

Module 5: Dual Diagnoses in the Context of Substance Use Disorders

Duration: 90 minutes

Goal:

- ♦ To provide a description and discussion about comorbidity in individuals with substance use disorders which will improve clinical decision making skills of practitioners.

Objectives:

Following this module the participant will be able to:

- ♦ Describe comorbidity in individuals with substance use disorders.
- ♦ Describe three viable reasons for the high incidence of comorbidity observed in individuals with substance use disorders.

Teaching Activities:

Introduction	5 minutes
Temporary substance-induced disorders	25 minutes
Exacerbating pre-existing psychiatric disorders	25 minutes
Psychiatric disorders as an enhanced risk for substance use disorders	25 minutes
Summary	10 minutes

Teaching Format:

This training is designed to be delivered primarily in a classroom / didactic lecture format. The design will incorporate a method which presents accepted data for presentation in a medical school environment. Information will be presented by the instructor for facilitated discussion of some concepts.

Suggested Literature

Brown, S. A., & Schuckit, M. A. (1988). Changes in depression among abstinent alcoholics. Journal of Studies on Alcohol, 49, 412-417.

Gibson, S., & Becker, J. (1973). Changes in alcoholics' self-reported depression. Journal of Studies on Alcohol, 34, 829-836.

Goodwin, D. W., Schulsinger, F., Moller, N., Hermansen, L., Winokur, G., & Guze, S. B., (1974). Drinking problems in adopted and nonadopted sons of alcoholics. Archives of General Psychiatry, 31, 164-169.

Isbell, H., Fraser, H. F., Wikler, A., Belleville, R. E., & Eisenman, A. J. (1955). An experimental study of the etiology of "rum fits" and delirium tremens. Journal of Studies on Alcohol, 16, 1-33.

Knop, J., Teasdale, T. W., Goodwin, D., & Schulsinger, F. (1988). Young men at high risk for alcoholism. In K. Kuriyama, A. Takada, & H. Ishii (Eds.), Biomedical and social aspects of alcohol and alcoholism. Amsterdam, Elsevier.

Mathew, R. J., Wilson, W. H., Blazer, D. G., & George, L. K. (1993). Psychiatric disorders in adult children of alcoholics: Data from the epidemiologic catchment area project. American Journal of Psychiatry, 150, 793-800.

Schuckit, M. A. (1992). Anxiety disorders and substance abuse. In A. Tasman & B. R. Riba (Eds.), APA annual review of psychiatry (Vol. 11, pp. 402-417). New York: American Psychiatric Press.

Schuckit, M. A. (1994). Low level of response to alcohol as a predictor of future alcoholism. American Journal of Psychiatry, 151, 184-189.

Schuckit, M. A. (1995). Drug and alcohol abuse: A clinical guide to diagnosis and treatment (4th ed.). New York: Plenum.

Schuckit, M. A., & Hesselbrock, V. (1994). Alcohol dependence and anxiety disorders: What is the relationship? American Journal of Psychiatry, 151, 1723-1734.

Schuckit, M. A., & Smith, T. L. (1996). An 8-year follow-up of 450 sons of alcoholic and control subjects. Archives of General Psychiatry, 53, 202-210.

- Schuckit, M. A., Irwin, M., & Brown, S. A. (1990). The history of anxiety symptoms among 171 primary alcoholics. Journal of Studies on Alcohol, 51, 34-41.
- Schuckit, M. A., Hesselbrock, V., Tipp, J., Nurnberger, J. I., Anthenelli, R. M., & Crowe, R. R. (1995). The prevalence of major anxiety disorders in relatives of alcohol dependent men and women. Journal of Studies on Alcohol, 56, 309-316.
- Schuckit, M. S., Tipp, J. E., Bergman, M., Reich, W., Hesselbrock, V. M., & Smith T. L. (1997). Comparison of induced and independent major depressive disorders in 2,945 alcoholics. American Journal of Psychiatry, 154, 948-957.
- Tamerin, J. S., Weiner, S., & Mendelson, J. H. (1970). Alcoholics' expectancies and recall of experiences during intoxication. American Journal of Psychiatry, 126, 39-46.
- Vaillant, G. E. (1983). The natural history of alcoholism. Cambridge, MA: Harvard University Press.

Teaching Outline

Module 5. Dual Diagnoses in the Context of Substance Use Disorders

Note to Instructors:

Before starting to teach you may want to review the goals and objectives of this module.

I. Introduction

OHD/Slide 5.1 on screen.

Refer to HO5.1.

- A. Two out of three individuals who have a substance use disorder (SUD) meet criteria for at least one additional Axis I or Axis II disorder.
- B. Half of these (one-third of the total) have an additional substance use disorder or antisocial personality disorder (ASPD).
- C. In other words, after excluding ASPD, one out of three individuals with substance use disorders appears to meet criteria for an Axis I major psychiatric disorder.
- D. This rate is a good deal higher than that observed in the general population.

Ask participants what they think about this statistic.

- ♦ What has been their experience?
- ♦ What are their observations about this phenomenon?

Allow a few minutes for discussion and move on with lecture.

OHD/Slide 5.2 on screen.

- E. Other than ASPD the most common psychiatric syndromes seen in people with substance use disorders involve:
 - ♦ anxiety
 - ♦ depression
 - ♦ psychotic symptoms

II. *Potential Explanations for High Levels of Comorbidity in SUD*

The instructor will now focus on three primary explanations for the high levels of psychiatric comorbidity observed among individuals with substance use disorders.

Deliver the following information using a method which involves frequent check-ins with the participants.

A. Reason #1: Temporary Substance-Induced Disorders

Ask participants:

- ◆ What can you tell me about Temporary Substance-Induced Disorders?

Allow the participants an opportunity to answer the question then continue with the presentation.

OHD/Slide 5.3 on screen.

Refer to HO5.2.

1. **The first reason for comorbid psychiatric symptoms: the majority of “comorbidity” is the result of temporary, but often intense, substance-induced disorders.**
2. All drugs of abuse cross to the brain and can alter behavior.
3. Substance-induced behavioral changes or psychiatric symptoms can frequently last days to weeks beyond abstinence.
4. This is similar to substance-induced medical problems.
5. Two classes of drugs:
 - ◆ stimulants
 - ◆ depressantsare especially likely to induce clinically relevant temporary psychiatric syndromes.
6. When a major psychiatric syndrome develops during intoxication or withdrawal from a substance, it can look identical to a major psychiatric disorder as defined in DSM-IV.

7. However, even when the symptoms are of severe enough intensity to meet DSM-IV diagnostic criteria, they are likely to markedly improve or disappear within several days to perhaps a month of abstinence.
8. The patient is frequently left with lingering symptoms as part of a protracted withdrawal syndrome.
9. These residual symptoms no longer resemble full blown DSM-IV major anxiety, psychotic, or depressive disorders.

OHD/Slide 5.4 on screen.

Refer to HO5.3.

The instructor may choose to use the relationship between alcohol dependence and major depressive disorder can be used as an example.

10. At least three major studies have demonstrated that the repeated administration of high doses of alcohol causes symptoms that resemble major depressive disorders.

The instructor can cite the studies by Isbell, et al.; Tamerin, et al.; Gibson and Becker.

11. These depressions, while intense, disappear with abstinence.
12. In another study by Brown (1988), among almost 200 alcohol dependent men who were tested after one week of abstinence, 40% had such high scores on a depression rating scale that major depression could have been considered a possibility.
13. With continued abstinence and in the absence of any cognitive therapy or antidepressant medication, the depression disappeared in four additional weeks in the vast majority of patients.
14. Between week four and week sixteen, depression rating scores increased, but only among those individuals who returned to drinking.
15. Other studies have shown that 80% of alcoholics report having felt severely depressed, and one-quarter to one-third have at some time had a depression that lasted two or more weeks and interfered with functioning.

16. Approximately 5% of male alcoholics and 10% to 15% of female alcoholics appear to have experienced depression independent of times of heavy drinking.

OHD/Slide 5.5 on screen.

Refer to HO5.4.

17. The distinction between prior major depressions independent of heavy drinking and those depressions that only occurred in the context of heavy drinking is made by using a time line approach.
18. The absence of clearly independent major depressions in the past indicates that any present depressive symptoms are likely to be alleviated with abstinence alone.
19. The first step in a time line for comorbid disorders is to identify the approximate age of onset of substance dependence. This could be the age that the person experienced the third of the seven DSM-IV dependence items for that drug. This can be repeated for each relevant substance.
20. The second step is to determine any periods of abstinence lasting for several months at a time since the onset of dependence. These are times when an independent psychiatric disorder might be observed if it exists.
21. The third step is to see if a full-blown DSM-IV psychiatric disorder can be documented before the onset of substance dependence or during a subsequent abstinent period.

OHD/Slide 5.6 on screen.

22. **If** the substance being used is capable of causing symptoms of the psychiatric syndrome, **and if** there are no episodes of the psychiatric condition that are clearly independent of substance use, then it is not likely that the present psychiatric symptom picture is a true independent psychiatric disorder.
23. In this case, the psychiatric symptoms are likely to improve markedly over the first week to month of abstinence.
24. If the full-blown psychiatric syndrome remains after this time, a diagnosis of an independent psychiatric condition should be considered.

These issues are discussed more in many of the readings, including Schuckit (1992).

The instructor is also encouraged to review the lecture on diagnostic approaches for a more detailed explanation of the use of the time line.

25. Similar statements regarding the potential for depressant withdrawal or stimulant intoxication to mimic major anxiety disorders are also supported by the literature.
 - ♦ An investigation of alcoholics by Schuckit and colleagues showed that a majority of alcoholics have had panic attacks, especially during withdrawal, but few were likely to fit criteria for long-term panic disorder.
26. In summary, a substantial proportion of substance dependent individuals, especially those involved with depressants and stimulants, demonstrate substance-induced mood, anxiety, and/or psychotic disorders.
27. These conditions must be recognized (e.g. suicide precautions must be taken if depression is severe), but the prognosis in substance-induced disorders is one for a high likelihood that the psychiatric symptoms will markedly improve within several days to a month or so of abstinence.
28. The person will then probably experience some residual protracted withdrawal symptoms, and these too will gradually disappear over the subsequent months.
29. Studies do not indicate that the use of antidepressants or antianxiety medications improve the prognosis or the rapidity with which the substance-induced psychiatric symptoms will disappear.
30. Antipsychotic medications can be used temporarily in substance-induced psychotic states, but these drugs must be stopped fairly quickly after several days to several weeks of treatment.

The instructor may want to expand in more detail about the use of medications.

B. Reason #2: Substance Use Disorders Exacerbate Pre-existing Psychiatric Disorders

OHD/Slide 5.7 on screen.

Refer to HO5.5.

1. The second major contributor to the rate of psychiatric comorbidity observed in individuals with substance use disorders is the manner in which heavy intake of alcohol and other drugs is likely to exacerbate pre-existing major psychiatric disorders.

Ask Participants:

- ♦ Can you tell me any disorders that substances of abuse can exacerbate?

When participants have responded be sure the following disorders have been included.

- ♦ This is likely to be true with all anxiety, mood, psychotic, sleep, sexual, and other disorders.
2. Symptoms might improve temporarily, but an escalation of substance intake is likely to worsen the symptoms of the prior psychiatric syndrome.

C. Reason #3: Some Psychiatric Disorders Contribute To Subsequent Substance Use Disorders

OHD/Slide 5.8 on screen.

Refer to HO5.6.

1. A third explanation for comorbidity is some psychiatric disorders contribute to an enhanced risk for subsequent substance use disorders.
2. There are a limited number of psychiatric disorders for which subsequent alcohol and drug abuse or dependence syndromes are likely to be observed at higher rates than the general population.

Ask participants:

- ♦ Can you name the psychiatric disorders that may contribute to a Substance-Use Disorder?

When the participants have responded be sure the list of answers includes these disorders.

3. Pscychiatric disorders which may contribute to a Substance-use Disorder include:
 - ♦ antisocial personality disorder
 - ♦ schizophrenia
 - ♦ the manic phase of manic-depressive disease

The instructor may choose to expand upon this.

4. In general, the data do **not** support the supposition that most other major psychiatric syndromes increase the risk for alcohol or drug dependence.
5. In other words, it is not likely that the majority of psychiatric comorbidity observed among alcohol and drug dependent people is the result of their attempts to “self-medicate” pre-existing psychiatric disorders.
6. If self-medication of prior psychiatric disorders was occurring, then the children of alcoholics, themselves at a threefold to fourfold increased risk for future alcoholism, should demonstrate high rates of psychiatric disorders before alcoholism develops.
7. No major study of children of alcoholics has demonstrated this increased rate. This conclusion is generated from:
 - ♦ The adoption studies of Goodwin et al., (1974).
 - ♦ A prospective study of 454 sons of alcoholics and controls by Schuckit and Smith (1996).
 - ♦ The prospective work by Knop et al., (1988).
8. One study of adult children of alcoholics (evaluated in their forties) did indicate a possible increased risk for anxiety disorders among offspring of alcoholics, but it is not clear these were observed prior to the onset of alcoholism in those middle-aged adult individuals (Mathew et al., 1993).
9. If most prior psychiatric disorders were likely to contribute to the future risk for alcoholism, then prospective studies of individuals in the general population should reveal a high rate of psychiatric disorders before alcoholism develops.
10. Prospective studies by Vaillant (1983) and others do not indicate any such phenomenon.
11. If substance use disorders and most major psychiatric disorders were closely related, then alcohol dependent men and women should have high rates of major depressive disorder and major anxiety disorders.
12. These data can only be appropriately generated when the focus is on psychiatric syndromes that are independent of heavy drinking.

13. A paper by Schuckit and Hesselbrock (1994) demonstrated no evidence of a markedly increased risk for anxiety disorders or major depressive disorders among alcohol dependent men and women.
14. Possible exceptions exist for panic disorder and, perhaps, social phobia.
15. The data for generalized anxiety disorder are much more tentative because of the very small number of studies involved.
16. While there is more debate in this area, if alcohol dependence (or other substance use disorders) and major psychiatric syndromes were closely related, there should be a high level of familial crossover between the two types of syndromes.
17. A recent review on anxiety disorders (Schuckit et al., 1990) did not support such a contention.
18. There are individuals with major psychiatric disorders who go on to develop substance use disorders.
19. The question is whether their risk is significantly higher than that of the general population and whether the psychiatric syndrome caused an increased risk for alcohol and drug dependence.
20. As stated earlier, there are a limited number of major psychiatric disorders that have been documented to significantly increase the risk for the subsequent development of substance use disorders:
 - ♦ schizophrenia
 - ♦ the manic phase of manic-depressive disease
 - ♦ the antisocial personality disorder
21. There are also some additional psychiatric syndromes that have interesting relationships with substance use disorders:
 - ♦ borderline personality disorder
 - ♦ attention deficit disorder with hyperactivity
 - ♦ panic disorderbut these relationships are not observed in the majority of alcohol and drug dependent individuals and further study will be required.

III. Summary

Refer to HO5.7.

1. The relationship between substance use disorders and major psychiatric syndromes is complex.
2. The data indicate that the majority of comorbidity involves the antisocial personality disorder or other substance use disorders.
3. The relationship between substance use disorders and Axis I major psychiatric syndromes appears to relate most closely to temporary substance-induced disorders, not lifelong independent major psychiatric syndromes.
4. Some psychiatric disorders do carry an increased risk for substance use disorders, but this does not explain the majority of psychiatric comorbidity observed in alcohol and drug dependent individuals.
5. Psychiatric symptoms observed in the context of substance use disorders must be carefully evaluated.
6. Acute treatments to deal with the present clinical status must be carried out.
7. It is not wise to assume that an independent major psychiatric disorder exists until patients have been evaluated regarding their prior history.
8. It is necessary that psychiatric symptoms have been observed over a month or so in order to determine whether the most intense symptoms fulfilling criteria for major psychiatric disorders disappear with abstinence.