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Editorial

Psychiatric comorbidity and its clinical importance

Mohammad S I Mullick

Naturally, comorbidity exists in psychiatry and is expected in nearly half of the cases across age, gender and time. The main reasons for comorbidity are shared biological and environmental risk factors that create complex psychopathology. Low reliability and validity of some disorders as well as other artefacts can be additional reasons for increased rate of comorbid diagnosis. Despite these limitations and controversies, considering comorbidity is one of the key issues in clinical psychiatry that requires adequate intervention to minimize the multiplied distress and impairment.

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The term comorbidity is used in psychiatry to describe more than one clinical presentation occurring simultaneously. High rate of comorbidity exists in psychiatry. Most psychiatric patients have more than one diagnosis across all ages, gender and time. Large-scale prevalence data can seemingly tell us much about the high rate of comorbidity in mental health. Data from US National Comorbidity Survey, for example, suggested that, of those reporting mental health difficulties (across a 12-month prevalence), only 55% carried a single psychiatric diagnosis.[1] Several community surveys have reported that, among respondents with at least one mental disorder, 45-54% have one or more additional lifetime diagnoses.[2,3] In a mental health survey among adolescents of 13 to 17 years age, 27.9% of the respondents met criteria for 2 or more disorders.[4] The recognized causes of comorbidity are shared biological and environmental risk factors.[5]

Furthermore, in a single diagnosis it is widely acknowledged that individuals treated for incident psychiatric disorders are at increased risk of subsequently developing other mental disorders. A nationwide population-based comprehensive cohort study in Denmark revealed that the age and sex-specific risk of comorbidity was pervasive across all pairs of disorders and that this risk was temporally patterned with higher estimates during the first year after the onset of the first disorder, but with persistently elevated rates during the entire observation period. The comorbidity within mental disorders is pervasive, and the risk persists over time.[6] This largest and most detailed examination of comorbidity within psychiatric disorders provides new insights into the complex nature of comorbidity and its importance. Further in-depth studies on existence, cause and risk estimates of psychiatric comorbidities are required for better intervention and prevention of comorbidity.

In psychiatry, it is sometimes difficult to conclude as to whether 'comorbid' psychiatric diagnoses are separate clinical entities, or multiple features of the same underlying cause. Comorbidity is often an artefact for several reasons: different assessment methods, improper utilization of the term comorbidity to indicate the association of symptoms instead of diseases, number and characteristics of hierarchical exclusion rules used in classification systems, nosologic classification in disorders instead of syndromes, excessive splitting of classical syndromes into small disorders with inappropriate and overlapping boundaries, too frequent revision of the diagnostic criteria that changes diagnostic threshold and number of clinical entities considered. Furthermore, certain diagnostic labels such as personality disorders, attract particular scrutiny due to their high levels of comorbidity with other psychiatric

diagnosis.[7] Low reliability and validity exists for some disorders, both in ICD and in DSM diagnoses, especially for the different types of personality disorders, anxiety and depressive disorders. This again creates uncertainty in the precise nature of the condition or conditions being diagnosed. Despite this controversy and limitations, it is well documented that comorbidity leads to poorer clinical and quality of life outcomes.

In addition, comorbidity is associated with a more severe course of illness. Patients suffering from both major depressive disorder and generalized anxiety disorder tend to have a poorer prognosis and a disproportionately higher functional disability when compared to patients suffering from only one disorder.[8] Similarly, old age patients having both dementia and psychosis, who usually are expected to have one or more co-occurring general medical conditions, could be difficult in all aspects. It can also be imagined that a child with autistic disorder and hyperactivity along with disruptive behaviour could be so stressful for the child and would have worse impact on the family. We can assume how far the distress and impact could be for an adolescent boy having conduct disorder and substance use disorder, or a girl with anorexia nervosa and depressive disorder. These facts have led to an increase in interventions targeting all diagnoses.

In psychiatry, a principal diagnosis is one of the key elements to make a treatment plan but not entirely. A psychiatrist has to consider all forms of comorbidities, from developmental to personality, co-occurring physical condition and other relevant conditions, including psychosocial adversities and disability. By any means, the psychiatric diagnosis in clinical settings is certainly axial. Traditionally, physicians are accustomed to keep and handle single diagnosis with the clinical dictum of 'one person one diagnosis' that influences clinical practice and the possibility remains in Psychiatry. This view is reflected in the under diagnosis of psychiatric disorders in clinical settings. Particularly, less diagnosis of personality disorders is well observed. This practice makes the intervention plan less comprehensive that leads to poorer outcomes. The largest study till date using standardized interviews to evaluate a wide range of psychiatric disorders in a general clinical outpatient practice, reports that 95% of psychiatric outpatients had more than one disorder on average, patients had 1.9 current diagnoses when seeking treatment, and more than one-third had at least three disorders.[9] Based on the results of this study, clinicians should assume that outpatients visiting for the treatment of psychiatric problems with diverse presentations, the patients have more than one diagnosis and that needs to be properly addressed.

However, the strategy of diagnosing maximal comorbidity may not be optimal. The practice of listing multiple diagnoses has the power to both enhance and obscure important clinical information.[10] Adopting strategies to prevent artefact of comorbidity and over diagnosis, formalizing conventions for omitting irrelevant diagnoses, practicing a dimensional system to characterize personality pathology and using a list that resembles a kind more commonly used in medical practice, should be explored.

There is a need to examine the comorbidity of mental disorders in a comprehensive fashion. As our understanding of psychiatric disorders continues to improve, so too hopefully will our understanding of comorbidity, and its relevance in clinical psychiatry will be increased. Therefore, clinicians should give more emphasis on diagnosis, evaluation and intervention of comorbid psychiatric disorders.

Correspondence: **Mohamamd S I Mullick,** Professor, Child and Adolescent Psychiatry, Bangabandhu Sheikh Mujib Medical University, Bangladesh.
Email: msimullick@gmail.com

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