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Co-occurrence of Axis I and Axis II disorders in female and male patients with panic disorder with agoraphobia

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Abstract

Objective: The aim of this study is to compare female and male patients with panic disorder with agoraphobia (PDA) for the co-occurring Axis I and Axis II (personality) disorders, to better understand sex differences in PDA.
Methods: The Structured Clinical Interview for *Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition* (DSM-IV) Axis I Disorders, Clinician Version and the Structured Clinical Interview for DSM-IV Axis II Personality Disorders were administered to 157 consecutive outpatients (112 females and 45 males) with principal diagnosis of PDA, who sought treatment at the 2 anxiety disorders clinics. Women and men with PDA were then compared with regard to the type and frequency of the co-occurring Axis I and Axis II disorders.
Results: Women with PDA had a statistically greater tendency to receive co-occurring Axis I diagnoses and a greater number of Axis I diagnoses than men. Such a difference was not found for personality disorders. However, no sex difference was found for the mean number of co-occurring Axis I and Axis II diagnoses per patient. There were significantly more women with at least one co-occurring anxiety disorder. Women had a significantly higher frequency of specific phobia, whereas men were diagnosed with hypochondriasis and past alcohol abuse or dependence significantly more often. With regard to Axis II disorders, the only significant sex difference pertained to the higher frequency of dependent personality disorder among women.
Conclusions: The results of this study suggest that there are more similarities than differences between sexes in the co-occurring Axis I and Axis II disorders. Still, the relatively specific relationships between PDA and excessive alcohol use in men and between PDA and dependent personality traits and personality disorder in women seem important and have implications for clinical practice and treatment.

1. Introduction

Panic disorder (PD) and panic disorder with agoraphobia (PDA) have consistently been found more often among women than men [1]. This has contributed to an interest in sex differences in PD/PDA, and women and men with PD/PDA have been compared in various aspects of these conditions, including overall severity [2,3], symptoms of anxiety and panic [3-8], characteristics of agoraphobia [3,5], tendency to catastrophize [2,3,7,9-11], age of onset [3,5,12-14], duration [3,5,14], course [6], and levels of functioning and disability [5,7]. Possible sex differences in the co-occurrence of other mental state (Axis I) and personality (Axis II) disorders in patients with PD/PDA have apparently attracted less research attention.

Several studies [2,6,7,9,10,13-15] reported the frequency of co-occurring Axis I disorders in PD/PDA patients separately for females and males, but they did so while focusing on other facets of PD/PDA. The findings of these studies were conflicting, without suggesting that there is a consistent, sex-related pattern of co-occurrence with other Axis I disorders.

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To the best of our knowledge, only one study [16] compared the rates of co-occurring personality disorders between the female and male patients with PD, whereas several studies [2,4,10,17] compared the personality traits and dimensions in women and men with PD/PDA. Barzega et al [16] reported that there were significantly more males with schizoid and borderline personality disorders and at least one *Diagnostic and Statistical Manual for Mental Disorders* (DSM) Cluster A personality disorder and more females with histrionic and dependent personality disorders. The results of the studies comparing personality traits and dimensions in women and men with PD/PDA generally failed to show convincing sex differences.

Studying co-occurrence with Axis I and Axis II disorders in patients with PD/PDA might help better understand the underlying psychopathologic mechanisms and relationships [18,19]; if these differ in women and men, that might help explain some of the observed sex differences in PD/PDA. With this in mind, we sought to compare female and male patients with PDA in the associated, co-occurring psychopathologic conditions, both at the level of Axis I and Axis II disorders. The findings of the study might have implications for psychopathologic mechanisms as noted above, which in turn, might ultimately lead to the better-targeted and more sex-specific treatments.

In view of the conflicting, inconsistent, or sparse findings, we did not have strong hypotheses about the results of our study. However, we expected that women with PDA would exhibit a greater tendency to have more co-occurring anxiety and depressive disorders than men because these disorders co-occur most commonly with PD/PDA [20], and in general population, there is a preponderance of females among those who experience most anxiety and depressive disorders [1,21,22]. As for personality disorders, we expected women to be more likely to have an association with the DSM "anxious" group (Cluster C) of personality disorders (especially with dependent and avoidant personality disorders) and men to be more likely to exhibit traits or disorders characteristic of the DSM "dramatic" and "odd" groups (Clusters B and A), with the exception of borderline and histrionic personality traits and disorders. These expectations were based on the differences in sex distribution between some of the personality traits and disorders in general population [23-25].

2. Methods

2.1. Study patients

The sample for this study consisted of 157 consecutive outpatients (112 females and 45 males) with principal diagnosis of PDA, who sought treatment at the Anxiety Disorders Day Clinic of the Institute of Psychiatry, Clinical Center of Serbia, and Anxiety Disorders Day Clinic of the Institute of Mental Health in Belgrade, Serbia. A principal diagnosis of PDA means that professional help was sought for it and/or that it caused most distress or interference with functioning. Patients were referred by primary care physicians and other psychiatrists or came on their own for treatment. Patients with a history of schizophrenia, other psychotic disorders, and bipolar disorder were excluded from the study because of diagnostic-psychopathologic hierarchical considerations. In addition, patients with current psychotic illness, bipolar disorder, melancholic or psychotic depression, suicidality, deliberate self-harm, severe personality disturbance, and substance abuse or dependence, are not treated in the clinics, and did not participate in the study.

Patients participated voluntarily in this study, approved by the local institutional review committee, after the procedures had been fully explained to them and after their written informed consents had been obtained.

2.2. Procedures and instruments

The assessment was carried out at intake, before the beginning of treatment. It consisted of the administration of the Structured Clinical Interview for DSM-IV Axis I Disorders, Clinician Version (SCID-I) [26] and the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II) [27].

The SCID-I was used to establish that DSM-IV PDA was the principal disorder and to ascertain the presence of co-occurring Axis I disorders (generalized anxiety disorder, social anxiety disorder, specific phobia, obsessive-compulsive disorder, hypochondriasis, major depressive disorder, dysthymic disorder, and past alcohol and other substance abuse and/or dependence). Patients were interviewed by one of the psychiatrists, trained in the use of the SCID-I, after an excellent interrater reliability for all diagnoses had been established (κ values >0.90). The psychometric properties of the SCID-I version for DSM-III–R, the "precursor" of the currently used SCID-I, suggest that this is a reliable instrument for establishing psychiatric diagnoses [28].

The SCID-II was used to determine the presence of the DSM-IV personality disorders. The actual interview was preceded by the administration of the screening questionnaire. Patients were not interviewed by the same psychiatrist who administered the SCID-I, with the goal of reducing impact that the knowledge of the co-occurring Axis I disorders might have on the assessment of personality disorders. The interviewers had been trained in the use of the SCID-II, and their interrater reliability figures were very good (κ values >0.80) for all personality disorder diagnoses. The psychometric properties of the SCID-II were reported as acceptable [29], as were those of the DSM-III–R version of the SCID-II [30].

We used the Serbian translations of the SCID-I and SCID-II. The instruments were translated using the back-translation method [31] to achieve semantic equivalence and make it likely for the psychometric properties of the translated versions to be comparable to those reported for their original versions.