Annex 8
Brief description of common psychiatric comorbidity (dual diagnosis) of drug abuse

Psychiatric comorbidity (dual diagnosis) is of great concern in the management of drug abusers. Epidemiological data suggests that almost half of individuals with current addictive disorder almost half have co-occurring mental disorders.

Conduct disorder, especially aggressive type

Conduct disorder is a repetitive and persistent pattern of behaviour in which the basic rights of others or major societal norms or rules are violated. There may be aggression to people and animals, destruction of property, deceitfulness or theft, or serious violations of rules.

Most evidence suggests that deviant behaviour and conduct disorder precede drug abuse. And factors of early conduct problems and aggressive behaviour may increase not only risk for later antisocial behaviour but also later drug abuse.

In adult, antisocial personality disorder is the psychiatric condition most commonly associated with drug abuse. Studies have shown prevalence of antisocial personality disorder in substance abusers being 35-60%.

Attention deficit hyperactivity disorder (ADHD)

This disorder begins generally in young children, may persist throughout childhood into adolescence, and may continue with a modified symptom complex into adult life. It includes diagnostic criteria of symptoms of inattention, e.g. difficulty sustaining attention in tasks or play activities, and symptoms of hyperactivity-impulsivity, e.g. often “on the go” or acts as if “driven by a motor”. Secondary symptoms as poor frustration tolerance, poor peer relations, aggressivity, and poor academic performance also occur.

Prevalence of substance abuse problems in ADHD is estimated to be 30%.

Mood disorders - Major depression
Dysthymia
Bipolar disorder
Cyclothymia

Mood (affective) disorders are a class of illnesses characterized chiefly by a disturbance in mood. They are very common, about one in ten persons will be diagnosed as having a clinically significant depression at least once in their lifetimes.

Patients with major depression show a number of symptoms indicating disturbances in cognitive, affective, and psychological functioning. The most common symptoms are depressed mood, loss of interest in living, and anxiety. In severe depression, feelings of guilt and suicidal thoughts accompany depressed mood. Other symptoms include difficulty of falling asleep, early morning wakening, loss of appetite, and fatigue or a lack of energy. In mild forms of depression, the patient may complain of numb feeling, or a total loss of ability to feel. Dysthymia refers to a type of depression that is less severe but more prolonged than a major depressive illness (may last for two or more years).

Bipolar disorder is much less common than major depression. It affects only about 1 percent of the population. In bipolar disorder, the prevalence of substance abuse disorder is 56.1%. Cyclothymic disorder is similar to bipolar disorder in that both involve up-and-down mood swings (mania and depression), but they are less extreme in cyclothymic disorder. Manic episodes may be mild, moderate, or severe and can occur with or without psychotic features. Patients may present with euphoric mood, grandiosity, hyposomnia, loquaciousness, and higher productivity in daily activities. Some may present with irritable mood, high level of distractibility, and psychomotor restlessness. Patients with this disorder show significant variation in their patterns of cycling among the manic, depressed, and euthymic phases of the illness.

The high prevalence of depressive disorders and depressive symptoms in adult drug abusers is well established. There are a number of studies on various clinical population of adolescents which have observed high rates of drug abuse and associated with mood disorders. In both adult and adolescent studies, a significant relationship between drug use/abuse and increased risk of suicide are found. Suicide is currently the second leading cause of death among youth in USA. Accumulating evidence suggests that much of the increase in adolescent and youth suicide is related to drug use/abuse.

Anxiety disorders - Social phobia
Generalized anxiety disorder (GAD)
Post-traumatic stress disorder (PTSD)

Anxiety disorders are characterized by anxiety and avoidant behaviour. They affect about 15% of the general population, making them the most common psychiatric illness. Patients with mild anxiety states may feel only moderate bodily tension, worrisome thoughts, or a feeling of vague apprehension. In extreme anxiety states, patient may complain unparalleled terror and a sense of doom and despair, as well as extreme physical discomfort.

The essential feature of social phobia is a marked and persistent fear of social or performance situations in which embarrassment may occur. Exposure to such situations typically provokes an anxiety response which may take the form of a panic attack. Symptoms include sweating, blushing, and dry mouth. Patients are preoccupied with the fear of being humiliated or embarrassed in social situations. If possible, patients tend to avoid the situations. This may lead to social isolation and incapacitation.

Patients with GAD show chronic free-floating anxiety, along with continual worry, often about trivial matters. They experience profound muscular tension and are unable to relax. They have headache, insomnia, tremulousness, sweating palms, flushing of the face, frequent urges to urinate, etc. They feel easily distracted and have very poor concentration which make work and study very difficult.

PTSD may result from any significant trauma. It may appear in victims of or witnesses to combat situations, natural disasters, and violent acts. The reaction may be acute, delayed, or protracted (chronic), lasting months or years beyond the traumatic event. There is a response of intense fear and helplessness to the traumatic event, a persistent re-experiencing of the trauma through recurrent and intrusive images, thoughts, and dreams. There is a persistent avoidance of stimuli associated with the trauma and persistent symptoms of increased arousal including sleep difficulty, irritability or angry outbursts, concentration problems, hyper-vigilance, and exaggerated startle response.

For individuals having an anxiety disorder, the risk of having drug related disorder is higher. One study demonstrates that among young adults with an anxiety disorder, there is an increased risk of developing a drug use disorder of 1.7 times above that seen for those without anxiety disorder. Study has found 36% of individuals with anxiety disorders also have a substance abuse disorder. Prevalence of lifetime substance disorders in individual with panic disorders estimated to be 36%. The rate of substance abuse in social phobia ranged from 8 to 56%. The prevalence of substance abuse in PTSD is 30 to 50% in males and 25 to 30% in females.

Bulimia nervosa

Bulimia is a chronic disorder characterized by episodic uncontrolled periods of rapid ingestion of food (usually sweets or junk food) typically followed by self-induced vomiting to prevent weight gain. Patients may also engage in prolonged fasting as well as laxative, diuretic, and cathartic abuse to control weight gain. They are aware of the abnormality of their obsession with thinness and their eating habits, but feel totally unable to modify their feelings or behaviour.

Eating disorders are often associated with drug abuse. Studies point to a high incidence of drug abuse among bulimic patients as opposed to those with restrictive anorexia nervosa. Bulimic behaviour is to maintain the reduction of adverse affective states rather than to get high.

Schizophrenia

Schizophrenia is the most devastating of the mental disorders. It affects about 1% of the general population. It is a neurophysiologic disorder characterized by fragmentation and breakdown in the continuity and interrelationships of thoughts, impulses, and behaviour. They experience profound internal and external chaos and lose touch with reality. Recent advance in pharmacological treatment and adoption of community treatment model enable patients more functional, productive and able to live in community in unsupervised or partially supervised settings. This increased autonomy has led to a higher rate of drug/substance abuse among them. Drug/Substance use/abuse increases their vulnerability and may lead to relapse to active schizophrenia. Understanding and treating this population, in drug dependency treatment programme, in standard inpatient/outpatient programme, or a new dual programme is important.

Borderline personality disorder

This is characterized by a pervasive pattern of instability in interpersonal relationships, self image, and affect, as well as marked impulsivity such as sex, drug abuse, reckless driving, binge eating, spending. There is affective instability (such as intense episodic dysphoria, irritability, anxiety), recurrent suicidal behaviour, gestures, or threats, or self-mutilation. Patient complains of constant feeling of emptiness. Unable to attain an inner sense of quiet calm, safety, and stability, patient turns to an external agent – for example, alcohol, drugs, or another person, to supply what the self cannot deliver. The patient is vulnerable to extreme separation anxiety when these external agents become unavailable.

Prevalence of substance abuse in borderline personality disorder is 39 to 84%.