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PROMOTING JUSTICE WORLDWIDE

INTERSECTIONS OF MENTAL HEALTH, SUBSTANCE ABUSE, & CO-OCCURRING DISORDERS

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INTERSECTIONS OF MENTAL HEALTH,
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DISORDERS

OBJECTIVES

- Describe the *link* between mental health, substance use disorder, and co-occurring disorder
- Identify at least four reasons *why* it is important to understand this high-risk subgroup
- Identify at least three *treatments* that are successful in treating this population



INTERSECTIONS OF MENTAL HEALTH,
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*Let's take a
step back...*

What is Mental Health?



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MENTAL HEALTH

IS...

- Emotional
- Psychological
- Social well-being



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Mental health affects our:
THOUGHTS, FEELINGS, & ACTIONS

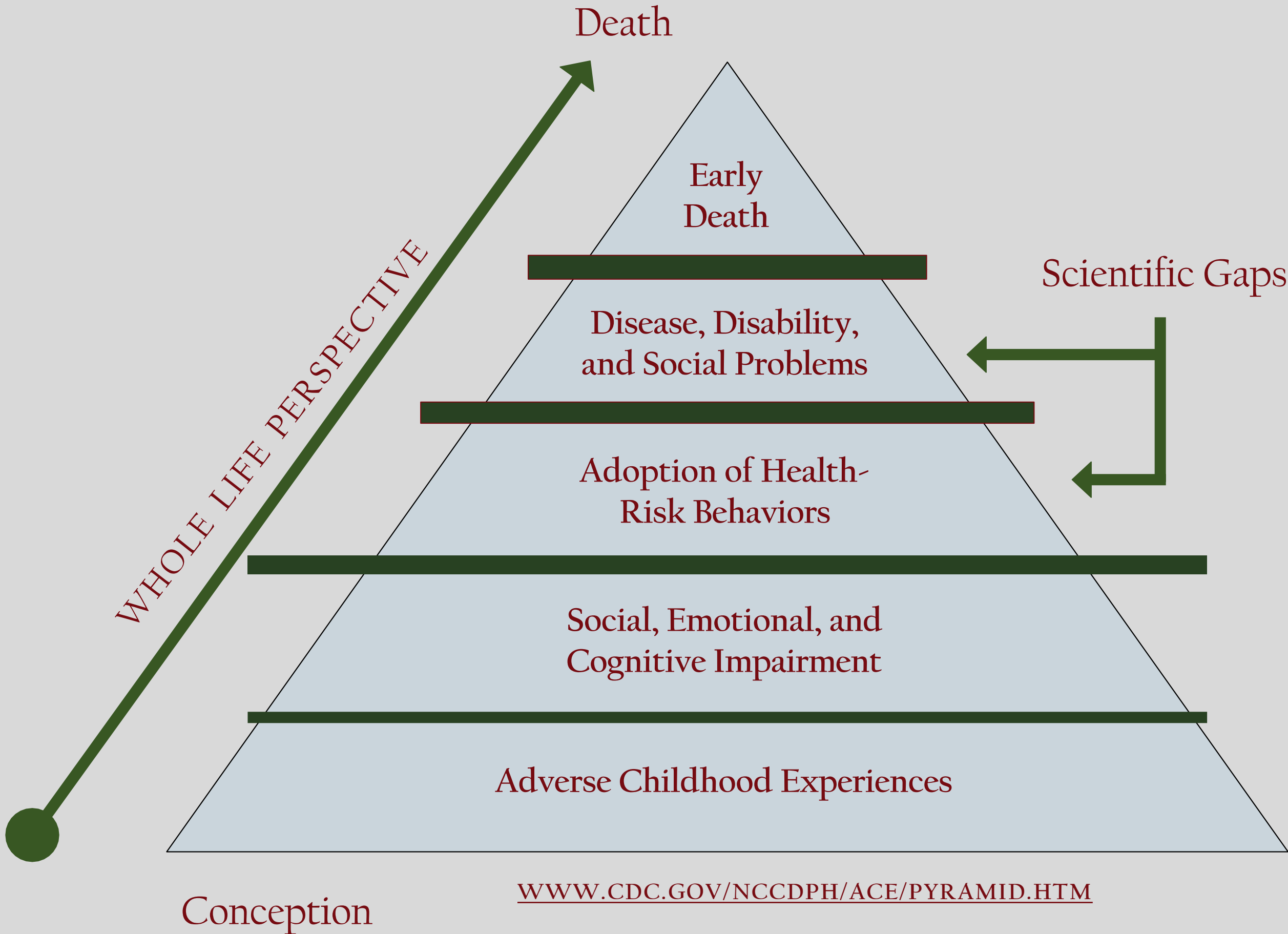


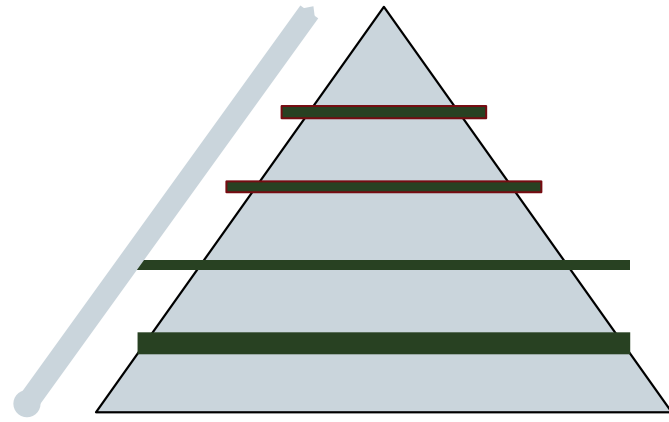
Mental health affects our:
THOUGHTS, FEELINGS, & ACTIONS

Mental health helps determine how we handle
stress, relate to others, and make healthy choices.



ACE PYRAMID





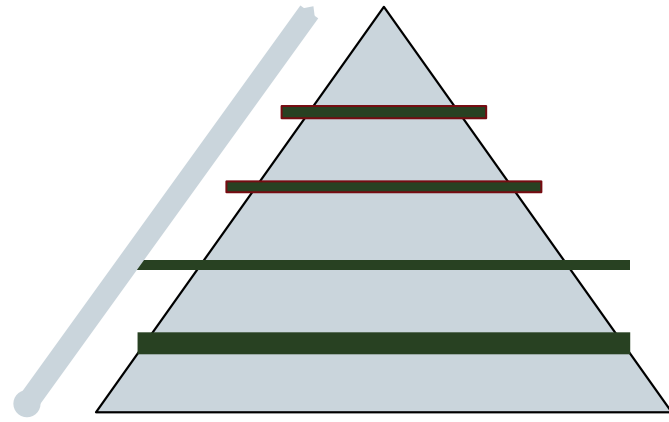
ACE SURVEY

*FELLITI, VINCENT, ET AL, "THE RELATIONSHIP OF
ADULT HEALTH STATUS TO CHILDHOOD ABUSE AND
HOUSEHOLD DYSFUNCTION."

**AMJ PREVENTIVE MEDICINE 1998, V14, 245-58;
WWW.CDC.GOV/NCCDPH/ACE

- Kaiser Permanente (1995-1997)
- N=17,000 undergoing physical exam
- Screened for Adverse Childhood Events:
 - Abuse - psychological, physical, or sexual
 - Violence - against their mother
 - Living with a household member who was:
 - Abusing substances
 - Mentally ill or suicidal
 - Imprisoned



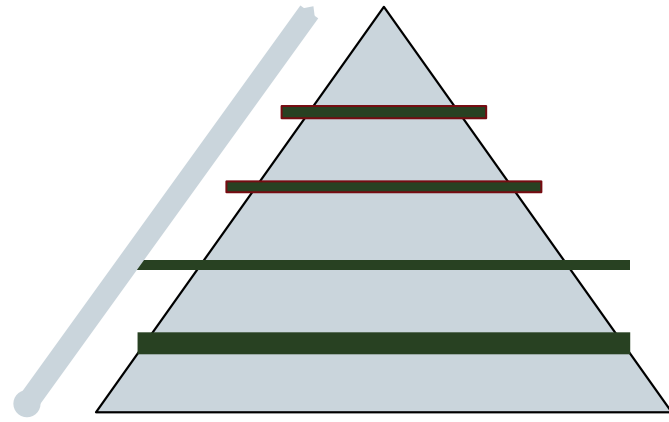


ACE RELATED HEALTH PROBLEMS

*(1998: RELATIVE INCREASED RISK)

- Alcoholism/drug dependence (4-12x)*
- Depression (4-12x)*
- Suicide attempts (4-12x)*
- Smoking (2-4x)*
- Multiple (>50) sexual partners (2-4x)*
- Sexually Transmitted Diseases (2-4x)*
- Poor health due to quality of life (2-4x)*
- Chronic Obstructive Pulmonary Disease (2-4x)*
- Obesity (1.4 - 1.6x)*
- Fetal death
- Obesity (1.4 - 1.6x)*
- Ischemic Heart Disease
- Liver disease, cancers
- Intimate partner violence
- Skeletal fractures
- Unintended pregnancies





ACE > 4 vs 0

*(1998: RELATIVE INCREASED RISK)

Conclusion: A strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.

ACE & MH COMORBIDITY SURVEY

*MFF = PARENTAL MENTAL ILLNESS, SUBSTANCE ABUSE
OR CRIMINALITY; FAMILY VIOLENCE;
PHYSICAL OR SEXUAL ABUSE; AND NEGLECT.

- Childhood Adversity had sub-additive association with DSM Dx onset
- Maladaptive Family Functioning is the strongest correlate for onset of Mental Disorder

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IMPACT OF CHILDHOOD ADVERSITY

DIMINISHES WITH LIFE COURSE

IMPACT OF CHILDHOOD ADVERSITY

*GREEN, J. "CHILDHOOD ADVERSITIES AND
ADULT PSYCHIATRIC DISORDERS IN THE
NATIONAL COMORBIDITY SURVEY REPLICATION 1" ARCH
GEN PSY, 2010: 67(2) 113-123 (N=5692)

- 57.1% of childhood onset
(4-12 yrs)
- 30.5% of adolescent onset
(13-19 yrs)
- 24.7% of early adulthood
(20-29 yrs)
- 20.5% of middle-late
adulthood (>30 yrs)



Substance Use Disorder:

A MENTAL DISORDER THAT AFFECTS A PERSON'S BRAIN AND BEHAVIOR, LEADING TO PERSON'S INABILITY TO CONTROL THEIR USE OF SUBSTANCES SUCH AS LEGAL OR ILLEGAL DRUGS, ALCOHOL, AND MEDICATION.

Symptoms can range from moderate to severe form of SUDs

EPIDEMIOLOGY

- Prevalence of AOD disorders greater in men, but the gap is closing
- Gender differential is higher for alcohol use disorders than drug use disorders
- Prescription drug abuse and tobacco use in women slightly less than men
- For adolescents, the gap disappeared for alcohol, marijuana, cocaine, and cigarettes



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DUAL DIAGNOSIS

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- Two diagnoses/disorders
- Two systems
- Double trouble
- In the eye of the beholder



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DRUG INDUCED PSYCHOPATHOLOGY

Drug States:

- Withdrawal
- Intoxication
- Chronic use

Symptom Group:

- Depression
- Anxiety
- Psychosis
- Mania

PSYCHIATRIC COMORBIDITY

Common in Women

- Anxiety disorders (especially PTSD)
- Depression
- Eating disorders
- Borderline personality disorders

*Onset more likely to precede
the onset of the substance
abuse disorder*



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PSYCHIATRIC COMORBIDITY

Common in Men

- Antisocial personality disorder
- Conduct disorder



STIMULANTS

- Later onset
- Clear regular heavy drug use
- Lifestyle
- More likely to preserve general function
- Usually paranoid and audio hallucinations
- In addition cocaine lasting minutes to hours vs. days to weeks

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CO-OCCURRING DISORDERS

- Psychotic (thought)
- Mood
- PTSD



SCHIZOPHRENIA

- Earlier on set negative symptoms include antisocial behavior
- More global impairment, thought disorder
- May have drug use but usually much less
- Requires lifelong treatment

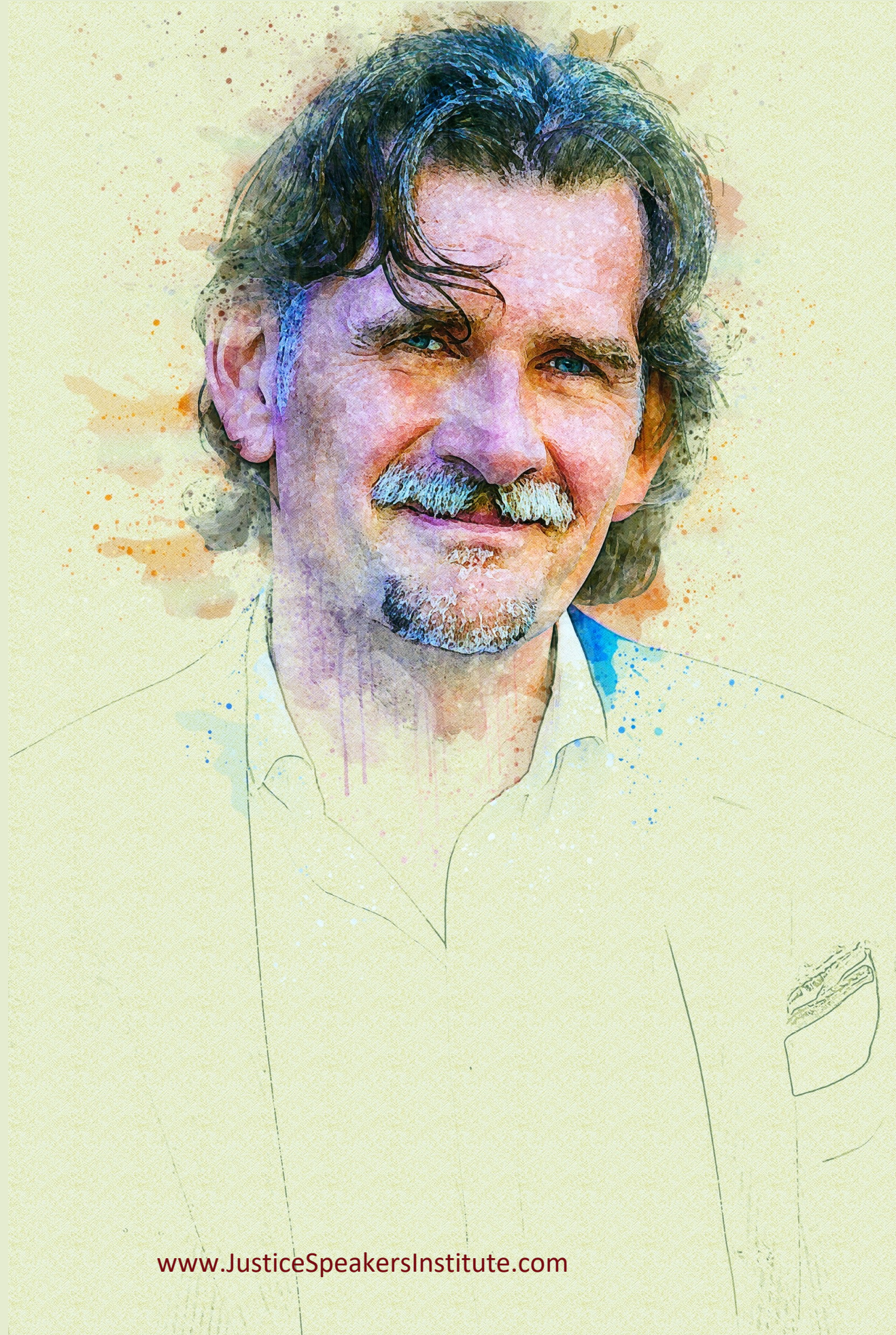


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SCHIZOPHRENIA

- Common biological set ups
- Poor judgments, fragile brains
- Boredom, lack or social role
- Live in drug infested areas





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Meet Neal

SAN FRANCISCO, CA

- 60 years old
- Polysubstance use since age 14
- Lived in the Tenderloin District
- 10 years abstinent
- Secure job and housing



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BIPOLAR I

- More severe depression
- Mania (non-drug) may trigger a break in reality (psychosis)
- Separate diagnosis than the Bipolar II (longer depression, more mild)



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Meet Charlie

SAN FRANCISCO, CA

- 30 years old
- AUD since age 22
- 3 suicide attempts
- MIA for several months
- Reunited with family



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POST TRAUMATIC STRESS DISORDER

- Convergence of trauma, PTSD, and SUD particularly important.
- Early life stress, especially sexual abuse, more common in girls
- Higher risk of alcohol dependence in women exposed to violence in adulthood
- AOD use elevates risk for victimization
- Uncontrollable stress increases drug self-administration in animals



Meet Jose

SAN FRANCISCO, CA

- 45 years old
- AUD/stimulant use disorder
- Child abuse
- Gang member
- Incarceration
- Secure housing and employment



Comorbidity as “the rule vs. exception”

HIGHER COMORBIDITY AMONG SUBSETS OF VA PATIENTS

- OEF/OIF vets have co-occurrence rate of 25-50% (1)
- Up to 75% of combat veterans with lifetime prevalence of PTSD, also meet lifetime prevalence of alcohol abuse or dependence (2)

Comorbidity as “the rule vs. exception”

HIGHER COMORBIDITY OF TRAUMA AMONG SUD POPULATION

- Among individual seeking tx for SUD, 36 - 50% (lifetime) and 25 - 42% (current) PTSD (3)
- 77% of veterans in an in patient substance use program reported severe childhood abuse (4)

1) Ouimette, Goodwin, & Brown, 2006; 2) Kulka et al., 1990; 3) Jacobsen, Southwick, & Kolsten, 2001;
4) Trifflemen et al., 1990

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Opposite Sides of the Same Coin

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Two Sides of the Same Limbic Coin

SUD SIDE

- Trigger cues to pleasure-seeking
- Reduced ability to assess potential harm
- Romantic memories of use

Treatment Goal: Increased fear of substances and increase their fear of their behavioral responses to triggers.

PTSD SIDE

- Trigger cues to safety-seeking
- Reduced ability to assess for potential pleasure
- Haunting memories of trauma

Treatment Goal: Decrease fear of potential harm and reduce their avoidant response to triggers.



Addressing Trauma

SYSTEM NEEDS TO BE TRAUMA INFORMED

- Knowledgeable about and sensitive to issues present in survivors
- Services delivered in a way that avoids re- traumatization and encourages participation in treatment
- Trauma specific services: appropriate assessments, specific interventions

Concerns About Trauma-Focused Treatment Among SUD Populations

- Fear of symptoms exacerbation
- “Fragile” patients
- Cognitive deficits (i.e. “wet brain”)
- Chaotic/high risk situations
- Drop out rates
- Insufficient trauma training for TF protocol among SUD clinicians



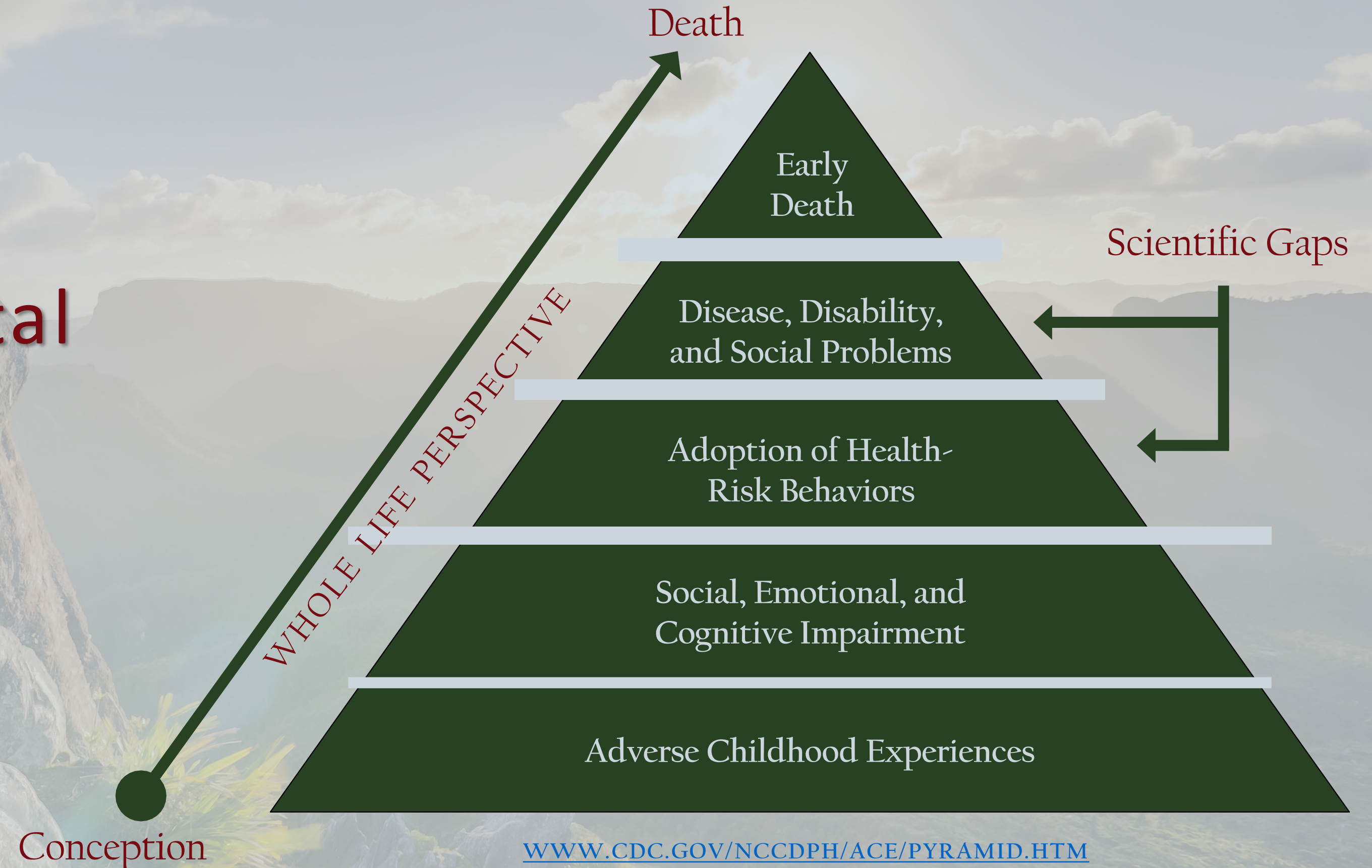
Rationale for Developmental Trauma

Key Characteristic of Exposure

1. Onset: Early disrupted development
2. Duration: Prolonged adaptation to trauma
3. Context: Caregiver as perpetrator, relationship to self and others



Rationale for Developmental Trauma





Treatment Planning

DETERMINE

- Trauma profile
- Pattern of use and state of change
- Additional diagnoses (i.e., pain, TBI, panicd/o)
- Barriers to and motivation for treatment
- Level of acuity/risk

PRIORITIZE

1. Safety
2. Attachment/engagement
3. Mastery



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TREATMENT: PSYCH VS. ADDICTION

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Bio: Labs & Meds

Psych: 1:1

cognitive/behavioral

- Psychoeducational
- Groups

Social: Couples conference

- D/C planning
- Housing, etc.

Bio: Labs & Meds (withdrawal, etc.)

Psych: Motivational Intervention

- Step work
- Groups

Social: AA Meetings

- Sober housing
- Family

Let's identify these:

C.A.G.E QUESTIONS

Cut Down (or stopped)

- Symptoms worsened
- Someone suggested it

Annoyed

- Irritated when asked about substance use

Guilt

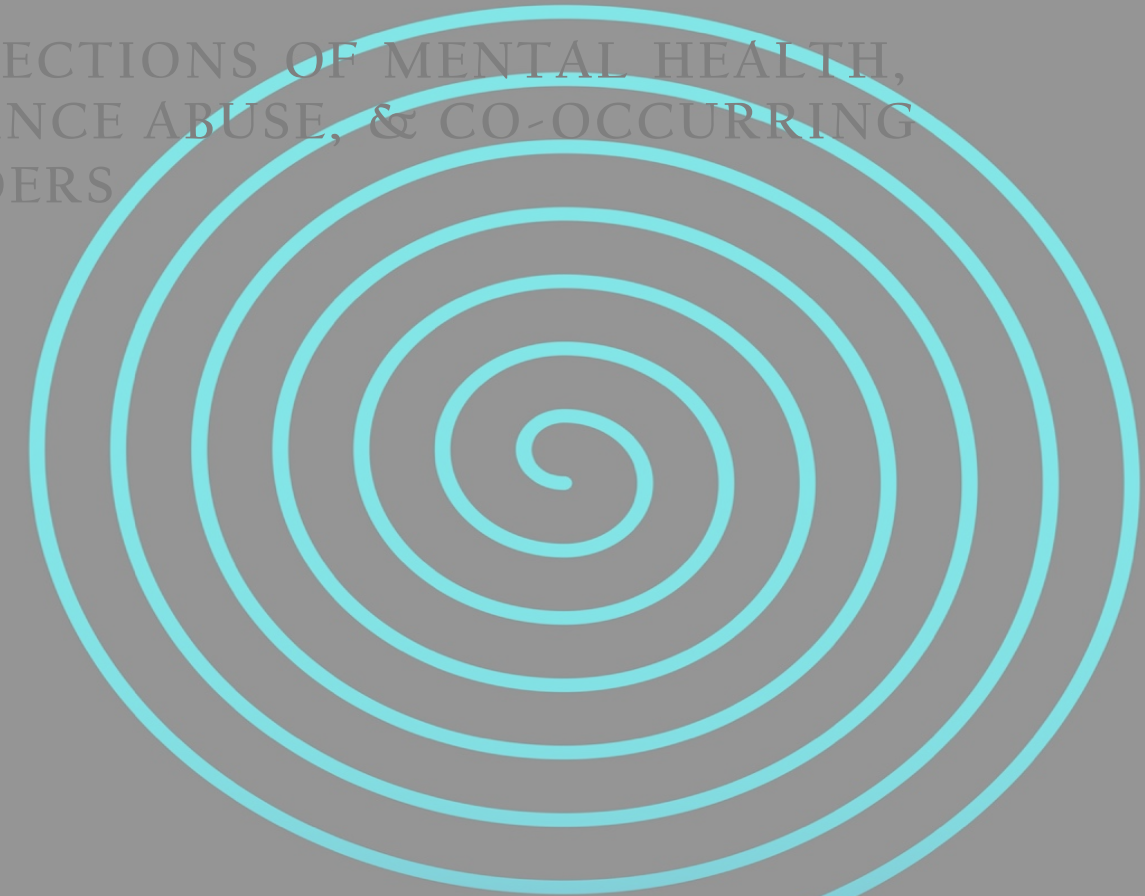
- Experiences guilt for actions under the influence (suicide attempts)

Eye Opener

- Uses substances in the morning to feel better
- Doesn't take meds due to other substances or forgets to



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Counseling Strategies

- Social support/case management
- 12 step facilitation
- Cognitive/behavioral
- Motivation interviewing
- Couples/family



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Evidence Based Practices

- Cognitive Processing Theory
- Seeking safety
- Motivation Interviewing/
Enhancement
- CBT for SUD





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