Co-occurring Addiction and Mental Disorders
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Disclosure

Speakers Bureau for Jansen, Lilly, Astra Zeneca and Reckitt-Benckiser
DUAL DIAGNOSIS IS:

- TWO DIAGNOSES/ DISORDERS
- TWO SYSTEMS
- DOUBLE TROUBLE
- IN THE EYE OF THE BEHOLDER
Examples of Dual Disorders:

**MENTAL DISORDERS**
- Schizophrenia
- Bi-polar
- Schizoaffective
- Major Depression
- Borderline Personality
- Post Traumatic Stress
- Social Phobia
- others

**ADDICTION DISORDERS**
- Alcohol Abuse/Depen.
- Cocaine/ Amphet
- Opiates
- Marijuana
- Polysubstance combinations
- Prescription drugs
Co-occurring Disorders (COD) Matrix Populations in King County

Severity of Chemical Dependency

Severity of Psychiatric Condition

Low  High  Low  High

LH  HH  LL  HL

1  2  3  4
Drug Induced Psychopathology

**Drug States**
- Withdrawal
  - Acute
  - Protracted
- Intoxication
- Chronic Use

**Symptom Groups**
- Depression
- Anxiety
- Psychosis
- Mania
- Rounsaville ‘90
“Dual CAGE” QUESTIONS

- **Cut Down (or stopped)**
  - Because mental symptoms worsened
  - Because MH doctor or therapist suggested
- **Annoyed when drug/alc. use discussed**
  - Annoyed, Anxious or Angry,…. fights when using
  - Admitted to ER or hospital for psych when using or not
  - ADHD when child
- **Guilty about use**
  - Guilty, depressed, suicidal when using or not
  - Ever made a suicide attempt when using or not
CAGE Questions

- **Eye opener**: taken drink or drug in AM to feel better
  - Taken a drink or drug to blot out symptoms
  - Taken drink or drug with psych med
  - Not taken meds because of using drug/alc (forgot, avoid mixing, etc.)

- What are 2 or 3 reasons you use alc/drugs?
- What are 2 or 3 reasons you might want to stop or cut down?
### Features of Schizophrenia

<table>
<thead>
<tr>
<th>Positive Symptoms</th>
<th>Negative Symptoms</th>
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<tbody>
<tr>
<td>Delusions</td>
<td>Affective Flattening</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>Alogia</td>
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<tr>
<td>Disorganized Speech</td>
<td>Avolition</td>
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<td></td>
<td>Anhedonia</td>
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<td></td>
<td>Social Withdrawal</td>
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<table>
<thead>
<tr>
<th>FUNCTION</th>
<th>Comorbid Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work</td>
<td>Depression</td>
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<tr>
<td>Interpersonal Relationships</td>
<td>Anxiety</td>
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<tr>
<td>Self-care</td>
<td>Aggression</td>
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<tr>
<td></td>
<td>Substance Abuse</td>
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<table>
<thead>
<tr>
<th>Cognitive Deficits</th>
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</thead>
<tbody>
<tr>
<td>Attention</td>
<td></td>
</tr>
<tr>
<td>Memory</td>
<td></td>
</tr>
<tr>
<td>Executive Functions (e.g., abstraction)</td>
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</table>
Why do Schizophrenic persons use alcohol drugs so much and so problematically?

- Dep/Abuse rates are 4-5 times NON mh pops
- Common Biological set ups?
- Poor judgement, fragile brains?
- Boredom, lack of social role
- Live in Drug infested area’s
- Others
Predicting the "revolving door" phenomenon among patients with schizophrenic, schizoaffective, and affective disorders.

Haywood TW, Kravitz HM, Grossman LS, Cavanaugh JL Jr, Davis JM, Lewis DA.

A multiple regression model, which included alcohol/drug problems, medication noncompliance, and six sociodemographic and diagnostic variables (age, gender, race, marital status, years of education, and diagnosis) accounted for a significant proportion of the ability to predict frequency of hospitalization.

Half of this predictability was due to the relationship of substance abuse and medication noncompliance with number of hospitalizations.

CONCLUSIONS: Alcohol/ drug problems and noncompliance with medication were the most important factors related to frequency of hospitalization. Preventing these behaviors through patient education may reduce rehospitalization rates.
It may not be that the med(s) stopped working, but......

- The patient stopped the med... or
- The patient stopped the med AND used drugs and/or alcohol......
- OR lowered the med and used...
- OR used on top of the med....
- OR used twice the dose on one day and nothing the next....
- Stimulants (cocaine/amphets) are most MSE destructive, but alcohol most suicide related
Substance Induced Mania

- Meth/Amphet/cocaine
- Ecstacy
- Halucinogens
- Alc/Benzo withdrawal
- Substance/medication induced in true Bipolar

About 50% of bipolars have an episodic alc/drg problem...women bipolars have 7x more addiction than non bipolar women
Substance Induced Pseudo “Bipolarity”

- Use of stimulant for weeks followed by crash and use of alcohol or Benzos, then back to stimulants
- Chronic Dysthymia in pt who episodically goes on Meth run
- Opiate user who episodically goes on cocaine run and back
Meth/ Coke vs Schiz

**Meth**
- Later onset
- Clear regular heavy drug use
- Lifestyle
- More likely to preserve general function
- Usually paranoid and voices, but not many negative sx
- Cocaine, like above, but lasting minutes to hours vs days to weeks

**Schiz**
- Earlier onset
- Prodrome of withdrawal, negative symptoms, few friends
- More global impairment, thought disorder
- May have drug use but usually much less
SMI Integrated Dual Dx Treatment Program

- Ongoing diagnosis and Rx adjustment
- Patient/Treatment matching
- Bio-psycho-social - vocational approach
- Medication monitoring/ IM Depo meds
- Interactive with shelters, housing, AA etc
- Consumer involvement/ Case management

- Voc and housing incentives, Legal, as well as Social Security payeeship, etc. (carrot and stick)
Dual Recovery TID exercise

- Three x Three (TID) Times a Day:
  - My Recovery Plan includes (Rx Plan)
    - 1. seeing my psychiatrist,
    - 2. taking my Bipolar meds and naltrexone and
    - 3. going to AA meetings and my groups
  - In order to (Rx Goals)
    - 1. get my health back
    - 2. keep my family together
    - 3. prevent another suicide attempt
  - And Three things I am grateful for include: (Gratitude)
    - 1. I have my family and job
    - 2. Bipolar meds work if you take them and don’t drink
    - 3. I am way better than last Spring...there is Hope
Co-occurring Depression and Anxiety

Key Assessment Issues

- Independence vs severity
- Most depressive disorders start later than substance disorders, while the opposite true for Anxiety disorders
- Most pts with one Psych disorder will have others, but there are huge overlaps in both psychotherapy and meds for all.
Comorbidity of Depression and Anxiety Disorders

50% to 65% of panic disorder patients have depression†

70% of social anxiety disorder patients have depression

49% of social anxiety disorder patients have panic disorder**

67% of OCD patients have depression*

11% of social anxiety disorder patients have OCD**
# Mood and Anxiety Disorders Among Substance Treatment Pts

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Respondents, % (SE)</th>
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<tbody>
<tr>
<td><strong>Those With Any Alcohol Use Disorder (5.81%)</strong></td>
<td></td>
</tr>
<tr>
<td>Any mood disorder</td>
<td><strong>40.69</strong> (4.11)</td>
</tr>
<tr>
<td>Major Depression</td>
<td>32.75 (4.01)</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>11.01 (2.74)</td>
</tr>
<tr>
<td>Mania</td>
<td>12.56 (2.81)</td>
</tr>
<tr>
<td>Hypomania</td>
<td>3.07 (1.37)</td>
</tr>
<tr>
<td>Any anxiety disorder</td>
<td><strong>33.38</strong> (4.17)</td>
</tr>
<tr>
<td>Panic disorder</td>
<td></td>
</tr>
<tr>
<td>With agoraphobia</td>
<td>4.10 (1.54)</td>
</tr>
<tr>
<td>Without agoraphobia</td>
<td>9.10 (2.48)</td>
</tr>
<tr>
<td>Social phobia</td>
<td>8.49 (3.48)</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>17.24 (3.10)</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>12.35 (3.01)</td>
</tr>
<tr>
<td>Any drug use disorder</td>
<td>33.05 (4.23)</td>
</tr>
</tbody>
</table>

*Data in parentheses are the percentages of respondents with the substance use disorders who sought treatment in the past 12 months.*

Grant B, JAMA 2004
Dual Dep/Anx RX plan

- Differential Dx
- Therapy:
  - 1:1 around Rx planning and 12 step facilitation
  - Group (often agency)
  - 12 step groups
- Meds if indicated (and I often use them)
  - Psych meds - non dependence inducing
  - Relapse prevention meds
- Visits:
  - Ries 1/week (12 step facil and meds)
  - Group and or AA 3x week or 90 in 90
  - Meet with sponsor
  - Meet with family
Common Somatic Complaints Of Social Anxiety Disorder

- Stuttering
- Blushing
- Palpitations
- Sweating
- “Butterflies” (Trembling And Shaking)

Social Anxiety Disorder

screening:

- Is being embarrassed or looking stupid among your worst fears?
- Does fear of embarrassment cause you to avoid doing things or speaking to others?
- Do you avoid activities in which you are the center of attention?

Katzelnick et al. Presented at 37th Annual Meeting of the American College of Neuropsychopharmacology; December 14-18, 1998; Los Croabas, Puerto Rico.
One year ABSTINENCE was predicted by:

- AA involvement (OR=2.9), (n=377)
- 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.

Kaskutas: Addiction 2002
Twelve-Step Facilitation: An Adaptation for Psychiatric Practitioners and Patients

Richard K. Ries, MD
Marc Galanter, MD
J. Scott Tonigan, PhD

The American Psychiatric Publishing
Textbook of Substance Abuse Treatment, Fourth Edition
Edited by Marc Galanter, MD, and Herbert D. Kleber, MD
What about Suicide and Addiction?
Attempts in Prospective Age-Matched Alcoholic Populations

- 4.5% of alcoholics attempted suicide within 5 years of dx.
  - (age 40.. n=1,237)

- 0.8% in non-alcoholic matched comparison group
  - (age 42..n=2,000)...

- p< .001........700% increased risk of Suicide Attempts

- Consistent with other studies showing
  5- 10 X increase in both attempts and completed Suicide

Preuss/Schuckit Am J Psych 03
Suicide Risk Factors

TIP 50: Addiction and Suicide ...

- **Prior history of suicide attempts** (most potent risk factor)
- Family history of suicide
- **Severe substance use**
- Co-occurring mental disorder (indep. or induced)
  - Proneness to negative affect (sadness, anxiety, anger)
  - Aggression and/or impulsive traits
- Personality disorder
Suicide Risk Factors Continued…

- History of child abuse (especially sexual abuse)

- Stressful life circumstances
  - Interpersonal disruption (divorce/separation/break-up)
  - Interpersonal isolation (living alone, low social support)
  - Unemployment and low level of education, job
  - Legal difficulties
  - Major and sudden financial losses

- Firearm ownership or access to a firearm
If you are in the Addictions business, you are in the Suicide business.

> If you don’t ask, you will probably miss a potentially lethal situation.
How to use AA as a treatment partner

1. Know AA, in your community, where, when mtgs.

2. Go as a professional guest to a couple of meetings
   - Call the AA # in phone book, identify self and why going
   - Go to the meeting with guide, talk about it afterward

2. Helpful Readings:
   - Brown: A psychological view of the 12 steps
   - AA: AA for the medical practitioner; and
   - The AA member and medications
   - Twelve Step Facilitation Therapy Manual-
     - Project Match, NIAAA web site
   - Forman: “One AA Meeting doesn’t fit all”
## 12 Step Facilitation vs Cog Behavioral Addiction Treatment

n=1774, 1 year follow-up  
Humphreys et al ..2001

<table>
<thead>
<tr>
<th></th>
<th>Outpt Visits</th>
<th>Inpt days</th>
<th>Abstinence Rates</th>
</tr>
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<tbody>
<tr>
<td>12 Step Facil</td>
<td>13.1</td>
<td>10.5</td>
<td>45.7</td>
</tr>
<tr>
<td>Cog Beh</td>
<td>17</td>
<td>17</td>
<td>36.2</td>
</tr>
</tbody>
</table>

* all p< .001  
** 64% higher medical costs for CBT but more abstinence in 12 Step facil
Double Trouble Recovery (DTR) 1 yr Outcomes

- Members of 24 DTR groups (n=240) New York City
- 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
Antidepressants and Addictions

- Major Depression/ Bipolar Dep
- Substance Induced Mood
- Panic
- Social Phobia
- PTSD
- Dysthymia/Atypical Depression
- Anger attacks
- Adult ADHD
Antidepressants for Specific Syndromes

- ADHD: Bupropion, Desipramine, Atomoxetine, SSRIs
- Bipolar Dep.: Bupropion, Mirtazapine, SSRIs, Quetiapine
- Social Phobia: Nefazadone, SSRIs, B-blockers
- Panic: Serzone, Venlafaxine, SSRIs
- PTSD: SSRIs, Prazocin, Others
- Borderline: SSRIs, Atyps, others?
Sleep in recovering Alc/Addicts

- Abnormal for weeks/months in most
- Is this “normal toxicity” and to be tolerated?
- Poor sleep associated with relapse, anx, dep, PTSD, and
- Protracted withdrawal
Medications for sleep in recovering addicts/alcoholics

- Treat the comorbid cause...ie dep/anx etc, with an antidepressant
- And/or protracted withdrawal.....with anticonvulsants (for one to several months)
- Prazosin for PTSD nightmares
- Anti-histamines, trazedone, mirtazepine as non-specific sedatives
- Avoid Benzos, or like meds (tolerance dependence and “kindling”
The differential effects of medication on mood, sleep disturbance, and work ability in outpatient alcohol detoxification........Malcolm R, Myrick H, Roberts J, Wang W, Anton RF.

**Carbamazepine** better than **Lorazepam**

Anxiety highest in those w multiple previous detoxifications (p = 0.02).

**Reducing anxiety** (p = 0.0007)

**Improving sleep** (p = 0.02)
Concurrent Alcoholism and Social Anxiety Disorder: a first step toward developing effective treatments.

Randall CL, Thomas S, Thevos AK.

Traditional Alc Rx +/- CBT Social Phobia Rx

RESULTS:
>both groups improved on alcohol-related outcomes and social anxiety after treatment.

Counter to the hypothesis, the group treated for both alcohol and social anxiety problems had worse outcomes on three of the four alcohol use indices.

No treatment group effects were observed on social anxiety indices.
Why aren’t Antidepressants more effective in addictions patients?

- **Psychiatric outcomes:**
  - Antidepressants beat placebo by 20% anyway in NON- addicts
  - Study patients also get “addiction rx” (IOP= 9 hrs group.wk)
  - Maybe addiction rx is more anti-dep, anti anx than we think...
  - This is poorly studied..how anti-dep is 12 step?
  - Sub Induced criteria are wrong?

- **Addictions outcomes**
  - Do Meds take focus off sobriety?
  - Do Meds reduce craving- or increase it?
  - Do Meds just not work well for this?
RESULTS: Prazosin compared with placebo significantly

- increased total sleep time by 94 min;

- increased rapid eye movement (REM) sleep time and mean REM

- significantly reduced trauma-related nightmares, distressed awakenings

- significantly improved normal dreaming.
Treatment of depression in patients with alcohol or other drug dependence: a meta-analysis.

Nunes EV, Levin FR.

“Antidepressant medication exerts a modest beneficial effect for patients with combined depressive- and substance-use disorders.

It is not a stand-alone treatment, and concurrent therapy directly targeting the addiction is also indicated.”
Dual Recovery TID exercise

Three x Three (TID) Times a Day:

- My Recovery Plan includes (Rx Plan)
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