Journal of Namibian Studies, 32 (2022): 2541-2563 ISSN: 2197-5523 (online)

Special Issue 0n Multidisciplinary Research

The Effect Of Addition To Psychiatric Medication On Patients Psychology And Community Subsequently. An Update

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Abstract

Epidemiological educations discover that psychiatric illnesses, together with psychological disorders and affluence procedure disorders, are mutual between adults and exceedingly comorbid. United management mentions to the emphasis of management on two or supplementary circumstances and to the usage of numerous treatments for instance mixture of

psychotherapy and pharmacotherapy. Cohesive behavior for comorbidity has been established to be dependably greater associated to cure of different disorders by means of detached treatment plans.

Aim- intended to summarize remaining crucial studies' outcome to define the mutual dominance and influences accompanying with psychotropic treatment non-adherence.

Background: Foremost psychiatric illnesses are increasing community health apprehension that attributed 12% of the comprehensive affliction of diseases. The administration of chief psychiatric disorders is stimulating essentially remaining to medicine non adherence. Nevertheless, there is a rareness of shortened indication on the occurrence of psychotropic capsule non-adherence and linked causes.

Keywords- Comorbidity, psychiatric disorders, substance use disorders, Medication, non-adherence.

INTRODUCTION

Psychiatric disorders have been a global public health challenge. Almost 450 million people are affected by psychiatric disorders worldwide. It contributes 14% of the overall global burden of diseases, and 30% of the non-fatal diseases burden, which is worsened by medication non-adherence. Psychiatric disorders cost approximately US$2.5 trillion in 2010 and are expected to rise up to US$6.0 trillion by 2030. Lost resources and production, unemployment, absences from work, and premature mortality are some of the indirect economic costs. The World Health Organization (WHO) has designed a comprehensive strategic action plan (2013– 2020) to promote mental well-being, prevent psychiatric disorders, and provide care and support to reduce morbidity, disability, and mortality. [1,2,3]

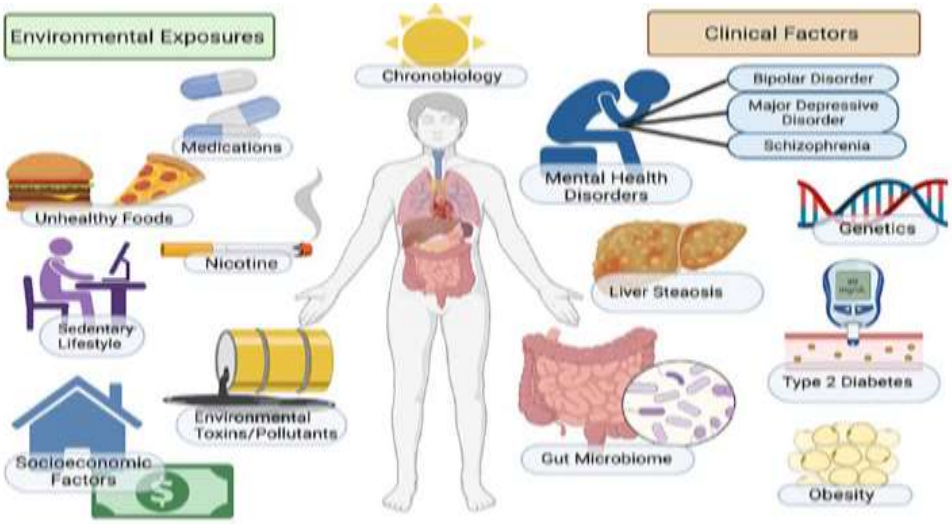

Figure 1

Nearly one third (31.7%) of people who suffer major psychiatric disorders end up with a long-term disability and dependency. Psychiatric disorders are associated with individual factors as well as community social support, cultural, social protection, living standards, and other environmental factors. Compliance to medication is essential but challenging in the management of major psychiatric disorders. The WHO defines medication non-adherence as, a case in which a person's behavior in taking medication does not correspond with agreed recommendations from health personnel. Patients with major psychiatric disorders are most likely to be non-adherent to medication due to poor reasoning and lack of insight about their illness and treatment. Psychotropic medication non-adherence can lead to exacerbation of their illness, reduce treatment effectiveness, or leave them less responsive to subsequent treatment. Other consequences of non-adherence include rehospitalization, poor quality of life or psycho-social outcomes, relapse of symptoms, increased co-morbid medical conditions, wastage of health care resources, and increased suicide. [14]

Research evidence on the level of psychotropic medication non-adherence and its associated factors among patients with major psychiatric disorders is essential to design appropriate interventions to achieve desired treatment goals for both patients and health care providers. Although several primary studies have

been conducted on this issue, there has not been any systematic review and meta-analysis carried out to inform policy. Thus, a systematic review and metaanalysis on the level and factors associated with psychotropic medication non-adherence is useful to inform policy makers and program planners. Therefore, the main aim of this systematic review and meta-analysis was to summarize available findings of primary studies to determine the level of psychotropic medication non adherence and associated factors.

HEREDITARY AND ENVIRONMENTALLY FRIENDLY OPTION FOR DEVELOPMENT OF COMORBID ILLNESSES

A strong genetic predisposition exists along with environmental risks for the development of comorbid disorders (Kessler, 2004). Kendler et al. (2011) studied twins to determine that people with behavioral disorders of childhood such as conduct disorder and ADHD, and antisocial personality disorder (ASPD) of adulthood have a genetic predisposition to develop drug and AUDs whereas people with major depression share an environmental risk for developing an AUD. An important line of research suggests that genetic and familial risk for the development and exacerbation of SUDs becomes more prominent in the late teens. One theory as to why this occurs is that in early and mid-adolescence the protective effects of parental monitoring reduces behavior associated with poor decision making. However, impulsive behavior and poor judgment associated with a genetic predisposition for engaging in substance use is given free reign as people age and are no longer under the influence of parental supervision (Bornolova, Hicks, Iacono, & McGue, 2012).

Of course developmental experiences and trauma can exacerbate SUDs among patients with already existing psychiatric illness, or contribute to the onset of both conditions. Patock- Peckham and Morgan-Lopez (2010) studied college students and found that the quality of parental bonds, including care, rejection, overprotection, and neglect affected behavior and contributed to antisocial behavior and alcohol use. In their study women with a caring mother were less likely to have antisocial tendencies and had fewer alcohol-related problems compared to women who felt neglected/rejected by parents. Similarly, men who perceived their fathers as neglectful had more alcohol-related problems, and men

with rejecting mothers and overprotective fathers were more likely to exhibit antisocial behavior that was linked to higher levels of alcohol use. In clinical samples, childhood emotional and physical neglect is related to having multiple SUDs, higher levels of aggression, suicidal behavior, and psychosis (Martinotti et al., 2009). Patients with bipolar disorder who report being physically abused in childhood are at greater risk for developing SUDs (Gao et al., 2010), especially cannabis dependence. Other clinical studies found that patients with higher levels of childhood trauma have higher rates of PTSD, substance dependence, especially alcohol, cocaine, and cannabis, and are more likely to report injecting drugs (Khoury, Tang, Bradley, Cubells, & Ressler, 2010; Wu, Schairer, Dellor, & Grella, 2010). Women who report having been raped report higher levels of PTSD, major depression, and alcohol abuse compared to others with child-victimization histories but who have not been raped (Zinzow et al., 2012).

NERVOUS AND MENTAL COMMUNICATION OF SUD AND NON-SUD PSYCHIATRIC CONDITIONS

The severity associated with having both substance and non-substance-related symptoms is heightened because the interaction of two conditions produces a synergistic effect. The interaction of two disorders results in an overall condition that is harder to treat and makes recovery more difficult (Grella et al., 2001; Murthy & Chand, 2012). Furthermore, the interaction of psychiatric disorders and SUDs takes place physiologically and psychologically. Over the past 20 years research into the nature of addiction has revealed that substance dependence is primarily a disease of the brain (Volkow, 2012). We now know that most drugs of abuse act to increase the release of the neurotransmitter dopamine, although the exact mechanism by which this occurs for all drugs is not the same (Van den Oever, Spijker, & Smit, 2012). Dopamine, known as the, “pleasure” and “antistress” molecule (Blum et al., 2012) is responsible for producing the euphoria associated with drug use. People find that, after using drugs, they want to repeat the stress relieving and pleasurable experience associated with drug use. Addiction is the result of the sequence of using-craving-tolerancewithdrawal and desire for continued use. [10]

Similar to the effect of drugs on dopamine, alcohol and the designer drug ecstasy have been found to damage neurons associated with the neurotransmitter serotonin, which is primarily responsible for regulating mood (Badawy, 2003; Urban et al., 2012). Badawy's (2003) review indicates that alcohol can deplete serotonin to the point of inducing aggression, even in people who are non-alcohol-dependent. Urban et al. (2012) conclude that even moderate use of ecstasy affects serotonin to the point of negatively affect mood, cognition, and impulse control. Other important neurologic effects include the impact of the two most abused drugs (excluding nicotine) on the endo cannabinoid system: alcohol and cannabis. Endo cannabinoids, or internally produced cannabinoids, function the same way as do exogenous cannabinoids, such as those found in marijuana. Cannabinoid receptors are located on nerve endings in the high density areas of the brain and influence pleasure, memory, concentration, cognition, coordination, movement, and sensory and time perception. Overstimulation of these receptors produces the "high" associated with cannabis use and chronic use interferes with the normal function of the system (Volkov, 2013). [8,9]

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NERVOUS AND EMOTIONAL RELATIONS OF SUD AND NON-SUD PSYCHIATRIC COMPLAINTS

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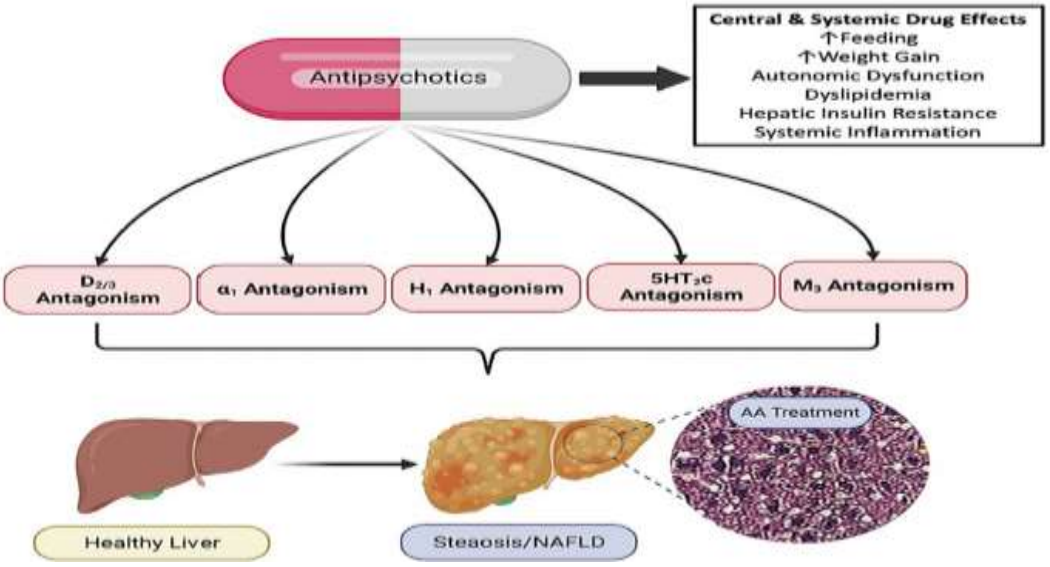

Figure 2

THE FUNCTIONING AND CONSCIOUSNESS OF ADDICTION

The neurology of addiction suggests that the connection between addiction and the psychological state of depression during withdrawal is likely to be related more to the desire to regain a normal mood than to get "high" (Taber, Black, Porrino, & Hurley, 2012). Consistent with this, Dennhardt and Murphy (2011) studied depression and alcohol use among college students and found that a depressed mood was associated with increased alcohol problems. Whites and African Americans in this study reacted similarly with regard to the primary finding that depression contributes to drinking, which leads to more depression, followed by more drinking to correct one's mood. However, African Americans reported a particularly reduced ability to cope with stress and negative emotions, and this was associated with their increased drinking. Therapists for African American college students should explore this symptom complex and account for this finding in treatment planning.

One other particular manifestation of the interaction of substance and psychological symptoms is the similarity between cannabis withdrawal and depression. Until recently cannabis withdrawal symptoms were considered to be of questionable significance (American Psychiatric Association [APA], 2000). However, a

withdrawal syndrome for cannabis is proposed for the newest revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the APA. The proposed syndrome includes depressed mood, irritability, anger, sleep disturbance, restlessness, decreased appetite, and other physiologic symptoms such as headache, all of which are consistent with depression. Furthermore, a condition associated with heavy use of marijuana referred to as a motivational syndrome has long been-recognized in clinical practice. [13]

The condition was first identified among teenage cannabis users and is a descriptive one that associates cannabis use with loss of educational and occupational goals and with a general impedance of normal maturation during adolescence (Schwartz, 1987). Recent studies suggest that chronic use of virtually all drugs of abuse decreases the growth and proliferation of neurons, impairing the ability to learn new ways of coping (Mandyam & Koob, 2012). This process results in two conditions that reinforce addiction. First, the decrease in nerve cells reduces the effectiveness of drugs of abuse for helping the user to get straight." Second, the strength of memory related to how the drug improved mood in the past, coupled with a reduced capacity for learning, reinforces compulsive use of the drug in a desperate attempt to stabilize mood. These findings are critical for understanding the significance of substance abuse among adolescents and young adults whose brains are still developing, and why they should abstain from substance use. From a psychological perspective the withdrawal from drugs and subsequent cravings for them increases the potential for continued use among those who are addicted, and for relapse among those who are trying to maintain abstinence and recovery. Gould (2010) discusses drug-stimulus cues that occur because of the strong mental associations between the intense pleasure associated with drug use and the surroundings in which drug use takes place. These cues reassert themselves during experiences reminiscent of drug use, and the cues trigger drug-seeking behavior. This relationship is reflected in the well-known tenet of Alcoholics Anonymous (AA) and Narcotics Anonymous to avoid the "people, places, and things" associated with substance use.

MANAGEMENT PERIOD AS WELL AS STRENGTH FOR COMORBID MATERIAL AND PSYCHIATRIC DISORDERS

Because of the differences between patients with single disorders and patients with comorbid disorders, patients with comorbid disorders have sometimes been referred to as system misfits," and efforts have been made to develop instruments that account for comorbidity during the process of placing them into appropriate treatments. Minkoff, Zweben, Rosenthal, and Ries (2003) describe the efforts of the American Society of Addiction Medicine (ASAM), which publishes placement criteria for assigning patients who abuse substances to different levels of treatment. ASAM is working to revise the classification system to account for comorbidity of psychiatric disorder. Minkoff et al. indicate that the effort came about because the prevalence of comorbidity is so high that it is now considered the expectation rather than the exception.

The longer patients stay in treatment the more likely they are to remain in recovery from substance abuse and have reduced psychiatric symptoms. However, patients who are comorbid are consistently found to be more noncompliant or to drop out of treatment before their peers who are noncomorbid. Daley and Zuckoff (1999) found that psychiatric inpatients with comorbid SUDs had significantly lower rates of entry to ambulatory care after hospitalization, lower rates of session attendance, higher rates of early treatment dropout, and higher rates of psychiatric rehospitalization. Cooper, Moisan, and Gregoire (2007) studied treatment compliance among patients with schizophrenia and found that more than 50% had either stopped taking medication or were non-compliant in other ways. Patients who were compliant after 1 year of treatment were more likely not to have a SUD and to have been treated with medication treatment of at least moderate intensity.

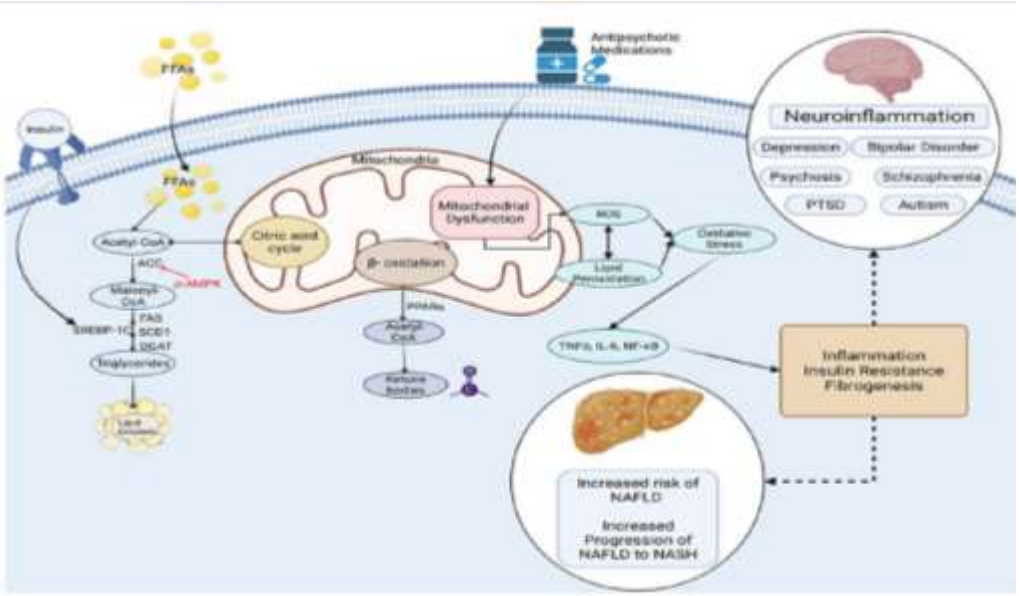

Figure 3

Importantly, longitudinal research consistently finds that treatment effects for chronic, relapsing diseases such as addiction degrade over time. D. M. Donovan et al. (2008) address this issue by suggesting that patients remain in treatment, possibly in a low-intensity treatment during periods of remission. In this way, if stress increases or patients report cravings and lapses that threaten recovery, treatment can be adjusted early in the process to help the patient maintain stability. Case management services, which are provided by some social workers, can be used for providing services on a continuing basis and can be effective for decreasing drug use and psychosocial needs among their clients even when they exhibit low levels of motivation for treatment (Jones, Svikis, Rosado, Tuten, & Kulstad, 2004).

Case management is also a very important component of maintaining clients in the community and decreasing need for inpatient treatment. In a study of a very large Veteran population with depression, increased intensity of outpatient monitoring following discharge from hospitalization was found to have a moderately protective effect against rehospitalization for Veterans with depression who also had a SUD.[9,12]

EVIDENCE-BASED MANAGEMENTS INTENDED FOR COMORBIDITY

Because social workers are mainly involved in delivering case management and individual, group and/or family services to clients with co-occurring disorders (COD) we focus on behavioral approaches (with and without medication). Readers interested in more detailed information regarding the psychosocial, medication, and/or combined therapies for COD are referred to Mueser and Gingerich in this volume, Douaihy et al. in this volume, Fox et al. (2010), Kelly et al. (2012), Mueser, Noordsy, Drake, and Fox (2003), Daley and Moss (2002), Daley and Thase (2004), Najavits (2000), Nunes, Selzer, Levounis, and Davies (2010), and Weiss and Connery (2011). The sections that follow provide an overview of integrated treatment of SUDS combined with (a) psychotic disorders, (b) mood disorders (depression and bipolar disorder), and (c) anxiety disorders.[11]

INVOLVEMENTS IN PLACE OF PSYCHOTIC ILLNESSES AND SUDS

Combined interventions are needed for treatment of psychotic disorders and SUDs with the understanding that medications can treat the symptoms of psychosis, but behavioral approaches must be implemented to help patients deal with the many challenges in recovery from schizophrenia and SUD. These challenges include managing persistent psychotic symptoms, dealing with negative symptoms adversely affecting on social relationships, managing cravings for substances, social pressures to use drugs, and so on. Most drugs of abuse can cause or exacerbate psychotic symptoms. Although substance induced psychoses are usually transient and may resolve without treatment, patients who experience them should be evaluated by a psychiatrist and treated because of the severe impairment in functioning associated with psychosis and risk for injury. Medications for psychotic illness are sometimes necessary to hasten the return-to-normal cognition (Leweke, Gerth, & Klosterkotter, 2004; Shoptaw, Kao, & Ling, 2009).

Patients who experience transient psychosis due to drug use are likely to have a recurrence if they continue to use drugs, and they must be informed of the dangers (Post & Kopanda, 1976). They should be treated with the recommendation that they remain abstinent from illicit drugs. The illicit drugs used most by patients with schizophrenia are alcohol, cannabis, and cocaine (Green, Young, & Kavanagh, 2005). Wilson and Cadet (2009) have described the schizophrenia and cannabis comorbidity as an

epidemic. Often referred to as stage of change, this model categorizes clients into five stages related to their perspective on substance use. Clients who do not view substance use as a problem are considered in the precontemplative stage, whereas those who are recognizing their substance use as a problem are considered in one of several increasing categories that include contemplation, planning, action or a maintenance phase as they consider participating, or are actually engaging in using alternative behaviors to drug use. This model "meets clients where they are" and is a critical element of maintaining a therapeutic alliance so clients remain active in therapy and stay in treatment rather than drop out. Other treatments for psychotic patients are Motivational Interviewing (MI; Miller & Rollnick, 2013), Cognitive-behavioral therapy (CBT) (Beck, Wright, Newman, & Liese, 1993), CM (Stitzer & Vandrey, 2008), and various models of family therapy. For an excellent review of these treatment models please see Wells et al. in this volume. Group therapies are also helpful, especially as part of follow up treatments that include 12-Step activities (Moos & Moos, 2005; Mueser et al., 2003; Ouimette, Brown, & Najavits, 1998). One recent, large-scale study found that a combined MI, CBT, and family therapy approach can be effective in reducing substance use among patients with schizophrenia for at least one year (Barrowclough et al., 2010). Bellack and Gearon (1998) developed a combined MI/CM approach (Behavioral Treatment for Substance Abuse in Severe and Persistent Mental Illness [BTSAS]) that includes relapse prevention strategies and short-term goal setting. Patient self-determination in goal setting has been emphasized as a critical part of this approach (Tenhula, Bennett, & Strong-Kinnaman, 2009). BTSAS is effective in retaining patients in treatment and reducing substance use. A case management component has been proposed for BTSAS that may improve the ease of implementation and its effectiveness (Bellack, Bennett, Gearon, Brown, & Yang, 2006).[11,13]

MANAGEMENT FOR DEPRESSION AND SUDS

Selective serotonin reuptake inhibitor (SSRI) antidepressants in combination with CBT have been found to be highly effective for treating clients with an AUD and depression (Cornelius et al., 1997; Moak et al., 2003). Despite the positive findings on the use of SSRIs antidepressants in these studies, contradictory evidence exists for the direct effect of SSRI antidepressants on drinking outcomes

(Mariani & Levin, 2004; Torrens, Fonseca, Mateu, & Farre, 2005). In fact, the preponderance of the evidence suggests that people with AUD and depression drink less when treated with antidepressants as a result of their depression improving. One finding that supports this theory exists as the result of a study that did not include CBT. Mason, Kocsis, Ritvo, and Cutler (1996) used a first-generation antidepressant (desipramine) and found clients on desipramine drank less alcohol over the course of the 24- week study. This study is significant because it did not have an active psychotherapy component. Importantly, evidence exists that antidepressant treatment may be more effective against drinking outcomes when patients have been abstinent from alcohol for at least 2 weeks (Pettinatti, 2004). This is logical because of the negative effect alcohol has on neurotransmission, as previously discussed. Regarding treatment of other SUDs, Schmitz and colleagues (Schmitz, Averill, et al., 2001; Schmitz, Stotts, Rhoades, & Grabowski, 2001) found CBT and relapse prevention psychotherapy improved depressive symptoms and reduced cocaine use in the samples they studied. CM too has been found to be effective for patients providing drug-free urines among cocaine users with depression, and residential treatment is consistently found to be effective for reducing depression among opioid users (Torrens et al., 2005).

PSYCHOTHERAPY AIMED AT BIPOLAR DISORDER AND SUDS

One behavioral treatment has been developed specifically for bipolar disorder, Interpersonal and Social Rhythm Therapy (IPSRT) (Frank, Swartz, & Kupfer, 2000). IPSRT focuses on helping patients with bipolar disorder gaining insight in the relationship between mood and interpersonal changes. The treatment assumes that the patient will be cooperative with highly structured interventions as the treatment emphasizes the therapist providing psychoeducation. The effect of IPSRT is to stabilize circadian rhythm by structuring daily routines, including sleep cycles and by addressing interpersonal problems. The patient and therapist work together to incorporate strategies for managing daily activities into the patient routine. IPSRT has been found to be more effective for preventing relapse, improving functioning in relationships, and increasing life satisfaction than medication management alone (Chambless & Hollon, 1998; Miklowitz, Otto, Frank, Reilly-Harrington, Kogan, et al. 2007 Miklowitz, Otto, Frank, Reilly-

Harrington, Wisniewski, et al., 2007). Although there have been no studies using IPSRT with patients with bipolar disorder who abuse substances it is likely to be effective because reducing psychiatric symptoms has been consistently found to be associated with reduced use of substances. Weiss, Najavits, and Greenfield (1999) developed Integrated Group Therapy (IGT), a CBTbased treatment for bipolar disorder and SUD. Along with medication, IGT has shown efficacy for reducing substance use and mood symptoms in several studies (Weiss et al., 2000; 2004; 2009).

PSYCHOTHERAPY IN ADDITION TO BEHAVIORAL TREATMENT OF ANXIETY DISORDERS

Research shows that, as long as therapists are well trained and supervised and use manualbased therapies, CBT is highly effective for all DSM-defined anxiety disorders (Hofmann & Smits, 2008; Stewart & Chambless, 2009). One trend that is emerging is that provocative therapies such as imaginal exposure and homework for CBT can be beneficial but should not be used prior to control of substance use because the anxiety associated with the therapy may exacerbate substance abuse. Imaginal exposure is a specialized therapy that involves the patient recalling aspects of the trauma he or she experienced in sessions with a qualified therapist who provides encouragement and support. The technique is beneficial because the patient's anxiety decreases as the patient endures continual exposure to the memory while realizing that experiencing the exposure is a nonthreatening event. Hesse (2009) reviewed the available studies on integrated psychological treatment for comorbid anxiety and SUD and indicates that psychological intervention increased days abstinent from substances, decreased symptoms, and improved retention in treatment. Hesse concluded that psychological intervention alone is not sufficient for treatment of anxiety and SUD and that there is a need for other integrated treatments for this comorbidity. Combining CBT with antidepressants has the most evidence-based support for treatment of comorbid opioid and anxiety disorder (Fatseas, Denis, Lavie, & Auriacombe, 2010).

PSYCHOTHERAPY AS WELL AS BEHAVIOR THERAPY OF PTSD

Comorbid PTSD and SUD have been studied in clinical trials more than any other anxiety disorder combined with a SUD. This dual disorder is prevalent in clinical populations with current

comorbidities estimated to be between 14% and 41% (Shafer & Najavits, 2007). Symptoms tend to be more severe in patients who are comorbid compared to patients who have only one or the other disorder (Jacobsen, Southwick, & Kosten, 2001). Women are more likely to need treatment for PTSD (Bromet, Sonnega, & Kessler, 1998), although combat Veterans with PTSD have high rates of AUDs (Jacobsen et al., 2001). Research suggests that with the exception of combat Veterans with AUD, substance-related comorbidities of patients with PTSD are more likely to be with harder drugs such as amphetamines and opioids, rather than with alcohol and cannabis (Mills, Teesson, Ross, & Peters, 2006; Najavits, Weiss, & Shaw, 1997). PTSD often causes or exacerbates substance use compared to the reverse temporal order (Back, Brady, Jaanimagl, & Jackson, 2006). A review of treatment studies for PTSD and SUD (Tiet & Mausbach, 2007) indicates that, although cue-exposure therapies are considered first-line psychotherapies for PTSD, they should only be used for participants with comorbid PTSD/SUD after substance abuse is under control because increasing PTSD symptoms often stimulate drug cravings and heighten the risk for substance abuse. A strategy for controlling substance use prior to uncovering therapies is to use CM, which can lead to reduction of drug use (Mancino, McGaugh, Feldman, Poling, & Oliveto, 2010).

Once substance abuse symptoms are under control, the technique of imaginal exposure (described above) is an important intervention strategy. It is critical to complete treatment by decreasing trauma-related anxiety because cravings for substances increase among patients with PTSD in response to trauma-related cues. Treatment studies have found that patients who received a course of imaginal exposure therapy reported less distress and decreased alcohol cravings compared to a control group (Coffey, Schumacher, Brimo, & Brady, 2005; Coffey, Stasiewicz, Hughes, & Brimo, 2006; Saladin et al., 2003).

Manualized group therapies have also been found to have some effectiveness. In a recent treatment study by Hien et al. (2010) women with PTSD and a SUD. Treatment as usual (TAU) consisted of 12 sessions that focused on women's health education compared to 12 sessions of a specific psychotherapy titled Seeking Safety (SS). These investigators found no overall differences

between the groups but found that participants with the most severe substance abuse in SS decreased their substance use more than those in the control condition. This finding suggests that such specialized treatment may be especially helpful for patients with severe comorbid PTSD and SUD.

TREATMENT OF SUD AND GENERALIZED ANXIETY DISORDER

Simon (2009) suggests that patients with generalized anxiety disorder (GAD) should be treated aggressively to reduce the risk that GAD will progress to major depression. One complication of the SUD/GAD comorbidity is that GAD cannot be accurately evaluated during active withdrawal from substances. However, Brady and Verduin (2005) suggest that antidepressants should be considered in conjunction with psychotherapy, if GAD symptoms persist following detoxification. Affect Focused Body Psychotherapy (ABP; Thornquist & Bunkan, 1990) is a specific psychotherapy that has been used with patients with GAD. ABP is based on exploring affect related to anxiety and integrates bodily techniques into a psychodynamic treatment. One study found patients in the ABP group were improved over the TAU condition. Interestingly, the TAU condition used a problem-solving approach and focused on directive counseling, whereas the ABP approach was less directive and focused on emotional support. An analysis of the content of the therapies found that the supportive, exploratory aspects of the ABP treatment were more important than the content of the ABP itself (Berg, Sandahl, & Clinton, 2008).

BEHAVIORAL MANAGEMENT OF SOCIAL ANXIETY DISORDER AND AUD

Alcohol is more likely to be abused than other drug by patients with social anxiety disorder (SoAD) because of its tranquilizing effects (Schneier et al., 2010; Zvolensky & Schmidt, 2004). One possible exception to this may be adolescents with SoAd. Adolescents often have the support of cannabis use by their social network, as well as easier access to cannabis than to alcohol. Whatever illicit drug is used for self-medication, comorbid SoAD and SUD is a significant public health problem. The combination of SoAD and AUD alone affects 2.4% of the general population. Randall, Thomas, and Thevos (2001) conducted a study of comorbid SoAD and alcohol dependence using individual CBT with patients who were comorbid using the manualized treatment used

in Project MATCH (Kadden et al., 1992). The groups received either CBT for alcohol dependence or a CBT that focused on alcohol dependence and SoAD. The investigators hypothesized that patients in the group that focused on treatment of both disorders would decrease their alcohol use in response to reduced social anxiety. Randall et al. (2001) found that both groups improved on percent of heavy drinking days as well as days abstinent from alcohol. In addition, both groups improved on social anxiety over 12 weeks of treatment and maintained their improvement over a 3-month follow-up period.

The investigators noted that the experimental group may not have improved as much as they would have because they may have drank more because of exposure to anxiety-provoking situations as a result of homework they performed for their therapy. One other interesting finding from the Randall et al. (2001) study should be noted. Although attendance at AA meetings was not encouraged, data on AA meeting attendance during the treatment was collected. AA attendance increased in both groups during active treatment and decreased again following the active phase of the study. Indirect evidence exists that it is necessary to focus on both types of symptoms when treating anxiety disorder and SUD. One study of a comorbid sample randomized patients to treatment in an intensive outpatient program for AUD (Schade et al., 2005). One group received treatment that focused on psychotherapy for anxiety only and TAU for alcohol dependence while the other received only TAU for alcohol dependence. Although the treatment group that received treatment for anxiety had a significantly greater reduction of anxiety, no difference was found between the groups on alcohol relapse rates. Taken together, the findings by Randall et al. (2001) and Schade et al. (2005) suggest that CBT programs that include a focus on anxiety and substance use appear to be more effective than CBT that addresses only anxiety-related symptoms. Another take-home message for clinicians is that group-based interventions, whether it be CBT or other group interventions, should be combined with support for 12-Step activities. D. M. Donovan and Floyd (2008) discuss ways to promote involvement in mutual self-help groups.

MANAGEMENT OF OBSESSIVE–COMPULSIVE DISORDER AND COMORBID SUDS

Fals-Stewart and Schafer (1992) found that patients with obsessive–compulsive disorder (OCD) are highly vulnerable to abuse of drugs or alcohol because they often find their symptoms to be confusing or even nonsensical. They therefore, may be unwilling to even report them to their doctor. As a result they do not receive treatment but may use drugs for self-medication. Furthermore, because these symptoms are often not reported the prevalence of OCD among substance abusers is likely to be higher than what is otherwise indicated. When it is detected, CBT is effective against OCD (Hofmann & Smits, 2008) and should be used routinely in the treatment of OCD. The Fals-Stewart and Schafer (1992) study used a three-arm design with patients diagnosed with OCD and SUD in a residential setting. It included behavior therapy and TAU with two control conditions, TAU and another being TAU and relaxation training. These investigators found the combined treatment condition was more effective than the two control conditions for reducing substance use during follow-up. At least one recent review notes the effectiveness of SSRI antidepressants for treating OCD and recommends their use. It includes information on how their effectiveness can be augmented by other medications, if needed (Simpson, 2010).

BEHAVIORAL ACTION OF PANIC DISORDER AND SUD

Recent studies have found that exposure therapy, consisting of exposure to avoided emotions, is beneficial to developing and practicing distress tolerance skills for panic, as well as the negative mood states associated with drug craving (Otto, Smits, & Reese, 2004). One model of treatment developed for this type of intervention is Panic-Focused Psychodynamic Psychotherapy (PFPP). PFPP focuses on recognizing the effect of anger in a person's life and the emotional conflicts related to feelings such as autonomy and loss or abandonment. One study of PFPP found that 73% of patients assigned to PFPP experienced a significant decrease in panic severity compared to 39% of patients who received a similar The Value of Combining and Intensifying Treatments Compared to participants in usual care alone, CM treatment added to TAU for patients who use cannabis and stimulants results in better treatment retention, more drug-free urines, and more patients who maintain complete abstinence from drugs. These findings are also relevant to patients in methadone maintenance programs (Alessi, Rash, & Petry, 2011; Pierce et al.,

2006; Petry et al., 2005). Aase, Jason, and Robinson (2008) reviewed the literature and found that 12-Step participation was effective for reducing substance use and mental illness because the social support provided by the 12-Step programs helped the patient stay in recovery. Twelve-step participation has been found to be very effective for patients with dual diagnoses, and findings suggest that the best approach may be to encourage 12-Step participation to assist with sobriety while providing other needed services. Donovan and Floyd (2008) discussed methods for improving 12-Step participation and indicate that 12-Step Facilitation (TSF) should be routinely integrated into treatment of addiction. We have already noted the importance of combining models into high-intensity treatments for clients with comorbid schizophrenia and substance abuse. Studies have found that a model known as Combined Behavioral Intervention (CBI), which is an integration of CBT, MI, and TSF, complements the effects of naltrexone alone and results in reduced drinking among participants who are alcohol dependent (Gueorguieva et al., 2010). Similarly, Longabaugh, Wirtz, Gulliver, and Davidson (2009) studied a psychotherapy called Broad Spectrum Treatment (BST) that was developed to include elements of CBT, Motivational Enhancement Therapy (MET), and TSF. The design of BST is a step forward for treatment of comorbidity as it combines effective elements of the same technology, that is, psychotherapy for treatment of patients with addictions. It is becoming increasingly clear that integrating the best elements of different evidence-based psychotherapies is necessary to produce more effective outcomes.

EXACTLY HOW COMMUNITY EMPLOYEES CAN ASSISTANCE AVOID RELAPSE FOR COMORBID USERS

As has been discussed, the interaction of emotions with addiction increases the risk for relapse among clients in recovery. Conner, Sorensen, and Leonard (2005) found that depression level is predictive of drinking severity and that even modest improvements in depressive states during the 12 weeks of treatment in Project MATCH were associated with dramatic reductions in alcohol. This is reminiscent of previously cited findings regarding depression and alcohol abuse (Cornelius et al., 1997; Dennhardt & Murphy, 2011; Moak et al., 2003).

Social workers are more likely to help their clients stay in recovery by keeping a low level of emotionality in their own relationship with their client and to intervene in ways that reinforce the value of the patient experiencing a low level of emotionality in their other relationships. Karno and Longabaugh (2003) report that therapeutic relationships that were characterized as having low levels of emotionality during the 12 weeks of treatment in Project MATCH were associated with greater improvements in depression and alcohol use. The authors suggest that low emotionality is associated with low arousal that was found strongly associated with improvement (see Mueser & Gingerich, this issue for additional discussion of this topic). Taken together, these findings suggest that the most therapeutic approach social workers can take with clients who abuse substances is one that decreases emotionality. This is best achieved by decreasing resistance in the client–social worker relationship. An approach that emphasizes empathy and egalitarianism, flexibility, and self-determination is one that decreases resistance and this is consistent with a MI approach. MI is a "style of relating" and reflects how therapists interact with clients more than it is a model of psychotherapy with a focus on content that must be covered to ensure that the treatment is being properly conducted. In our specialized world social workers often function solely in a case management role, and we have noted the very important role case management plays in treatment of comorbid disorders, especially in the treatment of comorbid schizophrenia and SUDs. However, all social workers, no matter their specialty, will do well to remember that the history of our profession is based on providing tangible services in helping meet the needs of our clients in their environment. This mission emphasizes our continuing attention to making referrals to effective treatments and case management.

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