Certain Psychiatric Disorders Drive Alcohol Dependence

BY DOUG BRUNK

SAN DIEGO — Mood or anxiety disorders, drug dependence, and nicotine dependence that co-occur with alcohol dependence can have negative effects on the long-term persistence of alcohol dependence.

Those are key conclusions from a 3-year follow-up of data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC).

"The effects of specific co-occurring psychiatric disorders on the persistence of alcohol problems are not well understood," Sharon Samet, Ph.D., and Deborah Hasin, Ph.D., of the department of psychiatry at Columbia University, New York, and the New York State Psychiatric Institute, reported in a poster presented at the annual scientific conference of the Research Society on Alcoholism.

"In patient samples, major depression is associated with greater risk for relapse to drinking and to alcohol dependence following treatment," they wrote.

"Patient samples provide important information about individuals in alcohol treatment, but these samples represent a small proportion of the total number of individuals with alcohol dependence. The present study uses general population data."

Dr. Samet and Dr. Hasin evaluated data from a nationally representative sample of adults who were interviewed in 2001-2002 for NESARC Wave 1 and re-interviewed in 2004-2005 for NESARC Wave 2. They used the Alcohol Use Disorder and Associated Disabilities Interview Schedule-DSM-IV (AUDADIS-IV) to diagnose DSM-IV alcohol dependence and other psychiatric disorders.

Then they used logistic regression to estimate the odds of persistence of alcohol dependence at follow-up among individuals who had co-occurring mood, anxiety, and substance disorders in the year before baseline or on year 1 or year 2 of follow-up, compared with individuals without comorbidity.

They adjusted the analyses for age, gender, race/ethnicity, education, employment status, marital status, and alcohol treatment.

At baseline, 1,172 individuals met criteria for DSM-IV alcohol dependence. Of those, 422 (36%) manifested persistence of alcohol dependence at follow-up.

Persistent alcohol use during the 3-year follow-up was predicted by major depressive episode (odds ratio 1.47), dysthymia (OR 1.96), and mania (OR 2.11), panic disorder (OR 2.19) and generalized anxiety disorder (OR 1.94), and nicotine (OR 1.74) and drug dependence (OR 1.94).

"This study improves on earlier studies of comorbidity in a number of ways," Dr. Samet and Dr. Hasin wrote in their poster. "The strengths of this study include first, a large representative general population sample that avoided potential biases of treated samples; second, the longitudinal collection of data that avoided potential recall problems in retrospective studies; and third, an extensively tested valid and reliable diagnostic measure."

The study was supported by the National Institute on Alcohol Abuse and Alcoholism and by the New York State Psychiatric Institute. ■

Should Fetal Alcohol Spectrum Disorder Be Included in DSM-V?

BY DOUG BRUNK

SAN DIEGO — Work on the fifth edition of American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders is well underway, and at least one psychiatrist thinks that alcohol-related neurobehavioral syndrome should be included.

Fetal alcohol spectrum disorder "has never been part of our taxonomy, and yet many psychiatrists wind up seeing these patients," said Dr. Howard B. Moss, associate director for clinical and translational research at the National Institute on Alcohol Abuse and Alcoholism, Bethesda, Md., and a member of the DSM-V Task Force. "It would be helpful to have in the DSM so psychiatrists can bill for services as well as provide some sort of diagnosis for these patients."

At the annual scientific conference of the Research Society on Alcoholism, Dr. Moss discussed the perceived shortcomings of the APA's current classification system, the DSM-IV, which was first published in 1994 and was updated in 2000.

First, he said, the DSM-IV tends to emphasize reliability over validity. "This is particularly problematic when you talk about the construction of psychiatric syndromes: whether or not the disorders as described in the DSM-IV represent conditions that clinicians actually see in their office, or whether they represent idealized conditions that really don't fit any given patient when you see them in real life," Dr. Moss said.

Issues surrounding severity, disability, and quantitative scaling of mental disorders "are pretty much absent," he added. "The thought is, through enhancing one's capacity to measure severity, disability, and quantitative aspects of the phenotype of interest in the DSM-V, you will be able to improve the quality of the diagnosis and perhaps increase its validity."

The DSM-IV is also characterized by high rates of psychiatric comorbidity, he said, noting that some patients seen in clinical practice might meet diagnostic criteria for five or more mental disorders simultaneously. This suggests that "perhaps we're not doing a great job in terms of accurately describing the nature of the syndromes that are physically present."

The extensive use of "not otherwise specified" criteria (NOS) in the DSM-IV is another concern. "NOS means that a patient sitting across from you has something that looks like a disorder that's in the DSM, but does not really meet any of the criteria specific for that disorder," Dr. Moss said. "There's also treatment nonspecificity, and there has been a concern about a lack of biomarkers available for these criteria. Several individuals have stated that the DSM-IV hinders progress in [mental health care] because of its lack of validity."

The DSM-V Task Force, launched in 2006, is chaired by David J. Kupfer, professor and chairman of the department of psychiatry at the University of Pittsburgh Medical Center. The vice chair is Dr. Darrel A. Regier, who directs the APA's division of research and is executive director of the American Psychiatric Institute for Research and Education. They oversee 13 work groups composed of more than 120 researchers and clinicians, including a work group on substance-related disorders (www.dsm5.org).

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DR. MOSS

Each work group is permitted to seek input from outside advisers to help identify specific issues in specific areas, but those advisers undergo a strict vetting process, Dr. Moss said, "such that individuals who have what is deemed as a conflict of interest due to their receipt of research grant dollars or consulting dollars from the pharmaceutical industry are eliminated from being able to participate. There is a threshold, but if an overwhelming amount of your research looks like it comes from the pharmaceutical industry, then you're asked not to participate."

Publication of the DSM-V is expected in 2012, and the International Classification of Diseases-11 should be completed and published by 2014. According to timeline projections, field trials of the DSM-V should be currently underway, but "it is unclear as to what the field trials are going to look like, how they are going to be funded, and what sort of format they are going to take," Dr. Moss commented.

Because of his position on fetal alcohol spectrum disorder, he has submitted a white paper arguing for the inclusion of alcohol-related neurodevelopmental disorder in the DSM-V. However, certain requisite questions must be answered before a new diagnosis is added to the DSM-V, he said. These include questions such as: Is the syndrome associated with clinically significant limitations in functioning or distress? Is the entity distinct from normal behavioral variations? Does the syndrome have diagnostic validity using one or more diagnostic validators?

Other questions might include: Does the proposed entity characterize a distinct group of people who need appropriate clinical attention? Have enough data been published on a wide range of topics related to the entity to warrant its inclusion in the DSM? Is there evidence for any effect of biological, psychological, or psychosocial treatment for a given disorder?

Dr. John E. Helzer, a psychiatrist who directs the Health Behavior Research Center at the University of Vermont, Burlington, said there are clear drawbacks to revising the DSM-IV, including disruption to clinicians and investigators, "because we have to learn to apply new diagnostic definitions. It sacrifices a longitudinal perspective because if you do population prevalence surveys with one set of diagnostic criteria and go out a few years later and do a different survey with a different set of criteria, it's very hard to compare the results."

However, in his opinion, the shaping of the DSM-V provides an opportunity to create a more quantitative approach to making psychiatric diagnoses. "DSM has always been a categorical system; you either have a diagnosis or you don't," said Dr. Helzer, a co-author of the Diagnostic Interview Schedule. "It does not allow for gradations of severity. If we can use things like item response theory and differential weighting to have a scaled score rather than a yes/no diagnosis, that's going to be immensely helpful, not only clinically but also in terms of our research work."

He described the DSM-IV as a top-down diagnostic system and the DSM-V as a bottom-up diagnostic system. A top-down system "begins with expert committees that propose disorders, they decide the criteria and the thresholds, and that becomes a classification system," he explained.

A bottom-up system, on the other hand, begins "with a large pool of data on problems; we use statistical analysis to identify thresholds, and that becomes a classification system," Dr. Helzer said.

"The difference is the input of the clinical experts. There is heavy input of clinical experts in the top-down approach versus very little in the bottom-up approach," he said.

"It's a very legitimate question about which of the two [approaches] would be more appropriate and give us a more valid diagnosis, but it seems that this is an opportune time for us to make this comparison." ■