Chapter 5
Comorbidity Issues and Treatment in Chronic Mental Illness

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ABSTRACT

Comorbidity refers to presence of one or more additional disorders along with a primary disorder. It affects the prognosis and course of treatment. It is often difficult for clinician to make correct diagnosis in presence of various disorders. The clinical picture of various disorders interferes with treatment process and the outcome. There are some disorders in psychiatry, known as chronic illness. These are schizophrenia, bipolar disorder and obsessive-compulsive disorder. All these three disorder have a major effect on individual’s life. Anxiety, depression, substance abuse and panic symptoms are common in schizophrenia; hence the clinical picture changes frequently. While the literature suggests that presence of two or three disorders make treatment worse, hence multidisciplinary treatment need to be used.

INTRODUCTION

Comorbidity is generally defined as the presence of one or more additional disorders along with a primary disorder. It was first introduced by Feinstein in 1970; to denote some cases in which some additional symptoms occurred during the course of a particular illness. Psychiatric comorbidity is defined as “the co-occurrence of two psychiatric disorders in presence of other illness in the same person” (First, 2005). The nature of symptom is overlapping and do not necessarily imply that one is caused by the other (Feinstein, 1970). It also affects the prognosis and course of treatment. Anxiety, depression, and substance abuse are mostly common illness, that make symptoms worse. The clinical picture of various disorders occasionally changes in subsequent visits. It is found that the symptoms of panic disorders, psychosis, chronic depression and personality disorders are more common with paranoid schizophrenia.

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Bayle, 2001). There is high risk of developing psychotic symptoms in presence of affective illness as well. Bipolar disorder is highly prevalent and heterogeneous that incorporates psychiatric and medical comorbidities (Bhagwagar, 2007). Earlier the prevalence was less than other psychiatric disorder and the symptoms were characterized by episode of depression and euphoric excitement. It was easy for clinicians to diagnose and treat. Presently, the scenario is completely different. Obsessive Compulsive Disorder is one of the most debilitating disorders that disturb sufferer’s entire life. DSM 5 separated OCD from anxiety disorder in the view of the nature of symptomatology and higher prevalence. As all these three illnesses disturb individual a lot and required long term treatment, hence been considered as chronic mental illness. Chapter includes detailed discussion of schizophrenia, bipolar disorder and obsessive compulsive disorder.

SCHIZOPHRENIA

Schizophrenia is a cluster of disorders that alters an individual’s thoughts, perception, affect and behaviour. The concept of schizophrenia was formulated by the work of Benedict-Auguste Morel and Karl Kahlbaum in the mid-nineteenth century (Shorter, 1997). The term ‘Demence Precoce’ was coined by Auguste Morel to define a disorder characterized by cognitive impairments and progressive deterioration observed in young people. The detailed description of schizophrenia was highlighted by Emil Kraepelin. He suggested that the illness begins at an early age (‘praecox’) and have a relatively chronic course that is characterized by cognitive and social impairment (‘dementia’). In 1857 he proposed that the pathognomic symptom of schizophrenia is fragmenting of the thinking. Hedived symptoms into two groups i.e., fundamental and secondary group. Kurt Schneider proposed first rank symptoms that are characterized by loss of autonomy, such as thought insertion or delusions of being controlled by outside forces (Fish, 1967).

Incidence and Prevalence

Schizophrenia is a relatively common illness and most common form of psychotic disorder. In epidemiological studies, the mean incidence of schizophrenia is reported. It is a disorder with low incidence but a relatively high prevalence, and costs are reflected by its chronicity in many patients (Knapp, Mangalore, & Simon, 2004). The diagnosis is limited to core criteria and corrected for age, is 0.11 per 1000 (range 0.07-0.17 per 1000) (Jablensky, 1992). The mean age of onset is about 5 years greater in women although a lower female rate in adolescence with a second smaller peak after the menopause. The lifetime prevalence is between 0.4 and 1.4% (Cannon & Jones, 1996). Recent studies showed variation in incidence and prevalence rate. The annual incidence is 0.16-1.00 per 1000 population; which is comparatively lower than previous studies (Jablensky et al., 2011), see the changes diagnostic criteria in Table 1.
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