Editorial

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Old Borders and New Paths of Dual Diagnosis

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Editorial

The remix of psychiatric nosology, according to the DSM-V, unfortunately missed to reconsider the classification of substance-related syndromes, and somehow define the limits of the dual diagnosis world. Since its birth, the expression (dual diagnosis) received strong criticism for failing to distinguish between concurrent illnesses, drug-induced syndromes and epiphenomenic substance use as a symptom of primary psychiatric disorders.

To be said, the concept of dual diagnosis was itself not so ambiguous on theoretical grounds: two illnesses with independent though intermingled pathophysiology and course [1]. Moreover, it was meant to indicate a subgroup of addiction cases, rather than the wider common ground between substance use, at any stage, and psychiatric syndromes. Putative criteria for the definition of the diagnostic borders of dual diagnosis are: chronology of illness (psychiatric diagnosis forerunning addiction), lack of overlap with symptoms of intoxication and withdrawal (persistence after detachment from use); independent course (lack of overlaps between relapses).

Despite such premises, common was the overuse of the dual diagnosis, to label what was previously regarded to as "the psychiatric symptoms of chronic intoxication". This misusing attitude perhaps was partially justified by the fact that the diagnosis of chronic intoxication from substances was often limited to the period of active use, possibly extended over a following trail of so-called prolonged withdrawal. The follow-up of drug addicts and alcoholics through the decades, and between relapses has shed brighter light on the issue of persistent psychiatric damage after detoxification, and suggested that the drug-induced syndromes may outlive the endurance of drug-using habits, following an autonomous course such as spontaneous syndromes would do [2] .

On the other hand, there is a certain relationship between long-lasting symptoms persisting after detoxification, and the threshold of relapse. Although relapse does not require any specific substrate other from the acquired brain change in the incentive motivation/reward system, individuals still differ in the latency of relapse and malignancy of relapsing course of their addiction. The severity of core addictive symptoms (expressed during relapse periods) and residual symptoms (evident during protracted abstinence) seems to run parallel, so that some psychiatric symptoms loom as nothing but a mirror and predictor of addiction severity [3]. As far as syndromic pictures are concerned, drug users may just develop, as a consequence of chronic intoxication, pictures which are equivalent to otherwise spontaneous ones. Differently, in some cases substances may build up psychiatric syndrome which do not fit into the criteria of classic psychiatric syndromes, and should be defined as new independent pictures.

Let us consider the case of depression and psychosis. Late withdrawal from opiates is often characterized by depressive symptoms, which may resemble atypical depression, but also share some aspects with withdrawal, or masked depression dominated by somatic discomfort [4]. Nevertheless, aspects of irritability, sensitivity and chronic preoccupation with interaction with the environment are also features, which often preludes to short-term relapse and are promptly buffered by opiate agonist anti-craving treatment, while worsened by opiate antagonists. Depressive pictures of such a kind are atypical amongst the atypical, and deserve to be classified independently as "opiate addiction filtered mood disorders", which may resemble bipolar depression, or cyclothymia with prevalent dysthymic traits. On the other hand, similar symptoms during active phases of opiate use are better classified as part of chronic intoxication, and do not configure any additive diagnosis [5].

Psychosis following substance use usually improves in the absence of active use, but some symptoms may persist, either in terms of apathy and social isolation, or in terms of lower threshold to aggressive and disruptive behavior, which was not documented before the involvement into drug use. Former substance users then may become actual psychotic patients, schizoid-like negative

syndromes, or subjects with impulse-control disturbance, as an effect of repeated exposure to stimulants like methamphetamine or cannabinoids. These kinds of psychoses cannot be considered as "drug-related" as long as active use is not enduring, but must be considered drug-related as far as this category indicates a difference in pathophysiology and response to treatment [6].

In some cases, multiple addictions, too, are seen as dual diagnosis (dual addiction), without accounting for a possible common pathway and cross-relapsing between different patterns of substance abuse. Recent data support, for instance, the continuity between alcoholism and heroin addiction for some subjects, which start as drinkers, proceed as heroin addicts with possible concurrent alcohol abuse, and eventually display as pure alcoholics with possible residual heroin use.

To conclude, clinical pictures should be reclassified according to the autonomy of their course, and regardless of chronology with respect to substance use. Syndromes following substance use may be "new" and independent illnesses, although their origin roots in exposure to substances of abuse. On the other hand, major psychiatric syndromes accompanying substance intoxication should not be automatically classified aside of substance intoxication, just because they "resemble" some otherwise know clinical picture. In other words, knowledge into the psychiatric syndromes due to intoxication should be improved and deepened, while the concept of dual diagnosis should be extended to any syndrome that runs parallel with addiction, regardless of chronology, and thus including persistent syndromes following drug-exposure.

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