Comorbidity: alcohol use and other psychiatric disorders

Hamer Alves,[a] Felix Kessler[b] e Lilian Ribeiro Caldas Ratto[c]

[a]Unidade de Pesquisa em Álcool e Drogas (UNIAD) do
Departamento de Psiquiatria da Universidade Federal de São Paulo (UNIFESP), SP, Brasil
[b]Departamento de Psiquiatria da Universidade Federal do Rio Grande do Sul (UFRGS), RS, Brasil
[c]Departamento de Psiquiatria e Psicologia Médica da Faculdade de Ciências Médicas da Santa Casa, SP, Brasil

Abstract

Alcohol related disorders often coexist with other psychiatric disorders and its incidence is increasing in last decades. Studies show that patients with comorbidity, specially those with severe psychiatric disorders, have higher rates of suicide, relapse, money spent in treatment, homeless and they use more medical service. Their evaluation must be meticulous because the differencial diagnosis become complicated without a long period of alcohol withdrawal. These patients have a worse prognostic and their treatment is more difficult. Most of studies in this area have indicated that the integration of psychosocial and pharmacological techniques is more effective. The long term treatment must focus in the reduction of symptoms, improvement of social and familiar funcioning, coping skills and relapse prevention.

Keywords: *Alcoholic beverages. Substance- related disorders. Comorbidity.*

Introduction

The occurrence of any pathology in an individual with a previous illness, and the possibility of mutual interaction between them is known as comorbidity. The event of anthe additional illness may change the symptomatology, interfering in diagnosis, treatment and prognosis of both of them. Regarding mental disorders, alcohol use-related disorders often coexist with other psychiatric illnesses. In general, the use of even small doses of alcohol may have more serious consequences than those seen in patients without comorbidity.[1 2]

The incidence of these disorders seems to be increasing in the last decades. This finding may be related to the priority given to community-based mental health care: alcohol availability and tthe closing of psychiatric hospitals to give priority to outpatient treatment and the increase in the availability of alcoholcommunity-based mental health services.[3] However, it is possible that this e higher incidence of this kind of disorders is may be only due to the improvement of clinical conditions for the diagnoses diagnosis and the patients's follow-up. It is believed that about 50% of patients with severe mental disorders will develop alcohol/drug- use-related problems along some period of their lives.[5]

Studies show that patients with comorbidity, especially those with severe psychiatric disorders have higher rates of aggressiveness, suicide, relapses, and detention for illegal acts, costs with treatment and rehospitalizations, are homeless, rehospitalizations, are frequent users of medical services, stay longer periods hospitalized, rehospita- lizations,use expensive treatment and and ffrequently become homeless. These patients have a worse social evolution and a negative impact onin the family budget and on the health of inthe caretakers.[6 7 8]

The therapeutic approach for patients with comorbidity is complex and consequently they usually don't find a place forproper treatment. Professionals Physicians and clinical staff from General Psychiatric Centers and drug dependence centers Drug Abuse Centers usually lack both experience and confidence when treating severely-ill patientsin the treatment of alcohol users, feeling insecure regarding severe patients.[9 10] Thus, it is fundamental for health practitioners who deal with these patients to deepen the study of the differential diagnosis, evaluation and treatment of patients with comorbidity.

Evaluation and differential diagnosis

The clinical evaluation should be thoroughneeds to be meticulously accomplisheddone when there is evidence of a dual diagnosis. As a diagnosis needs to be done, even at the risk of labeling the patient, the possibility of a comorbidity should be considered, as it is extremely important for the therapeutic planning. Psychiatrists have to be acquainted with get use to the idea that in many cases the diagnosis will only be trustworthy reliable after a significant period of follow-up period.The patient's clinical history is extremely important. It should meticulously evaluate Tthe onset of alcohol use and of the associated illness should be meticulously evaluated and detailingexplain with details the symptoms and their associated problems must be detailed, in chronological order.[11] In periods of total alcohol abstinence withdrawal it is worth to investigate if any improvement of clinical condition occurred. Diagnostic criteria from international classifications for harmful use of alcohol and syndrome of alcohol depen- dence syndrome are a useful guide for diagnostic elucidation. The ICD 10 and the DSM-IV suggest that another diagnosis can be ononly should be only registered after four weeks of complete alcohol withdrawal.Since almost all psychiatric symptoms may be alcohol- related,[12] patients should always be inquired about their individual pattern of alcohol and other substances intake. It is important to investigate both the frequency and the amount quantity of alcohol ingestion since frequency sometimes proves to be more reliable than quantity.. Calculation in alcoholic units- one unit is equal to 10 grams of alcohol - enables a better comprehension of alcohol intake patterns.The family history is useful particularly when there is a significant pattern of family mental disorders. Friends and relatives should also be inquired to enable a bet-

ter validation of the patient's answers. The use of breath alcohol measuring devices (breathalyzers), urine toxicological tests, structured interviews and scales (or tables?) is also important for a better prognosis at of the first stages of treatment.[13] The differential diagnosis is difficult to be performed without a long-term period of evaluation and patient's total alcohol abstinence withdrawal. It is also difficult to determine the influence of alcohol on pre-existent primary symptoms as well as in the proper mental disorder proper, such as As an example: hallucinations experienced by alcohol- dependeants subjects may not differ significantly from those experienced by schizophrenic patients. Alcohol dependence may also produce symptoms of depression, anxiety, agitation, hypo mania/mania during periods of intoxication and abstinence.

Considering the onset of symptoms, a useful approach is to determine which problem has appearedshowed first (primary-secondary dichotomy).[14] It would be inadequate, for example, to diagnose Bipolar aAffective dDisorder if the patient has pressured speech, irritability, increased libido and grandiosity only during periods of heavy acute alcohol intake ('symptoms are not diagnostici'). Alcohol-induced disorders show a dramatic improvement of symptomatology within few weeks of alcohol withdrawal. Persisting symptoms after alcohol deintoxification suggests a mental primary disorder.

The permanent-transienttory dichotomy described by Kranzler and Liebowitz[15] proves also to be also useful too. Transienttory statesconditions last for a few weeks and do not persist along time. The symptomatology, although intenseacute, tends to decrease and clinical conditions usually improve with a supportive and psychotherapeuticy approach. In the case of persistent clinical conditions, the release of symptoms resolution relief is less likely without specific treatment.

Treatment

Individuals with mental disorders related to the use of psychoactive substances and concomitant psychiatric comorbidity have a worse prognosistic than those with only one of theseis disorders and their treatment is much more difficult.[16]

Health practitioners should have to be aware that these patientswith comorbidity have a slower improvementtreatment outcome. Since many patients do notwont accept total alcohol abstinence withdrawal as a goal, a precautious and tolerant attitude is ne- cessary to enable a consistent therapeutic alliancegreement, since this is one of the predictable factors predictive ofto treatment success.[17]

These patients usually respond poorly to therapies focused in only one disorder, makingturning necessary a therapeutical approach for both disorders, including the use of combined medication and the modification of psychosocial therapies. Ideally, it would be required an multidisciplinary staff team including psychiatrists with knowledge on drugs substances, professionals working in the drug dependencey field and clinical laboratory analysts. It is known that, in contrast with drug dependencey treatment models, self-helpaid-groups and counseling for patients with drug dependencey and other psychiatric comorbiditiesy should be less intense and avoid frequent confrontations since these patients are more sensitive and tend to drop outabandon treatment.[16]

The main models patternsoffor theof treatment of co morbidities treatment are usually divided in sequential and parallel or integrated (Table 1). The sequential model pattern defines that one disorder has to be treated before the other and is usually more useful in cases in which it seems clear that one of the pathologies is secondary to the other. The parallel treatment is performed by separated different services and have has the advantage of counting on with specialists in each one of the fields. However, it may sometimes be more beneficial to have only one clinician managing and planning the treatment, defining the role tasks of each member of the staff, and acting as a reference point for the patient.[18]

The current medical literature is not clear uncertain regarding of which kind of specialist and whichwhat duration and doseage of treatment should be prescribed for patients with this type of comorbidity. Research in this field is recent and still hasve methodological problems in the methodology. Most of the studies in this field evaluated patients with psychotic, depressive and anxiety disorders and indicated show that the integrated concomitant use of psychosocial and pharmacological techniques is the most effective. This kind of treatment includes the use of motivational ng strategies for patients to raise adherence to the treatment, education for ing patients about the relationship between the two pathologies, the training of behavioral/cognitive/behavioral coping skills to achieve and maintain alcohol abstinence, reorganization ing of the patient's social networksrelation net and the use of individualized specific treatment for each one of the disorders.[19] The outcome of psychiatric clinical condition comorbid with whensubstance substanceabuse is present is associated with a favorable evolution of the latter, reducing relapse risks and increasing the patient's quality of life.

Hospitalization may be necessary when the patient shows:

a medical or psychiatric conditions that requires constant observation (severe psychotic state, suicidal or homicidal ideation, severe weakness or abstinence);

Table 1 – Models of treatment for psychiatric comorbidities in alcohol users

TREATMENT MODEL	DESCRIPTION	CHARACTERISTICS
Sequential or Consecutive Treatment	Treatment programs are provided consecutively by mental health services according to the priority and the severity of each disorder.	- Good results in secondary disorders. -Poor communication between services. -Problems are discussed independently, as separate entities. -Lower therapeutical link.
Parallel Treatment	Patients are cared by two services at the same time, one specialized in the psychiatric disorder and the other in substance dependence.	- Specialized treatment. - Weaker therapeutic link. - The physician's responsibilities are not clearly defined. - Higher costs.
Integrated Treatment	Both psychiatric and substance dependence treatments are performed in a single service following a therapeutical model	- In general, better results. - Costs tend to be lower. - Stronger therapeutic link . - Defined responsibilities between physicians.

-inability to stop the use of substances in spite of therapeutic efforts;
-lack of psychosocial support to enable the start of abstinence;
Regarding the psychosocial and pharmacological approaches of the psychiatric disorder, the great majority suggest, whenever possible, a period of two to four weeks of alcohol abstinence before starting treatment. Most of the Sstudies in this field are also incipient and do not define precisely which medication should beto prescribed for each comorbidity. Despite the lack of consensus in the current up-to-date literature, some of the therapeutical trends evaluated are described in Table 2. Since alcohol interferes directly on the medication's Serum levels, it may be highlightedis convenient to point out that high-risk interactions may be generatedoccur associated with severe risk for the patient's health. Drugs like Dissulfiram, Naltrexone and acamprosate may be used during the treatment.[16]

It is known that 23 to 70% of alcohol dependent patients have anxiety or depressive disorders, those being those the most common alcohol related co morbidities. Clinical studies show that an adequate use of psychopharmacs drugs and concomitant psychotherapy significantly improves mood and anxiety symptomatology, inducinges a decrease ing in alcohol intake, in the lowers relapse episodes rates and increases the time length up to the first heavy drinking episode.

The Long-term treatment must focus in the reduction of symptoms, improvement of social and family functioning, coping skills and relapse prevention[20].

Final Considerations

Along this review the authors conclude that, we discussed despite the several difficulties regarding the therapeutic approach, the differential diagnosis and the treatment of patients with psychiatric comorbidities and alcohol abuse/dependence., Despite the appointed difficulties, we conclude that great advances haved already been achieved in this field. However, it It is important to point out that health professionals who treat this kind of patient have to keep up-to-date with the new evaluation techniques and psychosocial treatments as well as of the pharmacological indications for each type of comorbidity .

References

1.Drake RE, Osher FC, Wallach MA. Alcohol use and abuse in schizophrenia. A prospective community study. J Nerv Ment Dis 1989;177(7):408-14.
2.Menezes PR, Johnson S, Thonicroft G, Marshall J, Prosser D, Bebbington P, Kuuipers E. Drug and alcohol problems among individuals with severe mental illness in south London. Br J Psychiatry 1996;168(5):612-9.
3.Bartels SJ, Teague GB, Drake RE, et al. Substance abuse in schizophrenia: service utilization and costs. J Nerv Ment Dis 1993;181:227-32.
4.Kessler RC, Crum RM, Warner LA, Nelson CB, Schulenberg J, Anthony JC. Lifetime co-occurrence of DSM-III-R alcohol abuse and dependence with other psychiatric disorders in the National Comorbidity Survey. Arch Gen Psychiatry 1997; 54 Apr(4):313-21.
5.Cupffel BJ. Prevalence estimates of substance abuse in schizophrenia and their correlates. J Nerv Ment Dis 1992;180(9):589-92.
6.Clark RE, Drake RE. Expenditures of time and money by families of people whit several mental illness and substance use disorders. Community Ment Health J 1994;30:145-63.
7.Duke P, Pantelis C, Barnes TRE. South westminster schizophrenia survey: Alcohol use and its relationship to symtoms, tardive dyskinesia and ilness onset. Br J Psychiatry;164(5):630-6.
8.Yesavage JA, Zarcone V. History of drug abuse and dangerous behaviour in inpatient schizophrenics. J Clin Psychiatry 1983;44:259-61.
9.Cohen ST, Jacobson NA. Diagnóstico duplo: abuso de substância e doença psiquiátrica. In: Jacobson JL, Jacobson AM. Segredos em psiquiatria, Porto Alegre: Artes Médicas; 1997.
10.Rigdely M, Goldman H, Willenbring M. Barriers to the care of persons with dual diagnoses; organizational and financing issues. Schizophr Bull 1990;16:123-32.
11. Anthenelli RM, Schuckit MA. Affective and Anxiety Disorders. American Society of Addiction Medicine 1994;Chapter 3:1-7.
12.Schuckit MA, Monteiro MG. Alcoholism, anxiety and depression. Br J Addict 1988;83:1371-80.
13.Watkins TR, Lewellen A, Barret M. Issues and problems with dual diagnosis. In: Dual diagnosis: An integrated approach to treatment. Sage publications; 2001.
14. Goodwin DW, Guze SB. Psychiatric Diagnosis, 4th ed. New Yourk, NY. Oxford University Press; 1989.
15. Kranzler HR, Liebowitz NR. Anxiety and depression in substance abuse: Clinical implications. Med Clinics North Amer 1988;72(4):867-85.
16.Cornelius JR, Bukstein O, Salloum I, Clark D. Alcohol and psychiatric comorbidity. Recent Dev Alcohol 2003;16:361-74.
17.Woody G, McLellan A, Bedrick J. Comorbidade – um desafio no tratamento de dependência de drogas. R Psiquiatr RS 1995;17(3):189-200.
18. Jerrel JM, Rigdgely MS. Comparative effectiveness of trhee approaches to serving people whit severe mental illness and substance abuse disorders. J Nerv Ment Dis 1995;183:566-76.
19. Lynskey M. The comorbidity of alcohol dependence and affective disorders: treatment implications. Drug Alcohol Depend 1998;52:201-9.
20. Moggi F, Ouimette P, Moos R, Finney J. Dual diagnosis patients in substance abuse treatment: relationship of general coping and substance-specific coping to 1-year outcomes. Addiction 1999;94(12):1805-16.

Correspondence

Felix Kessler
R: Dona Laura, 354/301. Bairro Moinhos de Vento
90430-090 Porto Alegre, RS, Brasil
Phone.: (51) 3332-8172
E-mail: kessler.ez@terra.com.br

Table 2 – Trends in the current literature regarding the indication of psychopharmacs in the alcohol-related comorbidities

	FIRST CHOICE	SECOND CHOICE	OBSERVATIONS
Affective Bipolar Disorder	Anticonvulsants	Lithium	Alcohol may facilitate lithium intoxication.
Attention Deficit and Hyperactivity	Methylphenidate	Antidepressant and bupropione	Although the risk of methylphenidate abuse is low, it should be observed.
Anxiety Disorders	Buspirone e SSRI*	Benzodiazepines	The depressive effects of benzodiazepines are added to those of alcohol.
Depressive Disorders	ISRS*	Tricycles	Tricycles usually have more side effects.
Psychotic Disorders	Atypical antipsychotics	Typical antipsychotics	Some studies show that atypical antipsychotics have anticraving effect.

Selective serotonin reuptake inhibitors