

Treatment of Mood and Substance Use Disorders

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TOPICS

- Background Information
- Depressive Disorders
- Bipolar Disorders
- Treatment Strategies

1. Brief Background

Rates of Depression in Patients with a S.U.D.

- Review of 15 studies
- Samples sizes 64 to 2,945
- Multiple clinical groups (men, women, veterans, adolescents, inpatients, etc.)
- Rates varied from 10-59%
- Highest rates were among women

Problems Associated with SUD+Bipolar or Schizophrenia

- Higher rates of disability with more total diagnoses, days in hospital, ER visits and use of SUD and MH services
- Poorer treatment adherence rates and overall response to treatment
- Higher relapse and hospitalization rates

Problems Associated with SUD+Bipolar or Schizophrenia

- Higher rates of problems:
 - Medical, HIV infection, STDs
 - Unstable housing and homelessness
 - Violence, legal problems, incarceration
 - Unemployment
 - Depression and suicidality
 - Family and social problems

Relationships Between Mood and SUDs

- Having either disorder increases risk of the other one
- Mood disorder can complicate recovery from a SUD
- SUD can complicate recovery from a mood disorder

Studies of Dual Disorder at Western Psychiatric Institute & Clinic

Dual Diagnosis Patients Have:

- More diagnoses, days in the hospital, and psychiatric re-hospitalizations
- Higher rates of suicidality and homicidality
- Lower rates of treatment entry, completion, or attending sessions

--Daley et al; Cornelius et al; Salloum et al

2. Depressive Disorders

Prevalence, DSM-IV Categories and
Symptoms; Effects; Etiology

Depressive Disorders

DSM IV TR

- Major Depression
 - single episode
 - recurrent episodes
- Dysthymia
- Minor Depression (sub-syndromal)
- Depressive disorder NOS
- Induced by substance use or medical condition

Major Depression: Five Symptoms for 2+ Weeks

- One of these symptoms must be depressed mood and/or loss of interest in pleasure
- Significant weight loss or gain when not dieting
- Insomnia or hypersomnia
- Psychomotor agitation or retardation

Major Depression

- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thoughts of death, suicidal ideation w/o plan, or suicide plan or actual attempt

Major Depression

- Symptoms cause significant distress or impairment in functioning
- Not part of mixed bipolar episode
- Not due to substance effects
- Symptoms not accounted for by bereavement

The Black Dog of Depression

- Kathy Cronkite thought about swallowing a can of liquid Drano
- “When you’re depressed there’s no calendar, no days, no nights, there’s nothing. You’re just existing in this cold, murky, ever-heavy atmosphere like they put you inside a vial of mercury” (Rod Steiger)

-Kathy Cronkite (On the Edge of Darkness)

The Dark Side of Depression: N. Rosenthal

“There is not minimizing its shattering, destabilizing effects. Depression is dark days and endless nights. Trivial, mundane tasks become insurmountable. Depression has a domino effect--one defeat leads to another & another & another”

Course Specifiers for Major Depression

- Severity: mild, moderate, severe with and without psychotic features
- Remission: partial or full
- Longitudinal course: with or without interepisode recovery
- Seasonal pattern
- Chronic with catatonic, melancholic, or atypical features

Depression and Behavior

- Activity slows down
- Fatigue and inability to exercise are common
- Isolation is common
- May sleep too much or little
- Sleep can be disrupted

F. Scott Fitzgerald

“I could lie around and was glad to, sleeping or dozing sometimes 20 hours a day. . . . Every act of life from the morning toothbrush to the friend at dinner had become an effort”

-cf Jamison, 1993

Depression and Thinking

- Depression slows down thinking
- Indecision and rumination are common
- Concentration is impaired
- Irrational fears, obsessions, panic & delusion can be present
- Thoughts of suicide common

Depression and Thinking

- Aaron Beck: “If we see things as negative, we are likely to feel negative or behavior in a negative way
- Martin Seligman: “Your way of explaining events to yourself determines how helpless you can become, or how energized, when you encounter the everyday setbacks as well as momentous defeats”

-cf Thase &Lang

Depression and Relationships

- Mood changes, personality, behavior and thinking affects perceptions and moods of others as well
- Others may worry, overfunction, withdraw, get angry

Etiology of Mood Disorders

Biochemical Factors

- Dysfunction in neurotransmitter system (norepinephrine, serotonin, acetylcholine-adrenergic balance and dopamine)
- Neuroendocrine abnormalities
- Neurophysiological abnormalities

Psychological/Environmental

Medical Conditions Inducing Depression

- Endocrine disorders (diabetes)
- Metabolic disorders (severe anemia)
- Neurologic disorders (MS, dementia)
- Infectious diseases (hepatitis, mono)
- Connective tissue diseases (lupus)
- Neoplastic disorders (tumors)
- Digestive disorders (pancreatitis)
- Substance use disorders

3. Bipolar Disorders

Prevalence, DSM-IV Categories, Treatment Approaches and Treatment Issues

Bipolar Disorder

- Affects 1-2% of adults
- Represents 10-20% of mood disorders
- 40+% go untreated
- 15-25% die by suicide
- Heterogenous group
- Many, if not most, suffer a chronic, recurrent form of illness

Prevalence

- Over half of those with bipolar disorder have an alcohol or drug use disorder
- Those with BP are 8-10 X more likely to have an alcohol or drug use disorder
- Mania is more strongly related to alcohol or drug dependence than any other DSM axis I diagnoses

Bipolar Disorders

- Bipolar I
- Bipolar II
- Bipolar disorder NOS
- Cyclothymic disorder

Manic Episode

- Abnormally and persistently elevated, expansive, or irritable mood lasting 1+ week (or less if hospitalized for mania)
- During mood disturbance, three or more symptoms were present to a significant degree:

Manic Episode

- Inflated self-esteem or grandiosity
- Decreased need for sleep (rested after only 3 hours)
- More talkative than usual or pressure to keep talking
- Flight of ideas, racing thoughts

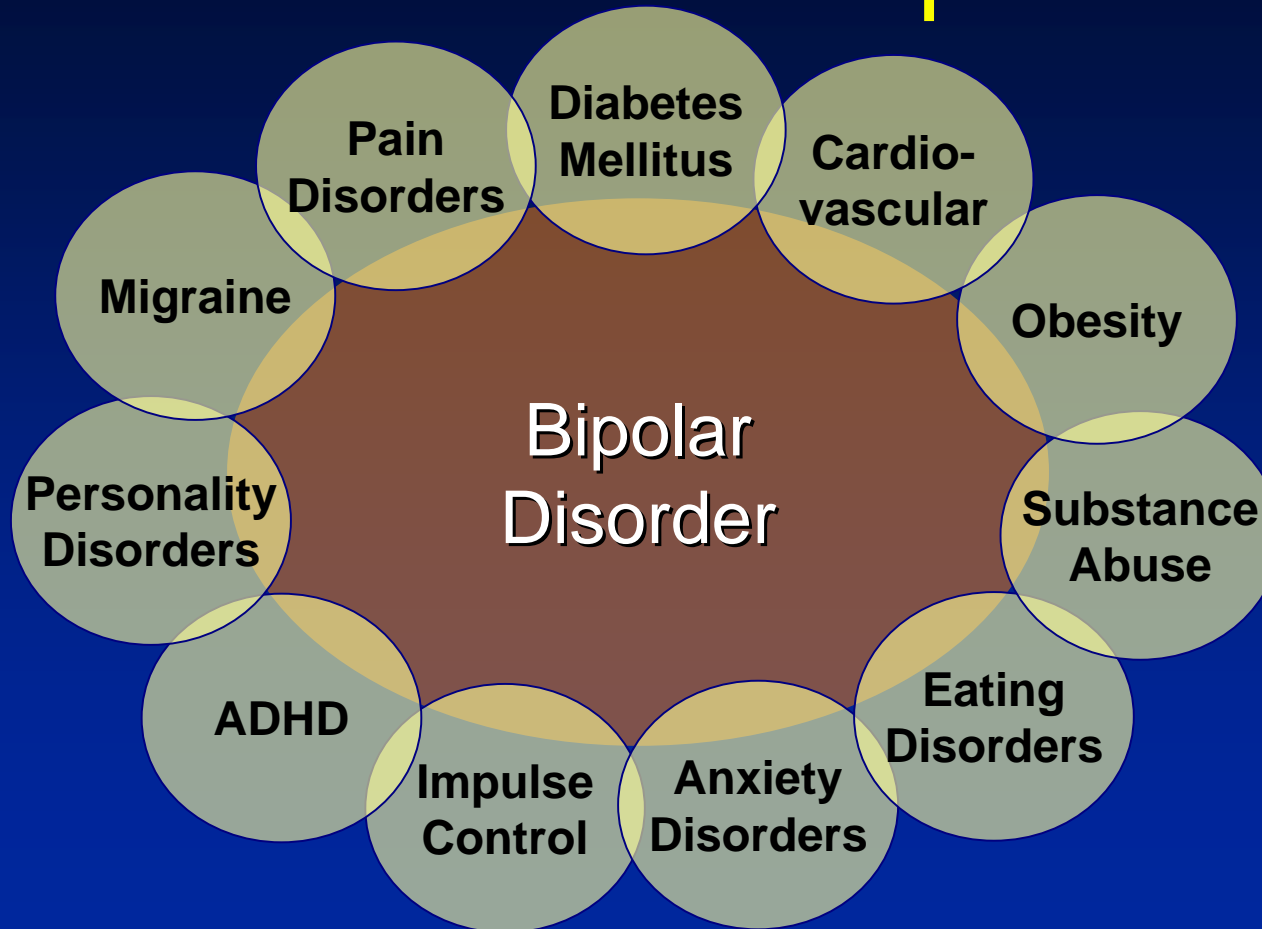
Manic Episode

- Distractibility (attention goes to unimportant stimuli)
- Increased goal-directed activity (socially, work, school, sexually) or psychomotor agitation

Manic Episode

- Excessive involvement in pleasurable activities with high potential for painful consequences:
 - Buying sprees
 - Sexual indiscretions
 - Foolish business investments

Co-morbidities in Bipolar Dx



The Experience of Mania

Judge Sol Wachtler

- Chief Judge of State of NY
- Bipolar disorder + substance abuser who ended up in jail
- “I didn’t consider my behavior strange; I thought other were bizarre. I’m not talking too fast . . .you’re listening too slowly”

4. Treatment of Mood and Co-occurring Disorders

Psychotherapies, Medications, and ECT

Treatment Approaches for Dual Disorders

- Daley & Montrose; Daley & Zuckoff; Salloum, Daley & Thase; Cornelius et al. (W.P.I.C.)
- Drake, Mueser, et al.
- Liberman; Linehan; Navajits
- Minkoff & Drake
- Pepper & Ryglewicz
- Rosenthal; Weiss; Westermeyer
- Ziedonis & Krejci

Evidenced-Based Treatments for Depressive Disorders

- Cognitive and cognitive-behavioral therapy have the most empirical support
- Interpersonal and social skills training also have empirical support
- Combined medications and psycho-social treatments are commonly used

Evidenced-Based Treatments of Bipolar Disorder

- Psychoeducation
- Cognitive-behavioral therapy
- Interpersonal psychotherapy and social rhythm therapy (IPSRT)
- Martial/family therapy

Phases of Treatment for Mood Disorders

- Acute
- Continuation
- Maintenance

-Kupfer & Frank; Thase

5. Clinical Strategies for Mood and Substance Use Disorders

Daley & Thase; Daley & Moss;
Jamison; Kupfer, Frank & Thase;
Markowitz; Miklowitz; Sammons &
Schmidt; Thase; Torrey & Knable;
Westermeyer, Weiss & Ziedonis

Strategy 1: Help Client Understand and Accept Illness

- Deal with denial of illness (e.g., feeling depressed vs. having an illness)
- Know and understand diagnosis
- View mood disorders as treatable
- Accept some require long-term treatment (e.g, bipolar or recurrent depression)

Strategy 2: Use Medications and Combined Treatments

- Most frequent combinations studied for depression are CT, CBT and IPT plus medications (TCAs mainly); however, in clinical practice SSRIs usually used
- Cognitive and cognitive-behavioral have the most empirical support
- Interpersonal and social skills training also have empirical support

Medications for Depression

- Many effective medications exist
- Need adequate blood level of some antidepressants
- Chronic drinking decreases blood plasma levels
- Acute doses of alcohol may increase blood levels of medications

Medications for Depression

Medications for Depression

- SSRI: Prozac, Paxil, Zoloft, Celexa
- TCA: Elavil, Tofranil, Norpramin, Pamelor
- Heterocyclics: Deseryl, Ludiomil, Wellbutrin
- MAO: Nardil, Parnate

Medications for Depressive Disorders

- Substance use adverse affects medication adherence
- Perception of “drug use” in recovery when taking medications
- Others may give a message that “all” medications need to be given up

Mood Stabilizers

- Carbatrol/Tegratol (carbamazepine)
- Depakene/Depakote (divalproex sodium)
- Lithium (Eskalith, Lithium Citrate, Lithobid, Lithotab)
- Lamictal (lamotrigine)

Mood Stabilizers

- Neurontin (gabapentin)
- Topamax (topiramate)
- Trileptal (oxcarbazepine)

Psychosocial Treatments and Medications with Bipolar

- Combine therapy with medications to help patient and family:
 - Deal with burden associated with disorder
 - Improve treatment adherence
 - Reduce risk of recurrence

Depression Treatment Outcomes at 24 Months

- One-half had recurrences
- Patients on medications + IPT or clinic care did better
- Patients with recurrences often were poorly compliant with medications
- Need full dose of medication during maintenance phase for full effect

-Kupfer, Frank et al

Reviews of Combined Studies

- Keller et al: results of a large multi-site study of chronic depression suggested that combined treatment is more effective than therapy or meds alone
- Thase et al: examined 6 studies of combined and therapy alone
 - Therapy alone was best treatment for moderate to low levels of depression
 - Combination treatment was best for more severe levels of depression

Effects on Preventing Relapse and Recurrence

- Hollon et al: found that CT, alone or combined with medications, was effective in preventing relapse of depression
- Fava et al: found similar results

Effects on Preventing Relapse and Recurrence

- Reynolds, Frank et al: found that combination treatment was more effective for geriatric patients than either treatment administered singly
- In another study of middle-age adults they also found combination treatment to be effective

Conclusions of Studies on Combined Treatment

- Combined treatment of therapy and medications is more effective for more severe and chronic types of depression
- There are no findings that certain antidepressants are superior to others

Treatment Algorithm for Major Depression

- Low to moderate severity: offer choice of combined, therapy alone or medication alone
- If patient is partial or non-responder to single treatment, offer combined treatment
- High severity: offered combined

Strategy 3: Focus on Managing Substance Disorder

- Obsessions and cravings
- People, places, events, things
- Impact on family and relationships
- Establishing a recovery network
- Managing negative affect
- Becoming aware of relapse triggers
- Impact of mood symptoms on substance use

Strategy 4: Focus on Managing Moods

- Monitor moods
- Discriminate “normal” moods from hypomania or depression
- Express feelings (appropriately)
- Use pen and paper inventories
- Connect moods to behavior, thoughts, relationships and life circumstances

Managing Feelings

- Give feedback on changes in mood and functioning
- For chronic condition, learn to tolerate some depression (acceptance)
- Address co-morbid anxiety; & anger
- Evaluate and determine when to address grief (loss of healthy self, past traumas, etc)

Strategy 5: Identify and Change Inaccurate Thinking

- All or none thinking
- Awfulizing
- Overgeneralizing
- Expecting the worse outcome
- Disqualifying the positive
- Jumping to conclusions
- Emotional responses

Identify and Change Inaccurate Thinking

- Should or must statements
- Labeling and mislabeling
- Personalization
- Cognitive therapy framework: cognitive distortions
- AA/NA framework: “stinking thinking”

Disqualifying the Positive or Select Abstraction

- A depressed addict who had done very well in recovery became upset at herself for experiencing depression following a setback on her job. “I’m back to the way I was before, I ain’t never going to get better.”

Disqualifying the Positive: Intervention

- Help client focus on present and past successes
- Help client identify personal strengths
- Help client put mistakes in proper perspective

Common Self-Defeating Beliefs (perfectionisms and fears)

- I should always feel happy, confident, and in control of my emotions
- I must never fail or make a mistake
- People will not love and accept me as a flawed and vulnerable human being
- I need everybody's approval to be worthwhile

-David Burns

Common Self-Defeating Beliefs (perfectionisms and fears)

- If I'm alone, then I'm bound to feel miserable and unfulfilled
- My worthwhileness depends on my achievements (or intelligence, status or attractiveness)
- People who love each other shouldn't fight
- I should not feel angry, anxious, etc.

Strategy 6: Evaluate and Enhance Relationships

- Complete a personal inventory of strengths & resiliencies
- Increase interpersonal interactions (decrease isolation)
- Identify and resolve interpersonal disputes or conflicts (know high risk relationships)
- Identify IP deficits and improve social skills

Interpersonal Relationships

- Improve ability to communicate to others
- Make amends to others hurt by disorders or behaviors

Strategy 7: Facilitate Lifestyle Change

- Participate in pleasurable activities
- Develop new leisure interests
- Use a daily or weekly plan in order to structure time

Lifestyle Changes

- Learn relaxation techniques
- Get physical exercise
- Learn sleep hygiene techniques
- Learn anger management techniques
- Develop regular “social rhythms
- Money management (especially for bipolar conditions)

Strategy 8: Facilitate Use Of Support Groups

- AA, NA and other 12-Step Programs
- Dual Recovery Anonymous
- Depression related
- Other (EA, EHA, Recovery, Inc)
- Helps client gain support, learn program, focus on spirituality & growth

Strategy 9: Address Relapse and Recurrence

Depression Risk Of Recurrence

- First Episode = 50%
- Second Episode = 70%
- Third Episode = 90%

Risk Factors In Depression Relapse & Recurrence

- Recurrent course
- Double depression
- Long duration of index episode
- Residual (persistent) symptoms at end of acute phase of treatment
- Being unmarried

-Fava & Kairi

Reducing Relapse Risk

- Focus on strategies to improve adherence to treatment
- Focus on identifying and managing:
 - High-risk relapse factors
 - Early warning signs
- Relapse of one disorder often leads to relapse of another (prepare to handle setbacks--lapse, relapse, recurrence)

Bipolar Disorder

- Recurrence rate is 50% at 30 months
- Literature shows 30-60% make 2 years without recurrence

Strategy 10: Involve Client's Family in Treatment

- Family input into treatment plan
- Impact of disorders on family
- Family concerns and problems
- Address fear of passing illness on to offspring, especially with Bipolar illness

Mood Disorders in General Population & First Degree Relatives

<u>Disorder</u>	<u>Gen Pop</u>	<u>Relatives</u>
Bipolar d/o	1%	5-10%
Major depression	5%	15%

Impact of Depression on Children

“Children can be deprived of basic needs in subtle ways that don’t constitute neglect or abuse. . . .These parents are far less able than others to provide children with almost all of the ingredients of growth.”

-Weissbound (*Vulnerable Child*)

Family Rating of Need for Education and Substance Abuse

- Schizophrenia: family members rated the need for information on substance abuse last on a list of 45 educational topics
- Mood Disorders: family members rated the need for information on substance abuse 32nd on a list of 45 educational topics

Psychiatric Disorders among Children of Opiate Addicts

- 37% School problems
- 30% Disruptive disorders
- 24% Anxiety disorders
- 21% Mood disorders

-These rates are higher than those found in community surveys (Nunes et al)

Controlled Studies of Children of Alcoholics Find Increased:

- Alcohol abuse
- Drug use/abuse
- Conduct problems/antisocial personality
- Anxiety disorders
- Combined mood and anxiety disorders

-Merikangas et al, 1985; Reich et al, 1993; Hill & Muka
1996

Symptoms of Family Members with Psychiatrically Ill Member

- Anxiety 58%
- Frustration 58%
- Worry 56%
- Sense of burden 55%
- Depression 48%
- Grief 47%
- Anger 42%
- Shame 21%
- Guilt 18%

Impact of Dual Disorders on the Family

Quality Improvement Study of 140
Patients in Treatment (Daley)

How Would You Rate The Overall Negative Effects That Your Alcohol And Drug Use Had On Your Family

1 2 3 4 5 6
7
Minimal Mild Moderate Serious Severe

Average Rating = 5.6

How Would You Rate The Overall Negative Effects That Your Psychiatric Problem And Related Behaviors Had On Your Family

1	2	3	4	5	6
7					
Minimal	Mild	Moderate	Serious		Severe

Average Rating = 5.7

Impact of Parental Substance Abuse on the Family (CSAT)

- Parental substance abuse underlies many family problems:
 1. Divorce
 2. Spouse abuse
 3. Child abuse and neglect
 4. Welfare dependence
 5. Criminal behaviors

Helping the Family and Children

Expressed Emotion (EE) and Psychiatric Relapse

- EE is a measure of emotional attitudes of relatives of psychiatric patients
- Review of audiotapes of family interaction with patients during acute phase of illness
- High EE: express many critical comments, hostility, or emotional overinvolvement
- Low EE: non-critical, non-hostile, normally involved

Relapse Rates in Schizophrenia or Mood Disorders--9-12 months

- Relapse rates of patients are twice as high in families with high rates of EE compared to low rates of EE
- Schizophrenia: 27 studies
- **Mood disorders: 6 studies**

-Mueser & Glynn

Ways to Help the Family & Individual Members

Provide education about dual disorders

- Recovery for the dual diagnosis member and resources available (e.g., self-help, ICM, housing, vocational, etc)
- Impact of dual disorders on the family
- Recovery for the family member and resources available (e.g., self-help)

Ways to Help the Family & Individual Members

- Provide support
- Explore experiences, concerns, & questions of family members
- Help identify and reduce enabling behaviors
- Address emotional burden of family (anger, guilt, confusion, anxiety, worry)
- Facilitate individual assessments

Ways to Help the Family & Individual Members

- Help reduce negative & emotionally charged interactions
- Help family deal with specific behaviors or symptoms of impaired member (depression, poor adherence, relapse, violence, etc)
- Facilitate entry into self-help programs
- Help access other resources

Ways to Help the Family & Individual Members

- Help prepare for setbacks & relapses
- Help with adherence
- Help parents help their children

Helping Children

Strategies for Getting Parents to Focus
on Needs and Issues of Children

Strategy 11: Assess Suicidality

Risk Factors

- Recent interpersonal loss (within 6 wks)
- Suicide by significant other
- Prior suicide attempt or a current plan
- History of self-destructive behavior

Assess Suicidality Risk Factors

- Recent loss or threat of loss
- Poor health or fear of poor health
- Inability to accept help
- Lack of available support

Suicidal Clients: Interventions

- Discuss suicidal thoughts and feelings
- Develop suicide prevention contract
- Seek help immediately if there is an actual plan

Suicidal Clients: Interventions

- Focus on the “why” of suicide in therapy sessions
- Remind client that suicide thoughts and feelings go away
- Catch early warning signs of psychiatric relapse -- this reduces likelihood of suicidal thoughts and feelings

Suicidal Clients: Interventions

- Make agreement with family/SO that hospitalization should be initiated if an attempt has been made or appears imminent
- Avoid drug/alcohol use
- Remember suicide is permanent solution to a temporary problem

Dimensions Of Suicidal Dangerousness

- Intent of behavior (death to communication of needs without wish to die)
- Lethality of behavior (lethal to non-lethal)
- Probability of behavior occurring (very high to none)

Outcome of Treatment: Suicidality

- Majority of suicides occur in context of major mood disorder
- Review of 28 reports with over 16,000 patients shows suicide rate is 6-8 times lower in patients treated with Lithium

-Donald Goodwin (cf Fawcett et al, 2000)

Strategy 12: Address Sleep Related Problems

- Definition
- Epidemiology of sleep problems
- Medications
- Psychological Treatments

-Morin

Insomnia

- Affects large segments of the population
- Can be situational, acute or chronic
- Sleep disorders may involve insomnia, hypersomnia, or abnormal behaviors
- Insomnia most frequent problem
- Heterogeneous complaint about impaired quality, duration or efficiency of sleep

Insomnia

- Poor sleep quality may result in daytime fatigue and low energy
- Defined as latency to sleep onset or wake-after-sleep onset greater than 30 minutes with corresponding sleep efficiency (ratio of time asleep to time in bed)

Epidemiology

- Can cause substantial problems in any area of life:
 1. Occupational
 2. Psychosocial
 3. Health
 4. Economic

Epidemiology

- Poor sleepers use more sick leave and health care benefits than good sleepers
- Persistent insomnia is associated with prolonged use of hypnotic medications, and increased risk of depression

Epidemiology

- Insomnia remains untreated in most people
- Many people use self remedies such as alcohol or OTC meds
- When brought to physician, meds are most common tx; most use for >1 year

Epidemiology

- Behavioral interventions are infrequently used in clinical practice besides general sleep hygiene advice (to reduce caffeine and exercise more)

Psychological Treatments for Insomnia

- Relaxation training
- Stimulus control
- Sleep restriction
- Cognitive therapy
- Sleep hygiene

Pharmacotherapy: Types of Medications

- Medications used to treat insomnia include:
 1. Benzodiazepines (BZD)
 2. Non-BZD hypnotics
 3. Antidepressants
 4. Over-the-counter medications

Drugs of Choice by Sleep Experts

- BZD receptor agents (BRAs)
 1. BZD's
 2. Newer non-BZD Hypnotics
- These present lower risk of dependence and lethal overdose than older drugs such as cloral hydrate or barbiturates

Evidence of Efficacy

- All BRA's are more effective than placebo in acute and short-term phases of insomnia
- Meta-analysis of 22 placebo-controlled trials (n=1,894) found reliable improvements in sleep onset latency, awakenings, total sleep time & sleep quality

Clinical Indications

- Patients unresponsive to psychological interventions
- As adjunct to insomnia secondary to major depression or an anxiety disorder

Contraindications for Sleep Medications

- Patients actively abusing alcohol or other drugs
- Patients with severe sleep apnea because it may worsen the breathing problem
- Pregnant women
- Those on call (nurse, fireman)