

COMORBIDITY IN PSYCHIATRY: ITS IMPACT ON PSYCHOPHARMACOLOGICAL TREATMENT

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SUMMARY

The existence of two or more diagnoses (psychiatric, or a combination with somatic) in one person leads to a dilemma when choosing psychopharmacs for the treatment of the patient. There are no acceptable and comprehensive guidelines or algorithms for the treatment of innumerable possible combinations of psychiatric and somatic disorders. A strategy for treatment of such conditions is needed.

Key words: comorbidity – psychopharmacotherapy

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INTRODUCTION

The concept of comorbidity in psychiatry has emerged as a consequence of inability to apply the principle “one individual – one disease”. Valid classifications in psychiatry (DSM IV, ICD-10) (APA 1994, WHO 1993) even though not consistent with practical experiences, still persistently classify mental illnesses as “pure” entities. Many studies have documented high comorbidity, especially of major depressive disorder (MDD), ADHD in adults, GAD, panic attacks, OCD, or PTSD, with individual mental disorders. Approximately two thirds of patients with major depressive disorder (MDD) and generalized anxiety disorder (GAD), social anxiety disorder (SAD), or posttraumatic stress disorder (PTSD) have their anxiety disorder onset first. Co-occurrence of PTSD and substance abuse disorders is a frequent diagnostic combination that severely affects course and outcome of the disease. The general opinion among psychiatrists is that over 50 percent of people with a psychiatric diagnosis, and an alcohol abuse diagnosis, and over 75 percent with a substance abuse diagnosis, has a comorbid relation.

WHAT IS MEANING THE TERM COMORBIDITY?

This use of the term ‘comorbidity’ to indicate the concomitance of two or more psychiatric diagnoses appears incorrect because in most cases it is unclear whether the concomitant diagnoses actually reflect the presence of distinct clinical

entities or refer to multiple manifestations of a single clinical entity (May 2005). Numerous compromises between existing and empirically obligating classifications have produced different forms of application of the principle of comorbidity. The prevalence of substance (marihuana, cocaine) abuse among patients with schizophrenia has risen dramatically over the past decade, with some comorbidity estimates of more than 40%. There is no single DSM-IV-TR (APA 2000) or ICD-10 (WHO 1993) diagnosis that describes a commonly encountered patient who presents panic attacks, depression, and a perfectionistic personality style. This discrepancy between practice and theory can only be removed by applying knowledge that comes from practical work and methodologically well-set studies.

IMPACT ON THE PSYCHOPHARMACOLOGICAL TREATMENT

Of course, the existence of two or more diagnoses (psychiatric, or a combination with somatic) in one person leads to a dilemma when choosing psychopharmacs for the treatment of the patient. Substance-abusing psychotic patients typically have a worse course of illness, more episodes of psychosis, poorer antipsychotic response, higher intensity of anxiety and depression, and require greater amount of antipsychotics than psychiatric patients that do not abuse substances.

At this moment we are aware that there are no acceptable and comprehensive guidelines or algo-

ritms for the treatment of innumerable possible combinations of psychiatric and somatic disorders. A strategy for treatment of such conditions is needed. But in order to build such a strategy, we need more controlled studies providing evidence-based approach – something we are lacking at the moment. What is happening in everyday practice? Usually after careful examinations of the medical conditions, the first decision should be about the application of medication for somatic disorders, if it is found.

DILEMMAS IN USING PSYCHOPHARMACS

What comes next is the decision about psychopharmac(s)? This issue is crucial. It opens more questions:

1. To give the patient one (monotherapy), or more drugs (polypharmacy)? Both options have their advantages and disadvantages, sometimes even leading to harmful consequences.
2. To treat one by one symptom, or all of them at the same time? Nowadays, what most practicing psychiatrists use to do in the most frequent cases of comorbidity, is:
 - To determine which disorder comes first, with the hope of intervening early to prevent the onset of the second disorder.
 - Drake and colleagues (Drake & Noordsy 1994) present a 4-stage conceptual model for treating co-existing substance abuse and severe psychiatric disorders. According to this model, the 4 phases of treatment are engagement, persuasion, active (or primary) treatment, and relapse prevention. The core aspects of the 4 stages include group therapy, case management, toxicological screening, family involvement, participation in self-help groups, and psychopharmacologic intervention. The treatment of comorbid substance abuse and psychosis should involve multiple modalities, incorporating behavioral and pharmacologic interventions.
 - For anxiety, first choice is cognitive-behavioral treatment that focuses on symptoms. The aims are cognitive restructuring, exposure, and relaxation training for anxiety disorders and comorbid conditions. The treatment of depression should be addressed first. For dual-diagnosis schizophrenia many authors propose a behavioral treatment for

substance abuse and schizophrenia along with pharmacotherapy (Kaufman & Charney 2000).

- Treatment of psychiatric comorbidities in bipolar disorder is not based on controlled data, but is largely empirically based. Controlled trials in patients with bipolar disorder and comorbidity are urgently needed. The presence of medical illnesses among inpatients with bipolar disorder is known to complicate treatment and lengthen hospital stay. Medical comorbidities increased with age. The most common systemic illnesses in bipolar outpatients were Endocrine and Metabolic Diseases (13.6% of the sample), Diseases of the Circulatory System (13.0%), and Diseases of the Nervous System and Sense Organs (10.7%). Significant specific diseases included cardiovascular diseases/hypertension (10.7%), COPD/asthma (6.1%), diabetes (4.3%), HIV infection (2.8%), and hepatitis C infection (1.9%) (Beyer et al. 2005).

CONCLUSIONS

In summary, it is possible to say that comorbidity in psychiatry is a common phenomenon. Practically, in the present time it is difficult to find “pure” diagnosis in any patient. What does it mean? Changing appearance of psychopathological entities (many genetical and environmental reasons for it!), inadequate official psychiatric classifications, and deficiency in proper diagnostic instruments, lack of knowledge about etiology of psychiatric disorders, or something else? Psychopharmacotherapy has a difficult task to find a solution for a satisfactory treatment for ever increasing number of patients today, although diagnostics is still far from being complete, classifications in psychiatry still being imperfect, and knowledge about the etiology of most mental disorders still being insufficient.

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