

Short Report

Dual disorders: an overview

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Abstract

The coexistence of substance use disorders (SUD) and other mental disorders – commonly referred to as dual disorders (DD) – is highly prevalent and clinically significant. Although various terms have been used over time (e.g., psychiatric comorbidity, dual pathology), the lack of a standardised definition has created inconsistencies in diagnosis, communication, research, and treatment. Epidemiological studies estimate that 30–80% of individuals with SUD have co-occurring psychiatric disorders, with prevalence depending on the substance involved, gender, age, and the population studied (general population, people in emergency rooms, mental health addiction facilities, harm reduction facilities, prison). Compared to individuals with a single disorder, people with DD exhibit more severe psychopathological symptoms, higher suicide risk, increased relapse rates, poorer treatment adherence, more medical comorbidities, and worse psychosocial outcomes, including unemployment, homelessness, and social exclusion. Despite extensive evidence, both SUD and other mental disorders often remain underdiagnosed and undertreated, partly due to diagnostic complexities such as overlapping symptomatology and the syndromic nature of psychiatric classifications. Additional barriers include the structural separation between mental health and addiction services and limited integrated care expertise. The “wrong door syndrome” exemplifies how patients are frequently directed to services unable to address both conditions, leading to suboptimal outcomes. Furthermore, individuals with DD are often excluded from clinical research, limiting the evidence base for tailored interventions. Improving the detection and treatment of DD is a major challenge for mental health and addiction systems. Integrated, holistic treatment approaches from the outset are essential to optimise outcomes for this highly vulnerable population.

Keywords: dual disorders; dual pathology; psychiatric comorbidity; substance use disorder

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The coexistence of a substance use disorder (SUD) and another psychiatric disorder in the same individual has been described in the literature over the years using various terms, including psychiatric comorbidity, *dual disorders*, comorbidity, and dual pathology, among others. This lack of terminological consensus has affected all stakeholders – patients, their families, healthcare professionals, and researchers – in multiple ways (see Table 1). While a universally accepted definition remains elusive, there is an increasing call for standardizing the term “*Dual Disorders*” (Szerman et al. 2022).

Multiple epidemiological studies have shown that co-occurring psychiatric disorders are common among individuals with SUD. The prevalence of this comorbidity varies widely (approximately 30–80%), depending on several factors, including the substance involved (e.g., stimulants, opioids, cannabis), gender, and the studied population (e.g., general population, treatment-seeking or non-treatment-seeking patients, prisoners, homeless individuals, migrants) (Alonso et al. 2004; Farrell et al. 2001; Jacobi et al. 2004; Reginsson et al. 2018; Torrens et al. 2015).

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People with *dual disorders*, compared to those with a single disorder (either SUD or another psychiatric condition), exhibit worse clinical and social prognoses (Torrens et al. 2012). They generally present with more severe psychopathological symptoms, a higher risk of suicide, increased substance use relapses, higher treatment dropout rates, lower medication adherence, and more medical comorbidities (e.g., HIV, hepatitis). Additionally, they experience higher rates of emergency department visits and hospitalizations, greater unemployment, increased involvement in violence and illegal activities, and a heightened risk of social exclusion (Torrens et al. 2015; Volkow et al. 2020; Volkow and Blanco 2023). Thus, these patients with *dual disorders*, place a high burden on society.

Despite extensive knowledge about this association, both non-SUD mental disorders and SUDs are often underdiagnosed and undertreated. This is partly due to persistent challenges in understanding and categorizing these conditions, as well as the difficulties in identifying and implementing the most appropriate treatment (Szerman et al. 2022; United Nations Office on Drugs and Crime [UNODC], 2022; Volkow et al. 2020).

The diagnosis of *dual disorders* presents two fundamental challenges. First, the acute and chronic effects of substances often mimic the symptoms of various mental disorders, making it

Table 1. Short description of problems derived from the “undefinition” of dual disorders

Problem	Description
Inconsistency in diagnosis	Different terms may be used to refer to the same condition, leading to confusion and inconsistency in diagnosis.
Miscommunication among healthcare professionals	When healthcare professionals use different terms for the same condition, it can create confusion and miscommunication, leading to errors in treatment and care.
Difficulty in research	Using different terms for the same condition can make it difficult for researchers to accurately identify comorbidities, leading to inaccuracies in research findings.
Stigmatization	Different terms can carry different levels of stigma, impacting how individuals with co-occurring disorders are perceived and treated.
Impacts treatment and outcomes	Different terms may imply different severity levels or patterns of symptoms, impacting treatment approaches and outcomes.
Barriers to accessing care	Using different terms can create confusion and misunderstanding among patients seeking care, resulting in barriers to accessing appropriate treatment and support.
Social attitudes	Different terms can reflect different social attitudes towards addiction and mental health, leading to blame and shame towards individuals with co-occurring disorders.
Differences in cultural context	The same term may not have the same meaning or be used in the same way across different cultures, impacting the ability to effectively identify and treat comorbid conditions.
Lack of consensus	The use of different terms reflects a lack of consensus among healthcare professionals and researchers, which can impede progress in understanding and addressing co-occurring disorders.

difficult to distinguish between psychopathological symptoms caused by substance use, withdrawal, or an independent psychiatric condition. Second, psychiatric disorders are classified as syndromes – patterns of symptoms with some clinical validity – rather than well-defined diseases with known pathophysiology and reliable biological markers. Overall, differentiating between primary psychiatric disorders, substance-induced disorders, and the expected effects of substance use or withdrawal is a key aspect of diagnosing *dual disorders* (Torrens *et al.* 2015). To facilitate this complex diagnostic process, various clinical tools are available, including standardized clinical interviews, which aid in establishing a diagnosis, and screening instruments (e.g., interviews, scales) designed to detect potential comorbid conditions (Torrens *et al.* 2015). The choice of tool depends on several factors, such as the context (clinical, epidemiological, or research), the assessment objectives (single or multiple diagnoses), the time available for evaluation, and the expertise of the assessing professionals.

Across many European countries, two primary barriers hinder the effective management of *dual disorders*. First, there is a significant divide between mental health care services and substance use treatment networks, leading to fragmented care.

Second, treatment services often lack the necessary integrated expertise to effectively address both types of disorders, resulting in suboptimal outcomes for patients (Mueser *et al.* 2003; Torrens *et al.* 2015).

The “wrong door syndrome” describes the challenges individuals with *dual disorders* face in accessing appropriate treatment services (UNODC, 2022). This occurs when a person seeks help from a medical or mental health provider who lacks the expertise or resources to address both substance use and psychiatric conditions – a phenomenon known as diagnostic overshadowing. As a result, these individuals often do not receive the integrated, comprehensive care necessary to manage both conditions simultaneously, leading to poorer outcomes. Furthermore, people with *dual disorders* are frequently excluded from clinical studies evaluating treatment efficacy, which limits the development of evidence-based guidelines tailored to this population.

Dual disorders are highly prevalent and significantly worsen clinical severity, impair psychosocial functioning, and diminish the quality of life of affected patients. Identifying co-occurring mental disorders in patients with SUD is crucial for tailoring the most effective treatment approach. The effective detection and treatment of *dual disorders* is a major challenge that health policymakers and professionals in addiction and mental health must address in the coming years. The therapeutic approach to *dual disorders* – whether pharmacological, psychological, or both – must take a holistic view of both conditions from the outset to determine the best treatment option for each individual.

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