



Mental disorder comorbidity and treatment utilization

Craig Rodriguez-Seijas^{a,*}, Nicholas R. Eaton^a, Malki Stohl^b, Pia M. Mauro^c, Deborah S. Hasin^{b,c,d}

^aDepartment of Psychology, Stony Brook University, Stony Brook, NY, USA

^bNew York State Psychiatric Institute, New York, NY, USA

^cDepartment of Epidemiology, Mailman School of Public Health, Columbia University, New York, NY, USA

^dDepartment of Psychiatry, College of Physicians and Surgeons, Columbia University, New York, NY, USA

Abstract

Objective: Effective interventions have been developed for myriad common psychological and substance use disorders, though they remain highly underutilized. Previous research has shown that the likelihood of treatment utilization varies across disorder diagnosis. However, studies that focus on individual disorders have resulted in a large, piecemeal literature that neglects the high rates of multivariate comorbidity. The current study investigated the association between treatment utilization and transdiagnostic comorbidity factors.

Methods: In a nationally representative sample of the United States adult population ($N = 34,653$), we applied the internalizing–externalizing latent comorbidity model to examine its association with lifetime utilization of various treatments for mood, anxiety, and substance use disorders.

Results: Both internalizing and externalizing transdiagnostic factors were positively associated with all forms of treatment utilization. Stronger within-domain (e.g., internalizing’s association with mood or anxiety treatment) than between-domain (e.g., internalizing’s association with substance use disorder treatment) associations were found. Significant antagonistic internalizing-by-externalizing interactions were also observed.

Conclusions: These results underscore the importance of applying a nuanced approach to modeling comorbidity when predicting treatment utilization. Clinical implications are discussed.

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1. Introduction

Despite the availability of effective treatments for most common mood, anxiety, and substance use disorders (SUDs) [1–9], such treatments remain underutilized [10–17]. For example, treatment utilization among those with alcohol use disorders has lingered around 20% since the early 1990s [11,18]. Given the disability associated with mental and SUDs [11,18,19], improving treatment utilization for these disorders is a major public health issue that must be informed by factors influencing such utilization.

The presence of psychiatric or SUDs is associated with increased treatment utilization [20,21]. Specific disorders vary in their likelihood of being treated [13,23,24]. For

instance, the odds of utilizing treatment have been shown to be 3.5 times higher for mood than anxiety disorders [13]. Further, disorder severity is associated with treatment utilization; severity of alcohol use disorder is positively associated with treatment utilization [11,24].

In addition, *comorbidity* robustly predicts increased likelihood of treatment utilization across multiple studies [10,13,15,23,25,26–32]. However, some anxiety and personality disorders are inversely related to SUD treatment [17], and antisocial personality disorder appears to be a barrier to treatment for anxiety disorders [31]. Given these complexities, examining the effects of comorbidity by considering pairs of individual disorders (the usual approach) may miss important information [33]. A reconceptualization of comorbidity as identified by multivariate research methods offers an emerging and empirically supported perspective [34] that may be more informative in understanding how comorbidity relates to treatment utilization.

In this perspective, the latent structure of common mental disorder comorbidity reflects two *transdiagnostic factors*:

* Corresponding author at: Department of Psychology, Stony Brook University, Psychology B Building, Stony Brook, NY 11794-2500, USA. Tel.: +1 917 780 9468.

E-mail address: craig.rodriquez-seijas@stonybrook.edu (C. Rodriguez-Seijas).

internalizing and externalizing [35–40]. This reconceptualization of comorbidity moves beyond previous pair-wise disorder comorbidity frameworks, suggesting that the observed comorbidity of common mental disorders is actually a manifestation of their shared associations with these underlying core transdiagnostic factors. The internalizing factor accounts for the observed comorbidity among common mood and anxiety disorders, while the externalizing factor accounts for that among SUDs and disorders of antisociality and impulsivity [41–50].

Transdiagnostic factor models fit observed mental disorder comorbidity data better than models reflecting *DSM*-type nosologies [46,47] and have many favorable properties. First, they are dimensional [50–54], incorporating information about severity and subthreshold psychopathology. Second, they are stable over time and predict longitudinal disorder continuity and development [43,49,51,55,56]. Third, the factors demonstrate measurement invariance across various population sub-groups [41,56–60] making them potentially generalizable predictors of treatment utilization across populations. They reflect additive genetic variance [61,62], but also connect mental disorders to environmental stressors [57,63–66]. Additionally, they account for the link between mental disorders and important outcomes [51,64,67–69]. These qualities make transdiagnostic factors potentially very informative constructs for better understanding the link between comorbidity and treatment utilization.

To our knowledge, only one study has applied transdiagnostic comorbidity to questions of treatment utilization, an Australian study showed treatment utilization history was more associated with the transdiagnostic internalizing factor than with unique diagnosis-specific variance [70]. This result suggests that a more comprehensive examination of the associations between utilization of various types of treatments with both internalizing and externalizing factors could be highly informative. We therefore examined the extent to which the internalizing and externalizing latent transdiagnostic comorbidity factors were associated with utilization of various forms of treatment in a nationally representative, longitudinal sample of adults in the United States. Further, we tested the hypothesis that within-domain associations (e.g., between internalizing and anxiety disorder treatment) would be stronger than between-domain associations (e.g., between internalizing and SUD treatment). Finally, we hypothesized that transdiagnostic factors would interact in their association with treatment utilization, such that the associations between within-domain factors and treatment utilization would differ depending on the level of between-domain factors.

2. Methods

2.1. Participants

The study used data from the two waves of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) [71]. Wave 1 ($N = 43,093$; fielded 2001–2002; 81% of those eligible) comprised a representative sample of the

civilian, non-institutionalized adult United States population, with race/ethnic minority and young adults oversampled. Wave 1 participants were contacted for a second, Wave 2 interview (fielded 2004–2005). Of these, 34,653 (86.7%) agreed to participate, for a cumulative response rate of 70.2%. Of the Wave 2 sample, 58% were women, and ages ranged from 20 to over 90 years of age. Race/ethnicity was assessed through respondents' selection of census-defined categories: 70.9% White, 11.1% African-American, 11.6% Hispanic, 4.3% Asian or Pacific Islander, and 2.2% American Indian and Alaska Native. Data were weighted to be representative of the age, gender, and race/ethnic demographics of the United States based on the 2000 Census. Written informed consent was obtained following complete description of the study. The research protocol, including written informed consent procedures, received full ethical review and approval from the U.S. Census Bureau and the U.S. Office of Management and Budget.

2.2. Assessment

2.2.1. Diagnoses

DSM-IV lifetime diagnoses were made using the Alcohol Use Disorder and Associated Disabilities Interview Schedule – *DSM-IV* Version (AUDADIS-IV) [71–73], a structured interview designed for administration by highly trained lay interviewers. Major depression, dysthymic disorder, panic disorder with or without agoraphobia, social anxiety disorder, specific phobia, generalized anxiety disorder, and posttraumatic stress disorder were utilized as indicators of the latent internalizing factor. Alcohol, marijuana, nicotine, and any other drug SUDs (abuse or dependence), and antisocial personality disorder (ASPD), served as indicators of the latent externalizing factor [74].

Across multiple samples, diagnostic reliabilities of the AUDADIS-IV ranged from good to excellent for *DSM-IV* alcohol and drug disorders ($\kappa = 0.60$ – 0.91) and from fair to excellent for mood and anxiety disorders ($\kappa = 0.40$ – 0.77) [72–74]. The AUDADIS-IV demonstrates as good or better test–retest estimates than other structured interviews [75] and has the benefit of assessing clinically significant distress and impairment after each syndrome is fully characterized [76]. AUDADIS-IV diagnoses also demonstrate high correspondence to clinician re-evaluations, illustrating the validity of the measure [77,78].

2.2.2. Treatment utilization

The current study utilized data from those participants who were asked about treatment utilization for mood, anxiety, and SUDs. This information was collected at both Waves 1 and 2. As done previously [22,79], treatment utilization responses from Waves 1 and 2 were combined to produce a single lifetime treatment utilization variable for each treatment modality among Wave 2 participants.

For mood and anxiety disorders, treatment utilization was assessed with questions on outpatient, inpatient, emergency room, and prescribed medication treatment. Participants who endorsed a sufficient number of criteria to receive a

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