Although complete abstinence is elusive, substance use should be controlled before addressing ADHD.

Substance use disorder and attention-deficit/hyperactivity disorder often co-occur. Treatment of substance abuse or dependence has been reported in 17%-45% of adults with ADHD, and drug abuse or dependence has been reported in 9%-30% of adults with ADHD. Concomitantly, the standard age-of-onset criteria, which are phrased in DSM-IV, may not be developmentally appropriate, said Dr. Frances R. Levin, Kennedy-Leavitt professor of clinical psychiatry at Columbia University, New York.

Taking a good developmental history is essential, but the standard age-of-onset criteria (symptoms before age 7 years) should be relaxed in light of the difficulty substance-abusing patients may have in recalling their early years, Dr. Levin said. One recent study found that the pattern of substance use was markedly similar in adults who met all criteria for ADHD and those who met all but age of onset (Am. J. Addict. 2007;16[suppl 1]:24-32).

In the absence of a documented earlier diagnosis, ADHD (like other psychiatric disorders) cannot be conclusively identified while substance use is ongoing or during withdrawal, when anxiety exacerbation, and poor concentration can obscure the picture. “Wait for at least a week of abstinence, when anxiety, confusion, and excessive, circumstantial speech have subsided,” he said.

Substance use should be controlled before ADHD treatment. “I have seen four placebo-controlled studies showing that if you just blast through the addiction, treatment for ADHD has no effect on substance abuse or substance use,” Dr. Levin said.

Most people recommend getting at least a toehold on the addiction first.

From a practical point of view, “you simply can’t tell if medication for ADHD is having any effect if the patient is intoxicated,” said Dr. William Dodson, a psychiatrist in private practice in Denver.

In addition, other comorbidities may require treatment before ADHD is treated. Mood and anxiety disorders are highly prevalent in the context of ADHD. Dr. Levin pointed out, and, when severe, may demand more urgent attention.

Although complete abstinence before initiating ADHD treatment is ideal, it is not always possible. ADHD symptoms such as impulsiveness may interfere with recovery, and concurrent treatment should not be ruled out. “Never say never,” said Dr. Levin.

“Wait for at least a week of abstinence before ADHD treatment,” Dr. Levin said. “There have been questions about the validity of ADHD in adults—up to the early 1990s, psychiatrists were not trained to think of substance-abusing patients can be a challenge. “Many patients were not trained to think of ADHD in adults—up to the early 1990s, psychiatrists were not trained to think of ADHD in adults,” Dr. Levin noted. You’ll want to see patients more often, and talk to them about substance use as well as ADHD,” he said. “Ask about cravings. It occurs, although infrequently, that in someone with an SUD history, stimulants trigger cravings for another drug.”

A real danger, Dr. Levin said, is the overly conservative approach that withholds effective treatment from those who would benefit. “I’m concerned about a clinician who is afraid to prescribe stimulants to a 19-year-old patient who was addicted to marijuana in college. It’s remarkable how many [clinicians] discriminate against patients with a past history of SUD and no current or even proximal problems.”

By Michele G. Sullivan, contributing writer

Women and Men May Respond Differently to Naltrexone

BY MICHELE G. SULLIVAN
Mid-Atlantic Bureau

CHICAGO — Naltrexone may have little positive effect either on drug-taking behavior in older women with alcoholism comorbid with depression or on drug-taking behavior in women with alcoholism and comorbid cocaine dependence.

Data presented at the annual meeting of the Research Society for Alcoholism—a subanalysis of a 2005 drug trial and a preview of a trial in press—hint that naltrexone may have very different effects in women than men, according to William Dunton, Ph.D., of the University of Pennsylvania, Philadelphia.

“Women metabolize alcohol differently than men, and respond to naltrexone differently as well,” he said in an interview. Although most trials haven’t seen a significant difference in gender response to the drug, that may reflect a demographic problem rather than a true drug response.

The number of women in most of these studies (symptoms before age 7 years) was generally less than 74 older adults (mean age 63 years) with alcohol dependence and depressive disorder. Most subjects (39) were male; there were only 15 female subjects. All of the patients received sertraline (Zoloft) 100 mg/day for their depression, as well as 10 sessions of therapy focused on both alcohol use and depression. They were also randomized to either naltrexone or placebo for 12 weeks. At the end of the 12-week trial, 42% of the patients were considered well, with no relapse to heavy drinking and with remission of depressive symptoms. An additional 24% remained depressed, but did not have a drinking relapse.

There were no significant differences between the placebo/sertaline group and the naltrexone/sertaline groups in terms of outcome measures: relapse to heavy drinking, abstinence, remission of depressive symptoms, and overall improvement.

The gender subanalysis showed a slightly different picture, Dr. Dunton said. Men with positive outcomes did equally well on either regimen, with 40% of the placebo/sertaline and 45% of the naltrexone/sertaline groups considered well by the trial’s end, compared with 70% of those in the placebo/sertaline group.

Because so few women were in the trial, Dr. Dunton said, he could not make clinical recommendations about naltrexone’s suitability for older women with comorbid depression and alcoholism.