

Short Communication

RETROSPECTIVE REPORTS OF PSYCHIATRIC SYMPTOMS BEFORE, DURING, AND AFTER DRUG USE IN A RECOVERING POPULATION

Lynn E. O'Connor, Ph.D.*

Jack W. Berry**

Andrea Morrison, Ph.D.***

Stephanie Brown, Ph.D.****

Recently there has been increased interest in the dually diagnosed patient who suffers from both chemical dependency and a concurrent psychiatric disorder (Wallace & Zweben 1989). This interest may realistically reflect the large number of severely disabled addicts currently entering treatment. However, it may also represent an attempt to reach a theoretical compromise between traditional psychodynamic practitioners and chemical dependency treatment specialists.

The psychodynamic tradition views alcohol and other drug abuse and dependence as a symptom of some other independent psychiatric disorder. The chemical dependency treatment practitioner more often views substance abuse as a primary disorder that is responsible for subsequent psychiatric difficulties. These historically oppositional worlds of chemical dependency treatment and mental health treatment appear to be merging in an effort to recognize, diagnose, and develop treatment strategies and programs for those patients described as dually diagnosed.

In many instances this alters the treatment provided a client. For example, when a clinician diagnoses a non-drug-related psychiatric illness, pharmaceutical interven-

tion with chemotherapeutic agents is frequently added to the treatment plan. Many clinicians suggest it may be important to medicate coexisting psychiatric disorders before a stable abstinence can be achieved. Zweben & Smith (1989) discussed the complexities of using medication in a recovering population.

In accordance with what may in some instances represent a compromise position, the addicted client is frequently classified as a dual diagnosis patient. In a study of 501 patients entering treatment for addiction, Ross, Glaser and Germanson (1988) found that 65% had a concurrent psychiatric disorder in addition to chemical dependency. In another report, Kosten and Kleber (1988) found that 80% of substance abusers fall into this category, with psychiatric comorbidity. Khantzian and Treece (1985) reported that 93% of narcotic addicts entering treatment are suffering from one or more psychiatric disorders other than substance abuse. Weiss and Mirin (1987) reported that 40% of substance abusers suffer from concurrent psychiatric disorders in addition to addiction.

In some cases, the diagnosis of two or more concurrent disorders may be accurate; in any population there is a percentage of individuals who suffer from nondrug-related psychiatric illnesses, and this holds true for the addicted population as well. Wallace and Zweben (1989) have suggested that the increase of recognized dual diagnosis patients may reflect a new sophistication on the part of drug treatment clinicians, and a lessening of the old antipsychiatry bias in the field of chemical dependency. However, it is also possible that the current tendency to label nearly half or more of clients entering chemical dependency treatment as dual diagnosis cases may be somewhat exaggerated, reflecting this new compromise position, which may itself be a bias.

To be sure, the addict seeking treatment often presents a confusing picture. Babor and colleagues (1990: 97) noted that "most of the commonly abused substances, including alcohol, opiates, sedatives and stimulants, have been found to have negative effects on mood and anxiety in acute intoxication, chronic use, and withdrawal. These effects frequently are indistinguishable from the endogenous psychiatric syndromes except that most patients improve with abstinence." Thus, while drug use often directly produces psychiatric symptoms and some substance abusers have a history of prior mental disorders, it is not clear to what

*San Francisco Psychotherapy Research Group; Research Associate, The Wright Institute, Berkeley, California; Research Associate, Haight Ashbury Free Clinic Detoxification and Aftercare Project, San Francisco; Private practice, San Francisco.

**Teaching Associate, The Wright Institute, Berkeley, California; San Francisco Psychotherapy Research Group.

***Dean, The Wright Institute, Berkeley, California; Private practice, Berkeley, California.

****Director, The Addictions Institute, Menlo Park, California; Research Associate, Mental Research Institute, Palo Alto, California; Private practice, Menlo Park, California.

Please address reprint requests to Lynn O'Connor, Ph.D., San Francisco Psychotherapy Research Group, 2420 Sutter Street, San Francisco, California 94115.

extent clients who have stopped taking drugs would be expected to suffer from other psychiatric disorders. This tendency to label an individual entering treatment with a concurrent psychiatric diagnosis may reflect the clinician's current theoretical perspective, as well as that of the client. Many clients have complied with popular psychological jargon and have learned to discuss — often using clinical terminology — their “endogenous depressions,” “vegetative signs and symptoms,” and a myriad of other details of their condition, which may influence the interviewing clinician.

It is difficult to gather empirical evidence concerning the prevalence of independent psychiatric diagnoses in the addicted population that is not confounded by recent drug use. All of the studies reported above looked at clients as they entered treatment and in their first months of abstinence from drugs, or while they were still using drugs, with a few including a one-year follow-up. As stated above, drug abuse, addiction, and withdrawal mimic many varying psychiatric syndromes, depending on the particular drugs being abused and the individual abusing them (Miller & Gold 1991).

While it has been recognized that some period of time after stopping drug use is necessary to make a comprehensive differential diagnosis, the time considered appropriate has not been ascertained (Weiss & Mirin 1989). Opiate withdrawal is associated with anxiety similar to that seen in panic disorders (Redmond & Huang 1979). Stimulant abuse is frequently followed by a long period of depression, and alcohol abuse can also have this effect (Mirin et al. 1988). Alcohol (Nutt, Adinoff & Linnoile 1989), sedatives, amphetamines, and cocaine may produce a long-lasting anxiety condition and possibly panic disorder. Recently some authors have suggested that the strong relationship between alcohol addiction and anxiety disorders may involve a common pathophysiology of alcohol withdrawal and nonalcohol-related panic attacks (Linnoila 1990). It is possible that clients suffering from depression, anxiety or panic subsequent to severe drug abuse may be experiencing a protracted withdrawal and not a preexisting condition. In a long-term study of abstinent alcoholics, De Soto and colleagues (1985) found that over a ten-year period the subjects' symptomatology decreased until it approximated normal after ten years. This study supported the concept of a protracted withdrawal phenomenon, including recurring symptoms of anxiety and depression.

Thus the picture of the client with chemical dependency problems who is seeking professional help may be obscured. The current popularity of the dual diagnosis label may reflect the biases of the chemical dependency treatment community and the mental health community, as well as current fashions in the general population, as much as or more than representing a real increase in con-

current independent psychiatric illnesses in this population. There may also be a political and economic aspect to this trend: recently there has been additional funding for dual diagnosis clients above and beyond that available for clients with a primary addiction diagnosis (Troyer & Presement 1991).

Utilizing self-reports to study the psychiatric problems and symptoms of the addict population without the confound of recent drug use, abuse or withdrawal, the present study looked at a group of abstinent addicts with varying amounts of time in recovery. Clinical experience with the recovering population has shown that they are quite willing and able to report on their experiences both before and during drug use. The sample was drawn from a 1990 convention of Narcotics Anonymous (NA). The subjects were questioned about psychiatric symptoms before, during, and after their addiction careers, as well as about their histories and current status with the mental health system, including experiences of psychotherapy, hospitalization, and psychiatric medication.

While resolving the confound of recent drug use and/or withdrawal, this study presents another confound, the fact that recovering people were self-selected by way of their active participation in an ongoing, voluntary recovery program and thus may represent a sample of the addict population that is less psychologically disturbed than the norm. However, the results of this study demonstrate that these addicts reported a high incidence of severe symptoms while they were using drugs and might well have been considered dually diagnosed when they first entered treatment.

METHODS

Subjects

Subjects were recovering drug addicts (N=125) with active involvement in NA. There were no special characteristics other than the self-diagnosis of addiction, as defined by participation in this voluntary self-help treatment program. One hundred fifty (150) questionnaires were distributed and 125 were returned. Of these, there were 70 male respondents and 55 female respondents. The time abstinent from alcohol and other drugs ranged from none to 192 months, with the average being 33.7 months. The subjects reported a variety of drug preferences: 21 preferred opiates; 20 preferred amphetamines; 17 preferred cocaine; 5 preferred marijuana; 6 preferred alcohol; 28 preferred a combination of stimulant and sedative drugs; and 7 reported preferring some other drug category, such as hallucinogens or PCP. The remaining subjects reported no clear drug preference.

Procedures

Research assistants who were participants in the NA

TABLE I
SUBJECTS REPORTING SYMPTOMS BEFORE,
DURING, AND AFTER DRUG USE

Symptom	Before (N=116)		During (N=118)		After (N=118)		F
	f	%	f	%	f	%	
Depression	55	47.4	104	88.1	38	32.2	63.36*
Anxiety	50	43.1	89	75.4	46	39.0	34.49*
Insomnia	24	20.7	73	61.9	17	14.4	58.69*
Obsessed with weight	30	25.9	40	33.9	39	33.1	1.64
Over- or undereating	33	28.4	64	54.2	30	25.4	17.89*
Bulimia	6	5.2	13	11.0	3	2.5	5.88
Considered suicide	34	29.3	68	57.6	10	8.5	53.16*
Harming self	21	18.1	28	23.7	4	3.4	15.50*
Panic	12	10.3	56	47.5	17	14.4	40.78*
Phobia	19	16.4	44	37.3	13	11.0	19.95*
Worry	62	53.4	98	83.1	69	58.5	20.76*
Anger	53	45.7	87	73.7	38	32.2	35.14*
Hearing voices	8	6.9	41	34.7	5	4.2	44.78*
Compulsions	29	25.0	61	51.7	24	20.3	31.28*
Intrusive thoughts	31	26.7	63	53.4	26	22.0	22.80*

*p<.001

12-Step program distributed questionnaires to recovering addicts at a Northern California annual NA convention. Everyone who walked by the researchers was invited to participate, and those who were interested were given questionnaires to be completed and returned at that time. One hundred fifty (150) questionnaires were distributed, of which 125 were returned completed. The questionnaire included demographic and drug history questions first piloted in 1988 (O'Connor and Berry 1990), and a list of psychiatric symptoms and complaints derived from clinical experience and interviews in an emergency setting. Whether each symptom was present was measured on a dichotomous scale. One hundred eighteen (118) subjects completed the symptom checklist.

RESULTS

Family History

Of this sample, 87.6% reported that there were other members of their families who either abused alcohol or other drugs in the past or who are currently using drugs.

Thirty-five percent (35%) reported nondrug-related psychiatric problems/disorders in at least one family member, including reports of manic-depressive illness, nervous breakdown, depression, schizophrenia, suicide, and panic disorder.

Psychiatric History

Over 23% of the subjects reported a history of psychiatric problems unrelated to drug use. Many (61.9%)

reported having been in psychotherapy at some point, and 59.1% said they had found their therapy to be helpful. Some (28.4%) were in therapy at the time of the study. Some (13.8%) had taken prescription psychiatric medication in the past. Some (16.2%) had made use of a psychiatric emergency clinic, and 24.8% had been hospitalized in a psychiatric unit. A large percentage (73.3%) had considered suicide at some point in their lives, and 34.2% had actually attempted suicide. Finally, 67.8% had been in jail.

Recovery Experiences

Currently, 89.8% of the subjects reported having a 12-Step sponsor, 63% reported being active in NA and having service commitments, such as meeting secretary, hospital or institutional work, or being a coffee maker or treasurer. All subjects were currently abstinent, but 58.5% reported having relapsed in the past.

Analysis of Self-reported Symptoms: Before, During, and After Drug Use

Table I presents frequencies and percentages of subjects self-reporting on 15 psychological symptoms before, during, and after drug use. For each symptom, except for bulimia and obsession with weight, a repeated measures ANOVA determined that there were significant changes before, during, and after drug use (see Myers et al. 1982 for use of F Tests for repeated measurements on dichotomous variables). A repeated measures ANOVA for total symptoms reported before, during, and after drug use was

also significant [$F(2,347)=154.31; p<.0001$]. The means for the overall sample before, during, and after drug use were 4.03, 7.81, and 3.24, respectively, indicating a significant increase in reported symptoms during drug use. In addition, the number of total symptoms reported currently was significantly lower than that reported as present before the subjects began using drugs. All results reported as significant were significant at the modified test wise alpha level of .002, corrected to protect the experiment-wise alpha at .05.

DISCUSSION

The results of this study suggest that within the recovering population active in NA, there was a significant increase in total psychiatric symptoms during the period of active drug use. Since the cessation of drug use, symptoms significantly decreased, even to a level below that reported as present prior to the initiation of drug use. It is interesting to note that these subjects reported frequent past use of the mental health system; over 60% had seen a therapist at some point. Only three subjects reported having a current psychiatric diagnosis, and only two reported current use of psychiatric medication (both antidepressants). These results would suggest that while many of

these subjects would have been considered dual diagnosis cases while they were using drugs, currently they would not.

The accuracy of self-report as well as subjects' ability to correctly remember and disclose past situations and states may be questioned. Also, the list of symptoms used in the study was developed particularly for this study, from clinical experience in a crisis psychiatric setting, and from a small qualitative pilot study; however, it was not validated on a large population. Furthermore, the significant decrease in current symptoms may reflect a specific treatment effect of involvement in a 12-Step program, or in NA in particular, and not be merely the result of the cessation of drug use. It is possible that recovering addicts without the experience of this specific treatment might report more psychiatric symptoms after active addiction. Another explanation for these findings may be that addicts who are attracted to a 12-Step or NA program, self-help voluntary programs, constitute a subgroup of addicts who suffer from fewer serious nondrug-related psychiatric illnesses. Such programs may attract less psychologically disturbed individuals from the addict population. Despite these qualifications, these results indicate a need for further investigation of dual diagnoses and treatment strategies for clients with chemical dependency problems.

REFERENCES

- Babor, T.F.; Orrock, B.; Liebowitz, N.; Salomon, R. & Brown, J. 1990. From basic concepts to clinical reality: Unresolved issues in the diagnosis of dependence. In: Galanter, M. (Ed.) *Alcoholism, Volume 8, Combined Alcohol and Other Drug Dependence*. New York: Plenum.
- De Soto, C.B.; O'Donnell, W.E.; Allred, L. & Lopes, C. 1985. Symptomatology in alcoholics at various stages of abstinence. *Alcoholism: Clinical and Experimental Research* Vol. 9(6): 505-512.
- Khantzian, E.J. & Treece, C. 1985. DSM-III psychiatric diagnosis of narcotic addicts. *Archives of General Psychiatry* Vol. 42(11): 1067-71.
- Kosten, T. & Kleber, H.D. 1988. Differential diagnosis of psychiatric comorbidity in substance abusers. *Journal of Substance Abuse Treatment* Vol. 5: 201-206.
- Linnoila, M.I., 1990. Approaches to the treatment of alcoholism and anxiety. *Drug Therapy Supplement* August: 27-33.
- Miller, N.S. & Gold, M.S. 1991. Dependence syndrome: A critical analysis of essential features. *Psychiatric Annals* Vol. 21(5): 282-288.
- Mirin, S.M.; Weiss, R.D.; Michael, J. & Griffin, M.L. 1988. Psychopathology in substance abusers: Diagnosis and treatment. *American Journal of Drug and Alcohol Abuse* Vol. 14(2): 139-157.
- Myers, J.L.; DiCecco, J.V.; White, J.B. & Borden, V.M. 1982. Repeated measures on dichotomous variables: Q and F tests. *Psychological Bulletin* Vol. 92(2): 517-525.
- Nutt, D.; Adinoff, B. & Linnoila, M. 1989. Benzodiazepines in the treatment of alcoholism. *Recent Developments in Alcoholism: Treatment Research* Vol. 7: 283-313.
- O'Connor, L. & Berry, J. 1990. The drug-of-choice phenomenon: Why addicts begin using their preferred drug. *Journal of Psychoactive Drugs* Vol. 22(3): 305-311.
- Redmond, D.E., Jr. & Huang, Y.H. 1979. Current concepts 11: New evidence for a locus coeruleus norepinephrine connection with anxiety. *Life Sciences* Vol. 25: 2149-2162.
- Ross, H.E.; Glaser, F.B. & Gemanson, T. 1988. The prevalence of psychiatric disorders in patients with alcohol and other drug problems. *Archives of General Psychiatry* Vol. 45(11): 1023-1031.
- Troyer, T. & Presement, J. 1991. Personal communication. Administrative Manager and Manager of Special Populations, respectively, Walden House, San Francisco.
- Weiss, R.D. & Mirin, S.M. 1989. The dual diagnosis alcoholic: Evaluation and treatment. *Psychiatric Annals* Vol. 19(5): 261-265.
- Weiss, R.D. & Mirin, S.M. 1987. Substance abuse as an attempt at self-medication. *Psychiatric Medicine* Vol. 3(4): 357-367.
- Zweben, J.E. & Smith, D.E. 1989. Considerations in using psychotropic medication with dual diagnosis patients in recovery. *Journal of Psychoactive Drugs* Vol. 21(2): 221-228.
- Wallace, J. & Zweben, J.E. 1989. Editors' introduction. *Journal of Psychoactive Drugs* Vol. 21(2): 135-137.