

Psychiatric Co-Morbidities (Dual Diagnosis)

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Goals

- To review the core features of psychiatric conditions that commonly occur in patients with opioid dependence.
- To familiarize the practitioner who uses office-based buprenorphine with these disorders
 - Psychiatric co-morbidity is common in opioid dependent patients
 - These disorders can complicate the successful treatment of patients.

Major Omission

- Other co-morbid substance use disorders
 - cocaine, alcohol, marijuana
- Polysubstance use
 - Complicates assessment / treatment of psychiatric symptoms
 - Impedes rehabilitation
 - Must be treated to optimize outcome

This Section's Discussion

- I. Epidemiology
- II. Principles of psychiatric assessment
- III. Common psychiatric co-morbidities
- IV. Treatment principles

Epidemiology of Psychiatric Co-Morbidity

- Prevalence of psychiatric disorders is higher among opioid abusers
- Reported rates vary with population studied (e.g., demographics, treatment seeking)
- Most common disorders
 - Depression
 - Anxiety disorders
 - Personality disorders

Epidemiology of Co-Morbid Major Depression

- Major depression
 - Common at treatment entry
 - Frequently resolves as patient engages in treatment
 - Lifetime rates: 15-50%
 - Current rates: 3-25%
- Prognostic significance
 - Illicit drug use is more common in those who present with depressive symptoms

Epidemiology of Co-Morbid Anxiety Disorders

- Most common
 - Phobias
 - Generalized anxiety disorder
 - PTSD
- Lifetime rates: 8-27%
- Current rates: 5-17%

Epidemiology of Co-Morbid Personality Disorders

- Highly prevalent in patients with opioid dependence
- Most common: Antisocial Personality Disorder, particularly in men
- Rates (any personality disorder): 35-68%
- Rates (APD): 14-55%

Epidemiology of Other Co-Morbid Psychiatric Disorders

- Schizophrenia
 - Relatively rare
- Bipolar disorder
 - Less common than unipolar
- Eating disorders
 - Lifetime history not uncommon
 - Not usually a current problem
- Attention deficit hyperactivity disorder
 - Associated with substance abuse, but little data

Principles of Psychiatric Assessment

- Overview
- Strategies
- Substance-induced versus independent disorders
- Essential assessment components

Psychiatric Assessment

Major foci

- Mood
- Anxiety
- Reality contact
- Personality
- Suicide and homicide risk

Assessment Principles

- Focus on the most likely / most harmful
- Can be done by interview or with questionnaires
- Questionnaires
 - Economical
 - Assess symptoms, don't diagnose
- Interviews:
 - Provide full diagnosis
 - Provides opportunity to begin therapeutic process
 - Time consuming
- Diagnosis need not be completed in one session.

Distinguish Substance Induced vs Independent Disorders

- Substance-induced:
Disorders related to the use of psychoactive substance; typically resolve with sustained abstinence
- Independent:
Disorders which present during times of abstinence; symptoms not related to use of psychoactive substance

Substance-Induced Disorders

- Symptoms related to times of active use
 - Intoxication
 - Withdrawal
 - Other (e.g. transmitter depletion)
- Symptom onset / course parallel increases or decreases in substance use
- To distinguish:
 - Collateral information
 - Attain period of sustained abstinence
 - Re-evaluate

Independent Disorders

- Symptoms occur during periods of abstinence
- Symptoms wax and wane independently of use
- ± family history of disorder
- Goals of addiction recovery and resolution of psychiatric symptoms pursued simultaneously

Assessment – Recognizing Intoxication / Withdrawal

- Intoxication and withdrawal
- Opioid, stimulant, alcohol, marijuana, others
- Mimic psychopathology
- Confuse diagnosis, treatment

Opioid Intoxication

- Effects

- Feeling “high” or euphoria
- Pupillary constriction
- Drowsiness to coma
- Slurred speech
- Impaired attention or memory

- Vary with

- Half life
- Degree of physical dependence
- Route of administration
- Combined substances

Opioid Withdrawal

Situations

- Stopping regular use
- Decreasing dose after regular use
- Between doses of short half-life drugs
- After receipt of a partial agonist or antagonist

Opioid Withdrawal

Dysphoria

Nausea / vomiting

Muscle aches / cramps

Lacrimation

Rhinorrhea

Mydriasis

Myoclonus (kicking)

Sweating

Piloerection (cold turkey)

Diarrhea

Yawning

Fever

Insomnia

Core Psychiatric Disorders

- Major depression
- Anxiety disorders
 - Phobias
 - Generalized anxiety disorder
 - PTSD
- Psychoses
- Personality disorders
 - Antisocial personality disorder

Major Depression

- Pervasive depressed mood or anhedonia
 - Sustained
 - Not due to bereavement
 - Not substance induced

Depression

Common in addictive disorders at treatment entry

- Sleep
- Interest
- Guilt
- Energy
- Concentration
- Appetites
- Psychomotor change
- Suicidality

Anxiety

- Common at treatment entry
- Mimics withdrawal
- May resolve with abstinence
 - Apprehension / fear
 - Tachycardia
 - Tremor
 - Diaphoresis
 - Dyspnea

Anxiety Disorders – Phobias

- Excessive and unreasonable fear
 - Object (animal)
 - Situation (flying)
 - Social / performance event (eating)
- Exposure produces intense anxiety/distress
- Avoidance

Generalized Anxiety Disorder

- Excessive anxiety and worry, difficult to control
- Restlessness / feeling keyed up
- Easy fatigue
- Difficulty concentrating
- Irritability
- Muscle tension
- Sleep disturbance

Anxiety Disorders: PTSD

Overwhelming trauma

Symptom triad

- Vigilance

- Startle
- Hyperarousal
- Anxiety

- Re-experiencing

- Nightmares
- Flashbacks

- Avoidance

- Specific / generalized withdrawal

Thought Disorder

- Suspiciousness
- Delusions
- Hallucinations
- Incoherence

Personality Disorders

- Enduring, problematic patterns of functioning
- Have no single defining feature
 - A heterogeneous grouping
- Characterized by extreme degrees of universal traits
 - Impulse control
 - Affective lability
 - Dependence
 - Interpersonal behaviors

Personality

- Behaviors engendered by the drug use lifestyle
 - Mimic personality disorder
 - Remit with sobriety
- Axis II disorders typically require specialty treatment
- Recognize limitations of office based treatment
- Refer to specialized services if office management flounders

Antisocial Personality Disorder

Features begin in childhood (Conduct Disorder)

- Repeated law breaking
- Lying / conning
- Impulsivity
- Physical fights
- Disregard for safety of self, others
- Consistent irresponsibility
- Lack of remorse

Assessment of Dangerousness

- Substance abuse –
A major risk factor for suicide / homicide
- You *must* ask
 - Thoughts
 - Intents
 - Plans
- Evaluate perceived consequences
 - Incarceration
 - Hell
 - Peace, relief

Suicide Risk Factors

- Family history
- Prior attempt
- Suicidal preoccupation
- Level of intent and formulation of plan
- Availability of lethal means
- Living alone
- Alienation

Suicide Risk Factors

- Active mental illness
 - Mood disorder
 - Agitation / restlessness
- Current negative life events
- Serious medical illness
- Active substance abuse

Suicide Assessment

- Determine level of intent
 - Is there a plan
 - Has it been communicated
 - Level of lethality
 - Pre death behaviors (giving away possessions, affairs in order)
- Are there reasons not to harm self
 - Family
 - Prospects for sober future
- Accessibility of means
- Is the desire active or passive
- Is there history of suicide attempts

Homicide risk

- Is there an identifiable person threatened?
- Is the threatened person aware?
- Access to weapons?
- History of violence / impulsivity?

Treatment Principles

- General principles
- Depression
- Anxiety
- Psychosis
- Personality disorders
- Suicidal and homicidal ideation

General Treatment Principles

- Clarify diagnosis by ensuring period of abstinence prior to diagnosis
- Evaluate for medical problems that may cause psychiatric symptoms
- Remember that those who are most uncomfortable are most motivated to change
- Vice versa

Treatment Principles – Depression

- Independent depression
 - Typically responds to usual pharmacological and psychotherapeutic treatments
- Substance induced depression
 - Responds to sustained sobriety

Treatment Principles – Anxiety

- Independent anxiety
 - Generally responds to tricyclics, SSRIs, venlafaxine, AEDs
- Substance induced anxiety
 - Generally responds to sustained sobriety
- Avoid benzodiazepines
 - Addictive
 - Intoxicating/disinhibiting → use of other substances
 - Possible interactions with buprenorphine

Treatment Principles – Depression, Anxiety

- Don't neglect non-pharmacological therapies
- Psychotherapy
- Biofeedback training
- Aerobics

Treatment – Psychosis

- Psychosis in withdrawal delirium may not respond to substance replacement
- Psychosis is never a result of opioid withdrawal
 - Alcohol / sedative withdrawal
 - Morphine toxicity
 - Hallucinogens
 - Stimulants
- Typical or atypical neuroleptics required

Treatment Principles – Axis II

- Difficult to treat
 - Especially borderline, narcissistic, histrionic, antisocial
- Consider referral to specialized services
- Often improve without specific treatment
 - Sobriety
 - Recovery work

Management of Suicidality / Homicidality

- Referral to crisis service, ED
- Recall that low intent persons can have high lethality
- Involuntary transport / admission
- Consider duty to warn threatened person

Summary

- Psychiatric co-morbidity is common in opioid dependence
- Assessment is complicated by substance-related and independent psychiatric disorders
- Treatment of both substance abuse and co-morbid psychiatric disorder is essential for successful outcome
- Referral to specialized services may be needed