Psychiatric Co occurring Disorders: Case Based Discussion

Ashwin A Patkar, MD, DFASAM

Adjunct Professor of Psychiatry, Rush University and Chief Avance Psychiatry

Steven Szabo, MD, PhD

Psychiatrist, Durham VA Hospital and Medical Director, Sunovion

Financial Disclosure Statement: Ashwin A. Patkar, MD

- **Grants/Research:** National Institute of Drug Abuse, National Institute on Mental Health, Atai Biosciences
- **Consultant/Advisory Board** Otsuka, Radeas
- **Shareholder:** Generys Biopharma

Financial Disclosures Statement: Steven Szabo, MD, PhD

Shareholder: Continuous Precision Medicine

Disclaimer: The views and opinions expressed herein do reflect those of the United States Government, and shall not be used for advertising or product endorsement purposes.

DISCLAIMER

All cases discussed in the following presentation are fictitious for learning purposes only**. All case identifiers have been changed for HIPPA purposes**

Learning Objectives

1. Recognize psychiatric comorbidity with substance abuse disorders.

2. Define the role of pharmacologic treatments for these disorders in the setting of co-occurring substance abuse disorders.

3. Outline treatment approaches for these disorders that minimize the potential for prescribed medication abuse.

Adjusted Odds of comorbidity of psychiatric disorders with 12-month Drug Addiction

Disorder	OR
Alcohol Dependence	15.0x
Mood Disorder	8.5x
Anxiety Disorders	6.0x
ADHD	6.2x
Personality Disorders	9.6x

Compton et al NESARC study Arch Gen Psychiatry 2007, McGough et al, Am J Psychiatry 2005

Bidirectional Nature of Comorbidity

- Psychiatric Disorders **strongly predict** development of substance use.
- Substance abuse **predicts** development of mood, anxiety and psychotic disorders
- Adverse impact on course and outcome, in particular suicide.

O'Brien et al, 2004, Kandel et al, 2002; Merikangas et al, 1998.

Communications matter

EDITORIAL

ADRIENNE BOISSY, MD, MA
Chief Experience Officer, Department of Patient Experience; Staff Neurologist, Mellen Center for Multiple Sclerosis, Neurological Institute, Cleveland Clinic

Labels matter: Challenging conversations or challenging people?

ANYONE WHO HAS tried to appreciate the challenges we face in medicine has probably read the 1978 article by Groves, "Taking care of the hateful patient."[1] This and a later article by Strous et al[2] label and group

The article begins to shift us from labeling patients as "dependent clingers" and "entitled demanders" to a much needed and more meaningful discussion about difficult patient behaviors and how we might more effectively

Boissey A Cl Clinic J M 2017 84:7

Diagnostic Classification

- Clinical history and examination supported by corroboration.
- SUD: Include primary & secondary diagnoses.
- Psychiatric Disorders: Attempt diagnosis in the absence of acute intoxication and withdrawal.

Agitation & Acting-Out behaviors

- Highly Correlated with alcohol and drug use & age.
- Occur at home, in community setting and range from verbal outbursts to suicidal behavior.
- Also associated with mental retardation, brain injuries and negatively correlated with depression.
- Associated with suicide attempts, suicide, self harm and violence.

McCarrick et al, Psychiatric Services 1985

Differential Diagnosis for Acting-Out behaviors

- Alcohol and/or Drug Intoxication or Withdrawal
- Personality Disorders (Antisocial and Borderline)
- Bipolar Disorder
- Panic Disorder

First treatment priority is SAFETY and potential for harm should always be assessed.

McCarrick et al, Psychiatric Services 1985

CASE 1

CANNBIS USE DISORDER WITH CO-OCCURING PSYCHOSIS DISORDER

- PT is a 22 year male student brought by parents after finding out that his grades declined in school and was put on academic probation
- Upon further inquiry, PT discloses that he has been smoking 3 to 6 “joints” or using his “vaper” loaded with THC cartridges 4-5 times/week since Freshman year
- He began using cannabis in high school, initially only taking “a couple hits” with friends. Over time, he has used more cannabis as it seemed to “take the edge off”.
- He has strong cravings to use daily. He admitted to isolating himself from hi friends and not trusting his room mates. He admitted to using internet to meet girls indiscriminately and has been spending tuition funds on gambling.

- Over the past year he ended up smoking more than he had intended, is often not present in the moment, and loses track of the time.
- He also reports that when trying to cut down on his marijuana use he feels anxious, particularly in social situations, something he recalls being a problem as early as when he was in primary school.
- He has had no previous contact with mental health professionals though a school counsellor suggested a psychiatric referral during high school for depressive and anxiety symptoms. He remains highly anxious when in groups and tends to avoid these situations.
- He said he has cut down marijuana to 3 /week after forced to return home from school. Over past 2 months, he still does not trust his room mates, and spends most of his time on line because he is convinced about after life and out of body experiences. He is considering leaving school and moving west " start a business". Parents report patient continues to spend money impulsively and remains paranoid.

What is your diagnostic assessment of PT

A. Symptoms are not out of the ordinary. No psychiatric or Substance Use Disorder is appropriate.

B. PT is suffering from Cannabis Use Disorder and cannabis withdrawal.

C. PT has Cannabis Induced Psychotic Diorder and co-occurring Cannabis Disorder – Severe

D. PT has Cannabis Use Disorder with Cannabis Intoxication.

What of following statements is FALSE for Association between cannabis Use and Psychosis

A. Vast majority of cannabis users will not received diagnosis of psychotic disorder.

B. Heavy and early use of cannabis are more likely in individuals who have vulnerability for psychotic disorders

C. Longitudinal studies have shown that cannabis related psychosis is not associated with subsequent risk for psychosis

D. Alcohol and stimulant induced psychosis is more common than cannabis induced psychosis

What advice for treatment will you provide to PT?

A. Advise that he cut back on his use of cannabis and offer reassurance that his difficulties are likely to resolve if he is able to reduce his cannabis use.

B. Recommend complete abstinence from use of cannabis with further evaluation and treatment of Psychotic Disorder in an inpatient setting

C. Recommend motivation interviewing and self help groups

D. Provide a prescription for Paxil to address Social Anxiety and depression and reassure PT will likely naturally reduce his use of cannabis as it is likely being used as "self-medication"

- Following your discussion about the effects that Cannabis Use has had on his life PT decides his use is causing significant problems in his life. He requests your assistance as he attempts to stop using completely. You schedule a follow-up appointment for 2 weeks. PT misses his appointment
- One week later PT phones your office complaining of an increase in anxiety and irritability, difficulty falling asleep and mood swings. He also has a persistent headache and his hands are shaky. Parents report agitated behavior.
- His message suggests that if he cannot get some relief he will probably go back to smoking weed in order for him to function and reduce conflict at home. He says weed is making him relaxed and less paranoid

What is most likely to be going on here?

A. Reemergence of anxiety relating to possible underlying anxiety disorder.

B. PT is demonstrating signs of Cannabis Withdrawal

C. PT is showing possible symptoms of mania

D. Symptoms are inconsistent with cessation of cannabis use and could be related to another substance use

What would you advise for PT?

A. Recommend an SSRI to treat anxiety disorder.

B. Explain to PT that he is having recognized symptoms associated with cessation of long-term use of cannabis and that the most acute symptoms are likely to resolve in a week or 10 days. Offer a short course of benzodiazepine to reduce distress.

C. Tell HR to be patient and refer for substance abuse counselor to reduce risk of relapse.

D. Explain to patient and family that hospitalization is necessary to arrive at an accurate diagnosis and there is a high possibility of comorbid mood, psychotic or anxiety disorder

At his follow-up appointment, his father comes along. PT reports that father has been more supportive as he now understands about the challenges of recovery from addictive disorders.

He notes his anxiety is in better control, he has returned to work. Your drug screen, however, continues to show positive for THC.

What is your next step in managing PT's morbidities?

A. Confront PT about his obvious continued use of Cannabis

B. Continue SSRI, obtain consent and educate spouse about your plan of treatment and prognosis for improvement with current approach.

C. Discharge patient from your care as there is no evidence for pharmacologic treatment of Cannabis Use Disorder

D. Order quantitative THC levels to verify absence of Cannabis Use.

. PT refuses inpatient admission but agrees for outpatient treatment. During his next follow-up PT acknowledges continued use of cannabis and and asserts his belief that use of marijuana serves as a treatment for his depressive illness. For the first time he reveals a history of mental disorder in his father who was diagnosed with bipolar disorder.

He further reports that he has had periods of depression in high school have lasted for 6 to 8 weeks during which he has little motivation and sleeps for long hours.

It is during these periods that he finds it most difficult to study or participate in his hobbies.

Which of the following information would be helpful in making a diagnosis more specific for HR?

A. History of distinct periods of abnormally and persistent elevated, expansive and irritable mood activity, decreased need for sleep and increase in goal directed activity.

B. Family history of generalized anxiety disorder

C. Presence of forced thoughts that cannot be avoided or suppressed

D. Persistent use of cannabis despite adverse consequences to his marriage and work.

You inquire about the presence of past episodes of mania or hypomania.

PT responds by referring to a prior period in his life when he has had a lot of energy, requiring less than three hours sleep and lasting a few weeks. More recently in school, he planned to start an on line business and had spent $2000 in legal fees to register a company for international trading

What next steps in PTs care might you advise next.

1. Again reinforce the need to address his daily cannabis use.

2. Inform PT that there is a high likelihood that he is suffering with a bipolar disorder that requires additional pharmacologic treatment

3. Refer for psychodynamic-based psychotherapy

4. Avoid stressful situations

P

You suggest the PTs symptoms are likely due to bipolar disorder and may need additional pharmacotherapy beyond addressing his Cannabis use.

PT reluctantly agrees. Of the following which agent would be the most likely to be effective targeting bipolar depression?

1. Begin Venlafaxine at 75 mg daily for two weeks

2. Involuntarily hospitalize PT

3. Continue with your current approach and reassure PG that depressive symptoms are likely to remit with time.

4. Begin mood stabilizer such as Lurasidone at 20 mg daily.

- You offer to prescribe lurasidone and explain possible side reactions include sedation early in the treatment and possible feelings of motor restlessness that are unusual but might rarely occur. You provide further education relating to bipolar disorder and the goals of treatment. You advise him to take the medication with meals. You schedule a follow-up visit in 2 weeks and advise him to notify you about any concerns.

- Upon return PT reports that he has filled prescription and has taken it as advised. He acknowledges that he is feeling less down and is more functioning better at work. He has not had any side effects but notes some lingering depression.

- He has continue to use Cannabis daily, however, and feels that this is necessary in order to treat any residual anxiety and depression. He seeks your support to continue to use as it is clear to him that many states have approve it as effective medication

Which of the following statements about the daily use of cannabis that are supported by current evidence?

1. Cannabis has demonstrated benefit in treatment of anxiety, PTSD and bipolar depression.

2. Cannabis products are safe and do not have addictive potential.

3. Data from prospective observational studies suggest that daily use of cannabis is associated with reduced measured IQ that, for adolescents is only partially reversable upon discontinuation.

4. Smoking marijuana is not associated with respiratory complications.

- After two follow up visits and an adjustment of lurasidone dosage to 40 mg/d PT reports that he is convinced that the medication is helping his depression but he continues to believe that his use of cannabis is contributing positively.

- Which of the following approaches are most likely to lead PG to action to address his cannabis use?

1. Marital counseling
2. A Series of motivational interviews.
3. Group therapy
4. The passage of time.

- After 3 months PT returns having participated in a series of motivational interviews during which he had come to the conclusion that his daily use of cannabis is causing more harm than good in his life. He is tentatively ready to stop using and he states, since you helped improve his depression he will take your advice in regards to freeing himself from use of marijuana since he is clearly unable to stop on his own.

  Which of the following would be your next step in addressing the treatment of cannabis use disorder?

  1. Prescribe an exercise regimen of brisk walking 2 miles a day.
  2. Continue contact with motivational enhancement, adding referral for cognitive behavioral therapist with rewards for participation and abstinence adding n-acetyl cysteine (NAC) to reduce cravings
  3. Prescribe 3-month course of baclofen to reduce symptoms of withdrawal.
  4. Advise stopping cannabis offering support and follow-up in 1mo

You suggest continued psychotherapy and prescribe N-acetyl cysteine (NAC) at 1200 mg twice a day along with Lurasidone 40 mg/day and reinforce complete abstinence from THC and other substances

What factors increase PTs risk for relapse of bipolar illness?

1. Stopping Lurasidone
2. Heavy use of cannabis
3. Heavy use of alcohol
4. Stressful life events

CASE 2

ADHD, BIPOLAR DISORDER,
PSYCHOSTIMULANT USE

- 19-year-old male with recent hospital admission for flight of ideas, hypersexual, and thinking that he is “smarter that Einstein who was his cousin but was a covered up due to family infidelity”

- Has only been treated by his PCP and started to use Adderall 20 mg/day for lack of focus approximately 4 months ago.

- Prior to this, he has never been on any psychiatric treatments, but would often be irritable and have migraine headaches without requiring much sleep.

- Many people often tell SD that he talks too fast and does have a family history of his uncle committing suicide.

- 8 months after the hospitalization, he decides withdraws from classes
- He begins to play in a band and is living with his girlfriend who goes with him to his PCP appointment with concerns of his mental health
- Continues having lack of focus and at time many ideas of becoming a famous rock star, but she contents he is not that good of a musician
- He struggles to manage his irritability and at times will keep her up all night playing the guitar and singing.

- PCP decides to stop Adderall and feels that it may be inducing manic-like symptoms.
- SD then decides to take one of his band members Adderall and feels that he needs it and craves the feeling of being “awake and energized”.
- He continues having periods of irritability and increased energy, even without sleeping for days and when not having Adderall for weeks.
- SD’s girlfriend calls you for help and PCP has now referred to you for evaluation and follow-up care.

1. With established diagnosis of ADHD, what place do psychostimulants have in the management of someone with potential Bipolar Disorder, Type I?

A. Psychostimulants are commonly prescribed for ADHD, but are not to be used in individuals with Bipolar Disorder.

B. Bipolar Disorder patients with ADHD are able to be prescribed psychostimulants, as long as they are not short acting.

C. Antidepressants, and not psychostimulants, are known to induce mania in bipolar disorder patients with ADHD.

D. ADHD is mostly present in children and adults with symptoms of ADHD is almost always due to another mental illness

2. Does this patient have a psychostimulant use disorder in addition to possibly ADHD and Bipolar Disorder, Type I?

A. He misuses Adderall, but has not yet developed a substance use disorder but “at risk”.

B . He clearly has developed a pattern of addictive use of Adderall; Psychostimulant Use Disorder “severe”.

C. He does not have a substance use disorder but has been undertreated for Bipolar Disorder, Type I.

D. He has likely only experienced mania when on psychostimulants; further screening for Bipolar Disorder, Type I is not needed.

3. Upon presentation to your clinic for evaluation, explains that Adderall helps with focus and needs it. What do you advise about its use.

A. You recognize his suffering and you do not believe continued use of Adderall is advisable/will likely complicate treatment.

B. he should never take Adderall; perhaps a mood stabilizer may help in managing manic-like symptoms and lead to increased sleep and focus the next day.

C. Patients suffering Bipolar Disorder, Type I are not at great risk for substance use disorders. Although he has been using a band members Adderall, it is acceptable to prescribe once on a mood stabilizer.

D. OK to continue the Adderall if he agrees to use only as to taken when needed and re-enrolled in school.

4. SD enrolled in school and started to take Guanfacine to help with focus.
   What are the risks and benefits for use of Guanfacine together with Adderall for ADHD in Bipolar Disorder, type I.

A. There is little justification for use of the two agents together.

B. There is no problem with prescribing both drugs after establishing that ADHD is comorbid to Bipolar Disorder, Type I.

C. In a patient with a psychiatric disorder and family history of suicide, the risk of fatal overdose would cause me to hesitate using both agents together.

D. While acknowledging the risks of prescribing this combination it might be necessary here. I would provide for careful monitoring and early intervention for aberrant use or symptoms of mania.

Differentiating Bipolar Disorder from BPD

Bipolar disorder

- Persistent mood elevation
- Racing thoughts
- Refractory insomnia
- Genuine intense suffering

BPD

- Abandonment feelings
- Interpersonal conflicts
- Emotional chaos
- Boundary issues
- Trauma history

Note: Mixed bipolar states may be very difficult to distinguish from BPD

DSM-IV, APA 1994

Pharmacotherapy for Borderline Personality Disorder

Medication	Impulsive	Anger	Mood lability	Anxiety	Function
Lamotrigine Topiramate Valproate	+++	++	++	-	++
Aripiprazole Olanzapine	++	+++	-	+	+
Lithium	+++		+		+
SSRI	-	-	-	+	-
Benzodiaz	-	-	-	+	-

Kleb et al, Br J Psychiatry 2010

Medication guidelines for BPD

- First Line: Mood Stabilizer (MS) or Atypical Antipsychotic (AA) depending on symptom clusters.
- For non-response: Switch from MS ↔ AA or Add MS + AA
- Reserve Antidepressants for MDD or Anxiety episodes.
- BZ are not shown to provide substantial benefit
- In resistant cases, naltrexone, clonidine, MAO-Inhibitors, Omega-3 fatty acids may be considered.
- Always combine with behavioral treatments (CBT/ DBT)
- Detoxify intoxicated or heavily dependent patients prior to initiating pharmacotherapy.

Agent	Type of Mood Episode				
	Agitation	Manic	Mixed	Depressed	Maintenance
Aripiprazole	X	X	X		X
Carbamazepine		X	X		
Divalproex		X	X		
Lamotrigine					X
Lithium		X			X
Olanzapine	X	X	X		X
Olanzapine+Fluoxetin				X	
Quetiapine Cariprazine Lurasidone Lumateperone		X	X	X	
Risperidone		X	X		
Ziprasidone	X	X	X		

CASE 3

Combat-related PTSD

- 35-year-old female recent hospital admission after ingestion of Clonazepam, Hydrocodone and Trazodone while feeling "overwhelmed and hopeless and helpless."
- Former US Navy nurse for over 12 years with several deployments in Middle East war zones.
- Four years ago during convoy in Kuwait, she witnessed the death of 3 service members as a result of a roadside bombing. She retrieved and transported the bodies.
- In the weeks following she experiencing increased fearfulness and panic attacks, nightly nightmares with vivid images of the deaths.

- Placed on medical leave, but with persistent symptoms, she was retuned to the US and medically discharged with honorable status and diagnosed with PTSD.
- Returns to North Carolina and lives with aunt and her 12 yr. old daughter after separating from spouse.
- Continues having attacks of panic twice a day; dissociative spells, and irritability and social withdrawal.
- Struggled to reengage with civilian life and enrolls in community college after fired from numerous jobs.

- Seeks care from her PCP, prescribed lorazepam 1mg three times a day along and desvenlafaxine (Pristiq) 50mg daily.
- Visits local Mental Health Center but she could not “connect” with her therapist.
- Continues having severe daytime anxiety, panic attacks and traumatic nightmares over the next several months; frequently taking extra doses of lorazepam against recommendation of her PCP.
- Recently suffered back strain; prescribed oxycodone that she takes when her pain interferes with attending classes.

- Current crisis follows an evening of drinking during which she is overwhelmed with financial concerns. Denies suicidal intent. Just "wanted to go to sleep".
- Records indicate recent hospitalization at psychiatric facility after being assaulted by a male friend. Indicated only that she and her friend had too much to drink.
- Now referred to you for evaluation and follow-up care.

1. With established diagnosis of post-traumatic stress disorder, what place do benzodiazepines have in management of associated anxiety, nightmares or sleep related problems?

A. Benzodiazepines commonly prescribed for PTSD; appear to have some efficacy is moderating anxiety and sleep problems while psychotherapeutic efforts are mainstay of treatment.

B. Benzodiazepines can serve a valuable and primary role in treatment of PTSD

C. Little evidence for efficacy with benzodiazepines in treatment of PTSD; should never be used for short term relief of anxiety symptoms associated with PTSD.

D. Benzodiazepines likely to interfere with the long term goals; relatively contraindicated.

2. Does this patient have a substance use disorder in addition to PTSD?

A. She misuses lorazepam; not yet developed a substance use disorder but “at risk”.

B . She clearly has developed a pattern of addictive use of lorazepam; Sedative Use Disorder “severe”.

C. She does not have a substance use disorder but has been undertreated for PTSD.

D. She has sedative-hypnotic use disorder; further screening for alcohol use disorder is advised.

3. Upon presentation to VA clinic is tearful/remorseful. Denies suicidal intent for her overdose. Explains her anxiety responds only to lorazepam. What do you advise about continued use.

A. You recognize her suffering and you do not believe continued use of lorazepam is advisable/will likely complicate treatment.

B. She should never take lorazepam; perhaps Ambien would help in managing sleep problems.

C. Patients suffering combat-related PTSD are at great risk for substance use disorders. She has been overusing lorazepam and should never be prescribed substances with addictive properties.

D. OK to continue the lorazepam if she agrees to use only as prescribed and referral made to the PTSD counseling program.

4. JR was taking oxycodone “as needed” for back pain. What are the risks and benefits for use of opioids together with benzodiazepines for chronic back pain?

A. There is little justification for use of the two agents together.

B. There is no problem with prescribing both drugs after establishing an indication for each.

C. In a patient with a psychiatric disorder and SUD the risk of fatal overdose would cause me to hesitate using both agents together.

D. While acknowledging the risks of prescribing this combination it might be necessary here. I would provide for careful monitoring and early intervention for aberrant use.

5. What overall interventions might be suggested to help with the problems that AH presents?

A. Educate about the risks of untreated PTSD. Discontinue lorazepam, Offer prazosin for sleep-related problems. Schedule appointment for the PTSD Program emphasizing cognitive psychotherapy. Continue Pristiq.

B. Refer for orthopedic evaluation for evaluation of back pain, continue the lorazepam but stop the opioid; refer to PTSD Treatment Program.

C. Stop all pharmacotherapy; refer to a therapist focusing on mindfulness meditation.

D. Discontinue desvenlafaxine, begin Prozac and increase Trazodone while asking AH to consider referral to the PTSD program.

Medications for PTSD

Evidence A (2 RCT)

- <u>SSRI</u>

Paroxetine, Sertraline

Evidence B (1RCT)

- <u>Atypical Antipsychotics</u>

Risperidone,Olanzapine

- <u>Anticonvulsants</u>

Valproic Acid, Lamotrigine

- <u>Adrenergic inhibitors</u>

Prazosin

Evidence C(Open Label)

- <u>Anticonvulsants</u>

Topiramate, Carbamazepine

- <u>Beta Blockers</u>

Propranolol

Evidence D(Case Report)

- <u>Anticonvulsants</u>

Gabapentin

- <u>Others</u>

Lithium

Berger et al, Prog Neuropsychopharm Biol Psych 2009

CASE 4

Anxiety, sedative hypnotics and alcohol use disorder

- 39-year-old married male treated by his PCP of 11 years for chronic anxiety and episodic panic attacks.
- Diagnosed with social anxiety disorder and panic disorder with agoraphobia, maintained on Fluoxetine (Prozac) 80 mg daily and Trazodone 150 mg for sleep.
- At the time of diagnosis averaging six-pack per day, more on weekends, with episodes of binging and blackouts.
- Failed repeated attempts to reduce his drinking and several detox admissions, 4 years ago he became active in AA and has not had not a drink since.
- Continued anxiety - started on clonazepam .5 mg bid 3 years ago

- Continued complaints of anxiety lead to gradual increase in clonazepam dosage to 1mg qid
- Continued complaints of anxiety and sleeplessness and increased isolation, work-related difficulties
- No return to use of alcohol, confirmed with family
- Increasing numbers and severity of panic attacks and requests for additional medication (requests prn alprazolam)
- Rejects PCPs suggested referral to Psychiatrist

- Visits a walk-in clinic and obtains prescription for Xanax at 1 mg three times a day.
- Next visit his PCP queried the CSRS. Alprazolam listed from another provider.
- Informed this was potentially harmful and outside treatment agreement; referral for evaluation of his benzodiazepine use was a condition of his continued care.
- His PCP has now initiated referral to you!

1. What psychosocial or pharmacological treatment is appropriate given the degree of alcohol use upon presentation 11 years ago?

A. All pharmacotherapy is high risk in patients with active alcohol use disorder. Treatment of anxiety primarily with AA, counseling and lifestyle management.

B. Use of sedative-hypnotics might be useful but should be considered a short-term. Continue alcohol focused now on sedative misuse.

C. Use of benzodiazepines useful in reducing symptomatic anxiety, may assist with reducing harms of alcohol use.

D. Various non-scheduled medications such as SSRIs preferred in managing anxiety symptoms rather than drugs with reinforcing effects .

2. With stable sobriety what risks are involved in use of benzodiazepines for exacerbation of anxiety disorder? How would you respond to increasing complaints?

A. Benzodiazepines effective agents in treatment of anxiety disorder. Little evidence to support risk of alcohol relapse in this situation.

B. Benzodiazepines should be used with caution in patients with alcohol use disorder in remission; increased risk of relapse.

C. Use of any agent with reinforcing qualities is contraindicated for all patients with addictive disorders.

D. While generally considered risky, use in this circumstance is justified by the degree to which anxiety interferes with functioning.

3. Is use of increasing dosages of benzodiazepines within prescriptive parameters due to an underlying addictive process or inadequate treatment of the anxiety disorder?

A. Increased dosing of clonazepam was necessary and appropriate given continued anxiety. Pseudo-addiction.

B. Personal and family history suggests vulnerability to addictive substances and high risk for addiction to benzodiazepines. Offer enhanced monitoring while continuing use of benzodiazepines.

C. RR clearly addicted to benzodiazepines; using despite harmful consequences.

D. Benzodiazepines should not ever be used in patients with a history of addiction. Pharmacotherapy with non-scheduled agents might supplement counseling and support of AA.

4. What would you now recommend to this patient and his PCP?

A. This is a difficult situation but your management is optimal. Carry on.

B. Education about risk factors common to all addictions. Explain continued use of benzodiazepines only justified by attempts at non-drug treatment enabling discontinuation over the short term. Suggest return to AA; call his former sponsor.

C. Aggressive treatment of disabling anxiety is indicated and benzodiazepines should be continued.

D. The cycle of addiction is likely to progress and inpatient rehabilitative treatment indicated.