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## Understanding Mood Disorders: Who, What, Why, How, Where and When?

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### A. Who Are Affected by Mood Disorders?

#### 1. Prevalence of Mood Disorders

- Major Depression -OBJECTIVE: The National Comorbidity Survey reported the prevalence and risk factor profile of both pure and comorbid major depression. METHOD: To estimate the prevalence of psychiatric comorbidity in the United States, a national sample of 8,098 persons 15-54 years of age from the 48 conterminous states was surveyed with a modified version of the Composite International Diagnostic Interview. RESULTS: From the survey data the prevalence of current (30-day) major depression was estimated to be 4.9%, with a relatively higher prevalence in females, young adults, and persons with less than a college education. The prevalence estimate for lifetime major depression was 17.1%, with a similar demographic distribution. (DG Blazer, RC Kessler, KA McGonagle, and MS Swartz: "The prevalence and distribution of major depression in a national community sample: the National Comorbidity Survey." Am J Psychiatry, Jul 1994; 151: 979 - 986.)
- Lifetime Major Depressive Disorder (MDD) estimated at 10-25% for women and half that for men (TIP 42, page 374)
- Prevalence of co-occurring depression and substance use problems in an adolescent population: "Prevalence and characteristics of depression and substance use in a U.S. child welfare sample"

#### **Purpose**

Estimate separate and combined prevalence of depression and frequent substance use (FSU), evaluate gender differences, and compare the severity of depression and substance use across groups in a sample of youth in the U.S. child welfare system.

#### **Methods**

Data on youth aged 11 to 15 years from the National Survey on Child and Adolescent Well-Being were used ( $N = 1179$ ). Depression was assessed using the Children's Depression Inventory. Substances assessed included tobacco, alcohol, marijuana, inhalants, hard drugs, and use of prescription medication for non-medical purposes. Descriptive statistics and chi-square tests were used to estimate and compare prevalence rates. Multinomial logistic regression was used to estimate the age-adjusted effect of gender on depression/FSU.

#### **Results**

Depression was more than twice as common in girls as boys (17% versus 7%,  $p < 0.05$ ), but there were no gender differences in the prevalence of past month substance use. Differences in depression and substance use severity were found between groups. Depressed boys with FSU had more severe depression compared to boys with depression only.

#### **Conclusions**

Although the prevalence of depression was significantly higher among girls than boys, there were no gender differences in FSU prevalence. Boys with comorbid depression and FSU had more severe depressive symptoms as those with depression only.

(Heather D. Orton, Paula D. Riggs and Anne M. Libby: "Prevalence and characteristics of depression and substance use in a U.S. child welfare sample" Children and Youth Services Review Volume 31, Issue 6, June 2009, Pages 649-653)

- Prevalence in adults: National Comorbidity Study – about half (41 – 65%) of individuals with a Substance Use Disorder have an affective or anxiety disorder at some time in their lives (Kessler et al, 1996 I TIP 42, page 374)

- Dysthymic Disorder – 6% for both women and men (APA –DSM-IV-TR, 2000)
- Bipolar Disorder - Prevalence: Affects approximately 2.3 million adult Americans—about 1.2 percent of the population. (Source: excerpt from [Going to Extremes Bipolar Disorder: NIMH](#))
- Kathleen R. Merikangas, PhD; Hagop S. Akiskal, MD; Jules Angst, MD; Paul E. Greenberg, MA; Robert M. A. Hirschfeld, MD; Maria Petukhova, PhD; Ronald C. Kessler, PhD: “Lifetime and 12-Month Prevalence of Bipolar Spectrum Disorder in the National Comorbidity Survey Replication” *Arch Gen Psychiatry*. 2007;64(5):543-552.  
**Context** There is growing recognition that bipolar disorder (BPD) has a spectrum of expression that is substantially more common than the 1% BP-I prevalence traditionally found in population surveys.  
**Objective** To estimate the prevalence correlates, and treatment patterns of bipolar spectrum disorder in the US population.  
**Design** Direct interviews.  
**Setting** Households in the continental United States.  
**Participants** A nationally representative sample of 9282 English-speaking adults (aged  $\geq 18$  years).  
**Main Outcome Measures** Version 3.0 of the World Health Organization's Composite International Diagnostic Interview, a fully structured lay-administered diagnostic interview, was used to assess *DSM-IV* lifetime and 12-month Axis I disorders. Subthreshold BPD was defined as recurrent hypomania without a major depressive episode or with fewer symptoms than required for threshold hypomania. Indicators of clinical severity included age at onset, chronicity, symptom severity, role impairment, comorbidity, and treatment.  
**Results** Lifetime (and 12-month) prevalence estimates are 1.0% (0.6%) for BP-I, 1.1% (0.8%) for BP-II, and 2.4% (1.4%) for subthreshold BPD. Most respondents with threshold and subthreshold BPD had lifetime comorbidity with other Axis I disorders, particularly anxiety disorders. Clinical severity and role impairment are greater for threshold than for subthreshold BPD and for BP-II than for BP-I episodes of major depression, but subthreshold cases still have moderate to severe clinical severity and role impairment. Although most people with BPD receive lifetime professional treatment for emotional problems, use of antimanic medication is uncommon, especially in general medical settings.
- Epidemiologic Catchment Area (ECA) study – nearly 90% of those with bipolar disorder in a prison population had co-occurring substance use disorder (Regier et al, 1990 in TIP 42, page 389)

## 2. DSM-IV-TR Mood Disorders

(Appendix D -Center for Substance Abuse Treatment. “Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery” Treatment Improvement Protocol (TIP) Series 48. DHHS Publication No. (SMA) (SMA) 08-4353)

- In substance abuse treatment settings, you are likely to encounter clients with a variety of diagnoses of depressive illnesses. Most of these diagnoses fall in the category of Mood Disorders, as specified in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR; APA, 2000).
- You can, however, also work with people who have a diagnosis of Adjustment Disorder with Depressed Mood.
- Additionally, people with a variety of other psychiatric illnesses are susceptible to depression, and some of those illnesses are described in this appendix

The descriptions of depressive disorders and their primary symptoms are taken from DSM-IV-TR. Refer to the DSM-IV-TR for a more complete description of these disorders.

### 1. Major Depressive Episode and Major Depressive Disorder

### 2. Dsythymic Disorder

### 3. Bipolar Episode and Bipolar Disorder

Bipolar disorder is characterized by more than one bipolar episode. There are three types of bipolar disorder:

- Bipolar I Disorder, in which the primary symptom presentation is manic, or rapid (daily) cycling episodes of mania and depression.
- Bipolar II Disorder, in which the primary symptom presentation is recurrent depression accompanied by hypomanic episodes (a milder state of mania in which the symptoms are not severe enough to cause marked impairment in social or occupational functioning or need for hospitalization, but are sufficient to be observable by others).
- Cyclothymic Disorder, a chronic state of cycling between hypomanic and depressive episodes that do not reach the diagnostic standard for bipolar disorder (APA, 2000, pp. 388–392).

### 4. Substance-Induced Mood Disorder

Substance-Induced Mood Disorder is a common depressive illness of clients in substance abuse treatment.

- It is defined in DSM-IV-TR as “a prominent and persistent disturbance of mood . . . that is judged to be due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or somatic treatment for depression, or toxin exposure)” (APA, 2000, p. 405).
- The mood can manifest as manic (expansive, grandiose, irritable), depressed, or a mixture of mania and depression
- Generally, substance-induced mood disorders will only present either during intoxication from the substance or on withdrawal from the substance and therefore do not have as lengthy a course as other depressive illnesses.

### 5. Mood Disorder Due to a General Medical Condition

It is not as common to find depression due to a general medical condition in substance-abuse treatment settings.

- It is important to note that depression can be a result of a medical condition, such as hypothyroidism or Parkinson’s disease
- The criteria for diagnosis are similar to Major Depressive Episode or a manic episode; however, the full criteria for these diagnoses need not be met
- It is important in diagnosis to establish that the depressive symptoms are a direct physiological result of the medical condition, not just a psychological response to a medical problem.

### 6. Adjustment Disorder with Depressed Mood

Adjustment disorder is a psychological reaction to overwhelming emotional or psychological stress, resulting in depression or other symptoms

- Some situations in which an adjustment disorder can occur include divorce, imprisonment of self or a significant other, business or employment failures, or a significant family disturbance
- The stressor may be a one-time event or a recurring situation. Because of the turmoil that often occurs around a crisis in substance use patterns, clients in substance abuse treatment may be particularly susceptible to Adjustment Disorders
- Some of the common depressive symptoms of an adjustment disorder include tearfulness, depressed mood, and feelings of hopelessness
- The symptoms of an adjustment disorder normally do not reach the proportions of a Major Depressive Disorder, nor do they last as long as a Dysthymic Disorder
- An acute adjustment disorder normally lasts only a few months, while a chronic adjustment disorder may be ongoing after the termination of the stressor.

### 7. Other Psychiatric Conditions in Which Depression Can Be a Primary Symptom

Sometimes depression is symptomatic of another mental disorder.

- This is particularly true when the nature of the mental disorder causes excessive distress to the individual.
- While, in this context, the depression is a symptom, it is still important to recognize its impact on the person and his or her ability to respond to substance abuse treatment
- Some of the psychiatric disorders in which depression can play a major role include:

(a) Posttraumatic Stress Disorder (PTSD)

Symptoms include episodes of re-experiencing the traumatic event or re-experiencing the emotions attached to the event; nightmares, exaggerated startle responses; and social, interpersonal, and psychological withdrawal. Chronic symptoms may include anxiety and depression. PTSD is categorized as an anxiety disorder.

(b) Anxiety Disorders, including Panic Disorder, Agoraphobia (fear of public places), Social Phobias, and Generalized Anxiety Disorder

Symptoms of anxiety disorders are most often on the anxiety spectrum, but the chronic stress faced by individuals with anxiety disorders can produce depressive symptoms including irritability, hopelessness, despair, emptiness, and chronic fatigue.

(c) Schizoaffective Disorder and Schizophrenia

Individuals with schizoaffective disorder have, in addition to many of the symptoms of schizophrenia, a chronic depression with most of the features of Major Depressive Disorder. Because of the difficulty individuals with schizophrenia have in coping with the daily demands of living, depression is often a symptom. With both schizoaffective disorder and schizophrenia, the depression adds an additional dimension to treatment, specifically in helping the person mobilize in the face of their depression to cope with their illness.

(d) Personality Disorders

People with personality disorders are particularly susceptible to depression. These individuals are at high risk for substance use disorders. As a result, it is not uncommon to find clients in substance abuse treatment with all three diagnoses. Because personality disorders are categorized in DSM-IV-TR as Axis 2 disorders (see DSM-IV-TR for a description of multi-axial assessment), it is common to find their depression diagnosed separately (from the personality disorder) as an adjustment disorder, dysthymia, or major depressive disorder.

## B. Structure and Rationale of DSM-IV

### 1. Why Diagnostic Criteria?

- The need for classification of mental disorders has been clear throughout history of medicine
- There has been little agreement on which disorders should be included; and the optimal method for their organization
- The many nomenclatures (naming systems) that have been developed during the past 2,000 years have differed in their relative emphasis on phenomenology, etiology, and course as defining features
- Some systems have included only a handful of diagnostic categories; others have included thousands
- Various systems for categorizing mental disorders have differed with their principal objective for use in clinical, research, or statistical settings

### 2. Development of DSM-IV

- DSM-III represented a major advance in the diagnosis of mental disorders and greatly facilitated empirical research
- The development of DSM-IV benefited from the substantial increase in the research on diagnosis that was generated in part by DSM-III and DSM-III-R
- Most diagnoses now have an empirical literature or available data sets that are relevant to decisions regarding the revision of the diagnostic manual

- The Task Force on DSM-IV and its Work Groups conducted a three-stage empirical process that included 1) comprehensive and systematic literature reviews, 2) reanalyses of already-collected data sets, and 3) extensive issue-focused field trials
- On the other hand, lack of familiarity with DSM-IV or excessively flexible and idiosyncratic application of DSM-IV criteria or conventions substantially reduces its utility as a common language for communication

### 3. Definition of Mental Disorder

- DSM-IV recognizes that the term “mental disorder” unfortunately implies a distinction between “mental” disorders and “physical” disorders that is a reductionistic anachronism of mind/body dualism
- There is much “physical” in “mental” disorders and much “mental” in “physical” disorders
- The term persists in DSM-IV for lack of an appropriate substitute
- Each of the mental disorders in DSM-IV is conceptualized as *a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress e.g., a painful symptom or disability i.e., impairment in one or more important areas of functioning or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom*
- In addition, this syndrome or pattern *must not be merely an expectable and culturally sanctioned response to a particular event e.g., death of a loved one*
- Whatever its original cause, it *must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual*
- *Neither deviant behavior e.g., political, religious, or sexual; nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above*

### 4. Use of DSM-IV (DSM-IV-TR pp. 1-12)

#### (a) DSM-IV Organizational Plan

- DSM-IV disorders are grouped into 16 major diagnostic classes e.g., Substance-Related Disorders, Mood Disorders, Anxiety Disorders and one additional section, “Other Conditions That May Be a Focus of Clinical Attention”
- First section: “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence” – according to age at presentation; usually first evident in childhood and adolescence, but some individuals may not present for clinical attention until adulthood e.g., Attention Deficit/Hyperactivity Disorder; not uncommon for the age of onset for many disorders placed in other sections to be during childhood or adolescence e.g., Major Depressive Disorder, Schizophrenia, Generalized Anxiety Disorder
- Next three sections: “Delirium, Dementia, and Amnesic and Other Cognitive Disorders”; “Mental Disorder Due to a General Medical Condition”; and “Substance-Related Disorders” – these disorders are placed before the rest in DSM-IV because of their priority in differential diagnosis e.g., substance-related causes of depressed mood must be ruled out before making a diagnosis of Major Depressive Disorder
- The remaining sections (except Adjustment Disorders) group disorders based on their shared clinical features to facilitate differential diagnosis e.g., Mood Disorders, Anxiety Disorders, Somatoform Disorders, Eating Disorders etc.
- Adjustment Disorders are grouped based on their common etiology e.g., maladaptive reaction (depression, anxiety, disturbed conduct etc.) to a stressor – Adjustment Disorder With Depressed Mood; Adjustment Disorder With Anxiety; Adjustment Disorder With Disturbance of Conduct etc.

Multiaxial System	Section of DSM-IV	Disorders in Each Section
Axis I	Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence	Learning Disorders; Motor Skills Disorders; Communication Disorders; Pervasive Developmental Disorders; Attention-Deficit and Disruptive Behavior Disorders; Feeding and Eating Disorders of Infancy or Early Childhood; Tic Disorders; Elimination Disorders; Other Disorders of Infancy, Childhood, or Adolescence
Axis II	Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence (cont.)	Mental Retardation
Axis I	Delirium, Dementia, and Amnesic and Other Cognitive Disorders	Delirium; Dementia; Amnesic Disorders; Other Cognitive Disorders
Axis I	Mental Disorder Due to a General Medical Condition	Catatonic Disorder Due to....; Personality Change Due to....; Mental Disorder NOS Due to.....
Axis I	Substance-Related Disorders	See Attached DSM-IV table of Substance-Related Disorders
Axis I	Disorders grouped together based on their shared clinical features to facilitate differential diagnosis	Schizophrenia and Other Psychotic Disorders; Mood Disorders; Anxiety Disorders; Somatoform Disorders; Factitious Disorders; Dissociative Disorders; Sexual and Gender Identity Disorders; Eating Disorders; Sleep Disorders; Impulse-Control Disorders Not Elsewhere Classified;
Axis II	Disorders grouped together (cont.)	Personality Disorders
Axis I	Adjustment Disorders – grouped based on their common etiology	With Depressed Mood, Anxiety, Mixed Anxiety and Depressed Mood, Disturbance of Conduct, Mixed Disturbance of Emotions and Conduct, Unspecified
	Other Conditions That May Be a Focus of Clinical Attention	Psychological Factors Affecting Medical Condition; Medication-Induced Movement Disorders; Other Medication-Induced Disorder; Relational Problems; Problems Related to Abuse or Neglect; Additional Conditions That May Be a Focus of Clinical Attention

## 5. Multiaxial Assessment

A multiaxial system involves an assessment on several axes, each of which refers to a different domain of information that:

- May help the clinician plan treatment and predict outcome
- Facilitates comprehensive and systematic evaluation
- Pays attention to the various mental disorders and general medical conditions, psychosocial and environmental problems and level of functioning that might be overlooked if the focus were on assessing a single presenting problem
- Provides a convenient format for organizing and communicating clinical information; for capturing the complexity of clinical situations; and for describing the heterogeneity of individuals presenting with the same diagnosis
- Promotes the application of the biopsychosocial model in clinical, educational and research settings

DSM-IV has five axes:

**Axis I:** Clinical Disorders; Other Conditions That May Be a Focus of Clinical Attention

**Axis II:** Personality Disorders; Mental Retardation

**Axis III:** General Medical Conditions

**Axis IV:** Psychosocial and Environmental Problems

**Axis V:** Global Assessment of Functioning – The individual’s overall level of functioning

## 6. Specific Mood Disorders Diagnostic Criteria

### (a) Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

**Note:** Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** in children and adolescents, can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

### (b) Criteria for Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following have persisted (four if the mood is only irritable) and have been present to a significant degree:

(1) inflated self-esteem or grandiosity

(2) decreased need for sleep e.g., feels rested after only 3 hours of sleep

- (3) more talkative than usual or pressure to keep talking
- (4) flights of ideas or subjective experience that thoughts are racing
- (5) distractibility – attention too easily drawn to unimportant or irrelevant external stimuli
- (6) increase in goal-directed activity – either socially, at work or school, or sexually; or psychomotor agitation
- (7) excessive involvement in pleasurable activities that have a high potential for painful consequences e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments

C. The symptoms do not meet criteria for a Mixed Episode

D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features

E. The symptoms are not due to the direct physiological effects of a substance e.g., a drug of abuse, a medication (antidepressants) or other treatment (ECT or light therapy) or a general medical condition e.g., hyperthyroidism).

### (c) Diagnostic Features of Bipolar I versus Bipolar II Disorder

Bipolar disorder is characterized by more than one bipolar episode. There are three types of bipolar disorder:

- Bipolar I Disorder, in which the primary symptom presentation is manic, or rapid (daily) cycling episodes of mania and depression.
- Bipolar II Disorder, in which the primary symptom presentation is recurrent depression accompanied by hypomanic episodes (a milder state of mania in which the symptoms are not severe enough to cause marked impairment in social or occupational functioning or need for hospitalization, but are sufficient to be observable by others).
- Cyclothymic Disorder, a chronic state of cycling between hypomanic and depressive episodes that do not reach the diagnostic standard for bipolar disorder (APA, 2000, DSM-IV-TR. pp. 388–392).

Bipolar I Disorder – Essential feature of Bipolar I Disorder is a clinical course that is characterized by the occurrence of one or more Manic Episodes or Mixed Episodes. Often individuals have also had one Major Depressive Episode.

Bipolar II Disorder – Essential feature of Bipolar II Disorder is a clinical course that is characterized by the occurrence of one or more Major Depressive Episodes accompanied by at least one Hypomanic Episode (a true Hypomanic Episode not several days of euthymia that may follow remission of a Major Depressive Episode.) The presence of Manic or Mixed Episode precludes diagnosis of Bipolar II Disorder.

### (d) Criteria for Dsythymic Disorder

Depressed mood most of the day for more days than not, for at least 2 years, and the presence of two or more of the following symptoms that cause clinically significant impairment in social, work, or other important areas of functioning:

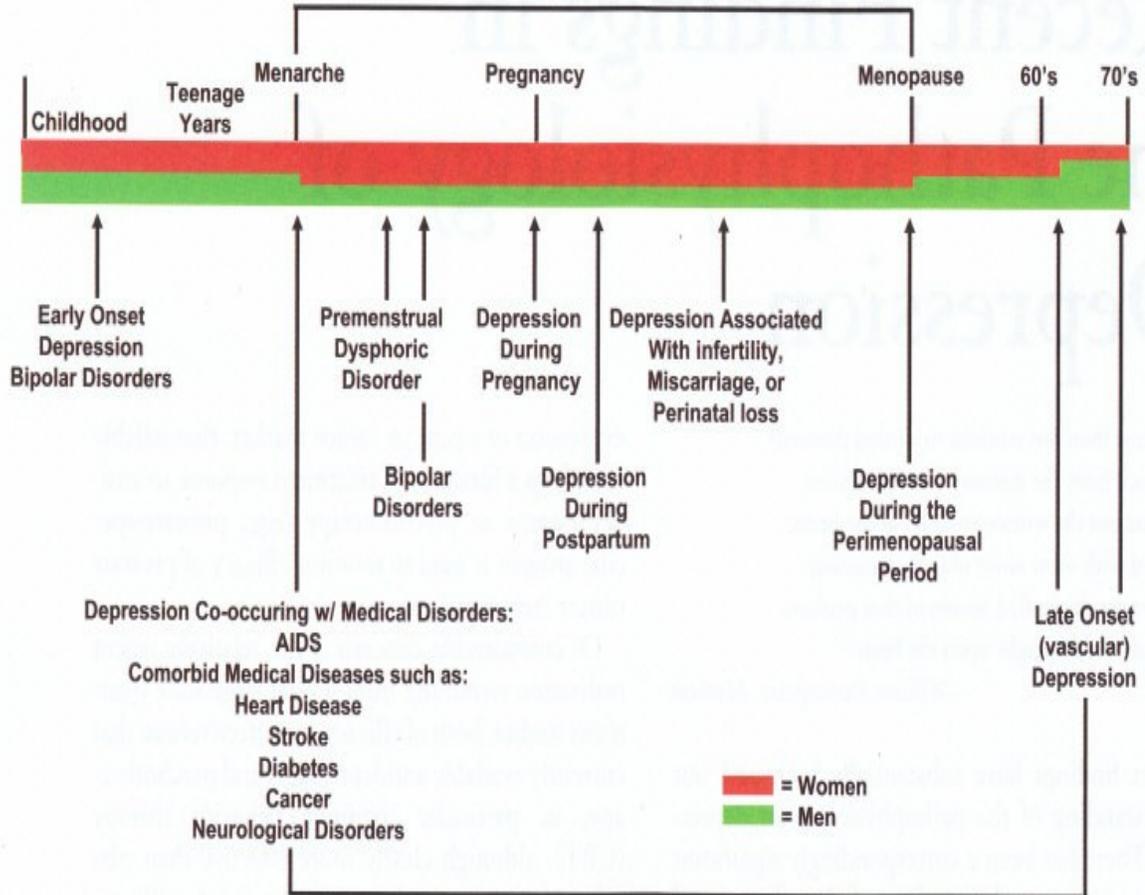
- Poor appetite or overeating.
- Insomnia or sleeping too much.
- Low energy or fatigue.
- Low self-esteem.
- Poor concentration or difficulty making decisions.
- Feelings of hopelessness (APA, DSM-IV-TR, 2000, p. 380).

## C. Causes of Mood Disorders - Biopsychosocial

### 1. Major Mood Disorders Across the Life Cycle

(Nemeroff, Charles B (2008): "Recent Findings in the Pathophysiology of Depression". Focus, Volume VI, No. 1 American Psychiatric Association. Winter 2008 pp. 3 – 14.)

Figure 1. Mood Disorders Across the Life Cycle



### 2. Contrast with Substance-Induced Mood Disorders

- List all the mood disorders that can be substance-induced or addiction illness related
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### 3. Cultural, age and gender features of DSM

- List all the cultural, age and gender issues that can influence WHY mood disorders arise; HOW they present and manifest themselves; and WHAT the treatment implications are
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## Depressive Symptoms Typically Caused by Substances of Abuse

### TIP 48, page 8 Figure 1.3

Substance	Associated Depressive Symptoms		
	Intoxication	Withdrawal	Chronic Use
Alcohol		Depressed mood, anxiety, poor appetite, poor concentration, insomnia, restlessness, paranoia and psychosis	Depressed mood and other depressive symptoms
Opioids	Low energy, low appetite, poor concentration	Depressed mood, fatigue, low appetite, irritability, anxiety, insomnia, poor concentration	Depressed mood and other depressive symptoms
Cocaine and stimulants	Anxiety, low appetite, insomnia, paranoia and psychosis	Depressed mood, increased sleep, increased appetite, anhedonia, loss of interest, poor concentration, suicidal thoughts	Depressed mood and other depressive symptoms
Cannabis	Anxiety, apathy, increased appetite	Anxiety, irritability	Low motivation, apathy
Sedative-hypnotics	Fatigue, increased sleep, apathy	Anxiety, low mood, restlessness, paranoia and psychosis	Depressed mood, poor memory

#### D. Diagnostic and Assessment Strategies

- Diagnosis - substance use disorder or psychiatric diagnosis or both?; primary or secondary disorder, or doesn't it matter?

##### 1. Why Diagnostic Confusion? - Diagnostic Confusion due to:

- Alcohol/drugs can cause psychiatric symptoms in anyone (acute toxicity)
- Prolonged alcohol/drug use can cause short or long-term psychiatric illness
- Alcohol/drug use can escalate in episodes of psychiatric illness
- Psychiatric symptoms and alcohol/drug use can occur in other psychiatric disorders
- Independent addiction and psychiatric illnesses (“Dual Diagnosis”)

(Marc A. Schuckit: Am. J. Psychiatry, 143:2 p. 141 - modified)

(a) Cognitive impairments

- Mental retardation
- Dementia – injury
- Learning disability – dyslexia
- Educational deprivation
- Drug related impairment – delirium or other substance-induced disorder such as persistent amnesic disorder, intoxication states

(b) Drug-Specific States

- Marijuana withdrawal – insomnia and irritability
- Marijuana intoxication – persistent amnesic symptoms; memory loss; apathy
- Inhalant intoxication – subacute delirium and disorganization
- Stimulant withdrawal – depression
- Stimulant intoxication – psychosis
- Ecstasy, ketamine – affective disorders +/- psychosis
- Hallucinogen induced persisting perceptual distortion syndrome – flashbacks can linger for months and years even

(c) Addiction is Not just a Symptom of Underlying Psychiatric Disorder, But can be...

- Self medication of psychiatric illness
- Anesthesia for childhood trauma
- Symbolic expression of intrapsychic conflict – stimulant use for someone shy and introverted

(d) Diagnostic Dilemmas in Cluster of Symptoms

(i) Differential diagnosis of inattention and hyperactivity

- Attention Deficit Hyperactivity Disorder
- Mania – looks like lability
- Depression
- Marijuana
- Antidepressants especially specific serotonin reuptake inhibitors (SSRIs) side effects

(ii) Irritable Mood

- Depression
- Demoralization
- Mania/Hypomania/Bipolar Disorder
- Intoxication especially with stimulants

(iii) Persistent affective instability, mood lability, explosive temper, tantrums, stormy emotions

- Bipolar Disorder
- Depression
- ADHD “plus” – overlap of childhood ADHD plus developmental issues
- Intoxication and withdrawal

## 2. Assessment Guidelines

- Pharmacological and psychosocial aspects of addiction can mimic psychiatric disorders
- Decision tree for “Addiction versus Psychiatric Diagnoses: Either or Both?”
- Take a good history - A definitive psychiatric diagnosis by history requires the psychiatric symptoms to have occurred during drug-free periods of time
- Observe the client for a sufficient time drug-free - shorter time for objective, psychotic symptoms; longer for subjective, affective symptoms; non-drug ways of coping; addiction is a biopsychosocial disorder, so encourage active involvement in a recovery program; incorporate meetings, tools, techniques, and a wide variety of non-drug coping responses to help client deal with the stresses of everyday living; diagnosis as a process, not an event

## 3. Mental Status Examination

**A – Appearance and Attitude:** physical characteristics; apparent age; peculiarity of dress, cleanliness; aggressive, passive, hostile, paranoid, suspicious

**B – Behavior:** posture (stooped, erect, slouched); gait (shuffling, staggering, stiff, awkward); gestures, tics, grimacing, mannerisms; verbal, non-verbal

**C – Cognition:** orientation; memory (short and long-term); abstract or concrete thinking; reasoning and judgment; rate of cognitions (flight of ideas, circumstantiality, perseveration)

**D – Disturbances of thought:** delusions; psychosis; thought blocking; hallucinations

**E – Emotions:** appropriateness of affect; lability of mood; depression, anxiety, mood swings

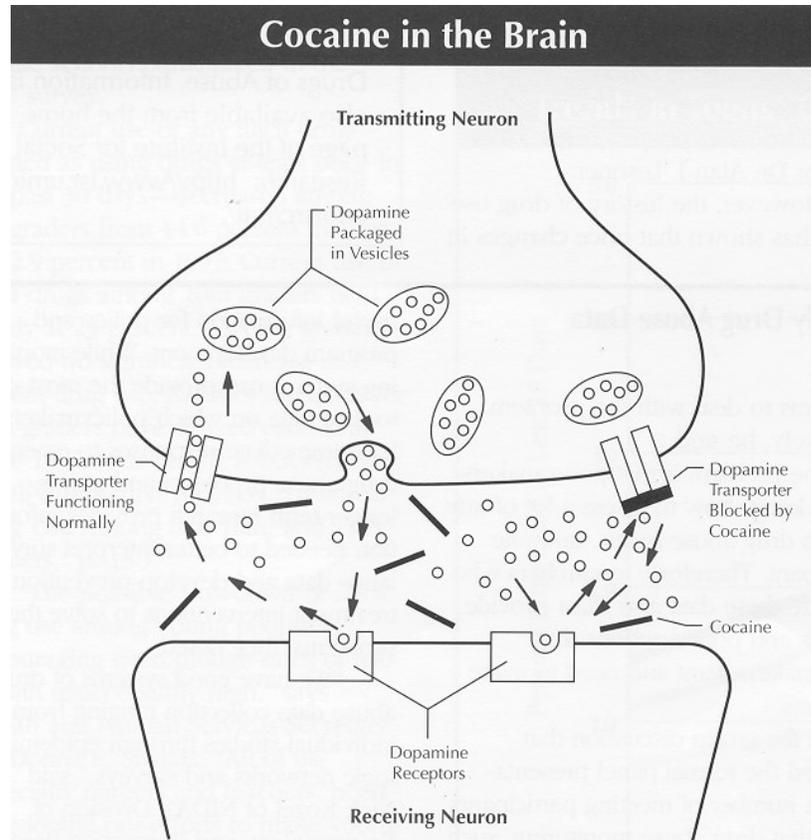
## E. Pharmacotherapy of Mood Disorders

### 1. Basic Brain Chemistry and Mechanisms of Pharmacotherapy

#### Current Attitudes and Awareness of Medications for Substance Use Disorders (SUD)

- Name three medications used in the treatment of Substance Use Disorders
- Do you consider addiction a brain disease, a behavioral disorder or a psychosocial problem?
- If a client said they would take Antabuse, but not go to AA, would you allow it in treatment plan?
- If a client said they would go to AA, but would not take Antabuse, would you allow that?
- A client says they use because they are depressed and want antidepressants, what would you do?

The neurotransmitter dopamine transmits brain signals by flowing from one neuron into the spaces between neurons and attaching to a receptor on another neuron. Normally, dopamine then is recycled back into the transmitting neuron by a transporter molecule on the surface of the neuron. But if cocaine is present, the drug attaches to the transporter and blocks the normal recycling of dopamine, causing an increase of dopamine levels in the spaces between neurons that leads to euphoria.



Drug	Target
<i>Opiates</i>	Agonist at mu, delta (mediate the addicting actions of opiates) and kappa (mediate aversive actions) opioid receptors
<i>Cocaine</i>	Indirect agonist at dopamine receptors by inhibiting dopamine transporters. Cocaine and amphetamine exert analogous actions on serotonergic and noradrenergic systems, which may also contribute to the addicting effects
<i>Amphetamine</i>	Indirect agonist at dopamine receptors by stimulating dopamine release
<i>Ethanol</i>	Facilitates GABA receptor and inhibits NMDA glutamate receptor function. Also affects several other ligand-gated channels, and at higher concentrations, voltage-gated channels as well. Also influences many other neurotransmitter systems
<i>Nicotine</i>	Agonist at nicotine acetylcholine receptors
<i>Cannabinoids</i>	Agonist at CB 1 receptors, which mediate the addicting actions. Agonist at CB 2 receptors, which are expressed in the periphery only
<i>Phencyclidine (PCP)</i>	Antagonist at NMDA glutamate receptors

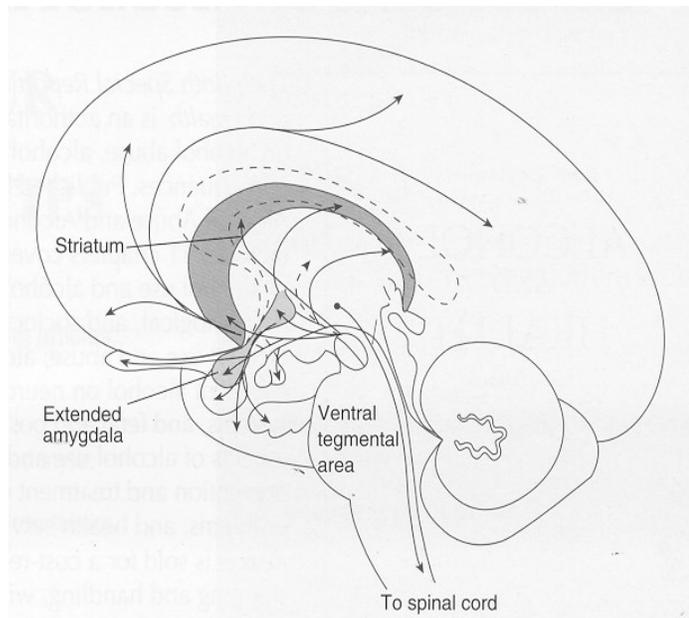
<i>Hallucinogens</i>	Partial agonist at 5HT 2A serotonin receptors
<i>Inhalants</i>	Unknown

Nestler EJ (2003): "From Neurobiology to Treatment: Progress Against Addiction", Chapter 6 in Section 1, Basic Science and Core Concepts in "Principles of Addiction Medicine" Eds Graham AW, Schultz TK, Mayo-Smith MF, Ries RK, Wilford BB, Third Edition. American Society of Addiction Medicine Inc., Chevy Chase, MD. (Above table is from page 74. Information and figure on General Strategies Used to Treat Drug Addiction or Associated Physical Withdrawal below, page 75.)

### Brain Reward Circuitry

- Amphetamine and cocaine are rewarding because they act at the dopamine transporter to elevate nucleus accumbens (NAS.) dopamine levels; nicotine is rewarding because of actions on nicotinic cholinergic receptors, expressed at both the cell bodies and the terminals of the mesolimbic system, that result in elevated dopamine release in NAS.
- Ethanol and cannabis act by unknown mechanisms to increase the firing of the mesolimbic dopamine system and are apparently rewarding for that reason
- The habit-forming effects of barbiturates and benzodiazepines appear to be triggered at one or more of the GABAergic links in the circuitry, not necessarily through feedback to be rewarding through some independent circuitry
- Heroin and morphine have two rewarding actions: inhibition of GABAergic cells that normally hold the mesolimbic dopamine system under inhibitory control (thus morphine disinhibits the dopamine system) and inhibition of output neurones in NAS

(Wise RA (2003): "Brain Reward Circuitry", Chapter 5 in Section 1, Basic Science and Core Concepts in "Principles of Addiction Medicine" Eds Graham AW, Schultz TK, Mayo-Smith MF, Ries RK, Wilford BB, Third Edition. American Society of Addiction Medicine Inc., Chevy Chase, MD. Page 65)

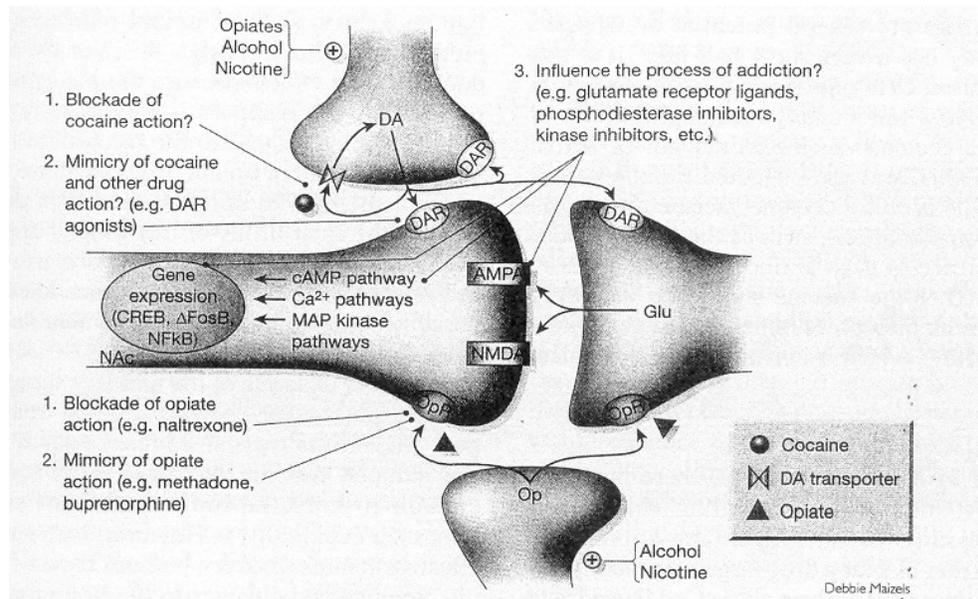


**Figure 3** Dopaminergic pathways in the brain. Most dopamine-containing neurons are located within the midbrain, extending to the striatum as well as to various sites in the forebrain. Dopamine modulates such varied functions as emotion, aggression, cognition, the coordination of movement, and aspects of the development of addiction.

## 2. Pharmacotherapy in Co-Occurring Disorders

### (a) Current Pharmacological Agents for Substance Use Disorders

#### General Strategies Used to Treat Drug Addiction or Associated Physical



#### Withdrawal

### (b) Treatment of Depressive Symptoms With Antidepressant Medications

(Reference: TIP 48, page 29)

If a patient has depressive symptoms or a depressive disorder that has not improved after entering substance abuse treatment, you should consider referral to a physician for evaluation for antidepressant medication. This assertion is supported by a meta-analysis of 14 placebo-controlled clinical trials of antidepressant medications in alcohol or drug dependent patients with depressive disorders (Nunes and Levin, 2004). Antidepressant medications were most likely to be effective in studies when patients were abstinent when diagnosed with depression. Hence, much the same as with medications for treatment of substance use disorders, treatment with antidepressants is not a panacea or a stand-alone treatment. If applied with appropriately diagnosed patients, antidepressant medications should improve mood, help reduce substance use, and facilitate the overall psychosocial treatment plan. Your collaboration with the medicating clinician is essential to support your client's recovery.

Bear in mind the following principles in regard to the treatment of your clients with medications for depression:

- Antidepressant medications rarely have abuse potential
- Any given medication has about a 50 percent chance of working well, and a 50 percent chance of failing.
- No method or test will predict the best medication for a patient.
- It often takes at least 4 to 6 weeks of treatment and the achievement of an adequate dose before an antidepressant medication begins to work.
- Depression symptoms should be monitored regularly and systematically during antidepressant treatment.

- If one medication fails to result in a significant improvement in depression symptoms after an adequate trial (generally 6 weeks of treatment at an adequate dose), then a different medication should be tried by the prescribing clinician.
- Counselors should be alert to possible adverse interactions between an antidepressant medication and the substances a patient is abusing (such as the potential for increased sedation or intoxication).

## F. Treatment and Management Strategies for Mood Disorders

### 1. Psychiatric Emergencies

- **A**ssaultive behavior violence • **S**uicide • **A**cute **A**nxiety • **P**sychosis

#### Assaultive Behavior or Violence

*Appearance:* Out of control; agitated; angry and attacking tone and appearance or paranoid, suspicious and isolative appearance

*Behavior:* out of control verbal and/or physical assaultive behavior; sporadic, specific violence related to intoxication or conflict situations or delusions

*Cognition:* intoxicated; psychotic; angry about a specific conflict or situation

*Differential diagnosis:* intoxication; psychosis; personality disorder; situational crisis

#### Suicide

*Appearance:* Depressed, sad, may be disheveled from depression's poor self-care or due to psychosis

*Behavior:* actual para-suicidal behaviors of wrist-scratching; minor overdose; half-hearted attempts; actual dangerous attempts and/or notes, planning when not likely to be found

*Cognition:* suicidal ideation, plans and lethal means arranged; depressed and guilty thinking; hopelessness (chronic illness, depressive illness)

*Differential diagnosis:* major depression; psychosis; intoxication; personality disorder

#### Acute Anxiety

*Appearance:* Panicky; anxious; distressed; trembling; sweating;

*Behavior:* hyperventilation; paresthesia of extremities and face with possible tetany (physical symptoms arise from respiratory alkalosis); agitated; chills or hot flushes; nausea

*Cognition:* feel impending doom; going to die; fear of losing control; feeling of choking

*Differential diagnosis:* panic disorder; other anxiety disorder; alcohol or sedative withdrawal; toxic conditions e.g., aspirin ingestion, amphetamines, caffeine and steroids; underlying acute medical condition e.g., metabolic disturbances, hypoglycemia, hyperthyroidism, Cushing disease, acute blood loss, incipient anaphylaxis, temporal lobe epilepsy

#### Psychosis

*Appearance:* Hallucinations; disheveled; poor personal hygiene; can be bizarre

*Behavior:* agitated, withdrawn, isolative, suspicious, mistrustful, inappropriate affect and talking

*Cognition:* diminished capacity to receive, retain, process, recall and act on information in a plausible or culturally acceptable way; delusions, thought blocking, derailment, tangential thinking, auditory or visual hallucinations

*Differential diagnosis:* acute functional psychosis - schizophrenia or mania; acute organic psychosis - usually develops faster than functional psychoses; first episode of psychosis over 40 y.o. more likely organic; previously diagnosed, serious medical illness (heart, lung, liver, kidney, endocrine systems) more likely to suggest treatment or illness complication if psychotic; absence of localized signs does not exclude organic psychosis; numerous medications

## 2. Suicide Risk Assessment and Potential Risk of Harm

**Risk of Harm:** This dimension of the assessment considers a person's potential to cause significant harm to self or others. While this may most frequently be due to suicidal or homicidal thoughts or intentions, in many cases unintentional harm may result from misinterpretations of reality, from inability to care adequately for oneself, or from altered states of consciousness due to use of intoxicating substances. For the purpose of evaluation in this parameter, deficits in ability to care for oneself are considered only in the context of their potential to cause harm. Likewise, only behaviors associated with substance use are used to rate risk of harm, not the substance use itself. In addition to direct evidence of potentially dangerous behavior from interview and observation, other factors may be considered in determining the likelihood of such behavior such as past history of dangerous behaviors, ability to contract for safety, and availability of means. When considering historical information, recent patterns of behavior should take precedence over patterns reported from the remote past. Risk of harm may be rated according to the following criteria:

• *Minimal risk of harm:*

- (a) No indication of suicidal or homicidal thoughts or impulses, no history of suicidal or homicidal ideation, and no indication of significant distress.
- (b) Clear ability to care for self now and in the past.

• *Low risk of harm:*

- (a) No current suicidal or homicidal ideation, plan, intentions or serious distress, but may have had transient or passive thoughts recently or in the past.
- (b) Substance use without significant episodes of potentially harmful behaviors.
- (c) Periods in the past of self-neglect without current evidence of such behavior.

• *Moderate risk of harm:*

- (a) Significant current suicidal or homicidal ideation without intent or conscious plan and without past history.
- (b) No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.
- (c) History of chronic impulsive suicidal/homicidal behavior or threats and current expressions do not represent significant change from baseline.
- (d) Binge or excessive use of substances resulting in potentially harmful behaviors without current involvement in such behavior.
- (e) Some evidence of self neglect and/or compromise in ability to care for oneself in current environment.

• *Serious risk of harm:*

- (a) Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so, or with ability to contract for safety.
- (b) History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from baseline.
- (c) Recent pattern of excessive substance use resulting in disinhibition and clearly harmful behaviors with no demonstrated ability to abstain from use.
- (d) Clear compromise of ability to care adequately for oneself or to be aware adequately of environment.

• *Extreme risk of harm:*

- (a) Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior without expressed ambivalence or significant barriers to doing so; or with a history of serious past attempts which are not of a chronic, impulsive, or consistent nature; or in presence of command hallucinations or delusions which threaten to override usual impulse control.
- (b) Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.
- (c) Extreme compromise of ability to care for oneself or to monitor adequately the environment with evidence of deterioration in physical condition or injury related to these deficits.

Source: American Academy of Community Psychiatrists 2000a

## G. **Treatment Principles**

- For dual diagnosis patients, treat vigorously every diagnosis you are reasonably sure of, but only if the assessment steps have excluded the mimicking effects of addiction.
- Because mental and substance-related disorders are biopsychosocial disorders in etiology, expression and treatment, assessment must be comprehensive and multidimensional to plan effective care. The common language of the six assessment dimensions of the ASAM Criteria (*modified* in Second Edition, Revised, ASAM PPC-2R, 2001) are used to focus assessment and treatment.
  1. Acute intoxication and/or withdrawal potential
  2. Biomedical conditions and complications
  3. Emotional/behavioral/*Cognitive* conditions and complications
  4. *Readiness to Change*
  5. Relapse/Continued Use/*Continued Problem* potential
  6. Recovery environment

- Regardless of the particular setting and client population, there are “generic” treatment strategies:

### 5 M's:

Motivate - dual diagnosis clients can have denial, resistance and passivity about their addiction and mental health problems; deal with resistance at a pace that keeps the patient engaged in treatment; family and healthcare workers may also need “motivating” to deal with both addiction and psychiatric issues equally. (Dimension 4)

Manage - because dual diagnosis clients easily present to both addiction and mental health programs, treatment is more case management across the addiction and mental health treatment systems, social welfare, legal, and family systems and significant others, than individual therapy; case management especially important for high risk, multiproblem and chronic relapsing clients; take a total systems approach; to improve outcomes, alternative services may be necessary e.g. educational or vocational services, child care and parenting training, financial counseling, coping with feelings and dual relapse groups, daily living skills, tutoring or mentoring services, transportation. (Dimensions 1 - 6)

Medication - for a diagnosed co-morbid psychiatric disorder, but only after sufficient assessment strategies exclude addiction mimicking; also for detoxification if necessary; educate clients about their medication and interaction with alcohol/drugs; prepare them on how to deal with conflicts about medication at AA/NA meetings; anti-craving medication; Antabuse; methadone; opioid antagonists. (Dimensions 1, 2, 3, 5)

Meetings - mainstream into AA and NA as much as possible, but prepare clients on how to not alienate themselves eg. too readily discussing medication and mental health issues unless with an understanding member or group; help clients deal with their “dual identity”; help identify appropriate meetings in the area and locate or develop special support groups for those unable to be “mainstreamed”. (Dimensions 3, 4, 5, 6)

Monitor - to ensure continuity of care, be alert to missed appointments; hospitalizations and professionals unfamiliar with dual diagnosis and the treatment goals eg. drug-free diagnostic trial; promote accountability for an ongoing treatment plan, rather than fragmented response to crises; recognize treatment as a process, not an event. (Dimensions 1 - 6)

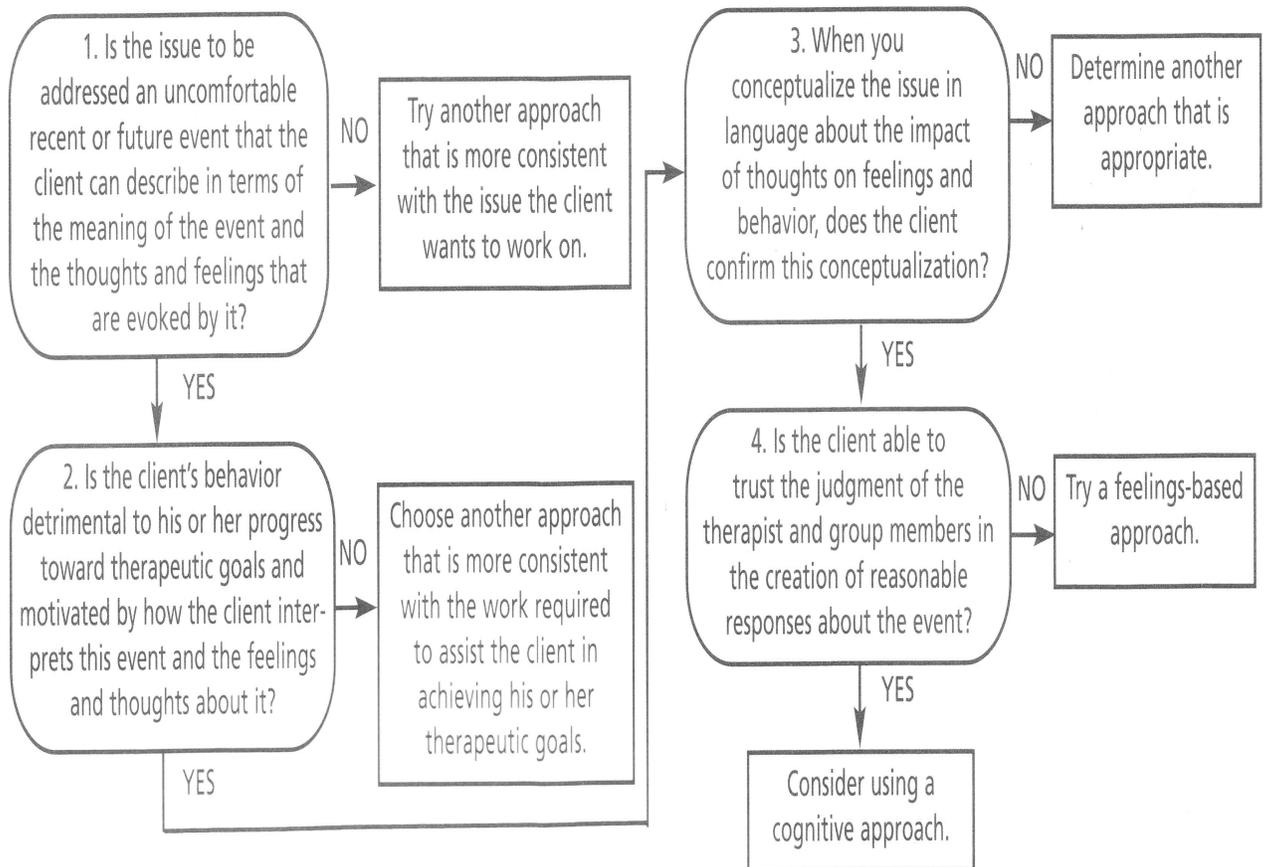
## 1. Cognitive Treatment for Mood Disorders

### TIP 48, page 57, Figure 2.5



**Figure 2.5**  
**Decision Tree**

### How to Determine Whether a Cognitive Treatment Approach Is Appropriate



## 2. Different Approaches for Different Dual Diagnosis Clinical Situations

Past abuse: help patient stay in recovery, but don't dig and uncover traumatic experiences until sufficient non-drug coping skills developed;

Verbally aggressive and challenging: empathize with the fear or the mistrust but don't patronize nor verbally spar with the patient;

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Intellectualizing, obsessing: allow discussion of ideas for five minutes at the end of session, but don't discount patient by saying, "don't analyze" or "get out of your head", provide action or doing tasks to communicate;

Withdrawn and reluctant to verbalize: provide action or writing tasks to facilitate discussion eg. reading to group from a homework or action assignment;

Hypomanic or manic: separate from the group if overstimulated or withhold from group or activity if escalating;

Psychotic or paranoid: empathize with the concern, but don't agree with or condone the delusion or misperceptions.

Criminal code and criminal thinking: help client develop the responsible code and reverse criminal thought processes. Feelings are signals to start thinking it through by going inside oneself and choosing responsible, accountable behavior. Criminal thinking goes outside and blames people, places and things using feelings to define the thought process, thus choosing irresponsibility and lack of accountability e.g., client awakes and feels bored and like skipping work; allows the feeling to form the thoughts and says "they're jerks", or "it's a stupid job", or "they don't pay me enough" - and then chooses not going to work or being responsible and accountable.

A responsible code person awakes with the same feeling of boredom and of not wanting to go to work, but then thinks: "they're relying on me", or "I've got a family to support", or "they pay me for this job" - and then chooses to go to work and be responsible and accountable. (David Koerner's training in corrective thinking and criminal thought process).

### 3. Medication Adherence Problems – Differential Diagnosis and What to Do About It

- It is important to diagnose why the person does not adhere to medication, otherwise the strategy may be counterproductive:
  1. Cognitive – (a) client had a bad side effect or felt meds have not worked before and so won't take medication anymore – treat the fear of side effects and/or the lack of confidence in medication.
    - (b) readiness to change issues – client not ready to accept medication as necessary for an illness which s/he may accept or about which is still ambivalent – motivational enhancement, stages of change work.
    - (c) wants to use natural substances rather than psychotropic medication.
  2. Cultural – believes the medication is dangerous from his/her cultural perspective – get a bi-cultural outreach worker.
  3. Unconsciously non-adherent; somatic complaints; sick role; characterological; the more the therapist is involved, the more it shows they care and the more the sick role pays off; love Assertive Community Treatment (ACT) for example, because the more you go to their home to count pills, the more they are non-compliant to keep you coming back.
  4. Drug addict – overusing pills due to an addiction.
  5. Psychotic – delusional – maintain the relationship and don't struggle over the diagnosis; ACT is appropriate in such situations.
  6. Malingering external incentives for the behavior e.g., keep getting workers compensation.
  7. Recovery Environment problems – Insufficient funds to pay for medication and/or transportation and/or childcare to keep appointments for medication monitoring

### 4. Counseling Techniques

#### (a) Be careful about reinforcing suicidal behavior

Imagine if every time a person becomes suicidal the response is to move from a stressful environment to a safe, caring treatment environment. The client quickly learns to see themselves as unable to cope in the community; and that all that will work is to have others take over control of them and their environment.

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So the next time a similar crisis arises, guess where the person thinks of first to go as a way to cope and get relief?

Most clients know that if they have run out of money and want to get off the streets; or get relief from the stresses at home or the street, the surest way to get to a 24 hour setting is to present depressed and suicidal. That is not to say that everyone who presents suicidal is not really suicidal; nor that we should never hospitalize people who are suicidal. But when hospitalization and intense treatment is always the first option, it reinforces this as the main coping and relief mechanism.

Marsha Linehan suggested that in a Dialectical Behavior Therapy approach, the message is that hospitalization and intense treatment is the last option if at all, but certainly not the first option. Compared with treatment-as-usual, DBT reduces the prevalence and medical severity of parasuicide episodes, therapy dropout, and inpatient psychiatric days.

You might say: *“I really understand that life feels hopeless and depressing right now and that it seems that death is the best and only option. But I am glad you are here talking to me, because that tells me a part of you actually has hope that it might not actually be the only option for you. So let’s work on how to explore all the options, not just the death one and I will hang in with you in that process. There is no magic in an inpatient stay. It will not solve all the problems right now; and it may even delay solutions and make things worse. So let’s think together on what we can do to focus on active functioning in the community and to get on with the part of you that found life worth living and brought you to reach out for help. You wouldn’t have called me if you wanted to die, as you know I don’t help people die. But you do know I want to be there for you to help you live. Thank-you for reaching out and asking me to help you live. Now let’s get on with focusing on that that.”*

#### **Reference:**

Linehan MM, Tutek DA, Heard HL, Armstrong HE: “Interpersonal Outcome of Cognitive Behavioral Treatment for Chronically Suicidal Borderline Patients” Am J Psychiatry. 1994; 151:1771-1776.

- (b) **Risk Domains.** A Risk Domain is an assessment subcategory within Dimension 3:
- ***Dangerousness/Lethality.*** This Risk Domain describes how impulsive an individual may be with regard to homicide, suicide, or other forms of harm to self or others and/or to property. The seriousness and immediacy of the individual's ideation, plans and behavior—as well as his or her ability to act on such impulses—determine the patient's risk rating and the type and intensity of services he or she needs.
  - ***Interference with Addiction Recovery Efforts.*** This Risk Domain describes the degree to which a patient is distracted from addiction recovery efforts by emotional, behavioral and/or cognitive problems and, conversely, the degree to which a patient is able to focus on addiction recovery. (Note that high risk and severe impairment in this domain do not, in themselves, require services in a Level IV program.)
  - ***Social Functioning.*** This Risk Domain describes the degree to which an individual's relationships (e.g., coping with friends, significant others or family; vocational or educational demands; and ability to meet personal responsibilities) are affected by his or her substance use and/or other emotional, behavioral and cognitive problems. (Note that high risk and severe impairment in this domain do not, in themselves, require services in a Level IV program.)

- **Ability for Self Care.** This Risk Domain describes the degree to which an individual's ability to perform activities of daily living (such as grooming, food and shelter) are affected by his or her substance use and/or other emotional, behavioral and cognitive problems. (Note that high risk and severe impairment in this domain do not, in themselves, require services in a Level IV program.)
- **Course of Illness.** This Risk Domain employs the history of the patient's illness and response to treatment to interpret the patient's current signs, symptoms and presentation and predict the patient's likely response to treatment. Thus, the domain assesses the interaction between the chronicity and acuity of the patient's current deficits. A high risk rating is warranted when the individual is assessed as at significant risk and vulnerability for dangerous consequences either because of severe, acute life-threatening symptoms, or because a history of such instability suggests that high intensity services are needed to prevent dangerous consequences.

For example, a patient may present with medication compliance problems, having discontinued antipsychotic medication two days ago. If a patient is known to rapidly decompensate into acute psychosis when medication is stopped, his or her rating is high. However, if it is known that he or she slowly isolates without any rapid deterioration when medication is stopped, the risk rating would be less. Another example could be the patient who has been depressed, socially withdrawn, staying in bed and not bathing. If this has been a problem for six weeks, the risk rating is much higher than for a patient who has been chronically withdrawn and isolated for six years with a severe and persistent schizophrenic disorder.

### **Wanda on Welfare**

Wanda is a 46-year old divorced, Latina female who was married at 18 to a male who was emotionally and physically abusive and lived at home less than half of the time of their eight-year marriage. The marriage was also characterized by infidelities by both her and her husband and regular and sometimes heavy marijuana and alcohol use. Two children resulted from this marriage, a son, Juan, now 26 and a daughter, Rosa, now 24. She has had no contact with either of these children for the last 12 years after she became pregnant and delivered a baby girl, Gloria, from an African-American father, whom she claims she met in a bar one night and doesn't even know his name. She was referred for assessment by her caseworker.

In the last 20 years, since the divorce, her drinking and marijuana use have increased markedly and she would often spend her days at home alone with Gloria, drinking and smoking heavily and neglecting her daughter. On one occasion the authorities became involved and threatened to remove Gloria from the home. As a result, she began seeing a counselor and at her suggestion, she began attending AA and NA briefly. Her counselor retired from practice and Wanda discontinued recovery group meeting attendance. The issue of custody apparently ceased being an issue but Wanda does not know why.

She is the child of an alcoholic father whom she alternately idolized and feared and who was seductive but not openly sexual with her as she was growing up. He father was killed in barroom brawl when she was 30 years old. Her mother 67 years old, lives alone and is still in denial about Wanda's father's alcoholism. She is the younger of two female children and her older sister is a teetotaler and a pillar of her church. They have not had contact in about three years.

A year ago she again began attending AA and claims she enjoys it. She attends weekly. She now drinks about once a week without apparent problem. She no longer smokes pot. She does feel hypocritical attending AA and still drinking but she neither wants to stop drinking nor discontinue her AA attendance because she has a few women friends there. They do not know about her current drinking. She had considered finding another counselor because of her dissatisfaction with her life but never translates this into action. She does not believe that she has a drinking problem. She is not sure what she wants, other than what she has.

She lives with Gloria in a rented apartment and spends most of her day watching television and considers herself a “soap opera addict.” She is in a relationship with a drug dealer although she claims not to use any of the cocaine or heroin that her boyfriend sells. She likes him because “he buys her things.” He also helps with the rent although he does not live there. Gloria is doing poorly in school and has been picked up for a shoplifting offense. On two occasions she told Wanda that she was spending the night with a girlfriend and this was later determined to be untrue. Wanda has no idea where she was each of those nights. They are in a constant struggle. Gloria calls her mother a “slob” and Wanda calls Gloria a “tramp.”

She has been on welfare for most of her adult life and sees nothing unusual or undesirable about it. She has never worked outside of a few brief stints earlier as a dishwasher (2 times, once for 2 weeks and once for 3 weeks) and as attendant in a car wash (1 month). Both jobs came to an end because of her failure to show up for work because of using, oversleeping or being hung over. She has no job skill and is not particularly interested in acquiring such skills or working. She is aware that her welfare benefits will be terminated if she doesn't do something about work and feels that the State is being unfair.

Wanda claims to have no medical problems although she states that she can't wait for menopause because her periods are so painful and her bleeding so heavy. She later added that she has migraine headaches although has never seen a doctor about them. Her affect is slightly flattened but beyond that, she neither appears depressed nor does she claim to be depressed. She has never sought substance abuse or mental health treatment except for the earlier six-month period with the counselor.

### Stephen

Stephen is 51 years old and is accompanied by his wife. He wants help, but is depressed. During his intake interview for this, his second DUI arrest, he looks disconsolate and he speaks in a monotone as he wonders if his wife will leave him. His alcohol use has resulted in alienation from his children, guilt feelings and his job may now be threatened, as he has been warned by his supervisor about his poor attendance and performance. Most of his friends drink, but none of them think he is an alcoholic.

He has not had any previous addiction treatment other than DUI classes after his first DUI four years ago. He attended AA for six months on and off and did have a sponsor, but felt more and more that he wasn't as bad as others at AA and gradually stopped going.

Stephen has been alcohol-free for three weeks. He has used cocaine (snorting) about three times per month over the past four years, but stopped two months ago. He has had no legal or financial problems related to cocaine. Stephen has continued on diazepam (Valium) 5 mg. qid which he has taken for five years to relax him because of mild hypertension. He has no other chronic physical problems but has lost 10 pounds weight over the past month and has been sleeping poorly. He wishes he could sleep and get away from all his problems but denies any organized suicidal plans and says he wants help.

### C.W.

February 18

The following is a report on C.W. The consultation issue involved the question of whether primary alcohol dependence or primary psychiatric interventions were needed; and also recommendation for level of care and treatment plan given this patient's three hospitalizations since age 15 with the current admission involving high risk suicidal behavior. CW is a 19 year-old, white, single, unemployed tire worker who was admitted 2/13 intoxicated on alcohol and also positive for marijuana in his drug screen. He was depressed and suicidal and had cut his chest; written “Die” on his chest; and taken an overdose of Prozac.

## **CASE VIGNETTES: MOOD DISORDERS**

**Instructions:** Develop an Axis I diagnosis and list the symptoms that led to this diagnosis.

### **CASE VIGNETTE 1:**

Jane is a 34 year old M.W.F. bank executive who is brought for evaluation by her husband. According to the husband, Jane was in excellent health until 2 weeks ago, when she began staying up later at night. He was initially not too concerned, until she began awakening him to talk about the “revolutionary” news ideas she had about creating an international bank cartel. He notes she was “full of energy” and talked rapidly about the many ideas that she had. He became quite concerned when at 3 A.M. Jane telephoned the president of the bank where she works to discuss her ideas. When her husband confronted her about the inappropriateness of her phone call, she became enraged and accused him of purposefully attempting to sabotage her venture.

On examination Jane’s speech is quite rapid and she jumps quickly from one subject to another. She states that she is about to revolutionize banking and control the world currency market. When questioned about the likelihood of achieving this goal, she becomes irritable and threatens to leave. She admits to auditory hallucinations that are telling her how to corner the market on gold. She is on no medications, has no prior psychiatric history (including no prior depressive episodes), and denies drug abuse. Family history is positive for Mood disorders. Her younger brother had a severe depression 2 years ago that required hospitalization, and her mother was diagnosed as Manic-Depressive many years ago. Her physical examination is normal and toxic screen for drugs is negative.

### **CASE VIGNETTE 2:**

Tom is a 28 year old S.B.M. government employee referred by his family physician for evaluation. He reports 3 month history of worsening anxiety that is especially bad early in the morning. “I wake up at 3 in the morning and I can’t get back to sleep. My thoughts torment me.” He also reports decreased energy, inability to concentrate at his job, decreased appetite with a 10 pound weight loss, and suicidal ideation. “I feel so hope-less that suicide seems like an option.” He also states, “There is nothing in my life that I enjoy.”

Tom is tearful during evaluation. He lacks animation and his mood is quite depressed. He denies prior hypomanic or manic episodes. Mental status exam reveals slowed thinking and no evidence of psychosis. He does report two previous depressive periods, one in late adolescence and another during his senior year in college. During the latter episode, his symptoms were severe enough that he was unable to attend classes. “I almost failed that semester.” Both depressive episodes remitted in a few months without treatment; he “felt like normal” during remission. He denies drug abuse or use and has no medical problems. The family history is positive for depression in a paternal grandfather, and in his father, and he reports that a depressed uncle committed suicide about 10 years ago.

## **Kim**

Kim is a 29-year-old, Caucasian, single mother, unemployed woman who was referred by her outpatient therapist because of depression with verbal threats towards the Child Protective Services office as well as suicidal threats and feelings. She talked of wanting to kill herself with a gun and also using a machine gun to kill others if she did not get her children back.

Two months earlier, her two sons, who are two and a half and eight were put in a foster home because she supposedly left them unattended. She says that her boyfriend of fourteen years actually pushed her down some steps and she fell and was unconscious for four days. She had taken two hits of crystal methamphetamine and says that as a result of the "dirty" urine test, her children were taken away from her and she is very angry and depressed about this. Her boyfriend who is now in jail for parole violation is apparently being charged with attempted murder because of the incident.

Kim has been depressed over wanting to get her children back and angry at "the system" because she feels she has been wronged. She says that she has not used any drugs other than one day two month's ago, for nearly three years and was very active in Alcoholics Anonymous having a sponsor and being involved up until eight months ago. Kim has drifted away from Alcoholics Anonymous and feels that this may have caused her relapse in two months earlier. She wants to get her life together but also has been feeling angry about the difficulty of getting public assistance and has been making verbal threats of wanting to "blow people's brains out" and also feelings of wanting to give up and "that she is cracking up".

Kim denies any current use of alcohol or other drugs although admits in the past to having had a significant problem with cocaine and marijuana. She has had a previous psychiatric hospitalization four years ago, when she had cut her wrists and needed a couple of sutures after an argument with her boyfriend. Her legal history is that she has had various violations for speeding and driving without a license. The court ordered her to get treatment as a precondition to getting her children back and she has been having outpatient therapy with a psychologist.

Kim has been having no trouble with sleep and has had an increased appetite with a slight increase in weight but her energy and libido have been decreased and she has had suicidal feelings. She has been having some trouble with constipation, poor hearing in her left ear and occasional headaches perhaps related to the fall two months ago. Her menstrual periods have been normal and she smokes a pack of cigarettes every two days. She does want help, however, mainly though to get her children back. On physical examination, there were no major abnormalities except for significantly diminished hearing in her left ear. On mental status examination, she was fully oriented, but related in an angry and hostile manner when talking of how she felt she has been mistreated as regards her children. She was not psychotic, but easily became so enraged that her impulse control over homicidal threats or rageful self-destructive ideas was very questionable.

**Vignette 1:**

296.04 Bipolar I, severe, single manic episode with mood congruent psychotic features  
Criteria influencing the diagnosis:  
Episode lasting longer than one week  
Flight of ideas  
Grandiosity  
Decreased need for sleep  
Rapid speech  
Quickly changes subject  
Expansive mood characterized by unceasing enthusiasm for occupational interactions  
Mood became irritable when her wishes were thwarted  
Auditory hallucinations  
Episode is not related to substance use or medical condition  
No prior depressive or manic episodes  
Not accounted for by another diagnosis  
Severity specifier is used to qualify that she has an observable disability that would prevent her from working in her current condition.

**Vignette 2:**

296.33 Depressive Disorder, Recurrent, severe, without psychotic features

Criteria influencing the diagnosis:

Three month increase in anxiety related to mood  
Tormenting thoughts  
Decreased energy  
Cannot concentrate  
Decreased appetite resulting in 10 pound weight loss  
Suicidal ideation  
Loss of pleasure  
Hopelessness  
Tearful  
Depressed mood  
Slowed thinking  
Family history of mood disorders  
Two prior depressed moods  
No prior hypomanic or manic episodes  
Not accounted for by another diagnosis  
Episode is not related to substance use or medical condition  
Severity specifier is used to qualify suicidal ideation and intervention is required to prevent injury to self

(<http://www.eiu.edu/~csd/files/leitschuh/leitschuhdsmvignettes.pdf>)

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4. **Co-Occurring Dialogues is an Electronic Discussion List** that specifically focuses on issues related to dual diagnosis. A subscription to the Co-Occurring Dialogues Discussion List is free and unrestricted and can be done simply by sending an e-mail to [dualdx@treatment.org](mailto:dualdx@treatment.org).

## **RESOURCES FOR ASAM PPC**

American Society of Addiction Medicine - 4601 Nth. Park Ave., Arcade Suite 101, Chevy Chase, MD 20815. (301) 656-3920; Fax: (301) 656-3815; www.asam.org; (800) 844-8948.

## **RESOURCE FOR ASSESSMENT INSTRUMENTS**

Level of Care Index (LOCI-2R): Checklist tool listing ASAM PPC-2R Criteria to aid in decision-making and documentation of placement.

Dimensional Assessment for Patient Placement Engagement and Recovery (DAPPER): Severity ratings within each of the six ASAM PPC-2R dimensions.

A variety of proprietary assessment instruments for identifying substance use disorders, psychiatric diagnoses for adults and adolescents.

To order: The Change Companies at 888-889-8866; www.changecompanies.net

For clinical questions or statistical information about the instruments, contact Norman Hoffmann, Ph.D. at 828-454-9960 in Waynesville, North Carolina; or by e-mail at evinceassessment@aol.com

## **CLIENT WORKBOOKS AND INTERACTIVE JOURNALS**

1. “Successful Living with a Dual Disorder” – Motivational, Educational and Experiential (MEE) Journal System. Interactive journaling for clients. This Journal is designed specifically for individuals who are suffering with a dual disorder. It provides important information that allows clients to understand the facts and challenges regarding their addiction and mental disorder.

To order: The Change Companies at 888-889-8866. www.changecompanies.net.

2. Foundations Co-Occurring Disorders Series Co-Occurring - The Recovery Workbook Series Workbook series on treating addictions and mental health conditions.

To order: Foundations Associates at 888.869.9230. www.dualdiagnosis.org

## **RESOURCE FOR HOME STUDY AND ONLINE COURSES**

1. “Dilemmas in Dual Diagnosis Assessment, Engagement and Treatment” By David Mee-Lee, M.D. This home study or online course (with CEU’s) is designed to improve practitioners’ abilities to assess, engage, and treat people with co-occurring mental health and substance use problems. Practical strategies and methods are offered to help change interviewing methods, treatment planning and documentation, program components, range of services, and policies to better engage the dually diagnosed client.

Professional Psych Seminars, Inc. Agoura Hills, CA Toll-free phone: (877) 777-0668. Website: www.psychsem.com

2. “ASAM 101: Basics on Understanding and Using ASAM Patient Placement Criteria, Revised Second Edition (ASAM PPC-2R)”

A 3-hour course that will introduce students to key concepts and issues of the ASAM Patient Placement Criteria. Clinicians involved in planning and managing care often lack a common language and systematic assessment and treatment approach that allows for effective, individualized services. The Patient Placement Criteria of the American Society of Addiction Medicine (ASAM) first published in 1991, provided common language to help the field develop a broader continuum of care. They were updated and the

second edition (ASAM PPC-2) was published in April 1996. A revised second edition was published in April 2001.

The Distance Learning Center for Addiction Studies (DLCAS) is an internet based educational service that provides comprehensive training and information in the field of addiction studies. It is a joint presentation of the Betty Ford Center and the Distance Learning Center, LLC. Toll-free phone: 866 471-1742. Website: [www.dlcas.com/course59.html](http://www.dlcas.com/course59.html)

### 3. Hazelden's Clinical Innovators Series

"Applying ASAM Placement Criteria" DVD and 104 page Manual with more detail based on the DVD with Continuing Education test (10 CE hrs), 75 minute DVD

David Mee-Lee (DVD) and Kathyleen M. Tomlin (DVD manual)

You can order from [www.Hazelden.org](http://www.Hazelden.org)

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3. Motivational Interviewing and Ambivalence – Principles of Motivational Interviewing; Spirit of Motivational Interviewing; Working with Ambivalence - Disc 3 of a Five Part Series Workshop
4. Establishing the Treatment Contract; Role Play – What, Why, How, Where and When to establish the Treatment Contract; and a role play with a "17 year old young man" to illustrate this technique - Disc 4 of a Five Part Series Workshop
5. Stages of Change; Implications for Treatment Planning – Stage of Change and the Therapist's Tasks; discussion of Relapse Policies; Using Treatment Tracks to match Stage of Change; discussion of Mandated Clients and relationship to the criminal justice system - Disc 5 of a Five Part Series Workshop

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## APPENDIX

(The following is an excerpt from the Clinical Practice Guidelines within: Minkoff, Kenneth (2005):  
“Comprehensive Continuous Integrated System of Care (CCISC) - Psychopharmacology Practice  
Guidelines for Individuals with Co-occurring Psychiatric and Substance Use Disorders (COD)”  
<http://www.kenminkoff.com/articles.html>)

### Psychopharmacological Treatment Strategies

#### A. General principles:

In patients with psychotic presentations, with or without active substance dependence, initiation of treatment for psychosis is generally urgent. In patients with known active substance dependence and non-psychotic presentations, it is recommended to utilize the integrated longitudinal assessment process *to* determine the probability of a treatable mental health diagnosis before medication is initiated. It can be very difficult to make an accurate diagnosis and effectively monitor treatment without this first step. It is understood that all diagnoses are “presumptive” and subject to change as new information becomes available. If there is uncertainty about diagnosis after reasonable history taking, evidence for initial efforts to discontinue substance use may need to occur prior to initiation of psychopharmacology, in order to establish a framework for further diagnostic evaluation. However, for high risk patients, with or without psychosis, developing a treatment relationship is a priority, and there should not be an arbitrary length of time required before treatment initiation takes place, nor should absolute diagnostic certainty be required. Individuals with reasonable probability of a treatable disorder can be treated

Psychotropic medications, particularly for anxiety and mood disorders, should be clearly directed to the treatment of known or probable psychiatric disorders, not to medicate feelings. It is important to communicate to patients with addiction that successful treatment of a comorbid anxiety or mood disorder with medication is not intended to remove normal painful feelings (such as normal anxiety or depressed feelings). The medication is meant to help the patient feel his or her painful feelings accurately, and to facilitate the process of developing healthy capacities to cope with those feelings without using substances. If psychotropic medications are used for mental illness in individuals with addiction, or if medication is used in the treatment of the addiction itself, the following precepts may be helpful to communicate to the patient:

“The use of medication for either type of disorder does not imply that it is no longer necessary for the patient to focus on the importance of his/her own work in recovery from addiction. Consequently, utilizing medication to help treat addiction should always be considered as an ancillary tool to a full addiction recovery program.”

Addicts in early recovery have great difficulty regulating medication; fixed dose regimes, not PRN's, are recommended in the treatment of mood and anxiety disorders.

Just as in individuals with single disorders, and perhaps more so, it is important to engage patients with co-occurring disorders as much as possible in understanding the nature of the illness or illnesses for which they are being treated, and to participating in partnership with prescribers in determining the best course of treatment. For this reason, most established medication algorithms (e.g. TMAP) and practice guidelines recommend that medication education and peer support regarding understanding the risks and benefits of medication use are incorporated into standard treatment practice. This is certainly true for individuals with co-occurring disorders, for whom information provided by peers may be particularly helpful in making good choices and decisions regarding both taking medication and reduction or elimination of substance use.

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## **B. Diagnosis specific psychopharmacological treatment for mental illness**

**1. Psychotic Disorders:** Use the best psychotropic agent available for the condition. Improving psychotic or negative symptoms may promote substance recovery. This includes treatment of substance-induced psychoses, as well as psychosis associated with conventional psychiatric disorders.

- a. Atypical neuroleptics: Consider olanzapine, risperidone, quetiapine, aripiprazole, ziprasidone or clozapine. In addition, it is well documented that clozapine has a direct effect on reducing substance use in this population, beyond any improvement in psychotic symptoms, and therefore may be specifically indicated for selected patients.
- b. Typical neuroleptics: Consider use in adjunct to the atypicals, especially in situations of acute agitation, unresolved psychosis, and acute decompensation
- c. Many individuals with COD will benefit from depot antipsychotic medications. Both typical and atypical neuroleptics (e.g., risperidone) are available in depot form. There have not been specific studies about the utilization of depot risperidone in individuals with co-occurring substance use disorder, but there is no apparent contraindication to its use.

**2. Major Depression:** The relative safety profile of SSRI's (and to a somewhat lesser extent SNRI's such as venlafaxine), other newer generation antidepressants and possibly bupropion (though higher seizure risk must be considered) make their use reasonable (risk-benefit assessment) in the treatment of individuals with CODs. SSRI's have been demonstrated to be associated with lower alcohol use in a subset of alcohol dependent patients, with or without depression. The use of tricyclic antidepressants (TCAs) and MAO inhibitors (MAOIs) can be more difficult and possibly more dangerous in the COD population if there is a risk of active substance use.

**3. Bipolar Disorder:** Use the best mood stabilizer or combination of mood stabilizers that match the needs of the patient. Be aware that rapid cycling and mixed states may be more common, hence consider valproate, oxycarbamazepine, carbamazepine or olanzapine (and other atypicals), in patients who may have these variants.

- 4. ADHD:** Initial treatment recommendations, in early sobriety, have included bupropion. Recently, atomoxetine has been available, and may be a reasonable first choice, though there have not been specific studies in co-occurring populations. In both adolescents and adults, there is clear evidence that if stimulant medications are necessary to stabilize ADHD, then these medications can be used safely, once addiction is adequately stabilized and/or the patient is properly monitored, and will be associated with better outcomes for both ADHD and substance use disorder.

**5. Anxiety disorders:** Consider SSRIs, venlafaxine, buspirone, clonidine and possibly mood stabilizers such as valproate, carbamazepine, oxycarbamazepine, gabapentin, and topiramate, as well as atypical neuroleptics. There is evidence of effectiveness of topiramate for nightmares and flashbacks associated with PTSD.

For patients with known substance dependence (active or remitted), the continuation of prescriptions for benzodiazepines, addictive pain medications, or non-specific sedative/hypnotics is not recommended, with or without comorbid psychiatric disorder. On the other hand, medications with addiction potential should not be withheld for carefully selected patients with well-established abstinence who demonstrates specific beneficial responses to them without signs of misuse, merely because of a history of addiction. However, consideration of continuing prescription of potentially addictive medications for consumers with diagnosed substance dependence, is an indication for both (a) careful discussion of risks and benefits with the patient (and, where indicated, the family) and (b) documentation of expert consultation or peer review.

**Sleep disturbances** are common in mental illness as well as substance use disorders in early recovery. Use of non-addictive sedating medications (e.g., trazodone) may be used with a careful risk benefit assessment.

### **C. Psychopharmacologic Strategies in the Treatment of Substance Use Disorders**

There is an increasing repertoire of medications available to treat substance use disorders, including medications that appear to directly interrupt the core brain processes associated with lack of control of use. All of these medications have demonstrated effectiveness in populations who may also have psychiatric disorders, including severe mental illnesses.

1. Disulfiram
  - A. Disulfiram interferes with the metabolism of alcohol via alcohol dehydrogenase, so that individuals who use alcohol will get ill to varying degrees when taking this medication. This can be a valuable tool in assisting individuals to resist impulsive drinking, but generally must be combined with additional recovery programming and/or positive contingencies. Disulfiram should NOT be used to coerce sobriety in any patient.
  - B. As a dopamine beta-hydroxylase inhibitor, disulfiram occasionally will exacerbate psychosis, necessitating adjustment of antipsychotic medication
  - C. As a dopamine beta-hydroxylase inhibitor, disulfiram has also been found to reduce cocaine craving and cocaine usage in some studies.
  
2. Opiate maintenance treatment
  - A. Methadone and LAAM are well established treatments for opiate dependence, and have been found to be successful in individuals with a wide range of psychiatric comorbidity, in the context of methadone treatment programs.. Methadone dosing is now informed by the capacity to measure trough levels. The prescriber must be aware that there are enzymatic interactions that affect the interaction of methadone with various psychotropics, the details of which are beyond the scope of these guidelines, but which should be reviewed when such combinations are being initiated.
  - B. Buprenorphine has been more recently introduced for opiate maintenance, does not require participation in a formal “program”, like methadone, and can be provided in office based settings by physicians who have addiction specialization and/or who have had eight hours of training. Oral buprenorphine is provided combined with naloxone to prevent diversion for parenteral use. It is a mixed m-opiate receptor agonist and a k-receptor antagonist, that appears to be easier to utilize, with fewer side effects, and less severe abuse or withdrawal risk, than methadone. Although not well studied in the co-occurring disordered population, all indications in the literature indicate that it is effective. Again, there are a range of interactions that may occur with enzymes that metabolize psychotropic medication, that need to be reviewed when initiating treatment.
  
3. Naltrexone
  - A. Opiate dependence: Naltrexone is a relatively long acting opiate blocker that can be effective given three times weekly for opiate dependence, particularly when combined with significant contingencies to support adherence.
  - B. Alcohol dependence: Naltrexone has been demonstrated to be effective in reducing alcohol use through reducing craving and loss of control, presumably by affecting endogenous opiate pathways that are involved in the development of the brain disorder of alcohol dependence. Naltrexone has been demonstrated to be effective in individuals with schizophrenia and other mental illnesses in preliminary studies.
  
4. Acamprosate Available in Europe for several years, acamprosate has recently been approved in the US. It reduces alcohol usage through an impact on endogenous GABA pathways. The combination of acamprosate plus naltrexone is reportedly more effective than either alone.
  
5. Bupropion for nicotine dependence appears to have an effect on reward pathways associated with nicotine use. . Nicotine replacement for nicotine dependence, including nicotine patch, gum, and more recently, nasal spray, which most closely mimics the effects of smoking in nicotine delivery. Bupropion and nicotine replacement combined tend to result in better outcomes than either alone

6. Topiramate for alcohol dependence (one study) has some potential value through its effect on GABA receptors
7. Desipramine for cocaine craving has yielded very inconsistent findings.
8. Dopaminergic agents for cocaine craving have also yielded inconsistent findings, with risk of exacerbation of psychosis.
9. Serotonergic agents (e.g., SSRIs) have been found in some studies to have a beneficial effect in reducing alcohol use in non-depressed alcoholics, particularly in certain subtypes of alcohol dependence.