

Commentary on the Comorbidity of Alcohol Use Disorder and Depression among Patients Attending a Tertiary Hospital in the Niger Delta Region of Nigeria

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Abstract

A commentary on "The co-morbidity of Alcohol Use Disorder and depression among patients attending a tertiary hospital in the Niger Delta region of Nigeria" is the objective of this exercise. The study demonstrated a higher rate of alcohol use disorders (AUD) among those who presented with depressive symptoms. Furthermore, about half of the subjects who met the criteria for AUD in the study also met the criteria for depression while only a quarter of those who didn't satisfy the criteria for AUD were also found to be depressed. This underscores the concept of co-morbidity which is well documented as a challenging phenomenon for therapists. The coexistence of two chronic illnesses in the same individual constitutes double jeopardy because of their synergistic deleterious consequences on the body. Even though many plausible theories have been propounded to explain the concept of co-morbidity of AUD and Depression, none has sufficiently explained the common risk factor for and/or the exact cause of this challenge.

Nevertheless, the need for a routine comprehensive clinical assessment of any patient with co-existing disorders in clinical settings is recommended.

Keywords: Co-morbid; Depression; Alcohol; Disorder; Studies; Psychiatric; Risk

Introduction

When a patient suffers from two or more disorders simultaneously, the person's health situation is referred to as "a co-morbid one" or a case of "co-morbidity". According to Kessler et al., "Majority of individuals who meet the criteria for a major psychiatric illness will also meet the diagnostic criteria for at least one additional disorder" [1]. Co-morbidity has become a topic of growing interest because of its clear impact on clinical severity. Many studies opine that "chronicity" and "treatment resistance" are the hallmarks of many co-morbid conditions and most sufferers are more vulnerable to experience disabilities of different types and varying dimensions than in a single psychiatric condition [2-4]. Studies show that depression with co-morbid substance use disorders are among the most common psychiatric co-morbidities recorded globally [5-7].

Okeafor et al. demonstrated significant more occurrence of alcohol use disorders among depressed than non-depressed patients [8]. They also noted that "45.8% of those with alcohol use disorders use were diagnosed with depression in comparison to 26.0% of those without" alcohol use disorder [8].

Several theorists have attempted to explain the phenomenon of this co morbidity. While some studies show that the pathological effects of a mood disorder may increase the risk for substance use disorder, others maintain that the presence of mood symptoms and substance use disorder in the same individual are mutually exclusive events [9,10]. Other researchers proposed "kindling", the concept that

repeated disruptions sensitize brain cells [5,9]. The kindling theory of co morbidity, posits that individuals who are predisposed to suffer these disruptions, a possible underlying neurobiological tendency to sensitization may promote both drug dependence and mood disorders [11]. The effectiveness of many mood stabilizers, most of whom are anticonvulsants in the management of mood disorders as well as alcohol use disorders validates the kindling theory.

Sullivan reported that "drinking and related symptoms may promote depression indirectly as well by contributing to stressful life circumstances that in turn are known to promote depression" [12]. This view has been supported by other researchers [13]. This stress-diathesis etiological model of psychiatric disorders is very applicable to the AUD/Depression co-morbidity. The fact that chronic stressful life events can precipitate psychological difficulties, including depression and that many individuals resort to alcohol use as an immature way of coping with their challenging life events is common knowledge. Despite the multiple erudite explanations for co-morbidity that have been enunciated, none has sufficiently addressed the issue of the joint underlying cause and/or vulnerability for Depression and AUD [14].

Many studies have been done to elucidate the unique phenomenon of AUD/Depression co-morbidity in Psychiatry [15-18]. While some suggest that the frequency of alcohol use predicts the emergence of depression in a patient [19], others maintain that binge drinking is a more reliable risk factor for the development of depression [20,21]. It is difficult to ascertain which of these two is exactly correct because methodological differences and individual genetic differences in metabolizing alcohol as well as the body's response to the effects of alcohol are confounding factors.

Risk ratios for the development of AUD and mood disorders of 1.8 to 4.2 have been reported, which indicates an appreciable link between the two disorders [22,23]. Nevertheless, it is not clear which of these disorders constitute more of a risk factor for the development of the other [24-27]. While some researchers suggest that women are more prone to start using alcohol in response to their depressive symptoms and hence are more likely to suffer from co-morbid AUD/Depression than men [26,28], others think otherwise [29]. The less tolerant stance by societies especially in the undeveloped world towards use of alcohol by women is a confounding variable for genuine comparison of alcohol habits and effects between both genders.

Conclusion

The high prevalence and the consequences of the co morbidity between AUD and Depression demand more urgent attention. The need for a routine comprehensive clinical assessment of any patient with one of these disorders or the other in clinical settings is recommended.

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