Co-Occurring Disorders: Compassionate Care for Healing and Recovery

Highlights & Key Concepts

Presenter: Elizabeth Black, MRC, LADC, C4 Innovations

Summary Ideas:

Co-Occurring Disorders overview:

- When an individual experiences both a mental health and substance use disorder, those are termed "co-occurring disorders (COD)."
- About half of the people who experience a mental illness will also experience a substance use disorder at some point in their lives and vice versa (SAMHSA, 2019).
- More than 8 million Americans have a co-occurring disorder.
- ***Co-occurring disorders are the expectation, not the exception.***

Which comes first?

- Establishing which disorder came first or why can be difficult as they influence each other.
- Substance use can contribute to the development of mental illness.
  - Substance use may change the brain in ways that make a person more likely to develop a mental illness.
- Mental illnesses can contribute to substance use.
  - Some people with mental illness may use substances to self-medicate.
- Both disorders share common risk factors including genetics and environmental factors.
- Establishing sequence is unnecessary, as best practices have determined that both disorders need to be treated simultaneously.

Co-Occurring Disorders

- Persons with CODs tend to have symptoms that are more persistent and severe than those with only one type of disorder. Over 90% of people receive treatment for only one condition or no treatment at all.
- Co-occurring disorders are associated with a variety of negative outcomes.
- The provider's role is to recognize and refer clients, utilize and share resources, develop relationships with partner providers, coordinate care to create a comprehensive treatment team, monitor symptoms, include goals for managing the co-occurring disorder in the treatment plan, and ***offer person-centered care.***

Person-centered care supports recovery in persons with co-occurring disorders.

- Person-centered care is the collaborative process where care recipients participate in the development of treatment goals and services provided to the greatest extent possible.
- This approach is strengths-based and focuses on individual capacities, preferences, and goals.
- This helps us meet the person "where they're at," while fostering resiliency and recovery.

Shame and Compassion

- Higher rates of substance use are linked to a deep sense of shame; the substance use often starts as a form of self-medication.
- However, using alcohol and drugs (or engaging in other forms of addiction) creates further feelings of shame, creating a downward spiral.
- Providing non-judgmental, compassionate care works to reduce resistance and break the cycle of shame.

Questions & Responses:

Q1 ***Can you share a bit about your background and what path brought you here to talk to us about co-occurring disorders?***

A1 I am a licensed alcohol and drug counselor, and I've been in the field for going on 20 years. During my career, I have worked a lot with people with co-occurring disorders. Besides my professional work with this population, I also have my own personal lived experience with co-occurring disorders. In my youth, I struggled a lot with undiagnosed, untreated anxiety and depression and as a means to cope with that, I turned to substances specifically, in my case, alcohol, as a way to self-medicate. And so, I know both personally and professionally the struggles that people with co-occurring disorders face not only with the disorders themselves, but also in the barriers that prevent them getting into recovery and into treatment systems. So happy at this point in my life that I can really be an advocate.

Q2 ***Why is it important that we look at co-occurring disorders together?***

A2 I think it's really important that we look at them together because they are so closely related and intertwined. They really impact and influence one another. Somebody with a substance use disorder who's actively engaging in substances—we know that that impacts the brain chemistry and that in turn could trigger a mental health disorder. Conversely, it's not uncommon that somebody with a mental health disorder, especially before they're getting any kind of formal treatment, will self-medicate through some sort of addictive behavior. What the decades of research and experience we have behind us now shows us is that it's really important that we are treating them in tandem as one even though traditionally we have looked at them as two different conditions. Because if we treat one without treating the other, a lot of times we set people up for failure and relapse. As an example, if I am using alcohol to self-medicate for anxiety disorder, and you as a provider are only focused on my alcohol use, and you're not really paying attention to the anxiety disorder, then you're essentially going to set me up for failure, because we're not addressing the root problem that's driving the alcohol use to begin with. And that's really why it's so important that we work on and we look at and we treat these disorders together.

Q3 ***In your view and experience, why is compassion important when we talk about co-occurring disorders care?***

A3 I would say because of shame, hands down. Other brain disorders like Alzheimer's, Parkinson's, epilepsy—those we don't really view as moral failings, we understand that that is something organically going wrong with the brain. However, when it comes to substance use and mental health disorders, traditionally, as a society, we don't give those folks the same kind of deference. Instead, we tend to lay fault at their feet: that if only they tried harder, or were more disciplined or had more willpower, or were just willing to look at the positive side of things that they could get themselves out of their position. And that's absolutely not the case. And what that narrative does that we continue to have as a society is fuel a sense of shame in people who have co-occurring disorders, because it leads them to believe that there's something fundamentally wrong with them, or that there's something they're not doing right, that they're not trying hard enough, and that if they had just tried a little bit harder that they could get on top of it. And that's just not true. Compassion is to let them know that I see you just as you are, and I accept you just as you are. And I acknowledge that this clinical disorder is no different than any other chronic condition. And so there's not going to be judgment, there's not going to be blame and shame. I'm going

to use my compassion and my consistent positive regard to meet you where you are. As we offer compassion, and we show people that we actually see them for who they are, that shame organically starts to crumble on its own. And we start to lose those defenses that people build up so high to protect themselves because shame is a very intensive, invasive, painful emotion. And most of us will go to great lengths to avoid it.

Q4 ***What is the difference between phobias and fears?***

A4

Per the American Psychiatric Association:

"**Anxiety** refers to anticipation of a future concern and is more associated with muscle tension and avoidance behavior.

Fear is an emotional response to an immediate threat and is more associated with a fight or flight reaction – either staying to fight or leaving to escape danger. There are several types of anxiety disorders, including generalized anxiety disorder, panic disorder, specific phobias, agoraphobia, social anxiety disorder and separation anxiety disorder.

A **specific phobia** is excessive and persistent fear of a specific object, situation or activity that is generally not harmful. Patients know their fear is excessive, but they can't overcome it. These fears cause such distress that some people go to extreme lengths to avoid what they fear. Examples are public speaking, fear of flying or fear of spiders."

Q5 ***When people have lived with "symptoms" e.g., depression, their whole lives, they adapt, and may not know this is a treatable condition. How can we help people identify these symptoms before they lose years trying to figure it out?***

A5

Addiction is frequently a symptom and not the problem itself. Addiction is kind of smoke to the fire: it lets us know that something else is going on that we really need to attend to. Well, part of the problem lies in the way our treatment system has been set up. Where we want to be and what SAMHSA named as a best practice is the integrated model of treatment: one competent treatment team at the same facility addresses both the mental health disorder and the substance use disorder at the same time. That's the gold standard, that's what we're all moving towards. But until we really get there, a lot of us are working in siloed systems. It's important that we recognize and refer for the other disorder that we are not working with. So, as mental health providers, we need to make sure we know to recognize substance use disorders and know who to refer them to so they can get that treated. It's also important to know what resources are available in our area and develop relationships with partner providers so that we can do warm handoffs back and forth. We also want to make sure we are coordinating care, we're getting those releases signed, we're having ongoing conversations with our partner people at the different organizations, so that we have one comprehensive treatment plan and treatment team to best support the people that we're working with. And we want to make sure that we're monitoring symptoms of the disorder that may not be our expertise and making frequent inquiries on symptoms and concerns.

Resources:

- Animated video illustrating the progression of a substance use disorder, titled, "Nuggets" and creators' website at https://filmbilder.de/nuggets/
- Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study
- SAMHSA toolkit: *Whole-Person Care for People Experiencing Homelessness and Opioid Use Disorder*
- Podcast episode from C4 Innovations featuring Elizabeth Black, titled "Power of the Language We Use with People We Serve"
- American Psychiatric Association on fear, phobia, and anxiety