

## The Agenda Coimbra Meeting

Final summary

Chair Dr. Néstor Szerman

**1.- THE DEFINITION OF DUAL DISORDERS/PATHOLOGY:** A range of terms are used to articulate or 'name' the co-existence of classical mental illnesses and substance use disorders. Addictive disorders are also psychiatric disorders and we should not maintain this differentiation. To address this terminological conundrum, this WPA Section has chosen to use the term Dual Disorders/Pathology. **Addictive behaviors associated with other psychiatric disorders** -psychobiological traits or states- , that we name "dual pathology", are probably *developmental disorders*. These are disorders that begin very early in development, possibly through the interaction of neurobiological and environmental factors, and may present with **different phenotypes**, such as addiction-related or other psychiatric symptoms, **at different stages of the lifespan**.

### Comments:

Dr. Célia Franco (Coimbra, Portugal)

- I think the most important thing to do is to uniform the terminology of these problems, between the members of the committee. It is important that we would be able to choose the term and to define the clinic syndrome. That will make possible to compare different studies and to use same Key words for all investigators.
- I agree that "Dual Pathology" is better than "Dual Disorders" to define the complex syndrome that associates Addictive Behaviors and Psychiatric Pathology, and to concept them as a biologic unit with different phenotypes.

Dr. Rajendra Kumar (UK)

- Most commonly used term in UK is Psychiatric Co-morbidity or Dual Diagnosis. I agree that these disorders are biopsychosocial in origin as are other psychiatric disorders.

Dr. Braquehais, Barcelona (Spain)

- I support the idea of dual pathology (DP) but I am less concerned about these conceptual arguments that, in fact, are linked to a certain comprehension of the brain-mind complexity (see answer to question 2). My interest on DP relies on the daily work with health caregivers with mental disorders who usually develop DP due to their easy access to some drugs (e.g.: sedatives, opiates, etc) and their resistance to ask for help when they suffer from mental disorders.

Dr. Rudinski, (Israel)

- For my mind, this definition reflects the problem rather comprehensive.

Dr. Mehdi Paes (Morocco)

- The terms related with this pathology are ambiguous and equivocal. It is important to get a consensus and to retain a term conventionally, may be Dual Disorders or Dual Pathology.

Dr. Arturo G. Lerner (Israel)

- I suggest to use the terminology found in the American Professional literature, eg, Co-Occurring Disorders. It should not be confounded with co-morbid disorders which mean one mental disorder and one physical disease. This nomenclature allows to include in the clinical diagnosis and treatment plan, more than two disorders (additionally implying personality disorders too) as is intrinsically and slightly equivocally suggested in Dual Disorders or Dual Pathology.

Dr. Carlos Roncero (Spain)

- I support the use of dual pathology better than dual diagnosis

Dr. Elvia Velásquez (Colombia)

- The term Dual Pathology, had been used and accepted by some sector but the English speaking professionals prefer the term comorbidity. Both terms are more or less generics in the sense that they designs the coexistence of two or more diagnostics in one person, and not only addiction and psychiatric disorders. For that reason the term Dual Pathology should be used thus “Dual Pathology, addictive and a psychiatric disorder”  
The proposed before definition including in the Flyer, at the beginning is okay. But, we have to work for a more precise definition in relation to severity and duration of symptoms, etc Also in the definition it should be add “with symptoms mainly mental and behavioral” which could be concurrent or sequential.

### Criteria of Disease for ICD-11

The definition of the disease “Dual Pathology” could consider the criteria that User Guide for Content Model for the ICD-11 of WHO (2011) recommends:

1. “” Disease: A disease is a set of dysfunction(s) in any of the body systems defined by:

1. Symptomatology: manifestations: known pattern of signs, symptoms and related findings
2. Aetiology: an underlying explanatory mechanism
3. Course and outcome: a distinct pattern of development over time
4. Treatment response: a known pattern of response to interventions
5. Linkage to genetic factors: e.g., genotypes, patterns of gene expression
6. Linkage to interacting environmental factors.

### 2. Disorder/Syndrome

A Disorder (Syndrome is used synonymously) refers to common patterns seen in clinical practice which represent similar manifestations such as a typical constellation of symptoms.

Disorder or Syndrome is similar to the disease definition; the main difference is that a disorder/syndrome may be a final common pathway of multiple aetiologies or its aetiology is not known to be identified as a particular disease.

“”

#### Dr L. Peris (Switzerland)

. Bearing in mind the interesting hypothesis that addictive behaviors associated with other psychiatric disorders are probably developmental disorders, the term dual disorders/pathology should better guide in my opinion the research and understanding of the co-existence of those called 'mental illnesses' and substance use disorders.

#### Prof. Roger Weiss (USA)

- I do prefer the term ‘co-occurring’ disorders because it doesn’t restrict the number of disorders. Many such patients have more than one substance use disorder and more than one other psychiatric disorder, in addition to Axis II and Axis III disorders. It is a broad term that has gained popularity in the U.S., for good reason I think.



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Dr. Nady el-Guebaly (Alberta, Canada)

- We speak different languages and we should be careful about literal translations into English. In Canada, we have adopted the terms “Comorbidity or Concurrent Disorders”; I doubt if I or the Section will be able to change that. As to whether they are “Developmental disorders”, it is an interesting hypothesis worthy of more research.

Prof. Gabrielle Fischer (Austria)

- I am rather in favor of co-occurring disorders : why - dual pathology might lead to further stigmatization in an already highly stigmatized disorder "addiction".

## 2.- WILL DUAL PATHOLOGY LEAD TO A NEW ADDICTION PARADIGM?

According to the article entitled *individual vulnerability to addiction* written by Swendsen & Le Moal published in 2011, we are moving from the **old paradigm** based on drug-induced neuroplasticity and on acquired vulnerability, largely dominant in laboratory research, **to a new paradigm individual-centered approach** that places individual variation as the focus of interest: The strong association of addiction with certain personality traits or comorbid mental disorders. The **old model of addiction** assumes that drugs of abuse “hijack” brain’s reward system, disrupting the normal behavioral responses to natural rewards. (Welberg, 2011). In the **new perspective** or paradigm, we must always try to diagnose dual pathology in patients requiring care for addictive behaviors and vice versa. One of the barriers to this goal is the lack of sensitivity and reliability of the current diagnostic criteria of mental disorders.

### Comments:

Dr. Célia Franco (Coimbra, Portugal)

- I agree that we are facing a new paradigm of understanding the abuse and dependence of addictive substances. The relapse isn’t because the **patient doesn’t want to become well**, but **because he is not able to get better**. That changes the perspective of the treatment of these patients. Motivation is important, has it is in any other psychiatric pathology, but is not enough to treat the addictive problems. They need the intervention of psychiatric care, with well-trained teams, that use all the pharmacology resources, to give the patient well-being and continuous treatment, as in schizophrenia or other severe psychiatric pathologies.

Dr. Rajendra Kumar UK

- I agree with this new paradigm with individual-centered approach that has been at the heart of other psychiatric disorders. Of course we need to assess and diagnose dual pathology in patients requiring care for addictive behaviours and vice versa and make

sure that they are understood as patients with complex needs requiring specialist assessment and treatment.

[Dr. Braquehais, Barcelona \(Spain\)](#)

- I support this new, individual-centered paradigm. However, I believe that if we do not change our conceptual framework of the brain-mind relationship and its development through the lifespan, it will be difficult to achieve an adequate comprehension of the phenomenon we are dealing with when we talk about “dual pathology”.

[Dr. Rudinski, Israel](#)

- For my clinical experience, the matter of personality traits or comorbid mental disorders is crucial for addictive spectrum behaviors care. Understanding of the relationship between two things is basic for adequate treatment of dual pathology/

[Dr. Mehdi Paes \(Morocco\)](#)

- I agree with this new approach

[Dr. Arturo G. Lerner \(Israel\)](#)

- I am in favor of the new paradigm. In clinical practice we almost always diagnose a Substance Use Disorder (meaning Abuse or Dependence - Addiction) which is accompanied by a Major or Minor Mental Disorder including Axis II Personality Disorders.

[Dr. Carlos Roncero \(Spain\)](#)

- I propose that diagnostic criteria should be re-evaluated.

[Dr. Elvia Velásquez \(Colombia\).](#)

Maybe the new paradigm of the individual vulnerability to addiction is not so new. We learnt in medical school that “There are no diseases but sick’s” and the same theory, we apply in the study of the patients. Maybe the new in this theory, is the advance in the discovery of different kinds of vulnerabilities in each person, and to put more emphasis on the individual vulnerability than drug effects, or environmental influences Although it is good remember that some drugs independent of characteristics of the sick, can produce. “Hijack” brain’s reward system like solvents and others.

[Dr L. Peris \(Switzerland\)](#)

- Individual-centered approach should always be the way to asses and diagnose dual disorder



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Dr. Nady el-Guebaly (Alberta, Canada)

- I join the Group in support of the need to individualize our care; in fact I thought we always did under the Biopsychosocial umbrella. I'm all for refining further the diagnostic criteria and perhaps we should consider for Barcelona a session to critique constructively the new DSM-5 (when it's published) and perhaps the recent developments of ICD-11.

### 3- WHERE SHOULD PATIENTS BE TREATED: IN ADDICTION CENTERS OR MENTAL HEALTH NETWORKS?

The anomaly of having **separate treatments** for a **single patient with "two disorders"** is not supported by scientific knowledge. As currently configured and resourced these patients cannot be adequately and efficiently managed by cross-referral between psychiatric and addiction services (Weaver et al, 2003). A new approach is needed to enable clinicians, researchers and managers to offer adequate assessment and evidence-based treatments to patients with dual pathology.

#### Comments:

Dr. Célia Franco (Coimbra, Portugal)

- I think these patients must be treated in psychiatric services, in differentiated units, by multidisciplinary teams, with psychiatrists doctors, psychologists, nurses, social workers and occupational workers. The resources to use must be pharmacologic, psychological and rehabilitations work.
- However, it is important that first care doctors understand these problems, diagnose them early, and oriented adequately. There is very important to have the responsibilities of different levels of care well defined, and where to send the patients.

Dr. Rajendra Kumar UK

- I agree that this group of patients have specific needs that could only be met by appropriately trained staff in integrated dual disorder centre/units. We have seen huge changes in delivery of addictions services in UK that are being provided increasingly by voluntary sector organizations with little access to psychiatrists and other mental health trained professionals. This group of patients with complex needs could fall between the addiction and psychiatric services with no organization taking the responsibility of care for these patients unless patients with dual disorders are seen to be in need for specialist dual disorder services.



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[Dr. Braquehais, Barcelona \(Spain\)](#)

- I think that all psychiatrists should be acquainted with the correct management of dual pathology problems as they can be both present at Mental Disorders Units and/or Addiction Treatment Settings. Education on dual pathology should be fostered among psychiatrists from their residency training and during their professional practice.

[Dr. Rudinski, Israel](#)

- Undoubtedly, the dual pathology patient must be managed by "addiction" and "mental" directions simultaneously in different kinds of Integrated Services.

[Dr. Mehdi Paes](#)

- The important thing is that the professionals who welcome this kind of pathology should be very well trained both in psychiatry and in addictology.

[Dr. Arturo G. Lerner \(Israel\)](#)

- Patients suffering from Co-Occurring / Dual Disorders should be diagnosed, treated and rehabilitated in Integrated Services which may provide a professional and adequate answer to these intertwined disorders.
- Integrated Services should be function at Outpatient Clinics, Day Therapy Services, and Psychiatric wards, Detox Centers, Substitution Centers (methadone and buprenorphine) and Modified Therapeutic Communities.
- Every "Addiction Center" must have a Psychiatric Staff and every Mental Health Service must have an "Addiction Treating Staff".

[Dr. Carlos Roncero \(Spain\)](#)

- Dual Diagnosis patients should be take care by a multidisciplinary team, no by two teams. All the staff need to receive training in the addiction and general psychiatric fields. Local realities can modulate where this team should be based on.

[Dr. Elvia Velásquez \(Colombia\)](#)

Patients who suffer Dual Pathology should be treated in services where they have, all that they need: trained professionals and different and continuous services. However patients are going to look for the program that better fit with his main problems; patients with more severe drugs problems will look for drug services and patient with more severe mental symptoms, will look for psychiatrist services.

[Dr L. Peris \(Switzerland\)](#)

- These patients should ideally be treated by an specialized multidisciplinary team on mental health networks.

[Dr. Nady el-Guebaly \(Alberta, Canada\)](#)

- In Canada, we agree that all institutions have a role to play based on the relative prominence of the presenting clinical practice. We have an understanding that the “quadrant” model from least to most prominent symptomatology in both conditions is probably the most practical.

[Prof. Gabrielle Fischer \(Austria\)](#)

- Regarding treatment facilities I support to have patients with substance dependence integrated into mental health units, based on the need to diagnose and treat the co-occurring disorders adequately. In addition it is Nr 5 in an evaluation of Wittchen et al. (2012) of mental disorders and Nr 2 (Rehm et al, 2012) regarding costs. Specialized units should probably focus on that and cooperate with GP`s who need to be involved in treatment to cover the quantity of involved patients. We also need to emphasize that treatment retention is in general a major problem in chronic illnesses - the treatment of co-occurring disorders will enhance compliance and therefore reduce the high indirect costs for the society. Another aspect we need to focus is gender sensitivity, which differs quite a lot in co-occurring disorders between women and men.

**4- FUTURE EDUCATIONAL ACTIVITIES THAT WE CAN PROPOSE FOR THIS YEAR: FORUM ON WPA INTERSECTIONAL COLLABORATION:**

- 1- WPA **Bucharest** Regional meeting (10-13 April 2013)
- 2- WPA's International Conference at **Istanbul** (18-23 June 2013)
- 3- WPA International Conference in **Vienna** (27-30 October 2013)
- III International Congress on dual Disorders/Pathology in **Barcelona** (23-26 October 2013) (with the co-sponsorship of the WPA and the NIDA)

**Comments:**

[Dr. Célia Franco \(Coimbra, Portugal\)](#)



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- I think committee should profit these events to do meetings to discuss the important themes and to define the principal guidelines of diagnostic and treatment of these patients.

[Dr. Rajendra Kumar UK](#)

- See you all in Barcelona.

[Dr. Braquehais, Barcelona \(Spain\)](#)

- I look forward to meeting all members of this WPA section in Barcelona. In fact, we invite you to the parallel symposia on dual pathology (DP) in health caregivers that will take place during that Congress. I think that we should devote more efforts to promote help seeking among health professionals with mental disorders as they are more vulnerable to developing DP due to their easy access to self-treatment with legal drugs.

[Dr. Rudinski, Israel](#)

- I would like to attend.

[Dr. Mehdi Paes](#)

- I expect to attend to the Barcelona Congress.

[Dr. Arturo G. Lerner \(Israel\)](#)

I will attend III International Congress on dual Disorders/Pathology in Barcelona (23-26 October 2013) (with the co-sponsorship of the WPA and the NIDA). If there is a possibility of Video Conference the Israel Forum will try to participate in all the planned events.

[Dr. Carlos Roncero \(Spain\)](#)

- III International Congress on Dual Disorders/Pathology in Barcelona (23-26 October 2013) (with the co-sponsorship of the WPA and the NIDA)
- As President of the local organizing Committee I can offer a room for the meeting in the hotel. We look forward to see all of you in Barcelona!!

[Dr. Elvia Velásquez \(Colombia\)](#)

I will be in Barcelona in October 2013. But I also would like to be in Vienna



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[Dr L. Peris \(Switzerland\)](#)

- A parallel symposium/workshop (or another kind of activity) at the III International Congress in Barcelona seems a good opportunity to begin with and to project future activities, as most of us are intended to assist to it.

[Dr. Leo Sher \(USA\)](#)

- This is an interesting and important summary. If you wish, I can publish this document on the website, [www.internetandpsychiatry.com](http://www.internetandpsychiatry.com)

[Dr. Nady el-Guebaly \(Alberta, Canada\)](#)

- North Americans have financial difficulty in crossing the Atlantic too often. Hopefully, we will be in Barcelona.

[Prof. Gabrielle Fischer \(Austria\)](#)

- Regarding the proposed meetings I am happy to be involved.