



## Substance dependence and remission in schizophrenia: A comparison of schizophrenia and affective disorders

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### ABSTRACT

The present study examined psychiatric functioning, substance use and consequences, and motivation to change in people with schizophrenia and affective disorders and current or remitted cocaine dependence. Data were collected as part of a naturalistic, longitudinal study examining substance use, motivation to change, and the process of change in people with schizophrenia and affective disorders who were currently dependent or in remission from cocaine dependence. We examined the following questions: (1) Do those in remission show better psychiatric functioning than those who are currently dependent? (2) How do people with schizophrenia and current cocaine dependence differ in terms of substance use and consequences from people with schizophrenia in remission and people with affective disorders and current drug dependence? (3) What internal factors and external factors are associated with changes in substance use in schizophrenia and how do these compare to those in nonpsychotic affective disorders? Results indicated that people with schizophrenia and current dependence reported higher levels of positive and negative symptoms than those in remission. Remission status was related to less use of other drugs, fewer days of drug problems, less distress from drug problems, and more lifetime drug-related consequences. Those with current dependence reported more days of drinking and drinking to intoxication, as well as higher rates of current alcohol use disorders than the remitted group. When compared to those with affective disorders and cocaine dependence, those with schizophrenia and current dependence reported fewer days of problems associated with their drug use, less distress from drug problems, and fewer recent and lifetime consequences associated with their drug use. The schizophrenia dependent group generally showed the lowest readiness to change, fewest efforts being made to change, and lowest confidence in the ability to change. Implications of these findings are discussed.

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### 1. Introduction

Substance use disorders (SUDs) in people with schizophrenia are among the most pressing problems facing the mental health system. People with schizophrenia report six times the risk of developing a drug use disorder as do those in the general population (Regier et al., 1990), and clinical studies find that between 20–65% of schizophrenia patients surveyed in treatment settings experience comorbid substance use disorders (Alterman, Erdlen, Laporte, & Erdlen, 1982; Barbee, Clark, Crapanzano, Heintz, & Kehoe, 1989; Drake, Osher, & Wallach, 1989; Mueser, Bennett, & Kushner, 1995; Mueser, Yarnold, & Bellack, 1992; Schneier & Siris, 1987). SUDs in people with schizophrenia confer a range of serious psychiatric (Alterman et al., 1982; Barbee et al., 1989; Carpenter, Heinrichs, & Alphas, 1985; Drake &

Wallach, 1989; Hays & Aidroos, 1986; Haywood et al., 1995; Lambert, Griffith, & Hendrickse, 1996; Negrete & Knapp, 1986; Owen, Fischer, Booth, & Cuffel, 1996; Pages et al., 1998), social (Carey, Carey, & Kalichman, 1997; Cohen, Test, & Brown, 1990; Dixon, 1999; Landmark, Cernovsky, & Merskey, 1987; Marzuk, 1996; Soyka, 2000), and economic (Bai, Lin, Hu, & Yeh, 1998; Dickey & Azeni, 1996; Garnick, Hendricks, Comstock, & Horgan, 1997) consequences that compromise the functioning of an already multiply handicapped clinical population and the mental health system charged with its care.

As clinical interest in dual diagnosis has increased, research has focused on investigating and documenting the high prevalence and far-reaching negative impact of SUDs in schizophrenia. As a result, we now have a good understanding that SUDs affect a majority of people with schizophrenia and are a major impediment to good outcomes. Several other lines of research have contributed in important ways to our understanding of SUDs in schizophrenia by highlighting the ways in which drug use among people with dual SUDs and schizophrenia is similar to that of other less impaired substance abusers. For example, research has examined drug of choice and use patterns in people with

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schizophrenia, finding that there is not a consistent relationship between substance use and specific forms of symptomatology (Dixon, Haas, Weiden, Sweeney, & Frances, 1991; Mueser, Bellack, Douglas, & Wade, 1991). Rather, the data suggest that preference for street drugs varies over time and as a function of the demographic characteristics of the sample, similar to patterns in the general population (Mueser et al., 1992). Similarly, people with schizophrenia often report the same reasons for their drug use as primary substance abusers: using to cope with negative affective states, interpersonal conflict, and social pressures (Bradizza, Stasiewicz, & Carey, 1998; Dixon et al., 1991; Krausz, Mass, Haasen, & Gross, 1996; Noordsy et al., 1991; Pristach & Smith, 1996; Sandberg & Marlatt, 1991), as well as reasons related to socialization and boredom (Carey, Prunine, Maisto, Carey, & Barnes, 1999; Mueser et al., 1995; Warner et al., 1994). The situational context seems to be an important determinant of substance abuse for people with schizophrenia, as it is for other abusers (McCready, 1993), with findings that about half of alcohol abuse occurs in a social context (Dixon, Haas, Weiden, Sweeney, & Frances, 1990). In addition, there has been a good amount of research attention devoted to ways to structure treatment of SUDs for people with schizophrenia. As a result, we now have a general consensus on a number of elements required for effective treatment, including integration of psychiatric and substance abuse treatment (Carey, 1996; Drake & Mueser, 2000; Lehman & Dixon, 1995; Ziedonis & Fisher, 1994; Mueser, Noordsy, Drake, & Fox, 2003), conceptualizing treatment as a long-term, ongoing process (Bellack & DiClemente, 1999; Minkoff, 2000; Osher & Kofoed, 1989), and use of a harm reduction model, especially during the early stages of treatment (Carey, Carey, Maisto, & Prunine, 2002; Ziedonis, Williams, Corrigan, & Smelson, 2000). We are also starting to accumulate evidence that a number of strategies for treating SUDs can be adapted to meet the needs of people with schizophrenia (Bellack, Bennett, Gearon, Brown, & Yang, 2006). When taken together, these lines of research illustrate that SUDs in schizophrenia are prevalent and dangerous. While in some ways substance use in schizophrenia resembles that of people more broadly, at this point we have a good understanding that people with schizophrenia have additional unique and challenging treatment needs.

While research to date has provided an important outline of the problem of SUDs in schizophrenia, in-depth questions about factors that contribute to the maintenance and resolution of substance dependence in schizophrenia have yet to be examined. In a review of the literature on the epidemiology and course of comorbid schizophrenia and SUDs, Westermeyer (2006) identified several areas of research that would “support clinical efforts” (p. 352) with people with dual SUDs and schizophrenia, including comparing the ways in which people with schizophrenia and SUDs differ from those with other psychiatric disorders in order to better understand features and consequences of SUDs that are common across different disorders versus those that are specific to schizophrenia. In addition, Westermeyer (2006) stressed the need for a closer examination of remission out of SUDs and conversion from early and partial remission to sustained remission among people with schizophrenia. Others have similarly called for research on how remission is achieved and maintained in schizophrenia, as well as more and better information on the heterogeneity among people with schizophrenia and substance dependence or in remission that can, ultimately, help us tailor interventions to specific subgroups of people in need (Drake, Wallach, & McGovern, 2005). Importantly, it is assumed there is a range of negative consequences of drug use for people with dual SUDs and schizophrenia, and that these negative consequences are ameliorated or reversed during a period of remission (i.e. no or minimal drug use). However, the hypothesis that functioning in any domain (psychiatric, social, cognitive) substantially improves in remission has not been fully examined. Some have found that people with SMI who are former or remitted substance abusers are similar to current abusers on measures of symptoms and depression (Carey, Carey, & Simons, 2003;

Margolese, Carlos Negrete, Tempier, & Gill, 2006), while others have found that remission is associated with improvements in these domains (Cuffel & Chase, 1994). The mixed nature of these findings suggests that a more in-depth examination of how people with schizophrenia in remission differ from those with current SUDs is needed. Importantly, such findings would inform those who work with this population of the kinds improvements that can be expected in remission, as well as the limitations on functioning that will remain even once remission is achieved.

In addition, we have little understanding about the factors that lead people with schizophrenia to make changes in their drug use. The Transtheoretical Model of Change (TTM; Prochaska, DiClemente, & Norcross, 1992; Prochaska & DiClemente, 1992) has, over the years, transformed our thinking about substance abuse treatment, with an increasing emphasis on internal motivational states as the major factors underlying change efforts. While the TTM has proven to be a useful model for understanding the development and persistence of addictive disorders in diverse populations (Prochaska et al., 1992), it is unclear if such a conceptualization provides the best explanation for change in people with schizophrenia and SUDs. The standard measures for assessment of these constructs have been found to perform well in people with severe mental illness (Nidecker, DiClemente, Bennett, & Bellack, 2008), and there is evidence to suggest that people with schizophrenia can understand TTM-related constructs (Carey et al., 1999). However, the many and varied cognitive deficits associated with schizophrenia may make it difficult for people with the disorder to understand some of the abstract, internally-focused concepts that are inherent to the TTM model. It could be that events that are more concrete and immediately relevant to the lives of people with schizophrenia, such as homelessness, victimization, arrests, or advice/threats from family or friends are more relevant to pushing people with schizophrenia into making changes in substance use than motivational factors.

The present study examined psychiatric functioning, substance use and consequences, and motivation to change in people with schizophrenia and affective disorders with current or remitted cocaine dependence. Data were collected as part of a naturalistic, longitudinal study examining substance use, motivation to change, and the process of change in people with schizophrenia and affective disorders who met DSM-IV criteria for current Cocaine Dependence or Cocaine Dependence in Early Remission with five assessments over twelve months ( $n=240$ ). We examined the following questions: (1) Do people with schizophrenia in remission from cocaine dependence show better psychiatric functioning than those who are currently dependent? (2) How do people with schizophrenia and current cocaine dependence differ in terms of substance use and consequences from people with schizophrenia in remission and people with affective disorders and current drug dependence? (3) What internal factors and external factors are associated with changes in substance use schizophrenia, and how do these differ from those with non-psychotic affective disorders?

## 2. Methods

### 2.1. Participants

Data were collected as part of a naturalistic longitudinal study examining substance use and motivation to change in people with affective disorders or schizophrenia with either current cocaine dependence or cocaine dependence in remission. Participants were assessed five times over twelve months. Participants were recruited from outpatient mental health clinics affiliated with a Veterans Administration Medical Center and a division of psychiatry at a public university. Individuals with affective disorders or schizophrenia/schizoaffective disorder and a DSM-IV diagnosis of current cocaine dependence and those who fulfilled criteria for cocaine dependence in

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