

# Co-Occurring Disorders: *How do we know?*

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## Goals

- 1) Consider the impact that co-occurring psychiatric disorders can have in patients with substance use disorders
- 2) Understand that there are ways to determine if a mental health diagnosis is caused by substance use
- 3) Identify common medication classes used to treat patients with co-occurring disorders



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## SUPPORTING RECOVERY

INTEGRATING TREATMENT FOR CO-OCCURRING DISORDERS



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## Language

- “Substance-induced”
- “Co-occurring disorders” (CODs)
  - = Co-occurrence of SUD(s) and *other* (independent) mental health/psychiatric disorder(s)
- “Dual diagnosis”
- “SUD(s) ± Primary psychiatric disorder”



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## Spectrum



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|--|---|
| <ul style="list-style-type: none"><li>• Purely substance-induced disorder</li></ul> <p>↓</p> <ul style="list-style-type: none"><li>• Exclusive focus on treatment of substance use</li></ul> | <ul style="list-style-type: none"><li>• Purely 2/2 underlying psychiatric comorbidities</li></ul> <p>↓</p> <ul style="list-style-type: none"><li>• Exclusive focus on treatment of other mental health disorder</li></ul> |
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**Guesses?** What proportion of people with at least one SUD also have another psychiatric disorder?



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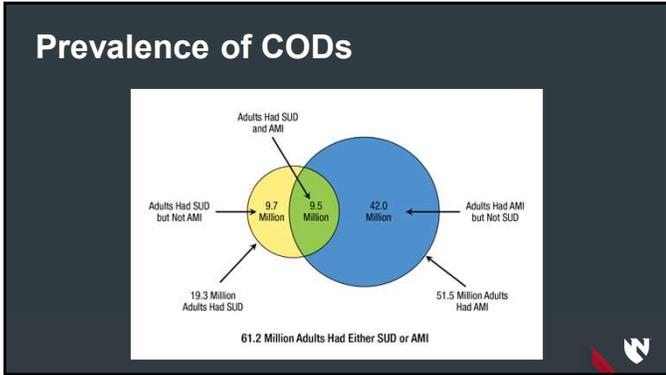
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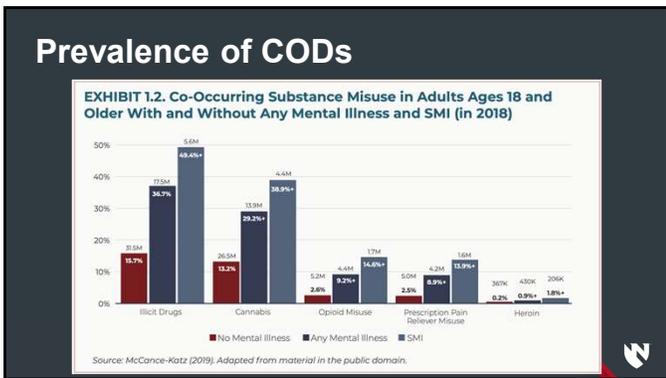
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- ### COD Outcomes
- Worse prognosis
    - Worse treatment outcomes
    - Higher risk of return to use
    - Higher risk of hospitalization
  - Poorer quality of life
  - Increased risk of suicide
  - Effective COD *treatment* improves outcomes

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- Which of the following is most likely to co-occur with a substance use disorder (SUD)?
  - A) Schizophrenia
  - B) Bipolar disorder
  - C) Major depressive disorder
  - D) Generalized anxiety disorder
  - E) Posttraumatic stress disorder



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  - E) Posttraumatic stress disorder



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Among people with OUD, which co-occurring other mental health disorder is most common?



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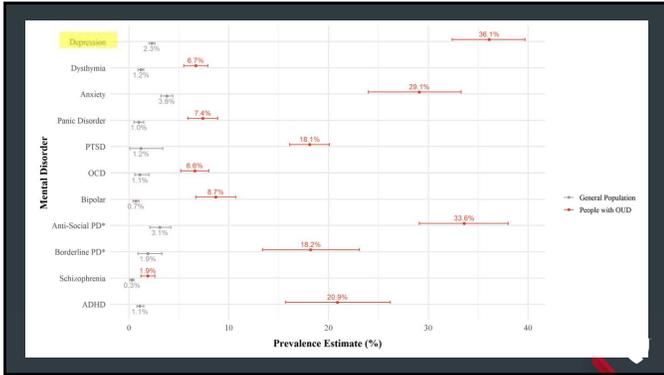
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What do you know/think/hear patients say about self-medication?

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**It Is Not About Supply, It Is About Demand: Why the Self-Medication Hypothesis Is Still So Important (Khantzian, 2020)**

- “Addictive drugs have their appeal and become compelling principally for two reasons:
  - They relieve human psychological suffering
  - There is a considerable degree of specificity in a person’s drug-of-choice”
- “Demand for drugs and drug dependency becomes compelling as a solution for life challenges that have been insurmountable for individuals who succumb to these disorders.”

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### Time to Abandon the “Self-Medication Hypothesis” in Patients with Psychiatric Disorders (Lembke, 2012)

- SMH: “Causation,” “specificity,” & “treatment” postulates
- Minimizes the inherent biological effects of substances
  - Positive reinforcement: Pleasure of use
  - Negative reinforcement: Pain of cessation or withdrawal
- Implies therapeutic effect of substance not supported by evidence
- Negative reinforcement confused as independent psychiatric disorder
  - “Justifies need” for continued use of substances
- Misguides treatment to “underlying psychopathology” and away from the SUD
  - Reinforces “pill for everything” mentality
- “Theory of the individual” with one’s subjective experience creating addiction “from the inside out”
  - Versus cultural context, environment, risk factors that influence addiction “from the outside in”




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### DSM-5 Approach

- Primary X
- Substance-induced X
- Usual effects of substances




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### DSM-5: Primary-X

- Temporally independent
  - Preceding substance use
  - Persistent with abstinence (usually > 1 month)
- → True co-occurring disorders with integrated treatment of both SUD and other psychiatric disorder
  - Prioritization based on:
    - Safety
    - Severity
    - Time to effect
    - Patient preference
    - Access




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### DSM-5: Substance-induced X

- Not temporally independent
  - Symptoms developed during/soon after substance use (within 30 days of I/W)
  - Substance *capable* of producing the symptoms
- *Exceeds* expected symptoms of intoxication/withdrawal
  - “Warrants clinical attention”
  - Clinically significant distress/impairment
- Symptoms not exclusively during delirium
- → Focus on substance use (disorder) treatment
  - May still require treatment initially, though expected to clear with abstinence/time

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### DSM-5 Substance Use Disorder Criteria

- A *problematic pattern* of X use leading to *clinically significant* impairment or distress, as manifested by *at least two* of the following, occurring *within a 12-month period*...

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### DSM-5 Substance Use Disorder Criteria

- Control
  - Use in greater amount/duration than intended
  - Excessive time spent obtaining, using, recovering
  - Desire/unsuccessful efforts to cut back
  - Cravings
- Physilogic
  - Tolerance
  - Withdrawal
- Risky use
  - Physically hazardous situations
  - Continued use despite physical/mental problems
- Social impairment
  - Failure to fulfill major role obligations
  - Interpersonal problems due to use
  - Decreased activities due to use
- Severity
  - 2-3 → Mild
  - 4-5 → Moderate
  - 6+ → Severe
- Specifiers
  - Early remission
    - 3-12 months w/o criteria (except craving)
  - Sustained remission
    - > 12 months w/o criteria (except craving)
  - On maintenance therapy
  - In a controlled environment

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### DSM-5 Substance Use Disorder Criteria

- Caveats
  - If only tolerance and withdrawal, then **not** a substance use disorder
    - → Physiological dependence
  - What's left out?
    - Amount, frequency, dollars spent, end organ damage, legal consequences



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### Spectrum of Use



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- Substance-induced panic attacks are frequently seen with:
  - A) alcohol withdrawal
  - B) cannabis withdrawal
  - C) LSD intoxication
  - D) cocaine withdrawal
  - E) A and C



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- Substance-induced panic attacks are frequently seen with:
  - A) alcohol withdrawal
  - B) cannabis withdrawal
  - C) LSD intoxication
  - D) cocaine withdrawal
  - **E) A and C**

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### DSM-5 Substance-Induced Disorders

- Substance-induced depressive disorders
- Substance-induced bipolar and related disorders
- Substance-induced anxiety disorders
- Substance-induced psychotic disorders
- Substance-induced obsessive-compulsive and related disorders
- Substance-induced sleep disorders
- Substance-induced sexual dysfunctions
- Substance-induced delirium
- Substance-induced neurocognitive disorder

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Diagnoses associated with substance class

Dis	Psychotic disorders	Bipolar disorders	Depressive disorders	Anxiety disorders	Obsessive-compulsive and related disorders	Sleep disorders	Sexual dysfunctions	Delirium	Neurocognitive disorders	Substance use disorders	Substance intoxication	Substance withdrawal
Inhalants	F		I	I				F		X	X	
Opoids			L/W	W		L/W	L/W	L/W		X	X	X
Alcohol												
Induction, hypnosis, or anaesthetics	L/W	L/W	L/W	W		L/W	L/W	L/W	F	X	X	X
Other												
Alcohol**	I	L/W	L/W	L/W	L/W	L/W	I	I		X	X	X
Hallucinogens						W				X		X
Phenol	L/W	L/W	L/W	L/W	L/W	L/W	L/W	L/W		X	X	X
Other (or unknown)	L/W	L/W	L/W	L/W	L/W	L/W	L/W	L/W		X	X	X

Note: X = The category is recognized in DSM-5. I = The specifier "with onset during intoxication" may be noted for the category. W = The specifier "with onset during withdrawal" may be noted for the category. L/W = Either "with onset during intoxication" or "with onset during withdrawal" may be noted for the category. F = The disorder is presenting. \*Also hallucinogen persisting perception disorder (flashbacks).

\*\*Includes amphetamine-type stimulants, cocaine, and other or unspecified stimulants.

27

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- It is prudent to wait several months prior to making a formal diagnosis of a psychotic spectrum disorder when treating a patient with psychotic symptoms and use of which of the following substances?
  - A) Phencyclidine
  - B) Cocaine
  - C) Methamphetamine
  - D) Cannabis
  - E) Inhalants



31

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- It is prudent to wait several months prior to making a formal diagnosis of a psychotic spectrum disorder when treating a patient with psychotic symptoms and use of which of the following substances?
  - A) Phencyclidine (?)
  - B) Cocaine
  - **C) Methamphetamine**
  - D) Cannabis (?)
  - E) Inhalants (?)



32

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What have you found most challenging in considering the *diagnosis* for individuals reporting both substance use and mental health symptoms?



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### Challenges: Diagnosis

- Chicken or egg?
  - Or chicken and egg? +/- Bidirectional relationship
- Limited, imperfect histories
  - Substance use can affect memory/cooperation with interview
- Early and chronic substance use
- Insidious onset of substance use and/or psychiatric symptoms
- Polysubstance use




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### Challenges: Diagnosis (cont.)

- Possible contribution of medical comorbidities or social determinants
- Post-acute withdrawal syndromes
- Persistent syndromes beyond typical "substance-induced" timeline that can mimic other mental health disorders
  - Ex: Meth-induced psychotic disorder, hallucinogen persisting perception disorder, alcohol-induced neurocognitive disorder
- Patient or provider (unconscious) preference for particular explanation
  - Threats to therapeutic alliance in challenging
- Other unconscious biases
  - More likely to be diagnosed with schizophrenia if Black (3-5x) or Latinx (~3x) than if white




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### Post-Acute Withdrawal Syndrome

- AKA "Prolonged withdrawal syndrome" or "Protracted withdrawal syndrome"
- Cluster of symptoms seen weeks to months, even years, after abstinence from a substance
  - Mood swings, depression, anxiety, irritability, insomnia, cognitive changes, cravings
  - Sometimes, obsessive-compulsive behaviors or apathy
- Often varies with amount/chronicity of use
- Most common with alcohol/benzodiazepines (up to 75%), opioids (up to 90%)
  - Though observed with other substances too
- Exact mechanism unknown but likely 2/2 physiologic changes a/w substance use (i.e., neuroadaptations → excitability)
- Treatment may include therapy +/- medication (i.e., acamprosate/others)




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What have you found most challenging in considering the *treatment* of individuals reporting both substance use and mental health symptoms?

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**Challenges: Treatment**

- What to treat?
- When?
- With what?
  - Potentially addictive medications?
- Determining level of care (quickly)
- What if symptoms and SUD persist?

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**Challenges: Treatment (cont.)**

- Limited studies to guide treatment
  - Patients with SUDs may be excluded from some trials looking at treatment of other psychiatric disorders
    - More likely to drop out
    - More likely to show reduced efficacy of active treatment
  - Patients with certain psychiatric disorders may be excluded from some SUD treatment trials

39

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### Challenges: Doing Our Best

- Requires:
  - Patience
  - Patient engagement
  - Tolerating uncertainty
  - Humility
  - Some trial & error
- Consider stage of change
- Identify priority symptoms and functional goals
- Weigh potential benefits and harms of under/over diagnosis and under/over treatment




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- A 28-year-old patient is admitted to a psychiatric hospital with acute onset of paranoia, auditory hallucinations, and irritability. The patient admits to recent use of cocaine. Which of the following is most likely to help clarify whether the patient's psychosis is due to a substance-induced disorder or co-occurring schizophrenia and cocaine use disorder?
  - A) Administering urine toxicology on admission
  - B) Making serial assessments of psychiatric symptoms over time
  - C) Eliciting a family history of substance use disorders
  - D) Using a structured diagnostic interview on admission
  - E) Eliciting a history of prescriptions for antipsychotic medication




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41

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42

## History

- **Safety**
  - Withdrawal risk, suicidality, environment, etc.
- Detailed (and ideally serial) **longitudinal history**
  - *Get in the weeds*
  - Temporal relationship:
    - Age of onset of each substance use/psychiatric symptoms
    - Do symptoms precede use and/or persist after use?
    - History of clearly independent symptoms?
  - Typology:
    - Do the psychiatric symptoms make sense with type/phase of substance use?
  - Severity:
    - Do/did psychiatric symptoms fluctuate predictably with substance use?
    - Ex: More likely independent if distinct and severity anxiety in setting of constant pattern of use and without withdrawal
- SUD history:
  - First use, specific pattern(s) of use, stated reasons for use/experience while using, withdrawal, consequences, treatment



43

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## History

- Experience during **periods of abstinence** (when possible)
  - If not, (especially) consider...
    - **Developmental history**
      - DMDD tends to evolve into depression/anxiety > bipolar disorder
    - **Severity and chronicity** of symptoms/substance use
      - Correlate with ups/downs of substance use/WD or not necessarily?
      - Limited/less severe substance use
    - If **distinct anxiety syndromes**
      - Like specific phobia, social anxiety, agoraphobia, PTSD
    - **Effect of any past treatment**
      - Length of psychiatric hospitalizations
      - Response to medications
    - **Family history**
  - Consider **collateral information**
  - Consider **physical exam and labs** as relevant



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## General Treatment Approach

- Prioritize safety and acute stabilization
- Consider both med and non-med treatments
- Always treat the SUD (and often first)
- Treatment of other psychiatric symptoms
  - May wait to see what happens with abstinence
  - May start integrated treatment when convinced of independent disorder or if severe
    - If truly co-occurring dx, integrated > series/parallel when able
  - When possible, use medications that target multiple diagnoses
  - Appreciate potential biases for both over- and under-diagnosis/treatment of certain disorders, particularly when co-occurring substance use
    - Be thoughtful about potentially addictive medications
- Monitor for risks associated with return to substance use



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### Safety: Suicidality

Risk of Completed Suicide Higher Among Patients with Substance Use Disorder

Substance Use Disorder	Risk Increase
Heavy alcohol use	4x
Alcohol use disorder	10x
Opioid use disorder	14x

- How many opioid overdoses are suicide attempts or have a suicidal component?
  - “Strong desire to die” → 36%
  - “Definitely wanted to die” → 21%

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### Safety: Agitation

<p>Intoxication with CNS stimulant or undifferentiated PT:</p> <ul style="list-style-type: none"> <li>▪ Lorazepam 2 to 4 mg IM/IV</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>▪ Midazolam 2.5 to 5 mg IM/IV</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>▪ Lorazepam 2 mg IM/IV</li> </ul> <p><b>PLUS</b></p> <ul style="list-style-type: none"> <li>▪ Haloperidol 5 mg IM/IV</li> </ul>	<p>Intoxication with CNS depressant (eg, ethanol):</p> <ul style="list-style-type: none"> <li>▪ Haloperidol 2.5 to 10 mg IM/IV</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>▪ Droperidol 2.5 to 5 mg IM/IV</li> </ul>
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### Medication Treatment

- Psychotic disorders → Antipsychotics
- Bipolar spectrum disorder → Mood stabilizers
- Depressive disorders → Anti-depressants (SSRIs, SNRIs, atypical antidepressants / TCAs, MAOIs)
- Anxiety disorder → Anxiolytics, “anti-depressants”
- OCD, PTSD → “Anti-depressants”
- ADHD → Stimulants, non-stimulants
- SUDs → Medication for Addiction Treatment (MAT)
- Personality disorders → Therapy

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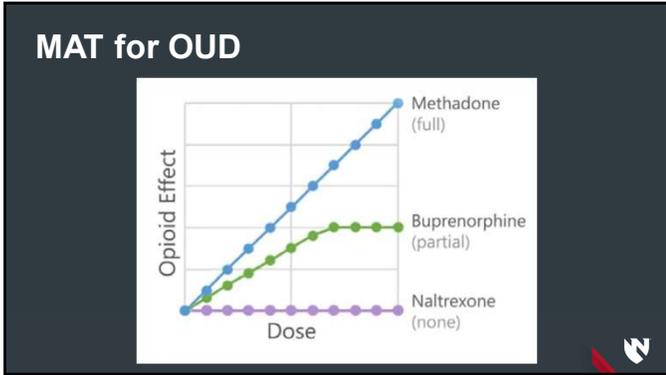
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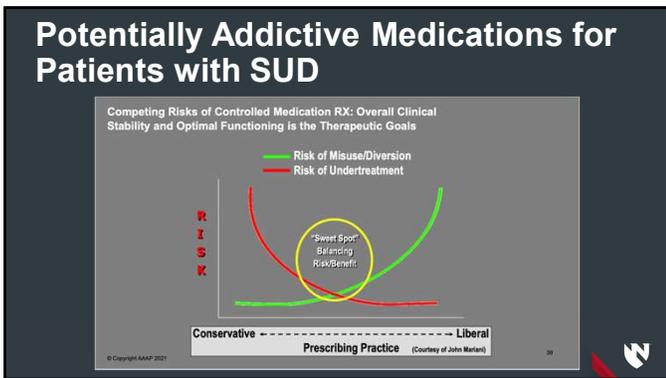
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- ### Potentially Addictive Medications for Patients with SUD
- Factors *favoring* use
    - Documented disorder
    - Solid trials of other treatments, including psychotherapy
    - Lack of history of misusing the prescribed drug in the past
    - No ASPD
    - Good life manageability and engagement in treatment
    - Involvement of family/other supports
  - Factors *against* use
    - Unclear diagnosis
    - No history of good trials with alternative treatments
    - History of misusing the prescribed drug in the past
    - History of ASPD
    - Won't allow contact with previous/current prescribing physician
    - Unstable psychosocial factors
    - Patient preference (i.e., desire to avoid addictive medications)

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### Potentially Addictive Medications for Patients with SUD

- Mitigating risk
  - Treatment agreements
  - Check PDMP
  - Favor longer-acting formulations
  - Scheduled > PRN dosing
  - Start low and go slow
  - Limit supply/refills
  - Close follow-up
  - Pill counts
  - UDSs as indicated
  - Collaborate with supports/other providers as relevant
  - De-escalate as possible
  - Documentation



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### Case

- Ms. M is a 28-year-old woman who comes to you requesting buprenorphine for treatment of opioid use disorder.
- She reports that she was first prescribed oxycodone 2 years ago after a fall in which she fractured her arm requiring surgical intervention. She reports about 1 month later she fractured her jaw, again after a fall, receiving another prescription for oxycodone. She tells you that since this time she has had a number of other injuries, and "aches and pains," for which she was taking oxycodone.
- She reports initially the "oxys" were "magic pills" not only treating her physical pain, but helped her "stay numb and emotionally checked out."



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### Case

- However, she tells you that over time she began to need increasing doses of oxycodone to achieve the same effect (tolerance). She describes using more than she planned, trying to cut back but being unable to, describes symptoms of opioid withdrawal when she has tried to stop, cravings that are "impossible to resist," and reports that financially she is "in trouble," as she is spending all of her money on oxycodone; she was recently fired from a job due to repeated absences, "I was out getting high." She is using about 150mg orally per day.
- She reports the desire to stop using oxys, stating "they've ruined my life," and she has heard that you can prescribe buprenorphine/naloxone (Suboxone).



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### Case

- You diagnose Ms. M with opioid use disorder, and believe that Suboxone is a reasonable treatment option.
- However, you begin to wonder about her "aches and pains" and the many fractures she has reported, particular given she is only 28 years old.
- You ask Ms. M a bit more about the circumstances leading to her injuries and she opens up to you, revealing that she had been in a domestic violence relationship for 4 years with her injuries the result of the physical abuse she suffered.
- Ms. M says that with the help of friends she was able to leave the relationship, and is currently living with a friend in a "safe environment."
- You begin to wonder if Ms. M might have post-traumatic stress disorder (PTSD).



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### Case

- Thoughts? Questions?
- Clues of a potential COD?
- Should she be encouraged to treat her OUD or PTSD first? In conjunction?
- Will treating her PTSD worsen her OUD?



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## Thank you! & Questions?

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