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An Overlap between Depression and Anxiety- A Literature Review

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ABSTRACT

Most studies show a high overlap between depression and anxiety syndromes. Relevant data come from representative studies. In clinical settings, the relative proportion of comorbid cases is even higher than that found in representative population surveys. Individuals with two concomitant disorders, suffering from a high overall burden, are more likely to seek treatment than individuals with only one disorder (Berkson's paradox). Both depression and anxiety syndromes also co-occur with other psychiatric conditions such as substance abuse or personality disorders.

1. Introduction

Comorbidity between depression and anxiety is quite common in everyday clinical practice. Similar clinical symptoms ranging from sleep disturbances and mood disorders cause these two disorders considered as one disease. The elevated risk of second disorder symptoms can be understood from a network perspective in psychopathology, where causal interactions between symptoms are theorized to promote the development of psychopathology, including comorbidities.^{1,2}

Central to the networking perspective is the proposition that psychiatric disorders arise because of symptoms that trigger other symptoms over time, such as when, for example, feelings of lethargy make it challenging to be active during the day, which in turn results in increased sadness and restlessness because

a person is not accomplishing what he wants to do. Hypothetically, the more strongly the depressive symptoms of the examples above trigger one another over time (i.e., the higher the tissue density), the more difficult it may be to interfere with activation, which may eventually lead to depressive disorders.³ This perspective also offers several potential explanations for comorbidities.²

Depression and panic disorder

Of all anxiety disorders, panic disorder has been investigated most thoroughly concerning its association with depression. Frequently, both panic disorder and depression co-occur. Consistently, high estimates of the lifetime prevalence of major depression in panic disorder between 22.5 and 68.2

have been reported.⁴ Point prevalence rates vary between 30 and 38%. Conversely, high lifetime rates of panic disorder among subjects with bipolar disorder or unipolar depression have been found. They vary from 10–59%.⁵

From different depression types, a lifetime prevalence rate of panic disorder of 20.8% was observed among subjects with bipolar disorder, compared to 10.0% among subjects with unipolar depression and 0.8% among reference subjects.⁶ Subjects with panic and depression usually have worse symptoms than those with only one disorder. The disorders begin earlier in life when they are comorbid than when they occur singly.

Models explaining the co-occurrence of panic disorder and depression include the hypotheses that the co-occurrence of panic attacks and major depression; results from a common underlying pathogenic process; a third disorder separate from panic disorder and depression; a coincidence of two common psychiatric disorders by chance; may be explained in some cases by secondary depression due to demoralization by panic attacks; In other cases may be explained by significant depression with secondary anxiety symptoms.^{7,8}

From the available epidemiological, family, and neurobiological studies, it is difficult to decide which model is most appropriate to explain the high frequency of comorbidity of panic disorder and major depression.

Depression and other anxiety disorders

In patients with major depression, comorbidity

with simple phobia was found in 24.3%, with social phobia in 27.1%, post-traumatic stress disorder in 19.5%, and obsessive-compulsive disorder in 5.4 to 10.9%. Conversely, patients with these disorders have a higher than expected rate of major depression. Of all anxiety disorders, generalized anxiety disorder shows the highest comorbidity with major depression. It can be assumed that the same comorbidity models apply to these anxiety disorders as to panic disorders.⁷

Is there a general neurotic syndrome?

It has been discussed that anxiety disorders (and probably “neurotic depression”) are not diagnosed entities but are just different manifestations of a “general neurotic syndrome” because there is such a high overlap between these disorders. Moreover, no biological markers have been found that can differentiate between these disorders, and antidepressants seem to be effective in all of these conditions. However, it still seems to make sense to demarcate different diagnostic entities.^{8,9} Reasons for this include: in most comorbid cases; one disorder can be identified in the foreground; some features, such as symptomatology and age of onset, seem to differ quite substantially between these disorders; and there is some evidence for specificity in genetic transmission.

Comorbidity of anxiety disorders

Although comorbidity rates are very high (Table 1), most patients still do not have another anxiety disorder, underlining the fact that anxiety disorders should not be easily lumped together.¹⁰

Table 1. Overlap between anxiety disorder (lifetime prevalence)

Comorbidity with				
First diagnosis	Panic disorder	GAD	Specific phobia	Social phobia
Panic disorder	-	23.5%	14.8%	10.9%
GAD	23.5 %	-	16.0-35.1%	13.3-34.4%
Specific phobia	-	35.1%	-	37.6%
Social phobia	10.9%	13.3%	37.6-44.5%	-

Healthcare utilization

Anxiety disorders show different patterns in healthcare utilization, explaining why prevalence rates found in representative epidemiological surveys differ from statistical studies in clinical settings. Panic disorder has a relatively high proportion of individuals seeking professional help. Patients with panic disorder often assume that they have a medical rather than a psychiatric condition and tend to have themselves rechecked repeatedly in internal medicine or emergency wards. In contrast, patients with social phobias tend to hide their problems. As shyness and shame are typical features of social anxiety, it is not surprising that patients are hesitant to see a physician and discuss their problems. Patients with a specific phobia can mainly cope with their problems. Without significant restrictions on the quality of life, they can avoid having contact with the objects or situations they fear, such as dogs, heights, or insects. Thus, these persons very rarely seek professional help.¹⁰

These considerations may explain why psychiatrists or unique anxiety disorder units mostly see patients with panic disorder, although specific and social phobias are more frequent according to epidemiological studies. Perhaps because they are overrepresented in representative epidemiological studies, GAD patients were also underrepresented in the clinical setting. The high healthcare utilization of panic patients also explains why more clinical studies have been conducted with panic disorder than with any other anxiety disorder, due to the easy access to high patient numbers needed for scientific studies.

2. Conclusion

Anxiety disorders and depression are among the most prevalent psychiatric disorders. They are associated with a considerable degree of impairment, high healthcare utilization, and an enormous economic burden on society. Epidemiological studies may help in planning treatment and prevention programs, and they also may help us better understand the etiology of these disorders. Future large epidemiological initiatives to investigate the

prevalence of depression and anxiety among different cultures are currently ongoing.

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