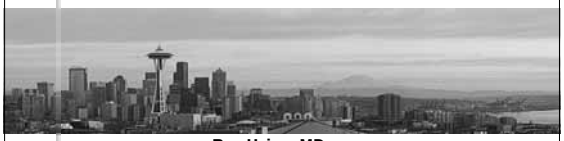
2008 WA COD Conference Workshop III: Differential Diagnosis of Common Co-Occurring Disorders in Adolescents



Ray Hsiao, MD
Co-Director, Adol. Substance Abuse Program
Seattle Children's Hospital

UW Medicine SCHOOL OF MEDICINE | Children's

Overview

- Definitions & learning objectives
- Practice Parameters on Substance Use Disorders (SUDs): American Academy of Child and Adolescent Psychiatry (AACAP, Bukstein et al., 2005)
- Literature Review of common CODs
- Practical Tips & Case Studies

Substance-Related Disorders

- Substances defined in DSM IV-TR: Alcohol, Amphetamine, Caffeine, Cannabis,, Cocaine, Hallucinogens, Inhalants, Nicotine, Opioids, Phencyclidine, Sedative/Hypnotic/Anxiolytic
- Nicotine & Polysubstance: No Abuse
- Substance Use Disorders (SUDs) = Substance Abuse or Dependence
- Substance-Induced Disorders = Substance Intoxication or Withdrawal

Substance Abuse

- A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
  - Recurrent use resulting in a failure to fulfill major role obligations at work, school or home
  - Recurrent substance use in situations in which it is physically hazardous
  - Recurrent substance-related legal problems
  - Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

Substance Dependence

- A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:
  - Tolerance: "a need for markedly increased amounts of the substance to achieve intoxication or desired effect" or "markedly diminished effect with continued use of the same amount of the substance"
  - Withdrawal: "the characteristic withdrawal syndrome for the substance" or "the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

Substance Dependence

- Substance is often taken in larger amounts or over a longer period than intended
- Persistent desire or unsuccessful efforts to cut down or control substance use
- Great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover
- Important social, occupational, or recreational activities are given up or reduced
- Substance use is continued despite knowledge of persistent or recurrent physical or psychological problem caused or exacerbated by substance

Dependence Specifiers

- With(out) Physiological Dependence
- Early Full Remission
- Early Partial Remission
- Sustained Full Remission
- Sustained Partial Remission
- On Agonist Therapy
- In a Controlled Environment

Co-Occurring Disorders

- SUDs + Mental Disorders: evolving
- COD is the rule, not the exception
  - 60% (Armstrong & Costello, 2002)
  - Disruptive Behavior Disorders (DBDs)
  - Depression & other mood disorders
  - Anxiety disorders
  - Attention-Deficit Hyperactivity Disorder (ADHD)
  - Learning disabilities & sensory problems
  - Others: Bulimia, Psychosis, Personality Disorders

Co-Occurring Disorders

- Presence of psychiatric disorders leads to increased risk of SUDs
  - Especially Conduct and Depressive Disorders
- COD vs. SUD alone:
  - More alcohol or drug dependence
  - More family, school, criminal problems
  - More likely to engage in delinquent behaviors and use hallucinogens & cannabis in the 12 months after treatment

DBD & ADHD

- Conduct Disorder (50-80%)
  - Most common COD
  - Onset usually precedes SUD
  - SUD progresses more rapidly in girls
- Oppositional Defiant Disorder
- DBD NOS
- ADHD (30-50%)
  - ?linkage through Conduct Disorder

Mood Disorders

- Depressive Disorders (24-50%)
  - Onset usually precedes SUDs
  - Significant on treatment course: severity, relapse
  - Secondary depression often not remit
- Bipolar Disorders
  - Increase risk of SUDs
  - Male, family history, adolescent onset, mixed
- Dysthymia: common in SUD pts
- Cyclothymia
- Mood NOS

Anxiety Disorders

- 7-40%: Obessive-Compulsives less common
- Social Phobia
  - Onset precedes SUD
- Posttraumatic Stress Disorder (PTSD)
  - Commonly from physical or sexual abuse
  - Onset precedes SUD
- Generalized Anxiety Disorder (GAD) and Panic Disorders
  - Onset after SUD

Practical Interview Tips

- Complexity = consistent methods/guidelines
- Confidentiality: double-edged sword
- Instruments
- Collateral, Collateral, Collateral!!!!
- Emphasis on non-verbal cues: address it!
- Validation mixed with irreverence
- Spectrum approach: data & feedback
- Past Treatment & Family/Social History

SUD Assessment

- Severity, risk factors, protective factors
- Outcome mediators/moderators: Preference, reasons, expectations, readiness, self-efficacy
- Self-reporting of use detects more than laboratory tests (Buchan et al, 2002) or collateral reports (Fisher et al. 2006)
- Parental/collateral sources report lower internalizing than externalizing
- Toxicology

SUD Assessment

- Self-Narrative approach
  - Age of onset→ Progression
  - Types, Frequency, Variability, Context
  - Multidimensional monitoring
  - Social network and attitudes
  - Treatment History: Self vs. Imposed
  - Stages of Change/Motivational theory

Psychiatric Assessment

- "Timeline" Approach (Riggs & Davies, 2002)
  - Comprehensive review of past and present psychopathology & treatment
  - Developmental events as anchors
  - Evaluate within context of substance
- Early childhood history
- Family & Social History
- Medical & Developmental History

Integrated Assessment

- Combine SUD & Psychiatric interviews
  - Follow the lead
  - Make suggestions
  - Default approaches: Carve-out per past treatment history or chronological
  - Diagnostic instrument: Gold Standard
  - Focus on clean & sober time & intox/withdrawal
- Templates
- Formulation: dynamic & evolving