Letters to the Editor

Prevalence of Substance Abuse in Psychiatric Patients

SIR: Alcoholism and other forms of substance abuse are among the most common psychiatric disorders in the general population. Prevalence studies show that substance abuse occurs at rates similar to those of anxiety and affective disorders, the two other very common psychiatric disorders (1).

However, substance abuse is not easily detected. In general medicine, substance abuse occurs frequently and is frequently missed (2). Since there is such a high rate of missed diagnosis, it is useful to know how often substance abuse occurs in the patients we see. I would like to report on a survey of substance abuse in a psychiatric population.

As a resident, I did a rotation in an outpatient psychiatry department that functioned as the community mental health center for a catchment area which included a small city as well as suburban and rural areas. One of the resident's duties was to do two initial evaluations of new patients each week. The patients were assigned randomly by the intake workers. Several patients were also referred by our department's social workers for medication evaluation or by residents graduating from the program. The policy of the clinic was not to treat primary substance abuse disorders but to refer them to other community agencies.

During 6 months on this rotation, I saw a total of 78 individual patients. Because of the random nature of patient assignment, I consider this a representative sample of the patients treated in this clinic.

On reviewing these 78 patients, I found that 31 (40%) had diagnoses of substance abuse. All but one of these patients abused alcohol, although several abused other drugs as well. An additional 26 (33%) of the patients did not have substance abuse disorders but were either spouses or children of substance abusers. Again, almost all cases involved alcohol.

None of the 31 substance-abusing patients presented with a complaint of substance abuse; they initially presented with other psychiatric complaints. All of them received other psychiatric diagnoses, although substance abuse was often the primary disorder.

These findings are consistent with three previous reports. Vaillant (3) reported an outpatient community mental health center survey which found that 40% of the patients abused alcohol, although only 2% had a diagnosis of alcoholism. At a Colorado psychiatric hospital, 40% of consecutive admissions to a short-term inpatient unit were related to drug or alcohol abuse (4). The third report was from a general hospital psychiatry unit, where the Michigan Alcoholism Screening Test was administered to consecutively admitted inpatients; 42% were found to have alcoholism, although only 4% had been given that diagnosis (5).

It appears that alcohol and other substance abuse disorders are very common in general psychiatric populations. The three reports I have cited and my own observations reported here suggest a rate of approximately 40%. This raises the possibility that reports of considerably lower rates could be the result of the diagnosis going undetected. These findings highlight the need for careful screening of all psychiatric patients for substance abuse.

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Divalproex in Posttraumatic Stress Disorder

SIR: A number of medications have been reported in research studies or in case reports to be partly effective in the treatment of posttraumatic stress disorder (PTSD). These include antidepressants, phenelzine, benzodiazepines, lithium, antipsychotics, and monoamine oxidase inhibitors (1). Although some of these reports have noted reduction of the irritability associated with PTSD (2), there has been little written about medicating patients with PTSD and intermittent explosive disorder, except for the report of Wolf et al. (3) that carbamazepine reduces their aggression. These patients are difficult to treat with drugs because of their potential for abusing medication, combining medication with alcohol, or refusing the blood tests or the diet associated with some of the medications; thus, there is a need to have alternative drug treatments available. We chose divalproex because of its ability to reduce agitation and irritability in patients with affective disorders (4). It also requires fewer blood tests during its use than lithium does. We report for the first time the successful use of divalproex in two patients with PTSD and intermittent explosive disorder without a current affective disorder.

Mr. A had been honorably discharged from the army in 1972 at the age of 19, following a year of infantry combat in Vietnam. Since that time he had been irritable and hyperalert, experienced flashbacks and intrusive thoughts of the combat he had seen, and spent much time alone in the woods. He was considered by the Veterans Administration to be 100% disabled by PTSD. There was no history of seizures or head trauma leading to unconsciousness. Alcohol and marijuana abuse occurred episodically throughout the course of his illness and was associated with physical violence against his girlfriend or other people. Violence also occurred while he was sober. Between 1984 and 1988, trials

of medication were unsuccessful; they included doxepin, buspirone, thioridazine, alprazolam, and chlorpromazine. Lithium carbonate, 300 mg t.i.d., led to moderate improvement, but he refused to continue taking it because he "felt weird." Diazepam helped slightly.

In 1989 Mr. A was given divalproex, which was gradually increased to 250 mg q.i.d. For the 6 months he took divalproex he had no temper outbursts and noted a marked reduction of irritability. His total score on the Brief Psychiatric Rating Scale (5) changed from 46 before he took divalproex to 30 afterward. He refused to have his blood levels of the drug checked. On some days he took more than prescribed, complained of blurred vision and gastric upset, and stopped the medication. Then he was given carbamazepine, 200 mg t.i.d., for 2 months. The result was a reduction of symptoms similar to that seen with divalproex. However, he stopped taking it, citing blurred vision and ataxia, and was lost to follow-up. An EEG while he was taking divalproex showed no abnormalities.

Mr. B had been in infantry combat in Vietnam for a year. He described the following symptoms since his honorable discharge in 1972 at the age of 19: irritability, decreased sleep, nightmares, flashbacks, and paranoia. He had no friends and seldom spoke to anyone. Alcohol abuse was episodic, and he had many fights while intoxicated or sober. In 1986 he shot at his car and also wounded another person. There was no history of seizures or head trauma leading to unconsciousness.

Between 1986 (his first psychiatric evaluation) and 1987 he was given nortriptyline, 100 mg b.i.d., or desipramine, 150 mg h.s., but neither helped. Unlike Mr. A (who was never diagnosed as having major depression), he was twice diagnosed as having major depression with PTSD during that time. In October 1987 his diagnosis was changed to PTSD and intermittent explosive disorder without major depression, and he was started on carbamazepine, 200 mg b.i.d., without any improvement. He failed to keep subsequent appointments, during which a dose increase had been planned. In December 1987 he was started on divalproex, which was gradually increased to 500 mg t.i.d. To help with sleep, he was also given amitriptyline, 50 mg h.s. He subsequently reported a prominent decrease in irritability and improvement in mood. The improvement was maintained for 2 months, but then he ceased coming to the clinic. No EEG was done.

We are struck by the usefulness of divalproex in these two patients, particularly for irritability or aggression. We suggest that a research trial of the efficacy of divalproex in patients with PTSD and intermittent explosive disorder be undertaken. In this population, it also remains to be determined whether the success rate of the drug would be higher than that of lithium, propranolol, or carbamazepine, all of which have been reported to reduce aggression (2, 3).

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The Obsessive Quality and Clomipramine Treatment in PTSD

SIR: In *DSM-III-R* one of the major criteria for posttraumatic stress disorder (PTSD) is that the traumatic event is persistently reexperienced. The intrusive and compelling quality of traumatic repetitions in PTSD has been described in the literature (1). Recently, it has been demonstrated that clomipramine is successful in the treatment of depression, obsessive-compulsive disorders (2), and behaviors that are undesirable but subjectively compelling, such as trichotillomania (3). On the basis of these findings, my associates and I thought it was reasonable to assume that clomipramine should improve the intrusive and compelling symptoms and the frequent coexisting depression in PTSD.

We used clomipramine to treat seven Vietnam veterans with PTSD who were inpatients. The Impact of Event Scale (4) and the Yale-Brown Obsessive Compulsive Scale (5) were used to quantify the severity of intrusions and the obsessive quality in these patients before and after clomipramine treatment. On admission, their mean±SD score on the Yale-Brown obsession subscale was 16.00±3.87 (full obsession score=20). The mean score on intrusions on the Impact of Event Scale was 18.43±2.44 (full intrusion score=21).

All of the patients were receiving clomipramine, 100–150 mg/day; these doses were reached within 5 days after the initial smaller doses. On discharge, the mean scores were 6.57±4.31 for obsessions and 12.14±6.20 for intrusions. The mean±SD number of medication days was 10.57±2.70. The correlation between the improvements in obsession and intrusion scores was 0.83 ($p<0.01$). Among the seven patients, only one failed to show improvement in his obsession and intrusion scores.

The findings in this report suggest 1) that the intrusive symptoms in PTSD are of an intense obsessive quality and 2) that these symptoms respond well to clomipramine treatment. On admission, all of the patients had severe intrusive symptoms and viewed these intrusions as uncontrollable, irresistible, extremely distressful, and severely interfering with their functioning. After clomipramine treatment, six of the seven patients showed marked improvement in their intrusive and obsessive symptoms.

Although in this report clomipramine seems promising for treatment of PTSD, the possibility of spontaneous remission and placebo effects should be considered. A large-scale, double-blind study is needed to prove the effect of clomipramine on PTSD.

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