

American Osteopathic Academy of Addiction Medicine

Co-occurring Disorders and Substance Induced Disorders



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Objectives

- ✓ Learn about common co-occurring and substance induced disorders
- ✓ Understand the factors contributing to co-occurring and substance induced disorders
- ✓ Review diagnostic criteria

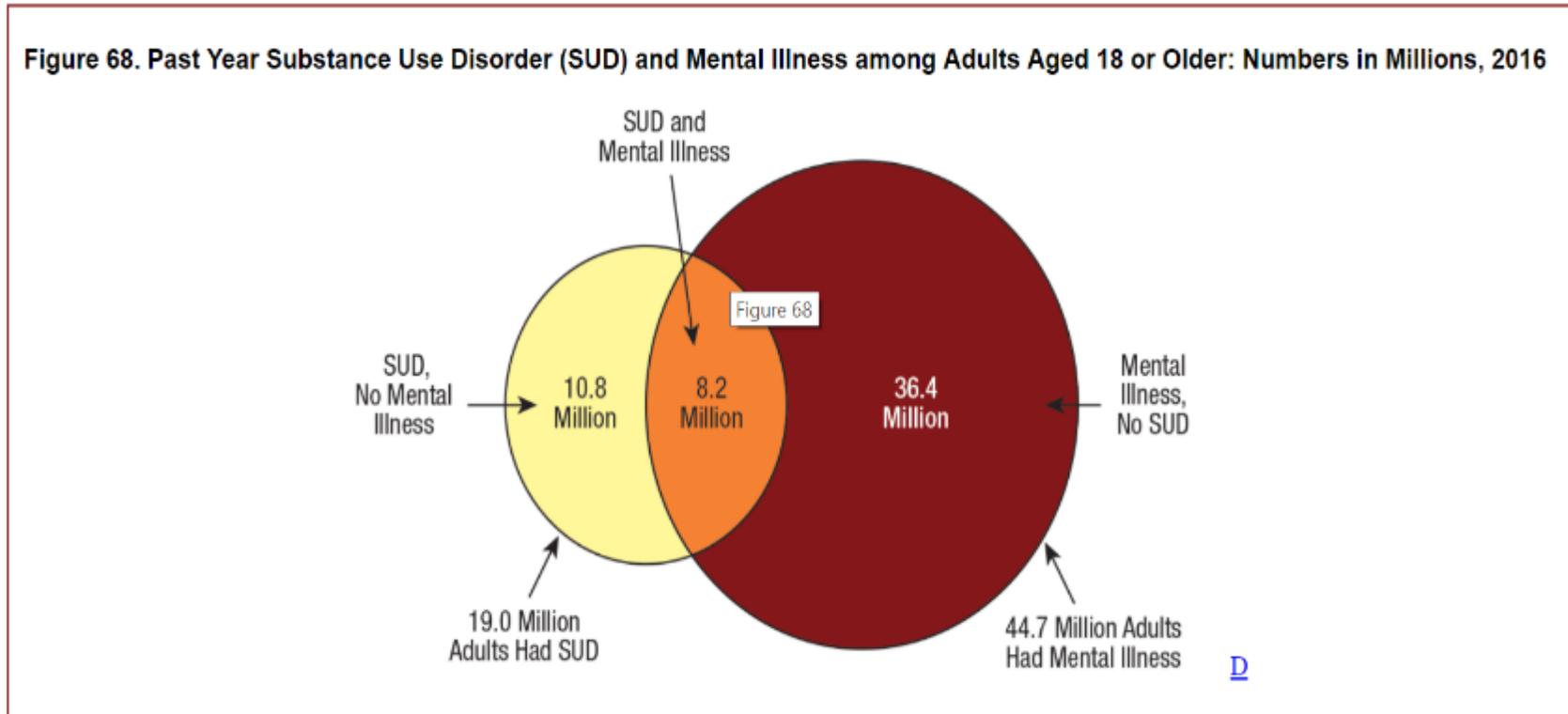


Frequency of Co-Occurring Disorders

Compared with the general population, individuals with a substance use disorder are roughly twice as likely to suffer from mood and anxiety disorders, with the reverse also true.



Epidemiology of Co-Occurring Disorders



Prognosis of Co-Occurring Disorders

- Comorbid psychiatric illness and SUD have poorer prognosis,
 - worse treatment outcomes,
 - higher relapse rates
 - shorter time to relapse of substance use,
 - more hospitalizations

Drake et al. 2001; Swofford et al. 1996; Haywood et al. 1995; Hasin et al. 2002; Levin et al. 2004

- Those with co-occurring disorders also have poorer quality of life.
Carpentier et al. 2009
- There is a high risk of suicide in those with co-occurring mental and SUDs, particularly in those with bipolar disorder. Dalton et al. 2003; Levy and Deykin 1989; Tondo et al. 1999



Co-Occurring Disorders

- Establish a comprehensive approach that identifies and evaluates *both*.
- It is important to note that sometimes even with the most prudent evaluation it can be very difficult to differentiate independent from secondary disorders.
- For some, reduction/abstinence can be difficult and delaying treatment for psychiatric symptoms can have serious consequences.



Etiologies of Co-Occurring Disorders

- *Drug abuse may bring about symptoms of another mental illness.* Increased risk of psychosis in vulnerable marijuana using young people suggests this possibility.
- *Mental disorders can lead to drug abuse, possibly as a means of “self-medication.”* Patients suffering from anxiety or depression may rely on alcohol, tobacco, and other drugs to temporarily alleviate their symptoms.



Diagnosis

- ❖ Difficult to diagnose psychiatric disorders when someone actively using substance
- ❖ Symptoms of intoxication and withdrawal may resemble symptoms of mood and anxiety disorders
 - ❖ Overlap in symptoms
 - ❖ Overlap in consequences (i.e., suicide attempt)
- ❖ DSM-5 provides diagnostic criteria for substance induced disorders
 - ❖ To diagnose mood or anxiety disorder, the full syndrome is established prior to substance use



Co-Occurring Disorders Trauma and Substance Use

Trauma and Substance Use Disorder

- Trauma and stress are risk factors for many forms of psychopathology, including depression, anxiety, and substance abuse *Brady et al., in Nunes et al., Best Practices for Diagnosis and Clinical Treatment. Kingston, NJ: Civic Research Institute 2010*
- Youth have the highest rate for being the victim of a violent crime. (3x adults)
 - Rape – highest rate in adolescent girls
- Three correlates with SUD
 - Substance use associated with trauma exposure
 - Substance use with high risk behavior
 - Substance use before committing violence
 - Risk of violent victimization and severe injury/loss of friends related to substance use

PTSD and SUDs

- Anyone can develop PTSD
 - According to the National Center for PTSD, 7 or 8 out of every 100 people will experience PTSD in their lifetime.
 - Some studies indicate particularly high comorbidity of PTSD and OUD (relative to alcohol and other drugs).
 - reported 33% of those with OUD had PTSD *Meier A, et.al., Am J Drug Alcohol Abuse. 2014 Jul;40(4):304-11, 2014; Mills KL,et.al., . American Journal of Psychiatry, 163:652-8, 2006*
 - People with PTSD develop drug addiction at 3 times the national average
- Veterans
 - 10-30% of returning combat veterans suffer from PTSD
 - Among veterans, psychiatric diagnoses, particularly PTSD, were associated with increased risk of receiving opioids for pain, high risk opioid use and adverse clinical outcomes *Seal KH, et.al., . JAMA, 307: 940-7, 2012*
 - 60-80% of PTSD Veterans have an AUD



Pharmacologic Guidelines for Treating Individuals with Post-Traumatic Stress Disorder and Co-Occurring Opioid Use Disorders

Pharmacologic Guidelines for Treating Individuals with Post-Traumatic Stress Disorder and Co-Occurring Opioid Use Disorders



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Co-Occurring Substance Use and Tobacco Use Disorder

- AUD individuals:
 - find nicotine more reinforcing,
 - meet more nicotine dependence criteria and withdrawal symptoms (Hughes et al. 2000; 2002).
- There is evidence that many people in substance abuse treatment are interested in smoking cessation treatment simultaneously (Joseph et al. 2002; Saxon et al. 1997)
- There is continued debate as to the best time for tobacco treatment during substance abuse treatment.
- Smoking prevalence rates of between 85 and 98 percent in OTPs (Berger 1972; Stark and Campbell 1993a)



DSM-5 Substance Induced Disorder

- ❖ The disorder represents clinically significant symptomatic presentation of a relevant mental disorder
- ❖ There is evidence from H&P or labs of both
 - ❖ The disorder developed during or within 1 month of substances intoxication or withdrawal or taking a medication
 - ❖ The involved substance/medication is capable of producing the mental disorder
- ❖ The disorder is not better explained by an independent mental disorder
 - ❖ The disorder preceded the onset of intoxication or withdrawal or exposure to the medication
 - ❖ The full mental disorder persisted for at least 1 month after cessation of acute withdrawal or intoxication or taking the medication
- ❖ The disorder doesn't occur exclusively in course of delirium
- ❖ Disorder causes significant distress or impairment in function



DIAGNOSES ASSOCIATED WITH CLASS OF SUBSTANCE

Substance	Anxiety	Depress	Bipolar	Psychotic	OC	Neurocognitive	Sleep	Delirium	Sexual
alcohol	I/W	I/W	I/W	I/W		I/W/P	I/W	I/W	I/W
cannabis	I			I			I/W	I	
hallucinogen	I	I	I	I				I	
inhalant	I	I		I		I/P		I	
opioid	W	I/W					I/W	I/W	I/W
sedative	W	I/W	I/W	I/W		I/W/P	I/W	I/W	I/W
stimulant	I/W	I/W	I/W	W	I/W		I/W	I	I
caffeine	I						I/W		
tobacco							W		

Onset during I = intoxication; W = withdrawal
P = persisting

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Symptoms of Substance Induced Disorders May Be Identical to Independent Disorders

- ❖ Important to differentiate because they have different prognoses
- ❖ Intoxication and withdrawal induced disorders resolve without psychotropic medications
 - ❖ Occasionally psychotropic medications may be needed for agitation
- ❖ Independent disorders may require psychotropic medications
- ❖ Error in diagnosis may lead to medical mismanagement



Substance Induced and Independent Disorders May Complicate Recovery

- ❖ Longitudinal study of 250 patients with alcohol, cocaine, heroin use disorders, followed for up to 18 months
- ❖ Substance induced depression significantly predicted post-discharge use of:
 - ❖ Alcohol (HR = 4.7)
 - ❖ Cocaine (HR = 5.3)
 - ❖ Heroin (HR = 6.5)
- ❖ Of those achieving remission, independent major depression predicted relapse to alcohol (HR = 2.3) and cocaine (HR = 2.7)

Samet et al., 2013



SUBSTANCE INDUCED DEPRESSIVE DISORDERS



Major Depressive Disorder

- 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.
- ❖ Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
 - ❖ Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
 - ❖ 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 gain.)
 - ❖ Insomnia or hypersomnia nearly every day.
 - ❖ Psychomotor agitation or retardation nearly every day (observable by others).
 - ❖ Fatigue or loss of energy nearly every day.
 - ❖ Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day.
 - ❖ Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
 - ❖ 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 cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The episode is not attributable to the physiological effects of a substance or another medical condition.
- D. Do not include symptoms that are clearly attributable to another medical condition.



Substance Induced Depressive Disorder

- A. A prominent and persistent disturbance in mood characterized by depressed mood or markedly diminished interest or pleasure in all, or almost all, activities.
- B. Evidence from the H&P or laboratory findings of both (1) and (2):
 - 1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal.
 - 2. The involved substance can produce the symptoms in Criterion A.
- C. The disturbance is not better explained by a depressive disorder that is not substance induced. Evidence of an independent depressive disorder may include:
 - 1. The symptoms preceded the onset of the substance use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is evidence of an independent depressive disorder (e.g., a history of recurrent non-substance related episodes).
- D. The disturbance does not occur exclusively during delirium.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.



Diagnosing Substance Induced Depressive Disorder

- ❖ Need evidence from H&P or labs indicating substance use, intoxication, or withdrawal
- ❖ Substance induced depressive disorders start within days to weeks after substance use or withdrawal
- ❖ Symptoms may last for days after use of substance, and can persist for weeks depending on half-life of substance and possibility of protracted withdrawal
- ❖ Primary depressive disorders may precede onset of substance intoxication or withdrawal and may occur during periods of abstinence
- ❖ Depressive symptoms may continue while the substance use continues



Prevalence

- ❖ Lifetime prevalence of substance/medication-induced depressive disorder is 0.26% (Blanco et al. 2012)
- ❖ NESARC 12-month prevalence of independent mood disorders were 9.21% in the total sample, while prevalence of substance-induced mood disorders was less than 1% (Grant et al., 2004)
- ❖ Langas et al. (2013) looked at patients with SUD and found
 - ❖ 42 had both SUD and MDD
 - ❖ 20 (47.6%) had lifetime history of independent MDD
 - ❖ 10 (23.8%) had history of substance induced depressive disorder (SIDDD) only
 - ❖ 12 (28.6%) had history of independent MDD and SIDDD
- ❖ Compared to independent MDD, those with substance-induced depressive disorder only
 - ❖ Had fewer years education
 - ❖ Smoked more cigarettes per day
 - ❖ Had shorter duration of depressive episodes



Diagnosing Substance-Induced Depression

- ❖ Substance-induced depressions may appear identical to major depressive episodes (Schuckit & Smith, 1996)
 - ❖ However, individuals with substance-induced depressions did not have
 - ❖ an increased family history of major depressive disorder
 - ❖ major depressive episodes are not observed at high rates in their children
- ❖ In patients with SUD, both primary and substance-induced MDD predict future depression (Nunes et al., 2006)



Demographics & Substance Induced Depressive Disorder

- ❖ Blanco et al. (2012) found those with substance-induced depressive disorder are more likely:
 - ❖ Male
 - ❖ African-American
 - ❖ Have at most a high school diploma
 - ❖ Lack insurance
 - ❖ Have lower family income
 - ❖ Have higher family history of substance use disorders and antisocial behavior
 - ❖ Have greater 12-month history of stressful life events
 - ❖ Greater number of DSM-IV major depressive disorder criteria
 - ❖ Report feelings of worthlessness, insomnia/hypersomnia, and thoughts of death and suicide attempts
- ❖ And less likely to report depressed mood



SUBSTANCE INDUCED BIPOLAR DISORDERS



Bipolar I Disorder – Manic Episode

- A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).
- B. During the period of mood disturbance and increased energy or activity, 3 (or more) of the following symptoms (4 if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:
- ❖ Inflated self-esteem or grandiosity.
 - ❖ Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
 - ❖ More talkative than usual or pressure to keep talking.
 - ❖ Flight of ideas or subjective experience that thoughts are racing.
 - ❖ Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli).
 - ❖ Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
 - ❖ Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
- C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
- D. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition.

Note: Criteria A–D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder.

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Bipolar II Disorder - Hypomania

- A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting **at least 4 consecutive days** and present most of the day, nearly every day.
- B. During the period of mood disturbance and increased energy and activity, 3 (or more) of the following symptoms (4 if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree:
- ❖ Inflated self-esteem or grandiosity.
 - ❖ Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
 - ❖ More talkative than usual or pressure to keep talking.
 - ❖ Flight of ideas or subjective experience that thoughts are racing.
 - ❖ Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
 - ❖ Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
 - ❖ Excessive involvement in activities that have a high potential for painful consequences (e.g., unrestrained buying sprees, sexual indiscretions, or foolish business investments).
- C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.
- D. The disturbance in mood and the change in functioning are observable by others.
- E. The episode is **not severe enough** to cause marked impairment in social or occupational functioning or **to necessitate hospitalization**. If there are psychotic features, the episode is, by definition, manic.
- F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition .



Substance Induced Bipolar Disorder

Diagnosis

- A. A prominent and persistent disturbance in mood that is characterized by elevated, expansive, or irritable mood, with or without depressed mood, or markedly diminished interest or pleasure in all, or almost all, activities
- B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):
 - 1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal
 - 2. The involved substance may produce the symptoms in Criterion A
- C. The disturbance is not better explained by a bipolar or related disorder that is not substance induced. Such evidence of an independent bipolar or related disorder could include the following:
 - 1. The symptoms precede the onset of the substance use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is evidence suggesting the existence of an independent non-substance induced bipolar disorder
- D. The disturbance does not occur exclusively during delirium
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

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Prevalence

- ❖ No known epidemiological data of substance-induced mania or bipolar disorder
- ❖ Persons with alcohol use disorder have about a 3% risk for bipolar disorder, compared to a 1% risk in the general population (Helzer & Pryzbeck, 1988)



Development & Course

- ❖ Course will be different with different substances, for example:
- ❖ PCP-induced mania (Rosen 1979; Slavney et al. 1977)
 - ❖ Initial presentation may be delirium, then becomes manic or mixed state
 - ❖ Typically happens within hours to days
- ❖ Stimulant-induced mania or hypomania
 - ❖ Onset within minutes-hours after ingesting, smoking, or injecting
 - ❖ Brief episodes, resolves in 1-2 days



Case Reports of Substance Induced Mania

- ❖ Ibogaine (Cole et al., 2015)
- ❖ Methylphenidate (Lahti et al., 2009)
- ❖ Alprazolam (France et al., 1984; Remick 1985; Mayerhoff et al., 1986)
- ❖ High dose caffeine (840 mg; Krankl & Gitlin, 2015)
- ❖ Lorazepam withdrawal (Turkington & Gill, 1989; Rigby et al., 1989; Lapierre & Labelle, 1989)
- ❖ Opioid withdrawal (Khalili & Gudarzi, 2012)



Substance Use and Antidepressants in Bipolar Disorder

- ❖ 53 patients diagnosed with DSM-IV bipolar disorder had retrospective interviews to identify:
 - ❖ Lifetime affective episodes
 - ❖ Pharmacotherapy trials
 - ❖ Information from interviews was corroborated with treating clinicians and reviews of medical, psychiatric, and pharmacy records
- ❖ Antidepressant-induced mania or hypomania was evident in 39.6% (21/53) of the study group
- ❖ 17 patients had SUD; 14 (82.4%) used alcohol +/- cannabis; 3 (17.6%) used cocaine
- ❖ History of substance use disorder was associated with substantially increased risk for antidepressant-induced mania (odds ratio = 6.99, 95% CI = 1.57 to 32.28, $p = .007$).
- ❖ Substance use preceded antidepressant-induced mania by >1 year in almost all cases

Goldberg & Whiteside, 2002



SUBSTANCE INDUCED PSYCHOTIC DISORDERS



Schizophrenia

- A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):
- ❖ Delusions.
 - ❖ Hallucinations.
 - ❖ Disorganized speech (e.g., frequent derailment or incoherence).
 - ❖ Grossly disorganized or catatonic behavior.
 - ❖ Negative symptoms (i.e., diminished emotional expression or avolition).
- B. Decrease in functioning in at least one area since symptoms started.
- C. Continuous signs of the disturbance persist for at least 6 months.
- D-F. Have ruled out this is not schizoaffective disorder, bipolar disorder, substance use, autism.

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Substance Induced Psychotic Disorder (SIPD)

- A. Presence of one or both of the following symptoms:
 - 1. Delusions
 - 2. Hallucinations
- B. Evidence from the H&P or laboratory findings of both (1) and (2):
 - 1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
 - 2. The involved substance can produce the symptoms in Criterion A.
- C. The disturbance is not better explained by a psychotic disorder that is not substance induced. Evidence of an independent psychotic disorder could include the following:
 - 1. The symptoms preceded the onset of the substance use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence of an independent non-substance induced psychotic disorder (e.g., a history of recurrent non-substance related episodes).
- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

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Diagnosing Substance Induced Psychotic Disorder

- ❖ History of primary psychotic disorder does not rule out the possibility of a substance induced psychotic disorder
- ❖ Consider primary psychotic disorder if there is persistence of psychotic symptoms for a substantial period after the end of substance intoxication or withdrawal (i.e., >1 month)



Diagnosing Substance Induced Psychotic Disorder

- ❖ Those intoxicated or withdrawing from a substance may experience perceptual disturbances
 - ❖ They may recognize them as drug effects and have intact reality testing regarding these perceptual experiences
 - ❖ This is not a substance induced psychotic disorder
- ❖ Instead, is substance intoxication or withdrawal with perceptual disturbance
- ❖ If they have perceptual disturbances in course of withdrawal delirium, these are part of delirium diagnosis



Prevalence

- ❖ In general population, prevalence is unknown
- ❖ In those presenting with first episode psychosis in different treatment settings, prevalence is 7-25% (Crebbin et al., 2009)

- ❖ In 198 methamphetamine users presenting to a syringe exchange program in Australia (Hides et al., 2015)
 - ❖ 101 (51%) participants had a lifetime psychotic disorder
 - ❖ 81 (80%) were determined to be substance induced
 - ❖ 20 (20%) were determined to be primary psychotic disorders
 - ❖ 62 (39%) had current psychoric disorder, of these 49 (79%) were substance induced



Study of Psychosis and SIPD

386 patients presenting to the ED with psychosis and substance use were interviewed using PRISM; 93.3% of subjects started regularly using substances before 1st psychotic symptom; 44% of cases of psychosis were determined to be substance induced

Type of Substance Induced Psychosis	n	%
Cannabis	32	18.9%
Alcohol	29	17.2%
Cocaine	26	15.4%
Hallucinogen	7	4.1%
Sedative	4	2.4%
Heroin	2	1.2%
Stimulant	1	0.6%
2/+ substances	67	39.6%

Caton et al., 2005



Table 2. Clinical Characteristics of Substance-Induced and Primary Psychotic Disorder Groups

Finding	Baseline Findings by Diagnosis Category, Mean (SD)		<i>P</i> Value
	Primary Disorder (n = 217)	Substance-Induced Disorder (n = 169)	
PAS score	0.32 (0.14)	0.31 (0.14)	.34
PANSS			
Positive subscale score	18.62 (7.26)	14.30 (5.36)	<.001
Negative subscale score	14.16 (6.24)	11.67 (4.74)	<.001
General psychopathology score	33.29 (10.46)	28.44 (6.86)	<.001
SUMD			
Unawareness of symptoms	2.79 (1.52)	1.98 (1.74)	<.001
Misattributions for symptoms	2.99 (1.77)	2.36 (2.00)	<.001
Age of onset of drug use, y	17.17 (4.14)	16.83 (5.19)	.47

Abbreviations: PANSS, Positive and Negative Syndrome Scale; PAS, Premorbid Adjustment Scale; SUMD, Scale to Assess Unawareness of Mental Disorders.

Caton et al., 2005



Follow-up of Psychosis and SIPD

- ❖ 6 & 12 months later, 319 subjects out of original 386 were reinterviewed and PRISM done again
- ❖ At follow-up,
 - ❖ 285 subjects (89%) retained their baseline diagnostic category
 - ❖ 10 (3%) subjects with a baseline diagnosis of primary psychotic disorder remitted during the follow-up interval and experienced a new substance-induced psychotic episode
 - ❖ 34 subjects (11%) changed from substance induced psychosis to primary psychosis
 - ❖ 25 (74%) diagnosis changed in the first 6 months due to persistent psychotic symptoms in the absence of substance use

Caton et al., 2007



SUBSTANCE INDUCED ANXIETY DISORDERS



Panic Disorder

- A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time 4 (or more) of the following symptoms occur:
- ❖ Palpitations, pounding heart, or accelerated heart rate.
 - ❖ Sweating.
 - ❖ Trembling or shaking.
 - ❖ Sensations of shortness of breath or smothering.
 - ❖ Feelings of choking.
 - ❖ Chest pain or discomfort.
 - ❖ Nausea or abdominal distress.
 - ❖ Feeling dizzy, unsteady, light-headed, or faint.
 - ❖ Chills or heat sensations.
 - ❖ Paresthesias (numbness or tingling sensations).
 - ❖ Derealization (feelings of unreality) or depersonalization (being detached from oneself).
 - ❖ Fear of losing control or “going crazy.”
 - ❖ Fear of dying.
- B. At least one of the attacks has been followed by 1 month (or more) of 1 or both of the following:
- ❖ Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, “going crazy”).
 - ❖ A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).



Generalized Anxiety Disorder

- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
- B. The individual finds it difficult to control the worry.
- C. The anxiety and worry are associated with 3 (or more) of the following 6 symptoms (with at least some symptoms having been present for more days than not for the past 6 months; only 1 item for children):
 - ❖ Restlessness or feeling keyed up or on edge.
 - ❖ Being easily fatigued.
 - ❖ Difficulty concentrating or mind going blank.
 - ❖ Irritability.
 - ❖ Muscle tension.
 - ❖ Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).



Substance Induced Anxiety Disorder

Diagnosis

- A. Panic attacks or anxiety are predominant in the clinical picture
- B. There is evidence from H&P or laboratory findings of both (1) and (2):
 - 1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal
 - 2. The involved substance is capable of producing the symptoms in Criterion A
- C. The disturbance is not better explained by an anxiety disorder that is not substance induced. Such evidence of an independent anxiety disorder could include the following:
 - 1. The symptoms precede the onset of the substance use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance induced anxiety disorder
- D. The disturbance does not occur exclusively during delirium
- E. The disturbance causes clinically significant distress or impairment



Diagnosis

- ❖ Substance induced anxiety disorder diagnosis should be made instead of substance intoxication or withdrawal only when panic attacks or anxiety predominate in the clinical picture and are severe enough to warrant clinical attention
- ❖ Panic or anxiety must have developed during or shortly after exposure to substance or withdrawal
- ❖ Substance must be capable of producing the anxiety symptom
- ❖ Panic or anxiety symptoms will usually improve or remit within days to 4 weeks (depending on the half-life of the substance and the presence of withdrawal)
- ❖ If panic or anxiety symptoms persist for substantial periods, other causes should be considered
- ❖ Urine toxicology may be helpful



Prevalence

- ❖ Based on NESARC (Grant et al., 2004)
 - ❖ 12-month prevalence of independent anxiety disorders = 11.08% while presence of substance-induced anxiety disorders was <1%



Summary

- ❖ Substance-induced disorders may have symptoms that overlap with independent psychiatric disorders and complicate the assessment of co-occurring disorders
- ❖ Important to get a timeline of onset of substance use and psychiatric symptoms
- ❖ Substance-induced disorders should clear within 1 month
- ❖ Lower likelihood of need for psychiatric medications for substance-induced disorders
- ❖ Abstinence from substance use is recommended for substance-induced disorders
- ❖ Primary disorders may benefit from treatment with medications and abstinence from substance use
- ❖ Review References



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