When resilience fails: dual diagnosis among physicians

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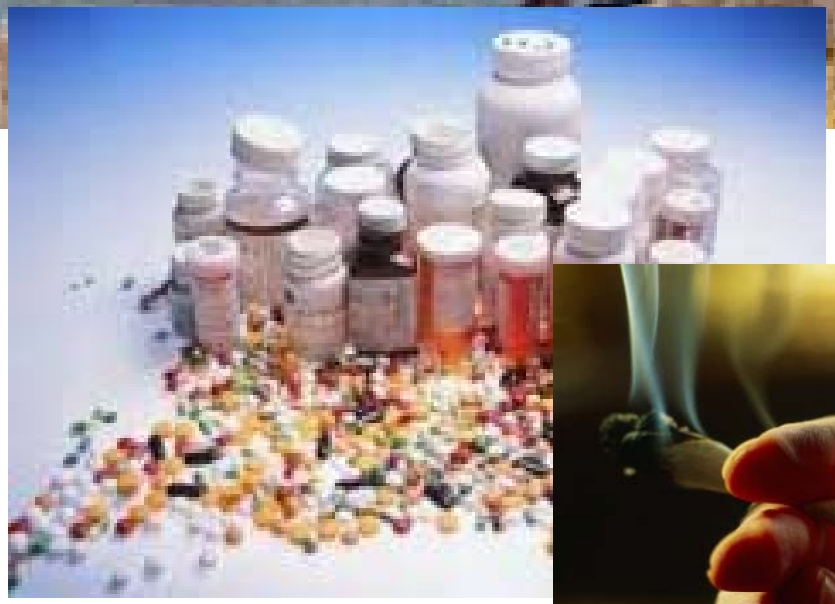
LEARNING OBJECTIVES

- Provide an overview of the prevalence of dual diagnosis among physicians

- Suggest a clinical etiological model to explain the appearance of dual diagnosis in doctors

- Give some recommendations about effective treatment strategies for doctors with dual diagnosis problems in order to increase their resilience

Prevalence of dual diagnosis among doctors




GETTY IMAGES

Dual diagnosis among doctors I. Scope of the problem.

- Substance use disorders (SUDs) + mental health disorders among doctors: serious impact on patients' safety, the lives and careers of the physicians, the health care system and the society.

- Dual diagnosis: ↑ severity and persistence of both mental health and alcohol-drug disorders, poor health and failed treatment attempts within the general population.

- Few studies on dual diagnosis among sick doctors.

(Talbott and Martin 1986; Boisaubin and Levine 2001; Dupont and Skipper 2012; Braquehais et al. 2014; Stholer and Rossler, 2005; Grant et al., 2004; Hasin et al., 2005; Kranzler and Rosenthal, 2003; Gual, 2007; Angres et al., 2003; Angres et al., 2004; Lusilla et al., 2008; McGovern et al., 2000).

Dual diagnosis among doctors II. Substance use among doctors.

- Prevalence of SUDs among doctors: at least, similar to that of the general population; an estimate 10-14% at some point during their career.
- Physicians tend to use alcohol and self-prescription of controlled medications such as benzodiazepine tranquilizers, minor opiates, and/or stimulants.
- Recent ↑ cannabis use during Medical school.
- Prevalence of nicotine dependence varies from one country to another.
- Higher risk among emergency physicians, psychiatrists and anesthesiologists.

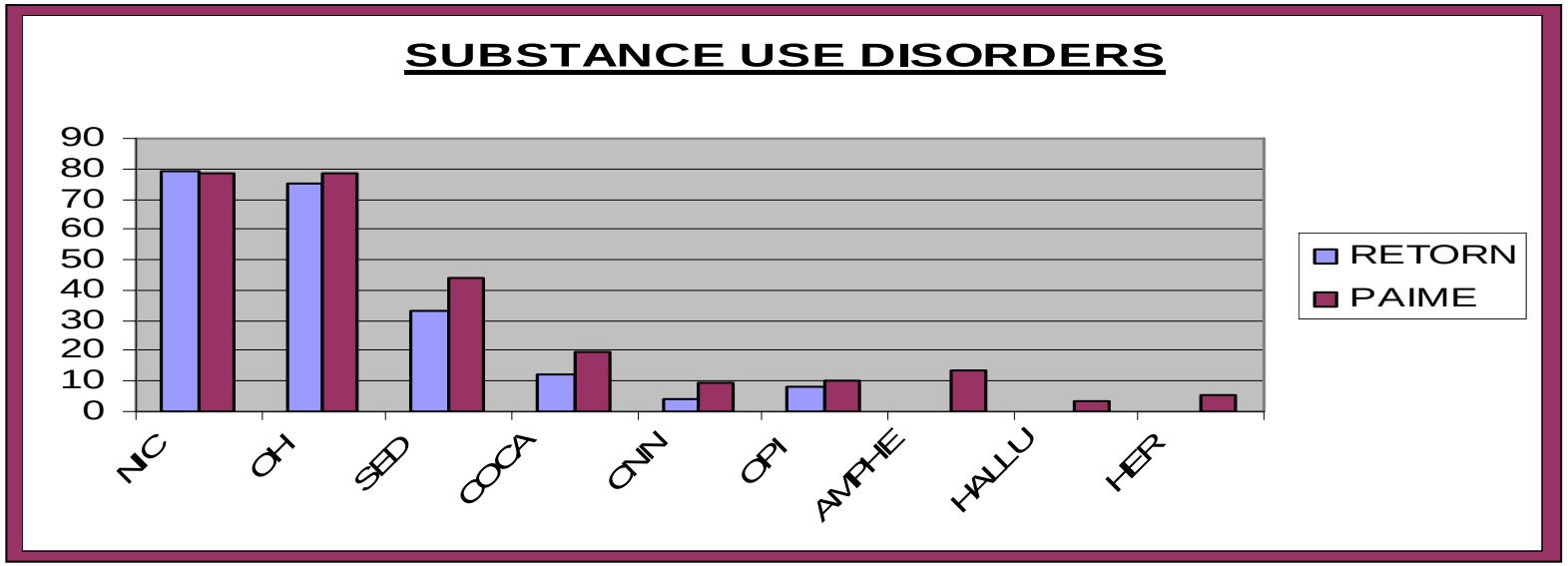
(Hughes et al., 1992; Flaherty and Richman, 1993; McGovern et al., 2000; McLellan et al., 2008; Dupont et al., 2009; Braquehais et al., 2012; 2014; Budhathoki et al. 2010, Rai et al. 2008; McBeth and Ankel 2008; Smith 2008, Pipe et al. 2009).

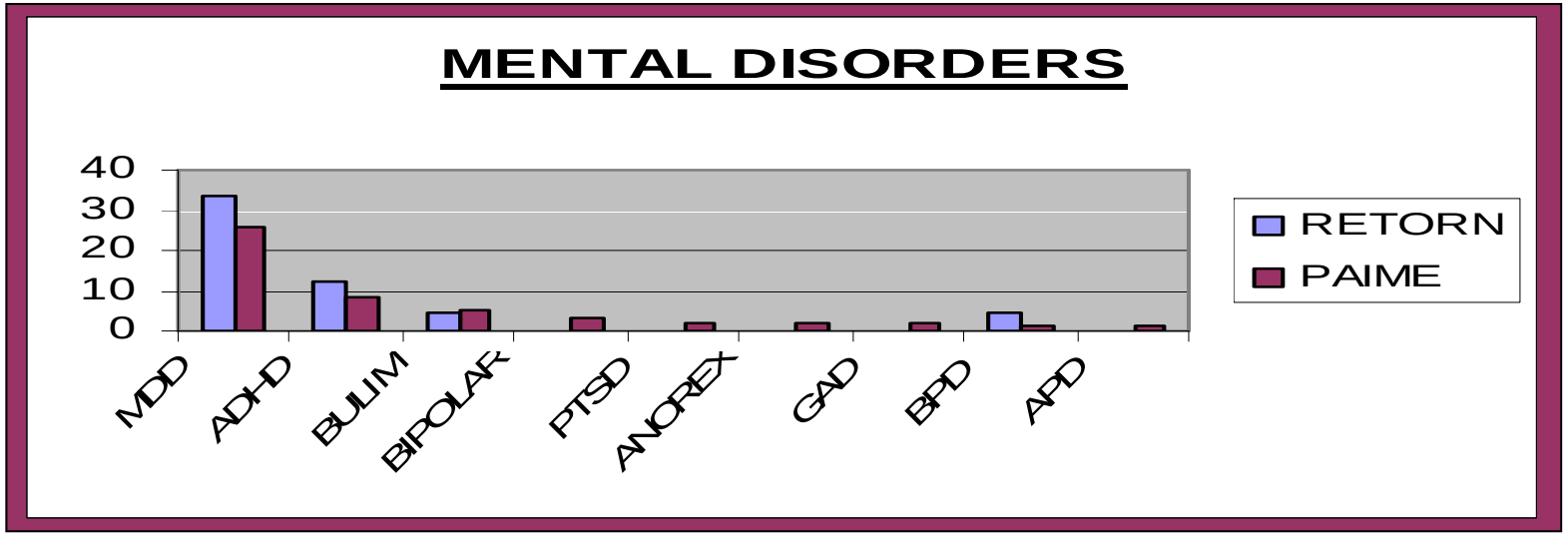
Dual diagnosis among doctors III.

- Mental disorders: Except for schizophrenia, prevalence (among doctors) = general population's. But, ↑ risk minor psychiatric disorders and ↑ risk of suicide.
- Highest comorbidity among doctors: affective disorders + alcohol use disorders.
- In samples with sick doctors under mandatory treatment, high prevalence of major depression + self-prescribed opiates/ polysubstances.
- Doctors with dual diagnosis, worse prognosis than those with separate diagnoses.

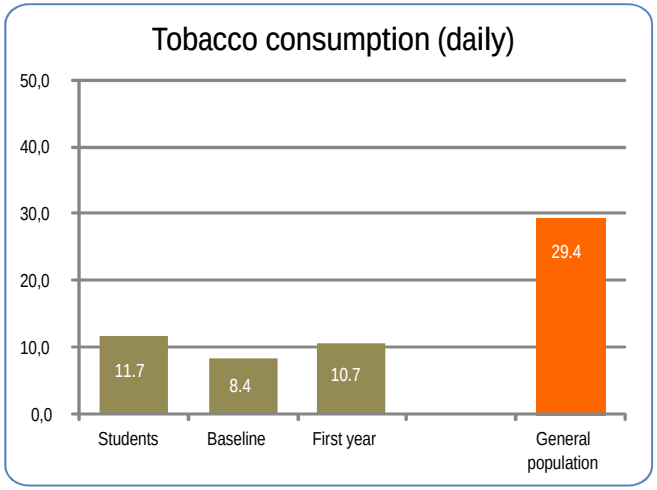
(Wall, 1997; Setnesss, 2002; Schernhammer, 2004; Angres et al., 2002; 2003; 2013; Lusilla et al., 2008; Braquehais et al., 2014; Comín et al., 2014).

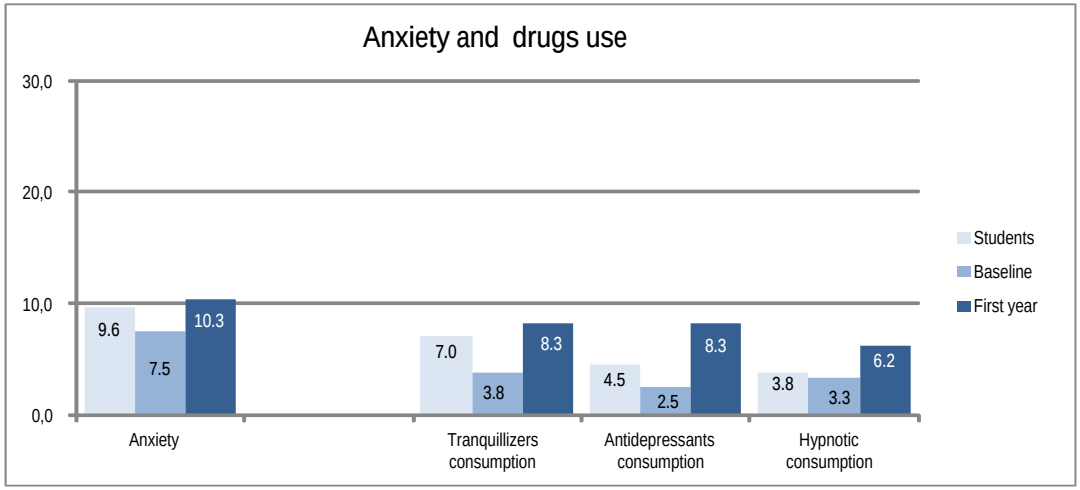
Our data I. Inpatient Unit. PRISM Interview.

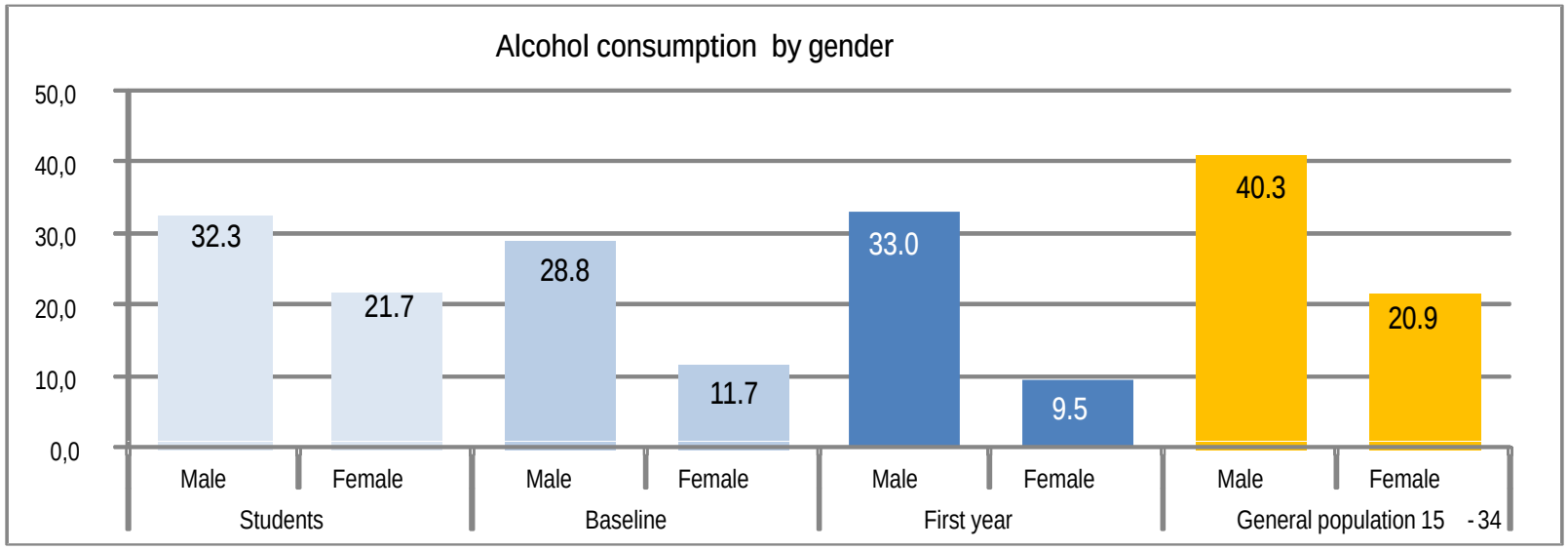




Our data II. Medical students and residents. Galatea Foundation.





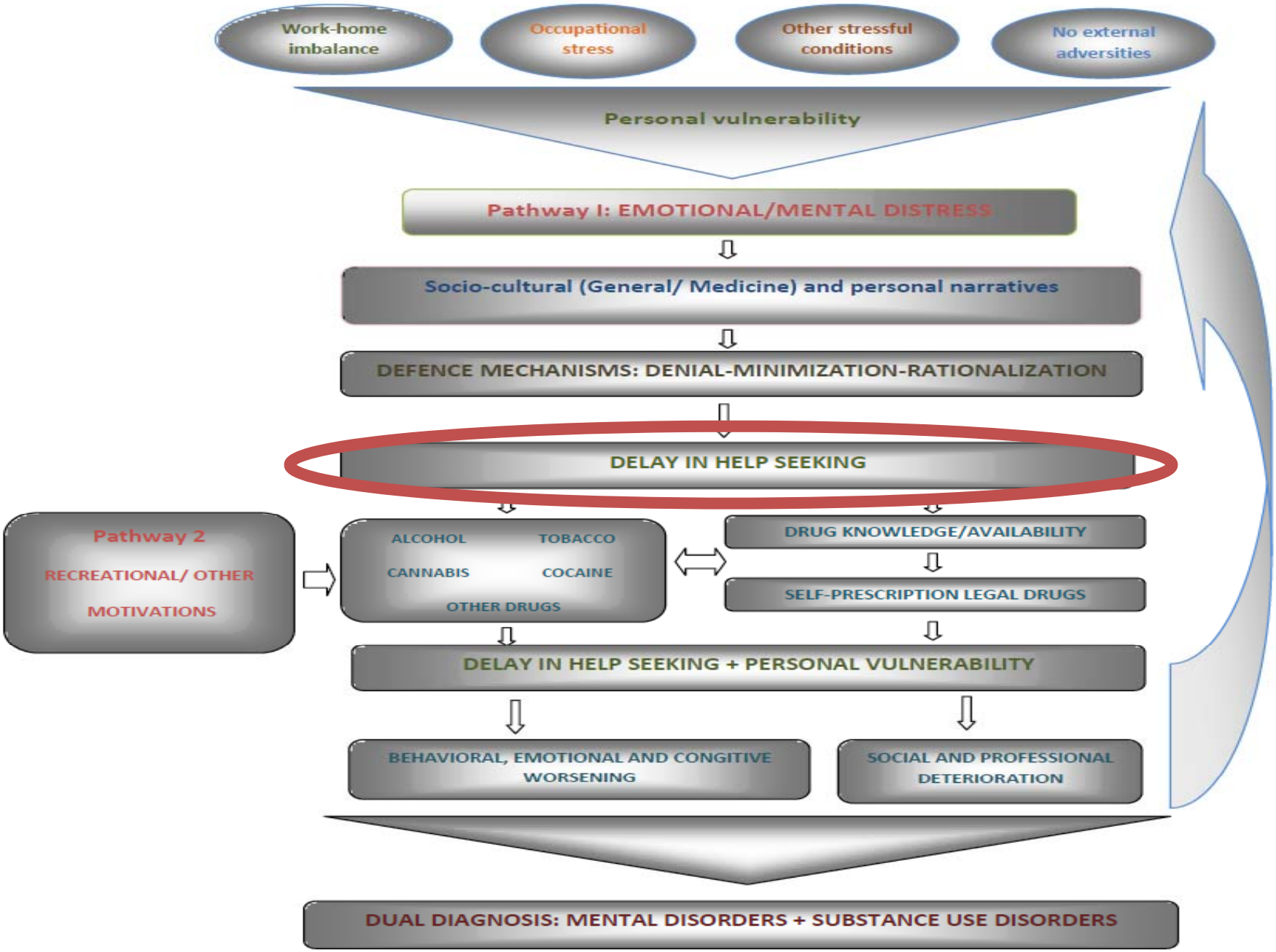


An aetiological model for dual diagnosis among doctors

Why?

Look

Listen


Work-home imbalance
Occupational stress
Other stressful conditions
No external adversities
Personal vulnerability
Pathway I: EMOTIONAL/MENTAL DISTRESS
Socio-cultural (General/ Medicine) and personal narratives
DEFENCE MECHANISMS: DENIAL-MINIMIZATION-RATIONALIZATION
DELAY IN HELP SEEKING
Pathway 2
RECREATIONAL/ OTHER MOTIVATIONS
ALCOHOL
TOBACCO
CANNABIS
COCAINE
OTHER DRUGS
DRUG KNOWLEDGE/AVAILABILITY
SELF-PRESCRIPTION LEGAL DRUGS
DELAY IN HELP SEEKING + PERSONAL VULNERABILITY
BEHAVIORAL, EMOTIONAL AND CONGITIVE WORSENING
SOCIAL AND PROFESSIONAL DETERIORATION
DUAL DIAGNOSIS: MENTAL DISORDERS + SUBSTANCE USE DISORDERS

Recommended treatment strategies

Recommended treatment strategies I

- **Primary prevention**:

1) Start at Medical School and during Residency training.
2) Support and counselling during medical career and pre-retirement.

- **Secondary and tertiary prevention**: Physicians' Health Programs (PHPs).

1) Doctors with SUDs treated at PHPs: around 80% abstinent.
2) Worse prognosis: Dual Diagnosis.

(Dupont et al., 2009; Brewster et al., 2008; Angres et al., 2013; Lusilla et al., 2008; Braquehais et al., 2014)

Recommended treatment strategies II

TABLE 1

Treatment Principles for Doctors With Substance Use Disorder and Dual Diagnosis

1. Immediate response and highly confidential treatment
2. Specialized treatment setting
3. Dual pathology and substance use disorder conceptualized as complex mental disorders with biopsychosocial underpinnings
4. Specifically trained staff
5. Peer-group therapy
6. Uninterrupted and long follow-up program
7. Frequent random drug testing
8. Family involvement
9. Appropriate reentry into practice when maintained abstinence
10. Advocacy and relapse contingency plan

(Braquehais et al., 2014).

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Dual Diagnosis Among Physicians: A Clinical Perspective

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Co-occurrence of mental disorders and substance use disorders (dual diagnosis) among doctors is a cause of serious concern due to its negative personal, professional, and social consequences. This work provides an overview of the prevalence of dual diagnosis among physicians, suggests a clinical etiological model to explain the development of dual diagnosis in doctors, and recommends some treatment strategies specifically for doctors. The most common presentation of dual diagnosis among doctors is the combination of alcohol use disorders and affective disorders. There are also high rates of self-medication with benzodiazepines, legal opiates, and amphetamines compared to the general population, and cannabis use disorders are increasing, mainly in young doctors. The prevalence of nicotine dependence varies from one country to another depending on the nature of public health policies. Emergency medicine physicians, psychiatrists, and anaesthesiologists are at higher risk for developing a substance use disorder compared with other doctors, perhaps because of their knowledge of and access to certain legal drugs. Two main pathways may lead doctors toward dual diagnosis: (a) the use of substances (often alcohol or self-prescribed drugs) as an unhealthy strategy to cope with their emotional or mental distress and (b) the use of substances for recreational or other purposes. In both cases, doctors tend to delay seeking help once a problem has been established, often for many years. Denial, minimization, and rationalization are common defense mechanisms, maybe because of the social stigma associated with mental or substance use disorders, the risk of losing employment/medical license, and a professional culture of perfectionism and denial of emotional needs or failures. Personal vulnerability interacts with these factors to increase the risk of a dual diagnosis developing in some individuals. When doctors with substance use disorders accept treatment in programs specifically designed for them (Physicians' Health Programs), they show better outcomes than the general population. However, physicians with dual diagnosis have more psychological distress and worse clinical prognosis than those with substance use disorders only. Future studies should contribute to a better comprehension of the risk and protective factors and the evidence-based treatment strategies for doctors with dual diagnosis. (*Journal of Dual Diagnosis*, 10:148–155, 2014)

Keywords *dual diagnosis, physicians, self-medication, substance use disorders*

Substance use disorders and mental disorders among doctors are causes of serious concern due to the potential impact on patients' safety, the lives and careers of the impaired physicians, and the socioeconomic burden to the health care system as a whole (Talbott & Martin, 1986; Boisaubin & Levine, 2001; DuPont & Skipper, 2012; Braquehais et al., 2012). In the last decades, the term dual diagnosis has been used when a mental disorder and a substance use disorder occur together in the same individual. Other terms have also been used to reference this psychopathological phenomenon, such as "co-morbidity," "co-occurrence," "double diagnosis," and "dual pathology" (Glas, 1970, Stone, 1973, Tsuang et al., 1982; Khantzian, 1985; Meyer, 1986; Casas, 1986, 1992; Regier, 1990; Raskin & Miller, 1993; Hasin et al., 1996; Kesler, 1997). In general, dual diagnosis is associated with severity and persistence of both disorders, poor health, and failed treatment attempts (Stholer & Rössler, 2005). Despite extensive studies on dual diagnosis within other populations (Grant et al., 2004; Hasin, Goodwin, Stinson, & Grant, 2005; Kranzler & Rosenthal, 2003; Gual, 2007), very little is known about this phenomenon among physicians (Angres, McGovern, Shaw, & Rawal, 2003; Angres, Delisi, Alam, & Williams, 2004; McGovern, Angres, & Leon, 2000; Lusilla et al., 2008).

Physicians are usually reluctant to ask for help when they suffer from mental-emotional distress or when they have developed an addictive disorder. (Lusilla, Braquehais, & Bel, 2011). However, when doctors with substance use disorders come to accept treatment at programs specifically designed for them (e.g., Physicians' Health Programs), they show better outcomes and recovery rates compared to the general population (Herrington, 1982; Carinci & Christo, 2009; DuPont, McLellan, Carr, Gendel, & Skipper, 2009). Factors associated with better clinical outcomes include close monitoring, peer support group therapy, long-term follow-up, highly

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