

**NAME OF MANUSCRIPT: STUDY OF PSYCHIATRIC COMORBIDITY IN ALCOHOL
DEPENDENCE SYNDROME. A CROSS SECTIONAL STUDY****Dr. Dinesh Dutt Sharma¹, Dr. Kamal Parkash*², Dr. Ramesh Kumar³**¹Associate Professor, Department of Psychiatry, Indira Gandhi Medical College, Shimla-1, Himachal Pradesh, India.²MD (Psychiatry), Indira Gandhi Medical College, Shimla-1, Himachal Pradesh, India.³Professor, Department of Psychiatry, Shri Lal Bahadur Shastri Medical College, Mandi, Himachal Pradesh, India.***Corresponding Author: Dr. Kamal Parkash**

MD (Psychiatry), Indira Gandhi Medical College, Shimla-1, Himachal Pradesh, India.

Article Received on 28/04/2018

Article Revised on 18/05/2018

Article Accepted on 08/06/2018

ABSTRACT

Background: To assess psychiatric comorbidities in patients of alcohol dependence syndrome. **Method:** All the patients of alcohol dependence syndrome attending psychiatric Out Patient Department for alcohol de-addiction were screened. Those fulfilling the inclusion criteria were included in the study. A detailed evaluation was done for socio-demographic variables and history of drug using semi-structured proforma prepared for the study. Diagnosis of alcohol dependence syndrome was made according to DSM-V-TR criteria. The patients were seen for co-morbid psychiatric illness by applying Structured Clinical Interview for DSM-V-TR I & II (SCID I & II). **Results:** Out of the 50 patients 36 (72.0%) were found to have comorbid psychiatric illness. Axis I and Axis II comorbidity was found in 72.0% and 6.0% of the samples, respectively. Patients of cluster A & B personality were equally distributed in the sample. Patients with more than one comorbidity accounted for 40.0% of the sample. **Conclusion:** Psychiatric comorbidity in alcohol dependence syndrome was very high. Number of comorbid diagnoses in a person may as high as three.

KEYWORDS: Alcohol dependence syndrome, psychiatric comorbidity.**INTRODUCTION**

In recent years nothing has come to light more shockingly than alcohol addiction. If this evil is allowed to take roots and spread, not only our present generation but the generations to come will fall victim to one of the most dangerously potent indulgence.^[1] On a historical background, the consumption of alcohol and other psychoactive drugs has probably been prevalent since time immemorial in India. Various researches have shown that the consumption of drugs in our country is increasing. The initiation of alcohol intake probably depends largely on social, religious, and psychological factors, although genetic characteristics might also contribute. According to psychological theories alcohol reduces tension, increase feeling of power, and decrease the effect of psychological pain.^[2,3]

“Comorbidity” denotes the presence of a distinct clinical entity that has existed or may occur during the clinical course of a patient having the index disease.^[4] Psychiatric comorbidities have a high prevalence among patients of alcohol dependence,^[5-7] and often pose challenges in their diagnosis and treatment. Comorbid psychiatric illnesses have been found to be a major contributor to relapses.^[8] Comorbidities commonly reported in this population include unipolar depression,

bipolar disorder, panic disorder, generalized anxiety disorder (GAD), antisocial personality disorder (ASPD), obsessive compulsive disorder (OCD) and schizophrenia.^[9,11]

Comorbid psychiatric disorders in patients of alcohol dependence is a crucial area of research due to various reasons: First is the already reported very high prevalence of such comorbidity. In National Comorbidity Survey (NCS), the largest household psychiatric disorder survey, about one-third of respondents with alcohol dependence had a comorbid mood disorder.^[12] Prevalence of comorbid major depressive disorder (27.9%) and anxiety disorder (36.9%) were very high in the NCS. Studies have shown that comorbidity in alcohol dependence would lead to more chronic alcohol use, treatment resistance of the comorbid disorder, and high suicide rates and disability.^[13] Moreover, presence of psychiatric comorbidities is associated with poor treatment seeking for alcohol dependence.^[14] Comorbid disorders also raise a challenging question of how to provide the best integrated treatment to address both the alcohol dependence and the comorbidities.

Among the Indian states, Kerala has the highest per capita consumption of alcohol - nearly three times the

national rate.^[14] A WHO-funded study conducted by Indian Council of Medical Research found that, in Kerala, 11% of the respondents had consumed alcohol over the past 30 days, and, of the total number of drinkers, the average consumption was three drinks per day.^[15] Such a severe alcohol dependence will be associated with high prevalence of psychiatric disorders too. But, to the best of our knowledge, no studies have looked into the pattern of psychiatric comorbidity in alcohol dependence in the state.

Our study aimed to find the prevalence of psychiatric comorbidities among alcohol dependence patients attending a de-addiction facility.

MATERIALS AND METHODS

The present study was a retrospective observational and conducted in the Department of Psychiatry, Indira Gandhi Medical College and Hospital, Shimla, which is a tertiary care centre of Himachal Pradesh. The sample consisted of fifty patients of alcohol dependence who following treatment for their condition had remained in a remitted state for at least four weeks, and had at least one relapse. The eligible patients fulfilling inclusion and exclusion criteria after obtaining written informed consent were enrolled in the study. These patients were assessed on semi structured proforma and structured clinical interview for DSM –V-TR (SCID I & II) to assess comorbidity.

Statistical analysis: Various socio-demographic and psychosocial variables were compared by using appropriate statistical methods. The categorical (sex, type of family, education, occupation) and continuous variables (age, age of alcohol use, duration of alcohol use) were reported as percentages and mean ± standard deviation, respectively. Data was analyzed using statistical software Epi Info version 3.4.3.

RESULTS

A total of 50 patients were included. All the participants were male. Majority were in the age group of 31-45

years (47%), married (78%), had completed secondary school education (48%), and unskilled workers (35%). Age at initiation was between 21-30 years in (59%) subjects, while the duration of alcohol dependence was in 1-5 year range in (54%) of them. Out of the 50 patients 36 (72.0%) were found to have comorbid psychiatric illness. Axis I and Axis II comorbidity was found in 72.0% and 6.0% of the samples, respectively. Patients of cluster A & B personality were equally distributed in the sample. Patients with more than one comorbidity accounted for 40.0% of the sample.

Table-1:

AXIS I Diagnosis	N=36 (%)
Mood disorder	22 (61.1)
Psychotic disorder	8 (22.2)
Anxiety disorder	17 (47.2)
Substance use disorder	15 (41.7)

*= Not mutually exclusive

Table-2:

AXIS II Diagnosis	N=36 (%)
Anti-social personality dis.	2 (5.6)
Paranoid personality dis.	1 (2.8)

Table-3:

No. of comorbid diagnoses	N=36 (%)
1	16 (44.4)
2	11 (30.6)
3	9 (25.0)

Table-4:

	With comorbidity N=36 (%)	Without comorbidity N=14 (%)	χ ² /t
Age at onset	37.5 ± 7.8	42.9 ± 9.7	0.4
Gender			
Male	36 (100)	14 (100)	0.7
Female	0	0	
Marital status			
Single	0	2 (14.3)	0.8
Married	31 (86.1)	12 (85.7)	
Widow/Separated	5 (13.9)	0	
Religion			
Hindu	32 (88.9)	14 (100)	0.6
Others	4 (11.1)	0	
Employment			0.3

Employed	29 (80.6)	13 (92.9)	
Unemployed	7 (19.4)	1 (7.1)	
Locality			
Rural	33 (91.7)	12 (85.7)	0.08
Urban	3 (8.3)	2 ((14.3)	

DISCUSSION

The present study was conducted on 50 patients of alcohol dependence syndrome. The present study was conducted to evaluate the presence of comorbidity in patients of alcohol dependence syndrome, using an analytical, observational study design. This study was planned because of several reasons. With changing diagnostic concepts, it is difficult to translate older studies into new diagnostic categories. Previous studies had used Research Diagnostic Criteria,^[16] DSM – IV^[17-18] and ICD- 9.^[19] Limited study on the presence of comorbidity in patients of psychoactive substance dependence using DSM-V-TR criteria could be the best option currently. The studies carried out so far did not distinguish between patients of psychoactive substance abuse and dependence.

72.0% of all the patients had a comorbid diagnosis. These findings are similar to the findings of Ross et al.^[17] Studies carried out in the community, however, report lower prevalence.⁽¹⁸⁻¹⁹⁾ This difference has been shown to reflect a difference between treatment-seeking and non-treatment-seeking patients. The higher presence of comorbidity in treatment seeking patients may suggest that comorbid disorders provide additional motivation for a person to seek treatment.^[16]

The common axis I disorders present in the sample were other psychoactive substance abuse (41.7%); mood disorder (61.1%); anxiety disorder (47.2%); and psychotic disorder (22.2%) (table-1). These disorders were also reported to have a high prevalence of comorbidity.^[16-18,20] A large proportion of the subjects of the present study had multiple comorbid diagnosis, 44.4% had one, 30.6% had two, and 25.0% had three diagnoses (table-3). Similar figures were also reported in other studies.^[16] This further shows the heterogeneity of the patients of psychoactive substance dependence and implies that the clinician should not stop after making one or two diagnoses.

6.0% of the patients of the present study had at least one comorbid personality disorder. A study using SCID and DSM-IV-TR criteria found a 59% prevalence of personality disorders in substance abusers.^[21] This study had not differentiated between cases of substance abuse and dependence and also included patients of LSD, marijuana, amphetamine and cocaine abuse. The major differences in the sample make its results incomparable with that of the present study. Those patients who presented with comorbidity had early onset of illness, but it was not statistically significant. All of them were male. More number of patients was employed in the group without comorbidity.

CONCLUSIONS

Psychiatric comorbidity in alcohol dependence is very high. Number of comorbid diagnoses in a person may be as high as three which signifies poor outcome and implies that the clinician should not stop after making one or two diagnoses. Psychosocial stressor increases the probability of having comorbidity.

LIMITATIONS

Small size of the sample may limit generalizability of the study and requires community based studies to conclude more accurately. We did not assess comorbid use of other substances (including nicotine), physical comorbidity, or treatment parameters. Personality evaluation scales or structured interview schedule for axis II disorders could have been used to detect personality disorders.

ACKNOWLEDGEMENT: Nil.

REFERENCES

- Gilder M, Mayon R, Cowen P. Misuse of alcohol and drugs: In Shorter Oxford Text book of Psychiatry. 4th ed Oxford: Oxford University Press, 2001; 533-79.
- Blane HT, Leonard KE, eds. Psychological Theories of Drinking and Alcoholism. 2nd ed. New York: Guilford Press, 1999.
- Dara A. and Charney M.D. et al. Association Between Concurrent Depression and Anxiety and Six-Month Outcome of Addiction Treatment. *Psychiatr Survey*, 2005; 56: 927-33.
- Feinstein AR. The pretherapeutic classification of comorbidity in chronic disease. *J Chronic Dis.*, 1970; 23: 455-68.
- Singh HN, Sharma SG, Pasweth AM. Psychiatric co-morbidity among alcohol dependants. *Indian J Psychiatry*, 2005; 47(4): 222-4.
- Glass JE, Williams EC, Bucholz KK. Psychiatric comorbidity and perceived alcohol stigma in a nationally representative sample of individuals with DSM-5 alcohol use disorder. *Alcohol Clin Exp Res.*, 2014; 38(6): 1697-705.
- Vohra AK, Yadav BS, Khurana H. A study of psychiatric comorbidity in alcohol dependence. *Indian J Psychiatry*, 2003; 45(4): 247-50.
- Rounsaville BJ, Dolinsky ZS, Babor TF, Meyer RE. Psychopathology as a predictor of treatment outcome in alcoholics. *Arch Gen Psychiatry*, 1987; 44(6): 505-13.
- Davis L, Uezato A, Newell JM, Frazier E. Major depression and comorbid substance use disorders. *Curr Opin Psychiatry*, 2008; 21(1): 14-8.

10. Cornelius JR, Bukstein O, Salloum I, Clark D. Alcohol and psychiatric comorbidity. *Recent Dev Alcohol*, 2003; 16: 361-74.
11. Boden JM, Fergusson DM. Alcohol and depression. *Addiction*, 2011; 106(5): 906-14.
12. Kessler R, Crum RM, Warner LA. Lifetime co-occurrence of DSM-II alcohol abuse and dependence with other psychiatric disorders in National Comorbidity Study. *Arch Gen Psychiatry*, 1997; 54: 313-21.
13. Helzer JE, Pryzbeck TR. The co-occurrence of alcoholism with other psychiatric disorders in the general population and its impact on treatment. *J Stud Alcohol*, 1988; 49(3): 219-24.
14. The extent of problem of Mental Health in Kerala. [Internet] Kerala State Mental Health Authority; 2010. [Cited 2018, May 20]. Available from: <http://www.ksmha.org/kerala.htm>.
15. Petrakis IL, Gonzalez G, Rosenheck R, Krystal JH. Comorbidity of alcoholism and psychiatric disorders, an overview. *Alcohol Res Health*. 2002; 22(2): 81-9.
16. Rounsaville BJ, Weissman MM, Kleber H, Wilber C. Heterogeneity of Psychiatric diagnosis in treated opiate addicts. *Arch Gen Psychiatry*, 1982; 39: 161.
17. Ross HE, Glaser FB, Germanson T. The prevalence of psychiatric disorders in patients with alcohol and other drug problems. *Arch Gen Psychiatry*, 1988; 45: 1023.
18. Regier DA, Farmer ME, Rae DS, Locke BZ, Keith SJ, Judd LL. et al. Comorbidity of Mental disorders with alcohol and other drug abuse. Results from the Epidemiological Catchment Area (ECA) study. *JAMA*, 1990; 164: 2511.
19. Dube KC, Handa SK. Drug use in health and mental illness in an Indian population. *Brit J Psychiatry*.1990; 134: 357.
20. Weissmann MM, Myers JK, Harding PS. Prevalence and psychiatric heterogeneity of alcoholism in a United States urban community. *J. Stud Alcohol*, 1980; 41: 672.
21. Nace EP, Davis CW, Gaspan JP. Axis II Comorbidity in Substance Abusers. *Am. J Psychiatry*, 1991; 148: 118.