

Affective disorders in comorbidity with alcohol addiction: clinical and dynamic features, social adaptation level of patients

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ABSTRACT

The aim of the study was to reveal clinical and dynamic characteristics of affective disorders (AD) in comorbidity with alcohol addiction (AA).

Materials and methods. 65 patients with affective disorders [22 women (34%) and 43 men (66%)] were examined. The main group included 34 patients aged 44.5 [36.0; 51.5] with affective disorders and comorbid alcohol addiction. The comparison group included 31 patients aged 45 years [32; 52] with affective disorders without comorbid narcological pathology. Compared groups were matched by sex, age and nosological structure ($p > 0.05$). The following methods were used in the study: clinical and psychopathological, clinical follow-up, psychometric, statistical, as well as these psychometric scales: Clinical Global Impression (CGI), Hamilton Depression Rating Scale (HDRS-17), Hamilton Anxiety Rating Scale (HARS), Social Adaptation Self-evaluation Scale (SASS).

Results. The comparative assessment of clinical and dynamic characteristics of affective disorders and social adaptation level was conducted. Chronology of occurrence of comorbid affective disorders and alcohol addiction was analyzed.

Conclusion. Addition of alcohol addiction to affective disorders worsens the clinical and dynamic indices and social adaptation level of patients.

Key words: affective disorders, alcohol addiction, comorbidity, clinical picture, adaptation.

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Аффективные расстройства при коморбидности с алкогольной зависимостью: клинико-динамические особенности, уровень социальной адаптации больных

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РЕЗЮМЕ

Цель исследования – выявление клинико-динамических характеристик аффективных расстройств (АР) при их коморбидности с алкогольной зависимостью (АЗ).

Материалы и методы. Обследованы 65 пациентов с АР – 22 женщины (34%) и 43 (66%) мужчины. Основная группа – 34 пациента с аффективными расстройствами и коморбидной алкогольной зависимостью в возрасте 44,5 лет [36,0; 51,5]. Группа сравнения – 31 пациент с аффективными расстройствами без коморбидной наркологической патологии в возрасте 45 лет [32; 52]. Сравнимые группы были сопоставимы по полу, возрасту и нозологической структуре ($p > 0,05$). В исследовании применялись следующие методы: клинико-психопатологический, клинико-катамнестический, психометрический, статистический, а также психометрические шкалы: шкала глобальной клинической оценки CGI, шкала депрессии Гамильтона HDRS-17, шкала тревоги Гамильтона HARS, шкала самооценки социальной адаптации SASS.

Результаты. Проведена сравнительная оценка клинико-динамических характеристик аффективных расстройств и уровня социальной адаптации. Проанализирована хронология возникновения коморбидных аффективных расстройств и алкогольной зависимости. Заключение. Присоединение алкогольной зависимости к аффективным расстройствам ухудшает их клинико-динамические показатели и уровень социальной адаптации пациентов.

Ключевые слова: аффективные расстройства, алкогольная зависимость, коморбидность, клиника, адаптация.

Конфликт интересов. Авторы декларируют отсутствие явных и потенциальных конфликтов интересов, связанных с публикацией настоящей статьи.

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INTRODUCTION

The problem of comorbidity of mental disorders remains relevant and requires further study, despite the huge number of studies devoted to it [1–4]. The high comorbidity level of affective disorders (AD) with other mental disorders is confirmed by the results of epidemiological and clinical studies [5, 4]. Alcohol addiction (AA) is one of the most common comorbid pathologies of individuals with AD along with anxiety and personality disorders [7–10]. The occurrence frequency of alcohol addiction among patients with AD is several times higher than that in the general population. In AD, men are more prone to develop an alcohol addiction, while women more often have anxiety disorders as comorbid pathologies [11]. In bipolar affective disorder (BAD), the risk of developing AA is six to seven times higher than in the general population, and with depression, it occurs in 25–40% [12, 13]. According to the data analysis collected from specialized institutions of eight European countries, among patients aged 18–64 years with alcohol addiction ($n = 1767$), depression was detected in 43.2% of cases (95% CI: 40.7–45.8) [14]. Patients with AD often use alcohol to alleviate symptoms of depression and anxiety [15]. In narcological pathology, the frequency of mood disorders also reaches a high level. Affective disorders increase the risk of AA and vice versa, but according to individual authors, such a pattern is observed only in males [16].

Numerous studies are devoted to identifying pathogenetic interactions in comorbidity between AA and affective pathology. The results indicating common genetic factors in the development of both disorders [17] and involvement of the same neuro-humoral mechanisms in the pathogenesis have been obtained. Such personality traits as alexithymia and social anxiety are common psychological factors of alcoholism and depression [18]. Currently, the problem of correlation between AD and pathological attraction to alcohol remains unresolved and relevant.

It is known that AA can be formed before and after the development of affective pathology. According to some sources, mood disorder manifests itself earlier and alcohol addiction develops during the course of the disorder [19]. The comorbidity of AD with alcohol addiction leads to differentiation difficulties with developed AA and symptomatic alcoholism on the one hand and with depressive disorders (DD) and secondary depression due to ethanol intoxication or a person's reaction to the social consequences of alcoholism on the other hand. An important differential criterion for primary depression is the manifestation of DD before the development of alcoholism.

Affective disorders in comorbidity with AA are characterized by a more frequent recurrence of depressive episodes (DE), a large number of suicidal attempts, a greater degree of maladjustment, and a worse prognosis [20, 21]. The literature data on the effect of comorbid alcoholism on the effectiveness of antidepressant treatment in depressive disorders are mixed. Some authors point out the negative impact of alcoholism on the results of depression treatment with antidepressants [22], while others do not confirm this effect [23]. Also, alcohol abuse complicates the cooperation of the doctor and the patient and reduces patient compliance.

The objective of the study was to reveal the clinical and dynamic characteristics of affective disorders in comorbidity with alcohol addiction. To achieve the objective, a comparative assessment of the clinical and dynamic indicators of AD comorbid with AA and AD occurring in isolation was carried out.

MATERIALS AND METHODS

65 patients with AD were examined 22 women (34%) and 43 (66%) men. [24] The median (ME) age of the female patients was 45.5 years; interquartile range (*MDQ*) – [35; 56], the median (ME) age of the male patients was 38 years old [31; 57]. A marital status analysis of the patients in the study group revealed a significant proportion of single patients – 39 (60%); widowed – 9 (14%), divorced – 9 (14%), unmarried – 8 (12%). In the study group, patients with higher education accounted for 59% ($n = 38$), specialized secondary education – 20% ($n = 13$), and secondary education – 21% ($n = 14$). Depending on the AD, the patients of the studied sample were distributed as follows: bipolar disorder (BPD), current DE – 18% ($n = 12$), recurrent depressive disorder (RDD) – 42% ($n = 27$), DE – 26% ($n = 17$), dysthymia – 14% ($n = 9$).

The studied patients were divided into two groups. The main group included 34 patients with AD and comorbid AA (11 women and 23 men), aged 44.5 years [36; 51.5]. The nosological structure of AD was presented: BPD – 24% ($n = 8$), RDD – 38% ($n = 13$), DE – 26% ($n = 9$) and dysthymia – 12% ($n = 4$). The AA duration of patients was 8 years [3.5; eleven]. In 60% of cases ($n = 19$), during the period of depression, patients changed their manner of alcohol consumption – they began to drink alone and in smaller portions. In isolated cases ($n = 3$), intakes of immense amount of alcohol were observed. The main motives for alcohol consumption in the development of depressive symptoms were to distract from painful dark thoughts, block out the feeling of anguish, forget about problems, and cope with anxiety and insomnia.

The comparison group consisted of patients with AD without comorbid narcological pathology: 31 people (11 women and 20 men) aged 45 years [32; 52]. Affective disorders were represented by the following nosologies: BPD – 13% ($n = 4$); RDD – 45% ($n = 14$); DE – 26% ($n = 8$); dysthymia – 16% ($n = 5$). The compared groups were matched by sex, age, and nosological structure ($p > 0.05$).

The ethical principles of the World Medical Association Declaration of Helsinki (1975), as amended (2008), were observed in working with the patients involved. Of the main research methods the following were used: clinical and psychopathological, clinical follow-up, psychometric and statistical. During the study the following psychometric scales were used: Clinical Global Impression (CGI), Hamilton Depression Rating Scale (HDRS-17) and Hamilton Anxiety Rating Scale (HARS). The levels of life quality and social functioning of patients in various spheres of life were determined by using the Social Adaptation Self-evaluation Scale (SASS), developed in 1997 by M. Bosc, A. Dubini, V. Polin. The questions included in the scale are aimed at assessing satisfaction with certain spheres of life (work, family relations and relationships outside the family, leisure, etc.) and their social functioning.

The following AD characteristics were evaluated in the study groups [25]: age at the onset of AD, syndromic variant of depression, indicators of suicidal behavior of patients, the number of affective episodes per year with BPD and RDD, depression level by HDRS-17, anxiety by HARS, disease severity by CGI-S. The level of social adaptation of patients according to SASS and the chronological sequence of AD and AA development were also evaluated.

Statistical data processing was carried out on a personal computer using the Statistica for Windows (V. 8.0) package of standard applications. For quantitative indicators that do not meet the criteria for a normal distribution, the median and interquartile range $Me [Q_1; Q_3]$ were calculated and the level of statistical significance of differences between the groups was determined by the Mann – Whitney criteria. The analysis of qualitative features was carried out through the study of their frequencies through contingency tables using the χ^2 criterion. When working with small samples, the F -test (Fisher's criterion) was used. The accuracy of the differences between the sample proportions was assessed using the Z -test.

RESULTS

The age at the beginning of AD in the main group was 28.5 years [20.0; 39.5], in the comparison group – 30 years [26; 40]. Groups for this indicator did not

have statistically significant differences ($p > 0.05$). The distribution of patients in the studied groups depending on the leading depression syndrome is presented in Table 1. No intergroup differences in the syndromic structure of depression were found ($p > 0.05$).

Table 1

Distribution of patients from the main and control groups depending on the syndromic variant of depression, n (%)		
Syndromic variants of depression	Main group	Comparison group
Anxious	13 (38)	9 (29)
Dysphoric	14 (41)	8 (26)
Hypochondriac	3 (9)	4 (13)
Conversion	2 (6)	5 (16)
Adynamic	2 (6)	5 (16)
Total	34 (100)	31 (100)

Next, the following indicators of suicidal behavior were analyzed: suicide ideation in the current episode and suicidal attempts in the past. The distribution of patients depending on the presence of suicidal thoughts in the current state did not have statistically significant intergroup differences ($p > 0.05$): in the main group, suicidal thoughts were present in the clinical picture in 65% of cases ($n = 22$), in the comparison group – in 48% ($n = 15$). On the background of alcohol withdrawal syndrome, suicidal thoughts of the patients from the main group became the most distressing, often obsessive. Analysis of anamnestic and follow-up data indicated a more frequent occurrence of suicidal attempts in medical history of patients from the main group: 27% and 6%, respectively ($p < 0.05$). In the main group, severe depressive experiences and psycho-traumatic circumstances, which were often the social consequences of alcoholization, were the most significant for suicidogenesis.

Estimation of the number of affective episodes per year in patients diagnosed with RDD and BPD showed that in the main group the indicator was higher compared to the comparison group – 1.5 [0.9; 2.0] and 0.9 [0.7; 1.6], respectively, $U = 200,000$; $Z = 2.509$, $p = 0.012$.

According to HDRS-17, the severity of depressive symptoms in the groups did not have statistically significant differences (Table 2).

The Hamilton Anxiety Rating Scale score in the studied patients showed that in the main group there were more patients with a high level of anxiety than

in the comparison group ($p < 0.05$). When analyzing the distribution of patients depending on the disease severity according to CGI-S, severe disorder

(6 points) was detected more often in the main group than in the comparison group: 35% ($n = 12$) and 13% ($n = 4$), respectively ($p < 0.005$).

Table 2

Distribution of patients from the compared groups depending on the severity of depression and anxiety, n (%)						
Scale	Main group			Comparison group		
	mild	moderate	severe	mild	moderate	severe
HDRS-17	2 (5.9)	24 (70.6)	8 (23.5)	4 (12.9)	23 (74.2)	4 (12.9)
HARS	1 (2.9)	10 (29.5)	23 (67.6)#	1 (3.2)	17 (54.9)	13 (41.9)

$p < 0.05$.

Depending on the total number of SASS points, patients of the compared groups were divided into three subgroups: with poor social adaptation (0–22 points), with difficult social adaptation (22–35 points) and with good social adaptation (35–52 points). Assessment of the social adaptation level of the studied patients in the main and comparison groups showed that a large proportion were patients with difficult and poor social adaptation (Table 3).

Table 3

Distribution of patients with different levels of social adaptation in the studied groups, n (%)		
Indicator	Main group	Comparison group
Poor social adaptation	7 (21)	3 (10)
Difficult social adaptation	23 (68)	17 (55)
Good social adaptation	4 (11)	11 (35) #

$p < 0.05$.

Also, it turned out that the main group consisted of fewer patients with good social adaptation according to the SASS ($p < 0.05$), as opposed to the comparison group. Assessment of the chronological sequence of the comorbid disorders occurrence in the main group showed that AD in most cases ($p < 0.05$) preceded the development of AA in 74% of cases ($n = 25$).

DISCUSSION

When analyzing the data, it is worth noting that in patients with AD, both with and without comorbidity with AA, anxiety and dysphoric variants of depression are revealed in more than half of the cases. According to the results of epidemiological and clinical studies, the prevalence of developed anxiety disorders in patients with AD and AA reached high values [9; 26; 27]. Patients with anxiety disorders were not included in the sample, and the existing symptoms of anxiety were an integral part of the AD

and AA clinical picture. An assessment of anxiety severity in the groups revealed a higher level of anxiety in patients with a combination of AD with AA compared to patients with AD without comorbid AA. According to the results of the study, the age of patients to the onset of AD with and without comorbidity with AA was not statistically significant. The literature contains data on a younger age of AD manifestation with their comorbidity with other mental disorders [28].

As it is known, AD and AA are often accompanied by suicidal behavior [29, 32], and their comorbidity leads to an even greater risk for suicide [33]. The data on a history of suicidal attempts have confirmed that AD comorbidity with AA increases the risk of suicidal behavior of patients. The obtained indicators confirm the literature data on the negative impact of AD and AA on the social adaptation of patients. The combination of these disorders leads to a more pronounced decrease in this indicator.

In the studied patients, AD preceded the development of AA in most cases, which is consistent with the published data [19]. At the same time, a number of authors indicate that prior to the AD manifestation, alcohol abuse, but not AA, is more common [34].

CONCLUSION

The results of the study indicate that with AD with comorbid AA compared with AD without alcohol addiction, exacerbations of affective pathology are more likely to occur. There is a higher risk of suicidal behavior, anxiety and disease severity. Moreover, patients with comorbidity of these disorders have worse indicators of social adaptation than patients with AD alone. In most cases, alcohol addiction develops on the background of AD. Thus, alcohol addiction in comorbidity with affective disorders negatively affects their clinical and dynamic indicators and the social adaptation level of patients.

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Vasilieva S.N., Lebedeva E.V. – carrying out of the research, statistical analysis and interpretation of data. Simutkin G.G. – conception and design, substantiation of the manuscript. Schastnyy E.D. – critical revision for important intellectual content. Bokhan N.A. – final approval of the manuscript for publication.

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