



Double screening for dual disorder, alcoholism and depression

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SUMMARY

Comorbidity of alcohol use disorder and major depressive disorder has been reported in samples. The aim of this study was to examine the relationship between alcoholism and depression in undiagnosed patients by simultaneously applying screening tests for both disorders. A total of 421 subjects were included in the study, of which 246 were female. Two screening tests, the Michigan Alcoholism Screening Test and the Beck Depression Inventory, were used. In the total sample, 28.03% of the respondents engaged in some type of harmful alcohol use and 55.82% experienced some level of depression; 24.70% of the respondents had both at the same time, some type of harmful alcohol use and some level of depression. Results of statistical analysis showed that a more problematic alcohol use type was associated with a more severe level of depression, with a greater positive association between problematic alcohol use and severity of depressive symptoms among females and more harmful alcohol consumption among males. This study points to the importance of screening for alcoholism and depression, because their timely detection and treatment improves the quality of life in newly diagnosed individuals and reduces the economic burden on society for health services due to greater use if a greater severity of dual disorder is reached.

1. Introduction

A dual diagnosis of substance use disorder and a comorbid mental illness is a common problem (Neven et al., 2018). Among dual psychiatric disorders, alcohol use disorder (AUD) and mood disorders commonly co-occur and are associated with a range of negative outcomes for patients (Hartnett et al., 2017). Studies have indicated that AUD and mood disorders co-occur at a higher rate than would be expected by chance (Sullivan et al., 2005). Observed individually, alcoholism is highly disabling and associated with many physical and psychiatric comorbidities; it also contributes substantially to global morbidity and mortality (Grant et al., 2015). On the other hand, depression is the leading mental health-related cause of the Global Burden of Disease (Reynolds and Patel, 2017). Major depressive disorder (MDD) and AUD are two of the top five leading causes of years of life lost to disability in the developed world, with young people bearing a disproportionately large share of the burden (Deady et al., 2016). Co-occurring alcohol use and major depressive disorders exacerbate the morbidity and mortality of each risk (Blanco et al., 2012).

Certain epidemiological data indicate the burden of alcoholism and depression, observed individually as well as in their comorbidity. According to the 2015 National Survey on Drug Use and Health

(NSDUH), about 7.6% of people over the age of 18 experience a major depressive episode in any given year. About 8% of adults experience a problem with alcohol in any given year. Depression and alcoholism co-occur in about 1.2% of adults. This means that about one out of eight depressed individuals has a problem with alcohol, and vice versa (SAMHSA, 2015). According to the 2014 Global Status Report on Alcohol and Health, the World Health Organization reported that in 2012, 3.3 million deaths, or 5.9% of all global deaths (7.6% for men and 4.0% for women), were attributable to alcohol consumption (WHO, 2014a; WHO, 2014b). In 2012, 5.1% of the burden of disease and injury worldwide (139 million disability-adjusted life-years [DALYs]) was attributable to alcohol consumption (WHO, 2014a; WHO, 2014b).

Depression is the leading cause of disability and is a major contributor to the disease burden worldwide (Wang et al., 2017), and the global prevalence of depression and depressive symptoms has been increasing in recent decades (GBD, 2016). The lifetime prevalence of depression ranges from 20% to 25% in women and 7–12% in men (WHO, 2002). Depression is a significant determinant of quality of life and survival, accounting for approximately 50% of psychiatric consultations and 12% of all hospital admissions (Kuo et al., 2015). Depression accounts for 40.5% of DALYs caused by mental and substance use disorders, and it significantly contributes to the burden allocated to

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suicide and ischemic heart disease, thus making it a public health priority (Shidhaye et al., 2017). MDD is the most prevalent psychiatric disease and is a major contributor to the global burden of disease, which originates in two major sequelae of depression: declining physical health and suicide (Li et al., 2017). MDD is responsible for 11% of years lived with a disability, and up to 15% of individuals with recurrent MDD commit suicide (Kessler and Bromet, 2013; Whiteford et al., 2013).

The comorbidity of alcoholism and depression is prevalent and is associated with high severity, high costs, and poor functional prognosis (Gopalakrishnan et al., 2009). Although cause and effect are difficult to establish, depressive symptoms typically predict increased alcohol use, and conversely, relapse to heavy drinking predicts poor response to depression treatment (Gopalakrishnan et al., 2009). Comorbid substance use disorder is high in major depression (MD), with lifetime rates of 40.3% for any alcohol use disorder and 17.2% for any drug use disorder (Pettinati et al., 2013). Individuals with substance abuse disorders and psychiatric comorbidity have a higher number of emergency room visits and general health service usage than individuals without psychiatric comorbidity, including specifically for alcohol and depression comorbidity (Sacco et al., 2015). Comorbid AUD is a risk factor for quicker re-hospitalization for individuals hospitalized with MDD (Lin et al., 2007). The prevalence of affective disorders in alcohol addiction is estimated to be 22.9% (Becker et al., 2017). High rates of comorbidity between depressive and alcohol use disorders have also been reported in clinical as well as community samples (Petersen and Zettle, 2009). According to research conducted with both outpatient and inpatient mental health and substance abuse treatment services, MD was the most prevalent Axis I diagnosis (60%), and alcohol was the most frequent substance of abuse (47%) (Grant et al., 2015). AUD often co-occurs with MDD, both in treatment and in general populations (Riper et al., 2014). Individuals with such comorbidity present a greater challenge to treatment because they tend to have more severe symptoms, greater disability, and poorer quality of life than individuals with just an AUD and may pose a greater economic burden to society due to their higher usage of treatment services (Hartnett et al., 2017).

Alcohol misuse is a common method of self-medication for depression, but it increases the likelihood of suicidal behavior (Anderson et al., 2017). Individuals with depression and alcohol abuse have greater life dissatisfaction and functional impairment and are at higher risk for suicide (Briere et al., 2014). Several studies indicate a strong association between alcohol use and suicidal behaviors, concluding that alcohol use has been associated with increased rates of suicide ideation, attempts, and completions (Lamis and Malone, 2012). In a review of the literature, it could be found that on average, 37% of suicide completers had been consuming alcohol at the time of their death (Cherpitel et al., 2004).

Taking into account all these facts about the disease burden AUD and MDD contribute separately, as well as their comorbidity, it is important to improve the diagnosis and treatment of persons with these psychiatric disorders. In 2013, the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) released criteria for AUD (APA, 2013). Many individuals with drinking and alcohol-related health problems are undetected by DSM diagnostic criteria for AUD but nevertheless are experiencing negative consequences associated with their use of alcohol or are at risk for such consequences (NIAAA, 2003). Empirical findings suggest that there are a number of alcohol-related behaviors that are poor diagnostic indicators of alcoholism, such as blackouts, occasional morning drinking, or drinking to feel better, that could yield many false-positive non-problem drinkers (Littrell, 2014). The preferred method for identification and treatment of risky or harmful drinking has, for the past decades, been screening and brief intervention (SBI), but important questions concerning the effectiveness of SBI in routine health care settings remain unanswered (Lid et al., 2016). The general solution seems to be a systemic approach to put screening and brief intervention on the health agenda combined with

explicit training of general practitioners, including introduction of screening instruments, administration of screening procedures, specific brief interventions, and strategies to raise the issue with patients (Nygaard and Aasland, 2011).

Primary health care is seen as an ideal context for the early detection and secondary prevention of alcohol-related problems, due to its high contact-exposure to the population and the frequency with which higher-risk drinkers present (O'Donnell et al., 2014). Routine, population-based alcohol screening is recommended in primary care settings to identify patients with unhealthy alcohol use who may benefit from brief alcohol intervention (Williams et al., 2015). Also, routine screening for depression in adult primary care attenders is a vital milestone in the journey toward reducing the very large treatment gaps globally and scaling up the robust evidence on cost-effective interventions for this common mental disorder (Reynolds and Patel, 2017). With very prevalent comorbidity of alcoholism and depression in mind, double screening seems to be the best way to detect this dual disorder early.

The burden on health services and the poor quality of life of persons suffering from this dual disorder indicate the need to complement the evidence of the association between harmful alcohol use and the manifestation of depressive symptoms. Although many facts about this issue are known, it is still necessary to conduct research that would provide additional knowledge to facilitate the diagnostic and therapeutic approach, improve prevention, and reduce the costs of the health services in the treatment of this complex disorder.

The aim of our study was to examine the relationship between alcoholism and depression in undiagnosed patients by simultaneously applying screening tests for both disorders in primary health care. We have hypothesized that there is an association between the use of alcohol and depression, that a more harmful type of alcohol use is associated with a higher degree of depression, and that there is no difference between males and females in terms of alcohol use.

2. Methods

The study was conducted at the Health Center “Dr Simo Milosevic” in Čukarica, Belgrade, for a period of six months, running from March to September 2017. For the purpose of the research, two screening tests, the Michigan Alcoholism Screening Test (MAST) for alcoholism and the Beck Depression Inventory (BDI) for depression, were applied simultaneously. Screening tests were administered by trained general practitioners. The statistical package Statistica 13.2 was used for the processing of data.

2.1. Subjects

The study population included patients who visited their general practitioner at the health center. A combined accidental and voluntary sampling method was applied. A total of 500 subjects were tested, of which 421 were included in the study, 246 females and 175 males. The remaining 79 subjects were not included in the statistical analysis due to incomplete test data about gender or age or lack of response to specific questions within the tests itself, or they did not meet the necessary criterion.

The inclusion criterion for the study was age between 19 and 65 years old, and the exclusion criterion was a previously verified psychiatric disorder at any time during the lifetime, to prevent the possibility of influencing depressive symptoms that may exist within certain psychiatric clinical entities.

2.2. Procedures

2.2.1. Screening tests

There are numerous screening questionnaires for detection of AUD, such as the well-known Cut down, Annoyed, Guilty feelings, and Eye

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