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Possible Comorbidities in Some Metal Health Conditions

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Abstract

Depression is not only one of the earliest diseases described in the history of medicine, but also one of the most common mental disorders. Depression is a disease of our time and represents a great challenge, not only for mental health professionals, but also for family doctors. High morbidity and mortality rates and frequent comorbidities are just some of the characteristics of depressive disorders. All this puts before doctors in primary health care an important task because they must know how to recognize depressive disorders, and refer the patient to specialist treatment. This paper does not discuss the issue of depression as an individual's health condition. This paper discuss about the comorbidities that can occur in patients who suffering from depression.

Key Words: Mental Health; Depression; Comorbidity; Psychiatry

Introduction

Comorbidity is the occurrence of one or more mental or medical disorders (conditions) along with a primary mental disorder [1]. Usually, these co-occurring pathologies have similar structure, development, or cause. For example, depression is a common comorbidity following a myocardial infarction (heart attack). However, in medicine "comorbidity" can indicate the simultaneous existence of two or more medical conditions that have different causes, structures, or development. This can lead to confusion about the nature of the multiple diagnoses. For treatment purposes, the interrelationship among the multiple conditions must be taken into account. The reason is that individuals with a diagnosed mental disorder have an increased risk of other diagnoses.

Disorders

Several factors foster comorbidity [1]. These include genetic predisposition, family history, environment, and a history of trauma. It is also possible that different unrelated predisposing factors are operative, leading to different unrelated diagnoses. Finally, it is often the case that the symptoms associated with one mental disorder operate as the predisposing factors of one or more other disorders or physical illnesses. Such differing factors that foster comorbidity may exist in isolation or coexist within the same individual. In brief, comorbidity is having more than one diagnosis at any given time.

Mental health professionals also use the term "comorbidity" when referring to the coexistence of multiple symptoms. This is especially true when a single diagnosis will not account for all client symptoms. The personality of the client is also a factor in comorbidity. Personality traits and coping styles influence the risks associated with developing comorbid mental health disorders. Personality disorder also has a tendency to coexist. It is not uncommon for a client diagnosed with a personality disorder to have features of another personality disorder. In fact, more than half of individuals with personality disorders will be diagnosed with a comorbid personality disorder. Mood disorders and anxiety disorders also have a high rate of comorbidity.

The substance disorders often have comorbid mental disorders and/or physical

illnesses. The term "dual diagnosis" is especially common when indicating the coexistence of substance-related disorders and other mental disorders. For example, depression is common in individuals with alcohol dependence.

The treatability of any disorder is likely to be reduced when there is comorbidity with other disorders [2]. This is frequently the case for personality disorder, where comorbidity with mood disorders and substance misuse are especially common. Treatability is also likely to be affected by developmental history, and the presence of risk and resilience factors. For example, most therapists assessing the treatability of personality disorder will look at the history of interpersonal relating from early childhood, arguing that treatment is more likely to be successful if there is any history of a positive attachment to another person.

Personality disorders are associated with poorer outcomes and higher healthcare utilization across a wide range of health problems [3]. One systematic review found personality disorders associated with sleep disturbances, back pain, incontinence, chronic pain, obesity, and varied chronic health conditions including allergic rhinitis, arthritis, asthma, cardiovascular disease, diabetes, gastrointestinal disease, HIV+ status, hypertension, ischemic heart disease, liver disease, stroke, and venereal disease. In national surveys from the USA including 34,653 adults, a variety of personality disorders were associated with cardiovascular disease, arthritis, diabetes, and gastrointestinal conditions. In a recent systematic review of health service utilization among those with mental disorders in the UK, the presence of a personality disorder, in addition to neurotic symptoms, comorbidity, and several demographic characteristics, were among the variables shown to predict a variety of types of health and behavioral health service utilization, including primary care contacts, medication usage, contacts with psychiatrists, attendance at psychotherapy, inpatient days, accident and emergency admissions, and a total service utilization score.

Juveniles

Addressing the unique treatment needs of dually diagnosed adolescents has become increasingly pressing in recent years as a result of high prevalence rates and serious clinical concerns associated with this population [4]. Several issues make comorbid disorders extremely challenging to treat, including complex treatment needs, increased severity of symptoms, high cost of treatment, necessity to integrate several interventions, and low treatment retention among dually diagnosed youth.

Dually diagnosed adolescents are identified as simultaneously having substance use disorders (SUDs) and comorbid psychiatric mental health disorders. The term dually diagnosed remains rather ambiguous, however, because it encompasses adolescents with a variety of substance use problems and a spectrum of mental health disorders. This lack of uniformity creates challenges for those who seek to study and treat dually diagnosed adolescents. For example, adolescents with SUD and comorbid mood disorders may have different needs and responses to treatment than do adolescents with SUD and conduct disorder (CD) or attention-deficit/hyperactivity disorder (ADHD).

Despite the difficulty in creating a uniform definition, several studies have reported extremely high prevalence rates of comorbid conditions. Among substance-abusing adolescents, 50% to 90% report comorbid psychiatric problems. The majority of adolescents seeking services today are thus likely to have substance use problems; mental health diagnoses; as well as myriad social, behavioral, and familial problems.

Geriatrics

Functional loss is a final common pathway for most clinical problems in older persons, especially in persons over age 75 [5]. Additionally, it may be the only sign or symptom of important underlying disease when more specific and typical symptoms of a particular disease are absent. Functional impairment means decreased ability to meet one's own needs and is easily measured by assessing activities of daily living (ADL) and instrumental activities of daily living (IADL). In addition, objective assessments of cognition and behavior and of social, economic, and emotional state are required to document health-related function of older persons. A systematic literature review identified risk factors highly correlate with functional decline, including cognitive impairment, depression, comorbidity/disease burden, increased and decreased body mass index, lower extremity functional limitation, low frequency of social contacts, low level of physical activity, no alcohol use compared to moderate use, poor self-perceived health, smoking, and vision impairment. Among the very old (85 years and older), impaired functioning and cognition predict institutionalization.

Presentation of illness in older persons less often is a single, specific symptom or sign, which in younger patients, announces the organ with pathology. Older persons often present with nonspecific problems that are in fact functional deficits. Stopping eating and drinking, or the new onset of falls, confusion, lethargy, dizziness, or incontinence in older patients may be the primary or sole manifestation of diseases with classic signs and symptoms in the young (e.g., pneumonia, myocardial infarction, pulmonary embolus, alcoholism or myxedema). These deficits have been named geriatric syndromes; they devastate independence without producing obvious or typical indications of disease. Geriatric syndromes may be defined as a set of lost specific functional capacities potentially caused by a multiplicity of pathologies in multiple organ systems. For example, dizziness among community-dwelling elderly people was shown to be associated with seven characteristics: anxiety; depressive symptoms; impaired hearing; use of five or more medications; postural hypotension; impaired balance, and past myocardial infarction. Comprehensive evaluation is usually required to identify and treat underlying causes. Although in many instances a geriatric syndrome has several contributing causes, remedying even one or a few may result in major functional improvement.

Primary Care Level

This broad range of mental disorders is common in primary care, with prevalence rates reported in the range of 30–50% [6]. Many of these very varied disorders can be successfully treated or managed in a way that reduces and minimizes their impact on a person's life. Mental disorders that are serious enough potentially to complicate the management of physical health problems are

also common. Accident and emergency (A&E) departments frequently see patients who have self-harmed or have suffered injuries owing to substance abuse. A person dependent on alcohol who is admitted for surgery may develop withdrawal symptoms and delirium tremens some days after admission to hospital because of forced abstinence from alcohol. Other examples are anxiety and depression, both of which may arise on a general medical ward in the context of a diagnosis of a life-limiting physical illness. People may also present with symptoms that are not readily explained in which anxiety and depression may be a significant factor.

Dementia is common in older people admitted acutely to hospital and in most cases it has not been previously diagnosed. According the Alzheimer's Society, 80% of people living in UK care homes have a form of dementia or severe memory problems. If these patients are admitted to an unfamiliar hospital environment, their behavioural problems can worsen and they may suffer a sense of bewilderment or psychological distress. Similar symptoms may be associated with an organic confusional state (delirium) that requires investigation and treatment in its own right. Studies have reported that perhaps 40% of people on a general medical ward have impaired decision-making capacity, much of which is likely to be secondary to a comorbid mental disorder. Thus, in all health settings and across all health disciplines, practitioners will be faced with clinical situations in which the co-occurrence of mental ill-health or the presence of cognitive impairments might result in, or contribute to, difficulties in clinical management that are ethically and legally challenging.

Comorbid conditions are always important to assess. Even in cases in which there is no previous psychological disorder, the presence of PTSD (posttraumatic stress disorder) is often complicated by the emergence of other disorders concurrently or over time [7]. In particular, disorders such as major depression and substance abuse can obfuscate the clinical picture and confuse even the most discerning eye. With respect to major depression, the clinician is most often struck by the unremitting course of the disorder since the occurrence of the traumatic event. Unlike other forms of depression seen in the absence of PTSD, depression, when combined with PTSD, seems to remain relatively constant, and sometimes in the most nefarious cases it is even exacerbated over time. Phenomenologically, the depressive state appears more as a "double depression," bearing characteristics of both a major depressive episode and longer-standing dysthymia.

Healthcare Providers

Healthcare providers usually begin to identify their first clinical ethics dilemmas in patients who are dying, or at the end of life [8]. In many of these situations, healthcare providers may have moral distress as well. Healthcare providers in the roles of mentoring and teaching may suffer from lingering moral residue themselves from such cases, which may affect the teaching culture and healthcare trainee expectations. Indeed, many healthcare trainees still do not get adequate training in end of life dialogues and truthful prognostication, which may not be available without skilled mentors. Finally, reducing unit moral distress that affects learners also requires formal educational forums for difficult end of life cases as well as an institutional mechanism for effective clinical ethics consultation and moral distress debriefings. Screening one of the films in this section as a unit exercise, followed by a panel discussion, may help serve that purpose if there are no other educational venues.

A further defining feature is that illness and disease or the 'breakdown' of the normal bodily state is due to 'faulty' or worn organs or systems, or changes that occur as the result of biological threats such as invading pathogens (bacteria or viruses), nutritional or chemical imbalance, injury, or simply through the ageing process [9]. In this way, the body has come to be viewed as a complex mechanism in which all of the parts must function together to ensure health.

The job of medicine, therefore, is to fix the body when it breaks down through the study, diagnosis and manipulation of physical and biochemical processes. The diagnostic process usually involves physically examining the patient, and then treating him or her, which may involve repairing or controlling the affected body systems. An important feature in this system, therefore, is the role of the clinician (medical), who intervenes to limit damage and to help to resume normal functioning in the event of a bodily malfunction.

Practitioners of biomedicine are expected to remain objective and analytical, drawing on their specialist knowledge to treat the disease or injured part of the body. They hold a privileged position within society, and are generally well-educated and respected specialists who practice in settings that resemble laboratories and other scientific institutions. As one of the learned professions established in medieval times (along with law and divinity) their position is upheld in law, giving physicians the authority to treat patients, to prescribe powerful medicines and to withhold treatment if they believe this is necessary. They also have the right to detain patients in hospital if, for example, it is believed that they are suffering from a mental illness or are a danger to other people. In clinical settings, a psychiatric diagnosis allows for efficient communication among health care providers across specialties regarding a patient's medical condition [10]. A psychiatric diagnosis summarizes succinctly a large amount of information about a patient, which can then be conveyed quickly among treatment providers. A diagnosis also helps to guide clinicians to the appropriate treatment and therapeutic management for the patient. A diagnosis can provide information regarding course of illness, risk of comorbidities and complications, and prognosis. It also provides a way to communicate to insurance companies regarding coverage for illnesses, medications, and other therapies. A diagnosis may open or close doors to other mental health care services and resources. Because a psychiatric diagnosis is used to communicate to multiple medical and non-medical entities and can determine treatment, it is very important to make thorough evaluations and accurate diagnoses.

A psychiatric diagnosis can also play a very important role for patients because it brings words to express their experience. For people struggling with mental illness, a psychiatric diagnosis can provide validation of their symptoms and their suffering. It can also help them to feel less isolated or ashamed and give them comfort that they are not alone in their disease. It can dispel the belief that the illness is "all in their heads" by appropriately defining their symptoms as a medical illness. A psychiatric

diagnosis can give hope to a patient by identifying an illness that has treatment options. A diagnosis can be the "answer" for which some patients and their families are looking to understand themselves and their loved ones. However, for some patients, a psychiatric diagnosis may feel shameful, devastating, and inconsistent with their experience, e.g. delusional, conversion, or somatoform disorders. Talking with patients about how they feel regarding their diagnosis as well as educating patients and the important people in their lives regarding the nature of psychiatric illness is necessary to decrease stigma and promote understanding of these complex biologic disorders.

Mental Health

The distinction between physical and mental health assessment is ultimately an arbitrary one; not only are people with mental health problems at increased risk of poor physical health but people with physical health problems are also more likely to develop a psychiatric illness [11]. This is reflected in the title of the government's mental health strategy document 'No Health without Mental Health', which calls for so-called parity of esteem between mental and physical health and an end to the stigmatisation and healthcare inequalities that have long dogged those experiencing psychiatric illness. It is therefore essential that healthcare professionals from all disciplines can competently assess people with mental health problems; indeed there is a growing body of evidence that the prognosis for people with mental health problems can be improved dramatically by offering them timely assessments and guiding them towards appropriate evidence-based interventions.

Despite being at higher risk of co- occurring physical ill- health, evidence suggests that people experiencing SMHP (severe mental health problems) are less likely to receive appropriate screening and care for physical ill- health, and quality of care has been found to be inferior to that provided to those with no comparable mental disorder [12]. For example, although depression is an established psychosocial risk factor for coronary heart disease, people experiencing a charted history of depression attending an emergency department with an acute myocardial infarction were more likely to receive a low- priority triage score and miss benchmark time for key screening and treatment procedures compared to people experiencing other comorbidities.

There are a number of potential reasons behind this discrepancy in care. Misdiagnosis may occur, with physical health symptoms being attributed to mental health or substance use (drug and alcohol) issues. External stigma, discomfort or lack of confi dence on the part of the health professional may result in treatment refusal or adjustment. Symptoms of the mental health condition itself (for example, thought disorder in chronic schizophrenia) may impede clear communication of concerns or problems to health professionals. Th e individual may avoid presenting to clinical services with problematic symptoms due to discomfort, internalised stigma or past negative experiences. Conversely, the person and/or their family may overcome real or perceived service barriers by engaging in less appropriate behaviours to get the person medical attention, potentially increasing existing tension between the individual and the professional.

Conclusion

Mental health is not just the absence of a mental disorder. It is defined as a state of well-being in which each person realizes his potential, deals with the daily stress of life, can work productively and is able to contribute to his community. The diagnosis is made on the basis of data obtained from the patient, the clinical picture, as well as information obtained from persons which are close with the patient. During the diagnosis, special attention should be paid to the presence of other psychiatric or physical disorders.

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