
UNIT 4 SUBSTANCE INDUCED MOOD DISORDER

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4.0 INTRODUCTION

When taking a drug or stopping a drug causes days or weeks of mood changes, the problem is called substance-induced mood disorder. Many medicines and illegal drugs can cause you to be depressed. The drugs make you feel sad, uninterested in daily events, and hopeless. You may also get manic symptoms. When you are manic you are overexcited, have too much energy, and have difficulty controlling your actions. If you were depressed or manic before beginning drug use and it worsens with drug use, it is not called substance-induced mood disorder. A Substance-Induced Mood Disorder is distinguished from Major Depressive, Manic, or Mixed Episodes by the fact that a substance (e.g., a drug of abuse, a medication, or

exposure to a toxin) is judged to be etiologically related to the mood disturbance. In the present unit we will discuss the etiology and symptoms substance-induced mood disorder. We will also discuss different types of substances and how these substances induce mood disorders during intoxication (i.e., while the individual is under the influence of the drug) or during withdrawal (i.e., after an individual stops using the drug).

4.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain the nature of substance induced mood disorder;
- Describe the diagnostic criteria of substance induced mood disorder;
- Elucidate the differences between due substance induced mood disorder and mood disorder due to general medical condition;
- Delineate the types of psychoactive drugs that may induce mood disorder; and
- Analyse the differences between substance induced mood disorders from a primary mood disorder.

4.2 SUBSTANCE INDUCED MOOD DISORDER

According to the Diagnostic and Statistical Manual of Mental Disorders- Forth Edition, Text Revised (DSM-IV- TR) substance induced mood disorder is diagnosed when

A: A person has significant disturbance in mood that includes either (or both)

Depressed mood or significantly reduced level of interest or pleasure in most or all activities.

Mood that is euphoric, heightened, or irritable.

B: The person's symptoms develop during (or within four weeks of) intoxication or withdrawal, or are caused by medication use.

C: Another disorder does not better explain the mood disturbance.

D: The mood condition is not present only when a person is delirious.

E: The symptoms are a cause of great distress or difficulty in functioning at home, work, or other important areas.

Before we start our discussion about the substance induced mood disorder, it is important to explain what we mean by psychoactive substance and also the level of involvement, that is which are substance use, intoxication, abuse and dependence.

4.2.1 Psychoactive Substances and Level of Involvement

Psychoactive substances are chemical compounds that are ingested to alter mood or behaviour. Thus all types of drugs, illegal (e.g. cocaine and heroin) as well as legal and safe drugs (e.g. alcohol, nicotine, and the caffeine in the coffee, soft drinks, and chocolate) are included in this category, as the safe drugs also affect mood and behaviour: they can be addictive, and they account for more health problems than those of illegal drugs (Durand & Barlow, 2000).

Substance use is the ingestion of psychoactive substances in moderate amounts that does not significantly interfere with social, educational, or occupational functioning.

Substance intoxication refers to the physiological reaction to ingested substances—drunkenness, or getting high. Intoxication depends on which drug is taken, how much is ingested, and the person's individual biological reaction. Intoxication may cause impaired judgment, mood changes, and lowered motor ability.

Substance abuse is defined in terms of how significantly the substances interfere with the user's life. If substances disrupt user's education, job, or relationship with others, and put him in physically dangerous conditions, he would be considered a drug abuser.

As far as *substance dependence* is concerned the term substance dependence or "addiction" is generally used to describe people who seem to be enslaved by drugs. Substance dependence is the person is dependent on drug or drugs, requires greater and greater amounts to experience the same effect (tolerance), and will respond physically in a negative way when the substance is no longer ingested (withdrawal) (Kalant, 1989).

Depending on their effect, psychoactive substances are grouped into four categories as depressants, stimulants, opiates, and hallucinogens.

Depressant are those substances which result in behavioural sedation. They include alcohol and the sedative (calming), hypnotic (sleep-inducing), and anxiolytic (anxiety-reducing) drugs in the families of barbiturates (e.g., seconal) and benzodiazepines (e.g., valium and halcion).

Stimulant substances are the substances which cause the person to be more active and alert, and can elevate mood. Amphetamines, cocaine, nicotine, and caffeine are included in this group. Heroin, opium, codeine, and morphine are included in the *opiates* group. Their major effect is to temporarily produce analgesia (reduce pain) and euphoria, while marijuana and LSD are included in *hallucinogens* category. These substances alter sensory perception and can produce delusions, paranoia, and hallucinations.

All psychoactive drugs cause alterations in normal mood. The severity and manner of these alterations are regulated by preexisting mood states, type and amount of drug used, chronicity of drug use, route of drug administration, current psychiatric status, and history of mood disorders. Substance induced mood alterations can result from acute and chronic drug use as well as from drug withdrawal. Moreover, substance induced mood disorders, most notably acute depression lasting from hours to days, can result from sedative-hypnotic intoxication. Similarly, prolonged or sub-acute withdrawal, lasting from weeks to months, can cause episodes of depression, sometimes accompanied by suicidal ideation or attempts.

Also, stimulant withdrawal may provoke episodes of depression lasting from hours to days, especially following high-dose, chronic use. Stimulant-induced episodes of mania may include symptoms of paranoia lasting from hours to days. Overall, the process of addiction per se can result in bio-psychosocial disintegration, leading to chronic dysthymia or depression often lasting from months to years.

Since symptoms of mood disorders that accompany acute withdrawal syndromes are often the result of the withdrawal, adequate time should elapse before a definitive diagnosis of an independent mood disorder is made. Conditions that most frequently cause and mimic mood disorders and symptoms must be differentiated from substance

induced conditions. When symptoms persist or intensify, they may represent substance induced mood disorders.

Transient dysphoria following the cessation of stimulants can mimic a depressive episode. According to the DSM-IV, if symptoms are intense and persist for more than a month after acute withdrawal, a depressive episode can be diagnosed. Symptoms of shorter duration can be diagnosed as a substance-induced mood disorder.

4.2.2 Diagnostic Features of Substance Induced Mood Disorder

A mood disorder can be classified as substance-induced if its etiology can be traced to the direct physiological effects of a psychoactive drug or other chemical substance, or if the development of the mood disorder occurred contemporaneously with substance intoxication or withdrawal. Alternately, an individual may have a mood disorder coexisting with a substance abuse disorder.

Substance-induced mood disorders can have features of a manic, hypomanic, mixed, or depressive episode. When the symptoms like those seen in a manic, mixed, or hypomanic episode may be part of an intoxication with or withdrawal from a drug of abuse. It is diagnosed as a Substance Induced Mood Disorder (e.g., euphoric mood that occurs only in the context of intoxication with cocaine would be diagnosed as Cocaine-Induced Mood Disorder, with Manic Features, with Onset During Intoxication).

Symptoms like those seen in a manic or mixed episode may also be precipitated by antidepressant treatment such as medication, electroconvulsive therapy, or light therapy, such episodes are also diagnosed as Substance Induced Mood Disorder. The essential feature of Substance Induced Mood Disorder is a prominent and persistent disturbance in mood that is judged to be due to the direct physiological effects of a substance.

Depending on the nature of the substance and the context in which the symptoms occur (i.e., during intoxication or withdrawal), the disturbance may involve depressed mood or markedly diminished interest or pleasure or elevated, expansive, or irritable mood.

Although the clinical presentation of the mood disturbance may resemble that of a major depressive, manic, mixed, or hypomanic episode, the full criteria for one of these episodes need not be met. The predominant symptom type may be indicated by using one of the following subtypes: (i) With Depressive Features (ii) With Manic Features (iii) With Mixed Features.

The diagnosis is not made if the mood disturbance occurs only during the course of a delirium. The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. In some cases, the individual may still be able to function, but only with markedly increased effort.

A Substance Induced Mood Disorder is distinguished from a primary Mood Disorder by considering the onset, course, and other factors. For drugs of abuse, there must be evidence from the history, physical examination, or laboratory findings of dependence, abuse, intoxication, or withdrawal.

Substance-Induced Mood Disorders arise only in association with intoxication or

withdrawal states, whereas primary Mood Disorders may precede the onset of substance use or may occur during times of sustained abstinence.

4.2.3 Substances and Accompanying Psychiatric Symptoms

Following is an overview of the most common classes of substances of abuse and the accompanying psychiatric symptoms seen in intoxication, withdrawal, or chronic use.

4.2.3.1 Depressants

Depressants decrease the activities of central nervous system. Their principal effect is to reduce the levels of physiological arousal and help us relax. Some of the most commonly used depressants are discussed below:

4.2.3.1.1 Alcohol

Alcohol is a depressant, but its initial effect is an apparent stimulation. The chronic abuse of alcohol can be associated with significant depression that may, by symptoms alone, be indistinguishable from idiopathic major depression.

However, of patients with depressive disorder from alcohol dependence who are monitored for 2-4 weeks without alcohol, more than 50% have full remission of symptoms without additional intervention for the depressive symptoms. A minority of patients, usually those with more severe symptoms, has a continued depressive syndrome despite sobriety and requires additional treatment (Schuckit, Smith, Danko, 2007).

In most people, moderate to heavy consumption is associated with euphoria, mood lability, decreased impulse control, and increased social confidence (i.e., getting high). Such symptoms might even appear “hypomanic.” However these often are followed with next-day mild fatigue, nausea, and dysphoria (i.e., a hangover). In a person who has many life stresses, losses, and struggles, which is often the case as addiction to alcohol proceeds, the mood lability and lowered impulse control can lead to increased rates of violence toward others and self. Prolonged drinking increases the incidence of dysphoria, anxiety, and such violence potential. Symptoms of alcohol withdrawal include agitation, anxiety, tremor, malaise, hyperreflexia (exaggeration of reflexes), mild tachycardia (rapid heartbeat), increasing blood pressure, sweating, insomnia, nausea or vomiting, and perceptual distortions.

Following acute withdrawal (a few days), some people will experience continued mood instability, fatigue, insomnia, reduced sexual interest, and hostility for weeks, so called “protracted withdrawal.” Differentiating protracted withdrawal from a major depression or anxiety disorder is often difficult. More severe withdrawal is characterised by severe instability in vital signs, agitation, hallucinations, delusions, and often seizures. The best predictor of whether this type of withdrawal may happen again is if it happened before. Alcohol-induced deliriums after high-dose drinking are characterised by fluctuating mental status, confusion, and disorientation and are reversible once both alcohol and its withdrawal symptoms are gone, while by definition, alcohol dementias are associated with brain damage and are not entirely reversible even with sobriety.

4.2.3.1.2 Sedative, Hypnotic, and Anxiolytic Substances

Acute intoxication with sedative, hypnotic, and anxiolytic drugs like barbiturates (which include Amytal, Seconal, and Nembutal) and benzodiazepines (which include

Valium, Xanax, Rohypnol, and Halcion) is similar to what is experienced with alcohol. The DSM-IV criteria for sedative, hypnotic, and anxiolytic drug use disorder do not differ substantially from those alcohol disorders.

Withdrawal symptoms are also similar to alcohol and include mood instability with anxiety and/or depression, sleep disturbance, autonomic hyperactivity, tremor, nausea or vomiting, and, in more severe cases, transient hallucinations or illusions and grand mal seizures. There are reports of a protracted withdrawal syndrome characterised by anxiety, depression, paresthesias, perceptual distortions, muscle pain and twitching, tinnitus, dizziness, headache, derealisation and depersonalisation, and impaired concentration.

Most symptoms resolve within weeks, though some symptoms, such as anxiety, depression, tinnitus (ringing in the ears), and paresthesias (sensations such as prickling, burning, etc.), have been reported to last a year or more after withdrawal in rare cases. No chronic dementia-type syndromes have been characterised with chronic use; however, many people who use sedatives chronically seem to experience difficulty with anxiety symptoms, which respond poorly to other anxiety treatments.

4.2.3.2 Stimulants

Stimulants are the most commonly used psychoactive substances. Included in this group are caffeine (in coffee, chocolate, and many soft drinks), nicotine (in tobacco products) amphetamines, and cocaine. In contrast to depressant substances, stimulants make us more alert and energetic. Several weeks of abstinence, many people who are addicted to stimulants report a dysphoric state that is marked by anhedonia (absence of pleasure) and/or anxiety, but which may not meet the symptom severity criteria to qualify as DSM-IV Major Depression. Some of the common stimulant substances are given below:

4.2.3.2.1 Amphetamine

Amphetamines are CNS stimulants and initially cause feelings of increased well-being, energy, and concentration. However, amphetamine abuse can cause development of psychotic symptoms. A low dose of amphetamines can induce feelings of elation and vigor and can reduce fatigue. We literally feel “up”. However, after a period of elation we come back down and “Crash”, Feeling depressed and tired. DSM-IV diagnostic criteria for amphetamine intoxication include significant behavioural symptoms, such as euphoria or affective blunting, changes in sociability, interpersonal sensitivity, anxiety, tension, anger, stereotyped behaviours, impaired judgment, and impaired social or occupational functioning.

Ecstasy (methylenedioxymethamphetamine [MDMA]), a designer drug synthetically derived from amphetamine, is often used in the context of large and energetic parties (raves) and at nightclubs. Initially, it causes mild euphoria, increased energy, and increased libido. Tolerance develops rapidly. Depression, anxiety, and psychosis have also been described with regular use, and some of the symptoms persist for months after cessation of use.

4.2.3.2.2 Caffeine

Caffeine is the most common psychoactive substances. It is used nearly by all people. It is called “gentleman stimulant” because it is thought to be the least harmful of all the addictive drugs. This drug is found in tea, coffee, many cola drinks, and in cocoa products. As with other stimulants, regular use of caffeine can result in

tolerance and dependence on the drug (Strain, Mumford, Silverman, & Griffiths, 1992). When denied the morning tea or coffee the person experiences headaches, drowsiness, and a general unpleasant mood characterised by withdrawal symptoms. When consumed in large quantities, caffeine can cause mild to moderate anxiety, though the amount of caffeine that leads to anxiety varies. Caffeine is also associated with an increase in the number of panic attacks in individuals who are predisposed to them.

4.2.3.2.3 Cocaine

Cocaine is derived from the leaves of coca plant. Cocaine is a powerful stimulant initially causing euphoria and increased alertness and energy. Cocaine can also make the heart beat more rapidly and irregularly, and it can have fatal consequences, depending on the person's physical condition and the amount of drug ingested. As the high wears off, the user may develop symptoms of anxiety and depression, often with drug craving. With continued regular use, symptoms of psychosis develop with hallucinations and frank paranoid delusions. The psychiatric presentation can appear similar to that observed in patients with chronic amphetamine abuse.

4.2.3.2.4 Nicotine

Clients who are dependent on nicotine are more likely to experience depression than people who are not addicted to it; however, it is unclear how much this is cause or effect. In some cases, the client may use nicotine to regulate mood. Whether there is a causal relationship between nicotine use and the symptoms of depression remains to be seen. At present, it can be said that many persons who quit smoking do experience both craving and depressive symptoms to varying degrees, which are relieved by resumption of nicotine use.

Mild to moderate intoxication from cocaine, methamphetamine, or other stimulants is associated with euphoria, and a sense of internal well-being, and perceived increased powers of thought, strength, and accomplishment. In fact, low to moderate doses of amphetamines may actually increase certain test-taking skills temporarily in those with attention deficit disorders and even in people who do not have attention deficit disorders. However, as more substance is used and intoxication increases, attention, ability to concentrate, and function decrease. As dosage of increases cocaine and methamphetamines, the chances of impulsive dangerous behaviours, which may involve violence, promiscuous sexual activity, and others, also increases. Many who become chronic heavy users go on to experience temporary paranoid delusional states.

Even with several weeks of abstinence, many people who are addicted to stimulants report a dysphoric state that is marked by anhedonia (absence of pleasure) and/or anxiety, but which may not meet the symptom severity criteria to qualify as DSM-IV Major Depression. These anhedonic states can persist for weeks. As mentioned above, heavy, long-term amphetamine use appears to cause long-term changes in the functional structure of the brain, and this is accompanied by long-term problems with concentration, memory, and, at times, psychotic symptoms. Month-long methamphetamine binges followed by week- or month-long alcohol binges, a not uncommon pattern, might appear to be "bipolar" disorder if the drug use is not discovered.

4.2.3.3 Opioids

The word opiate refers to the natural chemicals in the opium poppy that have a narcotic effect (they relieve pain and induce sleep). The broader term opioids refer

to the family of substances that include natural opiates, synthetic variations, and the comparable substances that occur naturally in brain (Jaffe, Knapp, & Ciraulo, 1997). Morphine, codeine, and heroin are produced from opium poppies. Opiates are analgesics (relieve pain). It also induces euphoria, drowsiness, and slowed breathing. Opioid intoxication is characterised by intense euphoria and well-being. Withdrawal results in agitation, severe body aches, gastrointestinal symptoms, dysphoria, and craving to use more opioids.

Symptoms during withdrawal vary, that is, some will become acutely anxious and agitated, while others will experience depression and anhedonia. Even with abstinence, anxiety, depression, and sleep disturbance can persist for weeks as a protracted withdrawal syndrome. Again, differentiating this from major depression or anxiety is difficult and many clinicians may just treat the ongoing symptom cluster. For many people who become opioid dependent, and then try abstinence, these ongoing withdrawal symptoms are so powerful that relapse occurs even with the best of treatments and client motivation. For these clients, opioid replacement therapy (methadone, suboxone, etc.) becomes necessary and many times life saving. There are reports of an atypical opioid withdrawal syndrome characterised by delirium after abrupt cessation of methadone. Such clients do not appear to have the autonomic symptoms typically seen in opioid withdrawal. Long-term use of opioids is commonly associated with moderate to severe depression.

4.2.3.4 Hallucinogens

Hallucinogens are the substances that can lead to hallucinogen use disorder. Ingestion of these substances change the way the user perceives the world. Sight, sound feelings, taste, and even smell are distorted. They produce visual distortions and frank hallucinations. Some people who use hallucinogens experience a marked distortion of their sense of time and feelings of depersonalisation.

Hallucinogens may also be associated with drug-induced panic, paranoia, and even delusional states in addition to the hallucinations. Hallucinogen hallucinations usually are more visual (e.g., enhanced colors and shapes) as compared to schizophrenic-type hallucinations, which tend to be more auditory (e.g., voices). The hallucinogens can cause a state of intoxication called hallucinosis, which has several features in common with psychotic disorders and a few in common with mood disorders.

4.2.3.4.1 Marijuana

Marijuana is an important drug of hallucinogens category. It is the name given to the dried parts of the Cannabis or hemp plant. Cannabis grows wild throughout the tropical and temperate regions of the world, which accounts for one of its nicknames, “weed.” Marijuana, which has sedative and psychedelic properties, can cause a variety of mood-related effects. In the individual who has not developed tolerance for the drug’s effects, high doses of marijuana can cause acute marijuana intoxication with euphoria or agitation, grandiosity, and “profound thoughts.” Together, these symptoms can mimic mania. Because marijuana is only slowly eliminated from the body, chronic use results in relatively constant marijuana levels. Thus, daily marijuana use can be, in effect, a chronic marijuana intoxication. This state may include symptoms of chronic, low-grade lethargy and depression, perhaps accompanied by anxiety and memory loss. Phencyclidine (PCP) intoxication can include symptoms of euphoria, mania, or depression, in addition to sensory dissociation, hallucinations, delusions, psychotic thinking, altered body image, and disorientation.

Other hallucinogens such as LSD (lysergic acid diethylamide) and drugs such as MDMA (methylenedioxy-methamphetamine, or Ecstasy) and MDA (methylenedioxyamphetamine) may precipitate intense emotional experiences that may be perceived as positive or negative mood states by the drug user. These experiences are affected greatly by personality, preexisting mood state, personal expectations, drug dosage, and environmental surroundings.

While many users will experience sensory and perceptual distortions, some will experience euphoric religious or spiritual experiences that may resemble aspects of a manic or psychotic episode. Others may have a deeply troubling introspective experience, causing symptoms of depression.

4.2.4 Prognosis

Depressive or manic symptoms induced by substance intoxication usually subside once the substance responsible is eliminated. Symptoms persist depending on the half-life of the substances (i.e., how long it takes the before the substance is no longer present in an individual's system). Symptoms, therefore, can persist for hours, days, or weeks after a substance is last used. Mood disorder symptoms induced by substances sometimes do not disappear, even although the substance inducing them has been eliminated. More intensive treatment for the mood disorder symptoms would be necessary and should include a combination of medication and behavioural therapy.

4.2.5 Treatment

A multidisciplinary approach to the treatment of substance induced mood disorder appears to be most effective because the problems are often complex, requiring flexibility and individualisation of treatment procedures (Margolis and Zweben, 1998). Treatment programme objectives usually include detoxification, physical rehabilitation, control over drug-abuse behaviour, and development of an individual's realisation that he /she can cope with the problems of living and lead a much more rewarding life without drugs. Psychotherapy along with some medications is effectively used for treating substance induced mood disorder.

4.2.5.1 Psychotherapy

Substance-induced mood disorder can be successfully treated with either group or individual psychotherapy. Therapy in a group with other people having substance abuse problems is often very helpful. Groups have the benefit of connecting with others having similar problems, thereby overcoming feelings of isolation. Groups provide clients with an opportunity to learn from, and give support to, each other. They can instill hope, encourage information sharing and provide role models. The group allows clients to find new ways to express themselves, or to review old conflicts in a supportive environment. In some cases, medicines for depression or anxiety may help the client to stop substance abuse. Following therapies have been found effective to cure substance induced mood disorder:

4.2.5.1.2 Aversion Therapy

Aversion therapy is based on conditioning model. In aversion therapy substance use is paired with something extremely unpleasant, such as brief electric shock or feelings of nausea. For example, a person might be offered a drink of alcohol, and receive a painful shock when the glass reaches his lips.

4.2.5.1.2 Covert Sensitisation

In covert sensitisation therapy a negative association is to be made by imagining unpleasant scenes. The Client might picture himself to snort cocaine and then becoming violently ill.

4.2.5.1.3 Contingency Management

In contingency management therapy the clinician and client together select the behaviour that the client needs to change and decide on the reinforcers that will reward reaching certain goals. In a study of cocaine abusers, clients received things like lottery tickets for having cocaine-negative urine specimens (Higgins et.al., 1993).

4.2.5.1.4 Biofeedback

Through biofeedback the client learns to control body functions such as muscle tension or brain wave patterns. Biofeedback can help with tension, anxiety, and concentration, and indirectly may help to avoid a return to substance abuse. Biofeedback should be done only in addition to psychotherapy.

4.2.5.1.5 Relaxation Therapies

Learning special relaxation methods can help with mood problems or substance abuse, along with psychotherapy. Yoga and meditation may also be helpful.

4.2.5.1.6 Art and Music Therapies

Some people find art and music therapy, along with psychotherapy, to be helpful.

4.3 LET US SUM UP

A mood disorder can be classified as substance-induced if its etiology can be traced to the direct physiological effects of a psychoactive drug or other chemical substance, or if the development of the mood disorder occurred contemporaneously with substance intoxication or withdrawal. Substance-induced mood disorders can have features of a manic, hypomanic, mixed, or depressive episode. When the symptoms like those seen in a manic, mixed, or hypomanic episode may be part of an intoxication with or withdrawal from a drug of abuse, it is diagnosed as a Substance-Induced Mood Disorder.

Psychoactive substances are chemical compounds that are ingested to alter mood or behaviour. Thus all types of drugs, illegal (e.g. cocaine and heroin) as well as legal and safe drugs (e.g. alcohol, nicotine, and the caffeine in the coffee, soft drinks, and chocolate) are included in this category. There are four levels of substance involvement: Substance use, Substance intoxication, substance abuse, and substance dependence or intoxication

Depending on their effect psychoactive substances are grouped into four categories as depressants, stimulants, opiates, and hallucinogens. Depressant are those substances which result in behavioural sedation. They include alcohol and the sedative (calming), hypnotic (sleep-inducing), and anxiolytic (anxiety-reducing) drugs in the families of barbiturates (e.g., seconal) and benzodiazepines (e.g., valium and halcion). Stimulant substances are the substances which cause the person to be more active and alert, and can elevate mood. Amphetamines, cocaine, nicotine, and caffeine are included in this group. Heroin, opium, codeine, and morphine are included in the opiates group. Their major effect is to temporarily produce analgesia (reduce pain) and euphoria, while marijuana and LSD are included in hallucinogens category. These

substances alter sensory perception and can produce delusions, paranoia, and hallucinations.

A Substance-Induced Mood Disorder is distinguished from a primary Mood Disorder by considering the onset, course, and other factors. For drugs of abuse, there must be evidence from the history, physical examination, or laboratory findings of dependence, abuse, intoxication, or withdrawal. Substance-Induced Mood Disorders arise only in association with intoxication or withdrawal states, whereas primary Mood Disorders may precede the onset of substance use or may occur during times of sustained abstinence.

Treatment of substance induced mood disorder usually include detoxification, physical rehabilitation, control over drug-abuse behaviour, and development of an individual's realisation that he /she can cope with the problems of living and lead a much more rewarding life without drugs. Psychotherapy along with some medications is effectively used for treating substance induced mood disorder.

4.4 UNIT END QUESTIONS

- 1) What do you mean by substance-induced mood disorder? Explain in the light of DSM-IV-TR.
- 2) Explain the diagnostic criteria of substance-induced mood disorder.
- 3) Differentiate between mood disorder due substance-induced mood disorder and mood disorder due to general medical condition.
- 4) What do you mean by psychoactive drugs? Discuss the types of psychoactive drugs.
- 5) Distinguish substance induced mood disorder from a primary mood disorder.

4.5 GLOSSARY

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|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| Abstinence | : Refraining altogether from the use of an addictive substance. |
| Addiction | : Pathological need for a substance. It may also involve the abuse of substance or the excessive ingestion of high caloric food, or gambling. |
| Alcoholism | : Dependence on alcohol that seriously interferes with life adjustment. |
| Amphetamine | : Drug that produces a psychologically stimulating and energizing effect. |
| Anhedonia | : Inability to experience pleasure or joy. |
| Barbiturates | : Synthetic drugs that act as depressants to calm induce sleep. |
| Biofeedback | : Treatment technique in which a person is taught to control his/her own physiological processes formerly thought to be involuntary. |
| Bipolar disorder | : Mood disorder in which a person experiences both manic and depressive episodes. |

- Caffeine** : Most common psychoactive drug of dependence found in many commonly available drinks and foods.
- Cocaine** : Stimulating and pain reducing psychoactive drug.
- Cyclothymic disorder** : A long lasting disorder that includes both mania and depressive episodes, neither of which meet the criteria for major episodes. Lasts for at least two years.
- Delirium** : Condition characterised by a confused mental state, usually resulting from shock or fever, accompanied by alterations in attention and by hallucinations, delusions, and incoherence.
- Depressants** : Psychoactive drugs that decrease the activities of central nervous system.
- Depression** : Pervasive feeling of sadness that may begin after some loss or stressful event, but that continue long afterwards.
- Depressive disorder** : Depressive symptoms that meet diagnostic criteria for either single episode of major depression, or recurrent episodes.
- Detoxification** : Treatment directed toward ridding the body of alcohol or other drugs.
- Drug Abuse** : Use of a drug to the extent that it interferes with health and/or occupation or adjustment.
- Drug addiction (Dependence)** : Physiological and/or psychological dependence on a drug.
- Dysthymia** : A longstanding depressed mood accompanied by loss of interest and lack of pleasure in situations which most people would find enjoyable.
- Episodic (disorder)** : Term used to describe a disorder that tends to abate and to recur.
- Hallucination** : False perception; things seen or heard that are not real or present.
- Hallucinogens** : Drugs which cause to induce hallucinations.
- Heroin** : Psychoactive drug derived from morphine, that relieves pain but more intense and addictive than morphine.
- Hypomania** : A disorder characterised by unusual elevation in mood that is not as extreme as that found in mania.
- Lability** : Instability, particularly with regard to affect.

- LSD (Lysergic acid diethylamide)** : The most potent of hallucinogens. It is so strong that it can produce intoxication with an amount smaller than that a grain of salt.
- Major depressive disorder** : A severe depression characterised by dysphoric mood as well as poor appetite, sleep problems, feelings of restlessness, loss of pleasure, loss of energy, feeling of inability to concentrate, recurring thoughts of death or suicide attempts. Depressive episodes occur most of everyday for at least two weeks.
- Mania** : Euphoric, hyperactive state in which an individual's judgment is impaired.
- Marijuana** : Mild hallucinogenic substance derived from hemp plant.
- Mood disorder** : One of a group of disorders primarily affecting emotional tones. It can be depression, manic excitement, or both. It may be episodic or chronic.
- Nicotine** : Addictive alkaloid that is the chief active ingredient in tobacco and a drug of dependence.
- Opium** : Narcotic drug that leads to physiological dependence and the development of tolerance, derivatives are morphine, heroin, and codeine.
- Psychoactive drugs** : Drugs that affect mental functioning.
- Psychotherapy** : Treatment of mental disorders by psychological methods.
- Stimulants** : Drugs that tend to increase feelings of alertness, reduce feelings of fatigue, and enable a person to stay awake over sustained periods of time.
- Unipolar disorder** : Mood disorder in which a person experiences only depressive episodes, as opposed to bipolar disorder, in which both manic and depressive episodes occur.

4.6 SUGGESTED READINGS

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