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Substance dependence and mental health: A case study

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Dealing with substance abuse, alcoholism, or drug dependence has never been easy, and it's even more difficult when there is co-occurrence of mental health problems. Both, the mental health issue and the drug or alcohol dependence have their own unique symptoms that may get in the way of the ability to function, handling life's difficulties, and relating to others. To make the situation more complicated, the co-occurring disorders also affect each other and interact. When a mental health problem goes untreated, the substance abuse problem usually gets worse as well. And when alcohol or drug abuse increases, mental health problems usually increase too. The present case-study brings forward a clear picture of both, substance abuse and mental health issues, by ways of discussing chief complaints, signs and symptoms, investigation from different point of views, diagnosis, and management. The follow up revealed remarkable recovery as the result of integrated interventions after a period of one year. Implications of this study have been discussed from the perspective of importance of early diagnosis and intervention.

Keywords: substance dependence, mental health, integrated intervention and management

Many people who are addicted to drugs are also diagnosed with other mental disorders and vice versa. For example, compared with the general population, people addicted to drugs are roughly twice as likely to suffer from mood and anxiety disorders, with the reverse also true (NIH, 2011).

Although drug use disorders commonly occur with other mental illnesses, this does not mean that one caused the other, even if one appeared first. It can be hard to tell which problem came first the drugs or the mental illness. Having a mental illness can make a person more likely to abuse drugs, to make their symptoms feel better in the short-term. Other people have drug problems that may trigger the first symptoms of mental illness. Some drugs cause a condition called drug-induced psychosis which usually passes after a few days. However, if someone has a predisposition to a psychotic illness such as schizophrenia, these drugs may trigger the first episode in what can be a lifelong mental illness. Using drugs can also make the symptoms of mental illnesses worse and make treatment less effective. Anyone who has, or is vulnerable to, mental illness is therefore strongly discouraged from using drugs.

A primary psychiatric illness may precipitate or lead to substance misuse. Patients may feel anxious, lonely, bored, have difficulty sleeping or may want to 'block out' symptoms or medication side-effects (Crome et al., 2009). Substance misuse may worsen or alter the path of a psychiatric illness. Intoxication and/or substance dependence may lead to psychological symptoms. It may act as a trigger in those who are predisposed (Crome et al., 2009).

The relationship between the two is complex, and the treatment of people with co-occurring substance abuse (or substance dependence) and mental illness is more complicated than the treatment of either condition alone. This is unfortunately a common situationmany people with mental illness have ongoing substance abuse problems, and many people who abuse drugs and alcohol also experience mental illness (NAMI, 2015).

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Review of literature

Co-morbidities: Different epidemiologic studies conducted in the past more than 20 years have demonstrated that many psychiatric disorders and substance use disorders co-occur in far greater numbers than would be expected by co-incidence alone. According to the Epidemiologic Catchment Area Study (Kessler, Nelson, & McGonagle et al., 1996; Eaton, Regier, Locke, & Taube, 1981) an estimated 45% of individuals with an alcohol use disorder and 72% of individuals with a drug use disorder had at least one co-occurring psychiatric disorder. In the National Co-Morbidity Study (NCS) (Regier, Farmer, & Rae et al., 1990) it was found that approximately 78% of alcohol-dependent men and 86% of alcohol-dependent women met criteria for another psychiatric disorder, including drug dependence and antisocial personality disorder.

If the co-occurrence of Depression and Substance Use Disorders is reviewed in previous studies, there are number of studies which found the same. Edward Nunes (2003) a Professor of Psychiatry from Columbia University School of Medicine, also mentioned about the comorbidity of depression and substance use disorders. He pointed out that depressed mood, dysthymia, and major depressive episode are among the most common symptoms and disorders seen in individuals with substance use disorders.

Discussing more about comorbidity, Tim Wilens (2003) from Harvard University, has mentioned that both ADHD and substance use disorders are commonly comorbid with conduct disorders and most often those individuals with ADHD who develop substance use disorders also have a conduct disorder.

Among those seeking treatment for alcohol dependence, an estimated 20 to 67 percent had experienced depression and 6 to 8 percent had experienced a bipolar disorder at some time in their lives (Brady, Myrick, & Sonne, 1998).

Alcohol and drug abuse sometimes results in mood destabilization in individuals with affective disorders (Markou, Kosten, & Koob, 1998). While comparing the histories of individuals with bipolar disorders, Sonne and colleagues (1994)

found that the onset age of bipolar episodes was early in those who were substance abusers, had relatively frequent hospitalizations, and more comorbid psychiatric disorders.

In a study, more than 60% of the individuals who committed suicide had an SUD (Rich, Fowler, & Young, 1989). In another study, Young and colleagues (1994) found that individuals with Major Depressive Disorder having comorbidity with alcohol and drug dependence were at the highest risk for suicide.

Treatment and intervention: Numerous studies have been done which shows the complexities of treatment and intervention in case of more than one condition. Apart from this, there effectiveness of certain therapies/strategies has also been studied by many researchers.

Keller and colleagues (1986) found that among a group of bipolar patients, those with alcohol dependence recovered more slowly than those without.

Brown, Evans, and Miller et al. (1997) studied the impact of cognitive behavioral therapy (CBT) in alcohol-dependent individuals with co-morbid major depression in which they found that, after the follow-ups of 3 and 6 months, the individuals treated with the integrated treatment approach had better outcomes with regard to both alcohol consumption and symptoms of depression.

In their study, Weiss and colleagues (2000) compared a manual-based CBT group therapy with treatment for the patients with SUD and bipolar disorder, and found that CBT produced significantly better outcomes in a number of domains. Another study of a large treatment-matching on alcohol-dependent individuals compared three psychosocial interventions: 12-step facilitation, CBT, and brief motivational therapy. The treatments were equally effective overall; however, patients with high psychopathology as assessed by the ASI had better outcomes with CBT than with 12-step facilitation (Project MATCH Research Group, 1997).

In a study done by Agency for Healthcare Research and Quality (2014) Integrated care programs have been tested for depression, anxiety, at-risk alcohol, and ADHD in primary care settings and for alcohol disorders and persons with severe mental illness in specialty care settings. In general, integrated care achieved positive outcomes.

Prevalence

Estimates of prevalence are difficult to come by, not least because various studies have used different diagnostic criteria (NHS Foundation Trust, 2011).

People with a mental illness experience drug problems at far higher rates than the general community. Different studies suggest that around 50% having mental illness also have a drug or alcohol addiction problem. In other words, nearly half of the populations with substance use disorder also have mental disorder. It is important, then, that both conditions are correctly diagnosed and receive the appropriate treatment (SANE Factsheet, 2014).

Recent other scientific studies (NAMI, 2015) have suggested that nearly one-third of people with all mental illnesses and approximately one-half of people with severe mental illnesses (including bipolar disorder & schizophrenia) also experience substance abuse. Conversely, more than one-third of all alcohol abusers and more than one-half of all drug abusers are also battling mental illness.

The 2002 Co-morbidity of Substance Misuse and Mental Illness Collaborative study (COSMIC) concluded that (Drug Scope & UK Drug Policy Commission, 2011):

- 75% of drug service clientele and 85% of alcohol service clientele had mental health problems.
- 44% of mental health service users used drugs or alcohol at hazardous or harmful levels in the previous year.

Background of the case

Shamsher was identified by a psychologist at an Early Intervention Center where he accompanied his son who was being assessed for disability. He became a subject of further investigation when some serious issues were discovered while talking to his wife, Sapna. Shamsher was also found experiencing tremors during his conversation with the psychologist. He was finally referred to a Rehabilitation Center that deals in drug de-addiction. A team of experts then intervened and provided treatment based on further investigations.

About the case

Shamsher is thin, 5'7" tall, weighted 50 Kg., 32 years old male who works as a salesman. He is married and father of three children. Shamsher has dependence on alcohol and also exhibits mental illness in his day to day life. Addiction in itself is mental illness. Addiction changes the brain in fundamental ways, disturbing a person's normal hierarchy of needs and desires and substituting new priorities connected with procuring and using the drug. The resulting compulsive behaviors that weaken the ability to control impulses, despite the negative consequences, are similar to hallmarks of other mental illnesses (NIDA, 2011).

Information elicited from Shamsher, his mother and his wife revealed that at the age of fourteen, Shamsher's father passed away, which left his mother alone to raise six children. Shamsher was the oldest of the six children. After his father's death, Shamsher was bound to support the family financially, thus forcing him to quit school. He found full time job in a shop nearby. Shamsher misses his school days. Shamsher showed symptoms of conduct disorder when in school.

Shamsher has been diagnosed and given treatment and management plan to overcome his dual diagnosis.

Symptoms and diagnosis

This section presents a description of Shamsher's problems and their diagnosis.

Chief complaints: His chief complaints presented a list of symptoms associated with particular kinds of disorders. Shamsher was experiencing irritability, suicidal ideation and substance withdrawal delirium such as tactile hallucinations and tremors. He was practicing physical violence at home and becoming socially withdrawn. He clearly showed following signs of mental illness:

- Shamsher showed distress and agitation
- He lost his self esteem
- Developed feelings of uselessness or guilt
- Attempted suicide
- Tried to kill his 4 years old disabled son
- He often practiced domestic violence
- He has been an alcoholic from last 8 years.

Mental State Examination: On examining Shamsher's mental state it was found that he lacked concentration, was restless and awkwardly confused, had variable mood, lacked confidence (Avoided making eye contact) and lacked insight into his medical condition.

Physical examination: The physical examination revealed Shamsher to be underweight, having signs of Anaemia and having clear tremors.

Investigations: Many investigations were done in three areas, namely physical, psychological and social. Physical investigations included Blood complete picture (Hb level) and other baseline Investigations (Urine, ECG, EEG, Lever Function Tests, etc.). The psychological investigations mainly involved use of Projective test (TAT), Alcohol dependence test (CAGE), Personality disorder assessment tool (IPDE, ICD-10), tests to measure level of Stress (BBSS), level of Depression (BDI-II), and level of Anxiety (HARS). The social investigation mainly dealt with detailed account of history and family dynamics and pre-morbid personality (including possible background of conduct disorder).

On the basis of different investigations, Shamsher was found to have dual diagnosis- Severe Depressive Episode without psychotic symptoms (F-32.3-ICD-10), Dependence Syndrome (F1x.2-ICD-10) along with Emotionally unstable Personality Disorder (F60.3-ICD-10).

Dual diagnosis is the term used to describe patients with severe mental illness and problematic drug and/or alcohol use. Personality disorder may also co-exist with psychiatric illness and/or substance misuse. The term originated from the USA in the 1980s and has been adopted in the UK more recently. The nature of the relationship between the two conditions is well established and may be genetically linked (NHS Foundation Trust, 2011; Di Lorenzo, Galliani, & Guicciardi et al., 2014).

In Severe Depressive Episode without psychotic symptoms, the sufferer usually shows considerable distress or agitation, loss of self esteem or feelings of uselessness or guilt, and suicide is a danger in particularly severe cases. Minimum duration of the whole episode is about 2 weeks (ICD-10, 2007).

Dependence syndrome is a cluster of physiological, behavioural, and cognitive phenomena in which the use of substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. There is a desire to take psychoactive drugs, alcohol, or tobacco with the intention relieving or avoiding withdrawal symptoms (ICD-10, 2007).

Emotionally Unstable Personality Disorder exhibits a marked tendency to act impulsively without consideration of the consequences, together with affective instability. The ability to plan ahead may be minimal, and outburst of intense anger may often lead to violence or "behavioural explosions"; these are easily precipitated when impulsive acts are criticized or thwarted by others (ICD-10, 2007).

The above conditions have been a very stressful problem for Shamsher and have put a strain on his relationship with his family and community. His family has been sympathetic and worried about him.

Treatment and management plan

This section presents the treatment and management plan that was used for dealing with the client's problem. Also, this section will describe the results and outcome of how that process was applied. This plan took into consideration the severity of Shamsher's disorder with regard to his resistance to treatment.

Shamsher was falling between the cracks of Mental health care and addiction treatment. Thus, his treatment and management plan included both which was altogether classified in three areas as were his investigations. The Biological component applied Iron Supplements, Medication for Alcohol de-addiction, Anti depressants and Physical workouts. Psychological included Therapeutic Counseling, Supportive therapy (Eg. NA or AA), Relaxation exercise and Daily Activity Chart. Finally the Social aspect of the whole plan provided Family Therapy and empowerment and worked towards strengthening the community. A holistic plan was designed for treatment and management. Thus, it involved different experts from different discipline such as a psychologist, psychiatrist, physiotherapist, social worker, and a counselor.

Throughout the implementation of this holistic plan, Shamsher showed resistance at various points and also tried to quit the treatment. But gradually as the therapies and treatment moved forward, Shamsher began to feel more comfortable discussing his problems with the professionals involved. As a result, executing the plan became relatively easier with time.

Results

This section presents the results of the treatment and management plan used in the study. After implementing the plan, Shamsher showed improvement. He mostly co-operated while showing reluctance to the treatment now and then. Due to the therapeutic counseling by the psychologist Shamsher found strength to overcome some of his problems. He realized his weaknesses and also realized the need of further intervention.

Supportive therapy, relaxation exercises, and associated strategies later used in the treatment process also provided successful results. Shamsher learned to overcome his suicidal tendencies and fears and gained relatively more confidence. It is hoped that the programme as a whole would help him realize his impulsive behaviours, thus reducing practicing domestic violence and risk of attempting murder.

The physical symptoms such as tremors, irritability, and other withdrawal symptoms lowered and some almost gone with the help of medicines. He also gained weight and recovered from anaemia.

Shamsher is now responding well to counseling and other interventions, though still in the Rehabilitation center. He is hoped to get discharge after a month. To prevent relapse, his involvement with Alcohol anonymous is being ensured.

Family therapy and community awareness was being done parallel to Shamsher's treatment. Very positive responses are shown from the family members and the community. It is hoped that they will accept Shamsher fully and help him fight through this difficult phase.

Conclusion

Co-occurrence of Mental Disorders and disorders related to Substance use are common and have an impact on prognosis and treatment. Diagnosis and assessment of these comorbid disorders are relatively difficult because of the possible overlap in the symptoms of intoxication, withdrawal, dependence and mental disorders. Circumstances in both the mental health and addiction treatment systems make the delivery of optimal care difficult. Using screening instruments to identify individuals with possible disorders would be useful in identification, intervention, treatment and prognosis.

Recent advances in the field of medicine have opened up new

possibilities for treating co-occurring disorders because the newer agents have less toxicity, fewer side effects, and fewer interactions with substances of abuse.

Active participation in Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) is expected to enhance recovery to a great extent and reduce the chances of relapses. Clinicians should encourage patients with co-occurring disorders to affiliate with 12-step groups that give clear, positive messages about the use of prescribed psychotropic medications.

Recognition of the prevalence of co-occurring disorders has led to the establishment of a number of self-help groups for dual-diagnosis patients modeled on AA and NA, such as Double-Trouble and Dual Recovery Anonymous. While this development in the field of treatment holds promise, the efficacy of these groups needs to be systematically explored.

It is expected that the case study presented here has communicated some of the issues and concerns associated with Dual diagnosis of Substance dependence and Mental illness. It is hoped to show the damaging effects of such conditions on the person in particular and on the society in general. Shamsher was not only suffering from alcohol addiction but also the psychological problems. With the help of, caring doctor, psychologist, therapists and the treatment program he was able move towards successful recovery while building hopes for further improvements and less chances of relapse. There is a shine of hope seen in Shamsher and his family.

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