

## The comorbidity of depression and anxiety

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The studies over the presence of an anxiety disorder and depression have shown that there are difficulties in separating these states or disorders (Goodwin, 2003). A study by Gorman (1996) found that the rates of the depressive disorders and anxiety as percentage of the combination of these disorders were up to 25% of general practice patients.

Bowen and Kohout (1979) found that 91% of a group of patients had the diagnosis of agoraphobia, and that they also presented criteria for primary affective disorders.

The comorbidity of depression and anxiety seen in the practice of psychiatry was demonstrated, especially in Goldberg's studies and reviews (Das-Munshi, Goldberg, Bebbington, Bhugra, Brugha, Dewey,... & Prince, 2008). For example, in a study conducted over a number of 88 patients with psychiatric disorders, the two most common symptoms were anxiety, present in 82 patients and depression in 71 from the patients of the mentioned group. These symptoms had mostly appeared together and it exists the possibility to prioritize certain components (Goldberg, 1996).

Another results registered in the Diagnostic and Statistical Manual of Mental Disorders revealed the fact that up to 60% of patients which are diagnosed with Generalized Anxiety Disorder have a comorbid condition; panic disorder and major depressive disorder are the most common (Sadock, 2007; Rapaport, Clary, Fayyad, & Endicott, 2005).

From the psychopathological content perspective it can be said that the symptom of anxiety comes close to fear, and the symptom of depression through its contents comes close to grief (Lawrence, Murray, Banerjee, Turner, Sangha, Byng,... & Macdonald, 2006). Theoretically the difference between anxiety and fear is simple. Fear is an emotional condition caused by the presence of an external danger. Anxiety, on the other hand even if it has the same nature, occurs in the absence of any external dangerous object.

Currently, it is established a distinction between the symptom of anxiety and the depression symptom (Kendler, Heath, Martin, & Eaves, 1987). The latter is made mostly from a particular quality of provision, whose central element is given by the suffering, may be regarded as a

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pathological sadness. The real ambiguity of the relationship between the two phenomena does not appear from the particularly content, but from the fact that the term of depression may be interpreted both as a symptom and a syndrome (McEvoy, & Mahoney, 2012). But the depressive syndrome usually associates the depressive symptom and the symptom of anxiety (Beck, & Alford, 2009). The presence of the first is mandatory to be able to talk about the depressive syndrome, but the balance between those two symptoms is variable.

There are cases where anxiety dominates and then it is discussed about an anxious depression (Kadam, Croft, McLeod, & Hutchinson, 2001). The presence of anxiety can be so great that causes us to neglect the existence of depression that can sometimes be hidden and masked (Holdevici & Crăciun, 2015). The report appears also vice versa in the moment in which anxiety is marked (Brown, & Harris, 2012). Isolated disturbances can advocate for an organic disorder. The study of pathological antecedents and careful scrutiny of experiencing anxiety, little apparent, can orient the diagnosis, avoiding a duplication of examinations and laboratory tests that instead of calming is likely to feed the unrest of the patient.

The difficulty that poses a specific problem is when depression and anxiety is associated and has characteristics in common (Watson, Clark, & Carey, 1988). It is important to be made differences since the arrangements for therapeutic approach differ from case to case.

A typical depressed mood is easily recognized when assigning signs of sluggishness in mental and motor functions which include rare and slow gestures, brief answers, slowness in ideation and a loss for the whole vital outburst (Depue, & Monroe, 1978). The intense feeling of tiredness representative, disinterest, the inability for any action appears. The disposal is net depressive, accompanied by a deep sadness that is immediately felt from the melancholic and depressive facieses – continuing with the dissatisfaction with oneself, ideation relating to inferiority, guilt, and worthlessness (Beck, & Alford, 2009).

At the same time it is possible to make a distinction between the anxiety which reveals personality traits - and which relates to the fund anxiety and transitory anxiety which may be expressed as a transitional state of the subject (Spielberger, 1966).

So in terms of conceptualization it is necessary the differentiation and specification of the term state anxiety and trait anxiety (Spielberger, 1976). The concept of state anxiety is a feature of a transient condition that may appear to any individual. Trait anxiety is an individual characteristic, which can manifest itself in two ways (Barlow, 2004). Hence it differentiates the predisposition to try states of fear in the presence of stimuli to which other individuals are less anxious or even non-anxious (Barlow, 2004). In the second place we are dealing with the predisposition to develop conditioned stimuli toward fears that are not anxious by themselves. A high level of anxiety as a feature is known as having pathological character (Beck, Emery, & Greenberg, 2005).

Anxiety disorders, such as generalized anxiety disorder (GAD), panic disorder and social phobia are represented by symptoms such as muscular tension, motor inhibition and neuro-vegetative manifestations (Martin, & Nemeroff, 2010). Among these, the most current are sweated tachycardia; pulse and respiration speed up even if the subject does not make effort, hot flashes, dizziness of heat or cold, excessive sweating, redness or excessive paleness, lump in the throat or sore breastbone, diarrhea or frequent urge to urinate (Davidson, & Turnbull, 1986).

In the case of anxiety disorders, the components described above are exacerbated and may take, for example, in generalized anxiety disorder, a more durable character. The pathological anxiety has also behavioral components that inhibit the action of the subject (McNaughton, & Gray, 2000) or an accelerated and cognitive component that lead to underestimate the actual capabilities (Clark, & Beck, 2011).

The biochemical researches, demonstrating the possible use of anxiolytics, beta-blocking allow approaching these disorders through an extensive insight (Altamura, Moliterno, Paletta, Maffini, Mauri, & Bareggi, 2013). On the other hand, the psychotherapeutic interventions especially in the area of cognitive-behavioral come with sustained scientific solutions in terms of improvement and healing of those conditions/disorders through the establishment of behavioral activation (Martell, Addis, & Jacobson, 2001) and the use of relaxation techniques and hypnotherapeutic methods (Vickers, & Zollman, 1999; Holdevici & Crăciun, 2015).

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