

**A Qualitative Examination of Co-occurring Disorders:  
Methamphetamine and Mental Illness**

**Executive Summary**

**By**

**Amber Ann Marinez, MSW**

**A project  
submitted in partial  
fulfillment of the requirements for the degree of  
Master of Social Work  
in the College of Health and Human Services  
California State University, Fresno  
May, 2009**

## **A Qualitative Examination of Co-occurring Disorders: Methamphetamine and Mental Illness Executive Summary**

### ***Abstract***

Individuals identified as having co-occurring disorders refers to the existence of both a substance use disorder and a mental illness. This qualitative study sought to explore the personal and recovery experiences of individuals receiving treatment services for methamphetamine abuse or dependence and a mental illness. Five participants were recruited from an outpatient treatment program located in the central valley of California. Qualitative interviews, consisting of six open ended questions were conducted and recorded; a content analysis was performed in order to identify common themes. The study findings showed that the following common themes existed among all participants: traumatic experiences, using methamphetamine to avoid feelings and/or to control symptoms of mental illness, system frustration, and receiving support from the current treatment agency. Additional shared experiences reported by most of the participants were strained parental relationships, significant loss resulting in unresolved grief, and criminal justice system involvement. The implications of these findings for Social Work practice are discussed as well as limitations of the current study and recommendations for future research.

### ***Problem Statement***

Epidemiological studies and surveys have provided evidence that approximately half of consumers with mental illness will develop a substance use disorder (O'Hare, 2002; RachBeisel, Scott, & Dixon, 1999). Especially troublesome is the co-occurring use of methamphetamine by those diagnosed with a mental illness. The co-occurrence of substance abuse and mental illness

poses many clinical challenges, and relapse is frequent (Hilarski & Wodarski, 2001). Additional adverse effects can include exacerbation of mental illness symptoms, repeated hospitalization, noncompliance with medication regimen, disruptive behavior, and diminished social functioning (RachBeisel, Scott, & Dixon, 1999).

Lack of clarity about the ordering of disorder development further complicates treatment considerations. The diathesis-stress theory provides one hypothesis regarding etiology of the development of co-occurring disorders (Sue et al., 2005). For individuals with co-occurring disorders, it is not clear if the substance abuse precipitates, exacerbates, is a consequence of, or is coincidental to the mental health issue (O'Hare, 2002).

The use of methamphetamine, colloquially known as crystal, ice, and crank, now spans across most areas of the United States and is considered to be a nationwide health concern (Volkow & Li, 2005). During treatment, social workers and other mental health clinicians commonly come into contact with individuals addicted to methamphetamine. This initial contact may be through an agency identified as a substance abuse treatment facility or in clinical practice. While some individuals seeking treatment might be self-referred, it is more common for external forces to be inducing motivation. Such forces might include the judicial or legal system, Child Welfare Services (CWS), a medical provider, or family and friends.

The initial interface between the consumer and the agency often determines the treatment approach. A historical split among mental health treatment services and substance abuse treatment services has proliferated two specific approaches to treatment of those with co-occurring disorders (Mueser, Noordsy, Drake, & Fox, 2003). *Sequential treatment* excludes individuals from treatment by dictating that one disorder must be stabilized prior to treatment of the subsequent disorder. *Parallel treatment* occurs when both the mental health and the

substance abuse are treated concurrently, but by different professionals and often in different agencies. While attempts to collaborate for the purpose of effective care should occur, they often do not. This leaves the integration of treatments as the responsibility of the consumer, who may not be as well equipped to complete integration as a professional.

Findings reported in this study help to illuminate the multifaceted nature of individuals with co-occurring disorders. Additionally, this study offers support for the necessity of the availability of integrated services provided by highly qualified and informed individuals.

### ***Literature Review***

Individuals with co-occurring disorders are underdiagnosed and underserved (Hilarski & Wodarski, 2001). As previously discussed, those who have both diagnoses identified for the focus of treatment have often been offered two types of treatment: sequential or parallel (Mueser et al., 2003). Sequential treatment often serves as an exclusion criterion for treatment, as it holds that disorders should be addressed one at a time. The disadvantages to the consumer can include worsening of the untreated disorder, disagreement regarding the order of treatment, and lack of follow up referral (Mueser et al.). Parallel treatment offers simultaneous intervention; however, this often occurs with two different providers who may or may not be in the same agency and requires coordination of care (Mueser et al.). This separation of services, along with placing the burden of coordination on a vulnerable individual, has resulted in deleterious outcomes for individuals with co-occurring disorders (Boyle et al., 2005). Due to the fact that integrated or multi-disciplinary treatment programs have shown improved treatment outcomes, the need for such services is necessary to meet the needs of this specific client population (Brems & Johnson, 1997; Mangrum & Spence, 2008).

There is a body of research that has been specifically dedicated to examining the effectiveness of integrated versus nonintegrated outpatient treatment for individuals with co-occurring disorders. Two experimental research designs (Barrowclough et al., 2001; Godley et al., 1994) compared two outpatient treatment types and found that intensive case management and family intervention (components of integrated treatment) were more effective at increasing the number of days abstinent than standard services (non-integrated treatment). Godley and associates had a 2-year follow up, whereas Barrowclough and colleagues had a 1-year follow up. Each of these studies had small sample sizes (n=36-38), and a high rate of attrition among participants (21%-84%).

Two intermittent quasi-experimental studies had more cohesive outcomes, in addition to larger sample sizes (n=208-217); however, both still suffered from a relatively high rate of attrition (14%-45%). The first study included individuals with schizophrenia and mood disorders co-occurring with both alcohol and drug use disorders (Drake et al., 1997). The second study consisted of individuals with schizophrenia, bipolar disorder, and major depression co-occurring with alcohol and substance use disorders (Carmichael et al., 1998). Both of these studies compared family intervention (integrated) with standard services (nonintegrated) on substance outcomes, hospital outcomes, and symptom outcomes. Each study concluded that family intervention was more effective than standard services in decreasing the severity alcohol abuse; Drake and associates also established better treatment outcomes using family intervention, while Carmichael and colleagues found no difference between family intervention and standard services in reducing drug use severity.

## ***Methodology***

Five participants were recruited from an outpatient treatment program in the Central Valley of California. Individuals receiving services within this program have been determined to be appropriate for outpatient care and met the study's selection criteria; they were self-sufficient, independently functioning, cognitively competent individuals. Eligibility criteria for inclusion in the study were: a) self-report of prior methamphetamine abuse or dependence, b) self-report diagnosis of a mental illness, c) aged 18 or over, and d) able and willing to provide written informed consent. Exclusion criteria were: a) use of methamphetamine within 72 hours of the interview, b) current experience of acute psychosis, and c) individuals who have current or past therapeutic interaction with the student investigator. Upon receiving the signed informed consent, participants were asked six (6) open-ended questions about their methamphetamine use/abuse, mental illness, and treatment/recovery experiences for both disorders.

## ***Results***

The individual interviews revealed that among those working towards recovery from methamphetamine abuse or dependence and a mental illness, common themes and shared experiences exist. These common themes included traumatic experiences, use of methamphetamine to escape intense feelings or to manage mental health symptoms, system frustration, and support within their current treatment agency. Additional shared experiences also emerged during the data analysis. These included strained parental relationships, significant loss resulting in unresolved grief, and diagnosis of mental illness within the criminal justice system.

## *Discussion*

Participants in this study readily recognized that there is an interacting effect between their use of methamphetamine and their symptomatic experience of their mental illness. This interaction was initially identified as a method of symptom management and is consistent with previous research (Sue et al., 2005). For those participants with a diagnosis of Bipolar Disorder, they reported using methamphetamine as a means of avoiding depressive states and to try to stop racing thought processes. They also stated that maintenance of mania was a key contributing factor for continual use. For the participants diagnosed with Major Depression, the avoidance of sadness and the induction of substance-induced self-motivation were main factors associated with continual use. Contrary to those stated intents, consumers found that use of methamphetamine exacerbated mental health symptoms resulting in more severe depressive states, hallucinations, paranoia, self-destructive behavior, and longer time periods of physical exhaustion accompanied with lack of motivation. These reported symptomatic experiences are consistent with the neurological dysfunction and imbalance provoked in the brain by the use of methamphetamine (Dyer & Cruickshank, 2005).

The participants in this study were not currently receiving integrated treatment services, but rather parallel services. This appears to be a contributing factor to the common experience of system frustration. Although the current treatment agency is making referrals to mental health service systems, other barriers existed that were problematic. One participant reported that she is unable to control her anxiety and fear when in public large public places, and thus has not followed through with her mental health referral. Another participant followed through, however does not have the financial means to obtain medication prescribed for his mental health. Multiple participants indicated that various geographic locations make adherence with treatment

appointments complicated and difficult. This is consistent with previous findings, which indicated that parallel services, which place the burden of integrating services on the consumer, provoke frustration and create additional barriers to adequate treatment (Boyle et al., 2005). Conversely, each participant reported that their main source of support and encouragement was provided by their current treatment agency.

### ***Policy Implications***

Individuals with limited access to medical or psychiatric services often pursue illicit drugs as a means of alleviating symptoms. In addition to avoiding emotions associated with traumatic events of the past, participants reported using methamphetamine as a way to avoid feelings associated with unresolved grief and strained parental relationships. Most of the participants in this study received mental health diagnoses and interventions following involvement within the criminal justice system. This speaks to the counterproductive way in which those with mental illnesses are diagnosed and served.

Policy-makers may wish to examine how programs are making attempts to integrate their service delivery for those with co-occurring disorders. The use of Mental Health Service Act funds, to integrated services and foster further collaboration between correctional, social service and behavioral health systems, may be one avenue to such an approach. The integration and the efficacy of such an approach would be helpful in determining the most appropriate way to treat those with co-occurring disorders.

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