Characteristics of patients with dual disorders and recommendations for treatment

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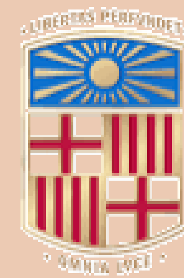

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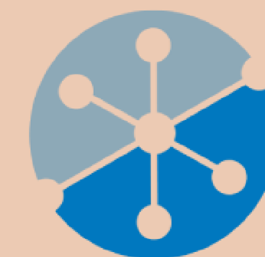

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1. What is a Dual Disorder?

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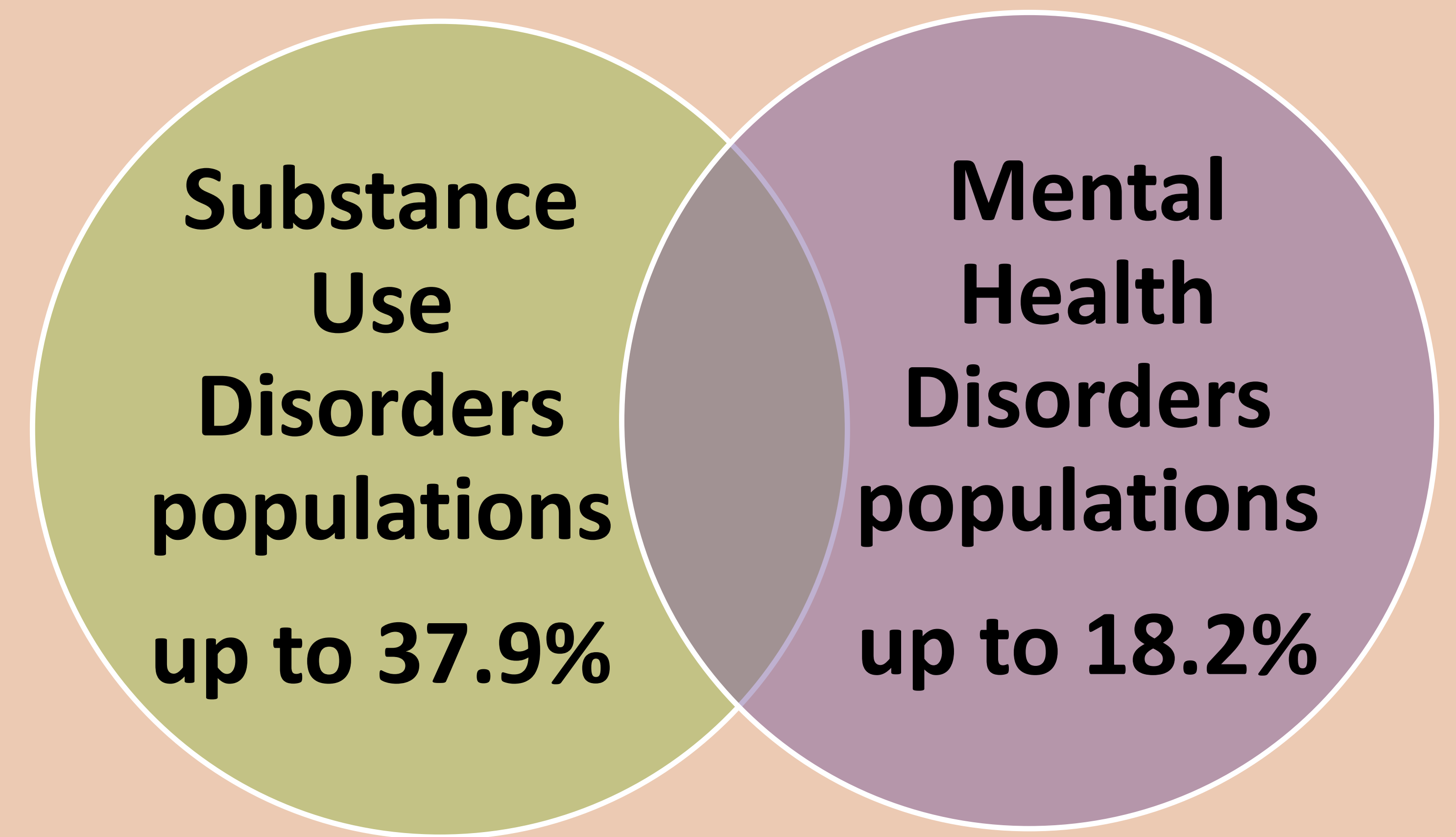
The term **Dual Disorder (DD)** or co-occurring disorder refers to the coexistence of a **substance use disorder (SUD)** and a **psychiatric diagnosis**/mental health disorder in the same individual.

Year 2017 → Term "Dual Disorder" instead of "Dual Diagnosis" or "Dual Pathology".

These two disorders can interact and influence each other, leading to unique challenges in diagnosis, treatment, and recovery.



Prevalence of DD depending on the studied samples

Hakobyan et al., 2020 ; NIDA, 2020; Szerman et al., 2022.

1. What is a Dual Disorder?

The most frequent psychiatric diagnoses among patients with DD are:

- Major Depressive Disorder: 25.5% - 30.9%.
- Anxiety Disorders: 13.0% - 26.7%.
- Psychotic Disorders: 11.0% - 37.9% (schizophrenia spectrum disorders).
- Personality Disorders: 33.0% - 42.0% (borderline personality disorder).

Most frequent psychoactive drugs use among patients with SUD: alcohol, THC, cocaine, and opioids.

- Type of substance – Cannabis (THC) related to Psychotic Disorders.
- Alcohol especially related to Depression and Bipolar Disorders.

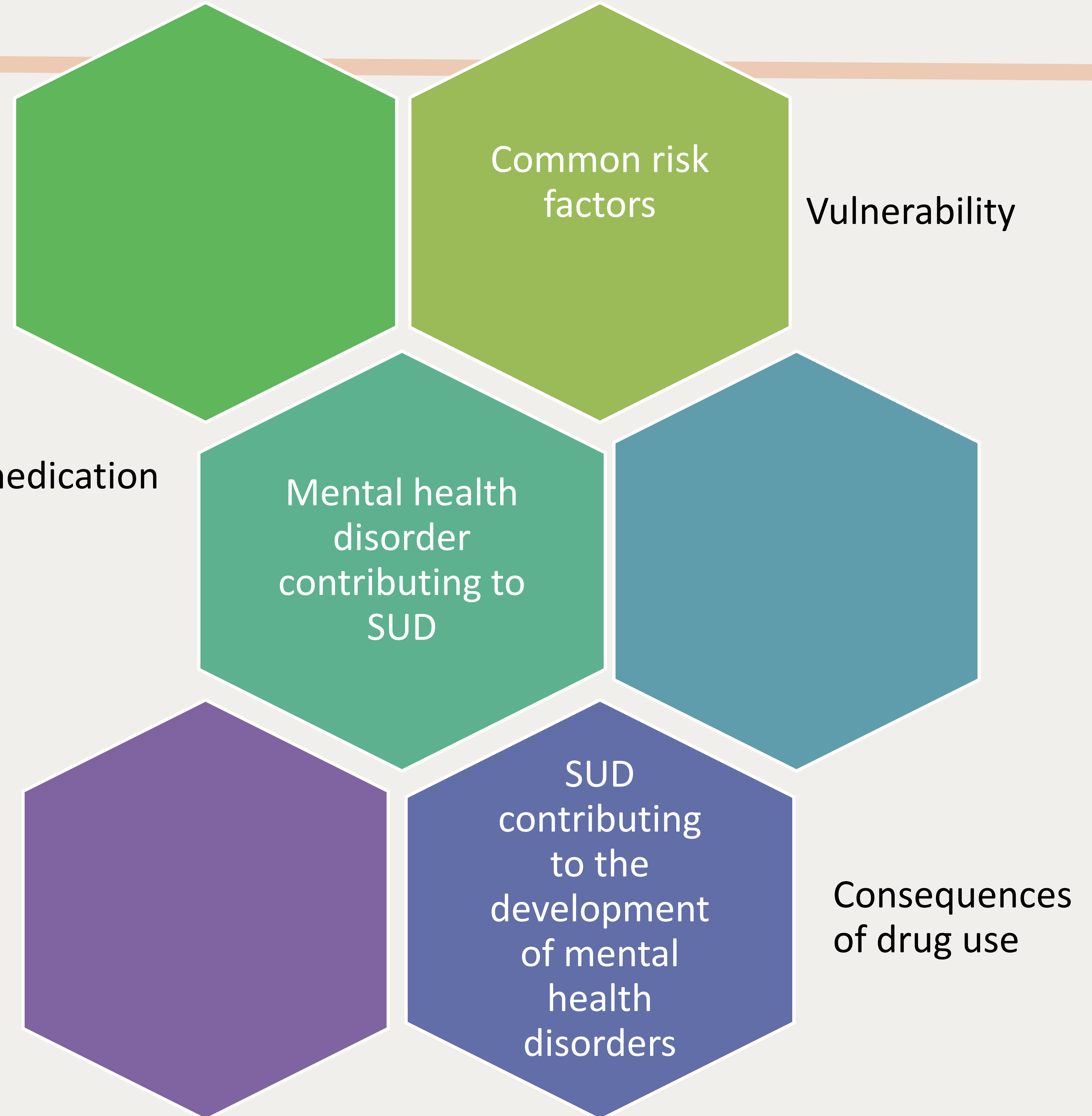
EMCDDA, 2022; Marquez-Arrico et al., 2022; McInerney et al., 2023; Mousavi et al., 2021; SAMSA, 2021.

1. What is a Dual Disorder?

Why are these two disorders co-occurring?

The evidence supports that:

- SUD functions as a precipitant factor for developing the mental health disorder.
- Age of onset of the mental health disorder occurs frequently latter than the one of SUD's.
- Better premorbid functioning observed in DD patients may suggest that they could have develop their psychiatric disorder due to SUD.



EMCDDA, 2022; Marquez-Arrico et al., 2022; SAMSA, 2021.

2. Characteristics of Dual Disorders.

2.1. Patient’s profile.

2.2. Empirical data and main findings.

2. Characteristics of Dual Disorders.

Increased severity and complexity

Reciprocal relationship between disorders

Suicide risk

Overlapping symptoms

Relapses and risk of overdose

Psychosocial characteristics associated with poor treatment outcomes

Fleury et al., 2023; Thomas et al., 2023; Roncero et al., 2023.

2. Characteristics of Dual Disorders.

When **DD patients are considered as a group:**

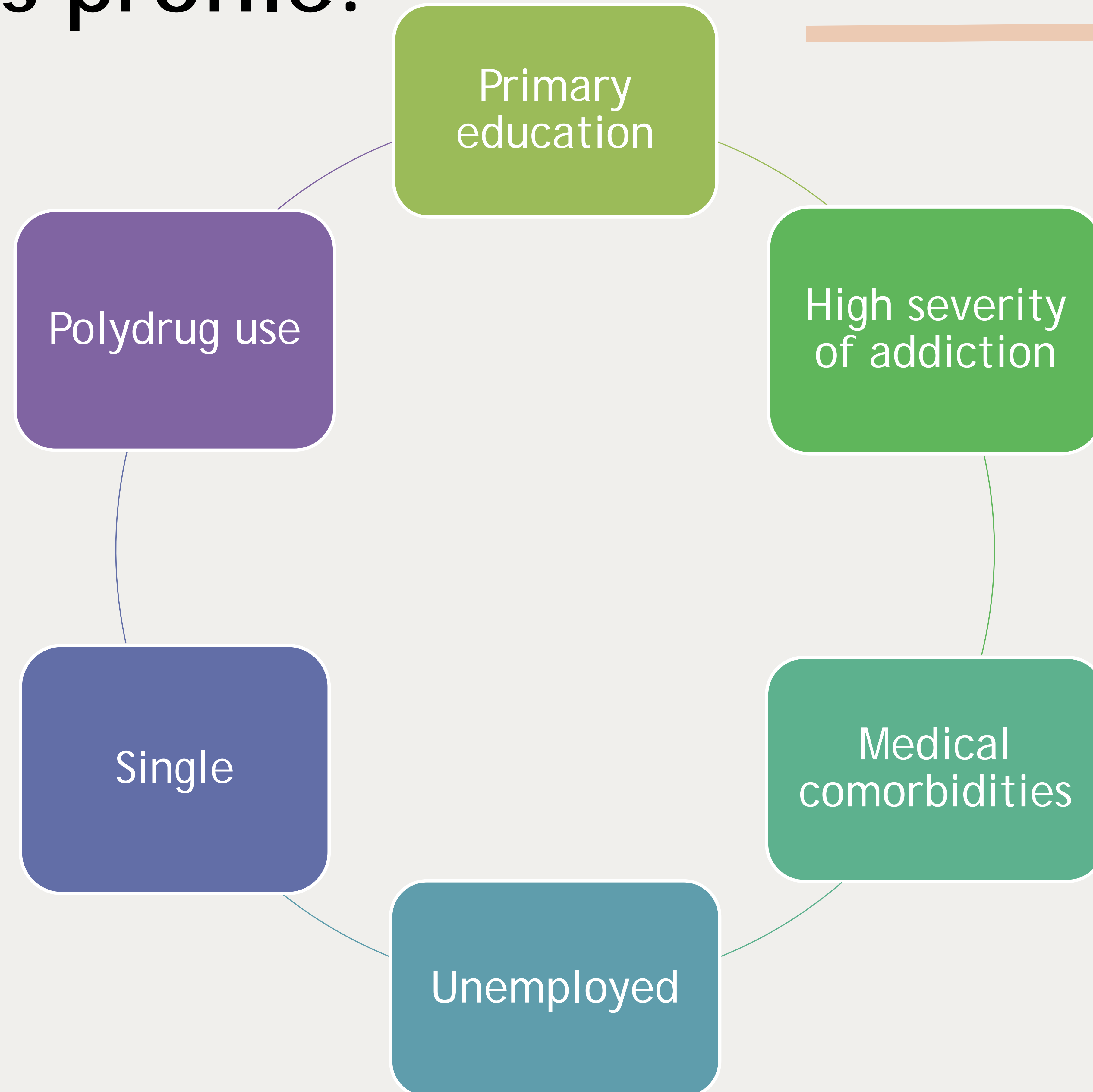
- The most prevalent drug depends on the country of the sample and their psychiatric diagnosis.
- Higher percentage of men (due to the attitudes towards women using drugs/seeking for treatment).
- Women more prevalent for borderline personality disorder, anxiety, and major depressive disorders.

The **type of mental health disorder** is associated with:

- Different clinical and personality features.
- Underperformance in specific neuropsychological functions.

EMCDDA, 2022; Marquez-Arrico et al., 2022; Serrano-Serrano et al., 2021; Puértolas-Gracia et al. 2022.

2.1. Patient's profile.



EMCDDA, 2022; Marquez-Arrico et al., 2022; Puértolas-Gracia et al., 2022; Serrano-Serrano et al., 2021.

2.2. Empirical data and main findings.

Personality

- Higher Neuroticism, Impulsivity, Novelty Seeking, and Sensation Seeking – associated with severity of addiction and major psychiatric symptoms.
- Lower Self-Directedness and Cooperativeness – associated to a younger age of SUD onset.

Neuropsychology

- DD do not show a worse performance in all the cognitive domains (but their performance is below average).
- Within DD samples Psychotic DD patients showed a worse neurocognitive profile (compared to Bipolar and Major Depression Disorder).
- Dual Schizophrenia patients: Impaired verbal learning, short-term memory, and recognition.

Benaiges et al., 2013; Hidalgo et al., 2022; Fernández-Mondragón & Adan, 2015; Marquez-Arrico et al., 2016; 2023; Oh et al., 2021.

2.2. Empirical data and main findings.

Other relevant findings:

History of **Psychological Trauma as a risk factor for DD →**

- Patients with DD presented more adverse events, childhood trauma and dissociative symptoms.
- Higher rates for emotional abuse, sexual abuse, and psychical neglect than only SUD patients.

Chronobiology → Morningness type as a protective factor for SUD.

- DD patients presenting with bad quality of wakefulness (DD with schizophrenia vs. with Bipolar and Major Depressive Disorder).
- Recent studies suggest that Morning-type (chronotype) is a factor to encourage in under treatment patients with DD → importance to set regular schedules synchronized with the light-dark cycle.
- Sleeping patterns showed a faster recovery than wakefulness.

Adan et al., 2012; Blanco et al., 2020; Kirlioglu & Balcioglu, 2020; Rio-Martínez et al., 2023; Serrano-serrano et al., 2022.

2.2. Empirical data and main findings.

Neurocognitive:

Cognitive Flexibility and Inhibition for **SUDs**

Personality:

Neuroticism, Novelty Seeking, and Impulsivity for **SUDs**

For **Schizophrenia**

Personality: Harm Avoidance

Neurocognitive: Impaired short-term memory

Research towards endophenotypes → characteristic or trait that is not directly observable, but can be measured or studied through intermediate biological markers or behavioral manifestations.

Commonly used in genetic and psychiatric research to understand the complex relationship between genes, brain function, and behavior.

Goldstein & Klein, 2014; Prat et al., 2021; Szerman & Peris, 2018.

2.2. Empirical data and main findings.

- **Gender perspective in DD → women are more likely to:**
  - Women who use drugs are stigmatized for their drug use behavior.
  - Self-medicate or use substances to deal with stress or pain.
  - Drink alcohol to regulate negative affect and stress reactivity → comorbid alcoholism and stress-related disorders.
  - Use benzodiazepines in a non-therapeutic form.
  - Present "telescoping": an accelerated progression from the initiation of substance use to the development of SUDs and entry into treatment.

- **Female gender roles can act to precipitate DD →**

Being a woman increases the probability of traumatic experiences such as abuse and gender-based violence which can hinder the development of adaptive coping strategies and can produce biological changes that themselves constitute vulnerability factors for substance use and mental illness.

EMCDDA, 2006; Ferrer-Farré et al., 2021; Fonseca et al., 2021; Greenfield et al., 2010; Lee & Boeri, 2017.

3. Treatment recommendations.

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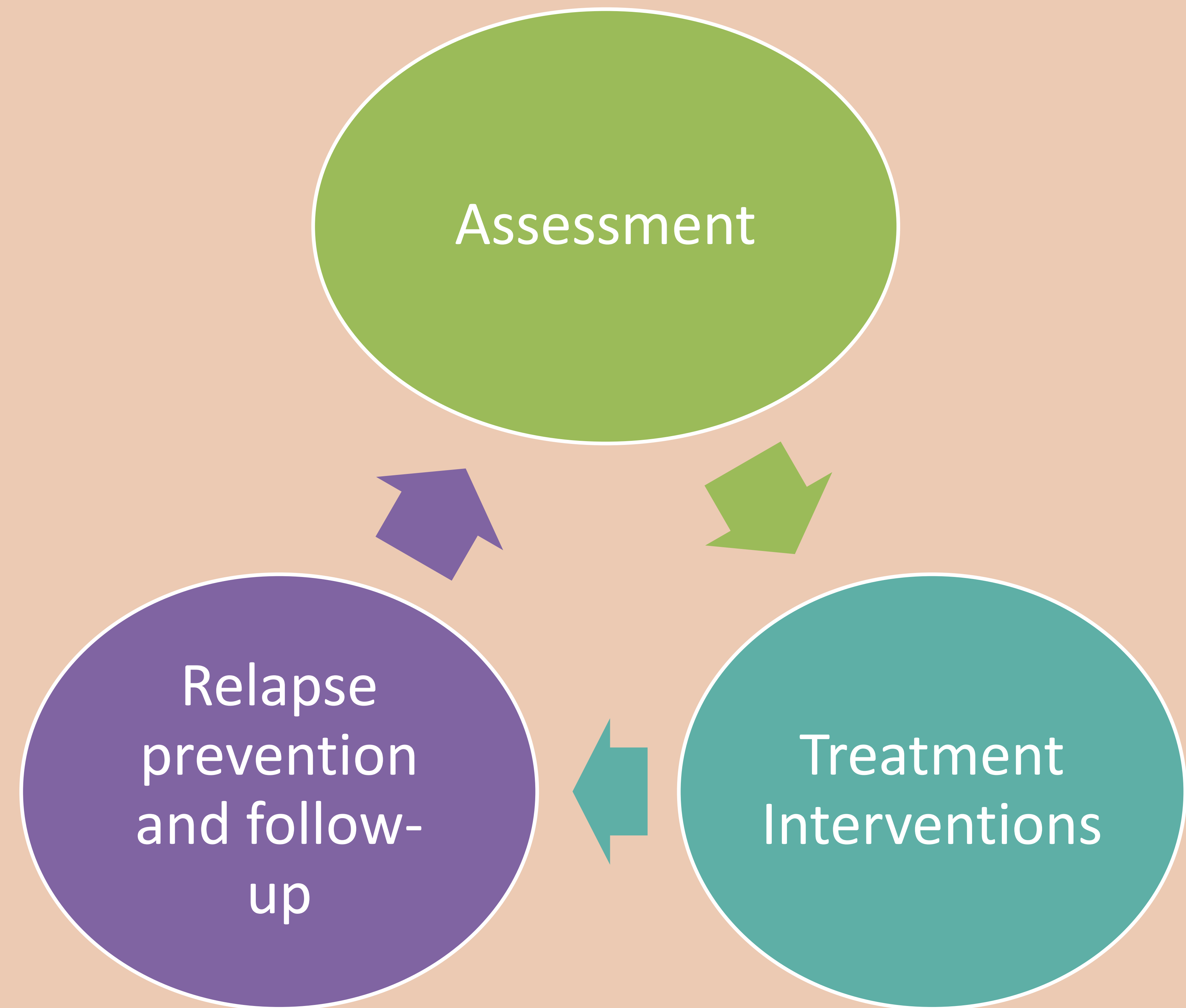
➢ **Comprehensive assessment.**

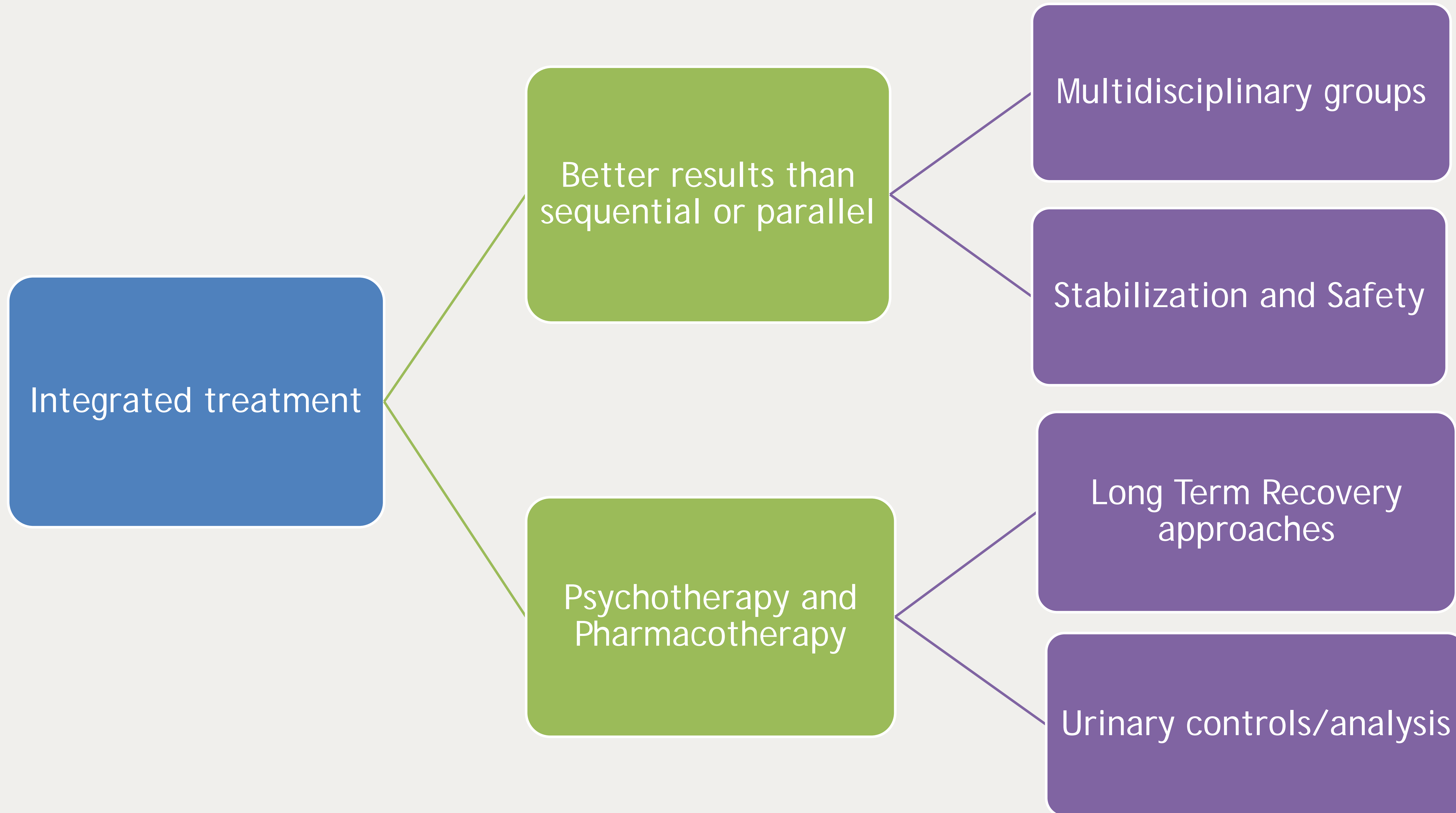
- Some factors should especially be evaluated and considered:
  - Clinical and psychosocial variables.
  - Stages of change.
  - Suicide risk.
  - Coping skills.
  - Personality traits.
  - Neuropsychological functioning.
  - Chronobiology.
  - Health-related quality of life.

- Possibility of establishing the **psychiatric diagnosis after 4 weeks of abstinence.**



EMCDDA, 2022; Marquez-Arrico et al., 2017; McInerney et al., 2023; Mousavi et al., 2021; Río-Martínez et al., 2023; SAMHSA, 2020, 2021.

3. Treatment recommendations.



Mueser et al., 2003; Hakobyan et al., 2020; SAMHSA, 2015; Subodh et al., 2018.

3. Treatment recommendations.

- Treatment models with evidence support → are the ones including **psychosocial components**.

- **Psychological treatment** with evidence (different levels):

- Cognitive-behavioral therapy (CBT) for:
  - Relapse prevention.
  - Contingency management.
  - Problem solving skills.
- Motivational enhancement or motivational interviewing.
- Brief interventions (BIs) for alcohol and tobacco.
- Family therapy.

Multiple Treatment Targets

- Psychiatric diagnosis
- SUD
- Family involvement
- Housing and employment
- Relationships with justice system

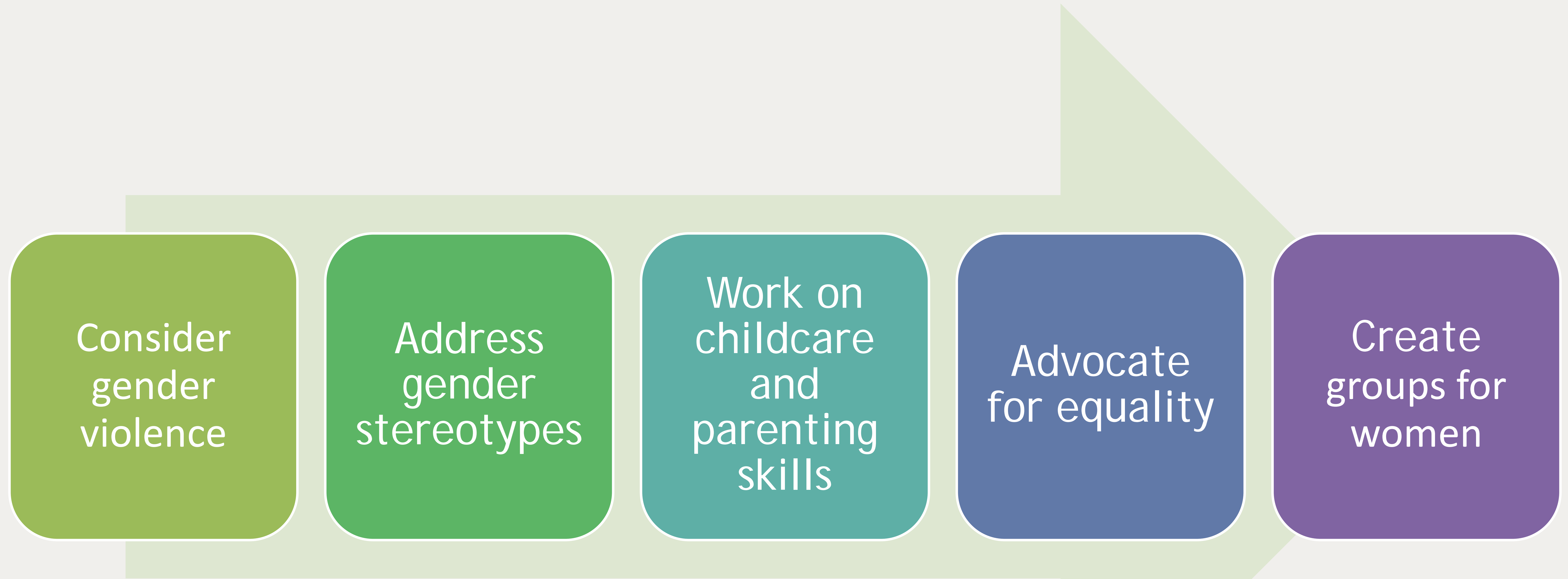
Garrido-Torres et al., 2019; Gimeno et al., 2019; NIDA, 2023; SAMHSA, 2004; Yule & Kely, 2019.

3. Treatment recommendations.

1. Establishment and maintenance of the therapeutic alliance.
2. Surveillance of the patient's clinical status.
3. Treatment of the different phases of abstinence and withdrawal.
4. Develop and facilitate compliance with a therapeutic individualized program.
5. Prevention of relapses.
6. Health education for both the individual in treatment and their family.
7. Reduction of psychiatric comorbidities and the consequences of drug consumption.
8. Encourage pharmacological compliance and therapeutic adherence.
9. Achieve the stabilization of the mental disorder.
10. Integration of the interventions carried out - coordinating with professionals from other disciplines, community organizations and programs, and non-professional organizations.

Garrido-Torres et al., 2019; Gimeno et al., 2019; Lee & Boeri, 2017; NIDA, 2023; SAMHSA, 2004, 2021; Yule & Kely, 2019.

3. Treatment recommendations.



EMCDDA, 2006; Ferrer-Farré et al., 2021; Fonseca et al., 2021; Greenfield et al., 2010; Lee & Boeri, 2017.

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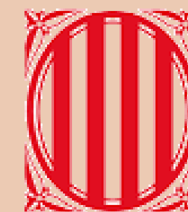

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