Eur Psychiatry 1997;12:102–3

AEP news

Alcoholism and drug addictions *

MJAJM Hoes

Department of Psychiatry, Rivierenland Hospital, PO Box 6024, NL – 4000 HA Tiel, The Netherlands

(Received 8 November 1996; accepted 19 November 1996)

Summary – In this symposium the nature, epidemiology and extent of psychiatric disorders comorbid with addictions, especially alcoholism, was exposed. Internationally reknown authors from several European countries highlight the diversity and complexity of this problem in particular for depression, anxiety and suicide. The conclusion is that every psychiatrist should be well acquainted with addiction disorders and that no addiction center be allowed to refuse treatment to patients with a psychiatric comorbid disorder. Comorbidity of schizophrenia with addictions should be a future focus of research. Multicultural Europe is an exciting area for further research of the comorbidity problems.

alcoholism / comorbid disorder / epidemiology / depression / anxiety / suicide

EPIDEMIOLOGY

Comorbidity has been defined by Feinstein as the occurrence of every clinical disorder in patients with the index disorder. The later definitions of Last and Burke as the occurrence of more than one specific disorder in a patient are less strict. However, when a patient has two or more disorders at the same time, the risk of hospitalization is significantly raised. When alcoholism is the index disorder, its lifetime prevalence in males under the age of 60 years varies between 9.8% (USA) to 43.8% (Canada). Sweden is with 23.9% close to the almost 30% that Helgason found in Iceland. In his study, the point-prevalence of comorbid disorders in alcoholics is higher than in the general population for affective disorders (2×), anxiety disorders (2×) and personality disorders (10×). In recent studies in the United States, Canada, Munich and Iceland, the lifetime prevalence of any comorbid psychiatric disorder with alcoholism varied between 39.4 to 83.6%. Drug addiction has the highest prevalence of comorbid personality disorders (80%). When the number of disturbed items on the General Health Questionnaire (GHQ) is the index disturbance, interesting sex differences in substance abuse are found (table I).

DEPRESSION

In alcoholics depression may occur before the index-alcoholism, it may occur secondary, pharmacologically provoked, after or during the alcoholism, or both may simply coexist, according to Adès. In France, 48.5% of all alcoholics have depression (80% secondary), 24% a dysthymia. In Adès's study, 40% of the alcoholics had on admission a score on the Hamilton depression scale of >20; 4 weeks after admission this was only 4% and 1 year later (still abstinent) just 2.1%. Bipolar patients have 22.5% alcoholism, the odds ratio for mania (6) being higher than for depression (2). The contrast is also possible for mania, with alcoholism giving rise to mania, as Winokur has pointed out. For others types of addictions, comorbid disorders data are more sparse. Opiate addicts whos mostly a secondary depression but only in 5%, while the prevalence in polydrug abusers is much higher (39.5%). For cannabis users, hardly any significant evidence on comorbid disorders exists. Cocaine users have a comorbid depression in 30.5% of the cases. Gambling has a comorbid major depressive episode (MDE) in 30.5%, sex addicts in 55%. Of patients with a MDE, 32%

* A report on the symposium "Alcoholism and Comorbid Psychiatric Disorders" of the section "Alcoholism and Drug Addictions" of the Association of European Psychiatrists at the AEP Congress, 8–12 July 1996, London.

Table I. Substance abuse with General Health Questionnaire (GHQ) disturbance as index disorder.

GHQ items disturbed	*Substance abuse point-prevalence (%)*		
	Male	*Female*	*Total*
Three to eight	36	64	40
Two or less	17	20	19
Mean	19	21	20

About 30% of psychiatric patients have an alcohol or drug problem.

Table II. Point-prevalence (%) of comorbid disorders according to setting.

Disorder	*Hospital*	*Outpatient*
Antisocial personality disorder	55	79
Anxiety disorder	14	3
Phobia	17	7

have comorbid compulsive buying and 39% are nicotine dependent.

ANXIETY

A clear difference in comorbidity between hospitalized and outpatient alcoholics has been shown by Puldrugo (table II). However, although comorbidity of anxiety disorders is high in alcoholics, psychiatric comorbidity tends to be low in patients in addiction settings, except for antisocial personality disorders. Intoxication with stimulants and withdrawal of depressants or stimulants is often accompanied by (transient) comorbid anxiety. One should, when evaluating these data, always take into account the sample set, the diagnostic criteria used, selection bias from setting, time of assessment of psychopathology, the chronical development of the disorders and treatment interventions. Before starting treatment, one should carefully redefine the disturbances in proper psychiatric terms, differentiating symptoms from syndromes. The primary/secondary dichotomy is important to research, as well as whether patients have already received psychosocial help or anxiolytics. One should always remember that there currently exists a fixed belief in 'comorbidity' or 'dual diagnoses', which implies a medicalization rather than the psychosocial approach.

SUICIDE

In Malmö there is fairly well centralized care for alcoholics, according to Berglund. There, 11% of the male and 3% of the female population (230,000) is or have been clients. Whereas somatic disorders in alcoholics rise sharply and steadily after 40 years of age in these patients, suicides show a peak at age 50 years. The lifetime risk of suicide in this population is 6.2% for inpatients and 2.6% for outpatients. Predictive factors are 1) lack of interpersonal support, 2) comorbidity and 3) the number of previous suicide attempts.

From 1946–1969, 88 of 1,312 ($f = 120$) alcoholics who were followed-up presented as relative risks for suicide: peptic ulcer (3×), explosive temper (2.8×), sensitive personality (2.0×), dysphoria (1.4×) and depression (1.4×). Intoxication was correlated with sensitivity, withdrawal with dysphoria. In another study of 2,456 women who were followed-up for 10 years between 1968–1988, 50 committed suicide. Most of them had sought contact with help institutions during the month before the suicide. Between 1984–1991 blood alcohol concentrations (BAC) were systematically studied in suicide victims: 35% of the male cases and 18% of the female cases had been clients at the Malmö addiction center. In male (73%) as well as female clients (77%) BAC were raised, being above 2 go/oo in 81/95 male and 21/28 female suicide victims. During 1993–1995 in a prospective study, systematic forensic autopsies of the addiction center patients revealed 96 suicide victims, 12 accidents and 89 deaths for other reasons. Half of the suicide victims were drug abusers (also benzodiazepines), but only 22% of the other cases. Risk factors for suicide in this study were psychiatric comorbidity, interpersonal loss and the number of previous suicide attempts.

CONSEQUENCES

The data presented on comorbidity in alcoholics should have five consequences according to Edwards:

– The general psychiatric clinics should be reorganized so that they can cope with comorbid addiction disorders; today, even many senior professors cannot deal with them.

– Specialized addiction clinics can no longer refuse patients because of their psychiatric comorbidity.

– More research on the comorbidity problem in addiction is needed; naturalistic studies are especially required.

– A problem in need of focused research is the comorbidity of alcoholism and schizophrenia.

– Europe, with its diversity of cultures and social conditions, represents one huge laboratory, and suicide varies according to culture. Eastern Europe should take part because they have their special cultural features. In addition, on the European level, the public health significance of psychiatric comorbidity is of special importance because alcohol consumption is rising.