SUNTEXT REVIEWS

SunText Review of Neuroscience & Psychology
ISSN: 2766-4503

Open Access
Commentary Article
Volume 3:2

The Comorbid Addicted Patient: Resilience, Rehabilitation and Reintegration

Mario Souza y Machorro*

Permanent Section of Medical Sexology, Mexican Psychiatric Association A. C, Mexico

***Corresponding author:** Mario Souza y Machorro, Permanent Section of Medical Sexology, Mexican Psychiatric Association A. C, Mexico

Received date: 19 June 2022; **Accepted date:** 13 October 2022; **Published date:** 25 October 2022

Citation: Souza y Machorro M (2022). The Comorbid Addicted Patient: Resilience, Rehabilitation and Reintegration. SunText Rev Neurosci Psychol 3(2): 146.

DOI: https://doi.org/10.51737/2766-4503.2022.046

Copyright: © 2022 Souza y Machorro M. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Abstract

The advancement of contemporary imaging that supports the development of neurosciences is the expected paradigm of mental pathology recommended by the WHO. Such advancement and clinical experience reinforce the conceptual-operational vision that replaces the traditional approach of the patient with addictive disorders (alcohol, cannabis, cocaine, fentanyl, etc.) and mental disorders -which have never been mutually exclusive-, with a new and broader vision oriented to a detailed, unconditional, and efficient approach. Evidence on addictive pathology, located at the molecular and cellular level of body systems and their behavior, converges on the notion of "abduction of neural mechanisms linked to learning and memory," which under normal conditions contribute to survival. This evidence now better studied, provides an explanatory model of people's resilience and vulnerability, derived from patterns of brain responses and other nervous mechanisms that mediate reward, fear, conditioning or extinction responses of adaptive social behavior and behavior, as prominent traits of the personality, possibly associated with the resistance/vulnerability that derives from the vital circumstantiality, in front of certain objects-stimulus. This condition could be equally valid, with respect to the effects of the etiologic-pathogenic consideration, of the mechanisms involved in the origin and maintenance of the psychopathology of the psychiatric patient.

Keywords: Neurosciences; Addictive disorders, Clinical approach; Resilience; Personality; Etiopathogenesis; Psychopathology

Introduction

The current complementary conceptual-operational vision, which replaces the traditional approach to patients with addictive disorders or mental disorders -which if they were mutually exclusive-, proposes a new and broader vision aimed at a detailed, simultaneous, and efficient clinical approach [1]. The common pathway of addictions is that the different substances administered in an individual directly or indirectly produce an unnatural increase in dopamine levels above normal.

The addiction process is mediated by a common pathway related to dopamine and other neuroreceptors, whose increased release in the ventral tegmental area raises their levels in the CNS [2]. Substance dependence is defined by the individual's need to take some psychotropic substance with a high level of abuse and dependence, in such a way that the substance progressively centralizes the individual's life, which will end up altering their daily life, at the expense of the consumption of the same and/or others, despite presenting clearly harmful effects. Similarly, it occurs in the processes described as addictive behaviors. Clinically it is characterized by the following signs and symptoms: dependence, tolerance, abuse, sensitization, and withdrawal syndrome. Such a set, related to the functioning of dopamine located at the molecular and cellular levels of the body systems and its peculiar behavior, converge in the notion of "rapture of the neural mechanisms linked to learning and memory", which under normal conditions contribute to survival [3].

Contemporary documentary evidence provides an explanatory model for the Resilience and vulnerability of people, which ideally would facilitate their social reintegration, derived from certain socio-family and individual conditions and patterns of brain responses, as well as other nervous mechanisms that mediate reward responses, fear, conditioning or extinction of

behavior and adaptive social behavior, as important personality traits. Which are associated with the resistance or vulnerability coming from the vital circumstantiality of everyone, in the face of certain stimulus-objects [4,5]. It has been corroborated by fMRI studies and genetic testing that dependence, the most severe form of substance use disorder, is a chronic brain disorder shaped by biosocial factors with devastating consequences for individuals and for society. The understanding of the addictive disorder has advanced significantly in recent decades, in part due to the great advances in genetic research, neuroscience and the development of new technologies, analytical tools for molecular changes in specific neuronal populations in experimental animal models, as well as brain imaging devices to assess brain function and neurochemistry in humans. These advances have illuminated the neurobiological processes through which biological and sociocultural factors contribute to resilience or vulnerability to drug use and dependence [6]. Delineation of neurocircuitry disrupted in the addictive process, including circuits that mediate reward and motivation, executive control, and emotional processing, has provided insight into aberrant behaviors displayed by comorbid addicted patients and provided new goals for treatment. Most prominent to this effect are disruptions in an individual's ability to prioritize behaviors that result in long-term benefit over those that provide short-term rewards and increasing difficulty in exercising control over their behaviors, even when associated with catastrophic consequences [7]. These advances in understanding brain development and the role of genes and the environment in brain structure and function have built a foundation on which to develop more effective tools to prevent and treat addictive disorder [8,9]. This could be equally valid for the effect of the etiopathogenic consideration of the mechanisms that may participate in the origin and maintenance of the psychopathology of the psychiatric patient [10].

Resilience of the comorbid addicted patient. The term Resilience It comes from the Latin word Resilio, interpreted as the "Universal human capacity to resist highly stressful situations or adversities", for which it is considered part of the evolutionary process of the human being, in its favour [11]. Both terms involved in the phenomenon, emanating from physics, present important differences: On the one hand, Toughness (stored energy per volume unit) grants the susceptibility to deform a material until it breaks; on the other hand, Resilience (energy per unit volume that can be absorbed within the elastic zone of the material in question) does not give rise to permanent deformation or its rupture [12]. Resilience represents the process of adequate adaptation to adversity, trauma, tragedy, threat, or significant sources of stress experienced in life, such as family problems, personal relationships, serious health alterations and various stressful work or financial situations, among other. A Resilient individual is one who, without ceasing to experience difficulties, anxiety or depression, etc. -at the moment or even some time later-, in the face of adversity, their emotional pain, sadness and other reactions -common in those who have suffered great and/or serious negative situations or traumas in their lives- experience a better handling of the situation and less unfavorable consequences than those who did not know, could not or did not adequately have biopsychosocial experience and resources for this purpose [12,13]. The concept of Resilience by extension -used in the fields of sociology, anthropology, psychology, and other sciences that study man-, also refers to the characteristics of people that include behaviors, thoughts and actions, which can be learned and developable by anyone; hence, a wide range of factors contribute to its development. It has been documented that one of the most important factors of Resilience is living loving and supportive relationships that converge on the concepts of J. Bowlby, regarding the secure attachment in childhood within and outside the family [14,15]. The importance of the Attachment Theory, widely corroborated in the clinic and in the literature on the subject, lies in the innate tendencies that regulate the way in which the human being responds to threats, danger, and losses, closely related to the way in which Establish relationships with significant others. Therefore, such behavior is organized through brain control systems related to protection and survival functions [13,14]. In such a way that children who develop positive interaction with their caregiver internalize the sense of security that allows them to expand their emotions. This Secure Attachment (when the caregiver shows affection, protection, availability, and attention to the baby's signals), allows him to develop a positive self-concept and a feeling of trust towards himself and others. Later, when interacting, such people tend to be more warm, stable, and satisfying intimate relationships, and intrapersonal, they tend to be more positive, integrated and with coherent views of themselves. Unlike Anxious Attachment (when the caregiver is physically and emotionally available only on certain occasions, it makes the individual more prone to separation anxiety and fear of exploring the world), such people do not assume trustworthy expectations regarding access and response of their caregivers, due to the inconsistency of emotional skills. In them, the ambivalence appears between a strong desire for intimacy and a feeling of insecurity with respect to others. Avoidant Attachment (when the caregiver constantly ignores the child's signals of need for protection, it is experienced as rejection, which does not allow him or her to develop in a desirable way the feeling of trust required for human interaction). This makes such people feel insecure towards others and expect to be rejected again, according to their previous experiences of abandonment [13]. Relationships that emanate love and trust, that simultaneously provide role models, that offer encouragement and security, are considered to contribute to affirming individual resilience. Other associated factors are a) The ability to make

realistic plans and follow the necessary steps to carry them out; b) A positive view of oneself, and confidence in one's own strengths and abilities; c) Skills in communication and problem solving, and d) The ability to handle strong feelings and impulses in terms of better techniques for coping with problems. All of them are factors that people can develop by themselves or, where appropriate, with specialized help for this purpose [12-14]. Resilience entails maintaining flexibility and balance in life as difficult circumstances and traumatic events are necessarily confronted. Therefore, the important thing to mention for the purposes of this communication is that it can be achieved, by those who did not acquire it naturally, in different ways, using some methodological guidelines used in psychotherapy that seeks to reconstruct the personality: a) Allow yourself to experience strong emotions and recognize at the same time, when you have to avoid them in order to continue functioning; b) Be proactive and seek to get ahead with optimism; c) Take actions to address the problems and face the demands of daily life; d) Going back on occasions can be beneficial for the purposes of a reorganization and planning of the new confrontation of the problem in question, now with new energy; e) Spend quality time with loved ones waiting to share concerns and perhaps receive support, encouragement and care that lead to trust in others and in oneself [13]. Given that resistance against destruction allows the development of the ability to protect integrity under vulnerable conditions of tension, regardless of their origin, resilience is also appreciated as the: “Capacity to build a positive and socially accepted vital behavior despite the difficult circumstances. Achievement derived from the combination of protective factors that allow an individual to face and overcome the problems and adversities of life”. Similarly, it was visualized and extended to group dynamics, described as: "The ability of a person or a group to develop well, to continue projecting into the future despite destabilizing events, difficult living conditions and trauma. sometimes serious” [14,15]. Since ancient times, the term is estimated as resulting from the interaction of the individual with the environment, his family and his living conditions, considering vulnerability the starting point for the emergence of Resilience, which is not absolute, total or permanent, but dynamic and evolutionary, since the response depends on the type, frequency and intensity of the trauma and its interpretation, according to the circumstances, cultural context of the trauma and stage of life in which it affects individual subjectivity [16]. Such a condition results from the interaction between protective factors and risk factors depending on personal characteristics and their sociocultural context [15,17].

Vulnerability to disease or other alterations that act on the body's economy is associated with the psychological resources available and with the ability to activate in stressful situations, such as real, constant, immediate, or delayed sensitivities and weaknesses [18,19]. The condition of invulnerability is taken as: “Strength, ability to resist stress, pressure, and potentially traumatic situations. But there will always be a risk, referring to the uncertain and variable result in the face of the individual's confrontation with internal or environmental stress. It is a perceptible phenomenon in which, at a certain level of stress, it can immediately result in maladaptive behaviors [20,21]. In the seventies, the term “invulnerable” was used as a synonym for resistance, referring to the robust constitution of a subject. But in various investigations it was observed that certain groups of children and adolescents manage to overcome adverse situations, without suffering serious psychosocial sequelae and therefore they were referred to with that adjective. However, resistance to stress is always relative and variable, according to the stage of development and the psychophysical strengths that it includes, as well as the quality of the stimuli to be faced [20,21]. The elements identified in different contemporary studies, regarding the "biological equipment" of individuals to face highly stressful events, created the concept of "empowerment", which has almost always been related to factors derived from protection initial maternal-infant and its effect throughout life. However, it should be emphasized that since resilience is never absolute, total, and permanent, it must be assumed because of vital evolutionary processes in which the transcendence of a trauma due to its characteristics can exceed the individual's resources to the point of overthrowing it. This condition tends to vary according to the circumstances, nature, context, and emotional maturity of the individual, which tends to express itself in different ways among different cultures, modified by individual and group traits [22].

A group of characteristics related to resilience have been documented : a) Initiative, ability to face problems and exercise adequate self-control; b) Humour, the ability to laugh at oneself, to find the comical and laughable in adversity; c) Creativity, activity that starts from chaos and disorder and manages to give order and purpose to acts; d) Morality , capacity for moral conscience that allows discernment between what is good and what is socially accepted bad; e) Introspection and independence, establishment of limits with oneself and the surrounding environment, with adequate emotional and physical distancing, without reaching isolation; f) Ability to relate to others, social ability to interrelate intimately and satisfactorily due to the need for sympathy and the ability to offer oneself to others. Ad hoc investigations have also pointed out some complementary protective factors associated with Resilience that are usually interpreted in the same desirable line of natural and acquired development: a) Favorable development of Self-esteem, b) Attained sociability, c) Sense of humor, d) Availability of a Life Project and e) Participation in the life of the people of the Community Support Networks [23,24]. Risk Factors have also been described, which, known for their psychophysical impact,

are related to vulnerability-Tenacity: a) Addictive disorders in the parents; b) Marital separation or breakup of the parents; c) Death of one or both parents; d) Presence of family conflicts; e) Existence of family violence; f) History of physical or sexual abuse; g) Poverty and restrictive circumstantiality; h) Serious and/or chronic illnesses and i) Disasters, whether natural or war, among others [25].

The existence of certain family and social traits that act by modulating the resilient phenomenon, paradoxically, support the professional management of acute, post-traumatic, addictive or comorbid mental disorders of various kinds, such as when the family decides to participate in a treatment or in the rehabilitation and social reintegration maneuvers of any of its members: a) Favorable temperament of the parents; b) affective cohesion of the family; c) Constant qualitative support to the children; d) Useful presence of support structures outside the family nucleus -teachers, church, substitute father/mother, support institutions, etc.-, and e) Positive peer relationship [26].

The resilience and its individual and collective scope, derives from an active, productive and constant action [27,28] requires: a) Building favorable and close family relationships, friendships and other important people in life, from whom you can accept and offer support, as well as those people who participate in community groups from their different approaches, ends and positive purposes of mutual benefit; b) Avoid the negative consideration of things, by a predisposed and insurmountable vision of adversity. Although no one it can prevent the occurrence of events that produce a great load of psychophysical and social tension, it can change the way of observing and interpreting them, especially the way of reacting to them; c) Accept that change is part of life, it becomes fundamental for the required vision of disposition, adaptation and management of changes, particularly when they are necessary; d) Accept the circumstances that cannot be altered and focus on the circumstances that make it feasible to modify; e) Effectively mobilize actions in favor of the proposed desirable goals; f) Carry out effective actions and omit the iterative consideration of the obstacles and their consequent tensions; g) Seek new opportunities for self-discovery, improving self-esteem and developing a better appreciation of life; h) Cultivate a positive view of oneself through the development of confidence focused on the ability to address and solve problems, based on confidence in one's own resources; i) Promote an objective and clear vision of the prevailing reality and its future perspective; j) Maintaining the hope of solving the problems, allows visualizing what is wanted, rather than increasing concern about what is feared; k) Taking care of oneself favors the effective satisfaction of needs, promotes interest in activities and favors the arrival of positive situations. Which requires a personal style to establish relationships and restore self-confidence [29,30].

Between the state of health and the resilient individual capacity as the most desirable social phenomenon -motivated by individual and group characteristics-, the prevention of disorders and the social reintegration of the comorbid addicted patient, indispensably mediate timely and adequate treatment [31-34]. And for this to take place and be effective, different obstacles and limitations must be overcome to access the health institution, whose multiple difficulties pose a serious threat against the provision of professional assistance [35], both by applicants due to its characteristics, as well as those of the institutions that grant it [36-37]. This includes, just to mention a few limiting elements, the clinical requirements and the systematization of the necessary knowledge, applied to the current and past health status of the user, through the correct application of propaedeutic and nosologically methods of systematized standardization , the essential record of the clinical history, the important antecedents linked to the case, the presumptive and definitive diagnoses, and its convenient management provided according to the experience and current documentation available for this purpose, which not all health institutions in the country, by the way, carry out, not in the same way [38-40].

The concept of social reintegration implies a whole process and the degree of rehabilitation achieved, which requires evaluating the application of a programmed management, which begins previously with awareness and information strategies for the community, as well as strategies for the timely detection of the cases. This process must include at least: a) A complete joint diagnostic assessment of the addictive and psychiatric problems of each patient; b) The elaboration of care plans with objectives established by the hierarchy of the health needs of the users and c) All this within the contextual framework of a defined structure and duration contained in the program carried out [41,42]. Programs that dispense with such characteristics -such as the multiple plans and "programs" of associations, groups and non-professional organizations that operate in our country, with the discretionary endorsement of the State-, cannot be considered useful for an adequate rehabilitation to long-term and the social reincorporation of those affected, as long as they do not show documentary efficacy of their results, given that they often fail to meet the clinical requirements of patients with concurrent addictive and mental diagnoses [43].

The coexistence of addictive disorders with mental disorders observed for four decades in the practice of the specialty is at least 20% to 50% in mental patients in general and between 50% and 75% in specialized addiction units. Other epidemiological data suggest that 60% of psychiatric patients show comorbidity due to addictive disorders compared to 6% in the general population, which even impact the field of medical education in the specialty [44-47], where there is a deficiency in the preparation formal, reflected among other things, in the comorbid

addictive disorder that often remains undiagnosed [48-50]. The range of services offered to the community by organizations and institutions must guarantee an adequate functioning of their units through their human resources, with quality activities supervised by the respective health authority. The therapeutic intervention supposes the understanding and knowledge of the concurrence of addictive and mental disorders -which can be located between 30% and 90% of the cases, depending on whether it is one or the other type of disorders and their combination, which roughly requires proposed way, of carrying out the following activities: a) Evaluation, delimitation and initiation of the problem; b) Formulation and control of hypotheses; c) Target selection; d) Specification of the participating variables; e) Programmatic treatment (according to the real availability of the units for this purpose); f) Evaluation of the process and its results; g) Monitoring of the results achieved and modification where appropriate. To this end, it is considered essential to locate, define and evaluate the motivational stage in which each patient is, to direct him towards a stage of change that enables him to make decisions and reincorporate, where appropriate, to an ad hoc treatment [51-54]. To comply with these approaches, it is recommended to develop: a) Training, updating and continuous clinical supervision programs for the staff; b) Epidemiological, clinical and sociomedical research activities; c) Systematic dissemination of the results obtained from the treatments provided, which feed back into the current programs or, if required, their pertinent modification [55]. The results and consequences obtained from such management of both types of comorbid disorders, will be whether or not, a better channeling to the purposeful restoration of the referred morbid condition is possible. Once the impediments have been cleared, there is an initial possibility of restoring the damage and its consequences to the extent that individual and institutional possibilities allow it, so that the rehabilitation maneuvers try to achieve the functionality that was had or that required for the case, depending on the case. Be this, at the service of an adequate final social reincorporation or, failing that, in those patients never inserted, their productive inclusion in the community [56-57]. The importance of psychopharmacological management must invariably be related to the global evaluation and diagnosis of the case, as part of the therapeutic plan. The circumstantiality given by comorbidity requires that the biological, psychological, and social planes coexist in the treatment, identifying the need to intervene from a multidisciplinary, complementary, and synergistic perspective. Psychotherapy carried out using procedures and techniques appropriate to the different types of addictive and psychiatric problems and their consequences, is a useful and indispensable tool [55,58]. It is convenient to spend the necessary time to motivate the comorbid addicted patient to receive treatment, instead of imposing any therapeutic intervention. If we start from the recognition of the scarcity of resources and the diversity of theoretical-practical frameworks that support the implementation of various "therapeutic- rehabilitative " alternatives, it is essential, not only pertinent, to establish a common national front to coordinate efforts and obtain the best long-term results [58,59].

Rehabilitation of the comorbid addicted patient. It is the pinnacle of all the management provided to patients for their disorders, without it the effort and achievements achieved are lost. To properly understand and develop rehabilitation, it is necessary to consider the person in their environmental context [55,56]. Human behavior results from the interactions between their abilities, their personality, and their environment, it is the concrete integration of the man-middle dialectic. This allows us to understand the person within their environment, influences and determines the family, community, work, and ecology [34-36]. Rehabilitation incorporates essential elements to build a comprehensive conception: a) The specific needs of the person, the disability and capacity profiles; b) The requirements established by the individual's environment; c) The provision of specific support; d) The treatment and rehabilitation of the comorbid addicted patient must be based on a multidimensional conception that integrates the different triggering and consequent factors, so that they form an integrated system of corresponding therapeutic responses [56-58]. Although it is difficult to draw a clear dividing line between treatment and rehabilitation and between rehabilitation and social reintegration of comorbid addicted patients. The treatment for example, brings together the maneuvers that tend to correct the syndromic manifestations of the pathology. Rehabilitation attempts to return the patient to his or her original emotional and social functional roles. So that the procedures require to go through the evolutionary overcoming of several phases. The need for rehabilitation presupposes that some personal and/or social dysfunction prevails, that it pre-exists that of the concomitant disorders and that it is maintained during their treatment, or even after achieving some functional operative stability or healthy control [55-57]. So that the individual competencies, which are activated for the restitution of the affectation, are seen as the set of interventions tending to reduce or eliminate the disability and the psychophysical handicap at the same time. For several decades, the countries interested in the problem have designed ad hoc programs so that patients with mental disorders alone or with comorbidities develop their capacities, to function as well as possible in their environment. Such is the case of addictive and mental disorders, and those others that present serious physical, mental or both limitations, of various types and more especially, towards those that derive from known psychiatric alterations [58-60]. The purpose of rehabilitating is to help people develop the emotional, social, and intellectual skills necessary to be able to live, learn and work in the community, with the least possible amount of support from

health professionals. the different areas. For this, certain strategies are used: a) That the patient develops the necessary skills for interaction in a stressful environment; b) The aim is to acquire and develop the necessary environmental resources to reduce the potential stressors that impact human beings and patients to a greater extent. Although rehabilitation in this field of addictive and mental disorders, in general, does not reject the existence of the impact caused by addictive (mental) illness and its comorbidity, the truth is that rehabilitation practices have been slowly changing the perception community of these types of disorders. Fortunately, the training of such patients changed from a disease ¬-focused model to a functional disability-focused model [59,60]. It is documented that more than 50% of people with severe mental disorders with comorbidity show complex patterns of symptoms, difficult to categorize, and a history of suicide attempt [25,31,34]. Therefore, health personnel must consider: a) The real vital circumstances that the affected person will possibly face in their daily life; b) Help patients identify their personal goals; c) Define the personal costs and benefits associated with the previously identified needs. d) Assess the individual's willingness to change and the recognition of the Stage of Change in which they find themselves to facilitate their participation e) Focus ¬rehabilitation planning on the strongest areas of the patient and the stigma that affects them [61,62]. The objectives are: a) Restore ¬hope in those who suffer a significant alteration in their self-esteem as a result of their disease and comorbidity, its complications and concomitants; b) Respect and protect their rights; c) Increase the efforts made to be directed to self-determination and its responsibility, regarding the therapeutic- rehabilitative process ; d) Incorporate these values into the concept of overcoming , where the ¬Therapeutic Alliance plays a decisive role in ¬getting the patient to participate in planning their care; e) Promote recovery from chronic diseases, aimed at greater life satisfaction and the enhancement of the ability to overcome vital stressors [63-65]. So, if the stated objectives are added, rehabilitation essentially becomes an exercise ¬in building social networks. It should be noted that the perspective held that ¬addictive and mental illness, its clinical manifestations, behavior and therapeutic adherence, etc., of comorbid patients, are only the result of the pathological process per se, is partial and incorrect. Numerous studies have evaluated stigmatizing attitudes against people with mental and addictive disorders, and in recent decades, scientific interest in the perspective of stigmatized individuals has increased. For example, the negative consequences of stigma and perceived stigmatization have been documented. Among them, demoralization, decreased quality of life, lack of work and reduction of social networks stand out [66-68].

A national treatment system for comorbid addictive and mental disorders is essential in the country, to deal with this serious and growing problem, which represents at least a third of all cases seen in the emergency room, which are added to the various tens of thousands of consultations (outpatient, hospital and residential) per year, granted by different organizations and institutions of the country. However, the available efficacy of current therapy, the different types of programs do not use the same methodology, and their maximum variance, in terms of approaches, content and effectiveness, are still not considered routine, the individual characteristics of each patient as has been noted in the literature for a long time by the WHO recommendation [69 -71]. The reduced efficacy of certain approaches requires better methodological selection and evaluation of the corresponding indication, to use it, under supervised evaluation, the most appropriate methods and clinical procedures for each problem. The comorbidity of addictive disorders includes a wide nosological range of mental disorders, which increases even more, when joining the modalities and variants caused by the addictive pathology and corresponding stigma [72-75].

Consequently, the good evolution of comorbid addicted patients in the post-treatment period depends on different factors of personal significance, which influence their adherence to treatment and involve motivation and performance in scheduled activities, which produces and maintains a documented improvement. in rehabilitation and social reintegration. In practice there are different difficulties for rehabilitation. In fact, the need to practice rehabilitation on comorbid patients implies the prevalence of some personal and/or social dysfunction that pre-exists the addictive disorder that must be reduced, since it is maintained during treatment or even after achieving stabilization of their addiction. Condition and, where appropriate, abstinence [76]. Such a situation of dysfunction, anomaly, or loss, which characterizes this type of complex pathology, is frequently framed by the theoretical concepts of disability and handicap mentioned above. Conceptually speaking, this condition usually extends and adheres to the goals of social reincorporation [77,78]. The design of rehabilitation approach strategies must articulate the individual and interpersonal spheres of patients in their social context. In other words, it must tend to integrate both processes, that of rehabilitation and another active and complementary process of continuity -although it may be considered implicit-, social reintegration [79,80]. With such a conjunction, one arrives at the understanding of a more complete concept of rehabilitation, whose goal is: " Reduce or eliminate the disability of comorbid addicted patients through the development of new capacities and reinforcement of diminished capacities, little developed or conserved, that allow them to structure a self-sufficient and satisfactory life system with stable control of their pathology and without substance use". Rehabilitation thus becomes an active and extensive process where the patient abandons his passive role as a patient and assumes –in the best of cases-, his responsibility

to the extent feasible in the collective effort for the improvement and improvement of his person. The biological, psychological, and social areas and their capacities that are not diminished or not yet developed, can be focused from an evaluation, to determine the disabilities and their impact, or the influence on the others and in this way structure a feasible and individualized for rehabilitation. Therefore, together with the patient, a proactive and realistic structure-commitment must be developed, with short, medium, and long-term objectives and goals, as objective and simple as possible. The more active the patient's participation and the deeper the understanding of their problems and the benefits they will obtain with the rehabilitation, the greater the possibility of progress. The documented experience indicates that if the concrete contribution of the community in the rehabilitation is not considered, it will not be specified. The feasible links of support (social networks) that the patient has established in his environmental context should be investigated, as well as the material resources and useful means in the development of rehabilitation programs, which, to be real and successful, requires of the operational conjunction of the individual and community processes, since their integration is essential for the active program, which must be gradual and clear with respect to the needs and possibilities of each person [81-84]. Social reincorporation of the comorbid addicted patient. The goal is the active and permanent achievement of their roles and community environment, through social participation, which allows those affected to have a favorable environment, so that they can use their "new" capacities and personal resources, lead him to assume his responsibilities and face the situations of his daily life. Therefore, its elements represented by the groups, networks, associations, and organizations that can contribute to the achievement of the ultimate objectives of rehabilitation become transcendent [80,81]. Actions are all those activities that lead to exercise; the "normal" functions that offer elements for an active contact with reality and those that lead the patient to propose and practice a daily life without drug use and having controlled or at least modified the mental symptomatology. The role played by this work will be a decisive part of comprehensive rehabilitation, as it is essential for the improvement and maintenance of self-esteem and self-confidence of comorbid addicted patients, and becomes an essential part of their aspirations, to replace a life affected and with a gloomy prognosis due to a productive activity outside the risks involved in the consumption of psychotropic drugs. This includes directing and stimulating the patient to the conquest of a new productive capacity [85-88]. Given the consideration that people's problems are not only individual or internal, the solutions reside in the interpersonal systems that involve each other, social networks, are nothing but the description of certain interactions that establish a certain number of people. The congruence between any living being and its environment is called Adaptation. This requires that the ecosystem maintain its consistency, maintain its adaptation, organization, and existence. As the construction of exchange and interaction (network) established by living beings, constitutes the medium and therefore, its realization as a living being, people's problems cannot be seen only as individual or internal. On the other hand, the existence of an unconscious problem pending resolution, that is, intrapsychic, is not ruled out, which must be addressed at some point and in parallel when the conditions for it are met. In some cases, it may occur as part of the psychopharmacological and psychotherapeutic management of their underlying disorders. In other cases, certain people do not meet the requirements (awareness of illness, interest, willingness to change, ability to think in psychological terms, reflection, or insight, etc.), for the required psychological analysis, so should be set aside after a proper evaluation in that regard. In fact, rehabilitation, due to its special reconstructive characteristics, is part of considerations about the desire, capacity, and power of people to overcome the disease and its consequences, so that its procedures could facilitate the transit through the analysis of the conflicts experienced and the produced and current problems, for the improvement of their vital condition. This can be used in some patients for the self-discovery of their psychic potentialities and their self-actualization, as well as for a possible attitudinal and behavioral change in this regard. To this effect, it is necessary to emphasize here that rehabilitation does not apply only to the physically handicapped, but rather this concept extends to all patients who need to overcome and overcome their failures, deficiencies, or sequelae of any kind. For this reason, although the solutions basically reside in the interpersonal systems that link them together, they do not exempt or limit the task of investigating oneself and oneself with the support of a professional. Social networks, a description of certain interactions established by a certain number of people, refer to a group in terms of a dynamic entity in constant evolution over time and the circumstances in which it finds itself at a given moment, depending on whether they are modified its features and functions [89-91].

Social reintegration, also called reinsertion, or initial insertion in its case, it is expected that it be active and permanent in its roles and community environment -with the support of the participation of the community-, so that it allows the individual to have a favorable environment for the use of their "new" individual capacities and resources that lead him to assume responsibilities and face the situations of his daily life. For example, in the case of those who have committed a crime [92,93]. For this purpose, it must be possible to count on the different participating elements of the different groups and organizations, focused on the same purpose. Hence, specific actions have been planned to achieve, through activities that lead to: a) Exercise of “normal” functions

that offer elements for an active contact with reality; b) Activities that lead the patient to propose and practice a daily life with adherence to the treatment of addictive and mental disorders; c) Work, essential for people's self-esteem and self-confidence, is an essential part of the aspirations to replace pathology with a social and productive life; d) The strengthening of the adaptive capacity, includes directing and stimulating the patient to the conquest of a new productive condition [94,95]. With this vision of active process, the patient is persuaded to abandon his passive role as a patient and assume his responsibility in the collective effort for the improvement and improvement of his person. The areas (biological, psychological, and social) and their capacities can be focused from an evaluation, to determine the disabilities and their impact or influence on the others and thus structure the respective program. A structure with objectives and goals in the short, medium, and long term, as objective and realistic as possible, should be developed together with the patient. The more active the patient's participation and the deeper their understanding of the problem and the benefits to be obtained, the greater the possibility of progress. If the concrete contribution of the community in the process is not considered, it can be restricted to the point of being able to materialize. Likewise, the links established by the patient in their environmental context (social networks), as well as the material resources and useful means in the development of the programs should be investigated. The process of improvement and change of circumstances, as well as the resources and resources for its success, require that the individual and community processes be integrated into an active, gradual, and clear program, adapted to the needs and possibilities of each person supported in the management psychopharmacology and the psychotherapeutic process [12-16]. As people's problems cannot be only individual or internal (intrapsychic), solutions are based on interpersonal systems that involve them among themselves, although they are not perceived that way (extra psychic). Social networks are the description of certain interactions that establish a certain number of people. The adaptive consistency of human beings is a paradigm and if an ecosystem maintains its consistency, it will maintain its adaptation, organization, and existence. Hence, the construction of exchange and interaction (Network) that people establish constitutes the medium, and, therefore, its realization as a living being. This provides certain favorable interactions for its members in its everlasting temporo-circumstantial evolutionary dynamics, depending on how its characteristics and functions are modified [91-93]. The provision of services to the community and large population centers, as well as to certain other groups (children/adolescents, the elderly, pregnant women, patients with HIV-AIDS, groups in prison, the disabled, indigenous people, among others). They have been neglected for a long time, so the members who take refuge there for lack of better institutional assistance will have to be included. Consequently, the mobilization of the network, as a cooperative support system, an access route to the growth of people's capacity for self-affirmation and self-independence, should be focused on those who most require it [93,94]. In this context, both the therapeutic intervention and the Social Network enable the transformation of the person-object into a person-subject through the self-esteem achieved by the process [91-94].

Conclusion. Advances in the understanding of addictive disorders and other concurrent mental disorders suggest that both alterations should be part of public health policies -as an obligation of the State-, from Resilience to Social Reintegration, as it is an imperative requirement of every individual affected on your health. The treatment plan must be continually evaluated and, where appropriate, modified to ensure that it keeps pace with changes in the person's needs [95]. It is essential that the form of treatment is appropriate to the patient's age, gender, ethnic group, and culture and that it be continued during a personalized observation period [47-49]. For many patients, medications form an important element of treatment, especially when combined with different types of therapy. From the perspective of the social reintegration of those affected, the intervention is the responsibility of the whole society, so the approach includes the areas: family, educational, work, and free time management, in order to implement social support networks and monitoring of the course of comorbid addictive disorder and long-term withdrawal [6]. It is about helping the patient from an ambitious vision to better understand and recognize their behavior in relation to their disease and with the rest of society, so the counseling sessions should focus on issues related to health in all its aspects, family relations, professional training, labor reintegration, housing support and other legal matters [94,95].

All comorbid addicted patients are expected to achieve full reintegration: a) They must recover their resilience, so they must build strong and positive relationships with loved ones and friends to obtain support and acceptance in good/bad times, b) Establish connections with the community, c) Make each day have meaning and carry out everything that gives a sense of achievement and daily purpose, d) Establish goals that help to look towards the future with meaning, e) Learn from experience, f) Assess how difficulties have been faced in the past, g) Remember the skills and strategies that helped in difficult times, h) Keep hope, i) Faced with the impossibility of changing the past, you can always look to the future, j) Accept and even anticipate change, facilitate adaptation and look at new challenges with less anxiety. Therefore, it is imperative that: a) You must take care of yourself, attend to your own needs and feelings, b) Participate in activities and hobbies with enjoyment, routine physical activity, sleep well, maintain a healthy diet, c) Practice stress management in all its forms, d) Be proactive without

ignoring the problems, face them through a participatory action plan, e) Recovering from a big setback, a traumatic event or a loss, takes time but you must trust that the situation can improve if you work on it. 34-36 In complementarity, it is necessary for health personnel to understand the dimension of the problem faced by each person, learn, and teach the patients in their care the common language of health, attend to it, manage it and promote it in the context of their profession and from the most basic social conscience [96].

References

1. Elsevier Connect. Addiction neuroscience: dependence, neuro-physiological dependence, processes, and correlations. 2017.
2. Volkow ND, Boyle M. Addiction neuroscience: relevance to prevention and treatment. Am J Psychiatry. 2018; 175: 729-740.
3. Brenner GM, Stevens C. Basic pharmacology. Elsevier. 5th edition. 2019.
4. Pereira R. Individual, family and social resilience. Bibliopsiquis.
5. Souza MM. Alcohol and personality: dual pathology. Editorial Alfil. Mexico, 2018.
6. Uhl GR, Koob GF, Cable J. The neurobiology of addiction. Ann NY Acad Sci. 2019; 1451: 5-28.
7. Luijten M, Schellekens AF, Kühn S, Machielse MW, Sescousse G. Disruption of reward processing in addiction: an image-based meta-analysis of functional magnetic resonance imaging studies. JAMA Psychiatry. 2017; 74: 387-398.
8. Kaplan G, Xu H, Abreu K, Feng J. DNA epigenetics in susceptibility to addiction . Front genet. 2022; 13: 806685.
9. Volkow ND, Maureen B. Neuroscience of addiction: relevance for prevention and treatment. Am J Psychiatry. 2018; 175: 729-740.
10. American Psychological Association. 2015.
11. Kristen D, Perry N. Toward a More Dynamic Understanding of the Influence of Resilience on Health. Behavioral Medicine. 2020; 46: 171-174.
12. Fuller-Thomson E, Sawyer JL, Agbeyaka S. The Toxic Triad: Childhood exposure to parental domestic violence, parental addictions, and parental mental illness as factors associated with child physical abuse. J Interpers Violence. 2021; 36 (17-18): NP9015-NP9034.
13. Agbeyaka S. Childhood exposure to parental domestic violence, parental addictions, and parental mental illness as factors associated with childhood physical abuse. J Interpersonal Violence. 2019.
14. Vella SLC, Pai NB. A theoretical review of psychological resilience: Defining resilience and resilience research over the decades. Arch Med Health Sci. 2019; 233-239
15. Hartigh D, Hill Y. Conceptualizing and measuring psychological resilience: What can we learn from physics? New Ideas in Psychol. 2022; 66: 100934.
16. Bowlby J. Attachment and Loss. Vol. 1 No. 79 Attachment. London: Hogarth Press. Institute of Psychoanalysis, International Psychoanalytic Library. 2022; 1969-1980.
17. den Hartigh R, Meerhoff R, Van Yperen NW, Neumann N, Brauers J, Frencken W, et al. Silience in sports: a multidisciplinary, dynamic, and personalized perspective. Int Rev Sport Exercise Psychol. 2022; 1: 6-10.
18. Silveira S, Hecht M, Adli M, Voelkle MC, Singer T. Exploring the Structure and Interrelations of Time-Stable Psychological Resilience, Psychological Vulnerability, and Social Cohesion. Frontiers Psychiatry. 2022; 13: 23-27.
19. Park ER, Lubert CM, Chad-Friedman E, Bring L, Hall DL, Perez GK, et al. A Comprehensive Resiliency Framework: Theoretical Model, Treatment, and Evaluation. Global Advances Health Medicine. 2021; 10: 2164956121.
20. Souza y Machorro M. Usefulness of psychotherapy and psychoanalysis in Dual Pathology Therapeutic Complementarity. Mexican Psychiatric Association. Psychiatry. 2014; 2: 30-44.
21. Bowlby J. Secure Base Clinical applications of Attachment Theory (Collected Papers) London, Tavistock, 1988.
22. Oldfield J, Stevenson A, Ortiz E, Haley B. Promote or suppress resilience to mental health outcomes in at-risk youth: the role of parent-peer attachment and school connection. J. Adolescentsc. 2018; 64: 13-22.
23. Poole JC, Dobson KS, Pusch D. Childhood adversity and adult depression: the protective role of psychological resilience. Child Abuse Negl. 2017; 64: 89-100.
24. Sawant N. Children of alcoholics: Are they vulnerable or resilient? Annals of Indian Psychiatry. 2020; 4(2): 111-114.
25. Oldfield J, Stevenson A, Ortiz E, Haley B. Promote or suppress resilience to mental health outcomes in at-risk youth: the role of parent-peer attachment and school connection. J Adolescentsc. 2018, 64: 13-22.
26. Shapero BG, Farabaugh A, Terechina O, DeCross S, Cheung JC, Fava M, et al. Understand the effects of emotional reactivity on depression and suicidal thoughts and behaviors: moderating effects of childhood adversity and resilience. J Affection Disord. 2019; 245: 419-427.
27. Fullerton DJ, Zhang LM, Kleitman S. An integrative process model of resilience in an academic context: resilience resources, coping strategies and positive adaptation. PLoS ONE. 2021; 16: e0246000.
28. Wong MM, Putter LI, Nigg JT, Zucker RA. Sleep and behavior control in early life predicted resilience in young adulthood: a prospective study of alcoholic children and controls. Addicted behavior. 2018; 82: 65-71.
29. Gil J. The inner child, resilience, trauma. Resilience as a response to childhood trauma. Barcelona. Gestalt therapy. 2020.
30. Sanchez-Garcia MD, Lucas-Molina B, Fonseca- Pedrero E, Pérez-Albéniz A, Paino M. Emotional and behavioral difficulties in adolescence: Relationship with emotional well-being, affect, and academic performance. Annals Psychology. 2018; 34: 482-489.
31. UNODC. Drug use prevention, treatment and care. 2019.
32. Yeh HH, Westphal J, Hu Y. Diagnosed mental health conditions and risk of suicide mortality. Psychiatr Serv. 2019; 70: 750-757.
33. APA. The road to resilience. American Psychological Association. 2017.
34. Pérez Santalla I. Humour, resilience and inclusion. 2017.
35. McLafferty M, Armor C, Bunting B. Coping, stress, and negative childhood experiences: The link to psychopathology, self-harm, and suicidal behavior. Psych J. 2019.
36. MacLeod S. The impact of resilience among older adults. Geriatric Nursing. 2016.
37. Mayo Clinic. Resilience: develops skills to resist in the face of difficulties. Mayo Clinic. Press. Mayo Foundation for Medical Education and research (MFMER). 1998-2022.

38. Dong C, Wu Q, Xu R, Zhang R. Family resilience and its association with the psychosocial adjustment of children with chronic diseases: a latent profile analysis. J Pediatr Nurs. 2021; 60: e6-e12.
39. Evelyn B. In Search of Family Resilience: The Example of Families Facing Pediatric Cancer. The New Review of Adaptation and Schooling. 2017; 79-80: 199-214.
40. Regine S. Sociologie de l'enfance et sociologie de l'éducation: va-et- vient. Éducation et sociétés. 2017; 2: 105-121.
41. Kubler-Ross E. Living with death and dying. New York. Scribner, Publisher, 2012.
42. Mina P, KyoungChoi E, JooLyu C, WooHan J, MinHahn S. Family resilience factors that affect family adaptation of children with cancer: a cross-sectional study. Family resilience factors that affect family adaptation of children with cancer: a cross-sectional study. Eur J Oncol Nurs. 2022; 56: 102078.
43. Arratia G, Lopez Fuentes NI. Self-esteem, optimism, and resilience in children in poverty. International J Psychology, 2018; 16: 1-119.
44. Herbell K, Breitenstein SM, Melnyk BM, Guo J. Family resilience and flourishing: Well-being among children with mental, emotional, and behavioral disorders. Res Nurs Health. 2020; 43: 465-477.
45. Souza and MM. Personality and addictions. Rev. Mex. Neuroscience. 2005; 6: 336-45. In: Souza and MM. Alcohol and personality: Dual pathology. Editorial Alfil. Mexico, 2018.
46. SAMHSA. Principles of Treatment for Drug Addiction: A Research-Based Guide. DrugFacts. Revised November 2019.
47. Souza y Machorro M. Vulnerability, causality and social reinsertion. In: Souza y Machorro M. Cannabis and health: from myth to evidence. Editorial Alfil. Mexico, 2017.
48. Souza y Machorro M. Addictions in Mexico: a therapeutic view of their myths and goals. Rev Fac Med (Mex). 2014; 57: 15-24.
49. NIDA. Principles of Drug Addiction Treatments a Guide Based on Research and Resources. 2022.
50. United Nations Office on Drugs and Crime (UNODC). Drug abuse: treatment and rehabilitation. Planning and implementation guide. Chapter VI. Effective integration of processing services. United Nations. Vienna, 2003.
51. Souza y Machorro M. Dual Pathology. Clinical and therapeutic aspects of addictive comorbidity. Design and technology. Mexico, 2011.
52. Mesman E, Vreeker A, Hillegers M. Resilience and Mental Health in Children and Adolescents: An Update on recent literature and future directions. Current Opinion Psychiatry. 2021; 34: 586-592.
53. Wendt DC, Gone JP. Group Therapy for Substance Use Disorders: A Survey of Clinical Practices. J Groups Addicts Recover. 2017; 12: 243-259.
54. Bahji A, Smith J, Danielewitz M, Crockford D, El -Guebaly N, Stuart H. Towards competency-based medical education in addiction psychiatry: a systematic review. Canadian Medical Education J. 2012; 12: 126-141.
55. Auerbach R, Mortier P, Bruffaerts R, Alonso J, Benjet C, Cuijpers P, et al. Collaborators of WMH-ICS of the WHO. International University Student Project of the WHO Global Mental Health Surveys: Prevalence and distribution of mental disorders. J Abnorm Psychol. 2018; 127: 623-638.
56. Souza and MM. Pharmacological and psychotherapeutic treatment of intoxication and withdrawal up to a-motivational syndrome. Presentation of the book. Addictions: Comprehensive view of their problems. dual pathology. International Congress 50 Years 1066-2016 APM and I International Congress AILANCYP. For a unified view of the psyche and the brain. Mexican Association of Psychiatry, AC and Ibero-Latin American Association of Neurosciences and Psychiatry. Puerto Vallarta, Jalisco. Mexico. 2016.
57. Izaak L, David me-Lee W. Coparticipative Adherence: The Reconstruction of Discharge Categories in the Treatment of Substance Use Disorders. Alcoholism Treatment Quarterly. 2017; 35: 279-297.
58. UNODC. Drug use prevention, treatment, and care. 2019. United Nations Office on Drugs and Crime (UNODC) Vienna, Austria. 2022.
59. Souza and MM. Dual Diagnosis, Addictive Disorders and Psychosexual Pathology in HLBT. Sexual egodystonia and gender dysphoria. Editorial Prado, Mexico, 2022.
60. Vedat Şar V, Türk-Kurtça T. The Vicious Cycle of Traumatic Narcissism and Dissociative Depression among Young Adults: A Transdiagnostic Approach. J Trauma dissociation. 2021; 22: 502-521.
61. Freudenreich O. Psychiatric rehabilitation and recovery. In: Psychotic disorders. Current Clinical Psychiatry. Human, Cham. 2020.
62. Sapag JC, Sena BF, Bustamante IV, Bobbili SJ, Velasco PR, Mascaiano F, et al. Stigma towards mental illness and substance use issues in primary health care: Challenges and opportunities for Latin America. Globe Public Health. 2018; 13: 1468-1480.
63. WHO World Report on Disability - WHO, World Bank. 2014. World Health Organi- zation, Geneva, 2014.
64. Van der Meer L, Wundernink C. Contemporary focuses on health rehabilitation. Epidemio-logy and Psychiatric Sciences. 2019; 28: 9-14.
65. Fernández-Catalina P, Ballesteros-Pérez F. Psychosocial rehabilitation of people with mental disorders: a model for community recovery and integration. Edupsykhé. J Psychology Education. 2019; 16: 15-36.
66. Souza and MM. Stigma, ethics, and professional therapy in Dual Pathology. Mexican Psychiatric Association, AC Psychiatry. 2014; 1: 25-30.
67. Shapero BG, Farabaugh A, Terechina O, DeCross S, Cheung JC, Fava M, et al. Understand the effects of emotional reactivity on depression and suicidal thoughts and behaviors: moderating effects of childhood adversity and resilience. J Affection Disord. 2019; 245: 419-427.
68. Yeh HH, Westphal J, Hu Y, Peterson L. Diagnosed Mental Health Conditions and Risk of Suicide Mortality. Serv. 2019.
69. Gil J. The inner child, resilience, trauma. Resilience as a response to childhood trauma. Barcelona. Gestalt therapy. 2020.
70. McLafferty M, Armor C, Bunting B. Coping, stress, and negative childhood experiences: The link to psychopathology, self-harm, and suicidal behavior. Psych J. 2019; 293-306.
71. Dirks S. Empowering Rather Than Hindering: Challenges in Participatory Development of Cognitively Accessible Software. HCI. 2019.
72. Saha S, Chauhan A, Buch B, Makwana S, Vikar S, Kotwani P, et al. Psychosocial rehabilitation of people living with mental illness: Lessons learned from community-based psychiatric rehabilitation centers in Gujarat. J Family Medicine and Primary Care. 2020; 9: 892-897.

73. Cho MS. Stigma and life satisfaction among out-of-school Korean youth: the mediating roles of self-esteem and depressive symptoms. Curr Psychol. 2021.
74. Crujiente AH, Gelder MG, Rix S, Meltzery HI, Rowlands OJ. Stigmatization of people with mental illness. British J Psychiatry. 2018; 177: 4-7.
75. Souza y Machorro M, Cruz MDL. On Nosography, Polysemy and Psychiatric Clinic. Rev Mex Neuroci. 2008, January-February 9 (1):38-46. In: Souza and MM. Addictive and Sexual Disorders. (Dysfunctions, Identity, paraphilias, Orientation and Egodystonia) in HLBT people. Dual pathology. Editorial Prado. Mexico, 2022.
76. McLafferty M, Armour C, Bunting B. Coping, stress, and negative childhood experiences: The link to psychopathology, self-harm, and suicidal behavior. Psych J. 2019.
77. Lyman MD. Drugs in society. Causes, concepts, and control. 8th Edition. Routledge, 2017.
78. Stucki G, Bickenbach J. Functioning: the third indicator of health in the health system and the key indicator for rehabilitation. Eur J Phys Rehabil Med. 2017; 53: 134-138.
79. United Nations Office on Drugs and Crime. UNODC. Introductory Handbook on the Prevention of Recidivism and the Social Reintegration of Offenders Criminal Justice Handbook Series United Nations Vienna, 2018.
80. United Nations Office on Drugs and Crime Vienna Custodial and Non-Custodial Measures Social Reintegration Criminal Justice Assessment Toolkit United Nations New York, 2006.
81. EMCDDA. Social reintegration and employment: evidence and interventions for drug users in treatment. The European Monitoring Center for Drugs and Drug Addiction, EMCDDA, Lisbon, 2012.
82. Souza and MM. Concept and evolution of alcohol dependence disorder. Mexican Society of Neurology, Neurosurgery and Psychiatry. J Neurology Psychiatry. 2018; 46: 14-30.
83. Yule A, Kelly JF. Integration of treatment for concurrent mental health conditions. Alcohol Res. 2019; 40.
84. Kaplan O, Nussio E. Community Counts: The Social Reintegration of Ex-Combatants in Colombia. Social Science Electronic Publishing, Inc., 2015.
85. Ponce Martinez C. Concurrent psychiatric disorders. In: Marienfeld, C. (eds) Absolute Addiction Psychiatry Review. Springer, Cham. 2020.
86. Sundin EC, Mrowiec A, Bowpitt G, Boatman CHA, Williams AJ, Sarkar M, et al. Feasibility and acceptability of an intervention to improve reintegration in adults with experience in homelessness. European J Public Health. 2020; 30: 578- 583.
87. Ford JH, Kaur A, Rao D. Improve access to medications within integrated treatment for people with co-occurring disorders in substance use treatment agencies. Research and Implementation Practice. 2021.
88. Bose J, Hedden SL, Lipari RN. Key Substance Use and Mental Health Indicators in the United States: Results From the 2017 National Survey on Drug Use and Health. Rockville, MD: Center for Behavioral Health, Substance Abuse, and Mental Health Services Administration Statistics and Quality. 2018.
89. Souza y MM. Patología dual y el problema de la rehabilitación y reintegración social. Sociedad Médica del Hospital Psiquiátrico Fray Bernardino Álvarez. Secretaría de Salud, México. Revista Psiquis. 2018, 27: 13-23.
90. Iqbal MN, Levin CJ, Levin FR. Treatment for substance use disorder with concurrent mental illness. Focus. Am Psychiatr Publ. 2019; 17: 88-97.
91. McGovern M. Living with co-occurring addiction and mental health disorders. A handbook for recovery. Dartmouth Medical School. Hazelden Publishing, 2020.
92. Dom G, Moggi F. Co-occurring Addictive and Psychiatric Disorders: A Practice-Based Handbook from a European Perspective. Springer, 2020.
93. Chakraborti S, Jahanara M. Gajendragad M. Reintegration of Mentally Ill Persons into Community - Strengthening Social Network, IOSR. J. Humanities and Social Science (IOSR-JHSS) 2015; 4: 52-55.
94. Vranda MN, Ranjith J, Febna M, Sreelakshmi PS. Reintegrating Homeless Patients with Mental Illness (HPMI) into the Community: Challenges Faced During the COVID-19 Pandemic. India J Psicológica Medicina. 2021; 43: 257-260.
95. SM S, Baikady R, Sheng-Li C, Sakaguchi H. Introducción: Social Work:A Profession Without Limits: Debates on Global and Contextual Social Work. In: SM. S; Baikady R; Sheng-Li C; Sakaguchi H. (eds) The Palgrave Handbook of Global Social Work Education. Palgrave Macmillan, Cham. 2020.
96. Souza y MM. El papel del lenguaje en el manejo profesional de la patología dual. Asociación Psiquiátrica Mexicana. A.C. Psiquiatría. 2017; 1: 28-45.