Comorbid Depression Disorders and Anxiety Disorders

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Perspective

Despite the fact that anxiety and depression are often comorbid diseases, it is unknown if and how a concomitant depression influences anxiety treatment outcomes. This study examines whether a comorbid diagnosis of depression and/or self-reported depression severity levels relate to the patients' improvement following anxiety treatment using anonymized Routine Outcome Monitoring (ROM) data from 740 patients who received specialized treatment for an anxiety disorder, OCD, or PTSD. The findings show that patients with and without comorbid depression benefited from anxiety, OCD, or PTSD treatment in the same way, regardless of whether depression was diagnosed prior to treatment or based on self-reported severity (and assuming a smallest effect size of interest of d = 0.35/r =.2). Significantly, decreases in self-reported depressed symptoms were highly and positively associated to reductions in self-reported anxiety symptoms and disorder-related impairment following therapy. Because of the retrospective cross-sectional design, no causal conclusions can be drawn. The findings in a naturalistic patient sample back up existing treatment recommendations for anxiety disorders, OCD, and PTSD in individuals with and without concomitant depression. Future therapy studies should look on the (bi) directionality of anxiety and depressive symptoms as they go during treatment.

Anxiety, Post-Traumatic Stress (PTSD), Obsessive-Compulsive (OCD), and depressive disorders are all common comorbidities, with 59-63 percent of those with an anxiety disorder, OCD, or PTSD having a current and up to 71–85 percent having a lifetime depressive illness. Patients with any type of comorbidity are more likely to not react to therapy and to report higher suicidal ideation, according to previous research. Furthermore, 55 percent of people with comorbid anxiety and depressive disorders acquire a chronic course of symptoms, compared to 42 percent for anxiety disorders alone and 24 percent for depressive disorders alone. Despite this, the majority of studies found that comorbid depression has no effect on the improvement of self-reported anxiety symptoms following disorder-specific treatment, implying that treatment of anxiety disorders, PTSD, and Obsessive-Compulsive Disorders (OCD) is also effective for patients with comorbid depression. OCD is also useful for people who have concomitant depression. The largest study to date, which included 1004 patients who received 18 months of treatment for anxiety disorders (including PTSD) as part of a Randomized Controlled Trial (RCT), found that patients with comorbid depressive disorder reported more improvement in their anxiety symptoms and anxiety-related disability at 12 and 18 months than their peers with anxiety disorder only. Importantly, the comorbid group's self-reported anxiety symptoms and anxiety-related impairment symptoms were consistently worse.

Similarly, research shows that people with comorbid anxiety disorders who undergo depression therapy react similarly to treatment than those who do not have comorbid anxiety disorders used data from the respective mental health organization's Routine Outcome Measuring (ROM) to see if pre-to-post treatment improvement differed for individuals with anxiety disorders (including OCD and PTSD) with and without concomitant depression. In the Netherlands, mental health organizations routinely employ ROM to track patient improvement during the course of treatment. It consists of questionnaires and structured interviews, and it gives the therapist with feedback on the efficacy and progress of therapy, Comorbid depressive disorders were not substantially related with reduced or superior improvements, while improvement rates of self-reported depressed symptoms were positively associated with rates of anxious symptoms. Although the authors could not make any causal inferences, they did indicate that monitoring depressed symptoms throughout therapy might be more informative for clinicians/researchers than the prevalence of pre-treatment depressive disorders. However, individuals with PTSD (61%) and OCD (17%), both of which are no longer categorized as anxiety disorders in the newest version of the Diagnostic and Statistical Manual of Mental Disorders, were the majority of the participants (DSM-5).

Our first goal was to see if a pre-treatment diagnosis of a comorbid depressive disorder and/or the severity of self-reported depression symptoms were linked to improvements in anxiety symptoms and disorder-related disability. We hypothesized that neither of these factors would have a negative impact on treatment outcome. Second, we predicted that relief from depression symptoms would be accompanied by relief from anxious symptom, we looked at quadratic connections between depressed symptoms and treatment change since some research claims that only severe, not mild, depressive symptoms negatively influence anxiety therapy, implying a quadratic rather than a linear link. Finally, while some research expected that concomitant depressive disorders would have no effect on therapy, others did not they all utilized analytical methodologies that can only refute, not confirm null effects. To do this, we created anonymized datasets using Regular Outcome Monitoring (ROM) data gathered in patients who received specialist therapy in the Netherlands in accordance with Dutch standards but were not enrolled in any RCT. We hope to resolve inconsistencies in the literature and provide new insights into comorbidity effects by using a naturalistic sample of patients seen in Dutch clinical practice. This is especially important in the context of treatment guidelines, which recommend disorder-specific, evidence-based treatment even for patients with comorbid depression. We also look at how comorbid depression might be appropriately operationalized in future clinical investigations, given the (research) focus has been mostly on the official diagnosis of a comorbid depressive illness rather than ongoing self-rated symptom intensity.

In conclusion, over half of the patients treated in secondary care settings for anxiety disorders, OCD, or PTSD had a comorbid diagnosis of depression, and nearly all had mild or (more) severe depression symptoms prior to treatment. Nonetheless, we found that, like individuals without concomitant depression, they all benefitted from disorder-focused therapy. Our findings back with existing treatment recommendations for individuals with comorbid depressive symptoms, which call for evidence-based disorder-specific therapy. Furthermore, our findings show that existing treatment options are helpful in lowering anxiety, OCD, PTSD, and concomitant depressive symptoms as well. Importantly, patients with comorbid depressive disorders reported more severe disorder-specific symptoms both before and after therapy, indicating that the course of their symptoms stays worse than those of individuals with anxiety, OCD, or PTSD exclusively. We use both null-hypothesis significance (i.e., traditional regression) and equivalency tests to quantify the effects of comorbid depression on anxiety, OCD, and PTSD therapy in such a large number of patients, offering extensive insights into the influence of depression on treatment response. Future research will need to identify whether comorbid depression decreases during disorder-focused therapy are a stronger predictor of treatment efficacy than a pre-treatment diagnosis, as well as whether the treatment directly or indirectly reduces depressed symptoms.

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