Psychiatric Co-Morbidities

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Topic Areas

• Terminology
• Epidemiology
• Substance induced mental disorders
• Treatment of specific co-occurring disorders
• Nicotine use disorders and mental illness
• General treatment recommendations

Terminology

• Dual dx
• MICA
• CAMI
• Co-Morbid Disorders
• Co-Occurring Disorders

Studies on Co-morbidity

Most widely cited studies:

• Epidemiologic Catchment Area (ECA) study
• National Comorbidity Survey (NCS)
• National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)

ECA Study

• Epidemiologic Catchment Area (ECA) Study
  • 20,291 interviews at 5 sites
  • Data Collected 1980 – 1984
  • DSM – III Diagnoses

Regier, DA, et al. (1990). Comorbidity of Mental Disorders with Alcohol and other Drug Abuse: Results From the Epidemiologic Catchment Area (ECA) Study. JAMA, 264, 2511-2518

ASAM Disclosure of Relevant Financial Relationships

Content of Activity:
ASAM Review Course 2014

<table>
<thead>
<tr>
<th>Name</th>
<th>Commercial Interests</th>
<th>Relevant Financial Relationships: What Was Received</th>
<th>Relevant Financial Relationships: For What Role</th>
<th>No Relevant Financial Relationships with Any Commercial Interests</th>
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### ECA DSM-III Diagnoses (rates per 100 people)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>1 Month</th>
<th>Lifetime</th>
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<tbody>
<tr>
<td>Any Alcohol, Drug or Mental Health Disorder</td>
<td>15.7</td>
<td>32.7</td>
</tr>
<tr>
<td>Any Mental</td>
<td>13.0</td>
<td>22.5</td>
</tr>
<tr>
<td>Alcohol Dependence</td>
<td>1.7</td>
<td>7.9</td>
</tr>
<tr>
<td>Drug Dependence</td>
<td>0.8</td>
<td>3.5</td>
</tr>
</tbody>
</table>

Regier, et al. (1990)

### Specific Mental Disorders and Substance Use Disorder Risk

- All Mood disorders 32% (O.R. = 2.6)
- Bipolar I disorder 61% (O.R. = 7.9)
- All Anxiety disorders 23.7% (O.R. = 1.7)
- Schizophrenia 47% (O.R. = 4.6)
- Personality disorders: Antisocial personality disorder 83.6%, Borderline personality disorder 50% (of those receiving treatment so may not reflect community sample)

Regier, et al. (1990)

### Lifetime Prevalence and Odds Ratios ECA Study

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Alcohol OR</th>
<th>Other OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any mental</td>
<td>36.6%</td>
<td>2.3</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>3.8%</td>
<td>3.3</td>
</tr>
<tr>
<td>Any affective</td>
<td>13.4%</td>
<td>1.9</td>
</tr>
<tr>
<td>Anti-social</td>
<td>14.3%</td>
<td>21.0</td>
</tr>
<tr>
<td>Alcohol</td>
<td>47.3%</td>
<td>7.7</td>
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</table>

Data from 1990

### NCS

- National Comorbidity Survey
  - 8,098 interviews across the country
  - Data collected 1990 – 1992
  - DSM-III-R Diagnoses

COD in Treatment Populations

- Estimates of psychiatric co-morbidity among clinical populations in substance abuse treatment settings range from 50-70%

- Estimates of substance use co-morbidity among clinical populations in mental health treatment settings range from 20-50%


Substance Induced Mental Disorders

- Psychotic disorders
- Bipolar disorders
- Depressive disorders
- Anxiety disorders
- Obsessive-compulsive and related disorders
- Sleep disorders
- Sexual dysfunctions
- Delirium
- Neurocognitive disorders
- Substance use disorders
- Substance intoxication
- Substance withdrawal

DSM 5 Substance Induced Mental Disorders

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DSM 5 Substance Induced Mood Disorder (Prototype for other SIMDs)

1. A prominent and persistent disturbance in mood predominates, characterized by (a) a depressed mood or markedly diminished interest or pleasure in activities or (b) an elevated, expansive, or irritable mood.

2. There is evidence from the history, physical examination, or laboratory findings that the symptoms developed during or within a month after substance intoxication or withdrawal, or medication use is etiologically related to the mood disturbance.

3. The disturbance is not better explained by a mood disorder.

4. The disturbance did not occur exclusively during a delirium.

5. The symptoms cause clinically significant distress or impairment.
Making the Diagnoses:

- A significant period of abstinence may not be available for examination
- What are nature of sx (are they typical for the substance being used or for the co-occurring disorder?)
- What is the duration of sx (are they typical for the substance being used or for the co-occurring disorder?)
- What is the family hx?
- Longitudinal observation has more validity than cross-sectional observation
- Not clear that a primary/secondary distinction has great meaning (both require "primary tx.")

Major Depressive Disorder vs. SIMD

- Take a careful history of the course of depressive episodes over the lifetime (e.g., age of first onset, age at subsequent episodes, duration and quality of episodes).
- Relate lifetime course of depression to the lifetime course of substance use and substance use disorders.
- Most depressive symptoms occur as part of intoxication or withdrawal syndromes of one or more substances (see also Table 8-3), so care is needed in attributing a symptom to a depressive disorder, as opposed to effects of a substance.
- Look for persistence of depressive symptoms ("most of the day every day") through increases or decreases in substance use or abstinence periods; symptoms that emerge and then resolve in step with substance use are more consistent with intoxication or withdrawal effects (e.g., insomnia that occurs only on nights after episodes of cocaine use).

Why aren’t Antidepressants more effective in addictions patients?

- Psychiatric outcomes:
  - Antidepressants only beat placebo by 20% anyway in NON addicts
  - Study patients also get “addiction rx” and maybe addiction rx is more anti-dep, anti-anx than we think… (Schuckit 80% > 20% symptomatic after alcoholics enter tx)
  - Positive effects on mood of 12 Step involvement
  - Research included patients with SIMD?
- Addictions outcomes
  - Meds take focus off sobriety for some patients?
  - Just don’t work for this
Bipolar Disorder vs. SIMD


Treatment of Bipolar and Substance Use Disorders

• Pharmacologic treatment of bipolar disorder required for success
• Usual treatments for bipolar disorder
• Anticonvulsants may confer some protection from withdrawal
• Integrated Group Therapy targeted to patients with “Bipolar Substance Abuse” who are encouraged to see their dx as one disorder. IGT supported by randomized controlled trials.


Treatment of Psychotic and Substance Use Disorders

• Pharmacologic treatment of psychotic disorder required for success
• Unique role for clozapine in patients unresponsive to other antipsychotic medication and in reducing substance use and suicidal behavior
• Need for comprehensive services and case management


DSM-5 Criteria for ADHD

People with ADHD show a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development.

1) Inattention: Six or more symptoms of inattention for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of inattention have been present for at least 6 months, and they are inappropriate for developmental level.

2) Hyperactivity and impulsivity: Six or more symptoms of hyperactivity-impulsivity for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for the person’s developmental level.

3) In addition, the following conditions must be met:
- Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.
- Several symptoms are present in two or more settings (e.g., at home, school or work, with friends or relatives, in other activities).
- There is clear evidence that the symptoms interfere with, or reduce the quality of social, school, or work functioning.


TABLE 88-3 SUBSTANCES THAT CAUSE PSYCHOTIC SYMPTOMS

During Intoxication
• Sedatives (alcohol, benzodiazepines, barbiturates)
• Stimulants (amphetamine, cocaine)
• Designer drugs (“ecstasy” and the like)
• Marijuana/THC
• Hallucinogens (LSD, ketamine, psilocybin, and the like)
• Opioids
• Phenycyclines
During Withdrawal
• Sedatives (alcohol, benzodiazepines, barbiturates)


TABLE 69-1 PSYCHOPHARMACOLOGIC TREATMENT OF ADHD AND SUD: 11 DOUBLE-BLIND TRIALS

DSM 5 PTSD

Criterion A: stressor. The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence

Criterion B: intrusion symptoms. The traumatic event is persistently re-experienced

Criterion C: avoidance. Persistent effortful avoidance of distressing trauma-related stimuli after the event

Criterion D: negative alterations in cognitions and mood

Criterion E: alterations in arousal and reactivity

Criterion F: duration. Persistence of symptoms (in Criteria B, C, D, and E) for more than one month

Criterion G: functional significance

Treatment of PTSD and Substance Use Disorders

- Cognitive Behavior Therapy: Combines didactic element, exposure, relaxation training, and examination and evaluation of cognitions related to traumatic experiences
- Seeking Safety (Najavits, LM /seekingsafety.org): Only model for PTSD and substance use disorder that meets standard criteria as an effective treatment (Chambless & Hollon, 1998).
- Pharmacotherapy: SSRIs, prazosin for nightmares and other sleep disturbances
Anorexia
Bulimia
Binge

The relatively

One or more pathological traits.

The impairments in personality functioning and the individual’s personality trait expression are relatively inflexible and pervasive across a broad range of personal and social situations.

The impairments in personality functioning and the individual’s personality trait expression are relatively stable across time, with onset that can be traced back to at least adolescence or early adulthood.

The impairments in personality functioning and the individual’s personality trait expression are not better explained by another mental disorder.

The impairments in personality functioning and the individual’s personality trait expression are not solely attributable to the physiological effects of a substance or another medical condition (e.g., severe head trauma).

The impairments in personality functioning and the individual’s personality trait expression are not better understood as normal for an individual’s developmental stage or sociocultural environment.

**DSM 5 General Criteria for Personality Disorder**

- Borderline personality disorder: Dialectical behavioral therapy has been modified for the treatment of co-occurring SUD (Linehan MM, et al. Drug Alcohol Depend 2002;67:13–26.)

**Eating Disorders**

- Lifetime co-occurrence between SUD and eating disorders is 25%
- Anorexia nervosa: high rates of prescription and OTC misuse to control appetite
- Bulimia nervosa: high rates of SUD
- Binge eating disorder: evidence that it may be a behavioral addiction such as gambling disorder, highest rates of SUD (57% of men with BED also have SUD, 28% of women) among eating disorders

**Gambling Disorder (First DSM 5 “Behavioral Addiction”)**


Study found elevated rates of depression, anxiety, and PTSD. Number of co-occurring disorders present correlated with gambling severity.

**Nicotine/Cigarette Statistics**

- Persons with behavioral health disorders die up to 25 years earlier than the general population (NASMHPD, 2006)
- Persons with addictions and mental health problems:
  - are nicotine dependent are a rate 2-3 times higher
  - represent over 44 percent of U.S. tobacco market
  - consume over 34 percent of all cigarettes smoked in the U.S. (Lasser et al., 2000)

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Psychopharmacology of Mental Disorders with Co-occurring Substance Use:

• Sparing use of benzodiazepines (which are not all created equal) and hypnotic medications.
• What’s the evidence for use of quetiapine as a stand alone treatment for anxiety or insomnia? What’s the risk/benefit? Does quetiapine have abuse potential?
• Remarkably few adverse interactions between drugs of abuse and prescribed drugs and abstinence not required for benefits of medication.

Cessation Concurrent with Mental Health or Addictions Treatment

• Smoking cessation has no negative impact on psychiatric symptoms and smoking cessation may even lead to better mental health and overall functioning (Baker et al., 2006; Lawn & Pols, 2005; Morris et al., Unpublished data; Prochaska et al., 2008)
• Participation in smoking cessation efforts while engaged in other substance abuse treatment has been associated with a 25 percent greater likelihood of long-term abstinence from alcohol and other drugs (Bobo et al., 1995; Burling et al., 2001; Hughes, 1996; Hughes et al., 2003; Hurt et al., 1993; Fletcher, 1993; Prochaska et al., 2004; Rustin, 1998; Saxon, 2003; Taylor et al., 2000)

Psychopharmacology of Substance Misuse in Patients with Co-occurring Disorders:

• Alcohol: Naltrexone has been found efficacious in pts. with alcohol dependence and other mental illness (depot preparation approved by FDA), disulfiram in well-selected patients, acamprosate not tested yet in this population
• Nicotine: nicotine replacement and bupropion found efficacious in pts with nicotine dependence and other psychiatric disorders
• Opiates: Methadone maintenance effective and buprenorphine allows treatment of opiate dependent patients outside of methadone maintenance programs. Does naltrexone have a role with this population?

Cognitive Behavioral Therapy

• Widely studied and found effective in variety of SUDs and other types of mental illness
• Also helpful in insomnia although not well tested in patients with COD
• Difficult to implement with fidelity to the approach use in (train, coach initial cases, monitor practice)
• CBT4CBT (promising computerized version of CBT with effectiveness and high patient/staff satisfaction, developed by Kathleen Carroll at Yale).

Contingency Management in Patients with Co-occurring Disorders:

• Co-occurring disorder patients more likely to obtain housing and employment when contingencies for abstinence in place (Milby et. al., 1996)
• Co-occurring disorder patients more likely to obtain abstinence when incentive of self-management of finances is offered (Ries, 1997)
• Attendance at “dual dx” group therapy was improved with contingency management for attendance (Helmus, et. al., 2003)
One Year of Abstinence is Predicted by:

- AA Involvement (OR=2.9)
- Not having pro-drinking influences in one’s network (OR<0.7)
- Having support for reducing consumption from people met in AA (versus no support; OR=3.4).
- In contrast, having support from non-AA members was not a significant predictor of abstinence.


Double Trouble Recovery (DTR) Outcomes

- Members of 24 DTR groups (n=240) New York City, 1 year outcomes
- Drug/alcohol abstinence = 54% at baseline, increased to 72% at follow-up.
- More attendance = better Medication adherence
- Better Medication adherence = less hospitalization

Magura, Add Beh 2003, Psych Serv 2002

Why Integrate Services for mental health and substance use disorders?

- 25-50% of people in the mental health system has a co-occurring substance use disorder.
- 50-75% of people in the substance use disorder treatment system have a co-occurring mental health disorder.

CSAT, 2006

The Four Quadrant Framework for Co-Occurring Disorders

A four-quadrant conceptual framework to guide systems integration and resource allocation in treating individuals with co-occurring disorders (NASMHPD, NASADAD, 1998; NY State; Ries, 1993; SAMHSA Report to Congress, 2002)

Current System Compartmentalizes Services

What Integration Can Do

- Help create a “no wrong door” system

CSAT, 2000
Sincere thanks for listening.

Questions?