

Comorbidity of Addictive Disorders and Mental Disorders: Experience of a Hospital Women's Psychiatry Department

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Abstract

Background: Problem substance use is a frequent reason for consultation. Whether isolated or co-morbid with another pathology, it remains important to manage within a dual framework.

Objective: The objective of this work is to describe the sociodemographic and clinical characteristics and addictive behaviors of patients who were admitted to the psychiatric emergency department (women's unit) of the Ar-Razi university psychiatric hospital from July 1 to September 30, 2021 as well as present the different comorbidities found in these patients.

Method: A retrospective cross-sectional study on the files of 65 patients who were admitted to the psychiatric emergency department (women's unit) for three months, using an evaluation sheet grouping together the sociodemographic criteria of the patients, addictive behaviors and psychiatric comorbidities.

Results: The average age was 36.81 years. 52% of participants were single. Tobacco and cannabis are the most consumed substances in our sample. The psychiatric comorbidities found in our patients were as follows: schizophrenia (40%), schizoaffective disorder (26%), depression (17%), personality disorder (14%), bipolar I disorder (13%), acute psychotic disorder (3%), bipolar disorder type II (3%) and anxiety disorder (2%).

Conclusion: To sum up, the most frequent addictive behaviors in this category of patients are: tobacco, cannabis, benzodiazepines and alcohol. Regarding psychiatric comorbidities, we note that psychosis, depression and bipolar disorders are the most frequent in our sample. These results should encourage all practitioners to have the reflex to look for possible addictive comorbidities in patients with psychiatric disorders for better patient care and prognosis.

Keywords

Addiction, Mental disorder, Women.

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Introduction

Comorbidity of addictive disorders and mental disorders, called dual pathology, refers to the coexistence of a substance use disorder and another psychiatric disorder in the same individual.

We consider “dual” or “co-occurring” pathology, the comorbid presence of one or various psychiatric disorders and one or more addictions, in the same patient, with the appearance of numerous synergistic processes between the two pathologies, which generates a change in symptoms, a reduction in the therapeutic response and a worsening and chronicization of the progression of the disease or even resistance.

The concept of “Dual Pathology” implies that the diagnostic and therapeutic approach must always be carried out jointly and globally for both disorders and that, the patient’s progress and remission will depend on the improvement of the entire clinical picture.

This “dual pathology” concept implies that the relapse of one of the two disorders (psychiatric or addictive) will necessarily cause that of the other, which forces caregivers to adopt prevention strategies from the start of treatment. relapse (whether psychiatric or addictive) in order to avoid the reappearance of the comorbidity.

The diagnosis of psychiatric comorbidity in addicted patients is problematic, mainly because the effects of the substance used, whether acute or chronic, can mimic the symptoms of many mental disorders. This makes it difficult to differentiate psychiatric symptoms occurring as a result of acute or chronic use of a substance or subsequently withdraw it from one that represents an independent disorder.

Identifying these psychiatric disorders is of great importance for patient care. The association of a psychiatric disorder can, in certain cases, modify the treatment methods and also the course of the addictive behavior. It requires integrated and simultaneous treatment of psychiatric pathologies and addictive behavior.

Compared to individuals with a single disorder, patients with comorbid mental health and substance use disorder have higher psychopathological severity, with more hospitalizations, increased risk of suicide, greater frequency of relapse and increased rates of HIV and hepatitis C infection, as well as psychosocial disorders, including criminal behavior. Given the burden on health, social and legal systems, the co-morbidity of problematic substance use and mental disorders imposes high costs on society.

Indeed, it is estimated, according to the world drug report published by the United Nations in 2015, that a total of 246 million people, or

one in 20 people between 15 and 64 years old, used APS in 2013 [1]. Large epidemiological studies carried out in the general population such as the National Epidemiologic Survey on Alcohol and Related Conditions Study (NESARC), the National Comorbidity Survey (NCS) and the Epidemiologic Catchment Area Study (ECA) have shown that the association of psychiatric comorbidities and addictological disorders were very common, in fact 38 to 51% of patients with a history of addiction have a comorbid mental disorder, 44% of alcoholic men and 65% of women present at least one psychiatric disorder [2].

Nationally, according to statistics published in 2009 by the Ministry of Health, 4.2% of Moroccans under the age of 17 have a problem with SPA. There are more than 500,000 users who consume cannabis. These figures can be explained by the accessibility to SPAs in our country [3]. The geographical proximity of Morocco to Europe as well as the multiple interactions favored by the migratory flows of populations undoubtedly contribute not only to the spread of the consumption of hard SPAs, notably heroin and cocaine, but also to the diversification of consumption methods (injectable SPA). In recent years, heroin and cocaine have become available, with their prices dropping significantly.

On the other hand, clinical research has shown that co-occurring disorders are reciprocally interactive and cyclical, and that unfavorable prognoses for both comorbid disorders are expected if treatment does not target each of them.

Material and Method

Goal of the study

The objective of this work is to describe the sociodemographic and clinical characteristics and addictive behaviors of patients who were admitted to the psychiatric emergency department (women’s unit) of the Ar-Razi university psychiatric hospital from July 1 to September 30, 2021 as well as present the different comorbidities found in these patients.

Study Methods

We conducted a retrospective cross-sectional study on the files of 65 patients who were admitted to the psychiatric emergency department (women’s unit) for three months, using an evaluation sheet grouping together the sociodemographic criteria of the patients, addictive behaviors and psychiatric comorbidities.

Sample

Our investigation includes 65 patients who were admitted to the psychiatric emergency department (women’s unit) over a period spanning from July 1 to September 30, 2021.

Inclusion criteria

- Any patient admitted to the psychiatric emergency department (women's unit) of the Arrazi hospital in Salé.
- Age between 20 and 66 years.

Inclusion criteria

- Incomplete patient data.
- Patient without addictive disorders.
- Patient with mental confusion or vigilance disorder.

Statistical analysis

Statistical analysis was carried out using SPSS statistical analysis software version 20.0.

Informed consent

Consent was obtained from patients and their legal guardians before the start of the study.

Results

The average age was 36.81 years (range 18 to 65 years) with a predominance of the age group between 18 and 40 years. In our sample, 52% of participants were single, 35% of them were married, 11% divorced and 2% widowed. As for the level of education, 37% of patients had a secondary level of education, 34% had reached a university level of study, 17% had not gone beyond primary school and 12% had never been to school. 64% of patients were housewives and 95% lived in urban areas. 85% of patients lived with their family.

The main histories of our patients are detailed in Table 1, including personal history of suicide attempt, criminal history, and medical-surgical history.

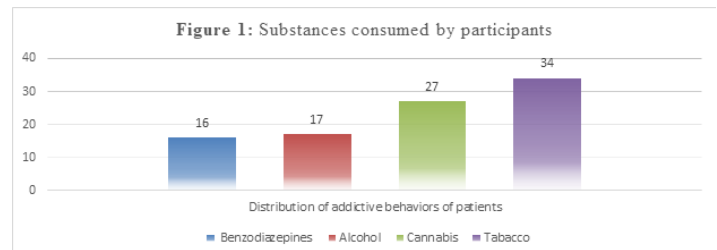
Table 1: Medical and surgical, psychiatric and legal histories of the participants.

Variables	Number of patients (%)
ATCD of hospitalization	
Yes	47
NO	53
ATCD attempted suicide	
YES	35
NO	65
ATCD medical-surgical	
YES	17
NO	83
Substance Use	
YES	37
NO	63
ATCD judicial	
YES	10
NO	90

*Abreviation: ATCD: history.

The main somatic comorbidities found were: diabetes, hypertensive heart disease, dysthyroidism, epilepsy, autoimmune thrombocytopenic purpura.

The addictive behaviors of the patients are described in the following graph (Figure 1). We note that tobacco and cannabis are the most consumed substances in our sample.



The prevalence of different psychiatric comorbidities is detailed in Figure 2.

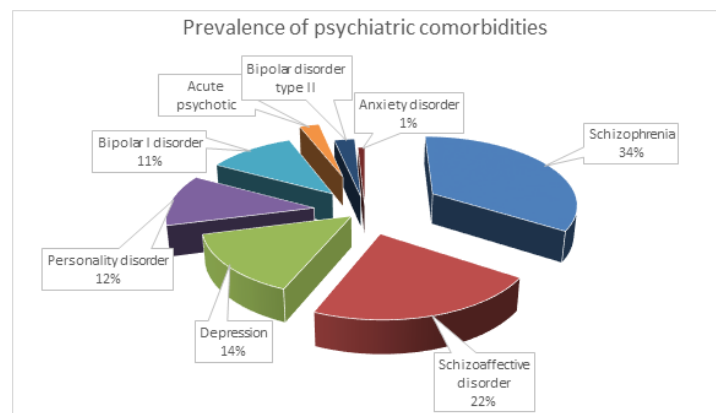


Figure 2: Psychiatric comorbidities among study participants.

In our study, the psychiatric comorbidities found in our patients were as follows: schizophrenia (40%), schizoaffective disorder (26%), depression (17%), personality disorder (14%), bipolar I disorder (13%), acute psychotic disorder (3%), bipolar disorder type II (3%) and anxiety disorder 2%.

Discussion

Addiction and psychotic disorder

We note that 40% of the patients in our sample are followed for schizophrenia, 26% for schizoaffective disorder and 3% presented an acute psychotic disorder. The study by E.Guillem et al. showed that 4.8% of cannabis users have schizophreniform disorder or schizophrenia [4]. The study by N. Libuy et al. found that 5.2% of cannabis users have a schizophrenic disorder and 1.1% of cocaine users have a schizophrenic disorder [5]. Cannabis can, on the one hand, precipitate the onset of schizophrenia in vulnerable subjects and, on the other hand, aggravate the progression of the pathology

in those who have already developed it. According to numerous longitudinal epidemiological studies and a meta-analysis, cannabis use is a risk factor for psychotic disorders (OR: 1.41; 95% CI: 1.20-1.65) [4]. The risk of psychotic disorders among cannabis users is increased if drug use began before the age of 15; if the dose of cannabis consumed is massive (dose-effect relationship), in the presence of a family history of psychotic disorders or if the person had suffered sexual abuse in childhood, and finally in subjects from immigration from first generation.

The lifetime frequency of problematic cannabis use is approximately 27% among patients with schizophrenia. Consumption worsens the progression of schizophrenia, delusions and hallucinations, increases the risk of suicide as well as the frequency of relapses and hospitalizations. Also, therapeutic compliance is less good and there is an increased risk of social disintegration [4].

Polyaddiction to drugs is noted in patients with schizophrenia [5]. Blanchard et al. [6] performed a meta-analysis of epidemiological studies on the association between abuse, dependence and schizophrenia, 1207 patients were included in their meta-analysis. Most patients were hospitalized, 64% of whom were men. The prevalence of alcohol abuse and dependence was 35%; that of abuse or dependence on other substances by 52%. The characteristics of addictive behaviors are particular in schizophrenics. Nicotine addiction is more severe. It appears earlier in psychotic patients than in the general population. Patients with schizophrenia consume alcohol more regularly than healthy subjects. Their cannabis consumption exposes them more than other patients to a risk of dependence. Finally, cocaine use is more intermittent among schizophrenics.

Addiction and Depression

We note that 17% of patients in our sample have depression. In a study carried out in Morocco, researchers found a significant comorbidity between dependence on psychoactive substances and depression. Thus, 28.1% of smokers dependent on tobacco presented moderate to severe depression compared to 14.3% among non-dependents. For cannabis, 35.4% of dependent users presented moderate to severe depression compared to 10% of non-dependent users. As for alcohol, 58.3% of dependent consumers had moderate to severe depression compared to 19.7% among non-dependents (“these150-16,” n.d.). Similar results were reported by FARGES et al. in a study carried out with 128 users of psychoactive substances, in whom the prevalence of depressive symptomatology was 66.4% [7] compared to only 26% among controls. The study by Richard A. Brown et al. reported that 48.6% of cocaine users had depression. The NESARC and National Survey on Drug Use and Health studies showed that the existence of characterized depressive disorders was associated with an increased risk of subsequent cannabis use, independently of the existence of other

addictions and/or psychiatric disorders.

Addiction and Bipolar Disorders

We note that 13% of the 65 patients in our study have bipolar I disorder and 3% have bipolar II disorder. Similar results were reported by the study by JR Cougle et al., which showed that 5.1% of tobacco users have bipolar disorder [8]. While FS STINSON’s study showed that 24% of cannabis users have bipolar disorder. A study in the United States of America carried out by KTBRADY and RBLYDIARD showed that 16.1%, or more or less 3.9%, of alcohol users have bipolar disorder (“brady1992,” n.d.). An international study by the World Health Organization (WHO), on all continents, also found frequencies 4 to 8 times higher than in the general population. In patients with bipolar disorder, the mood disorder appears earlier and mixed states are more common. Alcohol intake is caused by the disinhibition of manic access or by the irritability and impulsivity of mixed states [9]. In the NESARC study, the frequency of problematic cannabis use among bipolar patients (n = 1,905) was 7% in the 12 months preceding the study, compared to 1.2% in the general population. A systematic review estimated the frequency of cannabis abuse/dependence in bipolar patients to be 30% over their lifetime. Patients with a dual diagnosis of bipolar disorder and addictions have a more severe course than bipolar patients without addiction and a more poor prognosis. The mood episodes are more severe, longer, more frequent, and their remissions are of poorer quality. Cognitive disorders are more severe, particularly visual memory alterations. The cycles are accelerated; rapid cycles (more than 4 episodes/year) and mixed states are more common. The risk of suicide is higher. In bipolar patients with alcohol dependence, cerebral gray matter deficits in the left medial mid-frontal cortex and the right cingulate gyrus have been reported (doi.org/10.1684/ipe.2015.1432).

Addiction and Personality Disorder

In our sample, 14% of patients have a personality disorder. There is no specific pathological personality of addiction. The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), covering 43,093 subjects in the general population, found that personality disorders were very common among subjects with addictions: they concerned, for example, 40% of subjects. Alcohol dependent and 61% of those dependent on cannabis. Borderline personality disorders are among those most frequently encountered among patients seeking addiction treatment. However, this diagnosis is often late in addictological structures, with behavioral disorders sometimes being first considered from a moral point of view [10]. In these patients, addictive behaviors are usually compulsive, favoring self-destructive behavior and crisis situations. Several vulnerability factors for addiction are frequently found in borderline personality disorders: impulsivity, alexithymia, attachment disorders, history of post-traumatic disorders and abnormalities of the opioid system [11].

Addiction and anxiety disorders

We note that in our sample 2% of patients have an anxiety disorder. Nearly 10% of alcohol users have an anxiety disorder. In the general population, the prevalence of anxiety is only 3.7%. The frequency of panic disorder is 4.2% among patients who use alcohol and 1% in the rest of the population, while 3.2% of them present with social anxiety disorder, compared to 1.2% in the general population [12]. The study by JR COUGLE et al. showed that 15.5% of tobacco users have an anxiety disorder [8]. The ECA (Epidemiologic Catchment Area Study) showed that 36% of subjects with an anxiety disorder had a comorbid addictive disorder and the NCS (National Comorbidity Study) showed that 19% of subjects with an addiction had an anxiety disorder. The same is true for problematic use of opiates or certain forms of smoking. Patients with a phobic disorder then use the calming effects of alcohol, using it as a disinhibitory and stimulating molecule. This effect makes it easier for them to be exposed to situations that frighten them, such as when speaking or performing in public. In practice, the effects of alcohol on social anxiety are transient. The initial relief is often followed by a rebound of anxiety. In the medium term, alcohol worsens the phobia. Periods of heavier alcohol consumption are accompanied by an exacerbation of phobic symptoms. Alcoholism associated with social phobia is the most severe form of addiction. Patients do not dare to stop consuming a molecule that appears to them to be protective. They have high physical and psychological dependence scores. They consume alcohol more often to improve their social functioning [9].

Addiction and eating disorder

According to the literature, the prevalence of comorbidities between EDs and problematic substance use is 17% to 46% depending on the type of substance and the eating disorder. Thus, 50% of patients with an eating disorder have an addiction to alcohol or drugs (compared to 9% in the general population) and 35% of patients with problematic substance use have a TCA (compared to 3% in the general population). The general population [13]. Indeed, the relationship between eating disorders (TCA) and problematic substance use has been explored in the scientific literature since the 1980s. Bushnell's first publication concluded that patients suffering from ED consume twice as much substance as controls addictive. ED and problematic substance use share significant physiopathological and psychopathological vulnerabilities, explaining the high prevalence of these two disorders in the same patients.

Conclusion

The consumption of psychoactive substances can promote the occurrence and worsen the prognosis of psychiatric disorders. Likewise, psychiatric disorders increase the risk of exhibiting addictive behaviors and also worsen their outcome.

The identification of these psychiatric disorders is of great importance for the care of patients and this care involves prevention, screening and treatment.

The results of this study showed that the most frequent addictive behaviors in this category of patients are: tobacco, cannabis, benzodiazepines and alcohol. Regarding psychiatric comorbidities, we note that psychoses, depression and bipolar disorders are the most frequent in our sample.

These results should encourage all practitioners to have the reflex to look for possible addictive comorbidities in patients with psychiatric disorders for better patient care because not only do they have a negative impact on the prognosis but they also complicate the care pathway. It is important that the Moroccan health system, public or private, can give more importance to this problem shared between the medical and societal sectors in order to effectively reduce and prevent this social ill.

Limitations of the study

- The sample size remains small and therefore it is difficult to extrapolate these data to all female patients with mental illnesses
- The short duration of the study. Hence the need to continue this work with a larger sample over a longer period.

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