MASSACHUSETTS GENERAL HOSPITAL
PSYCHIATRY ACADEMY

Substance Use Disorders and Psychiatric Co-Morbidities – Mood Disorders

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Disclosures

"Neither I nor my spouse/partner has a relevant financial relationship with a commercial interest to disclose."

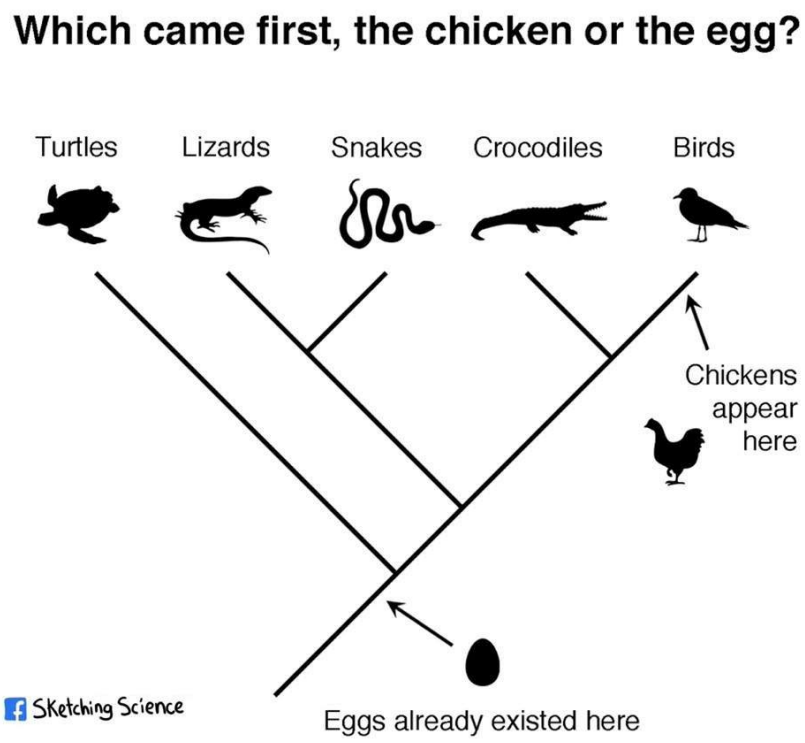
Goals & Agenda

1. Review Mood Disorders and SUDs
2. Major Depressive Disorder and Substance Use
3. Bipolar Disorder and Substance Use
4. Treating Mood Disorders - Recommendations

Mood Disorders and Substance Use, Epidemiology, Demographics and Risk Factors

Dual Diagnosis

Dual Diagnosis



Medical Health vs. Mental Health

"Organic" vs. "Somatoform"

Psychiatric (Primary) vs. Addiction (Secondary)

Impact goes beyond theoretical:

- Access to care
- Exposure to stigma
- Legal repercussions
- Guilt, blame and responsibility

Epidemiology

Mood Disorders and Substance Use are Highly Co-Morbid

- Lifetime prevalence of SUDs is 30%+ in patients with mood disorder (compared to 18.5% in general population)
- Lifetime prevalence of SUDs is 56% in patients with bipolar disorder

- Alcohol use disorder:
  - 20-60% with comorbid MDD
  - 6-15% with comorbid bipolar sx (mania/hypomania)

- Cocaine use disorder:
  - 30-40% with comorbid MDD
  - 10-30% with comorbid bipolar sx

Quello (2005) Grant B (2004)

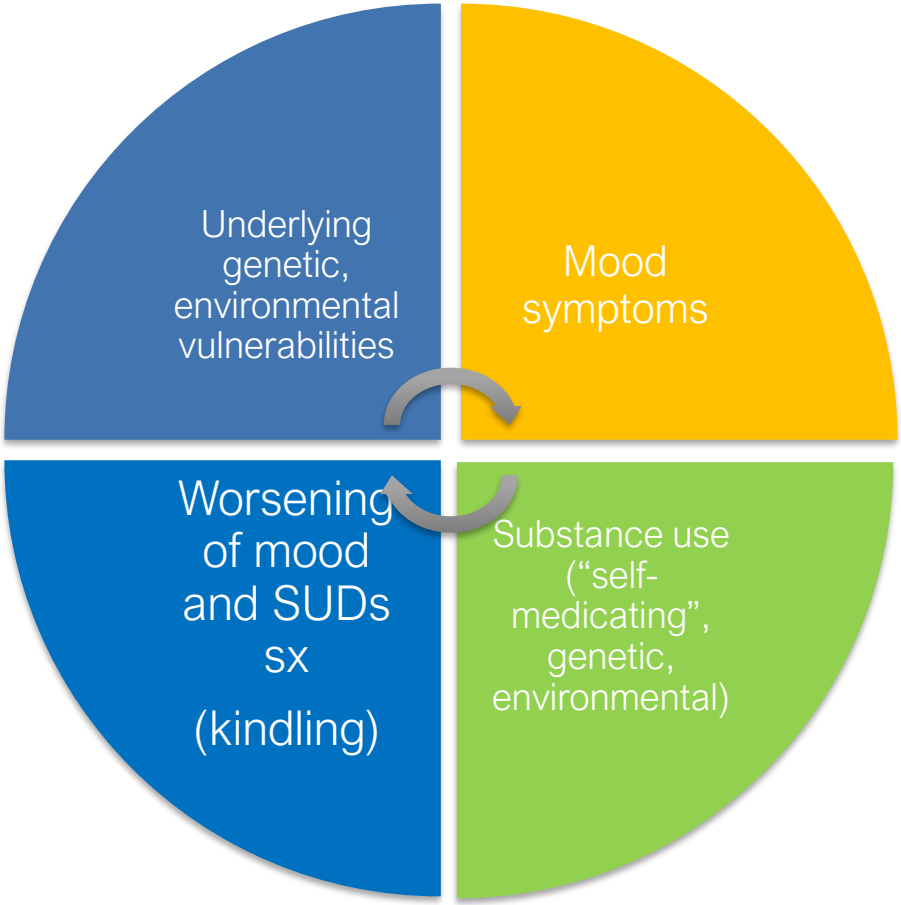
Epidemiology

Why are the Comorbidities so Common?

- Pathologic effects of mood disorder or SUD may increase risk for the other.
  - Mood disorder may motivate individuals to resort to drugs/alcohol to self-manage negative affective states ("self-medicating")
  - Substance use may unmask genetic vulnerability for a mood disorder
- Kindling – underlying neurobiological tendency to sensitization may promote both mood and SUDs progression.
- Overlapping genetic factors
- Diagnostic confounding

Quello (2005)

Alternative Approach To Dual Diagnosis



Diagnostic Approach

Suspect Comorbidity

Accept diagnostic uncertainty and maintain broad ddx on initial evaluation(s)

Ensure safety measures in place (e.g. suicide precautions, agitation management alcohol withdrawal management)

Observe sx change/improvement with cessation of use and withdrawal management – n.b. may take weeks

Clinical Outcomes, Suicide and SUDs

Comorbid SUDs increase the severity and duration of mood symptoms, may increase rates of hospitalizations.

Pre-existing or co-occuring MDD may reduce chances of patient achieving sobriety from substance-use

Sonne (1994), Hasin (2002)

Clinical Outcomes, Suicide and SUDs

Comorbid SUDs increases the chance of attempting or completing suicide by 5-10 times.

Alcohol or drugs are involved in 50%+ of all suicides

Risk factors for suicide in patients with SUDs:

- Prior attempts
- Single/Separated/Divorced
- Earlier onset of use, severity of use

Markou (1998), Rich (1989), Young (1994)

Major Depressive Disorder and Substance Use

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MDD and Substance Use

Common DDx considerations

- Intoxication with sedatives (e.g. alcohol, benzodiazepines, opioids) may exacerbate depressive mood sx
- Discontinuation of alcohol, benzodiazepine, opioids
- Discontinuation/withdrawal stimulants, cocaine

If suspected:

- Screen for suicidality, ensure appropriate measures in place regardless of degree of suspicion ("sluricidal" patient)
- Monitor for withdrawal emergence, and anticipate effect discontinuation of substance may have on patient's mood

When to treat depression?

MDD and Substance Use - Treatment

Am J Psychiatry. 2010 Jun;167(6):668-75. Epub 2010 Mar 15.
A Double-blind, Placebo-controlled Trial Combining Sertraline and Naltrexone for treating co-occurring Depression and Alcohol Dependence.
Pettinati HM, Oslin DW, Kampman KM, Dundon WD, Xie H, Gallis TL, Dackis CA, O'Brien CP.

Addiction. 2012 Nov;107(11):1974-83.
Mediational Relations between 12-Step Attendance, Depression and Substance use in patients with comorbid Substance Dependence and Major Depression. Worley MJ, Tate SR, Brown SA.

MDD and Substance Use

Treatment Considerations

- Treatment should be individualized for each patient, their needs and preferences.

- Therapeutic approaches:
  - Counseling: **CBT**, ACT, supportive
  - Peer support (AA, NA, recovery coaching)
  - **Voluntary** vs. mandated

- Medications:
  - **SSRIs**
  - SNRIs
  - Augmenting agents – e.g. trazodone, buproprion, mirtazapine

Brown (1997), Weiss (2000)

MDD and Substance Use

Treatment Considerations

- Integrated treatment as standard of care
  - Treat both disorders by same clinical team
  - Multimodal & collaborative care within same setting

- Special clinical scenarios:
  - Consider risk for serotonergic toxicity in patients using stimulants (e.g. MDMA)
  - Avoid MAOIs, tricyclics if possible given drug-drug interactions and side-effect profile
  - Buproprion has some street value/use potential
  - Benzodiazepines can help in acute setting, but may prove challenging to taper off

Bipolar Disorder and Substance Use

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BPD and Substance Use

Often difficult to diagnose (10+ years)

Common DDx considerations

- Intoxication with stimulants (e.g. cocaine, amphetamines)
- Intoxication with hallucinogens
- Discontinuation of alcohol, benzodiazepines

If suspected:

- Screen for suicidality, ensure appropriate measures in place regardless of degree of suspicion
- Monitor for withdrawal emergence, and anticipate what effects the discontinuation of substance may have on patient's mood

When to treat bipolar?

MDD and Substance Use

Treatment Considerations

- Treatment should be individualized for each patient, their needs and preferences.
- Side-effects and potential toxicity of most mood stabilizers considerably higher than SSRIs.
- Medications:
  - Mood stabilizers – lithium, valproic acid, lamotrigine
  - **Second generation (atypical) antipsychotics – olanzapine, quetiapine**
  - Haloperidol (intravenous), olanzapine, quetiapine for acute agitation
  - Benzodiazepines for insomnia

MDD and Substance Use

Treatment Considerations

- Special clinical scenarios:
  - Appropriate to defer initiating mood stabilizers until clear sx primary vs. secondary to substance use
  - Atypical neuroleptics a great choice given faster onset of action; Also helpful regardless whether the sx primary or secondary
  - Avoid stimulants (can exacerbate mania)
  - Benzodiazepines can help in acute setting, but may prove challenging to taper off