Psychiatric comorbidity presents special challenges in developing countries

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The developments in the field of psychiatric diagnosis over the last 50 years have been significant, but the current phase has both advantages and disadvantages.

I was trained in the early 1970s, when the ICD-8 and the DSM-II were the operating diagnostic systems. Since then, we have moved to a more criteria based diagnosis. The advantages that I have seen with this change are the greater ease for sharing of information and teaching of postgraduates in psychiatry, and the increased number of diagnostic categories. However, there is a big loss in this shift, as most professionals, especially young psychiatrists, tend to use the diagnostic criteria with greater degree of confidence than is appropriate for the current level of knowledge, in spite of the ICD-10 clearly stating "No classification is ever perfect: further improvements and simplifications should become possible with increases in our knowledge and as experience with the classification accumulates"(1). The whole issue of validity and utility of classification is a subject of intense debate (2).

The question of comorbidity is linked to the current phase of evolution of diagnostic systems. Since the presence of a certain number of symptoms/signs forms the basis for the diagnosis, more than one diagnosis becomes possible in the same patient. The article by Pincus et al explores the complexity of the situation very well. I would like to comment on two issues: the needs of developing countries and the difficulties of classifying psychiatric comorbidity in primary health care.

The availability of mental health services in developing countries is very limited. In general, they are available in the range of 1/50 to 1/1000 of what is available in well developed countries. Consequently, the type of patients seen, the duration of contact and the service needs are different. There is greater use of services by people suffering from severe mental disorders, as illustrated by the very low frequency of the diagnosis of personality disorders in psychiatric centers of developing countries. Further, the contact is often cross-sectional for a particular episode of illness or during the acute phase of the illness. The intervention provided is largely pharmacological, except in some centers where a wide variety of psychosocial treatments are used. These factors lead to the use of the most simple and obvious diagnostic categories. As a result, the identification of comorbidity gets low priority. Clinicians usually diagnose those conditions that can be effectively addressed at the level of available facilities. This situation will change as more and more facilities are created, especially as mental health care reaches the community.

Stimulated and supported by the World Health Organization (WHO), the integration of mental health care with primary health care is now occurring in several developing countries (3,4). In developed countries, the move to primary health care is a way of extending the reach of mental health services, while in developing countries it is the primary and often the only method of providing mental health care. The importance of this approach was reflected in the World Health Report 2001, whose first recommendation was "provide treatment in primary care" (5). This approach to organizing mental health care as part of primary health care has relevance to the discussion of comorbidity. It is well documented that comorbidity of mental disorders (especially of depression and anxiety disorders) is frequent in primary health care (6).

The ICD-10 primary health care version is a very simplified system that is considered suitable for primary care personnel. The twenty categories look simple compared to the full classification. However, experience in developing countries has shown that even this system of classification is difficult to use. The addition of comorbidity, however desirable, is not feasible with the current level of primary health care personnel (7). Moreover, psychiatrists in developing countries are currently making attempts to include psychiatric conditions into the general information system of primary health care. Due to the competing demands on the general information system, only a small number, usually four to six, conditions can be accommodated. Here again the classification of comorbid conditions would not be feasible. If we insist for such a coding, the general health information system at the level of primary health care may exclude psychiatric conditions. Such an exclusion would be a big loss.

A different problem of greater relevance is the comorbidity of physical conditions with mental disorders. This is a frequent occurrence in developing countries (6,8). The usual practice of the primary care is to give greater importance to physical disorders. A major educational effort has to be directed to sensitize and provide skills to general physicians to identify the comorbid mental conditions.

In conclusion, the proliferation of diagnostic categories to meet the growing numbers seeking help for a wider variety of mental health problems is a valuable addition to the development of psychiatric classification. However, this desire to describe and categorise everything should not come in the way of integrating mental health care in general health services. The classificatory needs of the professionals working in developing countries should be considered before universalizing an exhaustive system of coding all comorbid conditions (9). Professionals who will be caring for the mentally ill need simpler diagnostic systems, which are easy to use and relevant to care rather than academic needs. In that context, the emphasis on coding all comorbid conditions may be premature. The desire for the best should not come in the way of common good.

References

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