



# Substance-Induced Mood Disorder Treatment GuidW

## DSM IV Criteria for Substance-Induced Mood Disorder

- A.** A prominent and persistent disturbance in mood predominates in the clinical picture and is characterized by either (or both) of the following:

(1) depressed mood or markedly diminished interest or pleasure in all, or almost all, activities

(2) elevated, expansive, or irritable mood

- B.** There is evidence from the history, physical examination, or laboratory findings of either (1) or (2):

(1) the symptoms in Criterion A developed during, or within 1 month of, Substance Intoxication or Withdrawal

(2) medication use is etiologically related to the disturbance

- C.** The disturbance is not better accounted for by a Mood Disorder that is not substance induced. Evidence that the symptoms are better accounted for by a Mood Disorder that is not substance induced might include the following: the symptoms precede the onset of the substance use (or medication use); the symptoms persist for a substantial period of time (e.g., about a month) after the cessation of acute withdrawal or severe intoxication or are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or there is other evidence that suggests the existence of an independent non-substance-induced Mood Disorder (e.g., a history of recurrent Major Depressive Episodes).

- D.** The disturbance does not occur exclusively during the course of a Delirium.

- E.** The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: This diagnosis should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the mood symptoms are in excess of those usually associated with the intoxication or withdrawal syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.

### Code [Specific Substance]- Induced Mood Disorder:

(291.8 (new code as of 10/01/96: 291.89) Alcohol; 292.84 Amphetamine [or Amphetamine-Like Substance]; 292.84 Cocaine; 292.84 Hallucinogen; 292.84 Inhalant; 292.84 Opioid; 292.84 Phencyclidine [or Phencyclidine-Like Substance]; 292.84 Sedative, Hypnotic, or Anxiolytic; 292.84 Other [or Unknown] Substance)

### Specify type:

With Depressive Features: if the predominant mood is depressed  
With Manic Features: if the predominant mood is elevated, euphoric, or irritable  
With Mixed Features: if symptoms of both mania and depression are present and neither predominates

### Specify if:

With Onset During Intoxication: if the criteria are met for Intoxication with the substance and the symptoms develop during the intoxication syndrome  
With Onset During Withdrawal: if criteria are met for Withdrawal from the substance and the symptoms develop during, or shortly after, a withdrawal syndrome

## Medication Management

■ **The treatment for Substance Induced Mood Disorder may differ depending on whether the substance being used was prescribed for a medical purpose. If this is the case, the doctor may prescribe different medication or change the prescription dosage.**

- **Medications can be used to help with different aspects of the treatment process.**
- ❑ **Withdrawal:** Medications offer help in suppressing withdrawal symptoms during detoxification. However, medically assisted detoxification is not in itself “treatment”—it is only the first step in the treatment process. Patients who go through medically assisted withdrawal but do not receive any further treatment show drug abuse patterns similar to those who were never treated.
  - ❑ **Treatment:** Medications can be used to help reestablish normal brain function and to prevent relapse and diminish cravings. Currently, there are medications for opioids (heroin, morphine), tobacco (nicotine), and alcohol addiction and others are being developed for treating stimulant (cocaine, methamphetamine) and cannabis (marijuana) addiction.

SOURCE: National Institute on Drug Abuse. [DrugFacts: Treatment Approaches for Drug Addiction](#).

## Evidence-Based Psychosocial Therapies

■ **Best Support:** Cognitive Behavioral Therapy (CBT), Community Reinforcement, Family Therapy.

- ❑ Cognitive Behavioral Therapy (CBT) may be employed to assist the child with problem solving skills and in identifying solutions to interactions that seem impossible to the child. Cognitive-Behavioral Therapy may help adolescents control their aggression and modulate their social behavior. CBT can teach defiant teens self-control, self-guidance, and more thoughtful and efficient problem-solving strategies, especially as they pertain to relationships with their peers, parents, and other adults in authority.
- ❑ Family Therapy can help family members learn less defensive ways of communicating with each other when teenagers are willing to work with their parents in therapy. It can foster mutual support, positive reinforcement, direct communication, and more effective problem-solving and conflict resolution within the family.
- ❑ Community-reinforcement approach (CRA) is a substance abuse treatment approach that aims to achieve abstinence by eliminating positive reinforcement for drinking and enhancing positive reinforcement for sobriety. CRA integrates several treatment components, including building the client’s motivation to quit drinking, helping the client initiate sobriety, analyzing the client’s drinking pattern, increasing positive reinforcement, learning new coping behaviors, and involving significant others in the recovery process.

■ **Good Support:** Assertive Continuing Care, CBT and Medication, CBT with Parents, Family Contingency Management, Family Systems Therapy, Functional Family Therapy, Goal Setting Behavioral Family Therapy, Motivational Interviewing/Engagement (with and without CBT), Multidimensional Family Therapy, Purdue Brief Family Therapy.

SOURCE: American Academy of Pediatrics. Addressing Mental Health Concerns in Primary Care A Clinician’s Tool Kit: Evidence-Based Child and Adolescent Psychosocial Interventions.



## Practice Guidelines - Substance Abuse

### Phase 1

1. The clinician should observe an appropriate level of confidentiality for the adolescent during the assessment and treatment.
2. The mental health assessment of older children and adolescents requires screening questions about the use of alcohol and other substances of abuse.
3. If the screening raises concerns about substance use, the clinician should conduct a more formal evaluation to determine the quantity and frequency of use and consequences of use for each substance used and whether the youth meets criteria for Substance Abuse Disorders (SUDs).
4. Toxicology, through the collection of bodily fluids or specimens, should be a routine part of the formal evaluation and ongoing assessment of substance use both during and after treatment.

### Phase 2

5. Adolescents with SUDs should receive specific treatment for their substance use.
6. Adolescents with SUDs should be treated in the least restrictive setting that is safe and effective.
7. Family therapy or significant family/parental involvement should be a component of treatment.
8. Treatment programs and interventions should develop procedures to minimize treatment dropout and to maximize motivation, compliance, and treatment completion.
9. Medication can be used when indicated for the management of craving and withdrawal and for aversion therapy.
10. Treatment should encourage and develop peer support, especially regarding the nonuse of substances.
11. Twelve-step approaches may be used as a basis for treatment. Attendance at Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups is an adjunct to professional treatment of SUDs and should be encouraged.

### Phase 3

12. Adolescents with SUDs should receive thorough evaluation for comorbid psychiatric disorders.
13. Comorbid conditions should be appropriately treated.

### Ongoing

14. Programs and interventions should provide or arrange for post treatment aftercare.

SOURCES: 1. Practice Parameter for the Assessment and Treatment of Children and Adolescents With Substance Use Disorders, J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY, 44:6, JUNE 2005, AACAP.

NOTE: This resource is for reference purposes only and should not be used to replace medical information from prescribing health care professionals or pharmacies.