Complex Integrated Primary Health And Psychiatric Disorders

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Introduction

Psychiatric disorders are conditions primarily characterized by a disruption in personal cognition and thought regulations in emotions or actions that mirror the dysfunction in biological, developing, and psychological processes underlying brain function. Sometimes, psychiatric disorders are referred to as mental health ailments or mental health conditions. They are meant to interfere with the behavior of an individual, how he/she relates to others and even their normal functions in daily living. Several studies indicate that Major Depressive disorder and eating disorders, majorly Binge eating disorder, among others, contribute to the category of primary mental health conditions that occur in human beings (Ripke et al., 2013).

The studies show that anxiety and depression are not the only symptoms of these disorders but also, the patient experiences hopelessness and a high rate of appetite, among other symptoms. When the conditions are not treated or prevented in advance, they can easily lead to death. However, these disorders at the hospital level can be identified through the use of DSM-5 criteria. It is majorly administered by physicians, clinicians, and any other expert in the field of psychiatry to diagnose the mental health conditions that could be within a certain individual. People suffering from mental health illnesses rarely do they identify themselves as a patient but only think they are participants in a certain survey conducted within a particular community. The focus of this paper is to comprehensively discuss Major Depressive Disorder (MDD) and Binge eating disorder. The etiology, prevalence, signs, and symptoms of both Major Depressive disorder and Binge eating disorder will be addressed. The physical condition and mental health conditions will focus on discussing Binge and diabetes type 2 ailments. Still, the paper will aim to evaluate the DSM-5 criteria and instruments used in the diagnosis of these conditions. Finally, the paper will seek a certain case study situation including the patient’s demographic data presenting the psychiatric conditions.

Major Depressive Disorder

Major Depressive Disorder mainly affects the personal moods and code of conduct as well as interference with demographic fictions like sleep and appetite. Major depressive disorder entails the personal loss of interest in areas the person loved most, difficulties in performing daily activities, and total sadness in life. The individual suffering from this condition experiences a state of unworthiness. It has become the most common disorder in both men and women of the year 25-65 years old living

in low-income families, although adolescents and aging also experience it (Ripke et al., 2013). The feeling of ever sadness and pessimistic makes it difficult for individuals suffering from this ailment to enjoy life to their fullest. However, the disorder can be managed and treated through psychotherapy, among other methods that enhance the management of the symptoms.

Etiology

Predisposing, perpetuating, and precipitating factors are the etiology of Major Depressive disorder. The predisposing factors include the heritability aspects that are considered genetic, demographic health, behavior, and social livelihood. A study indicates that 30 percent of the condition occurs due to genetic history in the family, and fifty percent occur due to physical ailments of an individual. The precipitating factors like poverty, sadness and the feeling of hopelessness greatly contribute to Major Depressive disorder. Genetically, the neurotransmitters act as the etiology of Major depressive disorder (MDD). The discharge and re-uptake of serotine, dopamine, and norepinephrine in someone's mind are associated with personal moods. Dopamine becomes the main neurotransmitter that induces mood change and impulsions in someone's brain. The occurrence of neurotransmitter (NTs) imbalance in the brain of an individual contributes to the change of a person's moods; thus, the person suffers from a Major depressive condition. This occurs after the antidepressants act on the receptors of neurotransmitters as well as neurotransmitters themselves. Besides, a change or imbalance of brain activity causes Major Depressive Disorder (Moylan et al., 2013). The decreased activities of the left frontal lobe and raised activity cause depression.

Moreover, childhood disturbances increase the disorder for a period. Such traumas include sexual, mental and physical harassment and even neglect. These traumas cause depression conditions to worsen, especially in children. Also, the most severe happenings in the lifetime cause MDD in the individual. The high stress in a job or lack of a job that makes life most strenuous majorly causes the MDD condition, especially in adults between 25-65 years of age. The higher rates of MDD are seen in young adults who face challenges regarding straining to get a living for themselves and their families. Besides, a study by (Moylan et al., 2013) showed that a great number of women face Major Depressive conditions due to hormonal changes. The women approaching the menopause stage of life have alterations in hormones, which greatly contribute to depression in their lifetime. Therefore, the biological, social, and psychological factors discussed above significantly cause depression. These are all triggered by genetic aspects activated by the interaction between nature and nurture.

Prevalence

A study by (Rotenstein et al., 2016) indicates that in a median lifetime, the prevalence of Major depressive disorder is 16.1 percent and ranges between 4.4 to 18 percent. In the range of one year, the prevalence varies from five percent to ten percent in young adults, with females being at higher risk compared to males, contributing to the ratio of around 2:1. A study in South Africa, which was

documented in South African Stress and Health showed that lifetime prevalence of South Africa across all range age was 9.8 percent. In the survey done in 2003 and 2004 in South Africa of 4351 population adults, the prevalence of MDD was 4.9 during this time (Degenhardt et al., 2004). Still, the study found that women were more prone to develop Major Depressive disorder than males. The survey found MDD onset as early as childhood and adolescence. However, it becomes progressively more prevalent in individuals in the age bracket of the twenties to sixty-five. Also, the mean age of onset of the disorder in South Africa is 30 years. Similarly, in India, low incomes were associated with the occurrence of MDD. The prevalent individuals are those with lower monthly incomes. The prevalence symptoms were seen in more financially unstable individuals, and females were more prone to suffer from the disorder than males.

A study in China also found that girls had more depressive signs and symptoms than boys. Girls in the adolescence stage tend to show more anxiety and depression when challenged with personal stress than boys. Girls were more prevalent because of the character of blaming themselves during the occurrence of related challenges; therefore, they are more negative toward evaluations by the peer group than boys (Rotenstein et al., 2016). The study found that when girls' depression begins during adolescence, it progresses in their lifetime, especially in those women with low incomes. Therefore, women are found to be more at risk than men.

Signs And Symptoms Of Major Depressive Disorder

An individual is having Major Depressive disorder experiences a very low mood, which inhibits life enjoyment and pleasure. The general signs and symptoms differ from one individual to the other, and they include pessimism, loss or gain of appetite and weight, difficulties in remembering, decision making and easy loss of concentration, especially in adolescents, and persistent aches in the body even when no other sickness is observed to the individual (Rotenstein et al., 2016). The other significant characteristics of MDD are feelings of guilt, insignificance, or weakness. Also, insomnia is experienced, the aspect where a person oversleeps or wakes up more early in the morning than usual. Additionally, when the condition persists, thoughts of death invade the sufferer's mind, and attempts of suicide are witnessed. However, the sick person physically experiences headaches and fatigue.

DSM-5 Criteria And Instruments For The Diagnosis Of Major Depressive Disorder

The DSM-5 criteria for MDD comprise the presence of anhedonia, which is a depressed mood, together with other depressed signs and symptoms like loss or gain of appetite, insomnia, and lack of concentration, among others. These symptoms occur for two weeks. The symptoms should not be caused by other therapeutic conditions or any abuse of drugs (American Psychiatric Association. 2013). The disorder is termed to have ended when the signs have reduced below the verge of

diagnosis. Also, the condition is considered to have ended once the symptoms have resolved totally for a minimum of three subsequent months. In the departure from DSM-5, the case of sadness is no longer a prohibition for the diagnosis of Major Depressive Disorder. The assessment instruments helpful for the diagnosis of MDD include the Mood Disorder Questionnaire (MDQ), the MDD screening scale, the Composite International Diagnostic Interview (CIDI), and locating a family genetic history via the use of a Genogram. The genogram aids in recognizing and showing the Major Depressive disorder patterns in the family. However, the MDQ is considered to deliver a tool to help the physicians in the hospital set up to screen the current and past conditions of hypomania and mania. Besides, the CIDI scale helps to identify the verge of MDD.

Binge Eating Disorder

There are various types of eating disorders, including Anorexia Nervosa (AN), Bulimia Nervosa (BN), and Binge Eating disorder (BED), among others. Anorexia nervosa is majorly characterized by the fear of gaining weight, low body weight, and strong aspirations to be thin. Bulimia Anorexia is an eating disorder characterized by eating a large amount of food within a short span of time. However, Binge eating disorder, as the name suggests, is a mental illness that is characterized by eating extremely and excessively large quantities of food very frequently, even if not hungry. The eating is followed by feelings of guilt, disgust, and depression. The BED is similar to BN but not the same because BN involves purging activities that are absent in BED. This illness affects anybody despite age, ethnicity, and gender.

Etiology

A study (Nervosa, 2013) recognizes the genetic factors with the association with environmental factors as the etiological agents of binge eating disorders. The study found that hormone indiscretions and genetic mutations were connected to the occurrence of BED. Also, the low levels of serotine contribute to binge behavior in an individual. However, a survey by the Archives of General Psychiatric discovered that the family members of obese persons were twice as prone to suffer from the disorder compared to obese individuals who had no history of the condition. The characteristics of the BED are associated with the transcription of a genetic factor necessary for myelination accountable for the development of sheath protection around nerve fibers. A study of certain twins evidently showed that vomiting and other binge eating pathological attitudes are 72% heritable.

Prevalence

Several studies have been conducted on different populations to identify the Binge eating disorder within the population. In the community of Australia, certain research showed that 1 percent of had binge eating disorders (Smolak et al., 2013). The study indicated that 1.09-0.2 percent satisfied the

DSM-5 criteria. Also, BED was found to be more prevalent as the amount of obesity increased. Binge eating condition is found to be associated with obesity and unstable high weight while the individual seeks to reduce the weight. Besides, 10 percent of the population suffering from BED also suffered diabetes type 2. BED precedes type 2 in most individuals and is the major cause of diabetes type 2.

Signs And Symptoms

Entirely people with Binge eating conditions primarily eat enormous quantities of food at a particular time, which causes a sense of uncontrollable eating behaviors. Individual eats so many calories when they are not even hungry. Additionally, these individuals experience feelings of shame and guilt, depression, and disgust due to their eating manners. Besides, the feeling of impulsiveness and being overweight exceed in the patient suffering from the BED. The patients finally develop the act of secretly eating and avoiding social conditions (Kessler et al., 2013). Moreover, the individual faces distress, fear of condemnation by others, anxiety, sensitivity to their body look, and low self-esteem. Additionally, the patient experiences thoughts of suicide, and when the condition is not early controlled or treated, it may lead to death.

DSM-5 Criteria And Instruments For The Diagnosis Of Binge Eating Disorder

The main symptoms of Binge eating disorder are the excessive eating of large amounts of food, most regularly within short time intervals. The DSM-5 criteria integrate the feeding disorder into a corporate diagnostic structure to create a new world of eating condition assessment. The aspect of assessing the eating disorder is done through a specific interview like the Diagnostic of Eating Disorders, where the researcher gives it to the sample population (Walsh et al., 2013). Also, a Longitudinal Interval Follow-up Evaluation is conducted to assess the patients. Besides, the Eating Disorders Examination (EDE) evaluates the behavioral characteristics of the eating condition like the degree of food consumed and the inability to control overeating. The Self-Report Questionnaire and Semi-structured have subscales that show the different measures of the disease. The DSM-5 criteria are adapted for use as a web-based application that enables the assessor to enter the data given by respondents into the answer field of the application. Finally, the provides the best diagnosis for the patient according to the symptoms provided in the interview paper.

Binge Eating Disorder And Diabetes Type-2

The binge eating condition is discernible through excessive food eating while no purging. The people suffering from BED will show an indirect result through the development of obesity due to the calories and large amounts of food eaten. Most researchers connect the occurrence of diabetes type 2 to obesity in individuals with binge eating disorders (Raevuori et al., 2015).

Etiology

The main cause of the co-occurrence of binge eating disorder and type 2 diabetes is the genetic makeup of an individual. Both of these disorders are merely associated with family history. For diabetes to occur, the body must not produce insulin, or the patient's body may produce the insulin. However, the cells ignore it. Insulin is an important consideration for the operation of the body as it is responsible for removing the sugar from the blood and taking it to the body cells (Brownell & Walsh, 2017). Moreover, poor self-esteem and depressed mood about the body appearance contribute to the development of these two conditions in an individual.

Prevalence Of Diabetes Type 2 And Binge Eating Disorder

The prevalence rate for patients with type 2 diabetes and who also suffer from Binge eating disorders in the USA is 12 percent (Raevuori et al., 2015). The binge eating condition affects 2-3.5 percent of the adult population in the United States, and a rate of 9.3 percent of the total population of America suffers from diabetes type two infections.

Impact Of Their Co-Occurrence On Clinical Assessment

The Binge eating disorder adds a connection to both psychological and pathological nutritional conduct, thus enhancing a powerful combination of challenges for the control of type 2 diabetes. Moreover, binge eating affects the onset and progression of type 2 diabetes. The restriction to eating together with the binge feeding pattern contributes to gaining weight, which will further be related to the commencement of type 2 diabetes. However, being a covariate to overweight facilitates the development of diabetes type 2. A study by (Raevuori et al., 2015) shows that psychological stress affects insulin confrontation through the sympathetic nervous system and hypothalamic pituitary adrenocortical system activation and has more effects on diet and exercise. The DSM-5 criteria explain splurging as a loss of control of eating behavior and the omission of insulin as a maladaptive tactic to avoid gaining weight. The aspect of weight gain depresses the patient, contributing to type 2 diabetes and making it difficult for patients to adhere to diabetes medical instructions.

Patient's Case Scenario

A 29-year-old female patient by the name of Cecilia presented the signs of depression to the nurse. She claimed to have been crying daily, a feeling of sadness that occurred to her, a problem sleeping

at night, and overindulging. She reported going to bed at 2.00 am or 3.00 am and still lacking sleep. However, if she could afford to get sleep, she only slept for very few hours. She said that she spends the entire time thinking and worrying about her status. The client reported not having any challenges during childbirth, nor did she have any injuries to the head during her developmental stages (Allison, 2005). Therefore, no account for neurological problems. However, the condition worsened, and she thought she was having a problem with her husband and that she was not making a good mum. Also, she reported not having a good relationship with her mother.

The situation of depression began right away after her third childbirth. She acknowledged that the depression was affecting her since was not relating well with both kids and her husband, it excluded her from social events as it kept her away from events. The disorder was bringing sadness to her life. The woman looked for assistance for post-partum depressing conditions six months after the third childbirth (Allison, 2005). Her gynecologist recommended 20mgs of Paxil, but after a while, she felt it did not help and stopped taking it.

The lady recalls having messy conditions during her growth; the parents argued several times in the presence of the kids. At 11 years, her mother left quarreled with her father, and she left home. Therefore, the client, at 16 years of age, was responsible for preparing the meal for other siblings that their struggling dad brought back home. The mother's absence disappointed her, and up to date, that situation annoys her. She thus continued to have strong feelings of anger that forced her to become pregnant with a man who was irresponsible and unable to maintain her.

Later, at the age of 19, she broke up and admitted to raising her child. She was married to her current husband at the age of 23. She admits that her childhood stage was full of unstable and unsupportive emotions. After marriage, she became annoyed and depressed about her husband working for long hours and not having time for the two. Cecilia wishes to be a good mother, a sibling, and a good friend to everyone. The issue of sadness is family history since Cecilia's sister is married and experiences the same situation in the marriage (Allison, 2005). Currently, Cecilia remains guilty of the two incidents that happened during her time. She remembers her request from her grandmother who asked to pay a visit. Instead, she went on a date, and the grandmother passed away the same day. Additionally, during her teenage, her dad for help, and she refused, on the same night, the dad suffered a heart attack. These two incidents make her always sad and feel guilty, and she even blames herself for a date. Additionally, her third child pregnancy was unexpected, something that depressed her since she was on the pill (family planning program) when she got the pregnancy. She felt to have lost control over her life because of her third-born pregnancy.

Appropriate Diagnosis Tools For Screening This Case Scenario

The appropriate diagnosis tool for Cecilia's scenario is the DSM-5 criteria. The symptoms expressed are clear evidence of Major Depressive Disorder. For instance, she losses interest in some activities,

lacks sleep, feels unworthy and guilty, crying, anger, anxiety, and resentment are the major characteristics of a person suffering from depression (Allison, 2005). The client exhibits at least five symptoms of the Major depressive episode, and the symptoms persist for more than two weeks.

Conclusion

The essay has majorly focused on the psychiatric disorders exhibited in people's life. Different types of mental health disorders exist; some can be noticeable, while others are not easily identified. Most of these disorders are etiologically genetic with an association with environmental factors. These disorders have adverse symptoms, some of which can deny an individual pleasure in life and cause bad relationships with other people. However, at the onset of some symptoms in life, it is advisable that the client meets the appropriate screening process from a qualified psychiatrist and gynecologist who can guide them on a good treatment regime for the condition.

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