

Psychiatric Co-morbidity: Revisiting the “Mind-Body” Connection

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Co-morbidity refers to the presence of co-occurring mental and physical disorders in the same person. This is regardless of the chronological order in which they occur or the link between them (1). Co-morbid mental disorders such as depression and anxiety are well recognized globally and are important public health issues. Co-morbidity surveys estimate that approximately 29% of adults with medical conditions also have psychiatric co-morbidity and that 68% of adults with mental disorders also have medical conditions (2). Despite the high prevalence of mental disorders including co-morbid conditions globally, there exists a huge treatment gap. Research has estimated that less than one-third of individuals meeting the criteria for various mental disorders actually receive any treatment. This is magnified in low and middle income countries where almost two-thirds of patients with mental disorders do not receive adequate treatment that they require (3).

It has also been shown that persons diagnosed with chronic medical conditions are at increased risk for depression (4), with co-morbid depression ranging from 10–32% when looking from community to clinical samples (5, 6). Research done in Jamaica indicates that 43% of attendees of HIV/AIDS clinics and 21.6% of attendees of sickle cell clinics screened positively for depression (7, 8). At the University Hospital of the West Indies (UHWI), the commonest psychiatric disorders confirmed by the Consultation Liaison service among the patients referred were depressive disorders (19.9%), adjustment disorder (19.9%), psychiatric disorders secondary to an underlying medical condition (15.4%) and psychoses which were not secondary to schizophrenia [13.9%] (9). The research out of the UHWI also indicates that patients in the intensive care unit (ICU) at that hospital also have a high percentage of psychiatric co-morbidity. This is evidenced by the relatively high referral rate from the ICU (9).

There is a bi-directional and complex relationship between chronic medical conditions and mental illnesses. Many of the medical conditions carry a heavy symptom burden and as a result cause chronic stress and depression. The

existence of chronic medical conditions such as diabetes, hypertension, arthritis and heart disease are associated with lower quality of life. They cause disability and may impact on the individual's ability to self-care and attend to their activities of daily living (10). Medical conditions such as those associated with pain, including migraine, fibromyalgia and disorders of the spine can increase the risk of developing anxiety and depression (11, 12). As highlighted in this edition of the Journal, anxiety disorders may also be associated with oro-facial conditions and dental treatment (13).

Psychiatric co-morbidity also occurs as a result of the fact that some medical conditions and mental disorders share similar risk factors. These may include childhood adversity, low socio-economic status, obesity, overeating, smoking and a sedentary lifestyle (4, 14). Arising from some of these factors, persons may develop maladaptive attachment behaviours towards others making it challenging for them to develop trusting relationships with others, including physicians. This is likely to be a factor in why many physicians find patients with mental disorders such as depression to be more difficult to treat and why persons with mental disorders receive less adequate preventive medical care (15).

Persons with co-morbid mental disorders have been noted to have significantly more medically unexplained symptoms without identified pathology. This may also contribute to the difficulty that may be associated with diagnosing and managing these medical conditions. Additionally, many patients with chronic illness must learn to adapt and adjust to their chronic aversive symptoms, such as pain or fatigue. Persons with psychiatric co-morbidity have difficulty in doing so. Hence, they will have a heightened awareness and focus on both symptoms of that physical illness as well as physical symptoms associated with other body organ systems (4, 16).

There is a significant societal and individual cost attached to psychiatric co-morbidity. Belli *et al* (17) highlight one aspect, that is, those individuals who present for costly treatment interventions motivated by mental disorders such as body dysmorphism. The medical costs associated with managing persons with psychiatric co-morbidity also increases quite significantly when compared to treating persons without co-morbidity. There is a significant contribution to the expenditure as a result of the increased length of hospital stay of persons with psychiatric co-morbidity, as

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well as the frequency with which they are re-hospitalized (18).

Several strategies are recommended to identify mental disorders, improve treatment and referral mechanism and to improve the outcome of persons diagnosed with co-morbid mental health problems.

These include:

- * Systematic screening especially for common disorders for depression and anxiety among persons presenting with medical conditions who may have unexplained somatic symptoms, poor response to treatment *etc.* Although screening instruments do not diagnose a disorder, they can identify persons who are at risk. Several good screening tools exist for depression such as the Beck Depression Inventory, Centre for Epidemiologic Studies Depression Scale, the Zung Self Rating Scale, and the Edinburgh Postnatal Depression Scale.
- * The integration of mental health services into primary healthcare has been cited as an important strategy not only to expand mental healthcare but to better facilitate the detection and treatment of co-morbid mental disorders (2, 4).
- * Training of primary healthcare providers to detect, treat and refer common mental disorders.
- * Regular in-service training of health staff to sensitize them to the prevalence of mental disorders, the challenges they may present and the treatment of the common disorders.
- * Ensure that drugs used in the treatment of common disorders are available on the national formulary, that they are available in primary care facilities and that they are made affordable through subsidy and through the procurement of generic drugs especially in low and middle income countries where the treatment gap is highest.

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