxiety Disorder ($n=7$) and PTSD ($n=4$) were most prevalent; and 5% ($n=1$) met criteria for substance-induced disorders.

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