Editorial

iMedPub Journals
www.imedpub.com

Dual Diagnosis: Open Access
ISSN 2472-5048

2020
Vol.5 No.3

Framework of Dual Disorders and Its Flaws

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Citation: Gayatri M (2020) Framework of Dual Disorders and Its Flaws. Vol.5 No.3:1.

Received: November 24, 2020; **Accepted:** December 08, 2020; **Published:** December 15, 2020

Introduction

When psychiatric illness and substance use disorder coexist, the clinical approach to the patient is, unsurprisingly, awkward. This fact is due to a cultural context and, more directly, to the patient's psychiatric condition and addiction behaviors—a situation that does not favor a scientific approach. In dual disorder facilities, several types of professionals work together: counselors, social workers, psychologists, and psychiatrists. Treatment approaches vary from one service to another and even within the same service. It is crucial to provide dual disorder patients with multiple treatments, comprising hospitalization, rehabilitative and residential programs, case management, and counseling. Still, when treating Dual Disorder (DD) Heroin Use Disorder (HUD) patients, it is advisable to follow a hierarchical algorithm. First, we must deal with addiction: by detoxification, whenever possible. This means starting most patients on anti-craving pharmacological maintenance, though aversion therapy may be appropriate for a few of them.[1] Opiate antagonists may be used with heroin-addicted patients as long as those patients are only mildly ill. In contrast, agonist opioid medications, i.e., buprenorphine and methadone suit moderately and severely ill patients, respectively. Achieving control of mood instability or psychotic episodes is the next step, to be followed by a prevention strategy to counteract residual cravings and dominate mood disorders or psychotic episodes through long-term pharmacological maintenance that is focused on a double target.

Dead Ends and Start Lines in Dual Disorder

Several studies or reviews have discussed the issue of the disease chronology of dual disorder. In other words, how can primary psychiatric disorders be distinguished from substance-induced transient or persistent disorders with similar symptoms? A DSM-based classification is of little help, since the exclusion of putative substance-induced disorders from a primary psychiatric category resulted in little attention being paid to these secondary disorders. Substance-induced disorders are, in fact, commonly regarded as difficult to handle, resistant to treatment, and are without any standard treatment algorithm.[2] Similarly, it is not exactly clear what benefits can be gained by pressing the issue of whether a cluster of symptoms is substance induced or primary. Although it is true that the disorder may manifest itself later, the opposite hypothesis is true too. It is also important to carefully consider whether a cluster of substance-induced symptoms, like some psychotropic medications, can be contraindicated

Screening and Definition Criteria for Dual Disorder Heroin Addiction

In several studies, no psychiatric category is specified when reporting on the comorbidities of substance abusers; instead, authors refer to comorbid mental disturbance by drawing on syndrome names as labels or naming series of key symptoms.[3] The foremost criterion for the screening of dual disorders should be the deviance of putative diagnosis from the stereotype of transient chronic intoxication, either during substance use or soon after detoxification. Such a stereotype varies according to which substance is accounted for, even if not defined during mixed poly-

use phases. Nevertheless, the stereotype of heroin addiction has been reliably defined as the depressive–anxious–hypersensitive–somatic syndrome. This clinical picture runs parallel to acute opioid impairment (susceptibility to withdrawal) and the severity of the addiction [4].

Conclusion

To sum up, dual disorders may be present in cases of intense affective discomfort, especially when patients are free from current intoxication or are emerging after a long period of well-being after discharge from opiate agonist treatment. In all other cases, an addiction-related profile should be considered first—a profile that is likely to be improved by opiate agonist initiation, dose increase, or reintroduction.[5] Psychotic symptoms are more likely to indicate a dual disorder as being responsible for psychosis, except in situations of enforced acute withdrawal or acute psychotomimetic intoxication

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