

Co-occurring Disorders of Mental Health and Substance Abuse: Is There a Special Population?

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Abstract

While the concept of co-occurring disorders would seem to fit special populations, the diagnosis of both mental health and substance abuse issues is more prevalent than it would seem. A review of the literature finds that the concept was prevalent over 20 years ago. The four theories of co-occurring disorders are examined and the relevant worth of these theories is analyzed and considered for utilization in therapy by social workers. Consideration is given also to an appropriate format for utilization of a best practices concept of treating all individuals. It is determined that every client should be considered for co-occurring disorders. To do otherwise would possibly jeopardize appropriate treatment and serve only the mental health aspect or a substance use/abuse aspect of treatment when in fact both aspects may need consideration in treatment.

Keywords: self-medication, dysphoria, addictive personality, antisocial personality disorder, Axis I, Axis IV, SAMISS, PTSD, SUD {substance abuse disorder, ICOPSD, CCISC, comorbidity

Introduction

Several theories of co-occurring disorders will be discussed in the following paper. However, as the researcher has shown the co-occurring disorders are not strictly for special populations. Rather, co-occurring disorders have a very high incidence of occurrence in the general population that seeks mental health or substance abuse treatment. Individuals with co-occurring psychiatric and substance disorders are increasingly recognized as a population that is highly prevalent in both addiction and mental health service systems, associated with poor outcomes and higher costs in multiple domains. In addition, they have long been recognized to be “system misfits” in systems of care that have been designed to treat one disorder only or only one disorder at a time. Thus, instead of being prioritized for attention, these individuals with challenging problems are made more challenging because the systems of care in which they present have significant regulatory, licensing, and reimbursement barriers to the implementation of successful treatment.” (Minkoff & Cline, 2004, p. 2)

In their text McNeece and DeNitto (2005) described several models for co-occurring disorders. The first by Mueser in 1998 suggests that genetics and having an anti-social personality disorder (ASPD) contribute to substance abuse and mental disorders. Another model by Khantzian proposes a self-medication hypothesis in which those with substance use disorders find that,

Persons with substance use disorders suffer in the extreme with their feelings, either being overwhelmed with painful affects or seeming not to feel their emotions at all. Substances of abuse help such individuals to relieve painful affects or to experience or control emotions when they are absent or confusing. (Khantzian, 1997, p. 231).

In her critique of different models Mueser defines them as follows: common factor models- involves antisocial personality disorder, secondary substance use disorder models- the super sensitivity model- biological basis, secondary psychiatric disorder models- minimal support, bidirectional models- not yet systematically examined.

The etiology of the high prevalence of substance use disorders in patients with severe mental illness (schizophrenia or bipolar disorder) is unclear. We review the evidence of different theories of increased comorbidity, organized according to four general models: common factor models, secondary substance use disorder models, secondary psychiatric disorder models, and bidirectional models. Among common factor models, evidence suggests that antisocial personality disorder accounts for some increased comorbidity. Among secondary substance use disorder models, there is support for the supersensitivity model, which posits that biological vulnerability of psychiatric disorders results in sensitivity to small amounts of alcohol and drugs, leading to substance use disorders.

There is minimal support for the self-medication model, but the accumulation of multiple risk factors related to mental illness, including dysphoria, may increase the risk of substance use disorder. Secondary psychiatric disorder models remain to be convincingly demonstrated. Bidirectional models have not been systematically examined. Further clarification of etiologic factors, including the identification of subtypes of dual diagnosis, may have implications for developing more effective prevention efforts and treatment. (Mueser & Drake, 1998, p. 717) Mueser feels that a better understanding of the self-medication theory would be a general alleviation of dysphoria theory. This proposes that people with severe mental illness begin using alcohol and other drugs just like the general population, that is just to feel better. McClellan in 1985 proposed that chronic drug use might result in mental illness by possibly producing biological changes in the individual. However the National Comorbidity Survey found just the opposite, that mental illness often precedes a substance use disorder. Further, Mueser found that alcohol doesn't seem to be precipitating factor for severe disorders such as schizophrenia and bipolar disorders. Finally there is an untested theory that mental illness and substance abuse disorders exacerbate each other. (McNeece & Dinitto, 2005, p 430)

One has to give credence to Mueser's idea that genetics and having antisocial personality disorder contributes to substance abuse and mental disorders. McNeece states:

A report to the National Academy of Sciences ("Addictive Personality", 1983) concludes there is no single set of psychological *characteristics* that embraces all addictions. However, there are according to the report 'significant personality factors that can contribute to addiction.

These factors number 4 . . . and are as follows:

1. Impulsive behavior, difficulty in delaying gratification, an antisocial personality, and the disposition toward sensation seeking.
2. A high value on nonconformity combined with a weak commitment to the goals for achievement valued by the society
3. A sense of social alienation and a general tolerance of for deviance.
4. A sense of heightened stress. (McNeece, 2005, p. 29)

According to another study by Mueser, persons with antisocial personality disorder (APD) and juvenile conduct disorders (CD) have an earlier age of onset of abuse, more severe substance abuse as well as psychiatric and psychosocial issues. They also have a greater tendency to abuse drugs and have a stronger family history of disorders of substance use and family history of psychiatric disorders compared to those with no history of APD or CD. Mueser contends that the high rate of CD in childhood and adult APD in those with schizophrenia may be due to "assortative mating" of individuals with psychopathology and schizophrenia. As a result the offspring may be more vulnerable to develop both schizophrenia and APD with concurrent substance abuse. (Mueser et al, 1997)

Further enhancing Mueser's concept is the fact that it is generally accepted that the offspring of alcoholics have a higher probability of alcohol abuse themselves. This is based on a study by Russel in 1990. (McNeece 2005, p. 302). The antisocial personality concept could fit with Russel's study since it is very possible that the adult children of alcoholics could have personality disorders based on Family Systems Theory of Alcoholism and the Family or could have a genetic defect.

As previously stated, Khantzian (1985,1997) proposes a non-random self-medication hypothesis. This concept has support in the mental health community as well. Blume states:

The self-medication hypothesis suggests that clients use substances as a means to reduce their psychiatric symptoms. However, substance use as a form of self-medication also can be interpreted as exacerbating symptoms. Behavioral principles may provide a useful perspective to understand this apparent contradiction. The authors investigated the relationship of types of substance use with psychiatric symptoms among 220 participants with co-occurring disorders in an acute care psychiatric unit. Participants were assessed for their use of 6 different classes of substances within 3 months of admission. Hierarchical logistic regression analyses found that particular substances were associated with each of the diagnostic categories and that the pattern of associated substances differed by diagnostic category in a way that supported both self-medication and symptom exacerbation hypotheses. Self-medication and symptom exacerbation can be defined and treated in cognitive-behavioral terms. Harm reduction strategies seem to offer great promise in this context." (Blume & Mar, 2000, p. 379)

As a social work counselor one must be prepared for the possibility of a co-occurring disorder in each client. Co-occurring disorders represent somewhere between 49% to over 60% of persons in treatment. (Havassey, 2009) Four psychiatric disorders that commonly co-occur with substance use disorders are: depression/mood disorders, posttraumatic stress disorder, attention deficit hyperactivity disorder and schizophrenia. (Brady & Sinha, 2005). It should be recognized that consultation with a psychiatrist should be made if any of these coexisting diagnoses are present. This will allow the client receive appropriate medications for the psychiatric disorder while under the care of a social worker.

The concern one should have in treating clients is best expressed by Havassy:

A pervasive concern about treating persons with co-occurring mental and substance use disorders is whether they receive treatment for both disorders. This is a significant problem in that persons with co-occurring disorders represent from 49% to over 60% of persons in treatment settings . . . Several important population-based surveys . . . have found that most persons in need of mental health care or substance abuse treatment services or both do not get specialty treatment for these disorders. Lack of treatment seems to be worse for persons with co-occurring mental and substance use disorders. The 2005 National Survey on Drug Abuse and Health found that more than half of the adults with co-occurring disorders did not receive specialty mental health care or substance abuse treatment during the prior 12 months. In many locales, one problem in obtaining services is that the mental health and substance abuse treatment systems are segregated and have separate funding streams.... Persons with co-occurring disorders frequently need to navigate two systems of care to obtain treatment, and those who receive treatment in one sector may not receive adequate treatment in the other sector (Havassy, Alvidrez & Mericle, 2009, p. 218)

If for instance one were treating a homeless person for substance abuse, the counselor should be aware that a homeless person might have an antisocial personality or another major psychiatric disorder. The same would be the case for a high percentage of the criminal population Baillargeon (2009) found that:

Parolees with a dual diagnosis of a major psychiatric disorder (major depressive disorder, bipolar disorder, schizophrenia, or other psychotic disorder) and a substance use disorder had a substantially increased risk of having their parole revoked because of either a technical violation . . . or commission of a new criminal offense in the 12 months after their release. However, parolees with a diagnosis of either a major psychiatric disorder alone or a substance use disorder alone demonstrated no such increased risk. (Baillargeon et al, 2009, p.1516)

Likewise those clients with Axis IV disorders may also have Axis I disorders which are undiagnosed. So what is important is not necessarily which came first the substance use/abuse or the mental illness, or even if they occur simultaneously and exacerbate each other; instead an appropriate diagnosis of a sole occurring mental disorder, a sole occurring substance abuse disorder or co-occurring mental and substance abuse disorder is most important to the ultimate treatment of the individual. If they are co-occurring disorders they must both be treated as primary in the diagnostic scheme. Havassey found that this was not the case especially for clients in substance abuse programs. After the analyses controlled for demographic and clinical factors, participants recruited from the substance abuse treatment system were less likely than those from the mental health treatment system to obtain any mental health services, mental health day treatment, transitional residential care, case management, and other outpatient services. . . . They were more likely to obtain crisis residential detoxification, . . . had more days of drug residential treatment , but received fewer hours of outpatient services .

CONCLUSIONS

There were disparities in patterns of service utilization, although there were no significant diagnostic differences between the two groups. (Havassy, 2009, p. 217) An excellent screening tool for co-occurring disorders is the Substance Abuse and Mental Illness Symptoms Screener (SAMISS). This is a short 16 question screening tool that looks at depression, anxiety, PTSD symptoms as well as the manic side of bipolar disorder. The test was designed to screen persons with HIV for substance abuse as well as mental disorders. Whetten did an excellent study of the validity of SAMISS.

The positive predictive value of the screener in comparison to the SCID was 98.6% for mental disorders and 98.6% for substance use disorders. The agreement between specific screener symptoms and their corresponding SCID diagnoses was relatively high for alcohol dependence.

.....drug dependence... and drug abuse. The finding that the screener is highly predictive of having a general mental disorder and substance use disorder among those screening positive for mental illness symptoms and substance use problems, as well as its brevity and ease of administration, make it a useful tool to detect symptoms of co-occurring disorders so that patients can be referred to mental health and substance abuse specialists. The screener is not a diagnostic instrument and has limited value in predicting specific psychiatric diagnoses. (Whetten et al, 2005, p. 89).

Thus for the high-risk population of those who are HIV-positive, it's been shown that we have a good diagnostic screening tool for co-occurring disorders. Without any further information available, it is impossible to state at this time that the same test (SAMISS) would be applicable for other populations. Based on my review of the questions asked on the test, I cannot see why it would not apply to other populations as well, including the general population. However validation with appropriate studies must be done prior to recommending its use for other populations.

In addition to the patients for HIV/AIDS another group at risk is women with post-dramatic stress syndrome (PTSD). A study by Brady and others indicated that higher scores on the Addiction Severity Index were present in women with PTSD. These women were usually victims of sexual and physical abuse especially in childhood. This would lend credence to Khartzian's self-medication hypothesis and that these women were continuing to suffer the trauma of their assaults and began using and abusing through self-medication to lessen psychological pain of their trauma. Brady states,

To further explore the complex relationship between posttraumatic stress disorder (PTSD) and substance use disorders, the authors compared 30 women with PTSD in substance abuse treatment with 25 women without PTSD in substance abuse treatment on degree of addiction severity, psychopathology, and aftercare compliance. Women with PTSD were more likely to have been victims of sexual and physical abuse, particularly childhood abuse. They had significantly higher scores on the Addiction Severity Index, were more likely to have comorbid affective disorder, and less likely to comply with aftercare. These results suggest that screening for victimization and PTSD among women presenting for substance abuse treatment may have important prognostic and treatment implications. (Brady et al, 1994, p.160)

As a clinician counseling clients with substance use disorders or psychological dysfunction one must be constantly on the alert that it is very likely that there are co-occurring diagnoses. The diagnosis may involve not only Axis IV and/or Axis I, but there is a high possibility that there is also a substance use disorder as well. Coordination between different specialty groups is critical when there are multiple diagnostic criteria as I have just cited. Physicians as well as therapists who are most knowledgeable for each specific client case must be included in the overall treatment of the client/patient. A study by Back and others bring these complicated factors to light. The COHORT program for co-occurring disorders at Southern Connecticut State University is exceptional in that it appears to be the answer to her concern as expressed in Back's writings.

A significant proportion of individuals with substance use disorders (SUD) meet criteria for comorbid posttraumatic stress disorder (PTSD). *This comorbidity confers a more complicated clinical presentation that carries with it formidable treatment challenges for practitioners [italics added] . . .* As expected, the findings revealed that comorbid SUD/PTSD was rated as significantly more difficult to treat than either disorder alone. The most common challenges associated with treating SUD/PTSD patients included knowing how to best prioritize and integrate treatment components, patient self-destructiveness and severe symptomatology, and helping patients abstain from substance use. *The findings increase understanding of SUD/PTSD treatment challenges, and may be useful for enhancing therapist training programs [italics added],* supervision effectiveness, and designing optimal SUD/PTSD interventions. (Back, Waldrop & Brady 2009, p.15)

From the data and studies presented thus far it can be seen that co-occurring disorders are very prevalent in the population that seeks either mental health treatment or substance abuse treatment. To separate the treatment of co-occurring disorders between various practitioners is only a disservice to the client/patient. A therapist trained to recognize and support comprehensive care for these individuals is the most important concept at this time. Treatment can no longer be fractured between various specialties. Facilities and insurance providers have to be made aware of the prevalence of co-occurring disorders.

While it is not the purpose of this paper to determine the prevalence of coexisting disorder treatment, it is most interesting that Minkoff in 2004 stressed the same concept. He further elucidated protocols to be followed, which are described below. Again it may be stated that co-occurring disorders are very prominent in the general population seeking care and are not limited to special populations alone.

The Comprehensive, Continuous, Integrated System of Care (CCISC) model for organizing services for individuals with co-occurring psychiatric and substance disorders (ICOPSD) is designed to improve treatment capacity for these individuals in systems of any size and complexity. (Minkoff 2004, p. 4) The CCISC [Comprehensive, Continuous, Integrated System of Care] was first outlined by Minkoff, organized and elaborated as part of a national consensus best practice development project . . . and first utilized in a formal consensus process in Massachusetts in 1998-1999. . . The CCISC model is built on 8 evidence based principles of service delivery for co-occurring disorders that provide a framework for developing clinical practice guidelines for treatment matching . . . and can also be utilized to design a welcoming, accessible, integrated, continuous, and comprehensive system of care, initially within the context of existing resources

The eight research-derived and consensus-derived principles that guide the implementation of the CCISC are as follows:

1. Dual diagnosis is an expectation, not an exception.
2. All ICOPSD are not the same; the national consensus four quadrant model for categorizing co-occurring disorders . . . can be used as a guide for service planning on the system level
3. Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties.
4. Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting.
5. When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended
6. Both mental illness and addiction can be treated within the philosophical framework of a “disease and recovery model” . . . with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change
7. There is no single correct intervention for ICOPSD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.
8. Clinical outcomes for ICOPSD must also be individualized, based on similar parameters for individualizing treatment interventions. (Minkoff, 2004, pp. 6-8)

Minkoff recommends that since we now recognize the importance of providing appropriate services to those with co-occurring disorders, it is now time to “integrate” mental health and substance abuse programs and services in order to achieve that goal and that there is no special population alone to be served by this mode, but that it should serve all. (Minkoff 2006)

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