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Treating Adolescents Who Have Co-Occurring Disorders

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DESCRIPTION OF CO-OCCURRING DISORDERS

Definition

Co-occurring disorders involve the presence of one or more mental health disorder in conjunction with one or more substance use disorder. The terms co-occurring disorders and dual diagnosis are often used interchangeably (Denby, Brinson, & Ayala, 2011). In this brief, and consistent with the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration's (USDHHS-SAMHSA; 2006) language, the term co-occurring disorders will be used.

The term co-occurring disorders may imply a sort of similarity or homogeneity within the population due to the sharing of diagnoses and their associated challenges. While some symptoms may be common to adolescent clinical presentations, each adolescent who presents for treatment will have unique symptoms, historical antecedents, and skill sets, and require an individualized treatment plan (Hills, 2007).

Most research on co-occurring disorders has focused on the adult population, but increasingly, an emphasis is being placed on the treatment of adolescents (Hills, 2007; Riggs, 2003). When treating adolescents with co-occurring disorders it is important to remember that many of the treatment approaches in current use were developed for adults. As such, treatments must be adapted to the developmental needs of adolescents (Baltrinic, 2013; Minkoff & Cline, 2005).

The relationship between depression and substance use cannot be overstated. Findings from the 2009 SAMHSA national survey (2010) indicate:

- Adolescents who had major depressive episodes in the previous year were more likely to have used illicit drugs in the past year compared to youth who did not have past year major depressive episodes.
- Co-occurring substance use was specific to the use of marijuana, inhalants, hallucinogens, cocaine, or heroin, and the nonmedical use of prescription-type psychotherapeutics.
- Substance use or abuse is more likely to co-occur with the diagnosis of major depressive disorder among youth

Prevalence in the Adolescent Population

Co-occurring mental health and substance use disorders in adolescents are common (Lichtenstein, Spirito, & Zimmermann, 2010). However, adolescents' substance use patterns may not present as similar to those of adults. For example, adolescents may not appear to have the same physiological effects of substance use, endorse withdrawal symptoms, or use substances in predicable progressive patterns (i.e., binge use vs. continuous use). Nevertheless, it is critical to keep a watchful clinical eye for the presence of problematic substance use patterns when working with adolescents. Research revealed that the most common co-occurring diagnoses involve the presence of conduct disorder, attention-deficit/hyperactivity disorder, and mood disorders (Hills, 2007; Riggs, 2003).

Resources:

Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings.* Retrieved from http://www.oas.samhsa.gov.

IDENTIFICATION/ASSESSMENT STRATEGIES

The high rates of co-occurring disorders in adolescents in clinical settings, combined with the deleterious consequences that can result from these disorders, suggest the need for counselors to screen for both mental and substance use disorders. Hawkins (2009) provided the following assessment recommendations:

- Use a comprehensive evaluation to assess behavioral health symptomology and other life domains that may be affecting, or affected by, co-occurring disorders.
- Substance use and mental health assessments should be individualized, flexible, and ongoing throughout treatment.

Instruments that may be useful to include in the assessment process include the following:

- The Drug Use Screening Inventory (DUSI) and a revised version of the instrument (DUSI-R) can be used to identify consequences of alcohol and drug involvement. The DUSI is a 149-item multidimensional instrument that measures drug and alcohol use along with comorbid mental health and psychosocial concerns. The DUSI-R adds 10 additional items and incorporates a "lie scale" to account for denial of problem areas. (See: DUSI; Tarter & Hegedus, 1991) The DUSI yields indices of functioning in 10 domains: substance use, behavior patterns, health status, psychiatric disorder, social competency, family system, school performance and adjustment, work performance and adjustment, peer relationships, and leisure/recreation.
- The Substance Abuse Subtle Screening Inventory - Adolescent, is a 100-item questionnaire used to screen for substance abuse or dependence (SASSI-A2; Miller & Lazowski, 2001). According to the test developers, the SASSI-A2 identifies the probability of substance dependence and substance abuse disorders in adolescents and provides information relevant to family and social risk factors, the level of defensive responding, and the consequences of substance misuse. It is used with adolescents ages 12–18 years. For more information about the test, qualifications for users, and costs visit: http://www4.parinc.com/Products/Product.aspx?ProductID=SASSI-A2

INTERVENTION STRATEGIES

Overall, research has shown that family and behavioral treatment models have a strong evidence base and should be used when working with the adolescent co-occurring population. Intervention strategies that incorporate integrated treatment principles (see Minkoff & Cline, 2005) and address adolescents' functioning across multiple systems (e.g., school, home, & community settings) positively affect treatment outcomes. Further, intervention strategies that account for adolescents' developmental level (e.g., social-emotional intensity, the importance of peers, executive functioning differences vs. adults, the impact of substances on cognitive functioning) are also important treatment considerations. Specific treatment models that have proven efficacy for use with adolescents with co-occurring disorders include the following (Hawkins, 2009):

- Motivational enhancement therapy/cognitive behavioral therapy(MET/CBT) begins with sessions that focus on engaging clients into treatment, developing the motivation to change, and moving through the stages of change (Prochaska & DiClemente, 1993), whereas the CBT component stresses skill development and practicing coping skills to manage high-risk substance use situations (Dennis et al., 2004; Diamond et al., 2002).
- Seeking safety is described as a present-focused therapy intended to help clients with PTSD and substance abuse concerns. It can be conducted in individual or group sessions. There are five principles (Najavits, 2007): (a) safety as priority; (b) integrated treatment of both disorders; (c) a focus on ideals to counteract the loss of ideals in both PTSD and substance use; (d) four content areas: cognitive, behavioral, interpersonal, and case management; and (e) attention to therapist processes (see: http://www.seekingsafety.org/).
- Dialectical behavior therapy (Linehan, 1993), which addresses emotional regulation and acceptance along with skills training may be helpful when working with this population. While not empirically tested as an intervention for co-occurring disorders, DBT has been successful with adolescents in other clinical populations (e.g., disruptive behavior and depressive disorders; Hawkins, 2009; Nelson-Gray et al., 2006; Safer, Couturier, & Lock, 2007; Trupin, Stewart, Beach, & Boesky, 2002).
- Family behavior therapy (FBT) is an outpatient intervention rooted in behavioral principles intended to reduce drug and alcohol use and common co-occurring problem behaviors (e.g., depression, family concerns, school and work attendance, conduct problems in youth). FBT employs a validated method of improving engagement and attendance. Adults and adolescents attend counseling sessions together (Donohue & Azrin, 2001; see

NREPP: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=113).

- Multidimensional family therapy (MFT) uses a comprehensive approach that targets youth and parents individually as well as collaboratively on multiple domains of risk, protection, and functioning within the youth, his/her family, and community (Hogue, Dauber, Samuolis, & Liddle, 2006).
- Multisystemic therapy (MST) is a family- and community-based treatment approach that is offered in the youth's natural environment. Interventions are developed in partnership with the family to encourage less risky behaviors by restructuring the youth's environment (Butler, Baruch, Hickey, & Fonagy, 2011; Henggeler, Melton, & Smith, 1992; Ogden & Hagen, 2006; Timmons-Mitchell, Bender, Kishna, & Mitchell, 2006).

Given the challenges associated with implementing evidence-based practices (Fixsen & Blase, 2009) and the economic constraints evident in most mental health systems (Hawkins, 2011; Hills, 2007), evidence-based practices may not always be readily available or accessible. Therefore, research has suggested that communities integrate evidence-based interventions and principles into their existing treatment approaches by employing a process of evidence-based thinking (Minkoff & Cline, 2005). Additional information on the components of evidence–based thinking is provided in the COCE resource

Resource:
Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services. (2007). *Center for Substance Abuse Treatment. Understanding Evidence- Based Practices for Co-Occurring Disorders. COCE Overview Paper 5. DHHS Publication No. (SMA)* 07-4278. Retrieved from http://media.samhsa.gov/co-occurring/

MULTICULTURAL CONSIDERATIONS

It is necessary to consider and treat adolescents who have co-occurring disorders through a multicultural lens. Disparities in treatment are often a result of barriers that are insensitive to cultural differences (Alegria, Crason, Goncalves, & Keefe, 2011). For example, assessments that do not consider multicultural variations may over-pathologize certain behaviors in adolescents (Dana, 2002) and under-pathologize genuine behavioral disorders (Lopez, 1989).

Targeting services to encourage minority youth to seek treatment and providing health care literacy in multiple languages for parents and families (Alegria et al., 2011) may be helpful in closing the gap of care. Practitioners can advocate for client services that have the potential to reach ethnic minority youth through school-based prevention programs or culturally-based organizations (e.g., substance use prevention, teen pregnancy prevention, use of indigenous community resources and personnel, translation/ESL services, violence prevention/gang diversion).

REFERENCES

Alegria, M., Carson, N. J., Goncalves, M., & Keefe, K. (2011). Disparities in treatment for substance use disorders and co-occurring disorders for ethnic/racial minority youth. *Journal of the American Academy of Child & Adolescent Psychiatry,* 50, 22-31. doi:10.1016/j.jaac.2010.10.005

Baltrinic, E. (June, 2013). Counseling adolescents: A practice-based perspective. *Counseling Today,* 20-22.

Butler, S., Baruch, G., Hickey, N., & Fonagy, P. (2011). A randomized controlled trial of Multisystemic Therapy and a statutory therapeutic intervention for young offenders. *Journal of the American Academy of Child and Adolescent Psychiatry,* (50)12, 1220-1235. doi:10.1016/j.jaac.2011.09.017

Dana, R. H. (2002). Mental health services for African Americans: A cultural/racial perspective. *Cultural Diversity Ethnic Minority Psychology,* 8, 3-18. doi:10.1037/1099-9809.8.1.3

Denby, R. W., Brinson, J. A., & Ayala, J. (2011). Adolescent co-occurring disorders treatment: Clinicians' attitudes, values, and knowledge. *Child & Youth Services,* 32, 56–74. doi: 10.1080/0145935X.2011.553581

Dennis M. L., Godley, S. H., Diamond, G. S., Babor, T., Donaldson, J., & Liddle, H. (2004). The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment,* 27(3), 197–213. doi:10.1016/j.jsat.2003.09.005

Diamond, G., Godley, S. H., Liddle, H. A., Sample, S., Webb, C., Tims, F. M.,…Meyers, R. (2002). Five outpatient treatment models for adolescent marijuana use: A description of the Cannabis Youth Treatment

Interventions. *Addiction,* 97(1), 70-83. doi:10.1046/j.1360-0443.97.s01.3.x
Donohue, B., & Azrin, N. H. (2001). Family behavior therapy. In E. Wagner, & H. Waldron (Eds.), *Innovations in adolescent substance abuse interventions* (pp. 205-227). San Diego, CA: Elsevier.
First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. (2012). *Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I), Clinician Version, administration booklet.* New York, NY: American Psychiatric Publishing.
Fixsen, D. L., & Blase, K. A. (2009, January). Implementation: The missing link between research and practice. NIRN Implementation Brief #1. Chapel Hill, NC: The University of North Carolina, FPG, NIRN. Retrieved from http://nirn.fpg.unc.edu/resources/implementation-missing-link-between-research-and-practice
Hawkins, E. H. (2009). A tale of two systems: Co-occurring mental health and substance abuse disorders treatment for adolescents. *Annual Review of Psychology*, 60, 197-227. doi:10.1146/annurev.psych.60.110707.163456
Henggeler, S. W., Melton, G. B., Smith, L. A., Schoenwald, S. K., & Hanley, J. H. (1993). Family preservation using Multisystemic treatment: Long-term follow-up to a clinical trial with serious juvenile offenders. *Journal of Child and Family Studies*, 2, 283-293. doi: 10.1007/BF01321226
Hills, H.A. (2007). *Treating Adolescents with Co-Occurring Disorders.* Southern Coast ATTC Monograph Series #2, Tallahassee, FL. Retrieved from http://mhlp.fmhi.usf.edu/resourcesLinks/
Lichtenstein, D. P., Spirito, A., & Zimmermann, R. P. (2010). Assessing and treating co-occurring disorders in adolescents: Examining typical practice of community-based mental health and substance use treatment providers. *Community Mental Health Journal*, 46, 252-257. doi:10.1007/s10597-009-9239-y
Linehan, M. (1993). *Cognitive behavioral treatment of borderline personality disorder*. New York, NY: Guilford.
López, S. R. (1989). Patient variable biases in clinical judgment: Conceptual overview and methodological considerations. *Psychological Bulletin,* 106(2), 184. doi:10.1037/0033-2909.106.2.184
Miller, F. G., & Lazowski, L. E. (2001). *The Adolescent SASSI-2 manual: Identifying substance use disorders.* Springville, IN: SASSI Institute.
Minkoff, K., & Cline, C. (2005). Developing welcoming systems for individuals with co-occurring disorders: The role of the comprehensive continuous integrated system of care model. *Journal of Dual Diagnosis,* 1, 63-89. doi:10.1300/J374v01n01_06
Najavits, L. M. (2007). Seeking safety: An evidence-based model for substance abuse and trauma/PTSD. In K. A. Witkiewitz, & G. A. Marlatt (Eds.). *Therapist's guide to evidence based relapse prevention: Practical resources for the mental health professional* (pp. 141-167). San Diego, CA: Elsevier.
Nelson-Gray, R. O., Keane, S. P., Hurst, R. M., Mitchell, J. T., Warburton, J. B., Chok, J. T.,… Cobb, A. R. (2006). A modified DBT skills training program for oppositional defiant adolescents: Promising preliminary findings. *Behavior Research and Therapy,* 44, 1811-1820. doi:10.1016/j.brat.2006.01.004
Ogden, T., & Hagen, K. A. (2006). Multisystemic Therapy of serious behavior problems in youth: Sustainability of therapy effectiveness two years after intake. *Child and Adolescent Mental Health,* 11(3), 142-149. doi:10.1111/j.1475-3588.2006.00396.x
Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1993). In search of how people change: Applications to addictive behaviors. *Journal of Addictions Nursing,* 5, 2-16. doi:10.3109/10884609309149692
Riggs, P. (August, 2003). Treating adolescents for substance abuse and comorbid psychiatric disorders. *Science & Practice Perspectives,* 2(1), 18-29. doi:10.1151/spp032118
Safer, D. L., Couturier, J. L., & Lock, J. (2007). Dialectical behavior therapy modified for adolescent binge eating disorder: A case report. *Cognitive and Behavioral Practice,* 14, 157-167. doi:10.1016/j.cbpra.2006.06.001
Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings.* Retrieved from: http://www.oas.samhsa.gov.
Tarter, R. E., & Hegedus, A. M. (1991). The Drug Use Screening Inventory: Its applications in the evaluation and treatment of alcohol and other drug abuse. *Alcohol Health & Research World,* 15, 65-75.
Timmons-Mitchell, J., Bender, M. B., Kishna, M. A., & Mitchell, C. C. (2006). An independent effectiveness trial of Multisystemic Therapy with juvenile justice youth. *Journal of Clinical Child and Adolescent Psychology,* 35(2), 227-236. doi:10.1207/s15374424jccp3502_6
Trupin, W. W., Stewart, D. G., Beach, B., & Boesky, L. (2002). Effectiveness of a dialectical behavior therapy program for incarcerated female juvenile offenders. *Child and Adolescent Mental Health* 7, 121-127.
U.S. Department of Health and Human Services—USDHHS, Substance Abuse and Mental Health Services Administration—SAMHSA. (2006). *Definitions and terms relating to co-occurring disorders.* Retrieved from http://store.samhsa.gov/ product/PHD1130