# PSYCHIATRIC CO-MORBIDITY

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# OVERVIEW: PSYCHIATRIC DISORDERS

- Mood Disorders
- Anxiety Disorders
- Psychotic Disorders
- Personality Disorders
- PTSD
- Eating Disorders

# EXAMPLE

- What is the diagnosis?
- Sadness, Irritability, apathy, pessimism, hopelessness, fatigue, appetite changes, anxiety, insomnia, hyperinsomnia, euphoria, hyperactivity
- Too wide of an overlap … multiple studies among alcohol, opioid and cocaine use disorders have documented elevated scores on depression symptoms scales that improve after detoxification.

# CASE:

- 35 y/o Indian female presents to treatment after being found down at work. She works for a local hospital as a surgical scrub tech. She is found with needle marks.
- A code is called, and she is taken to the ED for treatment
- Urine toxicology is positive opioids and benzodiazepines
- Narcan and flumazenil are administered
- Transferred to ICU for observation before going to rehab for detoxification and treatment

# CASE: PART II

- History reveals 16 year history of heroin use that has been daily for the past 10 years. Vague history of “chronic pain.” Currently using 1-3 gm daily or what is excess at work
- History reveals 20 year of Xanax use initially prescribed for “anxiety” and Ambien for “sleep” …
- Patient is a single mother of 3 children (all under the age of 8) and she receives no financial assistance from her abusive ex-husband

# CASE: PART III

- During the first week of her residential treatment, she is fired from her job.
- During the second week of her treatment, her father dies.
- Patient endorses depressed mood, feeling overwhelmed, poor sleep, panic, racing heart, feels that she is not being listened to, and cannot accept the idea that she needs to stop.

# KEY TO DIAGNOSIS

- 1. Establish the presence of the DSM syndrome
- 2. Establish that each symptoms exists apart from the substance
- 3. Establish the relative onset and offset of symptoms during episodes of sobriety … with at least 1 week of sobriety.


psychomotor
characterized
suicide
somnolence
psychotic
physical
clinical
depressive
winter
alliteration
cyclothymic
women
coincident
benzodiazepine
diagnosis
manic
severe
mood
alcohol
hypomania
unipolar
mood
adjunctive
personsertraline
episodedysthymic
loss
hypomanic
disorder
leading
mixed
disorders
purposeless
month
symptoms
induce
bipolar
manic
intermittent
overdoses
nortriptyline
creativity
psychosis
depressed reactivity
hypersomnia
postpartum
electroconvulsivetherapy
state
refers
dysthymia
termmajor
neurochemistry
patient
recurrentcommonly
anhedonia

# OPIOIDS AND MOOD

- Intoxication/Withdrawal & Depression
  - Apathy, dysphoria, psychomotor retardation, dysphoria, insomnia, fatigue
- Intoxication/Withdrawal & Mania
  - Euphoria, agitation, impaired judgment or social functioning, irritability, insomnia
- Unique Intoxication/Withdrawal
  - Pupillary constriction, slurred speech, drowsiness, respiratory depression, stupor, coma, nausea, vomiting, muscle aches, lacrimation, rhinorrhea, piloerection, yawning, fever

# ODD RATIOS REFLECTING THE STRENGTH OF ASSOCIATION BETWEEN OTHER DRUGS AND MOOD

- Epidemiologic Catchment Area (ECA)
  - Major Depression Disorder: 3.7
  - Dysthymia: 3.6
  - Bipolar 8.3
- National Comorbidity Survey (NCS)
  - Major Depression Disorder: M: 2.0 F: 2.0
  - Dysthymia: M: 1.3 F: 1.3

# PRIORITIES IN TREATMENT

- Treat the alcohol use disorder
- Evaluate the mood symptoms
- Treat the mood symptoms

# TREATMENT

- Opioid or other substance related depression: no specific treatment recommendations
- Bipolar: mood stabilizer, atypical antipsychotics
- Limited benefit in treating a substance disorder without the mood component


anxiety
assault
stress
post traumatic stress disorder
neuroendocrinology
worry
sufferer
numbing
disturbance
veterans
disorder
behavioural
somatic
cognitive
falling
thinking
threat
memories
criteria
avoidance
irritable
distressing dreams
mental health problems
emotional
help
cortex
thoughts
stimulus
diagnose
cope
severe
escape
traumatic
psychological trauma
alcohol abuse
psychological
mood
diagnostic
guilty
avoid
feel
hippocampus
counselling
horror
accidents
death
anxious
trigger
acute
arousal

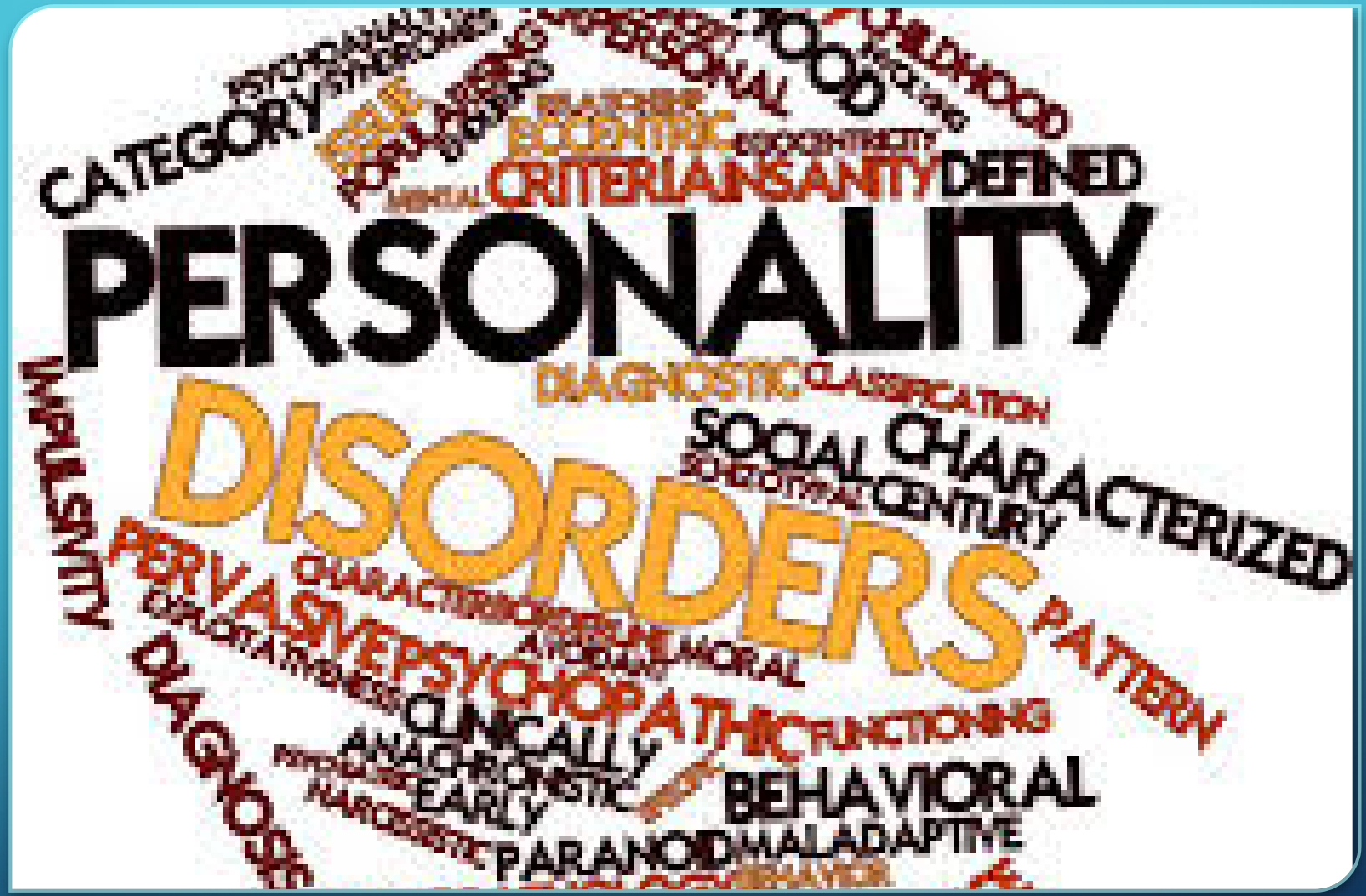
# ANXIETY DISORDERS AND OPIOIDS

- GAD: lifetime prevalence of OUD is 11%
- Social Anxiety: lifetime prevalence of OUD is 3-39%
- Panic: lifetime prevalence of OUD is 5-14%
- PTSD: Odds ratio 3.0 for men and 4.5 for women
- DDx: Anxiety is a key feature of opioid withdrawal


medications
DELUSIONS
antipsychotic
ANTIPSYCHOTIC
NEUROLOGICAL
HALLUCINATIONS
SCHIZOPHRENIA
DISORDER
ILLNESS
MENTAL
THERAPY
PSYCHOLOGICAL
GENETIC
NEUROLOGICAL

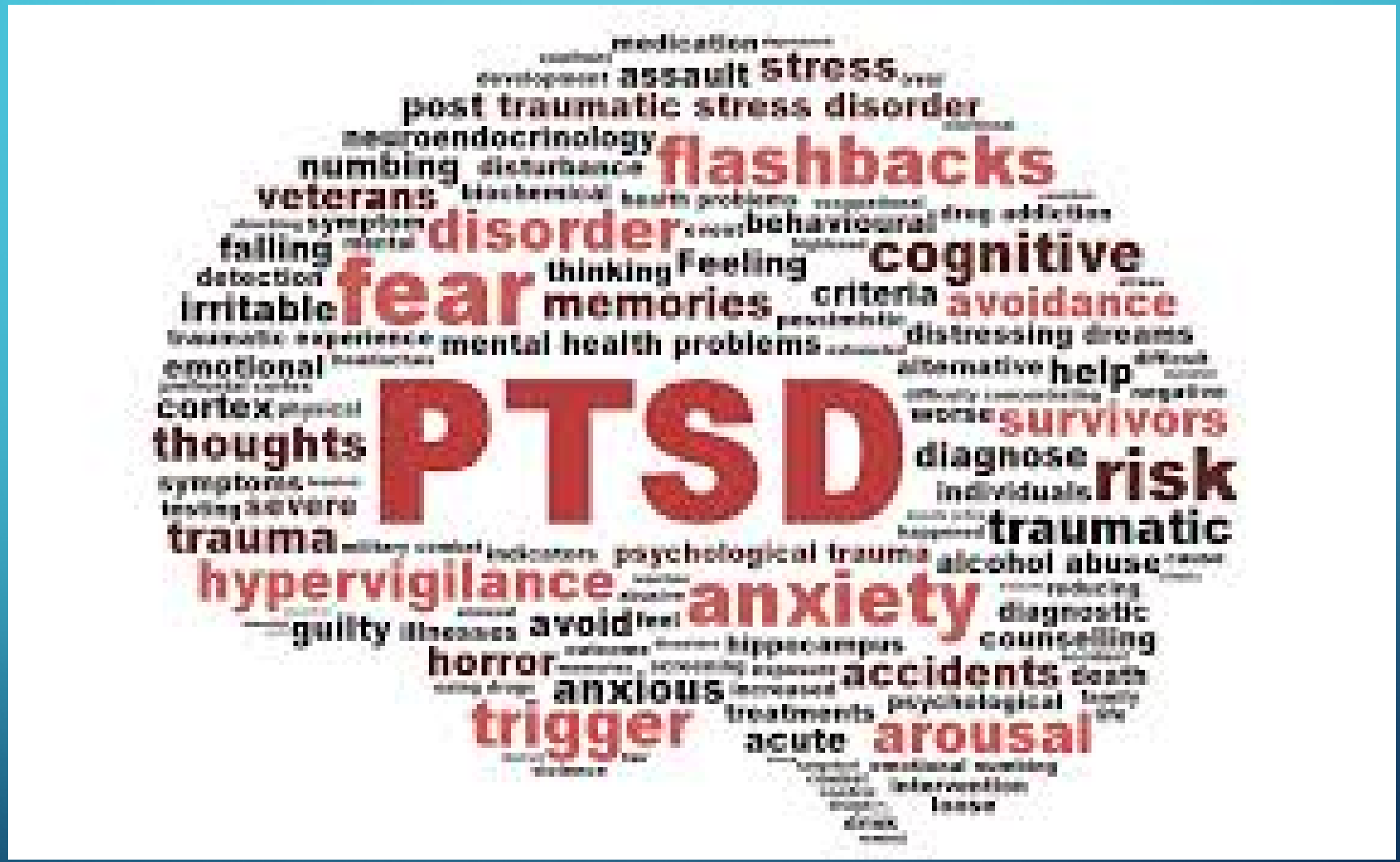
# PSYCHOTIC DISORDERS AND OPIOIDS

- No clear overlapping symptoms


PERSONALITY
DISORDERS
CATEGORY
CRITERIA
INSANITY
DEFINED
DIAGNOSTIC CLASSIFICATION
SOCIAL
CHARACTERIZED
CENTURY
PERVASIVE
PSYCHOPATHIC
PATTERN
FUNCTIONING
CLINICALLY
ANACHRONISTIC
EARLY
BEHAVIORAL
PARANOID
MALADAPTIVE
NARCISSISTIC

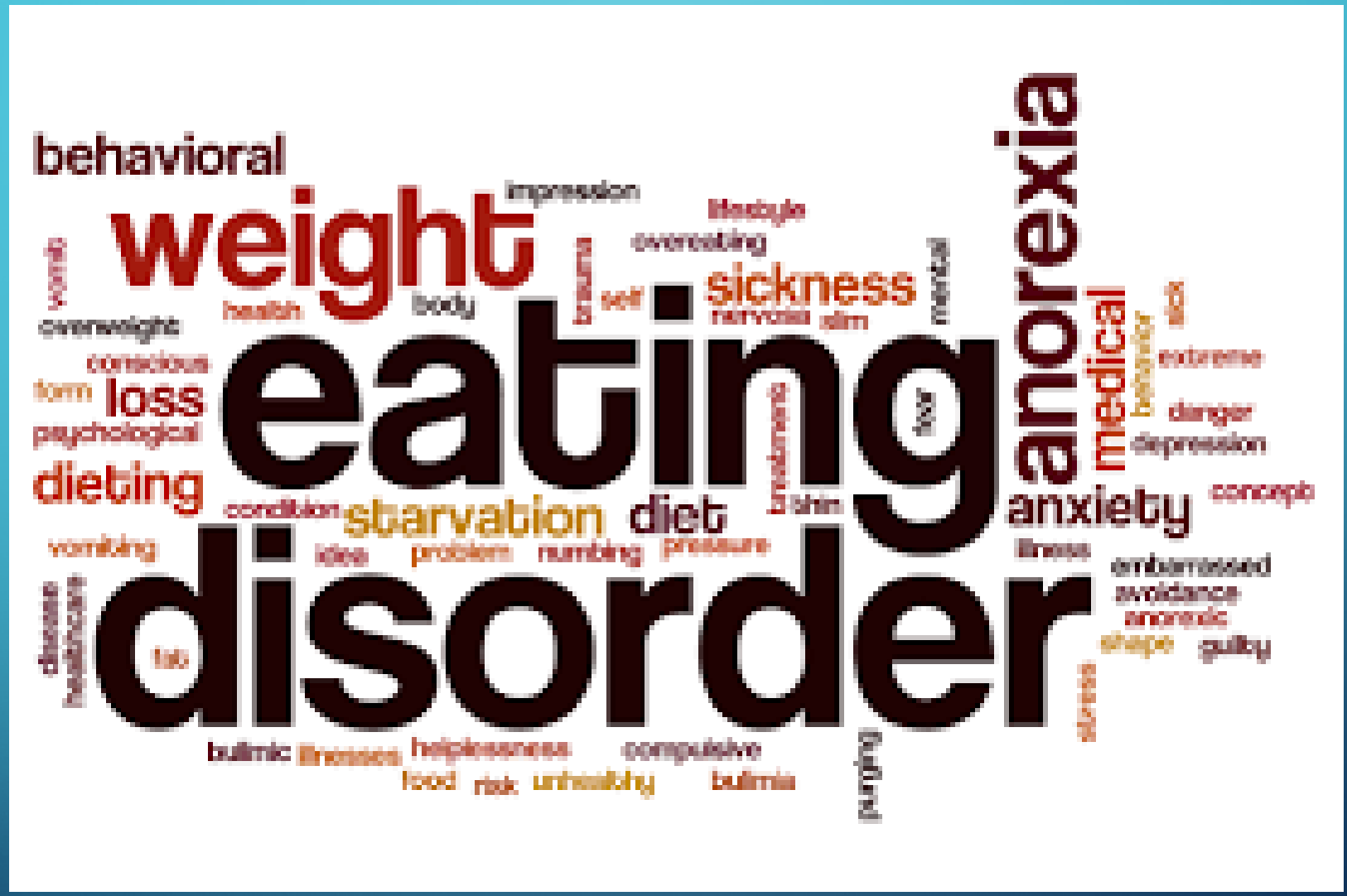
# PERSONALITY DISORDERS AND SUD

- Anti Social PD: 83% had co-occurring SUD
- Borderline PD: 5-65% had co-occurring SUD
- Although Cluster C are the most common in the community, ASPD &BPD clearly have the highest rates of co-occurring SUD


medication
assault
stress
post traumatic stress disorder
neuroendocrinology
flashbacks
numbing
disturbance
veterans
symptom
disorder
behavioural
drug addiction
failing
cognitive
detection
thinking
Feeling
fear
memories
criteria
avoidance
irritable
traumatic experience
mental health problems
distressing dreams
emotional
alternative
help
cortex
PTSD
survivors
thoughts
diagnose
risk
symptoms
severe
individuals
trauma
traumatic
psychological trauma
alcohol abuse
hypervigilance
anxiety
diagnostic
guilty
illnesses
avoid
counselling
hippocampus
horror
accidents
anxious
death
psychological
trigger
treatments
acute
arousal
intervention
leave

# PTSD AND SUD

- Lifetime prevalence of PTSD and SUD: 21.6-43.0%
- Lifetime prevalence of SUD: 8.1-24.7%
- Vietnam Veterans with PSTD: lifetime prevalence of SUD >75%
- Presence of PTSD + SUD = worse physical health, more somatic complaints, more sick employment sick days, and worse cardiovascular


behavioral
weight
impression
lifestyle
overeating
anorexia
sickness
health
body
nervosa
slim
medical
overweight
conscious
extreme
form
loss
danger
psychological
depression
eating
dieting
anxiety
concept
condition
starvation
diet
vomiting
idea
problem
numbing
pressure
illness
embarrassed
avoidance
anorexic
disorder
shape
guilty
fat
bulimic
illnesses
helplessness
compulsive
food
risk
unhealthy
bulimia

# EATING DISORDERS AND SUD

- Prevalence: ED and AUD = 15-24%
- Prevalence: ED and SUD = 16-26%
- Prevalence: Binge Eating and AUD = 28-57%
- Prevalence: Binge Eating and Stimulants: greater than general public
  - Higher risk of developing SUD following bariatric surgery in BED
- Detection among SUD patient is really hard, still it is important to screen

# TAKE AWAYS

- SUD and co-occurring behavioral health are common
- Substance-induced depression is just as dangerous as MDD in terms of suicidal ideations or self-injurious behaviors
- Safety is the first consideration of treatment