Comorbidity: alcohol use and other psychiatric disorders

Hamer Alves, Felix Kessler e Lilian Ribeiro Caldas Ratto

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 differential 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 functioning, 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 anhe 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. 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 the closing of psychiatric hospitals to give priority to outpatient treatment and the increase in the availability of alcohol community-based mental health services. However, it is possible that this increase in 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. 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, rehospitalizations, use expensive treatment and and frequently become homeless. These patients have a worse social evolution and a negative impact on the family budget and on the health of the caretakers. The therapeutic approach for patients with comorbidity is complex and consequently they usually don’t find a place for proper treatment. Psychiatrists have to be acquainted with get use to the idea that in many cases the diagnosis needs to be only done when there is evidence of a dual diagnosis. As a diagnosis need 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. The clinical evaluation should be thorough and meticulous, and the differential diagnosis become complicated with a long period of alcohol withdrawal. The patient’s clinical history is extremely important. It should be thoroughly evaluated. The onset of alcohol use and of the associated illness should be meticulously evaluated and detailed, explaining the symptoms and their associated problems must be detailed, in chronological order. 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 dependence, the ICD 10 and the DSM-IV suggest that another diagnosis can be only registered after four weeks of complete alcohol withdrawal. Since almost all psychiatric symptoms may be alcohol-related, 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-
The permanent-transient dichotomy described by Kranzler and toxification suggests a mental primary disorder. Persisting symptoms after alcohol deprivation show a dramatic improvement of symptomatology within few weeks of alcohol withdrawal. Alcohol-induced disorders show a dramatic improvement of symptomatology within few weeks of alcohol withdrawal. Persisting symptoms after alcohol detoxification suggests a mental primary disorder.

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

The permanent-transient dichotomy described by Kranzler and Liebowitz proves also to be also useful too. Transientitory states conditions last for a few weeks and do not persist along time. The symptomatology, although intense and acute, tends to decrease and clinical conditions usually improve with a supportive and psychotherapeutic 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 prognostic than those with only one of these disorders and their treatment is much more difficult. Health practitioners should have to be aware that these patients with comorbidity have a slower improvement/treatment outcome. Since many patients do not accept total alcohol abstinence withdrawal as a goal, a precautionary and tolerant attitude is necessary to enable a consistent therapeutic alliance agreement, since this is one of the predictable factors predictive of treatment success. These patients usually respond poorly to therapies focused in only one disorder, making turning necessary a therapeutic 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 dependency field and clinical laboratory analysts. It is known that, in contrast with drug dependency treatment models, self-helpaid groups and counseling for patients with drug dependency and other psychiatric comorbidities should be less intense and avoid frequent confrontations since these patients are more sensitive and tend to drop out abandon treatment.

The main models patterns for treatment of comorbidities treatment are usually divided in sequential and parallel 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 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 and tasks of each member of the staff, and acting as a reference point for the patient.

The current medical literature is not clear uncertain regarding of which kind of specialist and which what duration and dosage of treatment should be prescribed for patients with this type of comorbidity. Research in this field is recent and still have 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 comorbid use of psychosocial and pharmacological techniques is the most effective. This kind of treatment includes the use of motivational 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 of the patient’s social networks relation and the use of individualized specific treatment for each one of the disorders. The outcome of psychiatric clinical condition comorbidity with substance substance abuse 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>
<thead>
<tr>
<th><strong>TREATMENT MODEL</strong></th>
<th><strong>DESCRIPTION</strong></th>
<th><strong>CHARACTERISTICS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sequential or Consecutive Treatment</strong></td>
<td>Treatment programs are provided consecutively by mental health services according to the priority and the severity of each disorder.</td>
<td>- Good results in secondary disorders. - Poor communication between services. - Problems are discussed independently, as separate entities. - Lower therapeutic link.</td>
</tr>
<tr>
<td><strong>Parallel Treatment</strong></td>
<td>Patients are cared by two services at the same time, one specialized in the psychiatric disorder and the other in substance dependence.</td>
<td>- Specialized treatment. - Weaker therapeutic link. - The physician’s responsibilities are not clearly defined. - Higher costs.</td>
</tr>
<tr>
<td><strong>Integrated Treatment</strong></td>
<td>Both psychiatric and substance dependence treatments are performed in a single service following a therapeutic model.</td>
<td>- In general, better results. - Costs tend to be lower. - Stronger therapeutic link. - Defined responsibilities between physicians.</td>
</tr>
</tbody>
</table>
- 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 Studies in this field are also incipient and do not define precisely which medication should be prescribed for each comorbidity. Despite the lack of consensus in the current up-to-date literature, some of the therapeutic trends evaluated are described in Table 2. Since alcohol interferes directly on the medication’s Serum levels, it may be highlighted convenient to point out that high-risk interactions may be generated to associate with severe risk for the patient’s health. Drugs like Disulfiram, Naltrexone and acamprosate may be used during the treatment. It is known that 25 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 psychopharmac drugs and concomitant psychotherapy significantly improves mood and anxiety symptomatology, inducing a decrease 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.

**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 have already been achieved in this field. However, it is important to point out that health professionals who treat this kind of patient have to keep up-to-date with the new evaluations and treatment implications. 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. It is known that 25 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 psychopharmac drugs and concomitant psychotherapy significantly improves mood and anxiety symptomatology, inducing a decrease in alcohol intake, in the lowers relapse episodes rates and increases the time length up to the first heavy drinking episode.

**References**


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

<table>
<thead>
<tr>
<th>Affective Bipolar Disorder</th>
<th>Anticonvulsants</th>
<th>Lithium</th>
<th>Alcohol may facilitate lithium intoxication.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention Deficit and Hyperactivity</td>
<td>Methylphenidate</td>
<td>Antidepressant and bupropion</td>
<td>Although the risk of methylphenidate abuse is low, it should be observed.</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>Buspirone e SSRI</td>
<td>Benzodiazepines</td>
<td>The depressive effects of benzodiazepines are added to those of alcohol.</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>ISRS</td>
<td>Tricycles</td>
<td>Tricycles usually have more side effects.</td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>Atypical antipsychotics</td>
<td>Typical antipsychotics</td>
<td>Some studies show that atypical antipsychotics have antirelapse effect.</td>
</tr>
</tbody>
</table>

*Selective serotonin reuptake inhibitors*