Co-Occurring Persistent Depressive Disorder and Substance Abuse: Diagnostic Jenga

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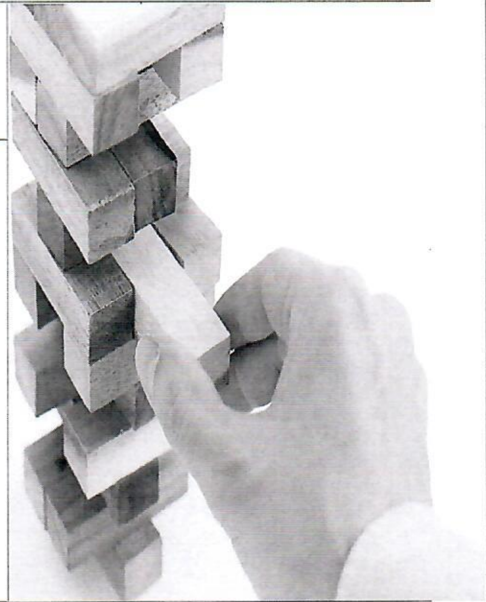

1 **Co-Occurring Persistent Depressive Disorder and Substance Abuse: Diagnostic Jenga**

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2 **Thank You**

CARE Conference Committee

Iowa Board of Certification

Courtyard by Marriott, Ankeny

You, The Participants

3 **Disclosure**

It is the intent of this presentation to shed light upon and discuss this co-occurring disorder combination for the purposes of increasing greater familiarity and knowledge toward the implementation of services for practitioners in the field.

Aside from conference honorarium and amenities, I am not provided in any way, offers to promote any therapeutic modality or the endorsement of products.

4 **Introduction**

62 years old.
Married <34 years. 2 Children 3 Grandchildren.
Disabled Veteran.
Human Services 39 years, Direct Practice 29 years.
Former Clinical Supervisor of Addictive Disorders Section, Dept of Psychiatry, Minneapolis VA Medical Center.
Former Developer and Director of a Dual Diagnosis Treatment Program for 17 years.
Currently in Private Practice.

5 **My Presentation Style**

1
- Use of slides to describe situations, provide needed information as well as ideas and concepts.....
- Interactive
- Not intended as, "Death by Powerpoint...."

2

6 **Discussion**

- What Is Persistent Depressive Disorder (PDD).

- How PDD Is Different from Other Mood Disorders.
- Why Is It Important to Differentiate PDD With Other Mood Disorders in Co-Occurring Treatment.
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7 **Why Understand Co-Occurring Disorders Combinations**

- "We need to first recognize that drug addiction is a mental illness. It is a complex brain disease characterized by compulsive, at times uncontrollable drug craving, seeking and use despite devastating consequences...these changes occur in the same brain areas that are disrupted in various other mental disorders such as depression, anxiety and schizophrenia. It is therefore not surprising that this population show a high rate of co-occurrence..."

  Nora D. Volkow, MD
  Director
  National Institute on Drug Abuse
  December, 2008.

8 **Why Understand Co-Occurring Disorders Combinations**

- Much More Common Than Not
- Significant Interplay Between Substance Use Disorders and Mental Health Conditions
- Clarification of Diagnosis Leads to Positive Treatment Interventions
- Better Overall Outcomes

9 **Persistent Depressive Disorder**

- Formerly known as "Dysthymic Disorder or as "Dysthymia".
- Diagnostically as common as Major Depressive Disorder
- Often mis-diagnosed as Major Depressive Disorder.
- Different course and presentation as Major Depressive Disorder

10 **Persistent Depressive Disorder-Presentation**

11 **Persistent Depressive Disorder-Presentation**

DSM V TR

Persistent depressive disorder (formerly dysthymic disorder) is characterized by chronic low-level depression that is not as severe, but may be longer lasting than, major depressive disorder. A diagnosis of persistent depressive disorder requires having experienced a combination of depressive symptoms for two years or more.

12 **Persistent Depressive Disorder vs. Major Depressive Disorder "Scorecard"**

1 PERSISTENT DEPRESSIVE DISORDER

2
- Does not require a Major Depressive Episode
- symptoms must have lasted for at least 2 years
-

3 MAJOR DEPRESSIVE DISORDER

4
- Requires at least one Major Depressive Episode
- episodes with a gap of at least 2 months between them.

13 **PDD "Scorecard" Continued...**

2
- feeling depressed or irritable
- having a poor appetite or overeating
- having insomnia or sleeping too much
- experiencing fatigue or low energy
- having low self-esteem
- having trouble concentrating or making decisions
- having feelings of hopelessness
-

4
- having a depressed mood that lasts for most of the day
- having less interest or pleasure in most or all activities
- experiencing fatigue
- feeling worthless or guilty
- having difficulty concentrating and making decisions
- having trouble sleeping — insomnia — or sleeping too much
- experiencing a type of restlessness called psychomotor agitation or finding it difficult to think, speak, and do other everyday things, called psychomotor impairment
- having frequent thoughts of death
-

14 **Persistent Depressive Disorder-Presentation**

Operationally
"Blah" Feeling and Affect More Days Than Not
History of Dysphoria
Developmental; Underachievement, Losses, Lack of Opportunities, Trauma.
Sedative Use Predominates: (Alcohol, Cannabis, Benzodiazepines and Opiates.

15 **Persistent Depressive Disorder-Presentation**

- An estimated 1.5% of U.S. adults had persistent depressive disorder in the past year.
- Persistent Depressive Disorder among adults higher for females (1.9%) than for males (1.0%).
- An estimated 2.5% of U.S. adults experience persistent depressive disorder at some time in their lives.[2]

16 **Persistent Depressive Disorder-Impairment**

- In a study of adults with persistent depressive disorder in a past year, degree of impairment ranged from mild to severe. Impairment was determined by scores on the Sheehan Disability Scale.
  - An estimated 49.7% of people with persistent depressive disorder had serious impairment, 32.1% had moderate impairment, and 18.2% had mild impairment.

17 **Persistent Depressive Disorder-Substance Use**

- Consistent with All Depressive Disorders
- Sedatives, Predominately Alcohol and Cannabis.
- Also Benzodiazepines and Opiates.
- Use Consistent with Mood State

18 **Frequent Diagnostic Correlates**
Comparative Analysis of Dual Recovery Program Participants, 2004-2010 Moore, L. 2010.
n=398

19 **PDD and SUDs-Implications for Practice**

- Cognitive-Based Treatments: CBT, MET, TSF appear to be most effective.
- Incorporate Challenging Negative Cognitions which have led to Negative Narrative.
- Group Work with Individualized Therapy/1:1 Sessions.

20 **PDD and SUDs-Implications for Practice**

- Focus on Developmental Milestones, Trauma History and Other Factors.
- Strength-Based, with the Ability to Impact Change.
- Concurrent Medication Therapy (SSRI/SNRI) Often Needed and Should Be Facilitated as Soon as Possible.

21 **PDD and SUDs-Implications for Practice**

- Client-Practitioner Relationship is Key.
- Willingness and Understanding of the Interplay Between PPD and SUDs.
- Treatment "Environment" is Conducive to Co-Occurring Treatment and Expectations are NOT Contrary or Unclear.

22 **PDD and SUDs-Implications for Practice**

- Understanding that Substance Use is Connected with Mood Management, and that Conjunctive Medication Treatment is Key to Prevention of Relapse.

23 **Summary and Key Points**

- PDD is as Common as MDD
- PDD Often Mis-Diagnosed as MDD
- PDD Has High Rates of Co-Occurring Substance Use
- Alcohol and Cannabis Most Common
- Treatment is Best Served by Cognitive-Based Group and Individual Interventions as Assisted by Medications
- Knowing and Implementing the Above By Providers Will Facilitate Optimum Outcomes

24 **Questions and Discussion**

25

12th Annual

Co-Occurring Disorders Symposium

Wednesday, January 24 through Friday January 26, 2024
Best Western and Empire Event Center
Rochester, Minnesota

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Resources

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3. Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry.* 2005 Jun;62(6):617-27. PMID: 15939839
4. Merikangas KR, He JP, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J. Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication--Adolescent Supplement (NCS-A). *J Am Acad Child Adolesc Psychiatry.* 2010 Oct;49(10):980-9. PMID: 20855043

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30 **Resources**

- Sheehan, D. V. (2000). Sheehan disability scale. *Handbook of psychiatric measures*, 113-115. ISBN: 0890424152, 9780890424155.