18 Substance Use Disorders

Essential Concepts
Screening Questions

- Do you smoke cigarettes?
- How often do you drink?
- Do you use any recreational drugs, such as marijuana, LSD, or cocaine?

First you take a drink, then the drink takes a drink, then the drink takes you.

—F. Scott Fitzgerald

CLINICAL DESCRIPTION

Substance use disorders (SUDs) are among the most prevalent psychiatric disorders in young people. Although experimentation with alcohol and drugs is sometimes considered one of the rites of passage for American youth, there is a high risk for misuse, addiction, and serious negative consequences (legal, social, and safety). Additionally, the treatment of any other psychiatric disorders is complicated by concomitant substance use. See Table 18.1 for diagnostic criteria for substance abuse.

Compared to adults, adolescents with SUDs present with a greater number of drugs used at any time. While substance-dependent youth may present with symptoms of tolerance, they present less often with symptoms of withdrawal or other symptoms of dependence noted in Table 18.2.

In general, substance abuse is a disorder that starts in adolescence or early adulthood. In evaluating even a prepubertal child, however, you have a goal to understand if smoking or substance use is present, to understand the nature and severity, and to ensure that it is addressed in treatment. Minors tend to have a higher rate of risk-taking behaviors than adults. They may begin to steal, lie, and participate in criminal behavior to support a habit. SUD youth often have comorbid conduct disorders.

TABLE 18.1. DSM-IV-TR Criteria for Alcohol/Substance Abuse

A maladaptive pattern of alcohol/substance use leading to clinically significant impairment or distress, as manifested by at least one of the following:

1. Failure to fulfill major role obligations at work, school, or home
2. Recurrent alcohol use in situations in which it is physically hazardous
3. Recurrent alcohol-related legal problems
4. Continued alcohol use despite persistent problems caused by its use

Adapted from American Psychiatric Association (2000), Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Text revision. Washington, DC. American Psychiatric Association.

KEY POINT

Youth don't tend to tell parents or other adults about their experimentation with substances. The first clues may be a decline in grades, irritability, or hanging out with a different group of friends. Ask about that.

TABLE 18.2. DSM-IV-TR Criteria for Alcohol/Substance Dependence

Mnemonic: **T**empted **W**ith **C**ognac. To be considered alcohol (or other substance) dependent, the patient must meet at least three of the following seven criteria:

Tolerance—a need for increasing amounts of alcohol to achieve intoxication

Withdrawal syndrome

Loss of **C**ontrol of alcohol use (five criteria follow):

- More alcohol ingested than the patient intended
- Unsuccessful attempts to cut down
- Much time spent in activities related to obtaining or recovering from the effects of alcohol
- Important social, occupational, or recreational activities given up or reduced because of alcohol use
- Alcohol use continued despite the patient's knowledge of significant physical or psychological problems caused by its use

Adapted from American Psychiatric Association (2000), Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Text revision. Washington, DC. American Psychiatric Association.

TIP

Although education about the dangers of substance use is important, it does little to dissuade youth, for whom worries of failing health seem light-years away, from experimenting. Providing alternatives, such as sports or other interests, alcohol-free parties, and other supervised activities is more effective at preventing use.

Epidemiology

It is estimated that over 5 million youth, by age 16, have met the diagnostic criteria for a SUD. In 2003, SUDs were second only to disruptive behavior disorders as the most commonly diagnosed psychiatric disorders in youth—an estimated 12.2% by age 16. In general, boys outnumber girls in rate of substance use. By age 16, 14% of boys and 10% of girls will have experienced an episode of SUD. Tobacco, alcohol, and marijuana are the most commonly used drugs. Almost half of all 12th graders in a recent National Institute of Drug Abuse survey used alcohol within the past month, and around a quarter smoked cigarettes or marijuana. Amphetamines were the second most commonly abused illicit substance, with use by about 5% of high school students. Other substances were less frequently used. By 12th grade, 4% of youth have used anabolic steroids at least once.

Etiology and Risk Factors

There is a complicated and multifactorial set of risk factors for substance abuse (Table 18.3). Alcoholism is the most thoroughly studied of the SUDs. It has a fairly significant genetic vulnerability, with up to 25% of fathers or brothers of an alcoholic individual also suffering from alcoholism. Children of parents with SUDs who are adopted at birth to nondrug-using families have a higher rate of developing SUD than does the general population. Ineffective parenting and inadequate nurturing also increase the risk for developing a SUD. Poor parental supervision and perceived parental approval (or lack of disapproval) of drug use also increase risk.

TABLE 18.3. Risk Factors for Substance Use Disorders

- Chaotic home environment
- Parental substance abuse
- Parental mental illness
- Ineffective parenting
- Lack of parental involvement
- Failing school performance
- Poor social coping skills
- Association with conduct-disordered peers
- Perceived parental/peer/community approval of drug use

KEY POINT

Individuals have the highest risk for continuous lifelong problems with substances if they started using them before the age of 15 years. Marijuana tends to be a "gateway drug" with marijuana use preceding that of cocaine, hallucinogens, and other dangerous substances. However, most marijuana users do not go on to use other substances. With the exceptions of cocaine and prescription drugs, most drug use tends to decrease after the age of 25.

Assessment

When assessing the child or adolescent for whom you suspect a substance use disorder, it is important to ensure an appropriate medical workup and to consider comorbidities, which tend to be common (Table 18.4).

CLINICAL VIGNETTE

This is an excerpt from an interview of a 16-year-old young man whom a resident is evaluating in outpatient clinic for a change in his behavior—he has become quite irritable and defiant of rules, his grades are slipping, and he has started staying out past curfew at night. His parents and teachers suspect that he has started using substances, but he has denied it. When the resident meets him, the youth is charming, engaging, and cooperative.

Interviewer: *You seem to be a popular guy.*
Youth: *Sort of, I guess.*

TABLE 18.4. Assessment Essentials for Substance Use Disorders

1. A comprehensive physical examination, with screening laboratory tests, including liver function tests, blood count, and toxicology (drug) screen.
2. Historic data should be collected from multiple sources (patient, parents, siblings, teachers, caseworkers, and peers, if possible). The patient alone is likely to minimize or deny use.
3. Try to determine how many psychoactive substances are being used and how available they are. Where and with whom is he or she using?
4. Determine if the youth has drug use, abuse, or dependence.
5. Assess family and home situation. How closely is the youth supervised? What is the overall communication level, involvement, and home support for the youth?
6. Obtain a genetic family history of substance abuse as well as alcohol and substance use by members of the family in the home.
7. Assess for other psychiatric comorbidity.
8. Substance abuse rating instruments can be helpful in screening for SUDs and for monitoring treatment response (e.g., **S**ubstance-**A**buse **S**ubtle **S**creening **I**nventory [SASSI]; **P**ersonal **E**xperience **S**creening **Q**uestionnaire [PESQ]; **A**dolescent **D**iagnostic **I**nterview [ADI]).

   Another screening tool normed for individuals over 16 is the CAGE Questionnaire—a mnemonic for attempts to *cut* back on drinking, being *annoyed* at criticisms about drinking, feeling *guilty* about drinking, and using alcohol as an *eye* opener).

Interviewer:	*Do you and your friends smoke when you hang out together?*
Youth:	*Sometimes.*
Interviewer:	*Get invited to parties?*
Youth:	*Yeah, some.*
Interviewer:	*Besides alcohol, what is available at the parties?*
Youth:	*Just a little weed.*

From there, the resident has set the stage for the expectation of alcohol and drugs to be at parties, and assuming he may be experimenting with them. She can then get to know more details about the drugs available and which ones this young man is using.

TIP

A word about confidentiality: Just as suicidal risk cannot be kept confidential, neither should dangerous substance abuse or dependence. Be sure that you don't tell the youth that all of the information he tells you is confidential, such that you are in a dilemma if you find out about substance abuse. Instead, let him know that you will support him in telling his parents if there is something that puts him at risk that they need to know.

Treatment

Treatment of children and adolescents with substance use disorders is multimodal and family centered (Table 18.5). No specific medications have demonstrated effectiveness in children and adolescents at curbing drug craving. The youth should stop using substances and be reassessed for psychiatric comorbidity prior to starting a medication to target symptoms of the comorbidity. Effective treatment of ADHD may decrease the risk of substance abuse.

TABLE 18.5. Essentials of Multimodal Treatment of Substance Use Disorders

1. Psychoeducation of parents and youth about the nature of the illness (including relapsing nature of SUDs) and the necessity of treatment.
2. Family therapy and involvement are critical to treatment. Improving communication is the primary focus. Additionally, addressing issues such as lack of parental involvement in the child's life, the need for clear family rules, and untreated parental SUDs may be targeted. Multisystemic therapy (MST) may focus on removing the youth from environments that trigger the use.
3. Set up a plan to avoid situations that trigger substance use (such as friends or hangouts).
4. Cognitive behavior therapy may be used to target thinking errors associated with substance abuse and to increase self control.
5. Group therapies and 12-step approaches may be helpful. Beware of the risk of "peer deviancy training" in groups with conduct disorders, in which younger, more naïve members learn "bad habits" from other group members.

(Continued)

TABLE 18.5. Essentials of Multimodal Treatment of Substance Use Disorders (*continued*)

6. Inpatient rehabilitation may be required for drug dependence. Intensive outpatient services are also indicated for the more seriously impaired youth.
7. School interventions may be required to ensure that the youth is receiving the services required to help motivate and engage him or her in the academic process. School counseling is often indicated.
8. There are medications aimed at treating intoxication states and withdrawal conditions, preventing continued use, and providing narcotic maintenance (e.g., naltrexone, disulfiram, methadone for heroin addiction, and benzodiazepines for withdrawal states). In general, substance abuse treatment tends to minimize psychotropic medication use. To fully assess psychiatric comorbidities, the substance use disorder must have been addressed. However, medication may be indicated for comorbidities.

   ADHD comorbidity: Substance abuse has been demonstrated to be lower when ADHD is effectively treated. Atomoxetine, bupropion, or guanfacine may be indicated first-line. The long-acting stimulant medications (that cannot be crushed and snorted) may also be used carefully in an at-risk population if the medication administration is closely monitored.

   Use other medications as appropriate for targeted symptoms and comorbid conditions.

   In general, it is advised that a youth be observed for several weeks off substances to determine whether another psychiatric condition persists prior to starting a medication.

KEY POINT

One of the best deterrents to substance abuse in teens is open communication at home. Parents who confront their teen if they suspect substance use, let him or her know that they do not condone it, and provide a safe environment in which to disclose his or her use and get help with abstinence tend to have briefer and less severe periods of use and to have better long-term prognosis.

19 Trauma-Related Disorders

Essential Concepts
Screening Questions

- Have you ever had anything really bad happen to you?
- Have you ever been physically hurt by someone?
- Have you been touched in a manner that you didn't like?
- Do you ever have thoughts or images that pop into your mind of something bad that has happened in the past?

All children have to be deceived if they are to grow up without trauma.

—Kazuo Ishiguro

CLINICAL DESCRIPTION

Many children grow up with the scars of physical or sexual abuse, domestic violence, or other traumas. Natural disasters, war, and serious illness with painful procedures are other sources of trauma. It is impossible to grow up without some bad things happening. However, for some children, the horrors they have had to endure have left serious emotional scars.

Posttraumatic stress disorder (PTSD) is an emotional disorder that occurs following an overwhelming and frightening event that threatened serious bodily harm. It results in a re-experiencing of the traumatic event and avoidance of situations that activate traumatic memories. In infants and young children, neglect or maltreatment may result in emotional consequences as well (Table 19.1). Reactive attachment disorder (RAD) is characterized by disturbed and distrusting social relatedness caused by grossly pathogenic care. This disorder results in the child displaying severe inhibition and hypervigilance in social interactions (inhibited type) or