Comorbid Psychiatric Disorders among Patients with Substance Use Disorder

Behrang Shadloo, MD

Iranian National Center for Addiction Studies

Introduction

- Definition
    - Concurrent (Axis I) non-substance use disorders

- Observations:
    - Highly prevalent
    - Worse clinical and functional outcome
    - Do not receive adequate treatment
    - Tend to use more costly services

Epidemiology

- Several decades of research
    - Both in treatment seeking populations and community
- Co-occurring psychiatric disorders far more than expected

Epidemiology

- Risk factors include:
    - Female sex
    - Older age
    - Poverty and low socio-economic status
    - History of incarceration
    - Urban residence

Epidemiology

- Among people with a psychiatric disorder, 30% had a co-occurring Substance Use Disorder (SUD):
    - Antisocial personality
    - Mood disorders
    - Anxiety disorders
- In SUD samples, more than half would experience an Axis I or II disorder in their lifetime.

Psychopathology

- Psychopathology as a risk factor
    - Self-medication
- Psychiatric symptoms may result from chronic intoxication
- Long-term substance use can lead to psychiatric disorders that may not remit

Psychopathology

- Substance abuse and psychopathological symptoms may be meaningfully linked.

- The SUD and psychiatric disorder are unrelated

- Typically require treatment of both
    - Exception: those with temporary symptoms of a substance-induced disorders

Other Theories

- Psychopathology may interfere with an individual's judgment or ability to appreciate consequences
- Psychopathology may accelerate the process of substance dependence
- Psychopathology may reinforce the social context of drug use

Diagnosis

- Can be a complicated process

- Routine screening:
    - History of trauma
    - Family history
    - Symptomatology
    - Client's safety and suicide
    - Cognition

Diagnosis

Rules and guidelines:

- Length: 4 weeks of abstinence
- If the symptoms are qualitatively or quantitatively not what one would expect, given the amount and duration of the substance use

Treatment

- A heterogeneous group
- Sequential, parallel, and integrated treatment models

Treatment

- General principles:
    - Empathy
    - Assist to set goals
    - Educate
    - Monitor symptoms
    - Monitor adherence
    - Assist to develop skills
    - Have available resources
    - Reinforce
    - Expect occasional lapses

Anxiety Disorders

- Difference between fear and anxiety

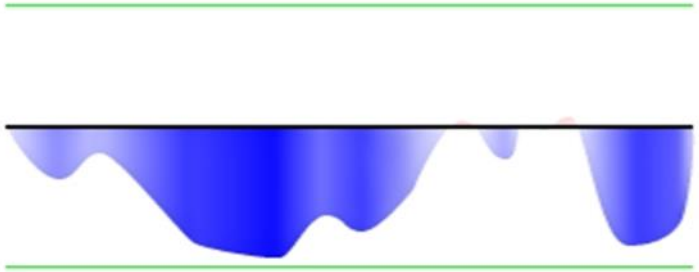
- Anxiety: a usually neglected presentation in psychiatric disorders

Generalized Anxiety Disorder

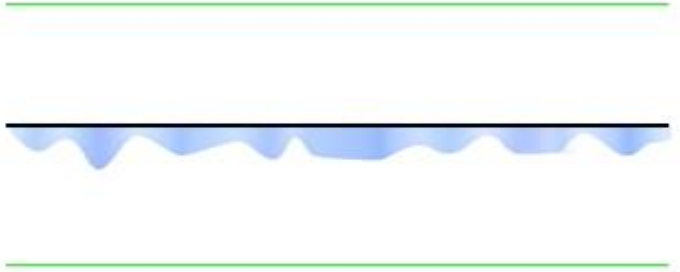
- Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months.
- The person finds it difficult to control the worry.
- The anxiety and worry are associated with three or more of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months):
  - Restlessness or feeling keyed up or on edge
  - Being easily fatigued
  - Difficulty concentrating or mind going blank
  - Irritability
  - Muscle tension
  - Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

Depressive Disorders

- Major Depressive Disorder



- Dysthymia



Depressive Episode

- Five or more of the following A Criteria (at least one includes A1 or A2)
  - A1 Depressed mood—indicated by subjective report or observation by others (in children and adolescents, can be irritable mood).
  - A2 Loss of interest or pleasure in almost all activities— indicated by subjective report or observation by others.
  - A3 Significant (more than 5 percent in a month) unintentional weight loss/gain or decrease/increase in appetite (in children, failure to make expected weight gains).
  - A4 Sleep disturbance (insomnia or hypersomnia).
  - A5 Psychomotor changes (agitation or retardation) severe enough to be observable by others.
  - A6 Tiredness, fatigue, or low energy, or decreased efficiency with which routine tasks are completed.
  - A7 A sense of worthlessness or excessive, inappropriate, or delusional guilt (not merely self-reproach or guilt about being sick).
  - A8 Impaired ability to think, concentrate, or make decisions— indicated by subjective report or observation by others.
  - A9 Recurrent thoughts of death (not just fear of dying), suicidal ideation, or suicide attempts

Major Depressive Disorder

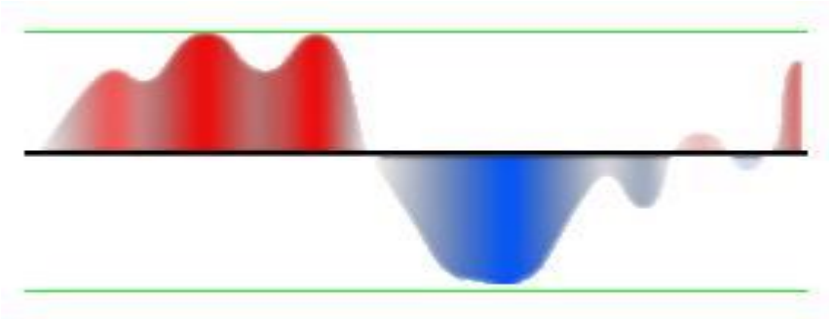
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The symptoms are not due to the direct physiological effects of a substance (e.g., drug abuse, a prescribed medication's side effects) or a medical condition (e.g., hypothyroidism).
- There has never been a manic episode or hypomanic episode.
- MDE is not better explained by schizophrenia spectrum or other psychotic disorders.
- The symptoms are not better accounted for by bereavement.

Dysthymia (Persistent Depressive Disorder)

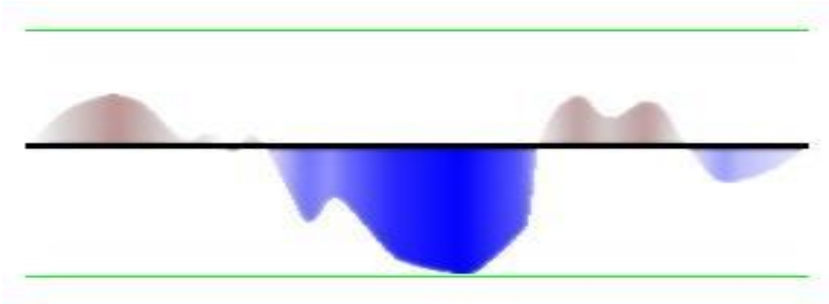
- Depressed mood for most of the day, for more days than not, as indicated by subjective account or observation by others, for at least 2 years.
- Presence while depressed of two or more of the following:
  - Poor appetite or overeating
  - Insomnia or hypersomnia
  - Low energy or fatigue
  - Low self-esteem
  - Poor concentration or difficulty making decisions
  - Feelings of hopelessness
- During the 2 year period of the disturbance, the person has never been without symptoms from the above two criteria for more than 2 months at a time.
- The disturbance is not better accounted for by MDD or MDD in partial remission.

Bipolar Mood Disorder

- Bipolar I Disorder



- Bipolar II Disorder



Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable):
   - inflated self-esteem or grandiosity
   - decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
   - more talkative than usual or pressure to keep talking
   - flight of ideas or subjective experience that thoughts are racing
   - Distractibility
   - increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
   - excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

Bipolar Depression

- Early age at onset
- Psychotic depression (esp before age 25)
- Post-partum depression (esp with psychotic features)
- Bipolar family history
- Cyclicity (onset, duration, frequency)
- Atypical, seasonal
- Psychomotor retardation (or even extreme agitation)
- Mixed features

Psychotic Disorders

- Characteristic symptoms (Criterion A): Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):
  1. Delusions
  2. Hallucinations
  3. Disorganized speech (e.g., frequent derailment or incoherence)
  4. Grossly disorganized or catatonic behavior
  5. Negative symptoms (i.e., affective flattening, alogia, or avolition)

ADHD

- Inattention

  a. often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities

  b. often has difficulty sustaining attention in tasks or play activity

  c. often does not seem to listen when spoken to directly

  d. often does not follow through on instructions and fails to finish schoolwork, chores or duties in the workplace

  e. often has difficulty organizing tasks and activities

  f. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort

  g. often loses things necessary for tasks or activities

  h. is often easily distracted by extraneous stimuli

  i. is often forgetful in daily activities

ADHD

- Hyperactivity/Impulsivity
  a. often fidgets with hands or feet or squirms in seat
  b. Often leaves seat in situations when remaining seated is expected
  c. often runs about or climbs excessively in situations in which it is inappropriate
  d. often has difficulty playing or engaging in leisure activities quietly
  e. is often "on the go" or often acts as if "driven by a motor"
  f. often talks excessively
  g. often blurts out answers before questions have been completed
  h. often has difficulty awaiting turn
  i. often interrupts or intrudes on others

Behavioral Addictions

- Eating Disorders
- Sex Addiction
- Pathological Gambling
- Internet Gaming Disorder

Pharmacotherapy

- Major depression
    - Efficacy comparable to depression alone group
    - 1 week abstinence
    - Rate of sustained abstinence
- Bipolar disorder
    - Mood stabilizers

Pharmacotherapy

- Schizophrenia and other psychotic disorders
  - Potential benefit of second-generation antipsychotic medications
- Anxiety disorders
  - Benzodiazepine controversy
- Attention Deficit Hyperactivity Disorder (ADHD)
  - Stimulant controversy
  - Bupropion for adult ADHD and cocaine abuse
  - Venlafaxine in patients with ADHD and alcohol use disorder

Pharmacotherapy

Medications with abuse potential

- Preparation which limit potential for abuse
- Objective measures for improvement
- Monitoring substance use
- Monitoring prescriptions

Pharmacotherapy

- Targeting substance dependence in dually diagnosed patients
  - Disulfiram may cause or exacerbate psychosis
  - Naltrexone may improve drinking outcomes in patients with alcohol dependence and schizophrenia

Psycho-social Interventions

Cognitive Behavioral Therapy (CBT)

- additional techniques include the identification of cognitive distortions associated with both disorders
- identifying meanings of substance use in the context of disorder
- teaching new coping skills

Psycho-social Interventions

Motivational Interviewing

- a brief treatment conducted in as few as two sessions, sometimes aimed at helping the patient accept other psychotherapy (e.g., CBT)

- The transtheoretical *stages-of-change model* describes a sequential process of five stages of change in recovery for patients with SUDs: precontemplation, contemplation, preparation, action, and maintenance.

Psycho-social Interventions

Contingency Management

- Systematic use of reinforcement
- reinforce behavior that meets specific, clearly defined, and observable goals such as abstinence, medication adherence, therapy attendance, or completion of treatment goals

Self-help Groups

Case 1

- A 34 year old male patient, with irritability and aggression, is referred to the emergency believing that the Intelligence Service has put cameras and microphones in his room. The symptoms have emerged following increased use of methamphetamine in the past month.

Case 2

- A 23 year old female university student, referred to you with poor grades at the university. During interview, she mentions that she can no longer enjoy from life and has though about ending her life. She has gained weight and has slept poorly. In history, she states she has used cannabis since college years and has increased the dose and frequency of cannabis recently.

Thanks