



## Dual Diagnosis: A Psychiatrist's Perspective

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**Q Alcohol- does alcohol cause depression or vice versa?**

**A** Yes. The answer really is yes. Both are possible pathways.

**Q Alcohol and depression are so commonly seen together that some experts say that they are the rule not the exception...is this true?**

**A** The crucial question is can we distinguish between sadness and clinical depression? Virtually every patient in detox has sadness. As therapists we want to encourage them to experience, discover and for them to learn, but not for them to be in misery.

**Q Do you always detox an alcoholic first and wait to see whether they remain depressed?**

**A** Yes, we need to complete detox to understand that the patient has a legitimate diagnosis. Our antidepressant agents cannot work if they have substance abuse or dependence and continue to use substances. They are biological illnesses.

**Q What happens if you have a depressed alcoholic outpatient? If abstinence clears the depression (removal of toxic effects of alcohol) then treating too fast with an AD might give you a false sense that it helped?**

**A** Correct, and that would commit the patient and future providers to use antidepressants which cause side effects, and up cost w/the patients noncompliance..

**Q Is AA an antidepressant?**

No. But AA is a wonderful support for recovering people who have reason to be sad because of losses.

**Q Alcohol plus depression has been called double trouble because of the sense that it is more than 1+1=2...maybe 4. Double trouble patients have more sleep problems, appetite changes, sexual dysfunction and suicidality than either alcohol or depression alone...what do you think?**

**A** That is absolutely true. However that does not at all mean double trouble patients cannot be helped. In fact, with right skills we can achieve excellent responses with double trouble patients.

**Q Are double trouble patients more sensitive to sexual or other side effects of ads?**

**A** They may be more concerned about side effects because resistance to meds or because chronic addictions make patients less patient and less willing to work through obstacles like side effects with the provider.

**Q At Betty Ford and FRC we have the time for a wash out to see what is and what is not double trouble...any advice if you do not have the time?**

**A** Yes. Look at family history, get corroborations from family members who know the patient well. Explore the patient's psychiatric condition prior to substance abuse. See if there was a stable period of substance use during which they either had no other psychiatric symptoms or had onset of psychiatric condition what we would call an intercurrent phase. Those data sources can help increase our suspicions of a dual diagnosis even before we have time for a drug free period.

**Q Alcohol + male + depression often = suicide...do you agree...any suggestions?**

**A** Yes that is a high-risk combination and we need to monitor the patient at an appropriate frequency and educate them to be wary of their own vulnerability.

**Q Does tobacco smoking treat depression?**

**A** Stimulants can have short term benefits for depression and we may use them in medically ill hospitalized depressed patients, particularly the elderly, but they are not effective for long term use. The more potent and shorter acting the more counterproductive they are with depression.

**Q What is your view of dual disorders? Are you from the Khantzian, self-medication school or another?**

**A** I only find the self-medication hypothesis applicable as a means of interpreting the patient's rationalization as to why he/she is using. The science of addiction has reached a much more sophisticated understanding of the variables for vulnerability so I prefer a multifactorial model that includes genetic, acquired cultural, as well as other psychopathological risk factors...

**Q Cocaine can cause life long panic...can you think of other dual disorders which are really drug precipitated or drug related changes in risk profile?**

**A** Seizure conditions, cognitive impairments, affective disease, thought disorder, essentially the gamut of psychological illness can be provoked directly by addictive substances at least in the short term and in many cases for prolonged periods.

David R. Gastfriend, MD is Director of the Addiction Research Program at Massachusetts General Hospital and Associate Professor of Psychiatry at Harvard Medical School. He founded the Fellowship in Addiction Psychiatry at the MGH and continues to teach and provide outpatient substance abuse clinical care at the MGH. He is one of the few physicians in the country to be certified both in Addiction Medicine by the American Society of Addiction Medicine and in Addiction Psychiatry by the American Board of Neurology and Psychiatry. Dr. Gastfriend has conducted studies of both pharmacologic and behavioral treatments of alcohol and drug use disorders. He initiated the first multi-site study to validate and refine the Patient Placement Criteria published by the American Society of Addiction Medicine, for which he has been funded for seven years by the National Institute on Drug Abuse. He was a Co-Principal Investigator on the National Institute on Drug Abuse's Cocaine Collaborative Psychotherapy Study and the National Institute on Alcohol Abuse and Alcoholism's collaborative study COMBINE. In COMBINE, he was chair of the Assessment Committee and the Publications and Analysis Committee. He chairs the Treatment Outcome Research Committee of the American Society of Addiction Medicine (ASAM), is a two-term elected Delegate-At-Large on ASAM's Board and also sits on the Board of the International Society of Addiction Medicine. He is co-editor of the leading book on treatment matching in the field, The ASAM Patient Placement Criteria for Substance-Related Disorders. In 2001 he was the recipient of a five-year Mid-Career Investigator Award for Patient-Oriented Research from NIDA and in 2002 he was nominated for the Robert Wood Johnson Foundation Award, "Innovators Combating Substance Abuse." He serves on the editorial boards of the Journal of Substance Abuse Treatment and the Journal of Addictive Diseases, and is Associate Editor of the Journal of Computers in Human Services. He is recognized for his work on implementing addiction placement criteria by provider networks, insurers, and state, federal, and international agencies.

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