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Double trouble: Co-occurring Disorders: Cultural Considerations

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Overview of the presentation

- The Addiction Technology Transfer Center network and history
- Cultural adaptations: what does it take?
- Principals of treatment of co-occurring disorders
- DSM-IV and DSM-V (APA, 2013)
- Anxiety disorders
- Depressive Disorders
- Psychotic Disorders



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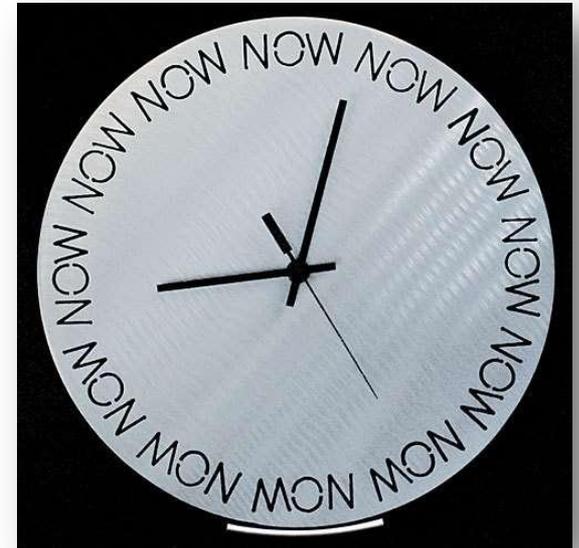
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ATTC NETWORK AND HISTORY



ATTC History

- October, 2012 – New Round of ATTC Funding Began
- Ten new Regional ATTCs working with ten new SAMHSA Regional Directors
- **2013 is the ATTC Network's 20th Anniversary**





ATTC Network from October 1st 2012 to September 29th 2017





Four National Focus Areas

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- National Frontier & Rural ATTC
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- National Hispanic & Latino ATTC
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- National Screening, Brief Intervention & Referral to Treatment ATTC
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CULTURAL ADAPTATIONS: WHAT DOES IT TAKE?



Cultural competence

- More than good clinical skills
- Self-assessment
- Understand historical trauma
 - Understand the socio-political context and history.
 - Understand diversity of culture.
 - Understand differences among tribes.
- Generational trauma
 - Efforts to take away culturally important rituals
 - Neglect
 - Discrimination
 - Exploitation
 - Injustice in medical research



Cultural adaptations of evidence-based treatment

- What is the essence of the treatment approach?
- How can the essence of the treatment be translated into culturally-appropriate treatment practices?
- What is practice-based evidence (Bigfoot, 2008).
- Cultural adaptations need to consider the following:
 - Language of therapy
 - World view
 - Persons in treatment
 - Metaphors
 - Content
 - Concepts
 - Goals
 - Methods
 - Context



- A meta-analytic review of culturally-adapted approaches across 76 studies (Griner & Smith, 2006) yielded the following results:
 - Moderately strong benefit of culturally adapted interventions.
 - Interventions targeted to a specific cultural group that were four times more effective than interventions provided to groups consisting of clients from a variety of cultural backgrounds.
 - Interventions conducted in clients' native language (if other than English) were twice as effective as interventions conducted in English.



Acculturation stress and protective factors

- **Acculturative stress and protective factors within cultures:**
 - the roles of religion and spirituality and the family in culturally sensitive interventions;
 - different manifestations and interpretations of distress in different cultures;
 - the impact of stigma and cultural distrust on help-seeking.
 - culturally sensitive and community- based interventions



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PRINCIPALS OF TREATMENT OF CO-OCCURRING DISORDERS

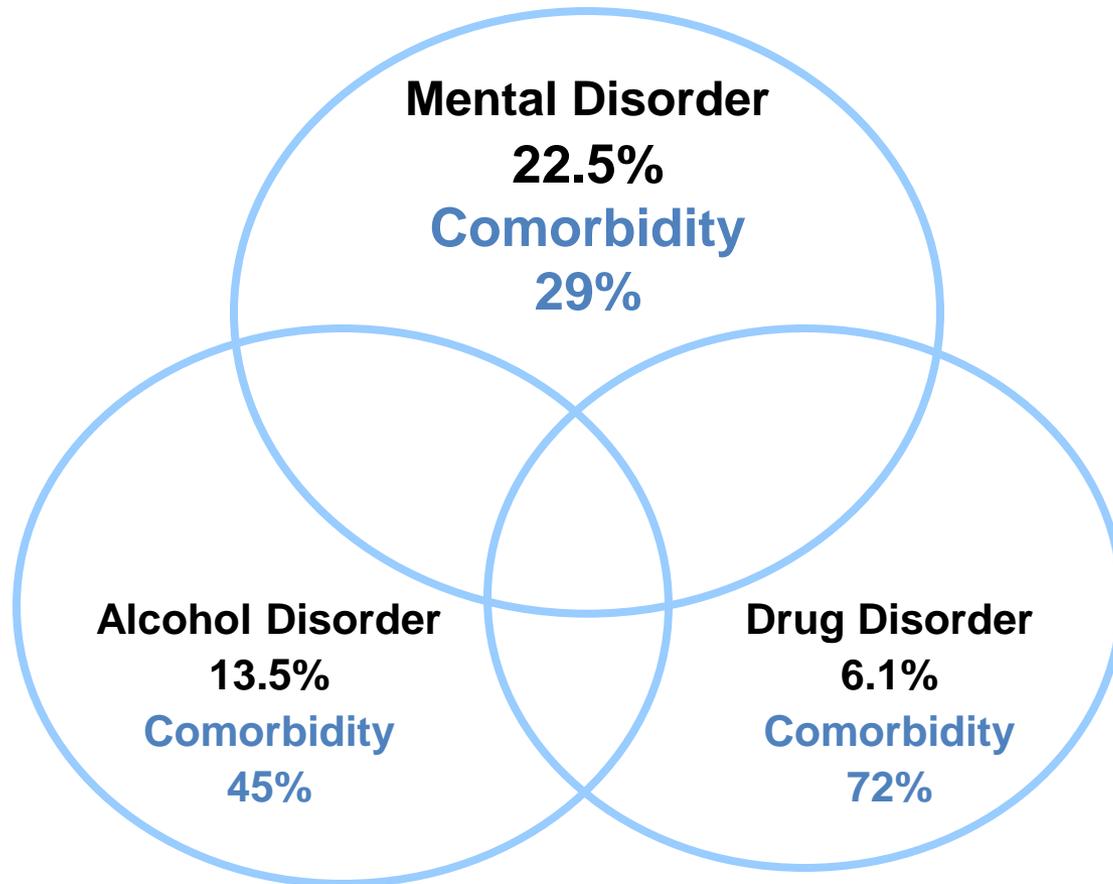


Comorbidity Defined

“Individuals who have at least one mental disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person....at least one disorder of each type can be diagnosed independently of the other.”

- *Report to Congress of the Prevention and Treatment of Co-Occurring Substance Abuser Disorders and Mental Disorders, SAMHSA, 2002*

Lifetime History





Treatment of co-occurring disorders

- Where are co-occurring disorders treated?
 - Psychiatric institutions and outpatient psychiatric agencies
 - Family care centers/primary care clinics
 - Department of Corrections



General principals of treatment of co-occurring disorders

- Options for treatment modalities of co-occurring disorders:
 - Sequential treatment
 - Parallel treatment
 - Integrated treatment
- Treatment approaches:
 - Psychopharmacology
 - Psycho-social treatment
 - Community support



National Comorbidity Study (2003)

- Reasons why integration became important.
- 9.3% of the adults (over 18 years of age) received primary care for MH and substance use disorders (SUD) (about 20.9 million people)
- Specialty care MH services were received by 8.8% adults (19.5 million)
- Of the patients in primary care receiving services for MH and SUD, about 12.6 million had a MH or SUD diagnosis during the year they were treated.
- Specialty services: 12 million had a MH or SUD diagnosis in the year they received treatment.



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COMORBIDITY BEST PRACTICES



Co-occurring Disorders

- **Over 50%** of our clients also meet criteria for **one or more additional DSM-5 diagnoses** in addition to their substance use disorder diagnosis.
- TIP 42 from www.samhsa.gov discusses the most common of these diagnoses in detail. Reading the TIP can substitute for reading the SM prior to testing, although the discussion is based on DSM-IV.

Substance Abuse Treatment
For Persons With
Co-Occurring Disorders

A Treatment
Improvement
Protocol
**TIP
42**



Disorders that Commonly Co-Occur with the Substance Use Disorders

- Schizophrenia
- Bipolar Disorders
- Depressive Disorders
- Anxiety Disorders
- Posttraumatic Stress Disorder (PTSD)
- Personality Disorders, especially
 - Antisocial personality disorder
 - Schizoid personality disorder
 - Narcissistic personality disorder
 - Borderline personality disorder



Service Planning Guidelines

1. Dual diagnosis is an expectation, not an exception.

Co-occurring Disorders by Severity

High
Severity

III
**Less severe
mental disorder/
more severe
substance abuse
disorder**

IV
**More severe
mental disorder/
more severe
substance abuse
disorder**

I
**Less severe
mental disorder/
less severe
substance abuse
disorder**

II
**More severe
mental disorder/
less severe
substance abuse
disorder**

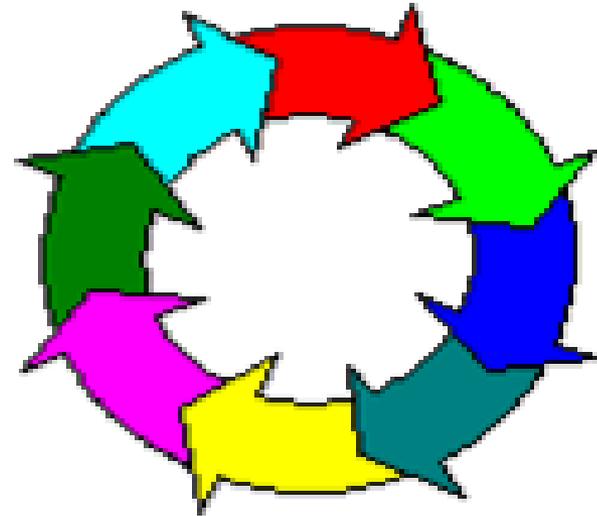
Low
Severity

High
Severity

Unified Services Plan

Case management should address:

- Mental health
- Education/vocation
- Leisure/social
- Parenting/family
- Housing
- Financial
- Daily living skills
- Physical health





Integrated Treatment

“Any mechanism by which treatment interventions for co-occurring disorders are combined within the context of a primary treatment relationship or service setting.”

-CSAT



Effective Interventions for Adults

- Cognitive/Behavioral Approaches
- Motivational Interventions
- Psychopharmacological Interventions
- Modified Therapeutic Communities
- Assertive Community Treatment
- Vocational Services
- Dual Recovery/Self-Help Programs
- Consumer Involvement
- Therapeutic Relationships



Effective Interventions for Youth

- Family Therapy
- Multi-systemic Therapy
- Case Management
- Therapeutic Communities
- Circles of Care



Prevalence and Pattern

- 7-10 million Americans affected
- Antisocial personality disorder, bipolar disorder, schizophrenia most likely to coexist with substance use disorder
- high prevalence of trauma histories and related symptoms
- more likely to have cardiovascular disease, cirrhosis, or cancer



Prevalence and Pattern in Youth

- Among adolescents entering substance abuse treatment, 62% of males and 83% of females had at least one emotional/behavioral disorder
- Almost 90% of those with a lifetime co-occurring disorder had at least one mental health disorder prior to the onset of a substance abuse disorder
- Mental disorder likely to occur in early adolescence, followed by the substance abuse disorder 5-10 years later



Multiple Diagnoses Increase

- Treatment seeking
- Use of services
- Likelihood of no services
- Treatment costs
- Poor outcome
- Suicide risk



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ASSESSMENT ISSUES



Assessment issues

- Cultural adaptation of assessment instruments (DIS, Manson et al., 1985)
 - Bio-demographic information
 - Indigenous categories and understanding of illness
 - DIS items relevant to depression and related to their understanding of illness
 - Use and abuse of alcohol
 - Somatization



Cultural formulations

- A clinical tool (American Psychological Association, 1996) includes the following five components and leads to a cultural analysis in treatment. It includes:
 - the individual's cultural identity.
 - cultural explanations for individual illness.
 - cultural factors related to the psycho-social environment and level of functioning.
 - cultural elements in the therapist-patient relationship.
 - overall cultural assessment for diagnosis and treatment.



Assessment issues

- Presence of medical illness, including:
 - Diabetes
 - Heart disease
 - Asthma
 - Traumatic brain disorders
- How does the physical illness influence the mental health disorders?
- Fetal Alcohol Spectrum Disorders



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RECOVERY FROM MENTAL HEALTH DISORDERS



Ten fundamental components of recovery

- 1) Self-directed
- 2) Individualized and person centered
- 3) Empowerment
- 4) Holistic
- 5) Non-linear
- 6) Strength-based
- 7) Peer support
- 8) Respect
- 9) Responsibility
- 10) Hope



Basic assumptions about recovery (Anthony, 1993a)

- 1) Recovery can occur without professional intervention.
- 2) Common denominator for recovery: support from significant others.
- 3) Recovery vision not related to one's understanding of mental illness.
- 4) Recovery can occur even though symptoms reoccur.
- 5) Recovery changes the frequency and duration of symptoms.
- 6) Recovery is not a linear process.
- 7) Recovery from the consequences of the illness is often more difficult than recovery from the illness itself.
- 8) Recovery from the illness does not mean that one was not ill in the first place.



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CO-OCCURRING DISORDERS



Anxiety Disorders and SUD

- 27% have a substance use disorder
- Anxiety disorders may be treated with TCAs, SSRIs and Benzodiazepines (with caution)
- Generalized anxiety disorder: Buspirone shown to treat anxiety and reduce alcohol consumption
- Social anxiety is a big risk factor for alcohol and drug use
- With PTSD, people will often use drugs or alcohol to sleep and stop recurrent nightmares, or to reduce anxiety



Anxiety Disorders

- “Anxiety disorders include **disorders that share features of excessive fear and anxiety and related behavioral disturbances**. *Fear* is the emotional response to real or perceived imminent threat, whereas *anxiety* is anticipation of future threat.”
- “The anxiety disorders differ from one another in the types of objects or situations that induce fear, anxiety, or avoidance behavior, and the associated cognitive ideation.” (DSM-5, p. 189)



Anxiety Disorders

- These disorders can seriously interfere with the client's social, vocational, family, and educational activities.
- Although the anxiety disorders are treatable with various cognitive behavioral and psychotropic therapies, **they are almost impossible to eliminate completely and they may return, especially when the client is under stress or drinking heavily.**
- These disorders commonly afflict our clients both when they are using and when they are sober.



Anxiety Disorders

- **The DSM-5 Anxiety Disorders include:**
 - Separation Anxiety Disorder
 - Selective Mutism
 - Specific Phobia
 - Social Anxiety Disorder
 - Panic Disorder
 - Agoraphobia
 - Generalized Anxiety Disorder
 - Substance-Induced Anxiety Disorder



Anxiety disorders in DSM-IV

- Panic Attack
- Agoraphobia
- Panic Disorder with or w/out Agoraphobia
- Agoraphobia w/out history of Panic Disorder
- Specific Phobia
- Social Phobia
- Obsessive-Compulsive Disorder (OCD)
- Posttraumatic Stress Disorder (PTSD)
- Acute Stress Disorder
- Generalized Anxiety Disorder
- Anxiety Disorder Due to a General Medical Condition
- Substance-Induced Anxiety Disorder
- Disorder not Otherwise Specified



Substance Abuse and PTSD

People with substance use disorders are more likely to experience traumatic events than non-users.

- One study of 84 men and women in an inpatient substance abuse treatment program found that 43% of women and 12% of men met criteria for PTSD.
- In data from 2,263 respondents participating in a large epidemiologic survey of substance use and psychiatric illness in the general population, substance users reported having experienced more traumatic events than non-users:
 - Opiate and cocaine users reported the greatest prevalence of trauma, with 19% meeting the criteria for PTSD.
 - 23% of pill/hallucinogen users experienced a qualifying PTSD trauma.
 - 18% of marijuana users experienced a qualifying PTSD trauma.
 - 16% of heavy alcohol users experienced a qualifying PTSD trauma.

(Meisler, 1996)



Treatment approaches

- National Child Traumatic Stress Network (NCTSN),
- Cognitive Behavioral Treatment ([LaFromboise & Bigfoot, 1988](#))
 - Suicide and substance abuse prevention interventions with AI youth using cognitive behavioral approaches that focused on improving coping and problem solving skills.
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS) CBITS
 - adolescents ages 11–15 with symptoms of PTSD and depressive and general anxiety symptoms
 - CBITS involves six components geared toward making maladaptive thoughts and behaviors more functional: education, relaxation training, cognitive therapy, real life exposure, stress or trauma exposure, and social problem-solving
 - 10 weekly group meetings with teens between 11 and 15 years of age
 - Significant decreases in PTSD symptoms, anxiety symptoms, and avoidant coping strategies at three-month follow-up: marginally significant decrease in participants' depression symptoms.



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MOOD DISORDERS



Affective Disorders and SUD

- 56% of people with Bipolar Disorder
- 20% of youth with depression have history of substance abuse
- 15 – 75% of patients in substance abuse treatment have affective disorder
- Use of TCAs and SSRIs show hope for treating affective disorder and reducing alcohol and drug intake



Prevalence of mood disorders

- About 6.5% of women and 3.3% of men experience major depression in any given year (SAMHSA, 1999).
- Lifetime prevalence estimate of any mood disorders (CDC, 2004):
 - 14.5% among young women
 - 8.4% among young men



What are the different Mood Disorders?

- Major Depressive Disorder
- Dysthymic Disorder
- Depressive Disorder Not Otherwise Specified
- Bipolar I Disorder
- Cyclothymic Disorder
- Bipolar Disorder Not Otherwise Specified
- Mood Disorder Due to a General Medical Condition
- Substance-Induced Mood Disorder
- Mood Disorder Not Otherwise Specified



What are the symptoms of depression?

- Someone with **major depression** has most or all of the following symptoms nearly every day, all day, for 2 weeks or longer
 - No interest or pleasure in things one used to enjoy, including sex
 - Feeling sad or numb
 - Crying easily or for no reason
 - Feeling slowed down or feeling restless and irritable
 - Feeling worthless or guilty
 - Change in appetite; unintended change in weight
 - Trouble recalling things, concentrating or making decisions
 - Headaches, backaches or digestive problems
 - Problems sleeping, or wanting to sleep all of the time
 - Feeling tired all of the time
 - Thoughts about death or suicide



Learned Helplessness theory of depression

- People become depressed because they do not feel they can control things happening in their lives
 - Is learned helplessness the cause or the consequence of depression?
- Development of a sense of hopelessness as a crucial cause of many forms of depression
- Pessimistic style of attributing negative events to one's own character



Negative cognitive styles

- Depressive cognitive triad (Beck, 1967)
- Negative cognitions about:
 - self,
 - world,
 - future
- Evidence supports this theory.
 - Depressive self-instruction influences our way of perceiving the world.
- Treatment:
 - Change our underlying cognitive errors and schemas.



Other things important for the development of depression

- Marital relationships
- Gender effect on prevalence of depression
 - Women living in more "uncontrolled" situations
 - Gender roles
 - Women's tendency to focus on their roles in relationship to others
 - Women ruminate more than men.
- Social support important for mental health.
- Life stressors
 - Recent and early life stressors



Characteristics of suicide

- Suicidal attempts
 - Actual attempts
 - Suicidal ideation
 - Suicidal thoughts
- Prevention of suicide on a community level (One Sky Center)
 - Community involvement shown to be quite effective (Example: Apache Indians)
- Prevention of suicide on an individual level



Risk factors

- Family history
- Friends who have committed suicide
- Neurobiology
- Existing psychological disorders
- Stressful life events





Risks posed by Depression

- Fifteen percent of patients with MDD that is severe enough to warrant hospitalization will die by **suicide**
- Approximately 10% of patients with MDD who attempt suicide will eventually succeed in killing themselves
- Roughly 50% of individuals who have successfully committed suicide carried a main diagnosis of depression



Treatment of depression

- American Indian and Alaska Native women
 - Seek treatment from spiritual leaders and healers
- Native American “stress and coping model “ (American Journal of Public Health, 2002)
 - Important individual- and community-level variables that may both heighten vulnerability to and protect against mental illness.
 - Externalized and internalized attitudes and behaviors , racism, sexism, religious intolerance and homophobia and other forms of stigmatization continue to affect AIAN.
 - Treatment for AIAN women must take into account co-morbid conditions, specifically, anxiety disorders with both substance abuse and major depression.
 - Building and maintaining a strong support network can aid in recovery from and future prevention of clinical depression.



Treatment of depression (Cont.)

- Treatment of depression need to include the following (UIHB, Seattle, 2012):
 1. A focus on family and community,
 2. Incorporation of traditional knowledge and practices into care.
 3. Emphasis on active skills building.
 4. Integration and linkage with prevention and treatment care systems,
 5. Expansion of cultural competency of both providers and health care systems.
 6. Development of flexible provider-client/patient relationships with adaptive treatment approaches.
 7. Implementation of environmental and structural changes to affect surrounding conditions.
 8. Development of policies, systems, and advocacy for adequate funding to improve health care and economic opportunities for AI/AN people.



Cognitive Behavioral Treatment

- Adolescents coping with depression (CWD-A)
- Cognitive Behavioral Treatment for Adolescents (Listug-Lunde et al.)
- Zuni Life-skills development curriculum (100 sessions)
- Coping with Depression course (Lewinsohn et al. 1989)



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- Two psycho-educational group programs for women
- Female consumers with co-occurring mental health and substance use disorders
- Healthy Women: Healthy Lives
- Hand-In-Hand



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PSYCHOTIC DISORDERS IN DSM-5



Psychotic disorders

- Different types
 - Schizophrenia
 - Schizophreniform Disorder
 - Schizoaffective disorder
 - Delusional disorder
 - Brief psychotic disorder
 - Shared psychotic disorder (Folie a Deux)
 - Psychotic disorder due to a general medical condition
 - Substance induced psychotic disorder
 - Psychotic disorder not otherwise specified



Prevalence

- Lifetime prevalence rate of schizophrenia is approximately 1% among the general population.
- Among individuals identified as having a lifetime diagnosis of schizophrenia or schizophreniform disorder, 47% have met criteria for an AOD use disorder.
- Odds of having an AOD disorder are 4.6 times greater for schizophrenics than in the general population.
- Odds of alcohol use disorders are 3 times higher
- Odds of drug use disorders are 6 times higher.
- Among patients who have an AOD use disorder, 7.4% have a lifetime diagnosis of schizophrenia.



Schizophrenia and SUD

- 47% have substance use disorders
- Alcohol use may decrease negative symptoms (depression, apathy, anhedonia, passivity and withdrawal)
- May also decrease positive symptoms of hallucinations and paranoia
- Schizophrenics often use and abuse stimulants
- Drug-induced psychosis marked by prominent hallucinations or delusions



Treatment of psychotic disorders

- Indigenous culture
 - Psychotic disorders are not considered as permanent as in Western culture.
 - Strength in the community
 - Community supports itself and their members.
 - Family members are involved and supportive.
 - Cultural rituals are supportive.
 - Beliefs and attitudes about serious mental disorders are often incongruent with the Western way of understanding serious mental disorders.



Treatment of psychotic disorders (Cont.)

- Traditional healing important (Manson, 2000)
 - Beyond Mind and Body dualism
- Participating in cultural rituals important.
- Inclusion in the community/ acceptance of the community
 - Job and employment
- Psychopharmacological treatment in addition to psychosocial support



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Can I answer your questions?



References

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