

Knowledge Notes
What exactly are “concurrent disorders?”
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Objectives

To summarize and review the state of knowledge concerning the definition of *concurrent disorders*, their prevalence, and how those with a concurrent disorder can be better served by the treatment system.

Issue

Background

Over the last 10 to 15 years, there has been a gradual acceptance of the phenomenon of concurrent disorders and the perceived need to integrate services for mental health and addiction problems to better serve individuals who may present with more than one problem. Alberta and other provinces in Canada are taking steps to enhance the capacity to treat and support concurrent disorders in the publicly-funded mental health care system. Yet, there remains a great deal of misunderstanding of what concurrent disorders are and how frequently they occur.

Coming to terms with the terms

The phenomenon of concurrent disorders has been captured using a variety of terms. Although the terms concurrent and co-occurring are often used interchangeably, this article will stick to the term *concurrent* to avoid additional confusion. According to Health Canada, people with a concurrent disorder experience a combination of mental/emotional/psychiatric problems with the abuse of alcohol and/or another psychoactive drug.¹

Before this term became popular, the older term used to describe this clinical phenomena was *dual diagnosis*. However, the dual diagnosis term in the United States referred to persons with severe and persistent mental illness (i.e., persons with psychotic disorders, severe personality disorders, and other chronic mental disorders) who also experienced a substance use disorder. In Canada, the term dual diagnosis is commonly used to describe persons with an intellectual disability and a mental health problem. The dual diagnosis label continues to be used, but is gradually being replaced by *concurrent disorders* and the more general term of *comorbidity*. The latter term is broadly used in medicine to describe two health conditions that appear in the same person during the same temporal period—e.g., the co-occurrence of diabetes and heart disease in a patient. The label ‘concurrent disorder’ has been adopted by psychiatry to specifically refer to the presence of a mental health and addiction problem (substance use or gambling) in the same person, while comorbidity is commonly used to describe concurrent non-addictive mental disorders (e.g., depression and social phobia) in the same person.

The issue of time frames

What do we mean by ‘concurrent?’ This is probably the most confusing aspect of concurrent disorders. When referring to a concurrent disorder it is important to specify the time frame. The main choices for time frames are lifetime, current, and 12-month (although variations on these have appeared in the literature). Lifetime means the two (or more) disorders occurred sometime during the individual’s lifespan but not necessarily during the same time period. For example, an individual who experienced a major depressive disorder in their 20’s and then developed cannabis dependence in their 30’s (after the depression resolved) would be labeled as having a lifetime concurrent disorder. Twelve-month comorbidity means the two disorders occurred within the same 12-month time period but not necessarily during the same month. This is a common definition of concurrent disorder used in epidemiology and can be used as an estimate of current comorbidity. In the strictest terms, however, a ‘current’ concurrent disorder means the two disorders happened during exactly the same time period.

Prevalence

Estimated rates of concurrent disorders vary substantially in the literature. This is due in part to the inconsistent use of the lifetime and current time specifiers. Furthermore, one needs to draw a distinction between population (sometimes called community) and treatment-seeking prevalence rates. The latter rates tend to be three to four times higher than the population rates.² This is because individuals with more severe and complex mental health conditions are also the most likely to seek help, hence this group tend to have higher rates of concurrent disorders. Less than 40% of persons with mental health problems seek any kind of treatment. The development of an addictive disorder with another condition tends to propel more people toward the health care system, possibly because the overall severity of their illness has increased and addictive disorders can contribute to a rapid decline in functioning. Consequently, rates of concurrent disorders tend to be highest among inpatient and emergency room patients. They are also higher within certain diagnostic groups—individuals with schizophrenia and personality disorders have rates of concurrent substance use disorders that are two to three times higher than persons with mood and anxiety disorders.

Readers have probably been told that comorbidity is the rule and not an exception in persons with mental health problems. However, this ‘rule’ doesn’t universally apply to the general population or even all treatment-seeking populations. The overlap of mood and anxiety disorders with substance use disorders varies from 5% to 20%, depending on the study. In the general Canadian population, one study estimated that about 7% of persons with any substance use disorder experience a major depressive disorder during the same 12 month period, and 12% of persons with major depression experience a substance use disorder during the same 12 month period.³ Lifetime rates of concurrent disorders range from 25% in persons with anxiety disorders, to 56% and 80% in persons with bipolar disorder and personality disorders, respectively.⁴ If one takes the average of all these rates, the overall lifetime prevalence rate of concurrent disorders becomes about 40% to 50%. Readers may have seen this figure quoted in the literature but should be aware that it represents an overall average with certain populations (schizophrenia, forensic patients, inpatients) representing the upper range of the distribution. Higher rates are also reported in US compared to Canadian studies.⁵

Another explanation for all this variability is the fact that the diagnostic criteria for mental and addictive disorders have changed over time. This would affect prevalence rates for individual disorders and amplify the variability for concurrent disorders. Second, surveys have used different diagnostic instruments. These instruments vary in how they manage the overlapping symptoms of mental disorders and addictions. One could argue that prevalence rates for some concurrent disorder combinations are artificially inflated by the presence of overlapping symptoms that result from present diagnostic criteria. The latest edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), which is now over 10 years old, continues to list disorders as separate diagnostic entities despite the fact that many include a similar set of symptoms. For example, many of the symptoms of intoxication and withdrawal can mimic the symptoms of depression.

Conclusions

Enhancing capacity in our treatment system to better serve persons with concurrent disorders is essential to providing the best possible care to those most in need of services. Although capacity enhancement is a resource intensive process, relatively simple policy changes—the removal of exclusion criteria for addictions for example—can make services more ‘concurrent disorder friendly.’ Routine screening for both mental health and addiction problems represents another quick win for service enhancement. Readers should consider that although the rate of addictive problems in mood and anxiety disorders may be only 10% to 20% of patients, the remaining 80% to 90% would be *at risk* for developing a concurrent disorder. A concurrent disorder may present at subthreshold levels in many patients. For example, substance abuse may be accompanied by mild symptoms of depression or anxiety that may not warrant a diagnosis but could nonetheless impede their progress in treatment. Clinicians can not assume that such symptoms are substance-induced; in many cases, symptoms will persist or get worse during periods of sustained abstinence. Similarly, individuals with mood or anxiety disorders may be at risk to use substances to alleviate their symptoms. A failure to respond to a prescribed treatment may be an indication that another condition is looming in the clinical picture. Lastly, decision makers need to consider that concurrent disorders represent only one type of comorbidity, and that service enhancements are also needed to manage the co-occurrence of physical and mental disorders, and more than one mental disorder in the same patient. Comorbid depression is common in persons with physical disorders. For example, the 12-month prevalence of major depression in individuals with cardiac disease is about 9%, a rate that is similar to the population prevalence for depression-alcohol dependence comorbidity.⁶ Periodic screening for signs of mental illness or addictions in persons with single disorders could be an effective prevention strategy.

Reference List

1. Rush, B., Fogg, B., Nadeau, L., & Furlong, A. (2008). On the Integration of Mental Health and Substance Use Services and Systems: Main Report. Canadian Executive Council on Addictions. <http://www.ccsa.ca/ceca/pdf/Main-reportFINALa.pdf>
2. Galbaud du Fort.G., Newman SC, Boothroyd LJ, Bland RC. Treatment seeking for depression: role of depressive symptoms and comorbid psychiatric diagnoses. *Journal of Affective Disorders* 1999;52:31-40.
3. Currie SR, Patten SB, Williams JV, et al. Comorbidity of major depression with substance use disorders. *Can J Psychiatry* 2005;50:660-666.
4. Grant BF, Stinson FS, Dawson DA, Chou SP, Dufour MC, Compton W, Pickering RP, Kaplan K. Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders. *Archives of General Psychiatry* 2004;61:807-16.
5. Kessler RC, Berglund P, Demler O, Jin R, Koretz D, Merikangas KR, Rush AJ, Walters EE, Wang PS, The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). *JAMA* 2003 Jun;289:3095-105.
6. Lichtman JH, Bigger JT, Jr., Blumenthal JA, et al. Depression and coronary heart disease: recommendations for screening, referral, and treatment: a science advisory from the American Heart Association Prevention Committee of the Council on Cardiovascular Nursing, Council on Clinical Cardiology, Council on Epidemiology and Prevention, and Interdisciplinary Council on Quality of Care and Outcomes Research: endorsed by the American Psychiatric Association. *Circulation* 2008;118:1768-1775.