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Co-Occurring Disorders in Young Adults: Common Issues in Treatment

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PRESENTER

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Co-Occurring Disorders in Young Adults: Common Issues in Treatment

Overview

- Definitions and Importance
- Common issues in traditional behavioral health or substance use disorder treatment
- Treatment considerations
- Case study

Some definitions

- Young adults (YA)
- Co-occurring disorder (COD; SAMHSA, 2020)
- Substance Use Disorder (SUD; APA, 2022)
  - *Mild: Two or three symptoms*
  - *Moderate: Four or five symptoms*
  - *Severe: Six or more symptoms*

Other definitions

- Substance-induced mental disorders (APA, 2022; SAMHSA, 2020)
- Any mental illness (AMI)
- Severe mental illness (SMI; SAMHSA, 2017)

Why is this important?

- 13.5%, or 4.5 million YAs, have an SUD and AMI (SAMHSA, 2022)
- 5.4%, or 1.8 million both YAs, have an SUD and SMI
- More profound functional impairment and worse outcomes (e.g., Mojtabai et al., 2014)

Why else is this important?

- Difficult to engage in care (Reavley et al., 2007)
- Less likely to receive services (SAMHSA, 2022)
- Least likely to be insured, have a PCP, or receive preventative care (White et al., 2018)

First common issue, CODs are complex

- Temporal nature is inconsistent and nuanced (SAMHSA, 2020)
- Bidirectional nature and other influences
- Not typically equal in severity
- Different populations more likely in different settings

Even current symptoms don’t always help

- Substance-induced can appear the same as independent disorders (SAMHSA, 2020)
- History is more important; prior diagnosis is presumptively valid
- No history or multiple diagnoses may confuse the picture
- Physical diseases can also mirror or mimic

Research is also lacking in diverse populations (SAMHSA, 2020)

- More frequent in Whites, less in Asian Americans
- Gaps in rates of behavioral health service access, utilization, and completion (e.g., Cook et al., 2017)
- Language differences, fear of stigma, and shame add to it (e.g., Pinedo et al., 2018)
- Underassessed, underdiagnosed, and under-referred (Priester et al., 2016)

Given the complexity, how do you diagnose?

- Almost impossible with ongoing use
- Client safety – medical and psychiatric, e.g., C-SSRS
- Past or present mental disorders, e.g., MHSF-III
- Past or present substance misuse, e.g., CAGE
- Trauma, e.g., PC-PTSD-5
- Functioning and impairment, e.g., WHO
- Biopsychosocial is a philosophy and approach and an assessment
- Standard of care (Wade & Halligan, 2017)
- Multiple contributing voices and consideration of family history

Also consider...

- Heritage, history and experience, beliefs, traditions, values, customs, behaviors, institutions, and ways of communicating
- Factors important to racial/ethnic/sexual and gender identity groups

Next, colleagues may differ in opinion, e.g.,
Incommensurability (Kuhn, 1962)

- "The substance misuse is the primary issue. While there may be something else going on, we're not going to know until we stabilize them. They need to get into recovery and then we can see what remains."

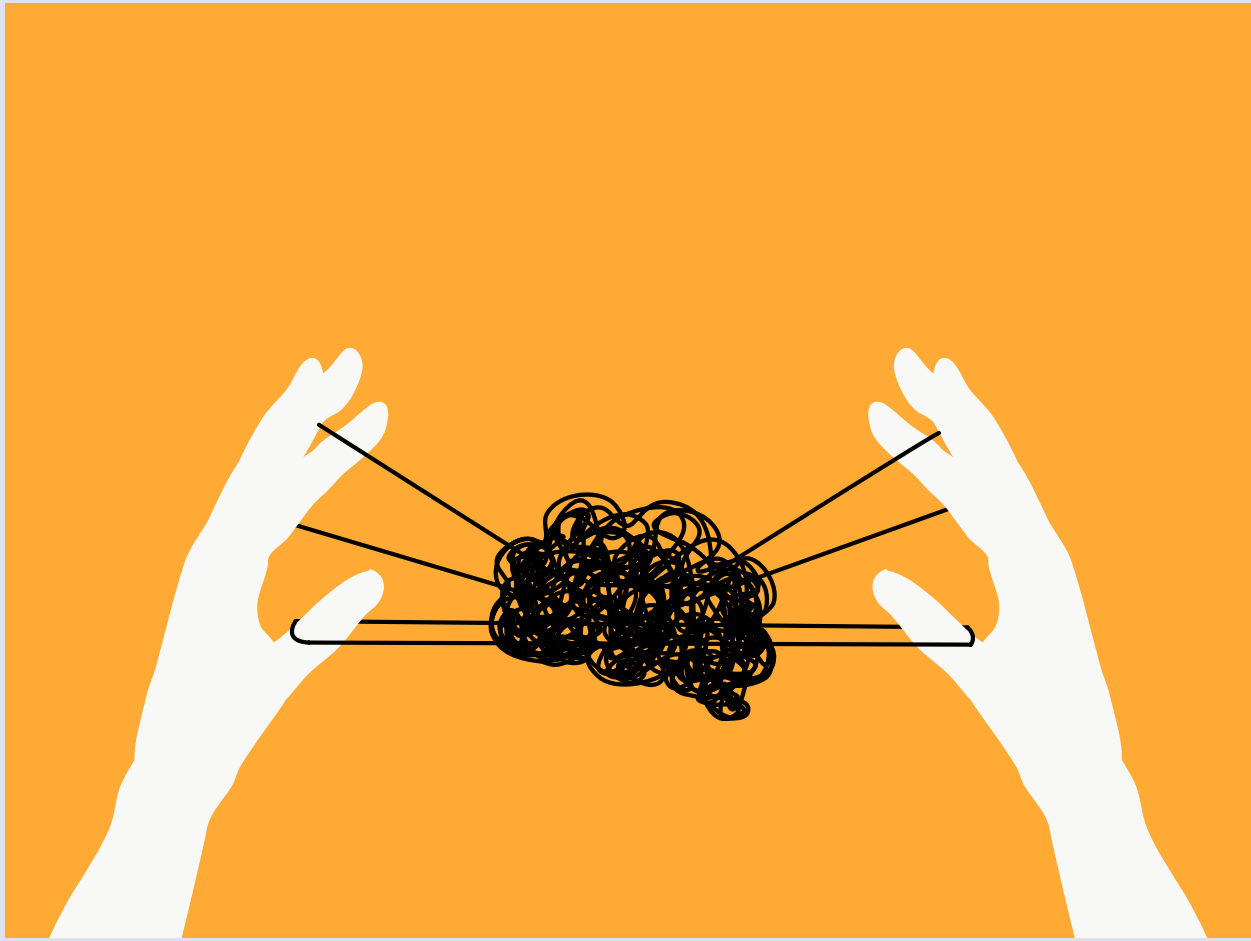
- "Substance misuse is a mental health condition. That is, we need to address what is feeding the compulsion to use, what is leading to the behavior to begin with. We can't expect them to stabilize until then."

And clinics have three distinct models of care (Morisano et al., 2014)

- Sequential or serial treatment
- Simultaneous or parallel treatment
- Integrated treatment – Demonstrated superiority (e.g., Kelly & Daley, 2013)

What if we don't have integrated care?

- Rarely within one system (Sterling et al., 2011)
- There is "No Wrong Door" (SAMHSA, 2020)



Not an issue…it's a lot about the relationship

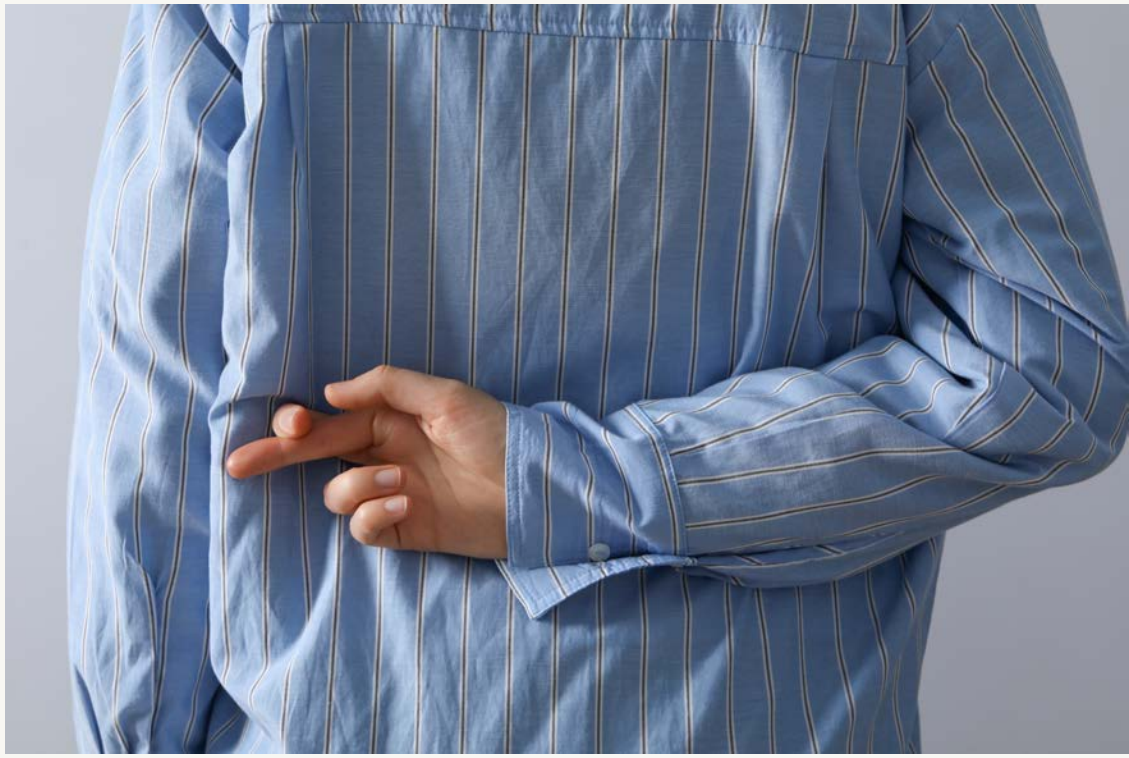
- Therapeutic alliance is cornerstone of COD care (SAMHSA, 2020)
- Strong, if not essential, factor in supporting recovery (e.g., Kelly et al., 2016)
- Improved symptoms, functioning, engagement, satisfaction, and quality of life
- (e.g., Dison et al., 2016)
- Strong alliance can be developed by people with PTSD (Howard et al., 2022)
  - Division 12 - https://div12.org/treatments/
  - APA PTSD guidelines - https://www.apa.org/ptsd-guideline

Might make a therapist uncomfortable

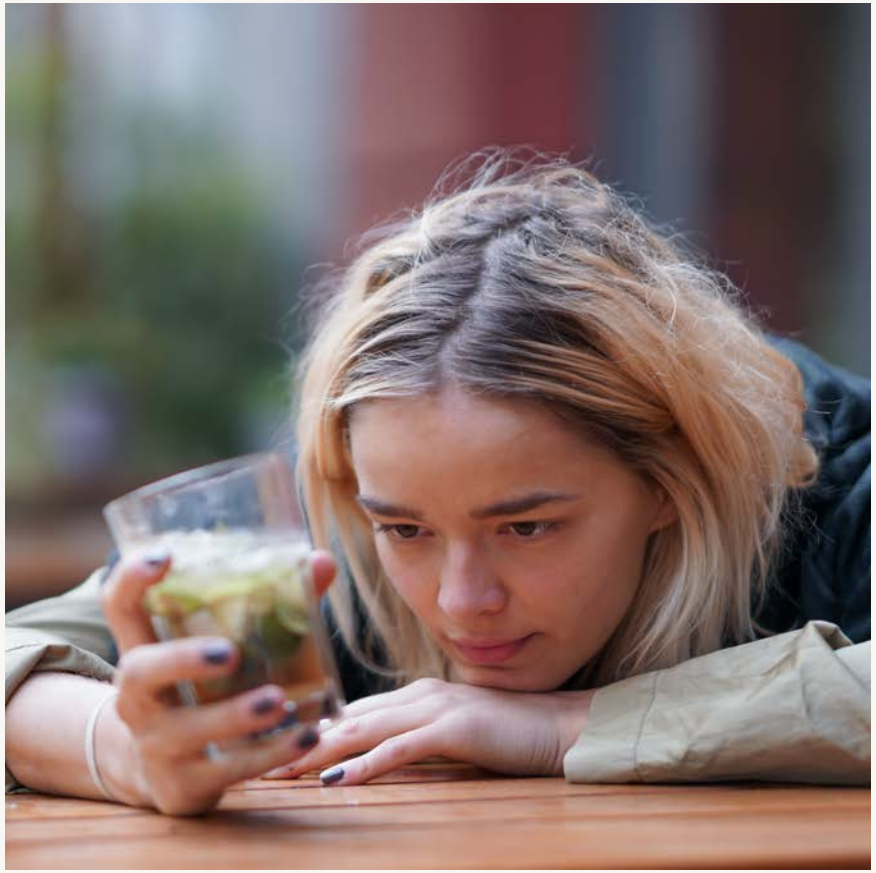
- Influenced by where you work, training and biases
- As well, by severity of disorders
- Invite feelings and recognize discomfort and reluctance (SAMHSA, 2020)
- Transference and countertransference
  - *Concordant (Racker, 1957)*
  - *Complementary*
  - Helps to respond appropriately while providing EBTs
- Actor in a role; know your part

Additionally, they may be dishonest

- View as symptom of CODs
- Confrontation interventions depicted as aggressive (e.g., Miller et al., 1993) to “break down denial” (Kennard, 1983)
- Confrontation can be a supportive, honest approach (Polcin et al., 2010)
- Humor is underrated and underdiscussed



Position on substance use often driven by policy



- Evidence SUDs mature out emerged (e.g., Sobell et al., 1996)
- Harm Reduction advocacy (e.g., Jenkins et al., 2017)
- SUDs likely to be chronic (Fleury et al., 2016)
- Most severe SUDs do not transition out (McCabe et al., 2022)

Case Study Background

- X lived with parents – Father is able to “handle me independent of my use. I have to comfort my mother even when I’m doing sh*tty”
- No known family history of MH or SUDs; may have “hidden” issues
- At 8, father implicated in an embezzlement scheme
- Began using at age 12 with few period of abstinence since; learned if he is “liked” could get away with misbehavior
- Would go through prolonged episodes of “feeling really depressed. I usually don’t get out of bed for days at a time. Just miserable.”

Case Study: Mr. X

- Reason for Referral – Second hospitalization; MDD vs. Substance-Induced Mood Disorder
- Prior recommendations – PHP and meds
- Previous Dx of MDD and Polysubstance Dependence. No temporal clarity
- “I did well for a while...I was happy and started to look for a job. But I had this relationship and then we started drinking…and ever since then I have been drinking daily and using heroin off and on.”
- Intense desires to die in prior weeks

Case Study Additional Information

- Medical History – Nothing remarkable; normal labs
- Appearance and Behavior – Mood was euthymic; denied current SI
- Reviewed med records, gave clinical interview, and discussed in Treatment Team
- Tests Administered: Trail Making Test (TMT), Parts A & B; Wide Range Achievement Test 3 (WRAT3); Beck Depression Inventory – II (BDI-II); Aggression Questionnaire (AQ); Minnesota Multiphasic Personality Inventory – II (MMPI-II); Rorschach Inkblot Method

Case Study Results

- On cognitive measures, more capable than most his age.
- On clinical measures: MDD, recurrent, moderate; alcohol use disorder, severe, opioid use disorder, mild
- On projective instrument, saw things the way others do, had insight into appropriate and inappropriate behaviors
- On various measures, chronic problems adjusting to conventional expectations; may appear friendly, while viewing others as untrustworthy

Diagnosis and recommendations

- Substance-Induced Mood Disorder; AUD, Severe; OUD, Mild
- Tends to externalize and intellectualize; a clearly defined and well-structured therapy is preferrable
- Overt efforts at rapport building may fail; will favor straightforward conversation
- Risky but useful, “It seems you want me to think you’re doing well. That concerns me, as I don’t know if you would tell me if it was the other way around. Maybe you think I can’t help. And that’s probably fair.”
- And I liked him and wanted him to like me; pull to not address issues

Additional recommendations and thoughts

- Harm reduction unlikely to work
- Would benefit from step down treatment, then mutual help group involvement, and Sober Living Environment (SLE)
- Also, mentors, positive adult figures, meaningful activities and work/school
- Will likely need ongoing support
- Can flourish and exceed all expectations

Conclusion

- Important population
- Complex and confusing
- Common challenges exist
- Simple treatment considerations
- Each case is unique and there is

  “No Right Answer,” either, so do your best

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