The coexistence of depression and anxiety

Task Force for Depression and Anxiety Disorders. Unión Latinoamericana Contra la Deresión (ULAD)

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Summary

In the clinical practice, anxiety and depression share some overlapping characteristics which result in the anxiety-depressive mixed syndrome with its, sometimes not too well delimited, characteristics besides some therapeutic and prognostic peculiarities.

A group of expert psychiatrists of various Latin American countries analyzed some of the controversies in relation to the coexistence of symptoms, pathophysiology and genetics, as well as the diagnostic, therapeutic and pronostic perspectives.

Key words: Depression, anxiety, comorbidity, mixed disorder.

Resumen

En la práctica clínica, la ansiedad y la depresión comparten características de sobreposición que dan lugar al síndrome mixto depresivo-ansioso. Este presenta características propias, en ocasiones poco delimitadas, además de particularidades terapéuticas y pronosticas. Un grupo de expertos psiquiatras de diferentes países latinoamericanos analizaron algunas de las controversias relacionadas con la coexistencia de los síntomas, la patofisiología y la genética, así como sus perspectivas diagnosticas, terapéuticas y pronosticas.

Palabras clave: Depresión, ansiedad, comorbilidad, trastorno mixto.

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Introduction

During the last decades, clinicians have shown a renewed interest in the coexistence of depressive and anxiety states as a diagnostic and therapeutic challenge. Anxiety and depression are in most cases inseparable and precede or succeed each other in most patients.

In patients suffering from crisis of anxiety, generalized anxiety and major depression we are undoubtedly dealing with an overlapping of symptoms.

Patients often meet the diagnostic criteria (DSM-IV and ICI-10) for an anxiety disorder and for a major depressive episode.

Diagnostic comorbidity is found in the everyday clinic, most of all in patients having anxiety and depressive symptoms, in whom many times the diagnosis is made by exclusion criteria (9).

Patients in whom both symptoms coexist have different family history, evolution, and therapeutic response.

Another underlying factor for the joint presentation of both syndromatic states is the presence of a personality disorder, such as paranoid or borderline, together with a dependent and evading personality (1).

A panel of internationally recognized clinical psychiatrists in Latin America responded to different questions on the coexistence of depression and anxiety.

Question 1
May we consider that a mixed anxiety-depressive syndrome is a uniform diagnostic entity?

We have frequently heard about the overlapping of a depressive disorder on a determined anxiety disorder. In the American classification DSM-IV we found for the first time in its appendix the term "mixt depressive anxiety disorder". A state of initial anxiety may be associated at the beginning or later, with enough depressive symptoms to reach the diagnostic criterium of a secondary depressive episode. Different investigators have observed that from 21 to 91% of the patients suffering from panic disorder, generalized anxiety or agoraphobia, also meet the diagnosis of major depression (13). Patients with an important association of anxiety and depressive symptoms are considered as more seriously ill and with less social and personal support (3).

There are three possible associations of these two dysfunctions. In the first one, there is a depressive disorder associated with insufficient anxiety symptoms to characterize an anxiety disorder. In the second one, we find two subsyndromatic disorders not meeting the necessary criteria for anxiety or depressive disorders. And in the third one, we find associated in the clinical practice the two clinically characterized disorders. The anxiety-depressive syndrome is the one in which the patient meets the criteria for both disorders: the depressive and the anxiety disorder. Therefore there are three different levels.

We emphazise the need to know whether it may be considered that the anxiety depressive syndrome is a uniform diagnostic entity, and whether we can talk of a syndrome, an illness or a disorder by adopting the last one. Finally, as it has been demonstrated that patients have simultaneously both disorders: the depressive and the anxiety disorder, it has been agreed to use the term **mixed anxiety-depressive disorder.**

Question 2
Are anxiety disorders and mood disorders clearly separated as two diagnostic entities in the clinical practice?

Undoubtedly, both disorders are different diagnostic entities. A lasting anxiety might lead to an homeostatic rupture, which is manifested by clear depressive symptoms meeting all the diagnostic criteria. Clayton points out that approximately 66% of the patients having a panic disorder also present a depressive disorder, and 60% of the depressive patients have some anxiety symptoms. This association of symptoms worsens the subjective personal experience of the illness, causing a poor response to the pharmacologic and psychotherapeutic treatment and a more chronic evolution (4).

It was emphasized at the discussion that, based on the new terminology, and as clinically confirmed, anxiety disorders and affective disorders are two separate diagnostic entities. It was reminded that in the clinical practice these diagnostic entities appear separated or mixed. They insisted on the difference of the therapeutic approach according to the form in which both states present themselves.

Question 3
Do we have a specific biological marker in order to differentiate anxiety and affective disorders?

Psychiatry keeps searching for a biological parameter to differentiate the multiple nosologic entities, which may produce certainty diagnosis for providing more and more specific treatments.

The biological markers used at this moment for differentiating anxiety disorders from affective disorders have poor sensitivity and specificity and are characterized by overlapping.

We know that major depressive patients present cortisol hypersecretion that may be normalized in 50% of those receiving a successful antidepressive treatment. Many of them present an anxiety symptomatology with the necessary requirements for be diagnosed as a comorbid anxiety disorder with a major depressive disorder.

One of the diagnostic tests used for differentiating a panic disorder from a major depression disorder is the lactate infusion which induces an anxiety crisis, though its application is clinically limited and lacks specific power.

As knowledge is being constructed in an indirect form, it would be rather daring to speak of a common physiopathology for a mixed state, while we still don't have the sufficiently solid knowledge to explain separatedly these disorders.

Question 4
Which are the main symptoms differentiating an anxiety disorder from a major depressive state?

Notwithstanding the important overlapping of various symptoms, the diagnosis may be established. In depression, the mood is diminished, there is terminal insomnia, motor agitation and a vespertine improvement of the symptoms. Patients with anxiety disorders are afraid of going out alone, have initial insomnia, are relatively calm and deteriorate in the evening. Panic disorder appears in late adolescence and early adulthood, and less frequently, after 35 years of age, while major depression may appear after this age. Finally, crises of anxiety in first grade relatives and anticipatory anxiety periods direct the diagnosis towards an anxiety disorder (9). On the contrary, depressive antecedents with or without anxiety crises, drug or alcohol consumption and a certain improvement after physical exercise would be in favor of a depressive diagnosis.

The validity of the formulation of the question was discussed based on the clinical fact that there are common symptoms to both disorders.

On the other hand, depressive mood, anhedonia and lack of vital energy are typical of depression but not of anxiety, unless it might be complicated with a depressive state.

The need to include the circadian rhythm in the differential diagnosis must be emphasyzed. It is concluded that, given the teaching value of the program, the order of the symptoms differentiating depression from generalized anxiety will be mentioned.

Question 5
Is major depression interrelated with an anxiety disorder associated with a personality disorder?

The overlapping of an affective disorder associated with an anxiety disorder and a personality disorder has been known for many years. These patients usually have an important family pathology, more severe depressive symptoms, poor therapeutic response and worse prognosis (11).

Patients with a depressive syndrome associated with a not panic anxiety disorder have a higher incidence of oral-neurotic traits as well as different personality disorders.

This fact has been known for many years. Within the personality disorders we may find the paranoid, borderline, dependent and evading types. Patients with a mixed disorder associated with a personality disorder present a strong genetic loading, a traumatic childhood, a more severe clinical state and poor response to treatment (1).

It is necessary to specify if we refer to an "interrelation" or to a "correlation" between disorders. The use of the term "interrelation" is suggested, as well as to respect the additional international classification axes in which the personality disorders are also codified. It must be remembered that hyperthymic and dysthymic cases belong to different categories.

Confussion may arise from the multiplicity of personality disorders having all of them different characteristics. Thus, it is important to specify to what type of personality it refers. Remember that the current classifications allow these differentiations.

Question 6
Which is the evolution of a mixed anxiety depressive disorder?

In a recently published bibliographical revision, the authors found an undoubtfully worse evolution in patients in whom depressive and anxiety disorders are associated than in those in whom they are presented separatedly (5). This fact conditions long term therapeutic results. In this study, the author emphasizes the limitations of the current international classifications, and the higher frequency of this association in psychiatry in relation with other entities. He also suggests a new term for the group identified with a dual symptomatology: "Generalized Neurotic Syndrome". Thus, an specific diagnostic entity for patients meeting the criteria of both disorders is needed. The severity of the anxiety symptoms is a severity index for a depressive episode.

It has been established that the anxiety-depressive mixed disorder has a bad prognosis and a higher suicidal risk. It is suggested that the lack of specialized care for such cases contributes to a deficient diagnosis and, consequently, to an inadequate treatment with a poor prognosis.

Therapeutic orientation guides are needed in order to help general practitioners in treating this disorder; if it is not well cared for, its prognosis will be worse.

Question 7
What is the information of some genetic studies in relation to anxiety disorders, depressive disorders and anxiety-depressive mixed diagnosis?

Clear anxiety disorders have an important genetic influence, while in the anxiety depressive mixed disorders the genetic influence is not well known. The importance of the environmental factors (traumatic family environments in childhood) in the development of dysthymic disorder (depressive neurosis), such as stress in adults, are important for the development of the anxiety-depression syndrome (12).

There is no evidence of anxiety and depression symptoms being specifically affected by genes. These data is very important to understand why anxiety and depression symptoms are so often overlapped. That is, genes act in a not specific form to influence psychiatric symtoms. However, determinate environmental factors seem to be specifically depresogenic while others are anxiogenic (8).

Certain stressful life events, dangerous or threatening, specifically associated with an anxiety disorder, while determinate life events related to a loss, are associated with depressive disorders (6).

Patients having experimented threatening or dangerous life events associated with a loss may suffer from an anxiety-depressive mixed disorder (7).

It is true that anxiety and mood disorders are influenced by genetics, but studies are not determinant. Sociocultural factors play a very important role in the multifactorial etiology of this disorder.

Question 8
Are primary attention physicians those who most frequently attend patients with anxiety- depressive mixed disorders?

Most answers coincide. Patients with an anxiety-depressive mixed disorder do not go in the first place to a psychiatrist, but are treated by a general practitioner.

Therefore, in order to improve the quality of the attention provided by the general practitioners, which should be the strategies followed in order to obtain an early diagnosis of the anxiety-depressive syndrome?

It is considered that general physicians are very receptive to continuos training, which would facilitate the elaboration of medical actualization programs.

It should be taken into consideration that the anxiety-depressive mixed disorder is a new diagnostic category,

and its diagnosis and treatment are difficult. Therefore, we must give a serious thought to the message to be transmitted to the general physicians. We must be very clear on the bad prognosis of this disorder.

It is suggested that the general practitioner should be trained on how to identify this disorder in their patients so they may be referred to an specialist in psychiatry.

Question 9
Are ansiolitics the first choice for the treatment of mixed disorders?

Present investigation data on a combined treatment of psychotherapy and psychopharmacotherapy for mixed anxiety and depressive disorders are incomplete (10). Therefore, more research should be made on this subject. However, some conclusions have been reached. The combination of a cognitive psychotherapy and antidepressive treatment is probably more clinically efficient than the two separated therapies. No empirical evidences show any preference for either one. In theory there is no incompatibility between psychotherapy and pharmacotherapy. Due to its better methodology, studies on cognitive therapy show it is more useful in the treatment of mixed anxiety depressive states, but both therapies seem to reduce the symptomatology and prevent a subsequent relapse and recurrence (2).

Regarding the pharmacologic treatment, it must be based in the use of antidepressives with anxiolytic effect. Drugs with these pharmacological characteristics should be considered as a first choice of treatment. The results obtained by this type of drugs should be evaluated in order to recommend their use in the ULAD programs, however, the intolerance of some patients to their adverse effects should be kept in mind.

A combined psychotherapeutic and pharmacologic treatment should be implemented in order to improve the results.

Conclusion

The panel of experts call our attention to the existence of a mixed anxiety depressive disorder, and pointed out that a correct diagnosis will ensure an adequate treatment which would avoid complications and improve its evolution and prognosis.

A good therapeutic approach should be a mixed psychopharmacologic-psychotherapeutic treatment.

The administration of antidepressives with anxiolytic action is the best option, though, sometimes, a short time administration of associated anxiolytics may be indicated.

A psychiatrist familiarized with these clinical states should be in charge of the patient due to its many diagnostic and therapeutic difficulties.

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