Recognition and Treatment of the Dual Diagnosis Patient

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Dual diagnosis and comorbidity are common, broad terms that indicate the simultaneous presence of at least two independent medical disorders in the same person. An understanding of comorbidity is essential in developing effective treatment and prevention programs for substance use disorders (SUDs). The treatment needs of patients who have another psychiatric disorder in combination with an SUD differ significantly from the treatment needs of patients with only a substance use or other psychiatric disorder.[1]

The relationship between SUDs and other psychiatric disorders is complex. Substance use disorders may induce, worsen, or diminish other psychiatric symptoms, complicating the diagnostic process. This article provides an overview of the relationship between multiple disorders, the importance of diagnosing patients and integrating their treatment, and the complex costs society pays when this is not done. Although the prevalence rates and other statistics apply specifically to the United States, those working with these populations can assume that they hold reasonably true for most countries.

Comorbidity

In a classification model that describes the primary relationships between SUDs and other psychiatric symptoms and disorders, all of the following possible relationships are given and must be considered during the screening and assessment process.[2]

- SUDs can cause psychiatric symptoms and mimic other psychiatric disorders. Both the direct changes to the brain and the destructive effects on a person's life caused by substance use can create symptoms such as anxiety and depression. The treatment of these symptoms is no different whether primary or secondary, but the emphasis will be different, with more attention paid to the SUD in this instance.
- Acute and chronic substance use can prompt the development, provoke the re-emergence, or worsen the severity of psychiatric disorders. For example, the symptoms of a patient with recurrent depression may increase or re-emerge due to the depressant effects of alcohol, sedatives—again both brain and life consequence effects—or withdrawal from stimulants.
- Substance use can mask psychiatric symptoms and disorders. Classic examples are the attempt to counteract depression with stimulants or mask it with sedatives, opioids, alcohol, or marijuana. Similarly, anxiety or manic-depressive symptoms can be tamed with sedatives, opioids, or marijuana.
- Withdrawal from substances can cause psychiatric symptoms and mimic psychiatric syndromes. The anxiety caused by withdrawal from alcohol or sedatives can mimic anxiety disorders; likewise, the depression caused by withdrawal from stimulants can mimic primary depression. The combination of symptoms frequently seen in withdrawal can be confusing and appear to be a mixed manic-depressive state.
- SUDs and other psychiatric disorders can coexist. Much of what we are discussing is coexistence. The point here is that they can operate fairly independently of each other unless one is left untreated, causing problems discussed in relevant literature.
- Psychiatric behaviors can mimic behaviors associated with substance use problems. Although this misidentification is less common than the converse, psychiatric symptoms of anxiety or depression may be thought to be caused by an SUD if other data make the clinician inaccurately suspicious of substance use.

Prevalence Rates

According to the US National Institute on Alcohol Abuse and Alcoholism, having either an alcoholic or other psychiatric disorder increases a person's risk of having both. Alcoholics, for example, are:

- 21 times more likely to have an antisocial personality disorder;
- 6.2 times more likely to have manic-depressive disorder:
- 4 times more likely to have schizophrenia; and
- 3.9 times more likely to have a drug abuse disorder.[3]

The Epidemiologic Catchment Area (ECA) survey was a landmark study conducted by the US National Institute of Mental Health, a component of the National Institutes of Health. This survey is the largest mental health prevalence study mounted in the United States and is recognized as the most comprehensive national survey to date. Of the more than 20,000

people surveyed, among addictive disorders as a group, comorbid disorders occur at greater than expected rates. It found that a history of mental disorder increases the risk of an SUD; psychopathology is a risk factor for substance abuse. According to the ECA, lifetime comorbidity of any mental disorder with an SUD varies by the drug of abuse:

- 76.1 percent for cocaine;
- 74.7 percent for barbiturates;
- 65.2 percent for opiates; and
- 36.6 percent for alcohol.[4]

Among the psychiatric treatment population, the most common drugs used are alcohol, marijuana, and cocaine.[5]

Diagnostic Assessments

The primary goal of a substance abuse clinical evaluation is to make an accurate diagnostic assessment of substance abuse or dependence, and to determine the relationship of substance use to other psychiatric and/or medical disorders. The diagnostic assessment is then used to plan and initiate effective interventions and treatment where indicated. The clinical assessment of substance use, abuse, and dependence should be considered a routine part of all psychiatric or medical evaluations.[6] (See "The Role of General Practitioners and Other Health Care Providers in Preventing and Screening Substance Abuse," page 22.) While data suggest that coordination between healthcare providers and substance abuse treatment practitioners should be an established pattern in primary healthcare services, in reality this is not the case. One study reported that nearly 70 percent of persons with alcohol, drug abuse, or mental health disorders are seen by a primary healthcare provider, many of whom are untrained to recognize addictive disorders.[7]

Integrated Treatment

Persons exhibiting comorbid substance use and other medical or psychiatric disorders often fall through the cracks of the healthcare system in the United States due to administrative distinctions.[8] Research has shown that integrated treatment—viewing the patient as a whole person—is more effective than serial or parallel treatment.[9] Parallel treatment means that treatment for substance abuse is provided separately and apart from treatment for other medical and/or psychiatric disorders. In this scenario, the patient is often required to go to separate facilities, meet different eligibility requirements, have different treatment regimens, etc. In serial treatment, treatment for the SUD may be required prior to treatment for other medical or psychiatric disorders, or vice versa.

Key Factors in Distinguishing between an SUD and Other Psychiatric Disorder

- the existence of psychiatric symptoms prior to the emergence of an SUD suggests a primary psychiatric problem as does continuation of the psychiatric symptoms during abstinence;
- severe psychiatric symptoms in the presence of a mild to moderate SUD also suggest a primary psychiatric problem; and
- a family history of an SUD or other psychiatric problems gives a clue as to the direction of those disorders.

In spite of what is known about the desirability of integrated treatment, funding streams and philosophical differences often dictate the eligible patient population and the services that can be provided in a particular setting, artificially separating and fragmenting the delivery of services. The result is often lower treatment retention, less treatment success, and a higher likelihood of relapse. In the United States, divided systems of care for mental illness, drug addiction, and alcoholism affect educational programs and clinical training. For example, general psychiatrists often receive little if any training related to SUDs. The same is true for the family physician, general internist, and pediatrician. As a result, there are serious gaps in services for the dually diagnosed and their families.[10]

During intoxication and withdrawal from substances, as many as 80 percent of substance-dependent individuals will demonstrate psychiatric symptoms.[11] Treatment programs must be aware of these temporary conditions, carefully evaluate their patients for the possibility of independent psychiatric disorders, and take appropriate steps to address the clinical symptoms.

In addition to these temporary, substance-related conditions, individuals with SUDs have at least as high a risk for other independent psychiatric disorders as the general population. If intense psychiatric symptomatology remains after approximately six weeks of abstinence, programs should have procedures in place to address these individuals who are very likely to have potentially important independent disorders.[12]

Impact on Society

Treatment can have a profound effect not only on substance abusers, but on society as a whole by significantly improving social and psychological functioning, decreasing related criminality and violence, and reducing the spread of AIDS.[13] Substance abuse is a primary cause of, and contributor to, crime.

Alcohol is a factor in

- 42 percent of homicides;
- 41 percent of assaults;
- 36 percent of reported rapes; and
- 33 percent of robberies

Illegal substances are involved in

- 45 percent of burglaries and thefts;
- 44 percent of larcenies;
- 28 percent of homicides; and
- 25 percent of reported rapes; [14]

Studies indicate that 30 to 40 percent of the homeless show evidence of alcohol problems, 10 to 20 percent show evidence of drug problems, and 10 to 20 percent also show evidence of dual disorder problems. One study reveals that dual diagnosis is a predictor of homelessness to the extent that more than half of those individuals diagnosed with both an SUD and other psychiatric symptoms had been homeless at some time in the six months prior to being interviewed for the study.[15]

The rates of fatal and non-fatal injuries are also higher for drug users than for nonusers. Substance abuse, as a cause of, or contributing factor to death, is often unrecognized or underreported due to patient confidentiality concerns and the stigma surrounding addictive disorders. And physicians sometimes incorrectly diagnose chemically induced disorientation or incoherence among elderly patients as dementia or signs of the natural aging process (see "Recognizing Dementia: The Importance of an Accurate Diagnosis," *CommonHealth*, Fall 2000, page 29). One study concluded that the under-reporting of substance abuse as a secondary cause of death or injury may be as high as 60 percent, and is the result of poor identification by medical practitioners and concerns about confidentiality and insurance reimbursement.[16]

Parental substance abuse underlies many symptoms of family dysfunction: divorce, spousal abuse, child abuse and neglect, welfare dependence, and criminal behavior.[17] Studies indicate that intimate partner violence (IPV) is a problem of considerable public health importance. Twelve-month rates of IPV among couples in the United States range between 17 to 39 percent and alcohol is an important risk factor for spousal violence.[18] Men who report dependence symptoms or social consequences from drinking and drug use are more likely than men without these problems to perpetrate male to female partner violence. The same is true of women; women who report these problems are more likely to engage in female to male partner violence.

According to the US National Association for Children of Alcoholics, there are over 28 million children of alcoholics in America alone; almost 11 million of whom are under the age of 18.[19] There is a clear association between the physical, emotional, and sexual abuse and neglect of children, domestic violence, and substance abuse in the family. These children are at risk of adverse developmental, social, and health outcomes.[20]

The pervasive effects of substance use disorders on individuals, families, and society are enormous and costly. The complications of a comorbid psychiatric disorder further confuse the clinical picture and must be carefully evaluated in order to increase the likelihood of treatment success.

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