

# Co-occurring Substance Use and Mental Health Disorders in Adults:

*An Integrated Treatment Approach to Dual Diagnosis*



**TRAINER'S MANUAL**



The Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

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Published by the Northeast Addiction Technology Transfer Center (NEATTC.)  
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At the time of this printing, Charles G. Curie, MA, ACSW, served as the SAMHSA Administrator. H. Westley Clark, MD, JD, MPH, served as the Director of CSAT., and Catherine D. Nugent served as the CSAT Project Officer.

The opinions expressed herein are the views of the ATTC Network and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA or CSAT. No official support or endorsement of DHHS, SAMHSA or CSAT for the opinions described in this document is intended or should be inferred.



# MISA TRAINER'S MANUAL DEVELOPMENT

**The** Northwest Behavioral HealthNet Training Subcommittee on MISA Curriculum developed this Mental Illness Substance Abuse (MISA) Trainer's Manual in conjunction with Gannon University through a grant funded by the Northeastern States Addiction Technology Transfer Center. Northwest Behavioral HealthNet is a consortium of 22 behavioral health agencies that provide services in Erie County, PA.

Kenneth Minkoff, M.D., provided Professional consultation for this project. Dr. Minkoff is the Director of Integrated Psychiatric and Addiction Services for Arbour Health System, and the Medical Director of Choate Health Management. He is a Board Certified psychiatrist with a certificate of additional qualifications in Addiction Psychiatry. He is a nationally known expert on dual diagnosis and the integration of mental health and substance disorder services. He has authored and edited numerous works, including "Dual Diagnosis of Serious Mental Illness and Substance Disorder," which he co-edited with Robert Drake, M.D. Dr. Minkoff is also Chair of the Center for Mental Health Services Public Managed Care Initiatives Panel on Co-occurring Psychiatric and Substance Disorders, and a member of the board of the American Association of Community Psychiatrists. Areas of consultation expertise include: psychiatric and addiction integration, managed care systems development, quality management, physician management, contracting and reimbursement, utilization management and levels of care assessment, hospital alternatives for mental health, and substance use disorder.

The manual development was directed by Margaret Shenefelt, MSW, LSW, along with the other members of the Northwest Behavioral Healthnet MISA Training subcommittee. Kathleen Pae, MS, LPC, CAC, provided grant writing and MISA expertise. Cathleen Miner Ashbaugh, M.S., David Rosswog, M.A. and Debra Thaler, M.A. of Gannon University designed and authored the manual under contract with the Northwest Behavioral Healthnet. Robert Nelson, Ed.D., Training Director and Chair of the Psychology Department of Gannon University, was an additional consultant to the project.



The current edition of this curriculum was completed in the Fall of 2005 and contains the newest information available on Co-occurring Disorders in Adults. This edition was re-written by Margaret Shenefelt, MSW, LSW and Kathleen Pae, MS, LPC, CAC. Thanks go to Joan Leary, Alabama Manager for the Southern Coast Addiction Technology Transfer Center, at University of Alabama-Birmingham and Kathy Seifried, Alabama Department of Mental Health, Substance Abuse Division, and the forty Co-Occurring Trainers from Alabama who gave us invaluable feedback for the revisions needed. The second edition revision was funded and supported by the Northeast Addiction Technology Transfer Center at the Institute for Research, Education and Training in Addictions (IRETA) in Pittsburgh, PA.

Included in this manual are trainee and trainer rating and evaluation scales to provide for ongoing improvement and adjustments by both trainers and trainees. If you have questions, suggestions or need additional help as a trainer, or would like to hire a trainer for this curriculum, please contact:

NEATTC/IRETA  
Regional Enterprise Tower  
425 Sixth Avenue, Suite 1710  
Pittsburgh, PA 15219  
412-258-8565  
[www.neattc.org](http://www.neattc.org)  
[www.ireta.org](http://www.ireta.org)  
[www.pa-co-occurring.org](http://www.pa-co-occurring.org)

# AUDIO/VIDEO RESOURCE INFORMATION

## CONTENT:

### MODULE 1

Minkoff, K. (2000). *Dual Diagnosis: An integrated model for the treatment of people with co-occurring psychiatric and substance disorders*. A lecture by Kenneth Minkoff. Brookline Village, MA: Mental Illness Education Program Videos, 2000. Available at: [www.kennethminkoff.com](http://www.kennethminkoff.com) or call 1-800-343-5540.

SAMHSA, Video VHS 167, *When Addiction and Mental Disorders Co-Occur*, 2003. Available at: [www.samhsa.gov](http://www.samhsa.gov).

### MODULE 2

Csernansky, J., Department of Psychiatry, Washington University School of Medicine, Malcolm Bliss Mental Health Center. (1994). *Diagnosis according to the DSM-IV: Real patients talking about their problems in their own words*. Tapes 1-4. Produced & directed by Wohl, I., Only Child Motion Pictures, Inc. A Newbridge Professional Program. New York: Brooks/Cole Publishing Company.

Linehan, Marsha, Pfizer Inc., *Life After Trauma: What Every Person Should Know*, TL334Y99, 2000. Available from: Pfizer Inc.

### OPTIONAL AUDIO TAPE

Virtual Hallucinations, a simulation of auditory hallucinations. (1997) Janssen Pharmaceutical. No longer available from Janssen, but your local NAMI chapter will probably have a copy somewhere in their library.

### MODULE 3

Csernansky, John, MD, Department of Psychiatry, Washington University School of Medicine, Malcolm Bliss Mental Health Center. (1994) "Diagnosis according to the DSM-IV: Real patients talking about their problems in their own words". Tape 3. Produced by Ira Wohl, Only Child Motion Pictures, Inc. A Newbridge Professional Program. New York; Brooks/Cole Publishing Co.

# AGENDA

## AGENDA MODULE 1~ 6 HOURS INSTRUCTION TIME

- Introduction (*60 minutes*)
- Historical Trends & Barriers to Integrated Treatment (*30 minutes*)
- BREAK (*15 minutes*)
- Definitions and Principles of Integrated Treatment Approach to Dual Diagnosis (*90 minutes*)
- LUNCH (*60 minutes*)
- The Process of Recovery (*60 minutes*)
- Other Models of Dual Diagnosis Treatment (*30 minutes*)
- BREAK (*15 minutes*)
- Cultural Differences: Implications for Practitioner's Role & Intervention (*75 minutes*)
- Summary, Post-test & Evaluation (*15 minutes*)

## AGENDA MODULE 2 ~ 6 HOURS INSTRUCTION TIME

- Introduction (*30 minutes*)
- What is a Mental Disorder? (*30 minutes*)
- Review of DSM -IV and DSM-IV TR (*30 minutes*)
- BREAK (*15 minutes*)
- Risk Assessment (*30 minutes*)
- Multi-axial Assessment (*45 minutes*)



# AGENDA

## AGENDA MODULE 2 ~ CONTINUED

- LUNCH (*60 minutes*)
- Axis I Disorders (*90 minutes*)
- BREAK (*15 minutes*)
- Axis II Disorders (*45 minutes*)
- Summary, Post-test & Evaluation (*15 minutes*)

## AGENDA MODULE 3 ~ 6 HOURS INSTRUCTION TIME

- Introduction & Review of Goals and Agenda (*30 minutes*)
- Definitions & Considerations: Substance Related Disorders (*60 minutes*)
- BREAK (*15 minutes*)
- Treatment Selection and Modalities (*30 minutes*)
- Substance Abuse Diagnosis in the DSM-IV-TR (*60 minutes*)
- LUNCH (*60 minutes*)
- Substance Abuse Diagnosis Continued (*45 minutes*)
- Drugs of Abuse Exercises (*60 minutes*)
- BREAK (*15 minutes*)
- Continue Drugs of Abuse Exercises (*60 minutes*)
- Summary, Post-test & Evaluation (*15 minutes*)

# **Co-occurring Substance Use and Mental Health Disorders in Adults**

*An Integrated Treatment Approach to Dual Diagnosis*

## **MODULE ONE: Integrated Concepts and Approaches**

# MODULE 1 HANDOUTS

- 1.0 Pre-test (Optional)
- 1.2 Definition of Serious Mental Illness—PA MH Bulletin
- 1.7a Levels of Functioning
- 1.7b Mini Cases
- 1.18 Four Categories of Client Resistant Behavior (adapted from Miller & Rollnick)
- 1.19 Counselor Responses that Heighten Resistance  
(adapted from Gordon, 1970; Miller & Jackson, 1985)
- 1.20 The Four“R’s” Other Than Resistance
- 1.21 Strategies for Handling Resistance  
(adapted from Miller & Rollnick, 1991, p 102-110)
- 1.22 Language that may decrease resistance, adapted from O’Hanlon, 1994.
- 1.24 Vignettes
- 1.28 Stages of Change—Prochaska and DiClemente
- 1.29 Qualities Which May Complicate Ambivalence
- 1.31 Three Barriers to Effective Multicultural Counseling
- 1.32 Culture Exercise
- 1.34 Case Study
- 1.35 Post-test (Optional)
- 1.36 Module 1 Evaluation

## HANDOUT 1.0 / PRE-TEST

### PRE-TEST

1. When people present with both substance abuse and a mental illness, it is important to determine which diagnosis is primary.  
True                      False
2. "Integrated Treatment" is defined as evidence-based or correct practice for treating dual diagnosis clients that combines techniques resulting in one "best" way.  
True                      False
3. Dual diagnosis is the exception in most cases.  
True                      False
4. Substance abuse and dependence are really moral issues due to personal weakness.  
True                      False
5. Psychiatric diseases in substance abusers occur at about the same rate as in the normal population.  
True                      False
6. One must be willing to explore new methods of treatment that take into account a client's specific cultural differences when working with multicultural clientele.  
True                      False
7. Multiple cycles of relapse usually occur before engagement in ongoing treatment can work.  
True                      False
8. Motivation enhancement theory postulates that the counselor's task is to release each client's potential for change and to facilitate natural change processes already inherent in the individual.  
True                      False
9. The most significant predictor of treatment success is the presence of an empathic, hopeful, continuous treatment relationship with integrated treatment and coordination of care.  
True                      False
10. There are few parallels between mental health disorders and substance disorders.  
True                      False

## **HANDOUT 1.2 / DEFINITION OF SERIOUS MENTAL ILLNESS— PA MH BULLETIN**

### **HIGHLIGHTS OF THE MENTAL HEALTH BULLETIN—COMMONWEALTH OF PENNSYLVANIA—MARCH 4, 1994**

**PURPOSE:** to establish the Adult Priority Group for planning and service development for adults with serious mental illness.

#### **DEFINITION OF “SERIOUS MENTAL ILLNESS” INCLUDES:**

- Persons 18 or over who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder according to DSM criteria.
- This has resulted in functional impairment that interferes with or limits major life activities.
- Disorders include those listed in the DSM with the exception of “V” codes, substance use disorders, and developmental disorders, unless they co-occur with other serious mental illness.
- Functional impairments affect: basic living skills (eating, bathing, dressing), instrumental living skills (managing money, getting around the community), and functioning in social, family and vocational contexts.
- These definitions are required to be used to aid in treatment planning and providing services under the Center for Mental Health Services Block Grant Program.
- Pennsylvania used this definition to establish an Adult Priority Group:
- Must be 18+ and meet the federal definition of serious mental illness (see above.)
- Must have a diagnosis of schizophrenia, major mood disorder, psychotic disorder, or borderline personality disorder
- Must meet at least one of the following criteria from A. (Treatment History), B. (Functioning Level), or C. (Coexisting Condition or Circumstance).

#### **A. TREATMENT HISTORY**

1. Current residence in or discharge from a state mental hospital within the past two years.
2. Two admissions to community or correctional inpatient psychiatric units or crisis residential services totaling 20 or more days within the past two years.
3. Five or more face to face contacts with walk-in or mobile crisis emergency services within the past two years.
4. One or more years of continuous attendance in a community mental health or prison psychiatric service within the past two years.
5. History of sporadic course of treatment as evidenced by at least three missed appointments within the past six months, inability or unwillingness to maintain medication regimen or involuntary commitment to outpatient services.
6. One or more years of treatment for mental illness provided by a primary care physician or other non-mental health agency clinician within the past two years.

#### **B. FUNCTIONING LEVEL:**

1. Global Assessment of Functioning Scale rating of 50 or below.

#### **C. COEXISTING CONDITION OR CIRCUMSTANCE:**

1. Coexisting diagnosis or psychoactive substance use disorder, mental retardation, HIV-AIDS, or sensory, developmental or physical disability.
2. Homelessness
3. Release from criminal detention

Any adult who has met the standards for involuntary treatment within the 12 months preceding the assessment is automatically assigned to the high priority consumer group.

*Summarized from the Mental Health Bulletin, Commonwealth of Pennsylvania, Department of Public Welfare, March 4, 1994.*

### **Complicated Chemical Dependency**

#### **Psych-Low, Substance-High**

Patients with alcoholism or drug addiction who have significant psychiatric symptomatology and/or disability but who do not have serious and persistent mental illness. This category includes individuals who have both substance-induced psychiatric disorders and substance exacerbated psychiatric disorders. Psychiatric syndromes found in this category include:

- Anxiety/Panic Disorder
- Depression/Hypomania
- Psychosis/Confusion
- PTSD Symptoms
- Suicidality
- Violence
- Symptoms Secondary to Misuse/Abuse of Psychotropic Medication
- Personality Traits/Disorder

### **Substance Abusing Mentally Ill**

#### **Psych-High, Substance Low**

Patients with serious and persistent mental illness, which is complicated by substance abuse, whether or not the patient sees substances as a problem.

- Schizophrenia
- Major Affective Disorders with Psychosis
- Serious PTSD

### **Substance Dependent Mentally Ill**

#### **Psych-High, Substance-High**

Patients with serious and persistent mental illness, who also have alcoholism and/or drug addiction and who need treatment for addiction, for mental illness, or for both. This may include sober individuals who may benefit from psychiatric treatment in a setting which also provides sobriety support and twelve step programs.

### **Substance Abuse & Non Severe Psychopathology**

#### **Psych-Low, Substance-Low**

Patients, who usually present in outpatient settings with various combinations of psychiatric symptoms and patterns of substance misuse and abuse, but not clear-cut substance dependence.

- Anxiety
- Depression
- Family Conflict

## HANDOUT 1.7B / LEVELS OF FUNCTIONING & TREATMENT PLANNING— MINI-CASES

**NICOLE:** Twenty-eight years of age, married for eight years, and the mother of two children in elementary school, Nicole has watched her drinking patterns change over the previous several years. She had been a social drinker since high school, but her consumption has changed in nature during her years of marriage. She was drinking not only socially, but also in the afternoons by herself. She awakened one morning and realized that even before she got out of bed, she was thinking of that first drink. Nicole's marriage is deteriorating as her drinking worsens. Intimacy is gone, and Nicole describes herself as "sinking deeper into a pit", not having any interest in her relationships, career, or children. She has noticed changes in her eating and sleeping patterns and has experienced suicidal thoughts.

**JOE:** Joe was released from the state hospital five years ago, when his psychotic symptoms of delusions and hallucinations became manageable with medication and the services of an intensive case manager. He is currently unemployed, lives in his own apartment, and attends a day treatment program sporadically. Joe's case manager noticed a change in his functioning three months ago, when Joe began a friendship with a neighbor. He began expressing dissatisfaction with his social situation and frustration about not feeling able to hold a job or date. He missed several appointments and became unreliable on his medication. During a home visit, Joe's ICM found Joe intoxicated with a large supply of alcohol in his home. Joe was off his medication and presenting disorganized thought and behavior as well as suicidal ideation.

**MELODY:** By the time she was admitted to the hospital, Melody was talking a mile a minute. Her movements were rapid and erratic. At the slightest provocation, she flew into a rage. She had not slept in three nights and her eyes gleamed with intense excitement. In obtaining a history from Melody's mother, the therapist found that this was Melody's second manic episode in the last 6 months. Melody was attending the local community college and struggling academically and socially. She experienced weeks of lethargy, sadness, and lack of motivation. Melody's mother also reported that Melody had been arrested twice for cocaine possession and that her drug use began in early adolescence with marijuana use and progressed to cocaine use more recently. She has relapsed from two residential treatment stays for substance abuse. Melody later confirmed that she used cocaine to escape and sought a heightened state when she was feeling depressed.

**JAKE:** Jake is an unemployed construction worker who is unmarried. He has fathered three children with his girlfriend. He is able to work when work is available, but he doesn't go out of his way to look for extra jobs. He sees his children only when his relationship with his girlfriend is going well. He reports drinking about a six pack of beer a night, and lately says he is beginning to get weird feelings of his heart beating fast and his breathing getting weak. He reports feeling as though he is having a heart attack. Upon numerous visits to the clinic, his physician has not found any physical basis for his feelings. He doesn't believe it, but the clinic referred him for mental health services.

## HANDOUT 1.18 / FOUR CATEGORIES OF CLIENT RESISTANT BEHAVIOR

(ADAPTED FROM MILLER & ROLLNICK, 1991, P. 101-102)

- 1. ARGUING:** The client contests the accuracy, expertise or integrity of the therapist.
  - **Challenging:** The client directly challenges the accuracy of what the counselor has said
  - **Discounting:** The client questions the counselor's personal authority and expertise
  - **Hostility:** The client expresses direct hostility toward the counselor.
  
- 2. INTERRUPTING:** The client breaks in and interrupts the counselor in a defensive manner.
  - **Talking over:** The client talks while the counselor is still speaking.
  - **Cutting off:** The client breaks in with words intended to cut the counselor off, like "Now wait a minute" or "I've heard about enough."
  
- 3. DENYING:** The client expresses an unwillingness to recognize problems, cooperate, accept responsibility or take advice.
  - **Blaming:** The client blames other people for problems.
  - **Disagreeing:** The client disagrees with a suggestion the counselor has made, offering no constructive alternative. This includes the familiar "yes, but..."
  - **Excusing:** The client makes excuses for his or her own behavior.
  - **Claiming impunity:** The client claims that he or she is not in any danger, for instance, from drinking.
  - **Minimizing:** The client suggests that the counselor is exaggerating risks or dangers and that it "really isn't so bad."
  - **Pessimism:** The client makes general statements about self or others that are pessimistic, defeatist or negativistic in tone.
  - **Reluctance:** The client expresses reservations and reluctance about information or advice given.
  - **Unwillingness to change:** The client expresses a lack of desire or unwillingness to change, or an intention not to change.
  
- 4. IGNORING:** The client shows evidence of not following or ignoring the counselor.
  - **Inattention:** Client response indicates that he or she has not been attending.
  - **Non-answer:** In answering the counselor's query, the client gives a response that is not an answer to the question.
  - **No response:** Inaudible or non-verbal reply.
  - **Sidetracking:** Client changes direction of the conversation that the counselor has been pursuing.



## **HANDOUT 1.19 / COUNSELOR RESPONSES THAT HEIGHTEN RESISTANCE**

(ADAPTED FROM GORDON, 1970; MILLER & JACKSON, 1985)

**Never meet the resistance head on, because certain kinds of reactions are likely to exacerbate resistance. These responses include:**

- Arguing, disagreeing, challenging
- Judging, criticizing, blaming
- Warning of negative consequences
- Seeking to persuade with logic or evidence
- Interpreting or analyzing the “reasons” for resistance
- Confronting with authority
- Using sarcasm or incredulity

## HANDOUT 1.20 / THE FOUR “R’S” OTHER THAN RESISTANCE

**RELUCTANT:** Pre-contemplators, due to lack of knowledge or inertia do not want to consider change. To these people the recognition of the problem has not become fully conscious and they are reluctant to change. The technique of providing feedback in a sensitive empathic manner can be most helpful for them.

**REBELLIOUS:** Addicts have a heavy investment in the problem behavior and in making their own decisions. They are resistant to being told what to do. Rebellion may be a residue of prolonged adolescence or the result of insecurity and fears. The rebellious pre-contemplators will appear hostile and resistant to change. This type of client does have a lot of energy invested in the problem behavior. The real task is trying to shift some of that energy into contemplating change rather than resistance or rebellion.

**RESIGNED:** These clients have given up on the possibility of change and seem overwhelmed by the problem. Instilling hope and exploring barriers to change are the most productive strategies for this group.

**RATIONALIZING:** These clients have all the answers. These clients are not considering change because they know all about it and the problem is a problem for others and not for them. Empathy and reflective listening seem to work best with this type of client.

## **HANDOUT 1.21 / STRATEGIES FOR HANDLING RESISTANCE (ADAPTED FROM MILLER & ROLLNICK, 1991, P 102-110)**

**SIMPLE REFLECTION:** A simple acknowledgement or a reflective listening statement of the client's disagreement, emotion, or perception can permit further exploration rather than defensiveness. Avoid playing out the confrontation-denial trap.

**DOUBLE SIDED REFLECTION:** A form of reflective listening which acknowledges what the client says, but adds to it the other side of the client's ambivalence. This requires use of materials that the client can offer from previous sessions or statements.

**AMPLIFIED REFLECTION:** Reflect back what the client has said in an amplified or exaggerated form. The response should be straightforward, not sarcastic or hostile.

**SHIFTING FOCUS:** This technique amounts to going around barriers rather than trying to climb over them. This is a good way to diffuse resistance when encountering a difficult issue.

**AGREEMENT WITH A TWIST:** This technique to resistance is to offer initial agreement, but with a slight twist or change. This allows the client and counselor to agree, but also the counselor continues to influence in the direction of change.

**EMPHASIZING PERSONAL CHOICE AND CONTROL:** When people believe their freedom is being impinged upon, they assert the position "I'll show you!" You can avoid this situation by allowing them to have choice.

**REFRAMING:** Another method to deal with resistance is to reframe the information that the client is offering. This is useful when a client is offering arguments that serve to deny a personal problem. This approach acknowledges the validity of a client's observation, but offers a new meaning or interpretation for them. It puts the client's information into a new form more helpful and supporting of change.

**THERAPEUTIC PARADOX:** This is a more risky technique in dealing with resistance but can be used as prescribing the problem; the client should continue on as before without changing or increase the behavior.

## **HANDOUT 1.22 / LANGUAGE THAT MAY DECREASE RESISTANCE (ADAPTED FROM O'HANLON, 1994)**

- Refer to the problems in the past tense using “were” or “have been”.
- Create expectance for positive change, using “when”, “yet”.
- Re-label, normalize, generalize
- Give credit, validate
- Assume the problem is not always occurring and ask questions
- Depict a time when the problem does not occur
- Resist invitations to blame and non-accountability
- Invent new names and labels
- Avoid using terms like accident or bad habit

### **ACCENTUATE THE POSITIVE**

- Find other people who do not view the client as disabled or disordered.
- Find out about hidden or non-obvious aspects of the client’s life which do not fit or are incompatible with their disempowered (hopeless, helpless or stuck) views about themselves or the problem. Ask the client how he/she explains the incompatibility. Search for other contexts of competence.
- Find out about their best moments in thinking about or experiencing themselves.
- Find and connect them with others who may have experienced similar things or struggles and either found different ways to think about it or deal with it. This can be through books, tapes, and letters or support groups.
- Normalize by letting them know that others have or do experience similar feelings.
- Find out when the client has not experienced their problems when they expected they would.
- Find evidence of choice in regard to the problem.
- Find exceptions to the problem behavior.

## HANDOUT 1.24 / VIGNETTES

1. Client is a mother of two on public assistance “enrolled” in a methadone maintenance treatment program where you work. The mother has been reported to CPS by a neighbor who was “concerned about your children being left alone.” The intake counselor knows about the investigation and told you that the worker, upon the first visit, found no evidence to substantiate neglect.
2. Client is a 33-year-old fireman proud of being in his profession. Client has been abusing cocaine regularly for the past two years. He does not admit to having a problem. The family tolerates alcoholism but feel negative towards drug abusers. At work, when he disappears to make his cocaine run, his workers cover for him. His wife has told him how frustrated and angry she is about his behavior. He entered a detox program after two workplace incidents and an ultimatum from his wife. He has completed detox and this is his first session with you in an outpatient clinic. It is evident to you that he is willing to recognize the seriousness of his use. He begins by telling you that he is not going to attend any 12-step program, he just wants to do what is necessary to return to full work status and get his wife “off his back.”
3. Client is presently living in a shelter. One of the conditions to remain in the shelter is to attend a treatment program. You saw the client last week for an initial session. The information that you now have is that your client has used alcohol and cocaine for over ten years and has been in three different treatment programs. For the past year, the client has been homeless and living in the streets. Client is aware of positive HIV diagnosis but reported not following any regular medical treatment. There was no family or significant other mentioned during the initial session.
4. You work in an inpatient detox unit. You have seen this patient during a prior inpatient stay. The patient was hospitalized because of depression and suicidal ideation. This will be your initial meeting during this hospitalization.
5. You are a counselor working in an outpatient treatment center and have been working with this client for one month. Client’s attendance has been irregular. The last test indicated marijuana usage. Client has told you that they want to “work the program.” When you discuss the reason for the absences the answers refer to: court appointments, lack of money, as well as simple answers like “too much trouble.” At the end of this week’s team meeting, you were told that unless client has consistent attendance this week they have to be released from the program.
6. Client is a professional that was referred by the company’s physician, after having an annual physical, which had indications of liver damage. The physician reported that the client reported blackouts, symptoms of depression and requested tranquilizers. Client is confused as to why a referral to EAP was made. Client presents no anger but is confused. During the interview the client has difficulty remembering some information, dates and important events, in his/her life. Client has been divorced for 16 years and reported having no contact with his/her two children.

## HANDOUT 1.28 / STAGES OF CHANGE—PROCHASKA AND DICLEMENTE

STAGE	CLIENT RESPONSE	MOTIVATIONAL TASKS FOR COUNSELOR
Stage I Precontemplation	No problem or need to make a change.	Raise doubt and provide information to increase client's perception of risks and problems with current behavior.
Stage II Contemplation	Considers change and rejects it. "Tipping the Balance"	Tip the balance—evoke questions to change, risks of not changing; strengthen the client's self-efficacy for change of current behavior, but no action.
Stage III Determination	Window of opportunity when a client considers change and develops a commitment to action.	Help client determine the best course of action to take in seeking change.
Stage IV Action	A particular action to solve or change the problem and begins to implement the solution or plan.	Help client take steps towards change.
Stage V Maintenance	Develops new behaviors to maintain changes and solution.	Help client identify and use strategies to prevent relapse.
Stage VI Relapse	Normal, expected but encouraged to start again.	Help client renew process of contemplation, determination, and action, without becoming stuck or demoralized because of relapse.

## HANDOUT 1.29 / QUALITIES WHICH MAY COMPLICATE AMBIVALENCE

- **VALUES**—People have particular value systems, which may impact their willingness to change. Treatment may be appreciated by some, yet has little importance to others.
- **EXPECTANCIES**—People have particular expectations about results, both positive and negative. The expectations can have a powerful impact. For example, someone who wants to stop drinking may not make an effort to do so in the belief that he or she will fail.
- **SOCIAL CONTEXT**—Social and cultural phenomena affect people’s perception of their population or behavior and as a result, impact their costs and benefits scale.
- **PARADOXICAL RESPONSES**—An external request to increase a particular behavior does not mean change is more likely.
- **IMPAIRED CONTROL**—Impairs one’s ability for self-control and being able to make good judgements.

# HANDOUT 1.31 / THESE 3 CHARACTERISTICS CREATE BARRIERS TO PROVIDING EFFECTIVE MULTICULTURAL COUNSELING

(SUE & SUE, 1999)

1. **CULTURE-BOUND VALUES**—Counseling’s common components are reflective of a white culture in values and beliefs.
  - **Focus on individual**—Counseling is individual centered. It is traditionally a one-to-one activity that encourages clients to talk about and discuss intimate aspects of their lives.
  - **Verbal/emotional/behavioral expressiveness**—Counseling typically demands active involvement from the client.
  - **Insight**—Counseling typically demands insight from the client.
  - **Self-disclosure (openness & intimacy)**—Therapist often expects client to exhibit some degree of openness or sophistication.
  - **Scientific empiricism**—Analytic/linear/verbal (cause-effect) approach; Emphasis on cause-effect relationships—isolated from clients environment/contacts
  - **Distinction between Mental and Physical functioning**—Clear distinctions between mental and physical well being
  - **Ambiguity**—Counseling is typically an unstructured activity.
  - **Patterns of Communication**—Communication is typically from the client to counselor.
2. **CLASS-BOUND VALUES**—counseling typically adheres to strict time schedules, utilizes ambiguous or unstructured approach to problems, and seeks long-term goals or solutions;
  - These class-bound values are typically those of middle and upper class segments of society.
3. **LANGUAGE VARIABLES**—counseling uses Standard English with an emphasis on verbal communication (a monolingual orientation).



## HANDOUT 1.32 / CULTURE AND YOU

You wake up tomorrow morning and find out that you belong to another culture—the culture you randomly selected. How would your life be the same and how would it be different?

### MY NEW CULTURE IS:

My life is the same or different in	SAME	DIFFERENT
1. The friends I associate with	<input type="checkbox"/>	<input type="checkbox"/>
2. The social activities I enjoy	<input type="checkbox"/>	<input type="checkbox"/>
3. The foods I prefer	<input type="checkbox"/>	<input type="checkbox"/>
4. The religion I practice	<input type="checkbox"/>	<input type="checkbox"/>
5. The way I dress	<input type="checkbox"/>	<input type="checkbox"/>
6. The community where I live	<input type="checkbox"/>	<input type="checkbox"/>
7. The home I live in	<input type="checkbox"/>	<input type="checkbox"/>
8. The job/position I hold	<input type="checkbox"/>	<input type="checkbox"/>
9. The car I drive	<input type="checkbox"/>	<input type="checkbox"/>
10. The music I enjoy listening to	<input type="checkbox"/>	<input type="checkbox"/>
11. The language I speak	<input type="checkbox"/>	<input type="checkbox"/>
12. The political party I belong to	<input type="checkbox"/>	<input type="checkbox"/>

*Adapted from: Managing Diversity: A Complete Desk Reference and Planning Guide, Gardenswartz & Rowe, 1993.*

## HANDOUT 1.34 / MULTICULTURAL CASE STUDY

(SUE & SUE, 1999 - PP. 53-54)

One of the most difficult cases I have ever treated was that of a Mexican-American family in southern California. Fernando M. was a 56-year-old recent immigrant to the United States. He had been married some 35 years to Refugio, his wife, and had fathered ten children. Only four of his children, three sons and one daughter resided with him.

Fernando was born in a small village in Mexico and resided there until three years ago when he moved to California. He was not unfamiliar with California, having worked as a “bracero” for most of his adult life. He would make frequent visits to the United States during annual harvest seasons.

The M. family resided in a small, old, unpainted, rented house on the back of a dirt lot that was sparsely furnished with their belongings. The family did not own a car nor was public transportation available in their neighborhood. While their standard of living was far below poverty levels, the family appeared quite pleased at their relative affluence when compared with their life in Mexico.

The presenting complaints concerned Fernando. He heard threatening voices, was often disoriented, stated the belief that someone was planning to kill him, and that something evil was about to happen. He became afraid to leave his home, was in poor physical health, and possessed a decrepit appearance, which made him essentially unemployable.

When the M. Family entered the clinic, I was asked to see them because the bilingual therapist scheduled that day had called in sick. I was hoping that either Fernando or Refugio would speak enough English to understand the situation. As luck would have it, neither could understand me, nor I them. It became apparent, however, that the two older children could understand English. Since the younger one seemed more fluent, I called upon him to act as a translator during our first session. I noticed that the parents seemed reluctant to participate with the younger son and for some time the discussion among the family members was quite animated. Sensing something was wrong and desiring to get the session under way, I interrupted the family and asked the son who spoke the best English, what was wrong. He hesitated for a second, but assured me everything was fine.

During the course of our first session, it became obvious to me that Fernando was seriously disturbed. He appeared frightened, tense, and, if the interpretations from his son were correct, hallucinating. I suggested to Refugio that she consider hospitalizing her husband, but she was adamant against this course of action. I could sense her nervousness and fear that I would initiate action in having her husband committed. I reassured her that no action would be taken without a follow-up evaluation and suggested that she return later in the week with Fernando. Refugio said that it would be difficult since Fernando was phobic about leaving his home. She had to coerce him into coming this time and did not feel she could do it again. I looked at Fernando directly and stated, “Fernando, I know how hard it is for you to come here, but we really want to help you. Do you think you could possibly come one more time? Dr. Escobedo [the bilingual therapist] will be here with me, and he can communicate with you directly.” The youngest son interpreted.

The M. family never returned for another session and their failure to show up has greatly bothered me. Since that time I have talked with several Latino psychologists who have pointed out multicultural issues that I was not aware of then. Now I realize how uninformed and naïve I was in



## HANDOUT 1.36 / EVALUATION—INTEGRATED TREATMENT CONCEPTS & APPROACHES

**INSTRUCTIONS:** Thank you for taking a moment to complete this evaluation and feedback form. Your input will help us to improve the curriculum. Your answers and comments are completely anonymous. *Do not put your name on this form.*

**CODE:** SD=Strongly Disagree, D=Disagree, U=Unsure, A=Agree, SA=Strongly Agree

ITEM	SD	D	U	A	SA
Content was relevant and current.	1	2	3	4	5
The facilitators were organized and had good presentation skills.	1	2	3	4	5
Handouts and audiovisual aids were relevant and helpful.	1	2	3	4	5
The facilitators provided opportunities for discussion and interaction	1	2	3	4	5
The facilitators were knowledgeable in the subject.	1	2	3	4	5
I learned information that will be useful in my current work.	1	2	3	4	5
Overall, this session was effective and informative.	1	2	3	4	5

If you circled one or more items above as a 2 or 3, please give us more information.

The most important thing I learned today was:

If I could change one thing about this session, it would be:

# TRAINING CURRICULUM

1

## CO-OCCURRING SUBSTANCE USE & MENTAL HEALTH DISORDERS IN ADULTS

### Integrated Concepts & Approaches

#### TRAINER NOTE

Both trainers need to introduce themselves to the participants before moving on to Slide 2.



2

### INTRODUCTION

The curriculum of the Co-occurring Disorders in Adults is intended to address the components of co-occurring disorders conceptualization and formulation, system considerations and entry, application of strategies, intervention techniques, ethics and special issues.

This training is aimed at bachelors and masters level staff who are team leaders, clinical supervisors or therapists. This is the level of staff that is optimal to reach to make system changes since they are the leaders of the treatment teams. This training is also beneficial for front line staff who provide services to persons with co-occurring disorders.

3

### AGENDA

- Introduction (60 minutes)
- Historical Trends & Barriers to Integrated Treatment (30 minutes)
- Break (15 minutes)
- Definitions and Principles of Integrated Treatment Approach to Dual Diagnosis (90 minutes)
- Lunch (60 minutes)
- The Process of Recovery (60 minutes)
- Other Models of Dual Diagnosis Treatment (30 minutes)
- Break (15 minutes)
- Cultural Differences: Implications for Practitioner's Role & Intervention (75 minutes)
- Summary, Post-test & Evaluation (15 minutes)

Review the agenda for the day, including when the breaks are planned and that lunch is one hour.



4

## COMPETENCIES

Familiarity with integrated models of assessment, intervention and recovery for persons having both substance-related and other mental disorders as opposed to parallel treatment efforts that resist integration.

Familiarity with the history of treatment and support services in the mental health and drug/alcohol service systems, including ongoing barriers to service integration and current efforts at integration.

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## COMPETENCIES

Capacity to maintain one's professional boundaries, to disagree without being controlling or punitive, to be clear without being harsh and to maintain consistency in one's approach and demeanor.

Comprehension of the effects on functioning and degree of disability related to substance-related and mental disorders, both separately and combined.

Familiarity with data, which support high prevalence of co-morbidity and poor outcomes related to fragmented treatment approaches, as well as data demonstrating improved outcomes related to integrated, continuous treatment approaches.

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## COMPETENCIES

Familiarity with the stage of recovery models when applied to assessment, service planning, selection of treatment and/or support modalities, and expectations of the degree to which the person is active and collaborative in the direction of treatment and responsible for directing his/her own recovery.

Belief in the ability of all persons to learn and grow, including the practitioner's need to refrain from dogmatism of any sort and to maintain flexibility and the willingness to learn from consumers, family members, colleagues, new scientific publications, program data, and life experience.

7

## COMPETENCIES

Develop sensitivity to, and respect for, persons with different disorders, characteristics, and cultural backgrounds, e.g., ethnic, racial, gender, sexual orientation, and socio-economic class.

8

## INTRODUCTORY ACTIVITIES

- Participant Introductions & Expectations
- The Change Exercise
- Review the objective and goals of this module (next slide)
- Review group participation expectations, rules about confidentiality, and the use of cell phones and pagers
- Administer Pre-test (optional) and review





## EXERCISE

- Ask participants to take a few seconds to write down at least one expectation for themselves by the end of this module.
- Next, ask participants to introduce themselves by name, organization, type of work and the expectation they have noted. Note these expectations on a flip chart and post it in the room for use later in the program.

## THE CHANGE EXERCISE

- Facilitate *The Change Exercise*. Ask participants to stand and turn to stand face to face in pairs. Ask them to observe each other silently for 30 seconds. Next, ask them to turn back to back and change three things about themselves. When they are done, ask them to all turn back to face their partner. Each person should take a minute to name the three things their partner has changed. Ask them to repeat this process three more times. You will hear moans and groans by the third time!

## CONTENT

- Process the exercise with the group by asking the following questions and encouraging discussion:
  - What was your comfort level during this exercise?
  - What made you comfortable or uncomfortable?
  - How hard was it to change things the first time? Second? Third?
  - How did you decide what things to change about yourself?
  - What does this exercise tell us about change?
  - Look around you: did people change back to the way they started as soon as they sat down?
  - What implications might this have about change?
- Points that should result from this discussion are below. If the group does not bring them up, you should. As the group calls out these points, write them on a flip chart and hang them in the room for future reference:
  - Change is difficult
  - Change is not always comfortable
  - Change requires creativity
  - We tend to go back to old ways
  - It is easier to stay the same
  - We like our comfort zones
  - Change requires an open mind
  - Change has emotional and cognitive components
- Relate this exercise to the challenges for both participants in looking at the integrated approach and to dual diagnosis clients trying to change their behaviors.
- Make the point that if it is so difficult for us to make these simple changes and to maintain them, then perhaps we can begin to understand this one aspect of our clients who face mental illness and substance use issues. Let's change our way of working with these clients and see if what we learn about an integrated approach to dual diagnosis clients can help us help clients change.

## CONTENT

Review group participation expectations:

- Questions are encouraged as we go along
- Remain open minded
- Show respect for each other's points of view
- Be critical thinkers
- Maintain confidentiality
- Begin to make changes in how you think about persons with co-occurring disorders and how this will affect your work with them



Let participants know that they can take additional breaks when needed but to leave and rejoin the group quietly. Encourage participants to turn off pagers and cell phones. If they cannot, then have them turn them to silent alert and ask that they quietly leave the room before answering their phone.

#### TRAINER NOTE

Administer the Pre-test (optional) Handout 1.0 Ask participants to not put their name on the paper. Review answers on Trainer Aid 1.0

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### OBJECTIVE OF INTEGRATED CONCEPTS AND APPROACHES

**OBJECTIVE:** Participants will gain an understanding of the concept of an integrated approach to the treatment of persons with co-occurring disorders, along with the complexities and challenges that these disorders present for engagement, diagnosis, treatment and recovery.

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### GOALS FOR PARTICIPANTS

At the end of this training module participants are expected to be able to:

1. Describe the historical basis for splits in services and barriers to integrated approaches.
2. List some of Dr. Minkoff's principles and rules for Co-Occurring Disorders.
3. Explain some advantages to an integrated approach to persons with co-occurring disorders.
4. Identify their own challenges in working with culturally diverse clients.
5. Identify an area for change in his/her practice with persons with co-occurring disorders.

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### THE HISTORICAL BASIS FOR SPLITS IN SERVICES AND BARRIERS TO INTEGRATED APPROACHES

#### TRAINER NOTE

- Explain to participants that this section of Module 1 will explore the historic trends that influenced splits in service provisions for mentally ill substance abusers and the barriers to integrated treatment. You will be using lecture, discussion and an exercise in this section.
- Although the content is listed below, you can use your own words to talk about the trends and barriers.
- You may find it helpful to use a chalkboard, dry-erase board or flipchart to list the key points.

#### HISTORICAL TRENDS

##### CONTENT

- Historically, there have been three general approaches used in delivering treatment to the dually diagnosed patient.
  - 1.) Sequential Treatment—treat one disorder first, then the other disorder.
  - 2.) Parallel Treatment—treat both disorders simultaneously but in different settings.
  - 3.) Integrated Treatment—treat both disorders simultaneously in the same setting.





- The goal of an integrated model for assessment, treatment and rehabilitation for mentally ill substance abusers is to provide a common language for mental health clinicians and professionals in the substance abuse field. Treatment is then matched to individuals with co-occurring disorders.
- Kenneth Minkoff, M.D. was chair of an expert panel in 1996 that studied the Co-occurring Psychiatric & Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies and Training Curriculum. These studies are funded by the Substance Abuse Mental Health Services Administration in Washington, DC. Dr. Minkoff is also a consultant to the State of Pennsylvania on systems level interventions. For the past several decades, the service industry has been confronted with treatment issues of dual diagnosis. This is due to two major trends in society:

#### 1.) De-institutionalization

- People with serious, persistent mental illness have been relocated from institutional settings to community-based services. The purpose is to provide more choice in services and self-determination.
- There is a high likelihood that these individuals will use, abuse, or become substance dependent. Use of substances relieves feelings of isolation, loneliness, and despair. With few alternative resources or the presence of cognitive impairments, the risk to turning to psychoactive substances is high.

#### 2.) Changes in the patterns of substance use in society in general

- People are using substances at earlier ages.
- There is more access to substances that can exacerbate the symptoms of mental illnesses
- The last 15 years have led to changes in our understanding of psychiatric diseases. There has been much research into biologically based brain disorders, such as mood disorders, post-traumatic stress disorder, anxiety and depression, rapid cycling disorders, obsessive-compulsive disorder, impulse-control disorders, cognitive impairment disorders, attention deficit hyperactivity disorder, and anger-control disorders.
- We now know that these psychiatric diseases are 2-3 times more common in people who have substance-use disorders.
- We are now more inclined to recognize that people with substance-use disorders may have separate psychiatric disorders that require separate and distinct treatment. We now refer to these individuals as having co-occurring disorders.

#### Decade of the brain:

- Recent advances in the field of neuropsychology, the study of brain based behavior and the roles of neurochemicals in the processes of learning, cognition and emotions have led to an increased understanding of the needs of dual diagnosis individuals.
- For additional information on integrated treatment concepts, including a discussion of advances in co-occurring treatment, please see CSAT's *Treatment Improvement Protocol (TIP) 42: Substance Abuse Treatment for Persons with Co-occurring Disorders*, pp. 10-16.

### BARRIERS TO INTEGRATED TREATMENT

#### TRAINER NOTE

- Ask participants to list some of the differences and barriers they might have noted. List these on a flip chart. Use these to move into the systemic barrier section next.

#### CONTENT

- There have been several organizational barriers to integrated diagnosis and treatment.
- On the state & county governmental levels, there is a formal separation of agencies for alcoholism, drug abuse, and mental health.
- These formal and informal separations have led to separate funding, licensing, and training, eventually leading to competition among the three (alcohol, drug, and mental health).



- In order to ensure the provision of services, government agencies have narrowed target populations for treatment, often considering people to be eligible for services only if they have one proper disorder.
- With these organizational separations, different training barriers developed.
- Training for alcohol and drug abuse counselors in the 1960's and 1970's grew primarily from the experiential philosophy of Alcoholic's Anonymous and Narcotic's Anonymous. Mental health clinicians focused on academic and scientific methods.
- The gap between mental health and substance abuse clinicians widened with disagreements about prescribing medication.

#### TRAINER NOTE

- In this section, you will ask participants to give definitions, explain the concept of integrated approaches, delineate the categories of MISA, review the principles of an integrated approach.
  - Distribute the materials for this section of Module 1 Handouts 1.2
  - Ask participants for their definition of dual diagnosis. You should get responses such as:
    - Co-morbid, Multiple Diagnosis, Co-occurring Disorders, a person with a substance abuse or dependency problem plus a mental illness, a person with mental illness plus substance abuse or dependency.
- (Skip this next section if you are training in a state other than Pennsylvania)
- Review Handout 1.2

#### CONTENT

Highlights of the Mental Health Bulletin, Commonwealth of PA, March 4, 1994

- Purpose: to establish the Adult Priority Group for planning and service development for adults with serious mental illness.
- Definition of "serious mental illness" includes:
  - Persons 18 or over who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder according to DSM criteria.
  - This has resulted in functional impairment that interferes with or limits major life activities.
  - Disorders include those listed in the DSM with the exception of "V" codes, substance use disorders, and developmental disorders, unless they co-occur with other serious mental illness.
  - Functional impairments affect: basic living skills (eating, bathing, dressing), instrumental living skills (managing money, getting around the community), and functioning in social, family and vocational contexts.
  - These definitions are required to be used to aid in treatment planning and providing services under the Center for Mental Health Services Block Grant Program.
- Pennsylvania used this definition to establish an Adult Priority Group:
  - Must be 18+ and meet the federal definition of serious mental illness (see above.)
  - Must have a diagnosis of schizophrenia, major mood disorder, psychotic disorder, or borderline personality disorder
  - Must meet at least one of the following criteria from A. (Treatment History), B. (Functioning Level), or C. (Coexisting Condition or Circumstance).
- A. Treatment History:
  1. Current residence in or discharge from a state mental hospital within the past two years.
  2. Two admissions to community or correctional inpatient psychiatric units or crisis residential services totaling 20 or more days within the past two years.
  3. Five or more face to face contacts with walk-in or mobile crisis emergency services within the past two years.



4. One or more years of continuous attendance in a community mental health or prison psychiatric service within the past two years.
  5. History of sporadic course of treatment as evidenced by at least three missed appointments within the past six months, inability or unwillingness to maintain medication regimen or involuntary commitment to outpatient services.
  6. One or more years of treatment for mental illness provided by a primary care physician or other non-mental health agency clinician within the past two years.
- B. Functioning Level:
    1. Global Assessment of Functioning Scale rating of 50 or below.
  - C. Coexisting Condition or Circumstance:
    1. Coexisting diagnosis or psychoactive substance use disorder, mental retardation, HIV-AIDS, or sensory, developmental or physical disability.
    2. Homelessness
    3. Release from criminal detention
  - Any adult who has met the standards for involuntary treatment within the 12 months preceding the assessment is automatically assigned to the high priority consumer group.  
(Summarized from the Mental Health Bulletin, Commonwealth of Pennsylvania, Department of Public Welfare, March 4, 1994.)

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## **REVIEW ADDITIONAL CO-OCCURRING DISORDERS INFORMATION AND MATERIALS ABOUT INITIATIVES IN YOUR STATE**



If you are presenting this training in a state other than Pennsylvania, please add content for your state here and give participants handouts as needed.

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## **PHILOSOPHICAL & CLINICAL DIFFERENCES**

### **Substance Abuse / Dependence—Mental Illness**

- |                               |  |
|-------------------------------|--|
| • Addiction System            | • Mental Health System                 |
| • Peer Counselor Model        | • Medical/Professional Model           |
| • Spiritual Recovery          | • Scientific Treatment                 |
| • Self-Help                   | • Medication                           |
| • Confrontation & Expectation | • Individualized Support & Flexibility |

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## **PHILOSOPHICAL & CLINICAL DIFFERENCES**

### **Substance Abuse / Dependence—Mental Illness**

- |   |   |
|---|---|
| • Detachment & Empowerment                  | • Case Management & Care                        |
| • Episodic Treatment                        | • Continuity of Responsibility                  |
| • Recovery Ideology                         | • Deinstitutionalization Ideology               |
| • Psychopathology is secondary to addiction | • Substance Use is secondary to Psychopathology |

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## **MORNING BREAK**

Please come back in 15 minutes

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## DEFINITION OF SUBSTANCE ABUSE

A maladaptive pattern of frequent and continued usage of a substance—drug or medicine—that results in significant problems, such as failing to meet major obligations and having multiple legal, social, family, health, work or interpersonal difficulties. These problems must occur repeatedly during a 12 month period to be classified as substance abuse.

“A maladaptive pattern of frequent and continued usage of a substance—a drug or medicine—that results in significant problems, such as failing to meet major obligations and having multiple legal, social, familial, health, work, or interpersonal difficulties. These problems must occur repeatedly during a single 12 month period to be classified as substance abuse.” (Plotnic, 1999)

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## DEFINITION OF SUBSTANCE DEPENDENCE

A maladaptive pattern of substance use leading to clinically significant impairment or distress. May involve tolerance; withdrawal; increase in quantity and frequency of use over time; persistent desire to cut down use; a great deal of time spent to obtain substance; reduction in social, occupational, and recreational activities; and substance use continues despite knowledge of the problem.

### CONTENT

Review the concept of addiction as a disease: addictive substances change the structure of the brain and brain chemistry and this new brain takes over. This newly structured brain is not only triggered by the drug or alcohol itself, but by hundreds of other triggers in everyday life. This is classical conditioning generalization. The cocaine addict might be triggered by the sight of powdered sugar, a road sign, friends, the dealer, someone who looks like the dealer, someone who has the same color hair as the dealer, etc. This is why people with substance disorders need a lot of help. This is like any other mental illness. For instance, you want to cheer up, but your brain is telling you no, you don't want to hear voices, but your brain is producing them anyway, you are sincere about not using anymore, but your brain is demanding you do.

The concept of an integrated approach to co-occurring disorders does NOT mean a special treatment design that combines all substance abuse and mental health treatments into a big single one way-to-treat-only category. We are not going to take a little bit of Substance Abuse/Substance Dependency technique and mix it up with a little Mental Health technique and come out with a magical mystery dual diagnosis treatment. We are going to use some of what we have in a different way. Let's review the basic principles of an integrated approach in treating dual diagnosis clients.

For additional information on the definitions of substance disorders, please see CSAT's *Treatment Improvement Protocol (TIP) 42: Substance Abuse Treatment for Persons with Co-occurring Disorders*, pp. 22-23.

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## VIDEO # 1:

“When Addiction and Mental Disorders Co-Occur”  
( 6 minutes)

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## BASIC PRINCIPLE # 1

The most significant predictor of treatment success is the presence of an empathic, hopeful, continuous treatment relationship, in which integrated treatment and coordination of care can take place through multiple treatment episodes.

### CONTENT

This section begins the information on Dr. Kenneth Minkoff's basic principles for treatment of Adults with Co-occurring Disorders.



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## VIDEO # 2:

**"Dual Diagnosis: An integrated model for the treatment of people with co-occurring psychiatric and substance disorders" Dr. Kenneth Minkoff (17 minutes)**

Encourage discussion and professional experience on this issue by asking these questions:

- How often does an empathic, hopeful and continuous treatment relationship actually take place?
- How often do we see the severely mentally ill and substance dependent or abusive clients come in and wonder what we can really do to help?
- How does the system work right now?
- How can we use our resources differently?



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## BASIC PRINCIPLE # 2

**Dual Diagnosis is an expectation, not an exception.**

How common is co-morbidity?

- What do you think is the occurrence of substance disorders in mental health clients and vice versa? The National Institute of Mental Health conducted an Epidemiological Catchment Area (ECA) survey in the late 1980's and early 1990's, and is generally still respected as the main source of data. However, smaller studies and specific geographic areas vary, often with higher rates than these:
  - Nearly half of those suffering from schizophrenic disorder develop a substance disorder
  - Over 60% of people with bipolar disorder have a co-morbid substance disorder.
  - More than 40% of those with alcohol dependence also have a psychiatric disorder.

Yet our entire system of care is organized as if this were not true.

- Highest consumers have the poorest outcomes, highest costs, and the treatments are least effective.
- Since we are already treating substance abuse and mental health clients, every treatment program in the system has the potential to become a dual diagnosis service provider. It doesn't necessarily cost any more money to treat dually vs. separately.
- Dual competency should be an expectation, not an exception.



**BASIC PRINCIPLE # 3**

Within the context of the empathic, hopeful, continuous integrated relationship, case management, care, empathic detachment and confrontation are appropriately balanced at each point in time.

This will depend on the level of functioning and the phase of recovery (we will be talking about this shortly)

- Describe the different levels of functioning—refer to Handout 1.7a.

**DIFFERENT LEVELS OF FUNCTIONING**

**Complicated Chemical  
Dependency**

**Psych-Low  
Substance-High**

**Substance Dependent  
Mentally III**

**Psych-High  
Substance-High**

**Substance Abusing  
Mentally III**

**Psych-High  
Substance-Low**

**Substance Abuse  
Non-Severe Psychopathology**

**Psych-Low  
Substance-Low**

For additional information on quadrants of care, please see CSAT's *Treatment Improvement Protocol (TIP) 42: Substance Abuse Treatment for Persons with Co-occurring Disorders*, pp 27-31.

**EXERCISE**

Use the mini-cases Handout 1.7b to ensure that the participants understand the levels of functioning concept.

**NICOLE:** Twenty-eight years of age, married for eight years, and the mother of two children in elementary school, Nicole has watched her drinking patterns change over the previous several years. She had been a social drinker since high school, but her consumption has changed in nature during her years of marriage. She was drinking not only socially, but also in the afternoons by herself. She awakened one morning and realized that even before she got out of bed, she was thinking of that first drink. Nicole's marriage is deteriorating as her drinking worsens. Intimacy is gone, and Nicole describes herself as "sinking deeper into a pit", not having any interest in her relationships, career, or children. She has noticed changes in her eating and sleeping patterns and has experienced suicidal thoughts. (SA/D High, MI Low)

**JOE:** Joe was released from the state hospital five years ago, when his psychotic symptoms of delusions and hallucinations became manageable with medication and the services of an intensive case manager. He is currently unemployed, lives in his own apartment, and attends a day treatment program sporadically. Joe's case manager noticed a change in his functioning three months ago, when Joe began a friendship with a neighbor. He began expressing dissatisfaction with his social situation and frustration about not feeling able to hold a job or date. He missed several appointments and became unreliable on his medication. During a home visit, Joe's ICM found Joe intoxicated with a large supply of alcohol in his home. Joe was off his medication and presenting disorganized thought and behavior as well as suicidal ideation. (SA/D Low, MI High).





**MELODY:** By the time she was admitted to the hospital, Melody was talking a mile a minute. Her movements were rapid and erratic. At the slightest provocation, she flew into a rage. She had not slept in three nights and her eyes gleamed with intense excitement. In obtaining a history from Melody's mother, the therapist found that this was Melody's second manic episode in the last 6 months. Melody was attending the local community college and struggling academically and socially. She experienced weeks of lethargy, sadness, and lack of motivation. Melody's mother also reported that Melody had been arrested twice for cocaine possession and that her drug use began in early adolescence with marijuana use and progressed to cocaine use more recently. She has relapsed from two residential treatment stays for substance abuse. Melody later confirmed that she used cocaine to escape and sought a heightened state when she was feeling depressed. (SA/D High, MI High)

**JAKE:** Jake is an unemployed construction worker who is unmarried. He has fathered three children with his girlfriend. He is able to work when work is available, but he doesn't go out of his way to look for extra jobs. He sees his children only when his relationship with his girlfriend is going well. He reports drinking about a six pack of beer a night, and lately says he is beginning to get weird feelings of his heart beating fast and his breathing getting weak. He reports feeling as though he is having a heart attack. Upon numerous visits to the clinic, his physician has not found any physical basis for his feelings. He doesn't believe it, but the clinic referred him for mental health services. (SA/D Low, MI Low)

#### **BASIC PRINCIPLE # 4**

**When mental illness and substance disorder coexist, both diagnoses should be considered primary, and simultaneous primary treatment for both disorders is required: multiple primary treatment.**

- We sometimes blame one on the other.
- We sometimes medicate because the client says they drink because of the mental health issues or vice versa.
- The disorders are interactive, but we don't have to overcomplicate the situation.
- Treat both at the same time!
- Substance abuse and dependence are seen as very close for people with healthy adult brains.
- But vulnerability and threshold is lower for mentally disabled or ill and causes:
  - Emotional instability
  - Social instability
  - Interferes with effectiveness of medication
- Message: maintain primary treatment of both conditions even when other is out of control.
- Ask participants for a show of hands on this question: "Who needs more addiction treatment?"
  - Alcoholic
  - Alcoholic with schizophrenia
  - Both equal
  - Don't know

Answer:

b.) Because substance dependence needs to learn skills of abstinence, schizophrenics have more difficulty learning these skills. Therefore more attention, more skills training, more reinforcement, more practice, more services are needed.

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**BASIC PRINCIPLE # 5**

Both major mental illness and substance dependence are examples of primary, chronic, biological mental illnesses which fit into a disease and recovery model of treatment.

- There are several parallels between the two disorders.
- Treatment for both is “The Process of Recovery”.



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**DISORDER PARALLELS**

**ADDICTION**

- A biological illness
- Heredity (in part)
- Chronic disease
- Incurable
- Leads to lack of control of behavior and emotions

**MAJOR MENTAL ILLNESS**

- A biological illness
- Heredity (in part)
- Chronic disease
- Incurable
- Leads to lack of control of behavior and emotions

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**DISORDER PARALLELS**

**ADDICTION**

- Positive and negative symptoms
- Affects the whole family
- Progression of the disease without treatment
- Symptoms can be controlled with proper treatment

**MAJOR MENTAL ILLNESS**

- Positive and negative symptoms
- Affects the whole family
- Progression of the disease without treatment
- Symptoms can be controlled with proper treatment

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**DISORDER PARALLELS**

**ADDICTION**

- Disease of denial
- Facing the disease can lead to depression and despair
- Disease is often seen as a “moral issue” due to personal weakness rather than having biological causes

**MAJOR MENTAL ILLNESS**

- Disease of denial
- Facing the disease can lead to depression and despair
- Disease is often seen as a “moral issue” due to personal weakness rather than having biological causes

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**DISORDER PARALLELS**

**ADDICTION**

- Feelings of guilt and failure
- Feelings of shame and stigma
- Physical, mental and spiritual disease

**MAJOR MENTAL ILLNESS**

- Major Mental Illness
- Feelings of guilt and failure
- Feelings of shame and stigma
- Physical, mental and spiritual disease



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## BASIC PRINCIPLE # 6

There is no one type of dual diagnosis program. For each patient, the proper treatment intervention at any point in time depends upon:

- The subtype of dual diagnosis
- Specific diagnosis
- Level of acuity, severity, disability of each disease
- Motivation for treatment for each disease
- Phase of recovery

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## ~LUNCH BREAK~

Please return in one hour

### TRAINER NOTE

- Advise participants that the next section will take us through the Minkoff theory of the Process of Recovery based on the principles we have discussed. Solicit questions and comments. Ask for discussion if time permits.

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## PHASE I: STABILIZATION

### DETOXIFICATION

- Usually inpatient, may be involuntary
- Usually need medication
- 3-5 days (alcohol)
- Includes assessment for other diagnoses

### STABILIZE PSYCHIATRIC ILLNESS

- Usually inpatient, may be involuntary
- Medication
- 2 weeks-6 months
- Includes assessment for effects of substances and for addiction.

### TRAINER NOTE

In this section, you will review the process of recovery using some didactic lecture, case studies and small group breakouts.

### CONTENT

The process of recovery is the same for substance users or the mentally ill, and includes four phases. Clients can be in any of these phases for each disease and may not be at the same phase in each disease process. The patient can progress through these phases in various settings.

### PHASE 1: STABILIZATION

- Stabilization of active substance use and/or acute psychiatric symptoms.
- Different disorders stabilize at different rates, i.e., detoxification can take a few days, psychosis weeks or months or suicidality in a day or two, opiate withdrawal weeks or months
- Phase does not imply level of care, just nature of treatment.

## PHASE II: ENGAGEMENT

### ADDICTION TREATMENT

- Engagement of patient in ongoing treatment is crucial for recovery to proceed.
- Engagement begins with empathy, then proceeds through the phases of education and empathic confrontation before the patient commits to ongoing active treatment.

### PSYCHIATRIC TREATMENT

- Engagement of patient in ongoing treatment is crucial for recovery to proceed.
- Engagement begins with empathy, then proceeds through the phases of education and empathic confrontation before the patient commits to ongoing active treatment.

For additional information on engagement strategies, please see CSAT's *Treatment Improvement Protocol (TIP) 42: Substance Abuse Treatment for Persons with Co-occurring Disorders*, pp. 163-164.

### PHASE 2: MOTIVATIONAL ENHANCEMENT

- Contemplation, preparation and persuasion.
- Also called Engagement
- Motivation is not a static trait that people have.
- Clinical techniques help people get motivated.
- Apply to psychiatric population and substance users.
- Opportunities to impose confrontation or consequences.

A useful way to view the engagement phase and our role in it is as follows:

Everybody with a mental health disorder and/or substance disorder is on his or her own personal bus and they are going on their own adventure. We are not inviting them on our bus, but we are going on their bus. They are the drivers, and we are the dual recovery companion indicating where to go and how to get there and pointing out the sights along the way. Sometimes it will be a windy, curvy, up and down wild ride. The bus might crash or the driver might take the wrong road, turning left when you said turn right. But if you and the driver get along, the driver may be inclined to listen to your direction to turn right next time. The driver may take several wrong turns and go around the block many times, perhaps go the wrong way on a one-way street, or maybe pull over for a nap. You are the companion, and your job is to stay with the driver, and to keep pointing out the better way. But the driver has to want to, or be motivated to, make the right turn. Let's take a closer look at Motivational Enhancement Theory.

### EXERCISE

The purpose of this exercise is to illustrate that motivation is internal, but that external incentives can introduce action.

- Ask participants: Please raise your right hand. Pause and thank the group.
- Ask participants: Now, why did you do that? Repeat some of the responses
- Ask participants: OK; now those that can, would you please stand and pick up your chairs?

You will probably get no action.

- Continue: If I told you there were some dollar bills scattered around the room under the chairs, would that motivate you to stand and pick up your chairs?

Most still will not move, so say: Well, let me tell you that there are indeed some dollar bills under some of the chairs.



At this point two or three participants might rise and soon most everyone will follow suit. As dollar bills are found, point out, "There's one over there", "in front", etc.

**ASK PARTICIPANTS:**

Why did it take more effort to motivate you the second time?

Did the money motivate you?

What's the only real way to motivate?

Point out that money, especially in small amounts is not a motivator. The process of change consists of support contingencies and external constraints.

**CONTENT**

What is Motivational Enhancement?

As counselors, we are fascinated by what motivates change in people struggling with personal problems. It is a common problem for people who seem stuck to persist in patterns of behavior that clearly harm them and those around them. Often the person is quite aware of damaging consequences and has resolved to control behavior (no more alcohol, stay on the meds, etc.), yet time and time again returns to the old familiar patterns. Motivational enhancement interviewing as a method of engagement focuses on the client's strengths and is especially helpful with people who are reluctant to change or ambivalent about it. Motivational enhancement interviewing specifically avoids argumentative persuasion, and instead operationally assumes the validity of the client's subjective experiences and perspectives.

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**PHASE II: ENGAGEMENT**

**ADDICTION TREATMENT**

- Education about substance abuse, dependence and empathic confrontation of adverse consequences are tools to overcome denial. Patient must admit powerlessness to control drug use without help (AA, NA, and other collateral).

**PSYCHIATRIC TREATMENT**

- Education about mental illness and the adverse consequences of treatment non-compliance are tools to overcome denial. Patient must admit powerlessness to control symptoms without help (medication).

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**PHASE II: ENGAGEMENT**

**ADDICTION TREATMENT**

- Education of the family and involving them in confrontation of the patient's denial, facilitates engagement.
- Engagement may take place in a variety of treatment settings: outpatient, day treatment, inpatient, and residential. May need extended inpatient or day treatment rehabilitation (2-12 weeks).

**PSYCHIATRIC TREATMENT**

- Education of the family and involving them in setting limits on noncompliance, facilitates engagement.
- Engagement may take place in a variety of treatment settings: outpatient, day treatment, inpatient, and residential. May need extended inpatient or day treatment rehabilitation (1-6 months).

## PHASE II: ENGAGEMENT

### ADDICTION TREATMENT

- Engagement may be initially coerced through legal mandate (Probation, etc.)
- Multiple cycles of relapse usually occur before engagement in ongoing treatment is successful (revolving door).

### PSYCHIATRIC TREATMENT

- Engagement may be initially coerced through legal mandate (Guardianship, etc.)
- Multiple cycles of relapse usually occur before engagement in ongoing treatment is successful (revolving door).

## BASIC PRINCIPLES OF MOTIVATIONAL ENHANCEMENT

- Focused on building the client's commitment to change and then assisting the client's own individual change process.
- Useful with people who are reluctant and ambivalent about change.
- Increases the client's perceptions of his/her capacity to cope with obstacles and problems, which then leads to change.
  - Focused on building the client's commitment to change and then assisting the client's own individual change process.
  - Useful with people who are reluctant and ambivalent to change.
  - Increases the client's perceptions of his or her capacity to cope with obstacles and problems which then leads to change.
  - Assumes a client is a capable individual, with insight and ideas for the solution to his or her problems.
  - More persuasive than coercive, more supportive than argumentative, with a positive attitude conducive to change.
  - Freedom of choice and self-direction are respected.
  - Counselor seeks ways to complement rather than denigrate, build up rather than tear down, listen rather than to tell.
  - Counselor does not assume an authoritarian role, responsibility for change is left with the client.
  - Counselor seeks to increase the client's intrinsic motivation, so change arises from within
  - Interviews proceed with a strong sense of purpose
  - Believes each person possesses a powerful potential for change that counselor task is to release
  - Focuses on strengths, resources and solutions
  - Intended to get the person "unstuck" and to start the change process
  - Resistance and ambivalence are not opposed but seen as part of the natural process

### TRAINER NOTE

Some participants may have a different view of how to deal with clients and find it difficult to conceptualize this approach. Listen to varying viewpoints, pointing out that Motivational Enhancement Interviewing is one method for eliciting change from within, which is in line with Minkoff's Integrated approach.

For additional information on Motivational Interviewing and Motivational Enhancement Therapy, please see CSAT's *Treatment Improvement Protocol (TIP) 42: Substance Abuse Treatment for Persons with Co-occurring Disorders*, pp. 112-121.



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### **BASIC PRINCIPLES OF MOTIVATIONAL ENHANCEMENT**

- Assumes a client is a capable individual, with insight and ideas for the solutions to his/her problems.
- More persuasive than coercive, more supportive than argumentative, with a positive attitude conducive to change.
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### **BASIC PRINCIPLES OF MOTIVATIONAL ENHANCEMENT**

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### **BASIC PRINCIPLES OF MOTIVATIONAL ENHANCEMENT**

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- Believes that each person possesses a powerful potential for change that is the counselor’s task to release.
- Focuses on strengths, resources and solutions.

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### **BASIC PRINCIPLES OF MOTIVATIONAL ENHANCEMENT**

- Intended to get the person “unstuck” and to start the change process.
- Resistance and ambivalence are not opposed but seen as part of the natural process

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### **CONTRAST BETWEEN CONFRONTATIONAL AND MOTIVATIONAL ENHANCEMENT INTERVIEWING APPROACHES**

#### **CONFRONTATIONAL**

- Emphasis on acceptance of self having a problem; acceptance of diagnosis essential for change.
- Emphasis on personality pathology, which reduces personal choice, judgment and control.
- Present evidence of problems to convince client to accept diagnosis.

#### **MOTIVATIONAL INTERVIEWING**

- Less emphasis on labels; acceptance of labels unnecessary for change.
- Emphasis on personal choice and responsibility for deciding future behavior.
- Counselor conducts objective evaluation, but focuses on eliciting client’s own concerns.



For further discussion on the issue of confrontation, please see CSAT’s *Treatment Improvement Protocol (TIP) 42: Substance Abuse Treatment for Persons with Co-occurring Disorders*, pp. 109-110.

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#### **CONFRONTATIONAL**

- Resistance is “denial” a trait requiring confrontation.
- Resistance is met with argumentation and correction.
- Goals and strategies for change are prescribed for the client since client is seen as incapable of making sound decisions.

#### **MOTIVATIONAL**

- Resistance is an interpersonal behavior pattern influenced by counselor’s behavior.
- Resistance is met with reflection.
- Goals and strategies for change are negotiated between the client and counselor; collaboration is vital.

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### **CONTRASTS BETWEEN COGNITIVE AND MOTIVATIONAL ENHANCEMENT INTERVIEWING**

#### **COGNITIVE APPROACH**

- Assumes client is motivated; no direct strategies used for building motivation.
- Seeks to identify and modify maladaptive cognitions.
- Prescribes specific coping strategies

#### **MOTIVATIONAL APPROACH**

- Employs specific principles and strategies for building client motivation for change.
- Explores and reflects client perceptions without labeling or “correcting” them.
- Elicits possible change strategies from client and significant others.

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#### **COGNITIVE APPROACH**

- Teaches coping behaviors through instruction, modeling, directed practice, and feedback.
- Specific problem solving strategies are taught.

#### **MOTIVATIONAL APPROACH**

- Responsibility for change method is left with client; no training, modeling or practice.
- Natural problem solving processes are elicited from the client and significant others.

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### **CONTRAST BETWEEN CLIENT CENTERED AND MOTIVATIONAL ENHANCEMENT INTERVIEWING**

#### **CLIENT CENTERED**

- Client determines the content and direction of counseling.
- Avoids injecting the counselor’s own advice and feedback.

#### **MOTIVATIONAL**

- Systematically directs the client toward motivation for change.
- Offers the counselor’s own advice and feedback where appropriate.

**CLIENT CENTERED**

- Empathic reflection is used non-contingently.
- Explores the client's conflicts and emotions as they exist currently.

**MOTIVATIONAL**

- Empathic reflection is used selectively, to reinforce certain processes.
- Seeks to create and amplify the client's discrepancies to enhance motivation for change.

**TRAINER NOTE**

- As you review these client resistant behaviors and counselor responses, participants should easily recognize them—solicit participants to cite some examples and definitions in an informal exercise. Remember that while humor is helpful, the goal is to respect the client's resistance for what it is—difficulty in recognizing or accepting the seriousness of the problem. Client respect is paramount.

**CONTENT**

Review four categories of client resistant behavior Handout 1.18 adapted from Miller & Rollnick, 1991, p. 101-102.

- 1) Arguing: The client contests the accuracy, expertise or integrity of the therapist.
  - Challenging: The client directly challenges the accuracy of what the counselor has said
  - Discounting: The client questions the counselor's personal authority and expertise
  - Hostility: The client expresses direct hostility toward the counselor.
- 2) Interrupting: The client breaks in and interrupts the counselor in a defensive manner.
  - Talking over: The client talks while the counselor is still speaking.
  - Cutting off: The client breaks in with words intended to cut the counselor off, like "Now wait a minute" or "I've heard about enough."
- 3) Denying: The client expresses an unwillingness to recognize problems, cooperate, accept responsibility or take advice.
  - Blaming: The client blames other people for problems.
  - Disagreeing: The client disagrees with a suggestion from the counselor has made, offering no constructive alternative. This includes the familiar "yes, but..."
  - Excusing: The client makes excuses for his or her own behavior.
  - Claiming impunity: The client claims that he or she is not in any danger, for instance, from drinking.
  - Minimizing: The client suggests that the counselor is exaggerating risks or dangers and that it "really isn't so bad."
  - Pessimism: The client makes general statements about self or others that are pessimistic, defeatist or negativistic in tone.
  - Reluctance: The client expresses reservations and reluctance about information or advice given.
  - Unwillingness to change: The client expresses a lack of desire or unwillingness to change, or an intention not to change.
- 4) Ignoring: The client shows evidence of not following or ignoring the counselor.
  - Inattention: Client response indicates that he or she has not been attending.
  - Non-answer: In answering the counselor's query, the client gives a response that is not an answer to the question.
  - No response: Audible or non-verbal reply.
  - Sidetracking: Client changes direction of the conversation that the counselor has been pursuing.



## CONTENT

Review counselor responses that heighten resistance Handout 1.19 adapted from Gordon, 1970, Miller & Jackson, 1985.

- Never meet the resistance head on, because certain kinds of reactions are likely to exacerbate resistance. These responses include:
  - Arguing, disagreeing, challenging
  - Judging, criticizing, blaming
  - Warning of negative consequences
  - Seeking to persuade with logic or evidence
  - Interpreting or analyzing the “reasons” for resistance
  - Confronting with authority
  - Using sarcasm or incredulity

## CONTENT

Review the four “R’s” other than resistance Handout 1.20.

- Reluctant: Pre-contemplators through lack of knowledge or inertia do not want to consider change. To these people the information of the problem has not become fully conscious and they are reluctant to change. The technique of providing feedback in a sensitive empathic manner can be most helpful for them.
- Rebellious: Addicts have a heavy investment in the problem behavior and in making their own decisions. They are resistant to being told what to do. The rebellion may be a residue of prolonged adolescence or the result of insecurity and fears. The rebellious pre-contemplators will appear hostile and resistant to change. This type of client does have a lot of energy invested in the problem behavior. The real task is trying to shift some of that energy into contemplating change rather than resistance or rebellion.
- Resigned: These clients have given up on the possibility of change and seem overwhelmed by the problem. Instilling hope and exploring barriers to change are the most productive strategies for this group.
- Rationalizing: These clients have all the answers. These clients are not considering change because they know all about it and the problem is a problem for others and not for them. Empathy and reflective listening seem to work best with this type of client.

## CONTENT

Review strategies for handling resistance Handout 1.21 adapted from Miller & Rollnick, 1991.

- Simple reflection: A simple acknowledgement or a reflective listening statement of the client’s disagreement, emotion, or perception can permit further exploration rather than defensiveness. Avoids playing out the confrontation-denial trap.
  - Client: I don’t want to quit!
  - Counselor: You don’t think that would work for you.
  - Client: I couldn’t change if I wanted to.
  - Counselor: You can’t see any way that you believe in and you might fail if you tried.
- Double sided reflection: A form of reflective listening, which acknowledges what the client says, but adds to it the other side of the client’s ambivalence. This requires use of materials that the client can offer from previous sessions or statements.
  - Client: I know that what you want is for me to give it up completely, but I’m not going to do that!
  - Counselor: You know that you have some real concerns about giving it up, but you’re not willing to think about quitting altogether.
- Amplified reflection: Reflect back what the client has said in an amplified or exaggerated form. The response should be straightforward, and not sarcastic or hostile.
  - Client: I couldn’t just quit. What would my friends think?
  - Counselor: In fact, it might be hard for you to change at all.





- Shifting focus: This technique amounts to going around barriers rather than trying to climb over them. This is a good way to diffuse resistance when encountering a difficult issue.
- Agreement with a twist: This technique to resistance is to offer initial agreement, but with a slight twist or change. This allows the client and counselor to agree, but also the counselor continues to influence in the direction of change.
 

Client: Why are you and my wife so stuck on my drinking? What about all her problems? You'd drink too, if your family was nagging you all the time.

Counselor: You've got a good point there, and that's important. There is a bigger picture here and maybe I haven't been paying much attention to that. It's not as simple as one person's drinking. I agree with you that we shouldn't be trying to place blame here. Drinking problems like these do involve the whole family. I think you are absolutely right.
- Emphasizing personal choice and control: When people believe their freedom is being impinged upon, they assert the position "I'll show you!" You can avoid this situation by allowing them to have choice.
- Reframing: Another method to deal with resistance is to reframe the information that the client is offering. This is useful when a client is offering arguments that serve to deny a personal problem. This approach acknowledges the validity of a client's observation, but offers a new meaning or interpretation for them. It puts the client's information into a new form more helpful and supporting of change.
- Therapeutic paradox: is a more risky technique in dealing with resistance but can be used as prescribing the problem; the client should continue on as before without changing or increase the behavior.

## CONTENT

Review language that may decrease resistance Handout 1.22 adapted from O'Hanlon, 1994.

- Refer to the problems in the past tense using "were" or "have been".
- Create expectance for positive change, using "when", "yet".
- Re-label, normalize, generalize
- Give credit, validate
- Assume the problem is not always occurring and ask questions
- Depict a time when the problem does not occur
- Resist invitations to blame and non-accountability
- Inventing new names and labels
- Avoid using terms accident or bad habit
- Accentuate the positive
- Find out about other people who do not view the client as disabled or disordered.
- Find out about hidden or non-obvious aspects of the client's life which do not fit or are incompatible with their disempowered (hopeless, helpless or stuck) views about themselves or the problem. Ask the client how he/she explains the incompatibility. Search for other contexts of competence.
- Find out about their best moments in thinking about or experiencing themselves.
- Find and connect them with others who may have experienced similar things or struggles and either found different ways to think about it or deal with it. This can be through books, tapes, and letters or support groups.
- Normalize by letting them know that others have or do experience similar feelings.
- Find out when the client has not experienced their problems when they expected they would.
- Find out evidence of choice in regard to the problem.
- Find out exceptions to the problem behavior.

## **COUNSELOR BEHAVIOR THAT INCREASES CLIENT MOTIVATION—ADAPTED FROM O’HANLON & DAVIS**

- Non-judgmental listening
- Focusing attention on what the client is asking for in the situation
- Identifying and amplifying of existing positive behaviors
- Accepting or normalizing current difficulties

## **COUNSELOR BEHAVIOR THAT INCREASES CLIENT MOTIVATION—ADAPTED FROM O’HANLON & DAVIS**

- Assisting in transferring existing behavioral skills from one life area to another
- Focusing on eliciting optimistic, pragmatic, concrete projections about the future
- Reinforcing the notion that solutions occur when they become the focus of attention.

### CONTENT

Review counselor behavior that increases client motivation adapted from O’Hanlon & Davis.

- Non-judgmental listening on the part of the counselor.
- Focusing attention on what the client is asking for in the situation.
- Identifying and amplifying of existing positive behaviors.
- Assisting in transferring existing behavioral skills from one life area to another.
- Focusing on eliciting optimistic, pragmatic, concrete projections about the future.
- Accepting or normalizing current difficulties.
- Reinforcing the notion that solutions occur when they become the focus of attention.

### TRAINER NOTE

- Handout vignettes for the role-play Handout 1.24. Have participants break into groups of four. Allow 10 minutes for review and preparation. Each role-play should then take about five to ten minutes. Allow 10—15 minutes for review.

### EXERCISE

- For the first round of this exercise, the groups should each appoint one person to be a counselor and one to be a client. The remaining two members of the groups should be the observers, prepared to make comments about the role-play. In this role-play, the client should demonstrate resistance, ambivalence, reluctance, rebelliousness, resignation, and/or rationalizing. The counselor should demonstrate responses that heighten resistance. Advise participants to try to play this out in as realistic a way as possible based on their own experience. Pause at this point and ask for the observers to make some observations to the whole group about what they saw.
- For the second role-play, the observers can switch roles with the counselor and client. This time, use some Motivational Enhancement principles to handle resistance. The client still remains ambivalent or resistant, but the counselor tries a new, non-confrontational approach. Again, go for about 5—10 minutes and then ask for the group to come together for discussion of the Motivational Enhancement principles with regard to these role-plays.



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- Questions to help with this debriefing include:
  - How did it feel to be the client in the first role-play? The second?
  - What particular aspects of the counselor might or might not motivate you?
  - What difficulties did you have as a counselor trying to practice Motivational Enhancement?

**PHASE III: PROLONGED STABILIZATION**

- Continued Abstinence (1 year)
- Patient consistently attends abstinence support programs (AA, NA) usually 3-5 times per week (initially 90 meetings in 90 days).
- Continued Medicine Compliance (1 year)
- Patient consistently takes prescribed medication and attends treatment sessions regularly.



- Active Treatment, Maintenance, Relapse Prevention
- Staying stable is as hard as getting stable.
  - Clients tend to discontinue treatment or meds.
  - It is work to stay with it.

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**CONTINUED ABSTINENCE**

- Patient usually participates voluntarily, but ongoing compliance may be coerced or legally mandated (probation).
- Ongoing education about addiction, recovery, and skills to maintain abstinence.

**CONTINUED MED COMPLIANCE**

- Patient usually participates voluntarily, but ongoing compliance may be coerced or legally mandated (medication guardianship).
- Ongoing education about mental illness, recovery, and skills to prevent relapse.

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**CONTINUED ABSTINENCE**

- Need to focus on asking for help to cope with urges to use substances and drop out of treatment.
- Must learn to accept the illness and deal with shame, stigma, guilt and despair.

**CONTINUED MED COMPLIANCE**

- Need to focus on asking for help to cope with continuing symptoms and urges to drop out of treatment.
- Must learn to accept the illness and deal with shame, stigma, guilt and despair.

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**CONTINUED ABSTINENCE**

- Must learn to cope with “negative symptoms”: social, affective, cognitive, and personality development.
- Family needs ongoing involvement in its own program of recovery (ALANON) to learn empathic detachment and how to set caring limits.

**CONTINUED MED COMPLIANCE**

- Must learn to cope with “negative symptoms”: impaired cognition, affect, social skills and lack of motivation and energy.
- Family needs ongoing involvement in its own program of recovery (AMI) to learn empathic detachment and how to set caring limits.

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**CONTINUED ABSTINENCE**

- May need intensive outpatient treatment and/or 6-12 months residential placement
- Continuing assessment
- Risk of relapse continues

**CONTINUED MED COMPLIANCE**

- May need extended hospital, day treatment or residential placement
- Continuing assessment
- Risk of relapse continues

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**PHASE IV: RECOVERY & REHABILITATION**

**CONTINUED SOBRIETY**

- Voluntary, active involvement in treatment
- Stability precedes growth; no growth is possible unless sobriety is fairly secure. Growth occurs slowly, “One Day at a Time”.

**CONTINUED STABILITY**

- Voluntary, active involvement in treatment
- Stability precedes growth; no growth is possible unless stabilization of illness is fairly solid. (May be symptomatic, but stable). Growth occurs slowly, “One Day at a Time”.

- Client learns new skills
- Utilizes newly discovered strengths
- Feels better about self
- Outcome is peace, serenity, i.e. “Serenity Prayer”

Review Minkoff’s parallels for this phase:

- Our clients can teach us about courage and fortitude in the face of adversity that most of us don’t have to deal with.
- This is not about disease recovery; it is about the recovery of the person who has the disease.
- Clients move from dehumanization and despair to feeling good about themselves and others.
- Research has taught us that treatment needs to be matched to the disease, and diagnosis, and it must be phase specific. If you force a pre-motivational stage person to go to Alcoholic’s Anonymous, it will not work.



## EXERCISE

Break up the participants into groups of four each. Be sure to make the mix of each group include substance abuse and mental health professionals. Ask one person to represent the group and present the case when the group work is complete. Handout 1.24 vignettes to each group and give the following assignment:

Using the Minkoff principles and Process of Recovery, determine where this person is in terms of Diagnostic classification and phase of recovery, and suggest an appropriate treatment plan based on these. If you have had similar cases, discuss how this approach may or may not have helped in the past, maintaining client confidentiality.

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### CONTINUED SOBRIETY

- Continued work in the AA Program, on growing, changing, dealing with feelings (12 Steps, Step Meetings)
- Thinking continues to clear
- New skills for dealing with feelings and situations

### CONTINUED STABILITY

- Continued medication, but reduction to lowest level needed for maintenance. Continued work in treatment program.
- Thinking continues to clear
- New skills for dealing with feelings and situations

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### CONTINUED SOBRIETY

- Increasing responsibility for illness, and recovery program brings increasing control of one's life.
- Increasing capacity to work and to have relationships.

### CONTINUED STABILITY

- Increasing responsibility for illness, and recovery program brings increasing control of one's life.
- Increasing capacity to work and to relate. (Voc rehab, clubhouse)

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### CONTINUED SOBRIETY

- Recovery is never "complete", always ongoing.
- Eventual goal is peace of mind and serenity (Serenity Prayer)

### CONTINUED STABILITY

- Recovery is never "complete", always ongoing.
- Eventual goal is peace of mind and serenity (Serenity Prayer)

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### ~AFTERNOON BREAK~

Please come back in 15 minutes

## PROCESSES OF CHANGE IN OTHER MODELS OF THERAPY

Theory	Notable Figures	Primary Process of Change	Techniques
Psychoanalytic	Sigmund Freud Carl Jung	Consciousness- Raising Emotional Arousal	Free association Analysis of resistance Dream interpretation
Humanistic/ Existential	Carl Rodgers Rollo May	Social Liberation Commitment Helping relationships	Clarification & reflection Empathy-warmth Free experiencing
Gestalt/ Experiential	Fritz Perls Arthur Janov	Self-Realization Emotional Arousal	Choice-Feedback Focusing Confrontation

### TRAINER NOTE

- Begin by asking participants for input regarding how different theories, notable figures or models may view the process of change. What processes may be involved in change? What techniques can therapists use to facilitate change?
- Provide participants with an overview of the processes of change in other models of therapy, Psychoanalytic, Humanistic/Existential, Gestalt/Experiential, Cognitive and Behavioral.



## PROCESSES OF CHANGE IN OTHER MODELS OF THERAPY

Theory	Notable Figures	Primary Process of Change	Techniques
Cognitive	Albert Ellis Aaron Beck	Countering Self-Reevaluation	Education Identifying dysfunctional thoughts; Cognitive restructuring
Behavioral	B.F. Skinner Joseph Wolpe	Environmental Control; Reward Countering	Assertion Relaxation training Managing reinforcements Self-control training

## STAGES OF CHANGE PROCHASKA AND DICLEMENTE

Stage	Client Response	Motivational Tasks for the Counselor
Stage I: Pre-contemplation	No problem or need to make a change	Raise doubt and provide information to increase client's perception of risks and problems with current behavior.
Stage II: Contemplation	Considers change and rejects it. "Tipping the Balance"	Evoke questions about change, risks of not changing; strengthen client's ability to accept change in current behavior, but no action plans

TRAINER NOTE: Pass out and discuss Handout 1.28

For more information on the Stages of Change, please see CSAT's *Treatment Improvement Protocol (TIP) 42: Substance Abuse Treatment for Persons with Co-occurring Disorders*, pp. 115-116.



## STAGES OF CHANGE PROCHASKA AND DICLEMENTE

Stage	Client Response	Motivational Tasks for the Counselor
Stage III: Determination	Window of opportunity when client considers change and develops a commitment to action	Help client determine the best course of action to take in seeking change
Stage IV: Action	A particular action to solve or change the problem; begins to implement the solution or action plan	Help client take steps toward change

## STAGES OF CHANGE PROCHASKA AND DICLEMENTE

Stage	Client Response	Motivational Tasks for the Counselor
Stage V: Maintenance	Develops new behaviors to maintain changes and solutions	Help client identify and use strategies to prevent relapse and reinforce new behavior.
Stage VI: Relapse	Normal, but frustrated; resolved to start again	Help client renew process of contemplation, determination and action, without becoming stuck or demoralized because of relapse

## QUALITIES WHICH MAY COMPLICATE AMBIVALENCE

- Values
- Expectations
- Social/Cultural Context
- Paradoxical Responses
- Impaired Control

- End with a discussion of qualities that might complicate ambivalence to change Handout 1.29. Refer to notes on values, expectancies, social context, paradoxical responses, and impaired control.

### Qualities Which May Complicate Ambivalence

- Values—People have particular value systems, which may impact their willingness to change. Treatment may be appreciated by some, yet have little importance to others.
- Expectancies—People have particular expectations about results, both positive and negative. The expectations can have a powerful impact. For example, some one who wants to stop drinking may not make an effort to do so in the belief that he or she will fail.
- Social Context—Social and cultural phenomena affect people’s perception of their population or behavior and as a result, impact their costs and benefits scale.
- Paradoxical Responses—An external request to increase a particular behavior does not mean change is more likely.
- Impaired Control—Impairs one’s ability for self-control and being able to make good judgments.



## INDIVIDUALS WITH CO-OCCURRING DISORDERS TREATMENT RULES (KENNETH MINKOFF, MD)

- All good treatment proceeds from an empathic, hopeful, clinical relationship.
- Consequently, promote opportunities to initiate and maintain continuing, empathic, hopeful relationships whenever possible.

These are Dr. Minkoff’s rules for all treating professionals, including physicians.



## INDIVIDUALS WITH CO-OCCURRING DISORDERS TREATMENT RULES (KENNETH MINKOFF, MD)

- Specifically, remove arbitrary barriers to initial assessment and evaluation, including initial psychopharmacology evaluation (e.g., length of sobriety, alcohol level, etc.)
- Moreover, never discontinue medication for a known serious mental illness because a patient is using substances.



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## **INDIVIDUALS WITH CO-OCCURRING DISORDERS TREATMENT RULES (KENNETH MINKOFF, MD)**

- Never deny access to substance disorder evaluation and/or treatment because a patient is on prescribed non-addictive psychotropic medication.
- In fact, when mental illness and substance disorder co-exist, both disorders require specific and appropriately intensive primary treatment.

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## **INDIVIDUALS WITH CO-OCCURRING DISORDERS TREATMENT RULES (KENNETH MINKOFF, MD)**

- There are no other rules! The specific content of dual primary treatment for each individual must be individualized according to diagnosis, phase of treatment, level of functioning and/or disability, and assessment of level of care based on acuity, severity, medical safety, motivation, and availability of recovery support.

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## **“CULTURE IS ANY COLLECTION OF INDIVIDUALS WHO...”**

- Have a common purpose
- Share common values
- Establish a set of norms and rules to support their values
- Share a common language or jargon
- Experience some sense of belonging, loyalty, pride, or fellowship

### TRAINER NOTE

- This section of the module will explore issues related to the importance of the practitioner’s ability to be culturally aware and sensitive to his or her clientele. You will need one hour to complete this section.
- For more information on issues of cultural competency and co-occurring disorders, please see CSAT’s *Treatment Improvement Protocol (TIP) 42: Substance Abuse Treatment for Persons with Co-occurring Disorders*, pp. 110-111.

### CONTENT

- We will explore:
- What is Culture?
- The definition of the term “multicultural.”
- The traditional barriers to multicultural counseling.
- The key points to becoming a competent multicultural practitioner.

### WHAT IS CULTURE?

#### TRAINER NOTE

- Have a discussion with the participants about “What is Culture?” Write their responses on a flipchart or dry-erase board for any discussion.

### CONTENT

The participants should identify most of the following. If areas are omitted, the trainer should review them.

- “Culture is any collection of individuals who....
- Have a common purpose
- Share common values



- Establish a set of norms and rules to support their values
- Share a common language or jargon
- Experience some sense of belonging, loyalty, pride, or fellowship”
- Some examples of “cultures” are:
  - Race/Ethnicity
  - Gender: Men/Women
  - Sexual orientation: Gay Men/Lesbian Women/Transsexuals
  - Physically Disabled
  - Socio-economic Status
  - Family
  - Community
  - Professional Groups
  - Organizations
  - Religious or Faith Groups
  - Persons with Mental Health Disorders
  - Persons with Substance Abuse Disorders
  - Persons with both MH and SA Disorders

Adapted from Tools for Building Bridges: ‘Building Cultural Competence in Corrections’, J. Tucker Burgo, Mid-American ATTC, UMKC, 1997.

The Definition of Multicultural:

- Share the definition of Multicultural with the group.

#### CONTENT

- Multicultural—the acknowledgment of the presence of other or many different groups. These groups may be identified as political, economic, educational, or by ways of cultural expression, language or symbol.

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### **THESE 3 CHARACTERISTICS CREATE BARRIERS TO PROVIDING EFFECTIVE MULTI-CULTURAL COUNSELING (SUE & SUE, 1999)**

#### **1. Culture bound values—Dominant white culture**

- Focus on individual
- Verbal/emotional/behavioral expressiveness
- Insight
- Self disclosure (openness and intimacy)
- Scientific empiricism
- Distinction between mental and physical functioning
- Ambiguity
- Patterns of communication

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### **THESE 3 CHARACTERISTICS CREATE BARRIERS TO PROVIDING EFFECTIVE MULTI-CULTURAL COUNSELING (SUE & SUE, 1999)**

#### **2. Class Bound Values— Middle & Upper Class**

#### **3. Language Variables— standard English**





## TRAINER NOTE

- Have a discussion with the participants to develop a list (on flipchart or dry-erase board) of what they feel are potential barriers to establishing effective multicultural counseling.
- Review Sue & Sue barriers below with referral back to the participant developed list.

## CONTENT

These 3 characteristics create barriers Handout 1.31 to providing effective multicultural counseling (Sue & Sue, 1999):

1. Culture-bound values—Counseling’s common components are reflective of a white culture in values and beliefs.
  - Focus on individual—counseling is individual centered. It is traditionally a one-to-one activity that encourages clients to talk about and discuss intimate aspects of their lives.
  - Verbal/emotional/behavioral expressiveness—counseling typically demands active involvement from the client.
  - Insight —counseling typically demands insight from the client.
  - Self-disclosure (openness & intimacy)—therapist often expect client to exhibit some degree of openness or sophistication.
  - Scientific empiricism—analytic/linear/verbal (cause-effect) approach;; Emphasis on cause-effect relationships—isolated from clients environment/contacts
  - Distinction between Mental and Physical functioning—and clear distinctions between mental and physical well being
  - Ambiguity—counseling is typically an unstructured activity.
  - Patterns of Communication—communication is typically from the client to counselor.
2. Class-bound values—counseling typically adheres to strict time schedules, utilizes ambiguous or unstructured approach to problems, and seeks long-term goals or solutions;
  - These class-bound values are typically those of middle and upper class segments of society.
3. Language variables—counseling uses Standard English with an emphasis on verbal communication (a monolingual orientation).
  - Training tends to (negatively) instill in the counselor trainee:
  - A mono-cultural assumption of illness (White Euro-American Culture)
  - Negative stereotypes of pathology for minority lifestyles (Common components of white culture in values/beliefs)
  - Ineffective, inappropriate, and antagonistic counseling approaches to the values held by minorities.

## EXERCISE

- Although this training can only briefly address the importance of cultural competency in both professional practice and in treatment organizations, this activity is presented so that participants can better draw upon each other’s knowledge of cultural beliefs, expectations and worldviews. Knowing one’s personal bias, cultural beliefs, expectations and morals is crucial in counseling diverse populations—including those persons with co-occurring disorders.
- Use the Trainer’s Aid 1.2 pre-printed culture cards. Cut them up into individual cards prior to the training so you are ready. Use a hat or container of some sort that allows each participant to randomly draw a card. Each participant selects only one card. Once all participants have selected a card, ask each to announce what “culture” they drew. In a large group you can group cultures together.
- Participants may suggest exchanging cards if the role chosen matches too closely with the participant’s personal culture. For this exercise to be meaningful, the goal is to have each participant select a role different from his/her personal culture.



Tell participants:

- The culture you try on in this exercise is meant to stretch your imagination. You wake up tomorrow morning and find out that you belong to another culture—the culture you randomly selected. How would your life be the same and how would it be different?

Distribute Handout 1.32

Ask participants to check the same or different boxes in the handout. Facilitate a discussion by taking turns reporting in:

- Which parts of your life would be the same? Which would be different?
- On what did you base your decisions about where to place your checks?
- What surprises did you have?
- What questions or issues did this raise for you? What did you learn from this activity?
- Wrap up by summarizing the key learning's participants shared with the group.

## **BECOMING AN EFFECTIVE MULTICULTURAL PRACTITIONER**

- **Practitioner needs to develop an awareness of his/her own assumptions, values and biases.**
- **Move from unaware to being aware and sensitive**
- **Aware of own values/bias and how they may affect minority clients**
- **Are comfortable with differences that exist between self and clients**
- **Sensitive to circumstances that may require a referral to another practitioner**
- **Aware of own racist attitudes, beliefs, feelings**

What it takes to become a Competent Multicultural Practitioner:

### TRAINER NOTE

- Have a discussion with the participants to develop a list (on flipchart or dry-erase board) of what they feel it takes to become an effective multicultural practitioner.

### CONTENT

1. Practitioner needs to develop an awareness of his/her own assumptions, values, and biases.
  - Move from unaware to being aware and sensitive.
  - Aware of own value/bias and how they may affect minority clients
  - Are comfortable with differences that exist between self/clients
  - Sensitive to circumstances that may require a referral to another therapist
  - Acknowledges/aware of own racist attitudes, beliefs, feelings
2. Practitioner needs to develop an understanding of the worldview of the culturally different client.
  - The Practitioner must possess knowledge/info about particular group working with
  - Have a good understanding of the sociopolitical system's in U.S. with respect to treatment of minorities
  - Clear/explicit knowledge/understanding of generic characteristics of counseling.
  - Be aware of institutional barriers that prevent minorities from using services
3. Practitioner needs to develop appropriate intervention strategies and techniques.
  - Skills—be able to generate a wide variety of verbal/nonverbal responses
  - Send/receive verbal/nonverbal messages accurately/appropriately



- Able to exercise institutional intervention skills on behalf of client when appropriate
- Aware of his/her helping style, recognize limitations, anticipate impact on culturally different clientele.
- Able to play helping roles characterized by an active systemic focus that leads to environmental interventions (consultant role/outreach role/ombudsman role/facilitator of indigenous support systems).

This is an active and ongoing process that never reaches an end point.

#### EXERCISE

Pass out the case study Handout 1.34 and follow-up with a discussion identifying the pitfalls to competency in this case.

Follow-up questions and discussion (Sue & Sue, 1999):

1. Was it a serious blunder for the therapist to see the M. family or to continue to see them in the session when he could not speak Spanish? Should he have waited until Dr. Escobedo returned?
  - Linguistic or language barriers place culturally different clients at a disadvantage.
2. While it may seem like a good idea to have one of the children interpret for the therapist and the family, what possible cultural implications might this have in the Mexican-American family? Do you think one can obtain an accurate translation through family interpreters? What are some of the pitfalls?
  - Interpreters suffer from certain limitations (accuracy, differences in concepts, etc.)
  - Culturally—by using the son as an interpreter, may have undermined the authority of the father and his sacred patriarchal role.
3. The therapist tried to be informal with the family in order to put them at ease. Yet, some of his colleagues have stated that how he address clients (last names or first names) may be important. When the therapist used the first names of both husband and wife, what possible cultural interpretation from the family may have resulted?
  - By trying to be informal, in traditional Latino and Asian cultures, such informality may be considered a lack of respect.
4. The therapist saw Mr. M.'s symptoms as indications of serious pathology. What other explanation might he entertain? Should he have so blatantly suggested hospitalization? How do Latinos perceive issues of pathology?
  - Did the therapist fail to look elsewhere for Fernando's paranoid reactions/suspicious/hallucinations?
  - Are there sociopolitical, cultural, or biological reasons for symptoms?
  - Fears—symbolize realistic concerns (deportation, creditors, police, etc.)?
  - Hallucinations—it is acceptable in the Latino culture to admit to hearing voices or seeing visions.
  - Could there be an external source to symptoms? Drugs, pesticides....
  - Did the therapist fail to recognize economic implications?
  - They are poor; don't own an automobile, public transportation is not available.
5. Knowing that Mr. M. had difficulty leaving home, should the therapist have considered some other treatment avenues? If so, what may they have been?
  - In meeting the needs of the family, should the therapist have explored home visits or some other form of outreach?

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### **BECOMING AN EFFECTIVE MULTICULTURAL PRACTITIONER**

- Practitioner needs to develop an understanding of the worldview of the culturally different client.
- The practitioner must possess information about particular groups he/she is working with
- Have a good understanding of the sociopolitical systems in the USA with respect to treatment of minorities
- Clear understanding of generic characteristics of counseling
- Be aware of institutional barriers that prevent minorities from accessing and using services

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### **BECOMING AN EFFECTIVE MULTICULTURAL PRACTITIONER**

- Practitioner needs to develop appropriate intervention strategies and techniques.
- Skills—be able to generate a wide variety of verbal and non verbal responses
- Send/receive verbal/nonverbal messages appropriately
- Able to exercise institutional intervention skills
- Aware of his/her helping style, limitations, anticipate impact on culturally diverse clientele.
- Able to play helping roles characterized by an active systemic focus that leads to environmental interventions

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### **WRAP UP ACTIVITIES**

- Final Questions & Answers
- Post-test (optional)
- Evaluation of module & distribute continuing education certificates for today
- What's coming up tomorrow

#### TRAINER NOTE

Trainers will take about 10-15 minutes to wrap up the session, answer final questions, distribute and collect the evaluation, and distribute continuing education certificates, if available

#### TOPICAL SUMMARY

In this module we have reviewed the following subjects:

- Definitions and considerations of substance disorder categories
- Prevalence and demographic considerations of substance disorders
- Treatment selection and modalities, including family, group and individual
- The effect of various substances on the brain
- Substance Disorder criteria and diagnosis



#### POST-TEST (OPTIONAL)

- Administer the post-test Handout 1.35 if required and collect. Participants should not put their names on the post- test.

#### WHAT'S NEXT?

##### TRAINER NOTE

Make an announcement here of upcoming trainings that are being sponsored, if any. If nothing is planned, then skip this section.

#### EVALUATION

##### TRAINER NOTE

- Distribute evaluations Handout 1.36 OR the evaluation you require. To ensure anonymity, collect evaluations in large manila envelope.
- Distribute continuing education certificates, if available.
- Thank the participants and end the module.

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### **WHERE TO GET MORE INFORMATION**

See the bibliography at the end of this Module

Websites: [www.coce.samhsa.gov](http://www.coce.samhsa.gov)  
[www.samhsa.gov](http://www.samhsa.gov)  
[www.pa-co-occurring.org](http://www.pa-co-occurring.org)  
[www.nattc.org](http://www.nattc.org)  
[www.kennethminkoff.com](http://www.kennethminkoff.com)

Make sure that participants have all the handouts including the bibliography for this module and direct them to the listed websites. Please feel free to add more information as it becomes available.



## MODULE I: REFERENCES

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# **Co-occurring Substance Use and Mental Health Disorders in Adults**

*An Integrated Treatment Approach to Dual Diagnosis*

## **MODULE TWO: DSM-IV & DSM-IVTR Mental Health Training for Addiction Professionals**

# MODULE 2 HANDOUTS

- 2.0 Pre-Test (Optional)
- 2.1a Definition of a Serious Mental Illness: Pennsylvania MH Bulletin
- 2.8 Risk Assessment Handout
- 2.11 What Kinds of Questions Should I Consider When Assessing Dangerousness?
- 2.12 Duty To Warn for Mental Health Professionals: Pennsylvania
- 2.14 Diagnostic Tree for Assessing Suicide & Suicidal Intervention
- 2.26 Case Studies A,B,C,D
- 2.30 Decision Tree
- 2.55 Thought Disorders & Delusions
- 2.60 Subtypes of Schizophrenia
- 2.77 Post-Test (Optional)
- 2.78 Module 2 Evaluation

# MODULE 2 TRAINING AIDS

## TRAINING AIDS FOR THIS MODULE

2.1 Apples: One for each Participant

### VIDEOS

- 2.1 Diagnosis According to the DSM-IV: Major Depressive Disorder clip, patient interview only, (Tape 1, Cut 1) 10.5 minutes
- 2.2 Diagnosis According to the DSM-IV: Bi-Polar Disorder with both Manic and Depressed states clip, patient interview only, (Tape 1, Cut 2) 17 minutes
- 2.3 Diagnosis According to the DSM-IV: Obsessive-Compulsive Disorder clip, patient interview only, (Tape 2, Cut 2) 6 minutes
- 2.4 Life After Trauma, Post Traumatic Stress Disorder, (entire video), 24 minutes
- 2.5 Diagnosis According to the DSM-IV: Schizophrenia clip, patient interview only, (Tape 2, Cut 3) 11.5 minutes
- 2.6 Diagnosis According to the DSM-IV: Anti-Social Personality Disorder, patient interview only, (Tape 3, Cut 1) 10 minutes
- 2.7 Understanding Borderline Personality Disorder: The Dialectical Approach: Borderline Personality Disorder, (entire video), 36 minutes

### AUDIO TAPE (OPTIONAL)

Virtual Hallucinations, Auditory Hallucinations play 2-3 minutes only

## HANDOUT 2.0 / PRE-TEST

### PRE-TEST

1. One in every twenty families is effected in their lifetime by a severe mental illness such as major depression, bipolar disorder, or schizophrenia.  
True False
2. A diagnosis of an Anxiety Disorder implies that the individual experiences symptoms of anxiety that go beyond what a normal person would have in certain situations.  
True False
3. People who talk about suicide always require hospitalization.  
True False
4. An identical twin has a 50% chance of developing schizophrenia if the other twin is diagnosed with schizophrenia.  
True False
5. Once a diagnostic label is given to a person, the label itself may create powerful negative influences that have serious social and political implications.  
True False
6. The experience of being mentally ill has many parallels with the experience of having a substance disorder.  
True False
7. Mental disorders have a very narrow range of severity.  
True False
8. More than half of those with bipolar disorder also have comorbid alcohol or drug abuse at some time in their life.  
True False
9. Men and women are equally effected by Bipolar I Disorder.  
True False
10. Borderline personality disorder is a pervasive pattern of instability in interpersonal relationships, self-image and mood with marked impulsiveness.  
True False

## HANDOUT 2.1A / HIGHLIGHTS OF THE MENTAL HEALTH BULLETIN—COMMONWEALTH OF PA-MARCH 4, 1994

**PURPOSE:** to establish the Adult Priority Group for planning and service development for adults with serious mental illness.

**Definition of “serious mental illness” includes:**

- Persons 18 or over who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder according to DSM criteria.
- This has resulted in functional impairment that interferes with or limits major life activities.
- Disorders include those listed in the DSM with the exception of “V” codes, substance use disorders, and developmental disorders, unless they co-occur with other serious mental illness.
- Functional impairments affect: basic living skills (eating, bathing, dressing), instrumental living skills (managing money, getting around the community), and functioning in social, family and vocational contexts.
- These definitions are required to be used to aid in treatment planning and providing services under the Center for Mental Health Services Block Grant Program.
- Pennsylvania used this definition to establish an Adult Priority Group:
- Must be 18+ and meet the federal definition of serious mental illness (see above.)
- Must have a diagnosis of schizophrenia, major mood disorder, psychotic disorder, or borderline personality disorder
- Must meet at least one of the following criteria from A. (Treatment History), B. (Functioning Level), or C. (Coexisting Condition or Circumstance).

A. Treatment History

1. Current residence in or discharge from a state mental hospital within the past two years.
2. Two admissions to community or correctional inpatient psychiatric units or crisis residential services totaling 20 or more days within the past two years.
3. Five or more face to face contacts with walk-in or mobile crisis emergency services within the past two years.
4. One or more years of continuous attendance in a community mental health or prison psychiatric service within the past two years.
5. History of sporadic course of treatment as evidenced by at least three missed appointments within the past six months, inability or unwillingness to maintain medication regimen or involuntary commitment to outpatient services.
6. One or more years of treatment for mental illness provided by a primary care physician or other non-mental health agency clinician within the past two years.

B. Functioning Level:

1. Global Assessment of Functioning Scale rating of 50 or below.

C. Coexisting Condition or Circumstance:

1. Coexisting diagnosis or psychoactive substance use disorder, mental retardation, HIV-AIDS, or sensory, developmental or physical disability.
2. Homelessness
3. Release from criminal detention

Any adult who has met the standards for involuntary treatment within the 12 months preceding the assessment is automatically assigned to the high priority consumer group.

*Summarized from the Mental Health Bulletin, Commonwealth of Pennsylvania, Department of Public Welfare, March 4, 1994.*

## HANDOUT 2.8 / RISK ASSESSMENT

The majority of mentally ill persons do not present an increased danger to others.

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Most people who threaten suicide generally do not follow through.

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Persons with severe mental illness, when actively experiencing acute symptoms may present an increased risk to self or others.

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Risk is increased greatly if a severely mentally ill person is also misusing or abusing drugs or alcohol.

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Persons with some types of personality disorders/traits (i.e.... Antisocial Personality Disorder, impulsivity, low frustration tolerance) may present an increased risk to others.

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## HANDOUT 2.11 / RISK ASSESSMENT

What kinds of questions should I consider when assessing safety and/or dangerousness?

1.) What is the “dangerous” behavior?

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2.) How severe are the likely consequences of it?

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3.) How imminent is it?

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4.) How predictable is it?

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5.) How likely is it?

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## HANDOUT 2.12 / DUTY TO WARN FOR MENTAL HEALTH PROFESSIONALS

The Pennsylvania Supreme Court, in the case “Emerich v. Philadelphia Center for Human Development” decided that

“...based upon the special relationship between a mental health professional and his or her patient, when the patient has communicated to the professional a specific and immediate threat of serious bodily injury against a specifically identified or readily identifiable third party, and when the professional determines, or should determine under the standards of the mental health profession, that his or her patient presents a serious danger of violence to the third party, then the professional bears a duty to exercise reasonable care to protect by warning the third party against such a danger.” (Tepper & Knapp, 1999)

This decision represents a duty to warn, which is narrower than the “duty to protect” standard set by the landmark “Tarasoff v. Regents of the University of California, et al” decision in California in 1976. In the duty to warn situation, the professional must provide some kind of warning to the third party, and this will meet the requirements under an ethical and legal duty of care. The nature of the warning, as described in the Pennsylvania Supreme Court’s review and analysis, points to the professional notifying and warning the third party directly of the intended harm. However, there is some lack of clarity regarding the provision of warning to additional persons such as relatives of the third party, others individuals close to the party or the police.

What is considered a situation that would require the duty to warn outlined above is defined by the Court as:

- the existence of a specific and immediate threat of serious bodily injury that has been communicated to the treating professional

AND

- the threat must be made against a specific or readily identified third party

Both of these criteria are necessary to require duty to warn on the part of the professional.

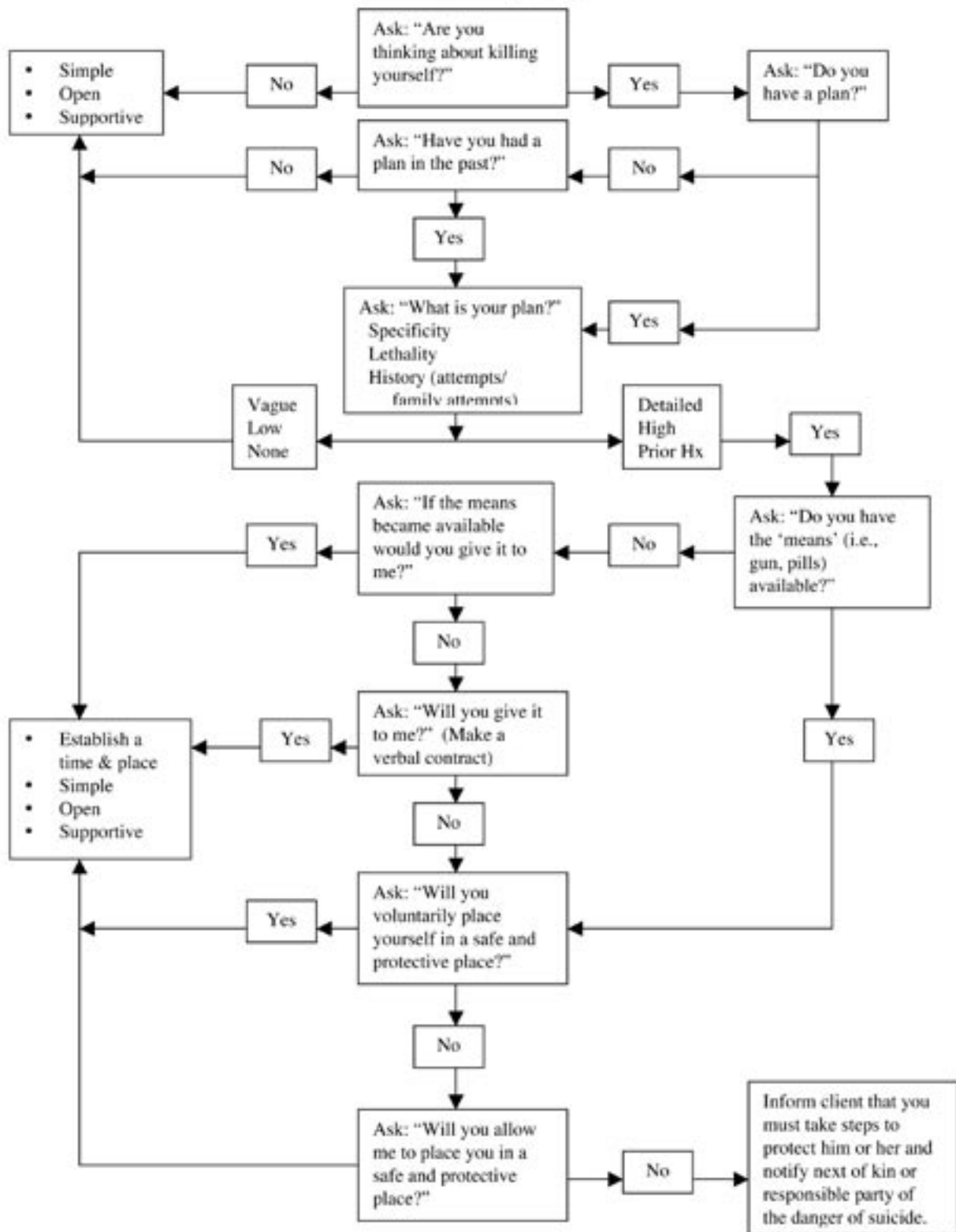
Another consideration is the timing of the warning, and the Court was not as clear on this issue. This makes it difficult for professionals, as predicting future behavior is not always absolutely clear. Each case will be different, requiring the professional to exercise judgement regarding the type of warning, timing of warning, and degree of urgency.

The best approach for professionals is a “well reasoned, well-documented, objective and logical approach to a problem” (Tepper & Knapp, 1999) based on the case law of the State. In Pennsylvania, it is clear that professionals have a duty to warn and are required to warn the intended victim at the least.

*Source: Tepper, A.M. & Knapp, S. (1999). Pennsylvania recognizes an affirmative duty to warn third party victims. The Pennsylvania Psychologist’s Quarterly, February, p.8 & 29.*

# HANDOUT 2.14 / DIAGNOSTIC TREE FOR ASSESSING SUICIDE & SUICIDAL INTERVENTION

When the counselor believes suicide ideation is present, the counselor should:



## HANDOUT 2.26 / CASE STUDY A, B, C, D

CUT ALONG THE PERFORATED LINES AND PASS OUT ONE CASE STUDY TO EACH GROUP:

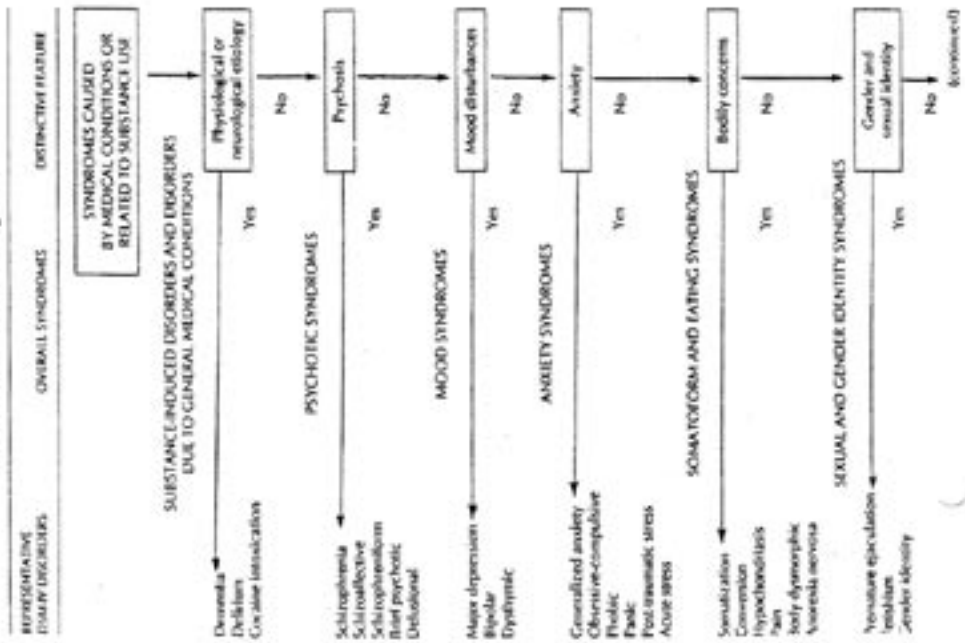
**(A) LAURIE:** a 45-year-old single mother whose son has committed suicide by overdose of pain medication.

**(B) LARRY:** a 41-year-old married man who has been accused of looking under the bathroom door to see his 16-year-old stepdaughter

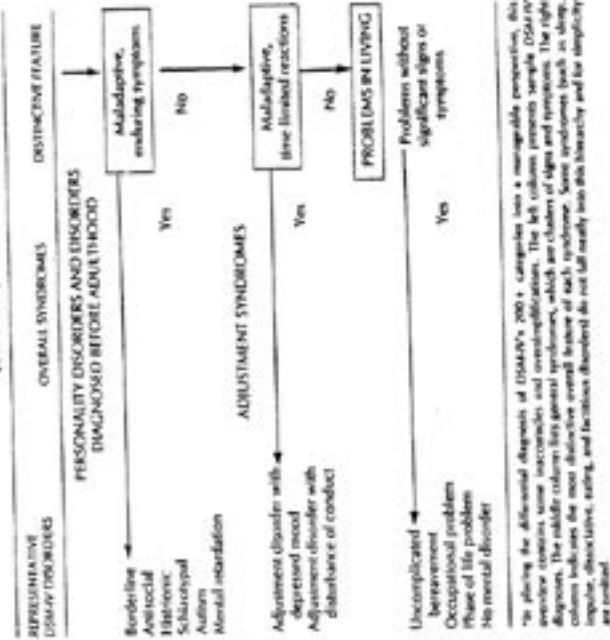
**(C) LUKE:** a 15-year-old boy who's continued disruptive and destructive behavior at home and school have become uncontrollable for his retired grandparents

**(D) LINDA:** a 24-year-old young woman who attempted suicide by cutting her wrists.

**FIGURE 3-1**  
An Overview of Differential Diagnosis\*



**FIGURE 3-1**  
(Continued)



\*In giving the differential diagnosis of DSM-IV's 200+ categories into a manageable perspective, this overview stresses some similarities and overlapping categories. The left column presents simple DSM-IV diagnoses. The middle column lists general syndromes, which are clusters of signs and symptoms. The right column lists the most distinctive overall features of each syndrome. Some syndromes branch in sleep, appetite, obsessive, eating, and functional disorders do not fall neatly into this hierarchy and for simplicity are omitted.

from *Essentials of Psychopathology*  
MANHATTAN & BIRD, 1995

# HANDOUT 2.55 /DELUSIONS AND THOUGHT DISORDERS

## DELUSIONS AND THOUGHT DISORDERS

**Delusion** — False beliefs that are inconsistent with the thinker’s background or level of intelligence.

**Thought Disorders** — Disrupted patterns of cognition, logic or language demonstrated in the thinker’s speech.

### TYPES OF DELUSIONS

- Persecution: The belief that someone is trying to harm the person or their loved ones.
- Somatic: The belief that involves a preoccupation with one’s body, especially that disease is present when it is not.
- Reference: The belief that events and behaviors of others are targeted toward oneself.
- Grandeur: The belief in an exaggerated view of one’s own importance. This belief can be specific or rather vague.
- Nihilism: The belief that oneself, the world and others are unreal and non-existent. One is “living in a dream.”
- Thought Insertion: The belief that thoughts are being inserted into one’s mind by an outside force.
- Thought Broadcasting: The belief that one’s thoughts can be heard by others.

### TYPES OF THOUGHT DISORDERS

- Flight of Ideas: Speech is intelligible, but marked by fast pace and rapid acceleration with fast changes of topic.
- Incoherence: Speech that is lacking in meaning or structure. Connecting words in a manner that make no sense.
- Loose Associations: Speech is illogical, unfocused and follows a vague train of thought.
- Clanging: The sounds of words determines the content of speech with a lot of rhyming.
- Neologisms: Speech that demonstrates the invention of new words or distortion of existing ones, to match some self-perceiving meaning.
- Perseveration: Repeating the same phrases over and over again.
- Circumstantiality: Long rambling speech filled with unnecessary, unimportant details.

*Adapted from: Halgin, R.P and Whitborne, S.K. (1994) Abnormal Psychology: The Human Experience of Psychological Disorders. Harcourt Brace: Fort Worth*

## HANDOUT 2.60 / SCHIZOPHRENIC DISORDERS

### **SUBTYPES:**

#### **Paranoid Type**

Prominent persecutory or grandiose delusions, multiple, but organized around a central theme, with hallucinations related to content of delusions.

#### **Disorganized Type**

Disorganized speech, disorganized behavior, flat or inappropriate affect.

#### **Catatonic Type**

Motoric immobility as evidenced by catalepsy (including waxy flexibility) or stupor; excessive senseless motor activity; extreme negativism (motiveless resistance to instructions or maintenance of rigid posture); posturing, stereotyped movements, prominent mannerisms or grimacing

#### **Undifferentiated Type**

Criteria for paranoid, disorganized or catatonic type not met

#### **Residual Type**

Absence of positive symptoms, presence of negative symptoms and attenuated criteria, i.e. odd beliefs, unusual perceptual experiences

## HANDOUT 2.77 / POST TEST

1. One in every twenty families is effected in their lifetime by a severe mental illness such as major depression, bipolar disorder, or schizophrenia.  
True False
2. A diagnosis of an Anxiety Disorder implies that the individual experiences symptoms of anxiety that go beyond what a normal person would have in certain situations.  
True False
3. People who talk about suicide always require hospitalization.  
True False
4. An identical twin has a 50% chance of developing schizophrenia if the other twin is diagnosed with schizophrenia.  
True False
5. Once a diagnostic label is given to a person, the label itself may create powerful negative influences that have serious social and political implications.  
True False
6. The experience of being mentally ill has many parallels with the experience of having a substance disorder.  
True False
7. Mental disorders have a very narrow range of severity.  
True False
8. More than half of those with bipolar disorder also have comorbid alcohol or drug abuse at some time in their life.  
True False
9. Men and women are equally effected by Bipolar I Disorder.  
True False
10. Borderline personality disorder is a pervasive pattern of instability in interpersonal relationships, self-image and mood with marked impulsiveness.  
True False



## HANDOUT 2.78 / EVALUATION

### AXIS I & AXIS II, A REVIEW OF MAJOR MENTAL DISORDERS

**INSTRUCTIONS:** Thank you for taking a moment to complete this evaluation and feedback form. Your input will help us to improve the curriculum. Your answers and comments are completely anonymous. *Do not put your name on this form.*

**CODE:** SD=Strongly Disagree, D=Disagree, U=Unsure, A=Agree, SA=Strongly Agree

ITEM	SD	D	U	A	SA
Content was relevant and current.	1	2	3	4	5
The facilitators were organized and had good presentation skills.	1	2	3	4	5
Handouts and audiovisual aids were relevant and helpful.	1	2	3	4	5
The facilitators provided opportunities for discussion and interaction	1	2	3	4	5
The facilitators were knowledgeable in the subject.	1	2	3	4	5
I learned information that will be useful in my current work.	1	2	3	4	5
Overall, this session was effective and informative.	1	2	3	4	5
Goals for this module were met	1	2	3	4	5

If you circled one or more items above as a 2 or 3, please give us more information.

The most important thing I learned today was:

If I could change one thing about this session, it would be:

# TRAINING CURRICULUM

1

## CO-OCCURRING SUBSTANCE USE & MENTAL HEALTH DISORDERS IN ADULTS

DSM-IV & DSM-IV TR Mental Health Training for Addiction Professionals

2

### INTRODUCTION

- This module of the Co-Occurring Disorders in Adults is intended to address the cross training needs of substance abuse professionals and to give them a basic understanding of mental illness diagnoses that frequently co-occur with substance abuse.
- This training is aimed at bachelors and masters level staff who are team leaders, clinical supervisors or therapists. This is the level of staff that is optimal to reach to make system changes since they are the leaders of the treatment teams. This training is also beneficial for front line staff who provide services to persons with co-occurring disorders.

#### TRAINER NOTE

The Trainer was introduced in previous day's training, so the focus can move on to today's participants who are substance abuse professionals.

Make sure that participants are in the correct session. Mental health professionals should be in the other session.

For more information on specific mental health disorders, please see Appendix D of CSAT's *Treatment Improvement Protocol (TIP) 42: Substance Abuse Treatment for Persons with Co-occurring Disorders*, "Specific mental disorders: Additional guidance for the counselor." In addition, Chapter 8: A Brief Overview of Specific Mental Disorders and Cross-Cutting Issues (pp. 213-248) may also be useful.

3

### AGENDA

- Introduction (30 minutes)
- What is a Mental Disorder? (30 minutes)
- Review of DSM -IV and DSM-IV TR (30 minutes)
- Break (15 minutes)
- Risk Assessment (30 minutes)
- Multi-axial Assessment (45 minutes)
- Lunch (60 minutes)
- Axis I Disorders (90 minutes)
- Break (15 minutes)
- Axis II Disorders (45 minutes)
- Summary, Post-test & Evaluation (15 minutes)

Review the agenda for the day, including when the breaks are planned and that lunch is one hour.

## 4

### COMPETENCIES

- Familiarity with categories within, and use of the DSM-IV as a means of reviewing current diagnostic criteria and related features of disorders described therein.
- Familiarity with DSM-IV diagnostic criteria for Axis I and II mental disorders including psychotic, affective and anxiety disorders and all three clusters of personality disorders, as well as associated epidemiological features.
- Comprehension of the effects on functioning and degree of disability related to substance related and mental disorders, both separately and combined.

## 5

### COMPETENCIES

- Knowledge of the bio-psychosocial components of assessment, including the spiritual dimension, when assessing both psychiatric and substance related disorders.
- Familiarity with interventions designed to aid in the recovery of persons with traumatic histories and co-occurring disorders.

## 6

### INTRODUCTORY ACTIVITIES

- Participant Introductions & Expectations
- Review group participation expectations, rules about confidentiality, and the use of cell phones and pagers
- Administer Pre-test (optional) and review
- Review the objective and goals of this module (next two slides)

#### TRAINER NOTE

Getting to Know You Exercise:

Ask the participants to pair up with someone that they do not know. Give them 5 minutes to interview each other and answer the following questions: name, where they work and what they want to learn from today's session about persons with co-occurring disorders. They will be introducing their partner to the larger group and identifying what this person wants to learn today about persons with co-occurring disorders. Trainer should list the topics or questions on a flip chart for reference through the day.

Review group participation expectations:

- Questions are encouraged as we go along
- Remain open minded
- Show respect for each other's points of view
- Be critical thinkers
- Maintain confidentiality
- Begin to make changes in how you think about persons with co-occurring disorders and how this will affect your work with them



7

Let participants know that they can take additional breaks when needed but to leave and rejoin the group quietly. Encourage participants to turn off pagers and cell phones. If they cannot, then have them turn them to silent alert and ask that they quietly leave the room before answering their phone.

- Administer the Pre-test (optional). Participants are not to put their names on the test. Handout 2.0 Correct answers are on the Trainer's copy, Trainer Aid 2.0 Quickly review correct answers. Collect.

## OBJECTIVE OF REVIEW OF MAJOR MENTAL DISORDERS FOR ADDICTION PROFESSIONALS

- OBJECTIVE: Participants will review psychotic, affective, anxiety disorders and personality disorders in the DSM-IV that usually co-occur with substance use. Risk assessment and information about psychopharmacology resources are also presented.

8

## GOALS FOR PARTICIPANTS

- At the end of this training module participants are expected to be able to:
- Demonstrate an increased understanding of the major mental illnesses, prevalence rates, signs & symptoms, and possible causes.
- Be able to recognize and make a provisional diagnosis based upon the DSM-IV.
- Identify the need for further exploration of symptoms, special problems or risk assessment and make proper referrals.
- Identify an area for change in his/her practice with persons with co-occurring disorders.

9

## WHAT IS A MENTAL DISORDER?

- Group exercise T/F
- Discussion

### TRAINER NOTE

Group Exercise: Review the following statements and ask participants to say whether they think they are true or false.

STATEMENT 1: If a person with mental illness has a really bad history, there isn't much hope.

FALSE - "A person's history is important in predicting his/her chances for recovery. But some may be ill for many years before they finally receive effective treatment or their condition improves for other reasons." Latest research is resulting in better medications and treatment techniques that are coming out on a regular basis. (The 14 Worst Myths About Recovered Mental Patients)

STATEMENT 2: The symptoms of schizophrenia are effectively treated by medications in about 62% of patients.

TRUE - Estimates range from 50-75%. There is also evidence indicating that certain family intervention models can contribute to reduced relapse rates. Additionally, there is growing support for the effectiveness of psychosocial rehabilitation and intensive



case management with this population. As a comparison, treatment success rate for heart disease is about 50%. (Myths of Mental Illness, NAMI, New Hope for People with Schizophrenia)

STATEMENT 3: A person with antisocial personality disorder has about a 1 in 3 chance of long term improvement with a combination of medication and therapeutic treatment.

TRUE - Antidepressants that raise serotonin levels have shown some promise, and long term studies of improvement over time are supporting this statement. (Introduction to Psychology)

STATEMENT 4: Those with schizophrenia are dangerous.

GENERALLY FALSE - They can be unpredictable. "Persons with schizophrenia, when they are ill, may have confused thoughts. They may also suffer from delusions or hallucinations. Appropriate medication will often control or eliminate these symptoms and any accompanying unpredictability." (The 14 Worst Myths About Recovered Mental Patients)

STATEMENT 5: One in every 20 families is affected in their lifetime by a severe mental illness, such as bipolar disorder, schizophrenia, and major depression.

FALSE - it is actually one in every 4 families. (The Myths of Mental Illness, NAMI)

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## **WHAT IS A SERIOUS MENTAL ILLNESS? – FEDERAL ADULT DEFINITION**

- Persons 18 years or over who currently, or at any time in the past year, have had a diagnosable mental, behavioral or emotional disorder according to DSM criteria.
- The disorder results in functional impairment that interferes with or limits major life activities.

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## **WHAT IS A SERIOUS MENTAL ILLNESS? – FEDERAL ADULT DEFINITION**

- Disorders in DSM except "v" codes, developmental disorders, and substance abuse disorders unless they co-occur with other serious mental illness.
- Functional impairments affect: basic living skills, instrumental living skills, and functioning in social, family and vocational contexts.

12

## **REVIEW INFORMATION ABOUT THE DEFINITION OF ADULTS WITH SERIOUS MENTAL ILLNESS IN YOUR STATE**

For states other than Pennsylvania: Review information about your state's definition of adults with serious mental illness and give your handouts, if available.

## WHAT IS A SERIOUS MENTAL ILLNESS? – PENNSYLVANIA ADULT DEFINITION

- Pennsylvania used this federal definition to establish an Adult Priority Group:
- Must be 18+ and meet the federal definition of serious mental illness
- Must have diagnosis of schizophrenia, major mood disorder, psychotic disorder or borderline personality disorder.
- Must meet one of following criteria from A, B or C.

*Skip these slides if you are presenting in another state.*

### CONTENT FOR TRAININGS IN PENNSYLVANIA

- Review the definition of a Serious Mental Illness Handout 2.1a
- Definition of Serious Mental Illness (from the Commonwealth of Pennsylvania's Department of Public Welfare's - Mental Health Bulletin dated March 4, 1994)

While the clinical definition of a mental disorder involves a prolonged or recurring psychological problem that seriously interferes with an individual's ability to live a satisfying personal life and function adequately in society, the Center for Mental Health Services published its official definition of serious mental illness in the Federal Register, May 20, 1992:

Pursuant to Section 1912(c) of the Public Health Services Act, as amended by Public Law 102-321, 'adults with serious mental illness' are persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-III-R that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

These disorders include any mental disorders (including those of biological etiology) listed in DSM-III-R or their ICD-9-CM equivalent (and subsequent revisions), with the exception of the DSM-III-R 'V' codes, substance use disorders and developmental disorders, which are excluded unless they co-occur with other diagnosable serious mental illness. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity of disabling effects.

Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in one or more major life activities including basic daily living skills (e.g. eating, bathing, dressing); instrumental living skills (e.g. maintaining a household, managing money, getting around the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts. Adults who would have met functional impairment criteria during the referenced year without benefit of treatment or other support services are considered to have serious mental illnesses."

- As a part of this CMHS definition, states were permitted to establish priority mental illnesses for access to federal funds and/or services under the CMHS block grant program. The State of Pennsylvania requires their Adult Priority Group to meet the following criteria:
  - Must be 18 or older (or age 22 or older if in special education)
  - Diagnosis of:
    - Schizophrenia
    - Major Mood Disorder
    - Psychotic Disorder, NOS
    - Borderline Personality Disorder
  - Review the Co-Existing Disorders criteria on Slides 17, 18 noting substance abuse as a Co-occurring Disorder that may affect priority eligibility for SMI services.



- But this definition is not enough for us to understand the internal experience of mental disorders. For those experiencing them, mental disorders are:
- Painful
- Maladaptive
- Out of control
- Substance disorders are a subset of mental disorders, and some of the things that drive people to substance abuse and dependence are characteristic of other mental disorders as well.
- There are parallels between substance disorders and other mental disorders. Those same internal experiences are true of substance disorders and other mental disorders.
- The experience of being mentally ill is something that happens consistently, with a feeling that you can't get out of it. This is different than having a period of emotional disturbance. We all get angry, sad, grieve losses, make mental mistakes, but we are not experiencing mental illness. Just as we can use a substance such as alcohol occasionally but not be addicted.
- A further consideration: use of the term "individual" brings with it all of the inconsistencies and unique characteristics of a person, and people with the same disorder don't always present exactly the same way.
- Despite our best efforts to categorize mental disorders and their symptoms, our efforts are complicated by individual characteristics.

**14**

### **WHAT IS A SERIOUS MENTAL ILLNESS? – PENNSYLVANIA ADULT DEFINITION**

- A. Treatment History:
  1. Current residence in or discharge from a state mental hospital within the past two years.
  2. Two admissions to community or correctional inpatient psychiatric units or crisis residential services totaling 20 or more days within the past two years.

**15**

### **WHAT IS A SERIOUS MENTAL ILLNESS? – PENNSYLVANIA ADULT DEFINITION**

- A. Treatment History:
  3. Five or more face to face contacts with walk-in or mobile crisis emergency services within the past two years.
  4. One or more years of continuous attendance in a community mental health or prison psychiatric service within the past two years.

**16**

## **WHAT IS A SERIOUS MENTAL ILLNESS? – PENNSYLVANIA ADULT DEFINITION**

- A. Treatment History:
- 5. History of sporadic course of treatment: three missed appointments in past six months, or inability or unwillingness to maintain medication regimen, or involuntary commitment to outpatient services.
- 6. One or more years of treatment for mental illness provided by a primary care physician or other non-mental health agency clinician within the past two years.

**17**

## **WHAT IS A SERIOUS MENTAL ILLNESS? – PENNSYLVANIA ADULT DEFINITION**

- B. Functioning Level: Global Level of Functioning Scale rating of 50 or below.
- C. Co-existing Condition or Circumstance:
  1. Co-existing diagnosis or psychoactive substance use disorder, mental retardation, HIV/AIDS, or sensory, developmental or physical disability.

**18**

## **WHAT IS A SERIOUS MENTAL ILLNESS? – PENNSYLVANIA ADULT DEFINITION**

- C. Co-existing Condition or Circumstance
  1. Homelessness
  2. Release from criminal detention

Any adult who has met standards for involuntary treatment within the preceding 12 months is automatically assigned to the high priority group.

**19**

## **BIO-PSYCHOSOCIAL CONSIDERATIONS OF MENTAL DISORDERS**

- Most disorders seem to contain more or less varying levels of biological, psychological, and social components.

### CONTENT

- Most disorders seem to contain more or less varying levels of biological, psychological and social components.
- For example, the disorder or disease of schizophrenia may include:
  - Genetic predisposition
  - Biological changes in the brain
  - Social and environmental stressors that trigger the disorder
  - Cognitive thought process disruption
  - Emotional flatness
  - Family adaptation





- The disorder or disease of substance addiction may include these same components at varying levels, as do other mental disorders
- So many differing views on cause, effect, and experience are included in the bio-psychosocial model, which represents the complexities of a disorder and the varying level of biological, stress, cognitive and affective, familial and social disturbances and stressors.
- Disorders have a wide range of severity, even within each kind of disorder There are persons with schizophrenia who are completely dysfunctional who do not respond well to medication; others who with medication can have jobs, spouses, etc.
- There are persons suffering from depression who are unable to get out of bed for weeks or more, others who are able to function with at least minimal effectiveness.
- There are people who are addicted to a substance that end up on the street and others who hold down a job.
- The bio-psychosocial model helps us to:
  - conceptualize disorders
  - understand the various contributors to disorders
  - view the uniqueness of each individual who suffers from a mental disorder
  - determine where and how to intervene with treatment

**20**

## **BIO-PSYCHOSOCIAL CONSIDERATIONS OF MENTAL DISORDERS**

### **The disorder or disease of schizophrenia may include:**

- Genetic predisposition
- Biological changes in the brain
- Social and environmental stressors that trigger the disorder
- Cognitive thought process disruption
- Emotional flatness
- Family adaptation

**21**

## **BIO-PSYCHOSOCIAL CONSIDERATIONS OF MENTAL DISORDERS**

Disorders have a wide range of severity, even within each kind of disorder.

**22**

### **THE BIO-PSYCHOSOCIAL MODEL HELPS US TO:**

- Conceptualize disorders
- Understand the various contributors to disorders
- View the uniqueness of each individual who suffers from a mental disorder
- Determine where and how to intervene with treatment

## ADVANTAGES OF USING THE DSM-IV

- Mental health professionals use it to communicate with one another and to discuss their client's problems.
- Researchers use it to study and explain mental disorders.
- Therapists use it to design their treatment program to fit their client's problems.
- Payers require it for billing/reimbursement

### TRAINER NOTE

- Ask participants to refer to their own copies of the DSM- IV.

### Content

- The DSM is an imperfect attempt to describe disorders that have an existence independent of their descriptors. The essence of the disorder is an inner experience. We can use the DSM as a starting point, but it is more important to think in terms of the essence of the inner experience of the individual. What is it like to have bipolar disorder? How would it feel to be addicted to cocaine?
- The Diagnostic and Statistical Manual of Mental Disorders describes a uniform system for assessing specific symptoms and matching them to almost 300 different mental disorders. The first DSM was published in 1952 and major improvements have been added with each revision.
- Point out that:
- The DSM IV TR (2000) is a text revision of the DSM IV, which was published in 1992. The goals of this revision included:
  - to correct any factual errors that were identified in the DSM IV
  - to ensure that all of the information is still up-to-date
  - to make changes that reflect new information from the literature reviews
  - to make improvements that will increase the educational value of the DSM
  - and to update that codes that were changed since the 1996 coding update
- All changes were supported by empirical data. No substantial changes were made in the criteria sets, and no proposals were entertained for new disorders, new subtypes, or changes in the appendix categories.
- Generally, since the text revision is not put into the organized format of the DSM IV with distinct boxes of symptom lists, it is easier to use the DSM IV with its format. Both the DSM IV and DSM IV-TR have decision trees in their appendices.

## APPLE EXERCISE

### TRAINER NOTE

- Tell participants it is time for an exercise; have participants choose an apple (oranges may be substituted - the trainer must ensure that there are enough differences between the oranges).
- Ask participants to describe the characteristics of an apple and write them on the flip chart or dry-erase board. They should come up with things like: the red color, it's a fruit, comes from certain climates, grows on a tree, makes good juice, has seeds and skin, etc.
- Explain that we all pretty much know and agree on the characteristics of an apple.



**25**

- Ask participants to examine their apple more closely and find one characteristic of their apple that would distinguish it from everyone else's and to memorize it. Next, ask participants to get up and put their apples on one table and return to their seats.
- Trainer should mix up the apples on the table. Now ask participants to come up and get their personal apple. The participants should be able to retrieve their own original apple.
- Process the exercise by asking:
  - How did you know which apple was yours?
  - Did you find it easy to distinguish your apple from the others?
  - What do they think this exercise tells us about labels and categories?
  - You should get various answers, but when someone brings up the idea of differences within categories or stereotyped labels, you can use it as a transition into the disadvantages of the DSM.
- Participants can keep their apple as a snack if they desire.

## **RISKS OF DIAGNOSIS AND CLASSIFICATION**

- Can result in a view of a person as a disorder, not a unique individual, bio-psychosocially developed with a disorder.
- Encourages us to forget the mental disorder as an inner, unique experience.
- Assigns a label with all of its powerful negative influences: personally, socially, politically. Stigma and depersonalization can result.

**26**

### **~MORNING BREAK~**

Please come back in 15 minutes

**27**

## **HOW DO WE DEFINE DANGEROUSNESS?**

- Dangerousness is the potential for behaviors that cause harm to self or others and/or the destruction of property.
- Dangerousness can be viewed as existing on different levels (high, moderate, low) depending on the interplay of contributing factors: behavior, timing, predictability and likelihood.

### **TRAINER NOTE**

Introduction - Group Handout/Discussion

- Distribute Handout 2.8 to participants and ask them to check whether they agree or disagree (and why or why not) with each statement on the handout. Give just a few minutes for participants to complete the handout.
- Review each statement with the participants by asking for a show of hands. Encourage participants to give examples from their own work, maintaining confidentiality.

### **CONTENT**

- These statements are general, vague and need to be viewed with a broad perspective. They are neither true nor false in every situation.



- The majority of mentally ill persons do not present in increased danger to others. Most mental disorders are not associated with risk to others, although some can present a danger to themselves and sometimes to others as well. Severe eating disorder is a risk to self; conduct disorder can present a risk to others.

- Most people who threaten suicide generally do not follow through. Although statistically this may be true, all suicide threats should be taken seriously by the mental health or substance abuse professional as requiring further assessment.

- Persons with severe mental illness, when actively experiencing acute symptoms may present an increased risk to self or others.

Once again, maybe, maybe not. Some, but not all, experiencing active hallucinations or delusions, or some going through detoxification, for example, can physically act out, increasing risk of harm

- Risk is increased greatly if a severely mentally ill person is also misusing or abusing drugs or alcohol.

Some stimulants and depressants can heighten the acute symptoms, while some can mask them. Substance misuse as an escape is a popular phenomenon, while barbiturates can heighten a depressive episode.

- Persons with some types of personality disorders/traits may present in increased risk to others.

Some persons suffering from anti-social personality disorder, impulsivity or low frustration tolerance may tend to acting out behaviors, some of which may or may not be of increased risk to others.

- In all these cases, it is the assessment that helps us identify which persons may be at risk of hurting themselves or someone else.

#### How Do We Define Dangerousness?

- Dangerousness is the potential for behaviors that cause harm to self or others and/or the destruction of property. Dangerousness can be viewed as existing on different levels (high, moderate, low) depending on the interplay of its contributing factors, such as:

- Behavior
- Timing
- Predictability
- Likelihood

- Although dangerousness cannot be predicted with 100% accuracy, the best predictor of future dangerousness is past dangerousness. Therefore, serious effort and attention should be given to obtaining an accurate history of past behavior. The clinical decision to deem individuals “dangerous” or “not dangerous” should rest on a comprehensive assessment.

## WHAT ARE THE TYPES OF DANGEROUSNESS?

- Type 1: High Severity

Consequences very likely to occur and include loss of life, limb, and/or major property destruction.

### CONTENT

What Are the Types of Dangerousness? (Richard Fields, MD)

- Type 1: High Severity  
Consequences very likely to occur and include loss of life, limb, and/or major property destruction.
- Type 2: Moderate Severity  
Consequences somewhat likely to occur and result in harm, injury or property destruction that is limited and not life threatening.
- Type 3: Low Severity  
Consequences unlikely to occur or result in harm, injury or property destruction.

### WHAT DOES “IMMINENT DANGEROUSNESS” MEAN?

#### CONTENT

- “Imminent” or “Not imminent” relates to the timing of behavior. Generally, imminent refers to the 24 hours following the actual assessment. Imminent can be defined as a longer period of time when necessary, but it is usually anticipated that these 24 hours will offer the opportunity to change one of the “dangerousness” circumstances.

## WHAT ARE THE TYPES OF DANGEROUSNESS?

- Type 2: Moderate Severity

Consequences somewhat likely to occur and result in harm, injury or property destruction that is limited and not life threatening.

## WHAT ARE THE TYPES OF DANGEROUSNESS?

- Type 3: Low Severity

Consequences unlikely to occur or result in harm, injury or property destruction.

## WHAT KINDS OF QUESTIONS SHOULD WE CONSIDER WHEN ASSESSING SAFETY AND/OR DANGEROUSNESS?

- What is the “dangerous” behavior?
- How severe are the likely consequences?
- How imminent is it?
- How predictable is it?
- How likely is it?





## CONTENT

- Effective assessment and treatment of safety risks and dangerousness potential is based upon a dialogue between professional and client that considers the following areas:
- What kinds of questions Handout 2.11 should I consider when assessing safety and/or dangerousness?

## TRAINER NOTE

- Ask the participants to answer the questions below and write the responses on the dry-erase or blackboard. If the participants do not come up with all the answers below, facilitator should provide them.

1.) What is the “dangerous” behavior?

Self harm	Suicide
Threat to others	Specific threats

2.) How severe are the likely consequences of it?

Self mutilation	Death of self or others
Physical harm to others	Property destruction

3.) How imminent is it?

In the immediate moment, what are the factors more or less likely to contribute to risk of safety or dangerousness?

Is the client planning on taking action now, in this moment? If so, can she or he? (For example, they may say they are going to commit suicide now and mean it, but the risk is much reduced if they are an inpatient, being observed, without means)

4.) How predictable is it?

Is there a history of similar behavior?

Are the current stressors likely to enhance the possibility of dangerousness?

What is the client’s current ability to cope with stress?

Given the DSM IV diagnosis, is dangerousness a more or less common occurrence? (i.e. acute manic episode, paranoia, hallucinations, depression with some increased energy)

Consider demographics, e.g.,

Male, age 15 - 25, acting out behavior

Socio-economic status as a stressor

5.) How likely is it?

Does the client have a plan?

Does the client have the means?

Does the client have the current motivation?

Is the client misusing or abusing stimulants or alcohol?

**DON’T BE AFRAID TO ASK THE CLIENT DIRECTLY ABOUT HIS/HER INTENTION TO HARM SELF OR OTHERS!**

## TRAINER NOTE

- Provide the T.A.S.S.I. - Diagnostic Tree for Assessing Suicide and Suicide Intervention (Welch, I. D., Ziegler, D. L., & Rosswog, D. M., 2000) Handout 2.14 as a model of suicide assessment that might be helpful. Explain that there are many models and that agencies may use their own. Ask participants to share their protocol and experiences with assessing risk of dangerousness.

## RESPONSES TO SAFETY AND DANGEROUSNESS RISKS

### CONTENT

- Responses vary depending on the level of risk, of course. They vary from voluntary or involuntary hospitalization, crisis stabilization, outpatient care and so on. If we have any doubts, seek supervisory assistance. Although we cannot be accurate in our risk assessment 100% of the time, professionals agree it is better by far to err on the side of caution.

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## REVIEW YOUR STATE'S POLICY ABOUT DUTY TO WARN

Review this using handouts from your state that address this issue.

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## DUTY TO WARN FOR MENTAL HEALTH PROFESSIONALS IN PENNSYLVANIA

- Pennsylvania Supreme Court case of Emerich vs. Philadelphia Center for Human Development.
- The existence of a specific and immediate threat of serious bodily injury that has been communicated to the treating professional.
- The threat must be made against a specific or readily identified third party.

### TRAINER NOTE

Review this only if you are training in Pennsylvania. If not, hit the space bar once to skip this slide.

Distribute handout Handout 2.12 and discuss.

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## WHY A PSYCHIATRIC DIAGNOSIS?

Define clinical entities so that clinicians have the same understanding of the disorder, which generally has similar:

- Symptoms
- Natural history: onset, prognosis, complications
- Etiology: origins
- Pathogenesis: course of development

Determine treatment

### AXIS DIFFERENTIATION

#### TRAINER NOTE

- The beginning of this section is heavy in the didactic area. Ask participants to follow along in the DSM IV if they like. Assess the level of sophistication of your participants - you may not have to read down all the lists below but rather, give a general overview.


#### CONTENT

- Why a psychiatric diagnosis?
- Define clinical entities so that clinicians have the same understanding of the disorder, which generally has similar:
  - ~ Symptoms (although not always presenting exactly the same)
  - ~ Natural history – onset, prognosis, complications (onset of Schizophrenia usually early twenties, sometimes late teens)
  - ~ Etiology – origins (genetically transmitted, runs in families, predisposition's)
  - ~ Pathogenesis – course of development (Borderline PD symptoms subside in middle age)
- Determine treatment

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## WHY A MULTI-AXIAL DIAGNOSIS?

Originally proposed in 1947 and incorporated into DSM in 1980

- Clarify the complexities and relationships of bio-psychosocial difficulties
  - Facilitate treatment planning
  - Distinguish between long term chronic and stable Axis II disorders and more treatable Axis I disorders
- 
- Why a multi-axial diagnosis? (Originally proposed in Sweden in 1947, but incorporated into DSM III in 1980.)
  - Clarify the complexities and relationships of biopsychosocial difficulties
  - Facilitate treatment planning
  - Distinguish between long term chronic and stable Axis II disorders and more treatable Axis I disorders
  - Shorthand message between clinicians
  - Attempts to assess the multiple factors contributing to the source and treatment of the disorder

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## WHY A MULTI-AXIAL DIAGNOSIS?

- Shorthand communication between clinicians
- Attempts to assess the multiple factors contributing to the source and treatment of the disorder

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## WHAT ARE THE FIVE AXES?

- Axis I: Clinical syndromes (mental disorders); developmental disorders; other conditions that may be a focus of clinical attention
- Axis II: Personality disorders and traits; mental retardation

What are the five axes?

- Axis I: Clinical syndromes (e.g. mental disorders); developmental disorders; other conditions that may be a focus of clinical attention
- Axis II: Personality disorders and traits; mental retardation
- Axis III: General medical conditions/symptoms that pertain to current problems
- Axis IV: Psychosocial & environmental problems
- Axis V: Global Assessment of Functioning (GAF)

Example of Multiaxial Diagnosis:

- Axis I: Major Depressive Disorder, Recurrent, and Severe without psychotic symptoms
- Axis II: None
- Axis III: Multiple Sclerosis, progressive relapsing remitting
- Axis IV: Occupational, acute - loss of employment due to Axis III DX, Primary support group, acute marital separation
- Axis V: GAF present: 45; Highest in last 12 months: 75





## TRAINER NOTE

- Pause here and take questions. Refer participants to the DSM IV manual for more information, and also refer to the book Essential Psychopathology and its Treatment (Maxmen & Ward) and Neuropsychology for Clinical Practice (Adams, Parson, Culbertson & Nixon), all of which were used for the information throughout this section. Explain that our next step is look at the five axes in more detail.

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## WHAT ARE THE FIVE AXES?

- Axis III: General medical conditions or symptoms that pertain to current problems
- Axis IV: Psychosocial and environmental problems
- Axis V: Global Assessment of Functioning (GAF)

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## EXAMPLE OF MULTI-AXIAL DIAGNOSIS

- Axis I: Major Depressive Disorder, Recurrent, Severe without Psychotic Symptoms
- Axis II: None
- Axis III: Multiple Sclerosis, progressive relapsing, remitting

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## EXAMPLE OF MULTIAXIAL DIAGNOSIS

- Axis IV: Occupational, acute — loss of employment due to Axis III Diagnosis  
Primary support group, acute-marital separation
- Axis V: GAF present: 45  
Highest in last 12 months: 75

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## AXIS I

- Disorders usually first diagnosed in infancy, childhood, or adolescence
  - Delirium, dementia, amnestic and other cognitive disorders
  - Mental disorders due to a general medical condition
  - Substance related disorders
  - Schizophrenia and other psychotic disorders
- 
- Axis I: Clinical Disorders and other conditions that may be a focus of clinical attention.  
Adjustment Disorders
    - Comment that if an individual has more than one Axis I disorder, all should be reported. If they have a mental disorder and a substance disorder, both should



be listed. The goal of dual diagnosis is to diagnose both mental and substance disorders and to be able to treat both as primary disorders.

- Move to Axis II listing, but don't spend too much time here as we will discuss Personality Disorders in another section of the module.
- Axis II: Personality Disorders and Mental Retardation
  - This axis refers to disorders that involve patterns of personality traits that are longstanding, maladaptive, and inflexible and involve impaired functioning or subjective distress. (Plotnic, 1999) Axis II may also indicate prominent maladaptive personality features or defense mechanisms that do not meet the threshold for personality disorders.
- Axis III: General Medical Conditions
  - This axis is used to report current medical conditions that are potentially relevant to the understanding or management of the individual's mental disorder. This medical condition may be directly etiological to the development or worsening of the mental illness, or the axis I disorder may be a psychological reaction to the medical condition.
- Axis IV: Psychosocial and Environmental Problems
  - This axis refers to psychosocial and environmental problems that might affect the diagnosis, treatment, or prognosis of mental disorders in Axis I or Axis II. When an individual has multiple problems of this nature, the clinician may note as many as are judged to be relevant that have been present during the year preceding the evaluation.
  - The problems are grouped together into categories
- Axis V: Global assessment of functioning (GAF) scale.
  - Why utilize the Axis V rating?
    - ~ Indicates client's current OVERALL level of social, psychological and occupational functioning
    - ~ Does not include physical functioning and limitations reported in Axis III
    - ~ Ascertains level of functioning in the present
    - ~ Along with Axis I, helps clinicians decide on any immediate actions
    - ~ Usually includes highest level of functioning in last 12 months to help with prognosis issues
  - DSM IV, page 32, gives a step by step method to determine the GAF, which you can review if they want to.

#### TRAINER NOTE

- Pause here and ask the participants why it is important to include all five Axes in a diagnosis?
- List their responses on the dry erase or blackboard. You should generate responses such as:

Communication between clinicians

Treatment considerations

Prognosis considerations

Dual diagnosis issues

Assessment assistance

Helps us avoid jumping to conclusions based on only one or two symptoms!

Mention here too that a full intake assessment is critical to gaining an accurate five-axis diagnosis, and that missing information can mean the difference between adequate treatment and failure to treat appropriately. Also mention that it is not always possible to be 100% on with diagnosis; there is still a clinical judgement involved, as people are usually complex.

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**AXIS I**

- Mood disorders
- Anxiety disorders
- Somatoform disorders
- Factitious disorders
- Dissociative disorders

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**AXIS I**

- Sexual and gender identity disorders
- Eating disorders
- Sleep disorders
- Impulse control disorders
- Adjustment disorders

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**AXIS II**

- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
- Antisocial Personality Disorder

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**AXIS II**

- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Avoidant Personality Disorder

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**AXIS II**

- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder
- Personality Disorder, Not Otherwise Specified (NOS)
- Mental Retardation

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**AXIS III**

- Infectious and parasitic diseases
- Neoplasm
- Endocrine, nutritional, metabolic diseases
- Immunity disorders
- Diseases of the blood and blood forming organs

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### **AXIS III**

- Diseases of the nervous system and sense organs
- Diseases of the circulatory system
- Diseases of the respiratory system
- Diseases of the digestive system

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### **AXIS III**

- Diseases of the genitourinary system
- Complications of pregnancy, childbirth and post-partum
- Diseases of the skin and subcutaneous tissue
- Diseases of the muscular-skeletal system and connective tissue

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### **AXIS III**

- Congenital anomalies
- Certain conditions originating in the perinatal period
- Symptoms, signs and ill-defined conditions, injury and poisoning

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### **AXIS IV**

#### **Psychosocial and environmental problems**

- Problems with primary support group
- Problems related to the social environment
- Educational problems
- Occupational problems

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### **AXIS IV**

- Housing problems
- Economic problems
- Problems with access to health care services
- Legal problems
- Other psychosocial or environmental stress

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### **AXIS V**

#### **Global Assessment of Functioning (GAF)**

- Why use the Axis V rating?
- Indicates client's current OVERALL level of social, psychological and occupational functioning
- Does not include physical functioning and limitations reported in Axis III
- Ascertains level of functioning in the present

**AXIS V****Global Assessment of Functioning (GAF)**

- Along with Axis I, helps clinicians decide on any immediate actions
- Usually includes highest level of functioning in the last 12 months to help with prognosis issues

**DIAGNOSTIC CASE STUDY EXERCISE****EXERCISE****TRAINER NOTE**

- The trainer will divide the participants into four groups. Distribute Handout 2.26 - A, B, C, D one case study to each group with the following instructions.
- Read the case study and together come up with, as best you can, the five axis diagnoses. You will have about fifteen minutes to complete your work, and then one of you should be prepared to present your case and results to the whole class, using a flip chart page.

**CONTENT**

- Case Studies:
  - (A) Laurie: a 45-year-old single mother whose son has committed suicide by overdose of pain medication.
  - (B) Larry: a 41-year-old married man who has been accused of looking under the bathroom door to see his 16-year-old stepdaughter
  - (C) Luke: a 15-year-old boy who's continued disruptive and destructive behavior at home and school have become uncontrollable for his retired grandparents
  - (D) Linda: a 24-year-old young woman who attempted suicide by cutting her wrists.

**TRAINER NOTE**

- Trainer asks each group to present their cases in terms of brief overview and possible diagnosis. Some discussion may ensue. Do not comment on the accuracy of the diagnoses at this point. Post the flip chart pages in the room for later referral. Indicate to the participants that you want to revisit these cases later in the session. Identify either from the discussion or by asking what problems groups had on making the diagnoses. They should mention that there is not enough information to make an accurate diagnosis. One of the problems will most likely be regarding differentiation, i.e. "Which diagnosis is primary?" Use this as a transition into differential diagnosis.

**TRAINER NOTE**

- Decision Tree & Handout 2.30:
- The DSM IV and DSM IV-TR have a number of examples of decision trees in its appendix. Now, use one or more of the case studies to demonstrate the use of a decision tree and diagnostic principles.



## ~LUNCH BREAK~

Please come back in one hour. We will start promptly.

### TRAINERS PLEASE NOTE!

The afternoon session of this module includes a total of 1:55 minutes of video clips that clearly demonstrate the symptoms of the most common mental illnesses that co-occur with substance abuse. That allows only 1:05 minutes for the rest of the lecture and discussion. You can modify the selection of the videos to match the interests of your participants. The videos “Life After Trauma” and “Understanding Borderline Personality Disorder” are excellent and cover etiology, symptoms and treatment so that you can skip the lectures on Post Traumatic Stress Disorders and Borderline Personality Disorder if you view the videos in their entirety.

### TRAINER NOTE

- For the purposes of this training, we will focus on a general overview of the mood, anxiety and psychotic disorders, as these are more likely to co-occur with substance disorders. Facilitators should monitor time closely. Do not go into lengthy discussions about subtypes of disorders, and cover the subtypes only briefly, referring participants to the DSM IV manual. The main idea here is to cover Major Depressive, Bipolar, PTSD, Schizophrenia, Borderline Personality Disorder and Anti-social Personality Disorder and only touch on the rest. By now, the participants should know about the DSM enough to look up the others on their own.



## THE SUBSECTIONS OF EACH DSM GROUPING OF DISORDERS

- Listing of all disorders in the group
- Organization listing of the disorder section
- Coding guidelines
- Episode or disorder
- Specifiers for coding

### TRAINER NOTE

- Review the DSM IV section on Mood Disorders. Participants will need the DSM IV for this entire Axis I Disorder section of this module.
- Use the Mood Disorders to give an overview of the organization and information provided by the DSM. Refer to the page numbers on which the below overhead information can be found in both the DSM IV and DSM IV-TR

### CONTENT

- First, let's review the section to see what the DSM has to offer in terms of organization and information.

Slide 57 describes the subsections of each grouping of disorders

- Listing of all disorders in the grouping
- Organization listing of the disorder section
- Coding guidelines
- Episode or disorder
- Specifiers for coding

Slide 58 describes the organization of one disorder

- Features
- Associated features and disorders
- Associated laboratory findings



- Culture, age and gender features
- Course of the disorder
- Prevalence of the disorder
- Differential diagnosis guidelines
- Criteria for episode or disorder

#### TRAINER NOTE

- Point out that the prevalence information can usually be found in the DSM, but that for this course we are presenting additional sources of information. The numbers vary depending on source. Our sources for this entire Axis I and Axis II sections are the NIMH studies in the early to mid nineties and a book entitled What Works for Whom, Roth & Fonagy, 1996, currently being used in the Gannon Doctoral Counseling Psychology Program as most recent data available and which draws on a number of sources. We have also used these sources with regard to the treatment of choice sections.
- For our purposes, we are less interested in cause than we are in persistence. For those with co-occurring substance and mental disorders, it is not necessarily important which came first, the substance abuse or the mental illness. If they exist together, and exist separately as well, then we need to treat them both.

#### MOOD DISORDERS

- Major Depressive Disorder
- Characterized by one or more major depressive episodes.
- Diagnostic Criteria for Major Depressive Disorder/Episode (refer to DSM IV)
- Prevalence Slides 59-60
  - During a six-month period 6% of the population have diagnoses of a mood disorder.
  - Major depressive disorder and dysthymia affect 3% of the population.
  - The actual numbers vary depending on each survey. These seem to be accepted numbers at present, although many believe the numbers are higher because of undiagnosed cases.
  - There is also agreement that depression is twice as high in women and greater in young adults and that overall rate of depression is increasing.
  - There is a high probability of relapse.

### ORGANIZATION OF ONE DISORDER

- Features
- Associated features and disorders
- Associated laboratory findings
- Culture, age and gender features
- Course of the disorder
- Prevalence of the disorder
- Differential diagnosis guidelines
- Criteria for episode or disorder

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## MOOD DISORDERS

- Prevalence:
  - During a six month period, 6% of the population have a diagnosis of a mood disorder.
  - Major depressive disorder and dysthymia affect 3% of the population.
  - The actual percentages vary depending on each survey. These seem to be accepted numbers at present, although may believe that numbers are higher due to undiagnosed cases.

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## MOOD DISORDERS

- There is also agreement that depression is twice as high in women, greater in young adults and that the overall rate of depression is increasing.
- There is a high probability of relapse in the future.

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## MAJOR DEPRESSIVE DISORDERS

- Treatment
  - The current treatments for Major Depressive Disorder include medication, psychotherapy or a combination of the two.
  - So far, studies are showing that cognitive-behavioral therapy or interpersonal therapy are the most effective forms of psychotherapy for treatment of depression.

### TRAINER NOTE

- The current treatments for Major Depressive Disorder include medication, psychotherapy, or a combination of the two.
- So far, studies are showing that cognitive-behavioral therapy or interpersonal therapy is the most effective.
- Additionally, the quality of therapy may be critical in maintaining clients' functioning.
- Dysthymic Disorder
- Characterized by at least 2 years of depressed mood for more days than not, accompanied by additional depressive symptoms that do not meet the criteria for a major depressive episode.
  - Diagnostic Criteria for Dysthymic Disorder (refer to DSM IV)
  - It is likely that 80% of those with dysthymic disorder will develop an MDD (refer to DSM IV)



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## MAJOR DEPRESSIVE DISORDERS

- Treatment
  - Additionally, the quality of the therapy may be critical in maintaining client's functioning.



## VIDEO # 1: "DIAGNOSIS ACCORDING TO THE DSM-IV" TAPE 1 MAJOR DEPRESSIVE DISORDER

(10 1/2 minutes)

Client interview only

### TRAINER NOTE

Video

- Stop here and show the "Diagnosis According to the DSM-IV" Video, Tape 1 Video 2.1, Major Depressive Disorder clip (approximately 10 1/2 minutes) patient interview only. You will not have time to show the clinical discussion following the patient interview. Explain before the tape starts that this is a real client interview.
- After the video, ask:
  - Has anyone seen clients who seem to show symptoms of Major Depressive Disorder?
  - How do you tell the difference between a substance induced mood disorder and a non-substance induced mood disorder?

## MOOD DISORDERS / BIPOLAR I DISORDER

- Prevalence:
  - In the course of one year, about 1 % of the population
  - Men and women are equally affected
  - There is controversy regarding this diagnosis for children
  - About 62% of those with bipolar disorder also have comorbid substance abuse problems at some time in their life.
- Bipolar I Disorder
- Characterized by one or more manic or mixed episodes usually accompanied by major depressive episodes.
- Prevalence
  - In the course of one year, about 1% of the population
  - Men and women equally affected
  - Controversy regarding diagnosis for children
  - More than half (about 62%) of those with bipolar disorder also have comorbid alcohol or drug abuse problems at some time in their life.
- Criteria for Manic Episode (refer to DSM IV)
- Criteria for Mixed Episode (refer to DSM IV)
- Diagnostic Criteria for Bipolar I Disorder (refer to DSM IV)

### TRAINER NOTE

- Review the criteria for manic, mixed and bipolar I disorder at this point, referring to the DSM

### CONTENT

- Treatment of choice at present is medication
  - There is insufficient research to determine the efficacy of psychological intervention and therapy, although evidence from available trials suggests the benefit from psychological service is to increase medication compliance, reduce hospitalization and find coping strategies to mitigate the effects of the disease.

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## MOOD DISORDERS / BIPOLAR I DISORDER

- Treatment:
  - Treatment of choice at present is medication.
  - There is insufficient research to determine the efficacy of psychological intervention and therapy; although the evidence from research trials suggest the benefit from therapy is to increase medication compliance and reduce hospitalization.

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## MOOD DISORDERS / BIPOLAR I DISORDER

- Diagnostic Challenges:
  - Clear and concise diagnosis is difficult
  - Clinical judgement is part of the process
  - In depth assessment is critical, so pertinent information is not missed

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## MOOD DISORDERS / BIPOLAR I DISORDER

- Diagnostic Challenges:
  - Usually a person is more than their initial presentation
  - Use caution in making a quick diagnosis

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### VIDEO #2:

## “DIAGNOSIS ACCORDING TO THE DSM-IV”: TAPE 1 BI-POLAR DISORDER SHOWING BOTH MANIC AND DEPRESSED STATES

(17 minutes)

Client interview only

### TRAINER NOTE

Video

- Stop here and show the “Diagnosis According to the DSM-IV” Video, Tape1 Video 2.2, Bipolar Disorder clip (approximately 17 minutes), both client interviews. Explain before the tape starts that this is a real client interview. Indicate that this particular client with Bipolar Disorder is a fairly extreme case with psychotic features in both the depressive and manic phases.

### CONTENT

- Bipolar II Disorder
- Cyclothymic Disorder
- Mood Disorder Due to a General Medical Condition
- Substance-Induced Mood Disorder
- Characterized by a prominent and persistent disturbance in mood that is judged to be a direct physiological consequence of a drug of abuse, a medication, another somatic treatment for depression, or toxin exposure.



- Does the mood disorder disappear when the effects of the substance are eliminated?
- Is the mood disorder transient and parallel to the substance abuse?
- First, ask the participants their reactions to this section. If they do not make the point, facilitator should indicate the following:
  - Clear and concise diagnosis is difficult
  - Clinical judgement is part of the process
  - In depth assessment is critical so as not to miss pertinent information
  - Differential diagnosis presents unique challenges
  - Usually a person is more than their initial presentation
  - Caution in making quick diagnosis

## ANXIETY DISORDERS GROUP 1

- **Panic Attack:**

A discrete period in which there is a sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. During these attacks symptoms such as shortness of breath, heart palpitations, chest pain or discomfort, choking or smothering sensations, and fear of “going crazy”, losing control or dying are present.

### TRAINER NOTE

- Spend most of your time on Substance induced Anxiety Disorder and on Post Traumatic Stress Disorder, as this Anxiety Disorder has highest co-morbidity with substance abuse. Refer to the DSM IV for Diagnostic Criteria. For ease in discussion, the anxiety disorders are grouped according to common treatments, prevalence and natural history. Briefly run through each disorder, and depending on time, only choose one of those other than PTSD, asking the participants which one, to actually review in detail in the DSM. Point out that anxiety disorders are also frequently comorbid with each other and with depressive disorders.

### CONTENT

- Anxiety Disorder Group 1
- Panic Attack Slide 69
- A discrete period, in which there is a sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. During these attacks, symptoms such as shortness of breath, palpitations, chest pain or discomfort, choking or smothering sensations, and fear of “going crazy”, losing control or dying are present.
- Agoraphobia Slide 70
- Anxiety about, or avoidance of places or situations from which escape might be difficult or embarrassing or in which help may not be available in the event of having a panic attack or panic-like symptoms.
- Social Phobia Slide 71
- Characterized by clinically significant anxiety provoked by exposure to certain types of social or performance situations, often leading to avoidance behavior.
- Generalized Anxiety Disorder Slide 72
- Characterized by at least 6 months of persistent and excessive anxiety and worry.
- Substance -Induced Anxiety Disorder Slide 73



- Characterized by a prominent symptom of anxiety that is judged to be a direct physiological consequence of a drug of abuse, a medication, another somatic treatment for depression, or toxin exposure.
- Prevalence of Anxiety Disorder Group 1 Slides 74-76
  - Relatively common in the general population
  - Most frequently occurring is panic disorder with agoraphobia (3.8 - 6%)
  - Generalized Anxiety Disorder (3.1%)
  - Social Phobia (1.2 - 2.2%)
  - Panic Disorder without agoraphobia (0.8%)
  - Specific Phobia (8.8%)
  - Anxiety Disorders highly co-morbid with each other
  - Also co-morbid with depression (10 - 65%)
  - 40-63% of agoraphobic have associated Avoidant or Dependent Personality Disorder (Axis II)
  - 50% of those with Anxiety Disorders have a co-morbid, Depressive Disorder and/or Personality Disorder
  - Some overlap between descriptors of Social Phobia and Avoidant Personality Disorder
- Treatment for Anxiety Disorders Group 1 Slides 77-78
  - So far, most effective treatment for anxiety disorders appears to be cognitive behavioral interventions, varying by type of disorder, i.e. systematic desensitization for Specific Phobias; exposure therapy for Social Phobia.
  - Pharmacological treatment has success for some Anxiety Disorders as long as the client continues the medication; cognitive-behavioral therapy has longer-term effects.

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## **ANXIETY DISORDERS GROUP 1**

- Agoraphobia:  
Anxiety about, or avoidance of places or situations from which escape might be difficult or embarrassing or in which help may not be available in the event of having a panic attack or panic-like symptoms.

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## **ANXIETY DISORDERS GROUP 1**

- Social Phobia:  
Characterized by clinically significant anxiety provoked by exposure to certain types of social or performance situations, often leading to avoidance behavior.

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## **ANXIETY DISORDERS GROUP 1**

- Generalized Anxiety Disorder:  
Characterized by at least 6 months of persistent and excessive anxiety and worry.

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## **ANXIETY DISORDERS GROUP 1**

- Substance Induced Anxiety Disorder  
Characterized by prominent symptoms of anxiety that is judged to be a direct physiological consequence of a drug of abuse, a medication, another somatic treatment for depression, or toxin exposure.

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## **ANXIETY DISORDERS GROUP 1**

- Prevalence:
  - Relatively common in the general population
  - Anxiety Disorders are highly co-morbid with each other
  - Most frequently occurring is panic disorder with agoraphobia (3.8%-6%)

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## **ANXIETY DISORDERS GROUP 1**

- Prevalence:
  - Generalized Anxiety Disorder (3.1%)
  - Social Phobia (1.2% - 2.2%)
  - Panic Disorder without agoraphobia (0.8%)
  - Specific Phobia (8.8%)
  - Also co-morbid with depression (10%-65%)

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## **ANXIETY DISORDERS GROUP 1**

- Prevalence:
  - 40% - 63% of persons with agoraphobia also have Avoidant or Dependent Personality Disorder (Axis II)
  - 50% of those with Anxiety Disorders have co-morbid Depressive Disorder and/or Personality Disorder.
  - There is some overlap between descriptors of Social Phobia and Avoidant Personality Disorder.

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## **ANXIETY DISORDERS GROUP 1**

- Treatment:  
So far, the most effective treatment for anxiety disorders appears to be cognitive behavioral interventions, varying by type of disorder, i.e., systematic desensitization for specific phobias, exposure therapy for Social Phobia.

## ANXIETY DISORDERS GROUP 1

- Treatment:  
Pharmacological treatment has success for some Anxiety Disorders as long as the client continues the medication; cognitive-behavioral therapy has longer term effects.

## ANXIETY DISORDERS GROUP 2

- Obsessive-Compulsive Disorder  
Characterized by obsessions, which cause marked anxiety and distress, and/or by compulsions that serve to neutralize anxiety.
- Anxiety Disorders Group 2
- Obsessive-Compulsive Disorder
- Characterized by obsessions, which cause marked anxiety and distress, and/or by compulsions that serve to neutralize anxiety Slide 79
- Diagnostic Criteria for Obsessive-Compulsive Disorder (refer to DSM IV)
- OCD is differentiated from OC Personality Disorder with regard to insight. Persons with OCD know that their obsessive thoughts and compulsive behaviors are not logical, whereas persons with OC Personality Disorder do not recognize the problem thoughts and behaviors as such.
- Obsessions are recurrent, persistent and distressing ideas, thoughts, impulses or images.
- Compulsions are repetitive and intentional behaviors or mental acts (praying, counting, and repeating words silently), usually performed in response to an obsession.
- Prevalence Slides 80-81
- 1.5% of population effected during six month period
  - Chronic, long term disorder with generally early age of onset
  - High co-morbidity with other Axis I disorders; e. g. 46.5% Phobic Disorder; 31.7% Major Depressive Disorder
  - 24.1% of OCD clients have a substance abuse diagnosis, usually alcohol
- Treatment Slide 82
- Treatments are rarely completely successful
  - Exposure and response prevention are most successful treatments
  - Pharmacologic intervention successful for some, but relapse high



## ANXIETY DISORDERS GROUP 2

### Obsessive-Compulsive Disorder

- Prevalence:
  - 1.5% of population is effected during a six month period
  - Chronic, long term disorder with generally early age of onset
  - 24.1% of persons with OCD have a substance abuse diagnosis, usually alcohol abuse

81

## ANXIETY DISORDERS GROUP 2

### Obsessive-Compulsive Disorder

- Prevalence:
  - High co-morbidity with other Axis I disorders:
    - 46.5% with Phobic Disorder
    - 31.7% with Major Depressive Disorder

82

## ANXIETY DISORDERS GROUP 2

### Obsessive-Compulsive Disorder

- Treatment:
  - Treatments are rarely completely successful
  - Exposure and response prevention are most successful treatments
  - Pharmacologic intervention is successful for some, but relapse is high

83

## VIDEO #3: "DIAGNOSIS ACCORDING TO THE DSM-IV": TAPE 2 OBSESSIVE-COMPULSIVE DISORDER

(6 minutes)

Client interview only

### TRAINER NOTE

Video

- Time permitting, stop here and show the "Diagnosis According to the DSM- IV", Tape 2 Video 2.3 of a person suffering from OCD. (Approximately 6 minutes). Discussions as appropriate. You may find that some participants want to talk about certain disorders more than others do, and this is often one of them. You will have to keep discussion relevant and watch class time.

84

## POST TRAUMATIC STRESS DISORDER

- Prevalence:
  - Lifetime prevalence of 1% to 9.2% of the general population; variance due to under reporting.
  - Chronic and disabling condition
  - Vietnam veterans prevalence 20%
  - Rape victims prevalence 35%
  - 50% of Enniskillen bombing survivors in Ireland had PTSD symptoms

Keep this overview really short if you plan to show the entire PTSD video.

- Characterized by the re-experiencing of an extremely traumatic event accompanied by symptoms on increased arousal and by avoidance of stimuli associated with the trauma.
- Diagnostic Criteria for Posttraumatic Stress Disorder (refer to DSM IV)
- Acute Stress Disorder



- Characterized by symptoms similar to those of posttraumatic stress disorder that occurs immediately in the aftermath of an extremely traumatic event.
- Diagnostic Criteria for Acute Stress Disorder (refer to DSM IV)
- Prevalence of PTSD Slides 84-85
  - Lifetime prevalence of 1 to 9.2% of the general population; variance due to underreporting
  - Chronic and disabling condition
  - Vietnam veterans prevalence of 20%; rape victims 35%
  - 50% of Enniskillen bombing survivors in Ireland had PTSD symptoms
  - Highly co-morbid with alcohol abuse - some studies show 70%
  - Highly co-morbid with depression - reported at 68%
  - 26% co-morbidity rate with Personality Disorders, primarily Antisocial Personality Disorder
- Treatment for PTSD Slides 86-87
  - Effective treatment involves a complex combination of treatment methods (cognitive-behavioral therapy, interpersonal therapy, supportive therapy), usually at a specialty location
  - Current treatment of choice appears to be Stress Inoculation Therapy, cognitive restructuring and exposure.
  - Some evidence of moderate pharmacological effects.

**85**

### **POST TRAUMATIC STRESS DISORDER**

- Highly co-morbid with Alcohol abuse; some studies show 70%
- Highly co-morbid with Depression; reported at 68%
- 26% co-morbidity rate with Personality Disorders, primarily Antisocial Personality Disorder

**86**

### **POST TRAUMATIC STRESS DISORDER**

- Treatment:
  - Effective treatment involves a complex combination of treatment methods (cognitive-behavioral therapy, interpersonal therapy, supportive therapy), usually at a specialty location
  - Some evidence of moderate pharmacological effects

**87**

### **POST TRAUMATIC STRESS DISORDER**

- Current treatment of choice appears to be Stress Inoculation Therapy, cognitive restructuring and exposure. Medication may also be effective.



## VIDEO #4: "LIFE AFTER TRAUMA" POST TRAUMATIC STRESS DISORDER

(24 minutes)

### TRAINER NOTE

Video

- Stop here and show the "Life After Trauma" Video 2.4 of two people suffering from PTSD. (Approximately 24 minutes). Discussions as appropriate. Point out that of all the Anxiety Disorders, PTSD has the highest co-morbidity rate with substance abuse.

## SCHIZOPHRENIA'S IMPACT

- Pervasive and profound impact - personally, socially and economically
- Patients with Schizophrenia occupy nearly 2/3 of psychiatric hospital beds (excluding geriatric patients with cognitive disorders)
- On any single day, there are 2 million people with schizophrenia in the USA

### TRAINER NOTE

- Indicate that the source book, besides the DSM, and previously mentioned sources, also includes Essential Psychopathology and Its Treatment (Maxmen & Ward, 1995).
- Introduce this section with the following: Ask the participants to list some of the descriptors of a person with schizophrenia and put these on a flip chart, chalk or dry erase board. Encourage participants to try to "make a mental picture" of what schizophrenia might be like for the person living with it.

### CONTENT

- Schizophrenia's Impact Slides 89-90
- Pervasive and profound impact - personally, socially, economically
- Schizophrenic patients occupy nearly two thirds of psychiatric hospital beds (excluding geriatric patients with cognitive disorders)
- On any single day, there are 2 million people with schizophrenia in the U.S.
- In any one year, there are 2 million new cases arising worldwide
- Families face incredible challenges emotionally, socially, economically
- The Schizophrenic Disorders are generally thought to exist on a continuum and are related to each other. It is important to keep in mind that some other disorders include psychotic symptoms (hallucinations/delusions) in acute phases (such as in the Bipolar video we saw earlier), so differential diagnosis is critical.
- Schizophrenic type disorders include schizophrenia, schizophreniform, schizoaffective, schizotypal, and delusional and brief psychotic disorders. We will look at the schizoaffective and schizotypal PD later in the class, if time permits.

### Schizophrenia

- Characterized by having psychotic symptoms. The disturbance must be present for at least six months with at least one month of active phase symptoms, including two or more of the positive symptoms: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior; and/or negative symptoms.



- Positive symptoms of schizophrenia Slide 91
  - Delusions
  - Hallucinations
  - Disorganized speech
  - Grossly disorganized or catatonic behavior, including inappropriate affect (If delusions are bizarre or hallucinations include voice keeping running commentary on person's thoughts and actions, then only one positive symptom is required for diagnosis.)
- Negative symptoms of schizophrenia Slide 92
  - Distinguished by what is missing
  - Unmotivated
  - All behaviors reduced
  - Fewer or no words spoken
  - Flat affect

**TRAINER NOTE**

- This handout Handout 2.55 lists some of the varying types of hallucinations and delusions, with some examples. Ask the participants about symptoms of schizophrenia and/or their own exposures and examples with clients.

**90**

**SCHIZOPHRENIA'S IMPACT**

- In any one year, there are 2 million new cases arising worldwide.
- Patients and families face incredible challenges medically, emotionally, socially and economically.

**91**

**POSITIVE SYMPTOMS OF SCHIZOPHRENIA**

- Delusions
- Hallucinations
- Disorganized speech
- Grossly disorganized or catatonic behavior, including inappropriate affect

**92**

**NEGATIVE SYMPTOMS OF SCHIZOPHRENIA**

- Distinguished by what is missing
- Unmotivated
- All behaviors reduced
- Fewer or no words spoken
- Flat affect

**93****VIDEO #5: "DIAGNOSIS ACCORDING TO THE DSM-IV":  
TAPE 2 SCHIZOPHRENIA**

(11 & 1/2 minutes)  
Client interview only



- Stop here and show the Video 2.5 clip from the "Diagnosis According to the DSM-IV", Tape 2 of Schizophrenia. (Approximately 11 1/2 minutes). After the video, ask participants to list positive and negative symptoms of the disorder, as they viewed them in the video, if time permits.

**94****SCHIZOPHRENIC DISORDER**

- Clinical Course:
  - Manifests during late adolescence or early adulthood (18-25 years)
  - Can present abruptly (1/4 of patients)
  - Majority have psychotic break after a slow, insidious onset of first negative, then positive symptoms
- Manifests during adolescence or early adulthood
- Can present abruptly (one fourth of patients)
- Majority have psychotic break after slow, insidious onset of first negative, then positive symptoms (prodromal phase)
- After psychotic episode, similar negative symptoms occur (residual phase)
- Generally, during prodromal and residual phases, others tend to label person with schizophrenia as "oddballs, eccentrics, weirdos"
- Chronic, characterized by exacerbation & remissions
- First several years dominated by active phases, later less or no psychotic episodes and more negative symptoms
- Generally requires episodic re-hospitalization

**95****SCHIZOPHRENIC DISORDER**

- After psychotic episode, similar negative symptoms occur
- Generally, during these phases, others tend to label the person with schizophrenia as "oddballs, eccentrics, or weirdos"
- Chronic condition characterized by exacerbations and remissions

**96****SCHIZOPHRENIC DISORDER**

- First several years dominated by active phases; later years with less or no psychotic episodes and more negative symptoms
- Generally requires episodic hospitalization

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## SCHIZOPHRENIC DISORDER

- Prevalence:
  - One month prevalence rate of 60 in 10,000 general population
  - Lifetime prevalence rate of 130 in 10,000 of general population
  - Roughly 1/2 of persons with schizophrenia report depressive symptoms at some point
- One month prevalence rate of 60 in 10,000 and lifetime prevalence rate of 130 in 10,000 of general population.
- Roughly half of schizophrenics report depressive symptoms at some point.
- Chief complication is suicide, about 10% commit suicide, about 20% attempt it.
- Highest risk time for suicide is after a psychotic episode.
- About a 15-20% higher risk of becoming homeless than general population.



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## SCHIZOPHRENIC DISORDER

- Prevalence:
  - Chief complication is suicide: 10 % commit suicide; 20% attempt it
  - Highest risk for suicide is after a psychotic episode
  - Persons with schizophrenia have a 15%-20% higher risk of becoming homeless than the general population

99

## SCHIZOPHRENIC DISORDER

- Prognosis: Better prognoses are associated with:
  - Acute onset
  - A clear precipitant
  - Prominent confusion and disorganization

Better prognoses are associated with:

- Acute onset
- Clear precipitant
- Prominent confusion and disorganization
- Highly systematized and focused delusions with clear symbolism and related to precipitant
- Being married
- Good pre-morbid functioning
- Family history of depression or mania
- No family history of schizophrenia
- Cohesive, supportive family
- Minimal negative symptoms



100

## SCHIZOPHRENIC DISORDER

- Prognosis: Better prognoses are associated with:
  - Highly systematized and focused delusions with clear symbolism and related to precipitant
  - Being married
  - Good pre-morbid functioning

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## SCHIZOPHRENIC DISORDER

- Prognosis: Better prognoses are associated with:
  - Family history of depression or mania
  - No family history of schizophrenia
  - Cohesive, supportive family
  - Minimal negative symptoms

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## SCHIZOPHRENIC DISORDER

- Treatment:
  - Treatment of choice is pharmacological with 50% to 75% effectiveness
  - Family education regarding the nature of the disorder does lead to a reduction of relapse rates
  - Cognitive behavioral techniques aimed at modifying delusions are getting more attention



- Treatment of choice is pharmacological with 50% to 75% effectiveness.
- Family education regarding nature of disorder does not lead to a reduction of relapse rates.
- Cognitive behavioral techniques aimed at modifying delusions are getting more attention.
- Supportive psychotherapy helpful, but expressive psychotherapy is not.
- Clients have a high rate of refusal to enter treatment and high dropout rates in therapy and family therapy, plus a tendency to stop medication in many cases.

Subtypes of Schizophrenia Handout 2.60:

- Paranoid Type
- Prominent persecutory or grandiose delusions, multiple, but organized around a central theme, with hallucinations related to content of delusions.
- Related Schizophrenic continuum disorders

Schizophreniform Disorder

- Duration less than six months with less than one month active phase. May not interfere with social/occupational functioning.

• Schizoaffective Disorder

- An uninterrupted period of the illness, during which, at some time, there is a Major Depressive, Manic or Mixed episode concurrent with symptoms that meet positive symptomatology for Schizophrenia, including a period of at least two weeks of active delusions and hallucinations in the absence of mood prominent symptoms.



- Delusional Disorder
  - Presence of non-bizarre delusions, which may be accompanied by, related tactile and auditory hallucinations. Apart from these delusions, functioning is not markedly impaired and behavior not obviously odd or bizarre.
  - Brief Psychotic Episode
  - Duration of positive symptoms for at least one day, but less than one month.
- Other:
  - Shared Psychotic Episode
  - Psychotic Disorder Due to a General Medical Condition
  - Substance-Induced Psychotic Disorder
  - Psychotic Disorder Not Otherwise Specified

**103**

## **SCHIZOPHRENIC DISORDER**

- Supportive psychotherapy is helpful; expressive psychotherapy is not.
- Clients have a high rate of refusal to enter treatment (this is part of the illness) and there are high dropout rates in therapy and family therapy
- There is strong tendency to stop medications

**104**

## **OPTIONAL ACTIVITY FOR SCHIZOPHRENIA: JANSSEN AUDIO TAPE OF VIRTUAL AUDITORY HALLUCINATIONS**

(2-3 minutes)

Close this section of the training on Axis I disorders by playing 2-3 minutes of the Janssen audiotape, “Virtual Hallucinations”. (This is OPTIONAL)



**105**

## **~AFTERNOON BREAK~**

Please come back in 15 minutes

**106**

## **PERSONALITY DISORDERS: AXIS II**

- Characterized by an *enduring pattern of inner experience and behavior that*:
  - Deviates markedly from the expectations of the individual’s culture
  - Is pervasive, inflexible and maladaptive
  - Has its onset in adolescence or early adulthood

### **TRAINER NOTE**

- Review why Personality Disorders and Mental Retardation is reported on Axis II. Ask participants to list what they believe to be characteristics of Personality Disorders and list them on the dry erase or black board. Then begin with content.



## CONTENT

- Personality Disorders are reported on Axis II so as to differentiate them from more treatable Axis I disorders, as we discussed earlier.
- Personality Disorders Slides 106-107
  - Characterized by an enduring pattern of inner experience and behavior that
    - deviates markedly from the expectations of the individual's culture
    - is pervasive, inflexible and maladaptive
    - has an onset in adolescence or early adulthood
    - is stable over time
    - leads to distress and/or impairment
    - is prominent in a wide range of personal and social contexts
- Clients do not usually have insight into their disorders, and therefore do not always have significant emotional distress (except for Borderline Personality Disorders).
- Often those around them are more distressed!
- Enduring is the key word.
- There is a high likelihood of co-occurring Axis I disorders with PD's, which often makes it difficult to both diagnose and treat the Axis I disorder(s).
- Generally, these Disorders are clustered into three groups based on some similar characteristics
- Cluster A (Odd or Eccentric) Slides 108-110
- Paranoid Personality Disorder :
  - “I trust me and thee and I'm not so sure of thee.” (Anonymous)
  - Distrust and unwarranted suspiciousness of others
  - Interpreting their motives as malevolent.
  - Hypersensitivity & hypervigilance
  - Emotional detachment
  - Over-valued ideas, but not delusions
- Schizoid Personality Disorder :
  - Detachment from social relationships
  - Restricted range of expression of emotions in interpersonal settings
  - Striking lack of warmth & tenderness
  - Indifference to others praise, criticisms, feelings or concerns
  - Lacking in desire for intimacy
- Schizotypal Personality Disorder
  - Pervasive pattern of social and interpersonal deficits
  - Acute discomfort with, and reduced capacity for close relationships
  - Cognitive or perceptual distortions and eccentricities of behavior.
- Note the relationship of some of the descriptors for the Schizoid and Schizotypal Personality Disorders to our previous review of positive and negative symptoms of schizophrenia. This supports the idea of a continuum of schizophrenic disorders.

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## PERSONALITY DISORDERS: AXIS II

- Characterized by an *enduring pattern of inner experience and behavior that*:
  - Is stable over time
  - Leads to distress and/or impairment
  - Is prominent in a wide range of personal and social contexts

**108**

## **PERSONALITY DISORDERS - CLUSTER A**

### **(Odd or Eccentric)**

- Paranoid Personality Disorder
  - “I trust me and thee, and I’m not so sure of thee.” (Anonymous)
  - Distrust and unwarranted suspicion of others
  - Interpret others motives as malevolent
  - Hyper-sensitive and hyper-vigilance
  - Emotional detachment
  - Over valued ideas, but not delusions

**109**

## **PERSONALITY DISORDERS - CLUSTER A**

### **(Odd or Eccentric)**

- Schizoid Personality Disorder
  - Detachment from social relationships
  - Restricted range of expression of emotions in interpersonal settings
  - Striking lack of warmth and tenderness
  - Indifference to others praise, criticisms, feelings or concerns
  - Lacking in desire for intimacy

**110**

## **PERSONALITY DISORDERS - CLUSTER A**

### **(Odd or Eccentric)**

- Schizotypal Personality Disorder
  - Pervasive pattern of social and interpersonal deficits
  - Acute discomfort with and reduced capacity for close relationships
  - Cognitive or perceptual distortions and eccentric behavior

**111**

## **PERSONALITY DISORDERS - CLUSTER B**

### **(Dramatic, Emotional, Erratic)**

- Antisocial Personality Disorder
  - Disregard for, and in violation of, the rights of others
  - Begins in childhood or early adolescence
  - Generally lacking in capacity for empathy or deep emotion
  - High co-morbidity with alcoholism and depression
  
- Cluster B (Dramatic, Emotional, Erratic)
  - Antisocial Personality Disorder
  - Disregard for, and violation of, the rights of others
  - Begins in childhood or early adolescence
  - Generally lacking in capacity for empathy or deep emotion
  - High co-morbidity with alcoholism and depression





## VIDEO #6: "DIAGNOSIS ACCORDING TO THE DSM-IV": TAPE 3

### ANTI-SOCIAL PERSONALITY DISORDER

(10 minutes)

Client interview only



#### TRAINER NOTE

- Stop here and show the video "Diagnosis According to the DSM-IV", Tape 3 Video 2.6 on Antisocial Personality Disorder. (Approximately 10 minutes). Discuss by asking participants to talk about some of the experiences they have had with this disorder and reviewing the criteria for diagnosis in the DSM-IV.

Mention that this diagnosis often shows up with males in the criminal justice system and also frequently may co-occur with a substance abuse disorder.

## PERSONALITY DISORDERS - CLUSTER B

### (Dramatic, Emotional, Erratic)

- Borderline Personality Disorder
  - Instability of interpersonal relationships, self-image and affect
  - Marked impulsivity
  - High expressed emotions



Keep this brief if you are showing the entire BPD video. It covers all this material.

- Borderline Personality Disorder
- Instability of interpersonal relationships, self-image, and affects
- Marked impulsivity
- High expressed emotions
- Look much better than they are
- View people as all good or all bad—splitting
- All or nothing thinking
- Co-morbid with depression, dysthymia
- Frequent suicide attempts
- Cutting/self-mutilation
- Comment that:
  - Some clinicians are lobbying for abandoning trait defined personality disorders and instead identifying groups of clients whose pervasive abnormality seems to be establishing and maintaining interpersonal relationships
  - Suicide attempt and success rate is very high for these BPD clients.
  - Self-mutilation or self-harm rate is also relatively high for these clients.
  - Take these threats seriously. By middle age, 10% of those diagnosed with BPD succeed in suicide attempts. Suicide is also a risk for many other PD's.

**114****PERSONALITY DISORDERS - CLUSTER B****(Dramatic, Emotional, Erratic)**

- Borderline Personality Disorder
  - Look much better than they are
  - View people as all good or all bad: splitting
  - Co-morbid with depression and dysthymia

**115****VIDEO #7: “UNDERSTANDING BORDERLINE PERSONALITY DISORDER: THE DIALECTICAL APPROACH”**

Dr. Marsha M. Linehan

(36 minutes)

**TRAINER NOTE**

- Show the Video “Understanding Borderline Personality Disorder” Video 2.7 to the class so that they can understand the symptoms, etiology and one of the more prominent successful treatment approaches for Borderline Personality Disorder. (This video is 36 minutes, but can be shortened SLIGHTLY by stopping when Dr. Linehan is interviewed by her colleague.) The lecture can be shortened if the entire video is viewed.

**116****PERSONALITY DISORDERS - CLUSTER B****(Dramatic, Emotional, Erratic)**

- Histrionic Personality Disorder
  - Pervasive and excessive emotionality
  - Attention seeking behavior

**117****PERSONALITY DISORDERS - CLUSTER B****(Dramatic, Emotional, Erratic)**

- Narcissistic Personality Disorder
  - Grandiosity
  - Need for admiration
  - Lack of empathy for others

**118****PERSONALITY DISORDERS - CLUSTER C****(Anxious and Fearful)**

- Avoidant Personality Disorder
  - Social inhibition
  - Feelings of inadequacy
  - Hypersensitivity to negative evaluation

**119**

## **PERSONALITY DISORDERS - CLUSTER C**

### **(Anxious and Fearful)**

- Dependent Personality Disorder
  - Excessive need to be taken care of
  - Leads to submissive and clinging behavior
  - Fears of separation

**120**

## **PERSONALITY DISORDERS - CLUSTER C**

### **(Anxious and Fearful)**

- Obsessive Compulsive Personality Disorder
  - Preoccupation with orderliness, cleanliness and perfectionism
  - Mental and interpersonal control at the expense of flexibility

**121**

## **PERSONALITY DISORDERS**

- Prevalence and Treatment:
  - Lifetime prevalence rates range from 0.4% for Schizoid Personality Disorder to 4.6% for Borderline Personality Disorder
  - Antisocial Personality Disorder lifetime prevalence rates are estimated at from 1.5% to 3.2%



### **TRAINER NOTE**

- Refer the participants to both the DSM and Essential Psychopathology and Its Treatment for more on the Personality Disorders. The key message is that PD's are pervasive, enduring, comorbid with several Axis I Disorders, difficult to treat, and complicate treatment success of comorbid Axis I Disorders.

**122**

## **PERSONALITY DISORDERS**

- Co-morbidity with generalized anxiety disorder is 56.4%
- Co-morbidity with simple phobia is 41.1%
- Co-morbidity with major depression is 40.7%
- Co-morbidity with agoraphobia is 36.9%
- Co-morbidity with social phobia is 34.6%

**123**

## **PERSONALITY DISORDERS**

- Co-morbidity rate with alcohol abuse is 21.9%
- Symptoms tend to peak in late teens, twenties and thirties, and by middle age the symptoms may tend to diminish although this does not indicate recovery
- High number of Antisocial PD in jails/prisons

**124**

## **PERSONALITY DISORDERS**

- Resistant to treatments; very little success with psychotherapy except for Marsha Linehan’s model of dialectical behavioral therapy for Borderline Personality Disorder which is effective
- Acute nature of symptoms, chronicity over time, and few effective treatments put pressure on mental health resources

**125**

## **PERSONALITY DISORDERS**

- Personality disorders are so enduring and pervasive that they can affect the success of treatment of co-occurring Axis I disorders. Often clinicians must focus on the Axis I disorder for which there is a treatment.
- Personality disorders are not generally diagnosed in childhood.

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## **PRINCIPLES OF SUBSTANCE ABUSE TREATMENT IN SEVERELY MENTALLY ILL INDIVIDUALS**

(Drake, et al. 1993)

- Assertiveness
- Close Monitoring
- Integration
- Comprehensiveness
- Stable Housing
- Flexibility
- Stages of Treatment (Longitudinal Perspective)
- Optimism



These principles are congruent with Dr. Kenneth Minkoff’s integrated concepts.

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## **WRAP UP ACTIVITIES**

- Final Questions and Answers
- Post-test (optional)
- Evaluation of module and distribute continuing education certificates for today



## **TOPICAL SUMMARY**

### **CONTENT**

In this section we have reviewed the following subjects:

- Definition of mental disorder
- Bio-psychosocial aspects of mental disorders
- DSM- IV diagnosis and classification
- Risk assessment issues
- Multi-axial assessment model



- Prevalence, course and treatment studies of disorders most commonly co-occurring with substance disorders
- Mood, Anxiety and Schizophrenic Disorders, Axis I
- Personality Disorders, Axis II: Antisocial Personality and Borderline Personality Disorders

#### POST-TEST (OPTIONAL)

##### TRAINER NOTE

- Administer the post-test , if required Handout 2.77. Collect.

#### WHAT'S NEXT?

##### TRAINER NOTE

Please review here any additional training for Co-Occurring Disorders that may be planned in the near future. If nothing further is planned, then skip this part.

#### EVALUATION

##### TRAINER NOTE

- Please take a few moments now to complete the evaluation, which will help us to improve the curriculum. We really need your input and help.
- Distribute evaluations. To ensure anonymity, collect evaluations in large manila envelope. The continuing education certificate can be distributed upon receipt of the evaluation.
- Thank the participants for their participation.

##### TRAINER NOTE

This module can be adjusted to run from 6-7 1/2 hours of content, not counting the breaks, depending on time spent on Axis I and Axis II sections. Videos can be eliminated or shortened depending upon the needs of the participants.

## WHERE TO GET MORE INFORMATION

- See the bibliography at the end of Module Two.
- Websites:
  - [www.coce.samhsa.gov](http://www.coce.samhsa.gov)
  - [www.samhsa.gov](http://www.samhsa.gov)
  - [www.nattc.org](http://www.nattc.org)
  - [www.kenminkoff.com](http://www.kenminkoff.com)
  - [www.nami.org](http://www.nami.org)
  - <http://faculty.washington.edu/linehan>

Make sure that all participants have a copy of the references for this module. Also distribute a copy of "Psychopharmacology for Counselors 2003" to every participant.



## MODULE II: REFERENCES

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- Tepper, A. M. & Knapp, S. (1999). Pennsylvania recognizes an affirmative duty to warn third party victims. *The Pennsylvania Psychologist Quarterly*, 60-1, p. 8-9.
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## **FURTHER INFORMATION ON WEBSITES**

<a href="http://www.cocce.samhsa.gov">www.cocce.samhsa.gov</a>	Substance Abuse and Mental Health Services Administration
<a href="http://www.nami.org">www.nami.org</a>	National Alliance for the Mentally Ill
<a href="http://www.nmha.org">www.nmha.org</a>	National Mental Health Association
<a href="http://www.nimh.nih.gov">www.nimh.nih.gov</a>	National Institute of Mental Health
<a href="http://www.kennethminkoff.com">www.kennethminkoff.com</a>	Dr. Kenneth Minkoff





# **Co-occurring Substance Use and Mental Health Disorders in Adults**

*An Integrated Treatment Approach to Dual Diagnosis*

## **MODULE THREE: DSM-IV Substance Use Training for Mental Health Professionals**

# MODULE 3 HANDOUTS

- 3.0 Pre-Test (Optional)
- 3.5 Criteria for Substance Intoxication
- 3.7 Criteria for Substance Abuse
- 3.10 Course Specifiers for Substance Dependence
- 3.12 Criteria for Substance Withdrawal
- 3.13 Considerations of substance dependence, abuse, intoxication, and withdrawal
- 3.18 Alcohol Consumption Norms for US Adults
- 3.22 The Brain on Drugs
- 3.24 Post-Test (Optional)
- 3.25 Module 3 - Evaluation
- 3.26 Psychotherapeutic Medications 2004: What Every Counselor Should Know

## HANDOUT 3.0 / PRE-TEST

### PRE-TEST

1. The lifetime incidence of alcohol and drug abuse approaches one tenth of the U.S. population.  
True                      False
2. Considerable evidence exists that addictions remain markedly under diagnosed and untreated in a variety of clinical settings  
True                      False
3. Substance -related disorders are usually diagnosed about the same amount in males and females.  
True                      False
4. At work for many substance abusers is a cluster of cells called the dopamine neurons.  
True                      False
5. Learning by association, or classical conditioning, plays a role in the cycle of addiction.  
True                      False
6. The CAGE questionnaire is frequently used for clarifying a client's use of alcohol during the initial interview  
True                      False
7. Some of the most recent data are showing that addiction entails a basic disruption of motivational circuits of the brain.  
True                      False
8. Motivational enhancement therapy is considered a tried and true method of treating addictive disorders.  
True                      False
9. The line between substance abuse and substance addiction is very clear and it is easy to classify clients as having one or the other disorder.  
True                      False
10. Persons who have certain serious mental illness are at a higher risk for co-occurring substance abuse and dependence.  
True                      False

## **HANDOUT 3.5 / CRITERIA FOR SUBSTANCE INTOXICATION (REFER TO DSM-IV)**

The development of a reversible substance-specific syndrome due to the recent use of a substance. Different substances may produce similar or identical syndromes.

Clinically significant maladaptive behavior may include; belligerence, mood lability, cognitive impairment, impaired judgment, impaired social or occupational functioning.

The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

## **HANDOUT 3.7 / CRITERIA FOR SUBSTANCE ABUSE INCLUDE: (REFER TO DSM-IV)**

Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home (e.g. repeated absences or poor work performance, suspensions, expulsions, neglect of children or household.)

Recurrent use in situations in which it is physically hazardous, i.e., driving or operating a machine

Recurrent substance related legal problems (i.e. arrests for substance related disorderly conduct, driving under the influence)

Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g. arguments with spouse, physical fights.)

## HANDOUT 3.10 / COURSE SPECIFIERS FOR SUBSTANCE DEPENDENCE

1. **early full remission:** for at least 1 month, but less than 12 months, no criteria for substance dependence or abuse have been met
2. **early partial remission:** for at least 1 month, but less than 12 months, one or more of the criteria for dependence or abuse have been met
3. **sustained full remission:** none of the criteria for dependence or abuse have been met at any time during a period of 12 months.
4. **sustained partial remission:** full criteria for dependence have not been met for 12 months or longer, however one or more criteria for dependence or abuse have been met.
5. **on agonist therapy:** the individual is on a prescribed agonist medication (example - methadone) and no criteria for dependence or abuse have been met for that class of medication for at least the past month (except tolerance to, or withdrawal from the agonist).
6. **in a controlled environment:** the individual is in an environment where access to alcohol and controlled substances is restricted and no criteria for dependence or abuse have been met for the last month. Examples: closely supervised and substance-free prisons, therapeutic communities, or locked hospital units.

## **HANDOUT 3.12 / CRITERIA FOR SUBSTANCE WITHDRAWAL (REFER TO DSM-IV)**

The development of a substance-specific syndrome due to the cessation or reduction in substance use that has been heavy and prolonged.

The substance-specific syndrome causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

## HANDOUT 3.13 / CONSIDERATIONS OF SUBSTANCE DEPENDENCE, ABUSE, INTOXICATION, AND WITHDRAWAL

- **Assessment issues:** The diagnosis of substance dependence requires obtaining a detailed history from the individual and, if possible, additional sources of information, such as spouse, relative, or close friend. In addition, physical examination findings and laboratory tests are helpful.
- **Route of administration:** This is an important factor. A substance that is administered by, for example intravenous, smoking, or “snorting” can result in more rapid intoxication and more efficient absorption into the bloodstream. The risk for dependence is higher. Routes of administration, such as intravenous, deliver a large amount of the substance to the brain and increase the likelihood of toxic effects or overdose.
- **Speed of onset within a class of substance:** Rapidly acting substances are more likely than slower acting to produce immediate intoxication and lead to abuse or dependence.
- **Duration of effects:** The half-life of a substance parallels aspects of withdrawal. The longer the duration of action, the longer the time between cessation and the onset of withdrawal symptoms and the longer the withdrawal is likely to last.
- **Use of multiple substances:** Often several substances are involved. When criteria for more than one substance-related disorder are met, multiple diagnoses should be given. For example, individuals with cocaine dependence frequently use alcohol, anxiolytics, or opioids.
- **Associated laboratory findings:** Laboratory analysis of blood or urine samples can help determine recent use of a substance. Blood tests can also indicate the amount of substance still left in the body and give us information about the individual’s tolerance level. It should be noted that a positive blood or urine test does not by itself indicate that the individual has a substance-related disorder.
- **Associated mental disorders:** Substance abuse is often a component of a presentation of symptoms of a mental disorder. When the symptoms are judged to be a direct physiological consequence of a substance, a substance-induced disorder is diagnosed. Substance-related disorders are commonly co-morbid with, and complicate the course of treatment of such disorders as conduct disorder, antisocial and borderline personality disorders, schizophrenia, and mood disorders.



## HANDOUT 3.18 / ALCOHOL CONSUMPTIONS NORMS FOR U.S. ADULTS (%)

**NOTE:** The numbers in this table are cumulative percentages-i.e., the percentage of the population that drinks at or below each drinking level.

**SOURCE:** 1990 National Alcohol Survey, Alcohol Research Group, Berkeley

DRINKS PER WEEK	MEN	WOMEN	TOTAL
0	29%	41%	35%
1	46%	68%	58%
2	54%	77%	66%
3	57%	78%	68%
4	61%	82%	71%
5	67%	86%	77%
6	68%	87%	78%
7	70%	89%	80%
8	71%	89%	81%
9	73%	90%	82%
10	75%	91%	83%
11	75%	91%	84%
12	77%	92%	85%
13	77%	93%	86%
14	79%	94%	87%
15	80%	94%	87%
16	81%	94%	88%
17	82%	95%	89%
18	84%	96%	90%
19	85%	96%	91%
20	86%	96%	91%
21	88%	96%	92%
22	88%	97%	92%
23-24	88%	97%	93%
25	89%	98%	93%
26-27	89%	98%	94%
28	90%	98%	94%
29	91%	98%	95%
30-33	92%	98%	95%
34-35	93%	98%	95%
36	93%	98%	96%
37-39	94%	98%	96%
40	94%	99%	96%
41-46	95%	99%	97%
47-48	96%	99%	97%
49-50	97%	99%	98%
51-62	97%	99%	98%
63-64	97%	>99.5%	99%
65-84	98%	>99.6%	99%
85-101	99%	>99.9%	99%
102-159	99%	>99.9%	>99.5%
160+	>99.5%	>99.9%	>99.8%

## HANDOUT 3.22 / THE BRAIN ON DRUGS SUMMARIZED FROM MSNBC.COM, ADDICTION SERIES; SEGELL, 2001 AND OTHER SOURCES

- At work for many substance abusers is a cluster of cells called the dopamine neurons, that evolved over millions of years to reward activities we find pleasing. These neurons release neurochemicals that reinforce behaviors that we like: working out, reading in bed, chocolate, helicopter skiing, sex. When the pleasure reward circuit is activated, it can cause a cascade of biochemical changes in the brain cells, creating a memory of the event and the motivation (this is learning)—to do it again.
- This learning process can result in, for instance cocaine users, in a sort of “euphoric recall” whereby any paired stimulus (friends you got high with, site of a buy, drug paraphernalia) activates a very basic, and sometimes even unconscious form of memory that results in uncontrollable craving.
- Virtually every psychoactive drug capable of being abused lights up the dopamine neurons. The drug directly activates the pleasure center, sometimes even better than the activities mentioned above.
- Dopamine neurons originate in the more primitive mid brain, but branch out into the limbic (emotion associated) area and into the cortex, the center for conscious learning.
- Because these neurons have a broad reach, we can see why we might pair drug use with certain emotions, smells, and events: cigarettes after a good meal; how an emotional setback can stimulate the desire for a drink; the joy of a paycheck in your hands can kindle the craving for cocaine.
- In the brain, every drug works a little differently, fitting into specific opioid receptors that communicate with the dopamine neuron circuit. Some of the receptors are close to the dopamine neurons (those for morphine actually straddle it); some are further away. One even works directly on the circuit: cocaine. Cocaine’s direct hits on this neural reward system explain why it drives addict’s behavior more than any other drug.
- Using cocaine as an example, studies show that people previously depending on cocaine have changes in brain activity not only shortly after they use the drug, but also as long as six months and more later. Additional studies on school age children who were exposed in utero to crack cocaine showed quantitative electrophysiological changes. (Joseph & Stimmel, 1996).
- Some addictionologists have theorized that some people, particularly those addicted to opiates, may have deficiencies in their brain reward systems, fewer natural opiates circulating, or fewer receptor sites, than those who do not become substance abusers or dependent.
- Scientists continue to discover more about substance effect on the brain. For instance, Yale University School of Medicine isolated a protein called Delta-FosB, that is produced in the brain after several uses of cocaine. This protein build up stimulates genes that intensify the craving for the drug. (Associated Press as reported on cocaineaddiction.com/news)
- These combinations of learning by association or classical conditioning, brain pleasure-reward processes, added to the social pressure & acceptance in some cases, along with other views on self medication for anxiety or distress reduction are the reasons why substance abuse and dependence are so difficult to combat.
- “The underlying foundation of any addiction is human compulsion to engage in one of three experiences, namely, relaxation (satiation), excitement (arousal), and/or fantasy (imagination). We learn that by creating initial, pleasurable moments followed by a negative low phase, addictive behaviors give impetus to repetition of the pleasurable moment. Consequently, people do not become addicted to drugs or mood altering activities, but rather to satiation, arousal, or fantasy.” (Milkman & Sunderworth, 1998)
- The American Psychological Association published in its monthly publication “Monitor on Psychology” May, 2001, information on research that is focused on the frontal cortex of the brain relative to addiction and relapse. PET scans and other behavioral research is suggesting that decision making, motivational and behavioral inhibition centers of the brain are affected by substance abuse. Coupled with the learning and brain pleasure center findings, this newest direction of research suggests areas of further understanding of the mechanisms at work in the brain and has implications for treatment.

## HANDOUT 3.24 / POST TEST

1. The lifetime incidence of alcohol and drug abuse approaches one tenth of the U.S. population.  
True                      False
2. Considerable evidence exists that addictions remain markedly under diagnosed and untreated in a variety of clinical settings  
True                      False
3. Substance-related disorders are usually diagnosed about the same amount in males and females.  
True                      False
4. At work for many substance abusers is a cluster of cells called the dopamine neurons.  
True                      False
5. Learning by association, or classical conditioning, plays a role in the cycle of addiction.  
True                      False
6. The CAGE questionnaire is frequently used for clarifying a client's use of alcohol during the initial interview.  
True                      False
7. Some of the most recent data are showing that addiction entails a basic disruption of motivational circuits of the brain.  
True                      False
8. Motivational enhancement therapy is considered a tried and true method of treating addictive disorders.  
True                      False
9. The line between substance abuse and substance addiction is very clear and it is easy to classify clients as having one or the other disorder.  
True                      False
10. Persons who have certain serious mental illness are at a higher risk for co-occurring substance abuse and dependence.  
True                      False

## HANDOUT 3.25 / EVALUATION

### AXIS I SUBSTANCE-RELATED DISORDERS

**INSTRUCTIONS:** Thank you for taking a moment to complete this evaluation and feedback form. Your input will help us to improve the curriculum. Your answers and comments are completely anonymous. *Do not put your name on this form.*

**CODE:** SD=Strongly Disagree, D=Disagree, U=Unsure, A=Agree, SA=Strongly Agree

ITEM	SD	D	U	A	SA
Content was relevant and current.	1	2	3	4	5
The facilitators were organized and had good presentation skills.	1	2	3	4	5
Handouts and audiovisual aids were relevant and helpful.	1	2	3	4	5
The facilitators provided opportunities for discussion and interaction	1	2	3	4	5
The facilitators were knowledgeable in the subject.	1	2	3	4	5
I learned information that will be useful in my current position.	1	2	3	4	5
Overall, this session was effective and informative.	1	2	3	4	5
Goals for this module were met	1	2	3	4	5

If you circled one or more items above as a 2 or 3, please give us more information.  
The most important thing I learned today was:

If I could change one thing about this session, it would be:

# TRAINING CURRICULUM

1

## CO-OCCURRING SUBSTANCE USE & MENTAL HEALTH DISORDERS IN ADULTS

DSM-IV Substance Use Training for Mental Health Professionals

2

### INTRODUCTION

- This module of the Co-Occurring Disorders in Adults is intended to address the cross training needs of mental health professionals and to give them a basic understanding of substance use diagnoses that frequently co-occur with mental illness.
- This training is aimed at bachelors and masters level staff who are team leaders, clinical supervisors or therapists. This is the level of staff that is optimal to reach to make system changes since they are the leaders of the treatment teams. This training is also beneficial for front line staff who provide services to persons with co-occurring disorders.

### TRAINER NOTE

The Trainer was introduced in previous day's training, so the focus can move on to today's participants who are mental health professionals.

Make sure that participants are in the correct session. Substance abuse professionals should be in the other session.

3

### AGENDA

- Introduction & Review of Goals and Agenda (30 minutes)
- Definitions & Considerations: Substance Related Disorders (60 minutes)
- Break (15 minutes)
- Treatment Selection and Modalities (30 minutes)
- Substance Abuse Diagnoses in the DSM-IV (60 minutes)
- Lunch (one hour)
- Substance Abuse Diagnoses Continued (45 minutes)
- Drugs of Abuse Exercises (60 minutes)
- Break (15 minutes)
- Continue Drugs of Abuse Exercises (60 minutes)
- Summary, Post-test & Evaluation (15 minutes)

Review the agenda for the day, including when the breaks are planned and that lunch is one hour.

## 4

### COMPETENCIES

- Familiarity with categories within, and use of the DSM-IV as a means of reviewing current diagnostic criteria and related features of disorders described therein.
- Familiarity with DSM-IV diagnostic criteria for substance related disorders, including distinctions between substance use, abuse and dependence, and classes of chemicals, including their basic actions in the body and brain, their intoxication and withdrawal symptoms, and their potential interactions.

## 5

### COMPETENCIES

- Comprehension of the effects on functioning and degree of disability related to substance-related and mental disorders, both separately and combined.
- Knowledge of the bio-psychosocial components of assessment, including the spiritual dimension, when assessing both psychiatric and substance related disorders.
- Familiarity with, and use of interventions designed to aid in the recovery of persons with traumatic histories and co-occurring disorders.

## 6

### INTRODUCTORY ACTIVITIES

- Participant Introductions and Expectations
- Review group participation expectations, rules about confidentiality, and the use of cell phone and pagers
- Administer Pre-test (optional) and review
- Review the objective and goals of this module (next slides)

#### TRAINER NOTE

Getting to Know You Exercise:

Ask the participants to pair up with someone that they do not know. Give them 5 minutes to interview each other and answer the following questions: name, where they work and what they want to learn from today's session about persons with co-occurring disorders. They will be introducing their partner to the larger group and identifying what this person wants to learn today about persons with co-occurring disorders. Trainer should list the topics or questions on a flip chart for reference through the day.

Review group participation expectations:

- Questions are encouraged as we go along
- Remain open minded
- Show respect for each other's points of view
- Be critical thinkers
- Maintain confidentiality
- Begin to make changes in how you think about persons with co-occurring disorders and how this will affect your work with them



Let participants know that they can take additional breaks when needed but to leave and rejoin the group quietly. Encourage participants to turn off pagers and cell phones. If they cannot, then have them turn them to silent alert and ask that they quietly leave the room before answering their phone.

Administer the Pre-test (optional)

Handout 3.0: Ask participants to not put their name on the paper. Review answers on Trainers Aid 3.0

7

## **OBJECTIVE OF REVIEW OF SUBSTANCE RELATED DISORDERS FOR MENTAL HEALTH PROFESSIONALS**

- Objective: Participants will review the categories of substance related disorders in the DSM-IV, the means of action in the body and the brain, intoxication and withdrawal patterns and potential interaction with other substances. They will also learn about recovery and the 12 Step programs that can provide supports for the person with co-occurring disorders.

8

## **GOALS FOR PARTICIPANTS**

- At the end of this training module, participants are expected to be able to:
- Demonstrate an increased understanding of categories of abused substances, their means of action in the body and the addictive process.
- Be able to utilize the DSM-IV diagnostic criteria for substance use disorders; including distinctions between substance use, abuse and dependence.
- Identify the need for further exploration of symptoms, special problems or risk assessment and make proper referrals.
- Identify an area for change in his/her practice with persons with co-occurring disorders.

9

## **TRUE OR FALSE STATEMENTS**

- Considerable evidence exists that addictions remain markedly under diagnosed and untreated in a variety of clinical settings.
- Fewer than 10% of addicted people are either in self-help groups or receive professional treatment. (Francis, Miller, 1991)

### **EXERCISE**

#### **TRAINER NOTE**

- Use Slides 9 & 10 to present the following statements to participants as a group and ask for a show of hands for true or false response. After each question, give the correct answer and, where appropriate, explain.

#### **CONTENT**

- More than 60% of those with Bipolar Disorders also have a co-occurring substance disorder. (True)



10

- Fewer than 10% of addicted people are either in self-help groups or receive professional treatment. (Francis, Miller, 1991) (True) This is due in some part to lack of accurate recognition and/or diagnosis. The myths, misinformation, and misunderstanding regarding substance abuse lead to avoidance of important issues and to stigmatization, which further contributes to avoidance, denial, neglect, fear, and suffering.
- The lifetime incidence of alcohol and drug abuse approaches one tenth of the population. (Francis, Miller, 1991) (False) It is actually one-fifth, posing a threat to our national health.
- Clients with substance disorders are a heterogeneous and complicated group. In the hands of therapists and clinicians with the proper skills and attitudes, they may have greater possibility of rehabilitation and recovery. (True)

### TRUE OR FALSE STATEMENTS

- The lifetime incidence of alcohol and drug abuse approached 1/10 of the population. (Francis, Miller, 1991)
- Clients with substance disorders are a heterogeneous and complicated group. In the hands of therapists with the proper skills and attitudes, they may have a greater possibility of rehabilitation and recovery.

11

### WHAT DO WE MEAN BY "SUBSTANCE"?

- A "substance" can refer to a drug of abuse, a medication, or a toxin.
- The DSM lists 11 classes of substances and we will focus on the following: alcohol, amphetamine, cannabis, cocaine, hallucinogens, inhalants, nicotine, opioids, phencyclidine, sedatives, hypnotics and anxiolytics.

#### CONTENT

- A "substance" can refer to a drug of abuse, a medication, or a toxin.
- The DSM lists 11 classes of substances and we will focus on the following: - alcohol, amphetamine, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidine, sedatives, hypnotics, and anxiolytics.
- Substances can also fall into somewhat broader categories:
  - Stimulants (speed up)
  - Sedative (slow down)
  - Hallucinogen
  - Other
- Substances of abuse/dependence can include both legal and illegal substances and both street and prescribed drugs.

12

### WHAT DO WE MEAN BY "SUBSTANCE"?

- Substances can also fall into somewhat broader categories:
  - Stimulants
  - Hallucinogens
  - Depressants
  - Other



**13**

## SMALL GROUP EXERCISE:

### Defining Substance intoxication, abuse, dependence, tolerance and withdrawal

#### EXERCISE

##### TRAINER NOTE

1. Divide participants into groups of four to six, depending on size of class. Give each a flipchart and markers.
2. Ask them to take ten to fifteen minutes to come up with definitions of substance intoxication, abuse, dependence, tolerance and withdrawal without referring to the DSM-IV. When presenting the didactic information on these areas, refer to work done in groups, asking for the group to offer a definition before or during your didactic work

**14**

## FEATURES OF SUBSTANCE INTOXICATION

- Essential feature is the development of a reversible substance specific syndrome due to the recent ingestion of (or exposure to) a substance.
- Clinically significant maladaptive behavior or psychological changes associated with intoxication are due to the direct physiological effects of the substance on the central nervous system and develop during or shortly after the use of the substance.

#### CONTENT

What is substance intoxication?

- Features of substance intoxication
- Essential feature is the development of a reversible substance-specific syndrome due to the recent ingestion of (or exposure to) a substance.
- Clinically significant maladaptive behavior or psychological changes associated with intoxication are due to the direct physiological effects of the substance on the central nervous system and develop during or shortly after the use of the substance.
- Criteria for substance intoxication (Refer to DSM IV) Handout 3.5:
- The development of a reversible substance-specific syndrome due to the recent use of a substance. Different substances may produce similar or identical syndromes.
- Clinically significant maladaptive behavior may include; belligerence, mood swings, cognitive impairment, impaired judgment, impaired social or occupational functioning.
- The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

**15**

## FEATURES OF SUBSTANCE ABUSE

- Essential feature is a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.





What is substance abuse?

Features of substance abuse Slide 15:

- Essential feature is a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.
  - The individual has never met the criteria for Substance Dependence.
  - The symptoms of mental illness may be exacerbated by substance abuse.
  - Remember, the patterns of use in healthy people can be problematic for a mentally ill person.
  - Abuse does not always lead to dependence.
- “A maladaptive pattern of frequent and continued usage of a substance—a drug or medicine—that results in significant problems, such as failing to meet major obligations and having multiple legal, social, familial, health, work, or interpersonal difficulties. These problems must occur repeatedly during a single 12 month period to be classified as substance abuse.” (Plotnic, 1999)
- Criteria for substance abuse include (refer to DSM IV) Handout 3.7:
- Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home (e.g. repeated absences or poor work performance, suspensions, expulsions, neglect of children or household.)
- Recurrent use in situations in which it is physically hazardous, i.e., driving or operating a machine
- Recurrent substance related legal problems ( i.e. arrests for substance related disorderly conduct, driving under the influence)
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g. arguments with spouse, physical fights.)

#### CONTENT

- Even though a diagnosis of substance abuse usually applies to someone who has only recently begun using the substance, it is possible to have substance related adverse consequences over a long period of time without becoming substance dependent.
- Nicotine and caffeine are not considered substances of abuse for the DSM-IV. Please note that there is evidence that they are abused, but this will not be covered in this training piece.
- Often, clinicians tend to conceptualize substance dependence as physiological dependence, while viewing substance abuse as non-physiological. While this view can be helpful, it is not absolute or accurate and, as pointed out above, the DSM IV gives criterion that still require clinical judgement.

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#### FEATURES OF SUBSTANCE ABUSE

- “A maladaptive pattern of frequent and continued usage of a substance, a drug or medicine, that results in significant problems, such as failing to meet major obligations and having multiple legal, social, familial, health, work, or interpersonal difficulties. These problems must occur repeatedly during a single 12 month period to be classified as substance abuse.” (Plotnic, 1999)

## DEFINITION OF SUBSTANCE DEPENDENCE

- A maladaptive pattern of substance use leading to clinically significant impairment or distress. May involve tolerance; withdrawal; increase in quantity and frequency of use over time; persistent desire to cut down use; a great deal of time spent to obtain substance; reduction in social, occupational, and recreational activities; and substance use continues despite knowledge of the problem.

What is Substance Dependence?

### TRAINER NOTE

- Point out here that the line between substance dependence and substance abuse is not completely clear, even in the DSM-IV. Use a dry erase or black board to list some of the key phrases relative to dependence. It is helpful to compare dependence and abuse on the board next to each other. Don't forget to refer to small group work.
- For additional information on the definitions of substance abuse and substance dependence, please see CSAT's *Treatment Improvement Protocol (TIP) 42: Substance Abuse Treatment for Persons with Co-occurring Disorders*, pp. 21-23.

## FEATURES OF SUBSTANCE DEPENDENCE

- Generally includes cognitive, behavioral, and physiological symptoms.
- Can be applied to every class of substance except is not generally applied to caffeine.
- Dependency: "A change in the nervous system such that a person addicted to a drug now needs to take it to prevent the occurrence of painful symptoms." (Plotnic, 1999)

### CONTENT

- Features of substance dependence
- Substance Dependence: A maladaptive pattern of substance use leading to clinically significant impairment or distress. May involve tolerance; withdrawal; increase in quantity and frequency of use over time; persistent desire to cut down use; a great deal of time spent to obtain the substance; reduction in social, occupational, recreational activities; and substance use continues despite knowledge of the problem.
- Generally includes cognitive, behavioral, and physiological symptoms...
- Can be applied to every class of substance except is generally not applied to caffeine.

## TOLERANCE

- Tolerance means that the body has adapted to the substance and it takes more of the substance to get the desired effects.
- Tolerance can be affected by sex, weight, synergistic effects of other medications and substances (poly-substance use), and duration of use.

### CONTENT

- Criterion includes:





- Tolerance: the need for greater amounts of the substance to achieve intoxication or a markedly diminished effect with continued use of the same amount of the same substance.
- Withdrawal: a maladaptive behavioral change, with physiological and cognitive symptoms, that occurs when blood and tissue concentrations of substance decline in an individual who has maintained a heavy and prolonged use of a substance.

The person is likely to take the substance to avoid these symptoms. Withdrawal symptoms vary across substances.

- Often, the substance has changed, damaged or affected the brain's neurotransmission system so that only the substance can fulfill the role that neurotransmitters normally play.
- Although not included in the criterion, a "craving", or strong subjective drive to use the substance is frequently present in substance dependence
- Please see DSM IV for detailed list of criteria and specifiers.

#### TRAINER NOTE

- Review these criteria carefully; pointing out that any and only three are necessary to diagnose dependence. Be sure to point out that physiological dependence may or may not be present!

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## COURSE SPECIFIERS FOR SUBSTANCE DEPENDENCE

- Early full remission
- Early partial remission
- Sustained full remission
- Sustained partial remission

#### CONTENT

Six course specifiers are available for substance dependence: Handout 3.10

1. early full remission: for at least 1 month, but less than 12 months, no criteria for substance dependence or abuse have been met
2. early partial remission: for at least 1 month, but less than 12 months, one or more of the criteria for dependence or abuse have been met
3. sustained full remission: none of the criteria for dependence or abuse have been met at any time during a period of 12 months.
4. sustained partial remission: full criteria for dependence have not been met for 12 months or longer, however one or more criteria for dependence or abuse have been met.
5. on agonist therapy: the individual is on a prescribed agonist medication (example - methadone) and no criteria for dependence or abuse have been met for that class of medication for at least the past month (except tolerance to, or withdrawal from the agonist).
6. in a controlled environment: the individual is in an environment where access to alcohol and controlled substances are restricted and no criteria for dependence or abuse have been met for the last month. Examples: closely supervised and substance-free prisons, therapeutic communities, or locked hospital units.



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## COURSE SPECIFIERS FOR SUBSTANCE DEPENDENCE

- On agonist therapy
- In a controlled environment

## FEATURES OF SUBSTANCE WITHDRAWAL

- Essential feature is the development of a substance specific maladaptive behavioral change, with physiological and cognitive concomitants that is due to the cessation or reduction in heavy and prolonged substance use.
- Withdrawal symptoms: “Painful physical and psychological symptoms that occur when a drug dependent person stops using a drug.” (Plotnic, 1999)

What is substance withdrawal?

- Features of substance withdrawal:
  - Essential feature is the development of a substance-specific maladaptive behavioral change, with physiological and cognitive concomitants that is due to the cessation or reduction in heavy and prolonged substance use.
    - Substance withdrawal is something that is not always associated with substance dependence. People can have withdrawal without having substance dependence. Similarly people can have substance dependence without having withdrawal.
    - It is the physical effect of removing a substance that has been used consistently.
- Criteria for substance withdrawal (Refer to DSM IV) Handout 3.12 :
- The development of a substance-specific syndrome due to the cessation or reduction in substance use that has been heavy and prolonged.
- The substance-specific syndrome causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.



## CONSIDERATIONS OF SUBSTANCE DEPENDENCE, ABUSE, INTOXICATION AND WITHDRAWAL

- Assessment issues
- Route of administration
- Speed of onset within a class of substance
- Duration of effects

### CONTENT

Distribute Handout 3.13

- Assessment issues: The diagnosis of substance abuse and dependence requires obtaining a detailed history from the individual and if possible additional sources of information, such as spouse, relative, close friend. In addition, physical examination findings and laboratory tests are helpful.
- Route of administration: This is an important factor. A substance that is administered by, for example intravenous, smoking, or “snorting” can result in more rapid intoxication and more efficient absorption into the bloodstream. The risk for dependence is higher. Routes of administration, such as intravenous, deliver a large amount to the substance to the brain and increase the likelihood of toxic effects or overdose.
- Speed of onset within a class of substance: Rapidly acting substances are more likely than slower acting to produce immediate intoxication and lead to abuse or dependence.



- Duration of effects: The half-life of a substance parallels aspects of withdrawal. The longer the duration of action, the longer the time between cessation and the onset of withdrawal symptoms and the longer the withdrawal is likely to last.
- Use of multiple substances: Often, several substances are involved. When criteria for more than one substance-related disorder are met, multiple diagnoses should be given. For example, individuals with cocaine dependence frequently use alcohol, anxiolytics, or opioids.
- Associated laboratory findings: Laboratory analysis of blood or urine samples can help determine recent use of a substance. Blood tests can also indicate the amount of substance still left in the body and give us information about the individual's tolerance level. It should be noted that a positive blood or urine test does not by itself indicate that the individual has a substance-related disorder.
- Associated mental disorders: Substance abuse is often a component of a presentation of symptoms of a mental disorder, or symptoms commonly associated with a mental disorder.

## CONSIDERATIONS OF SUBSTANCE DEPENDENCE, ABUSE, INTOXICATION AND WITHDRAWAL

- Use of multiple substances
- Associated laboratory findings
- Associated mental disorders

## SPECIFIC CULTURE, AGE & GENDER FEATURES

There are cultural variations in:

- Attitudes toward substance use
- Patterns of substance use
- Accessibility of substances
- Physiological reactions to substances
- Prevalence of substance disorders
- Some groups forbid the use of alcohol, while others use various mood altering substances.

- There are cultural variations in; attitudes towards substance consumption, pattern of substance use, accessibility of substances, physiological reactions to substances, and prevalence of substance disorders.
- Some groups forbid the use of alcohol, while others use various mood-altering substances.
- It is important to explore and consider an individual's context when evaluating a possible substance-related disorder.
- Individuals between the ages of 18 and 24 have relatively high prevalence rates for the use of every substance. Intoxication is usually the initial disorder, occurring in the teenage years, withdrawal can occur at any age, dependence can occur at any age, but typically has an onset in the 20's, 30's and 40's.
- Substance-related disorders are usually diagnosed more commonly in males than females. The sex ratios vary with the class of substance and will be presented later.



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## SPECIFIC CULTURE, AGE & GENDER FEATURES

- It is important to explore and consider an individual’s culture and context when evaluating a possible substance related disorder.
- Individuals between the ages of 18-24 have relatively high prevalence rates for the use of every substance. Intoxication is usually the initial disorder, occurring in the teenage years.

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## SPECIFIC CULTURE, AGE & GENDER FEATURES

- Withdrawal and dependence can occur at any age, but typically has onset in the 20’s, 30’s and 40’s.
- Substance related disorders are usually diagnosed more commonly in males than females. The sex ratios vary with the class of the substance.

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## ~MORNING BREAK~

Please come back in 15 minutes

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## SUBSTANCE RELATED TREATMENTS

- It is important to think of treatment as multi-modal, providing intervention at a variety of levels.
- Motivational Enhancement Interventions
- Skills Training
- Development of a Recovery Program (daily structure)
- Development of a Recovery Support Program (self-help groups and other supports)

### TRAINER NOTE

- This is a brief overview of treatments. You can ask for participant input if you like, especially regarding individual experience with cases. Spend just enough time here to give a flavor for some of the current data on treatment.
- For an excellent overview of treatment strategies for substance use disorders, please see Chapter 5: Strategies for Working with Clients With Co-Occurring Disorders in CSAT’s *Treatment Improvement Protocol (TIP) 42: Substance Abuse Treatment for Persons with Co-occurring Disorders*, pp 101-136.

### CONTENT

- Substance-related treatments are multifaceted, and can include any of the following:
- Motivational Enhancement Interventions
- Skills Training
- Development of a Recovery Program (daily structure)
- Development of a Recovery Support Program (self-help groups and supports)
- Drug & Alcohol Education
- Psychopharmacology
- Urine screenings
- Behavioral Contracting



- The above treatments can be conveyed in individual, family and group settings.
- It is important to conceptualize treatment in a multi-modal fashion, providing intervention at a variety of levels. For example, a client may be involved in cognitive behavioral therapy for relapse prevention, psychopharmacological treatments, family therapy to encourage interpersonal and relational skills, education about the disease, and recovery support.
- Current literature does not support the previously popular use of extensive inpatient stays with regard to success rates, primarily because these environments did not approximate the “real world” to which the client had to return.

## SUBSTANCE RELATED TREATMENTS (CONTINUED)

- Drug and Alcohol Education
- Psychopharmacology
- Substance Abuse Counseling
- Urine Screenings
- Behavioral Contracting
- Agonist and Antagonist treatments
- Interventions can be with individuals, families and/or group settings.

## STAGES OF CHANGE

(Prochaska & DiClemente)

Stage	Client Response	Motivational Tasks for the Counselor
Stage 1: Pre-contemplation	“No problem” or need to make a change	Raise doubt and provide information to increase client’s perception of risks and problems with current behavior.
Stage 2: Contemplation	Considers change and rejects it. “Tipping the Balance”	Evoke questions about change, risks of not changing; strengthen client’s ability to accept change in current behavior, but no action plans.

- It is helpful to conceptualize each client in terms of Prochaska & DiClemente’s “Stages of Change”, matching the treatment choice to the individual needs of the client (refer to Handout 1.28).
- For more information on the Stages of Change, please see CSAT’s *Treatment Improvement Protocol (TIP) 42: Substance Abuse Treatment for Persons with Co-occurring Disorders*, pp. 115-116.





## STAGES OF CHANGE

(Prochaska & DiClemente)

Stage	Client Response	Motivational Tasks for the Counselor
Stage 3: Determination	Window of opportunity when client considers change and develops a commitment to action	Help client determine the best course of action to take in seeking change.
Stage 4: Action	A particular action to solve or change the problem; begins to implement the solution or action plan	Help client take steps toward change.

## STAGES OF CHANGE

(Prochaska & DiClemente)

Stage	Client Response	Motivational Tasks for the Counselor
Stage 5: Maintenance	Develops new behaviors to maintain changes and solutions	Help client identify and use strategies to prevent relapse and reinforce new behavior.
Stage 6: Relapse	Normal, but frustrated; resolved to start again	Help client renew process of contemplation, determination and action, without becoming stuck or demoralized because of relapse.

## TREATMENT SELECTION VARIABLES

- "At Risk" treatment - may involve education, behavioral incentives (criminal justice involvement), and counseling.
- Substance Abuse treatment - may involve education, cognitive approaches, behavioral contracting, motivational enhancement therapy and family therapy.
- Substance Dependence treatment- may focus on education, skills training, behavioral contracting and the development of a Recovery program and Recovery supports system.

### CONTENT

- It is also helpful to consider whether the individual is being treated for substance abuse, substance dependence, or substance problems with co-occurring psychiatric impairments.
- Substance abuse treatment - may involve cognitive approaches, behavioral contracting, motivational enhancement, and family therapy.
- Substance dependence treatment - may focus on skills training, behavioral contracting, and the development of a recovery program.



- Treatment of a substance disorder with an individual with psychiatric impairments - may involve any of the aforementioned interventions, modified to be more concrete and clear. Treatment steps may be made in smaller increments. The individual may need extra help and practice in skills.

## TREATMENT SELECTION VARIABLES

- Treatment of Co-Occurring Disorders - may involve any of the treatment interventions, modified to be more concrete and clear. Education and treatment steps may be made in smaller increments. The person with Co-occurring disorders may need extra help and practice with skills. It is important to correlate the interaction of substance abuse on the symptoms of the mental illness. Relapse in one disorder, leads to relapse in the other!

## TREATMENT MODALITIES

- Individual Therapy
  - Individuals with Alcohol abuse appear to benefit very substantially from brief intervention, including motivational interviewing that includes non-confrontational advice on risk and change and an emphasis on personal responsibility. (Roth, Fonagy, 1996)
  - Cognitive Behavioral therapy may be effective in relapse prevention.

The following is a brief review of available individual, family, and group treatments. This list of treatment measures is not at all complete, but just touches on some of what the literature is showing as having some degree of success with regard to abstinence, management and relapse prevention.

Individual therapy :

- Individuals with alcohol abuse problems appear to benefit very substantially from brief intervention, including motivational interviewing that includes non-confrontational advice on risk and change and an emphasis on personal responsibility, (Roth, Fonagy, 1996)
- Cognitive behavioral therapy may be effective in relapse prevention.
- The intensity of treatment should be determined by severity and chronicity.
- Follow-up provision is an important component.
- Social skills' training offers a substantial benefit to individuals with substance abuse problems, especially with a focus on assertiveness skills and maintenance of abstinence.

Family Therapy :

- Family therapy is recognized as an essential approach to treating the full range of addictive problems in families. Research has found overwhelmingly favorable evidence in support of using family therapy methods. (Francis, Miller, 1991)
- The family system is important in the genesis, maintenance, and alleviation of symptoms of substance-related disorders.
- Addiction frequently reflects other family difficulties and may be exacerbated by the family process.



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## TREATMENT MODALITIES

- Individual Therapy
  - The intensity of treatment should be determined by severity and chronicity.
  - Follow-up is an important component.
  - Social Skills training offers a substantial benefit to individuals with substance abuse problems, especially with a focus on assertiveness skills and maintenance of sobriety/abstinence.

**38**

## TREATMENT MODALITIES

- Family Therapy
  - Family therapy is recognized as an essential approach to treating the full range of addictive problems in families. Research has found overwhelmingly favorable evidence in support of using family therapy methods. (Francis, Miller, 1991)
  - The family system is important in the genesis, maintenance, and alleviation of symptoms of substance related disorders.
  - Addiction frequently reflects other family difficulties and may be exacerbated by the family process.

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## SOME DISTINGUISHING FEATURES OF DYSFUNCTIONAL SUBSTANCE ABUSING FAMILIES

(Francis, Miller, 1991)

- A multi-generational pattern of substance abuse or other addictive behaviors, such as gambling
  - More primitive and direct expression of conflict, i.e. high expressed emotion and violence
  - More overt alliances and triangles, i.e. between a substance abuser and an over- involved parent
1. A multigenerational pattern of substance abuse or other addictive behaviors, such as gambling
  2. More primitive and direct expression of conflict, for example high “e.e.”, or expressed emotion
  3. More overt alliances and triangles, for example between a substance abuser and an over-involved parent
  4. A drug-oriented peer group to which the individual with substance-disorder retreats following family conflict.
  5. Enmeshed or symbiotic child rearing practices.
  6. A preponderance of death themes and premature, unexpected and untimely deaths in the family.
  7. More frequent acculturation problems. (Francis, Miller, 1991)



## CONTENT

- Many different modalities of family therapy may be considered, i.e. marital therapy, group therapy for parents, concurrent parent and identified patient therapy, sibling-oriented therapy, multiple-family therapy, individual family therapy, social network therapy, and family therapy with one person.

**40**

### **SOME DISTINGUISHING FEATURES OF DYSFUNCTIONAL SUBSTANCE ABUSING FAMILIES**

(Francis, Miller, 1991)

- A drug oriented peer group to which the individual with substance disorder retreats following family conflict
- Enmeshed or symbiotic child rearing practices

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### **SOME DISTINGUISHING FEATURES OF DYSFUNCTIONAL SUBSTANCE ABUSING FAMILIES**

(Francis, Miller, 1991)

- A preponderance of death themes and premature, unexpected, and untimely deaths in the family
- More frequent acculturation problems.

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### **TREATMENT MODALITIES (CONTINUED)**

- Group Therapy and Self-Help Groups
  - Treatment modalities that provide social networks, such as self-help groups and group therapy are especially valuable in the treatment of substance related disorders.
  - AA, NA, CA, "Double Trouble"

Group therapy and self-help groups:

- Treatment modalities that provide social networks, such as self-help groups and group therapy are especially valuable in the treatment of substance-related disorders.
- For more information about mutual help programs in the context of co-occurring disorders treatment, please see CSAT's *Treatment Improvement Protocol (TIP) 42: Substance Abuse Treatment for Persons with Co-occurring Disorders*, pp. 190-195.

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### **RECOVERY AND SELF HELP FOR SUBSTANCE ABUSE**

- 12 Step Programs
  - Alcoholics Anonymous
  - Narcotics Anonymous
  - Al-Anon (for friends & families)
  - Alateen (for friends & family members under 19 years of age)





## TRAINER NOTE

Stop here and ask if any of the participants have attended an AA meeting (or other related group) in order to learn more about it so as to understand their clients better. If you get an affirmative response, ask for some impressions from the participant(s).

- Helps in the area of denial, provides consensual validation, and provides ties to a therapeutic community.
- The optimum style for conducting a group is group-focused rather than leader-determined. The leader should be a facilitator, knowledgeable about substance abuse.
- Interestingly, there is in the scientific literature not enough data to support the success of AA, although we know that it often works for many people. The main reason for this is that the very nature of AA is not compatible with the rigors of scientific study.

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## RECOVERY MOVEMENT BASIC COMPONENTS

- Recovering persons have expertise; you help yourself by helping others; “sponsors”
- Spiritual component: Higher power
- 12 Steps
- “One day at a time”
- Serenity Prayer
- Total abstinence from drugs (medication can be appropriate)

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## 12 STEP PROGRAMS

- Familiarize yourself with the 12 steps and what it means to “work” them.
- Go to Alcoholics-Anonymous.org for more information (it is copyrighted by AA).
- Visit an “open” AA meeting in your area.

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## 12 STEP PROGRAMS

- Discuss the 12 Steps with your clients and encourage them to “work” the steps.
- Become familiar with the spiritual aspect of the 12 step programs and discuss with your clients how that fits into their own religious beliefs, spiritual practices, or their lack of belief in a higher power.

**47**

## ENABLING BEHAVIORS

- Are we doing too much for our clients?
- A good rule of thumb is to match what you do as a clinician with what the client is able to do for himself/herself.
- The more impaired the client is, the more your role increases and the more others need to be involved in daily care and treatment of the person.





## CONTENT

### Enabling:

- Are we doing too much for our clients? We sometimes ask this question.
- It is important to find a balance between care taking and case management.
- Our role is to provide a therapeutic relationship and education.
- A good rule of thumb is to match what you do as a clinician with what the client is able to do for him or herself. The more impaired a client, the more your role increases.
- The client shares responsibility and bears consequences for his or her actions and treatment success.
- This may be a process of trial and error! Providing services to our clients is an interactive learning process for both the therapist and the client.

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## ENABLING BEHAVIORS

- Our role is to provide continuous, empathic, hopeful relationships over time where the client can grow and learn to cope with their chronic illnesses. (This also means strengthening family and community supports and not having clients become totally dependent on one person.)

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## ENABLING BEHAVIORS

- Our role is to assess for safety and make appropriate referrals so that the client gets the appropriate interventions at the appropriate times.
- The client shares responsibility and bears the consequences for his/her decisions and actions and treatment success.
- This may be a process of trial & error! Providing services to our clients is an interactive learning process for both the client and the clinician.

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## TREATMENTS THAT ARE WORKING TODAY

- Individual skill based treatment
- Motivational enhancement therapy
- Environmental and relationship based treatment
- Behavioral, marital and family therapy
- 12 Step Programs
- Medications

A final note: In an article called “Today’s tried and true treatments” in the May, 2001 issue of Monitor on Psychology, Tori DeAngelis lists the following as treatments that are working today:

- Individual skill based treatment - Coping and social skills training based on social learning approach
- Motivational enhancement therapy - Based on client centered exploration of consequences
- Environmental and relationship based treatment - Uses family and community training of coping skills and supports detachment from the person’s behavior



- Behavioral, marital and family therapy
- Twelve step programs
- Medications - Disulfiram and naltrexone are already approved by FDA and a third, acamprosate is pending FDA approval for alcohol treatment.

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**Christopher Kahler, Brown University School of Medicine,  
"Monitor on Psychology," May 2001**

"It is important that clinicians work to develop a true proficiency in at least one of the approaches, rather than trying to incorporate all of the approaches into their work without having a sound framework for case conceptualization."

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**SUBSTANCE RELATED DIAGNOSES IN THE DSM-IV**

- Go to the DSM-IV and review the categories of diagnoses for Substance Related Disorders, including signs and symptoms of use.



**TRAINER NOTE**

Review substance related diagnoses in the DSM-IV

**53**

**~LUNCH BREAK~**

Please return in one hour  
We will start promptly

**54**

**SUBSTANCE RELATED DIAGNOSES IN THE DSM-IV**

- Continue with a review of the Substance Related Disorders, including signs and symptoms of use.



**TRAINER NOTE**

Continue to review the substance related diagnoses in the DSM-IV

**55**

**MAJOR CATEGORIES OF DRUGS OF ABUSE**

- |                      |                   |
|----------------------|-------------------|
| • Nicotine           | • Cannabis        |
| • Caffeine           | • Cocaine         |
| • Alcohol            | • Heroin          |
| • Prescription Drugs | • Inhalants       |
| • Club Drugs         | • Hallucinogens   |
| • Anabolic Steroids  | • Methamphetamine |





## TRAINER NOTE

### CONTENT

Review slide and categories. We will not be focusing on nicotine or caffeine addiction although these substances are frequently abused by persons with co-occurring disorders. They are legal and common drugs that do have a negative impact on health and but have also been found in recent years to have some components/chemicals that may have a positive impact on some mental health symptoms. Excessive use of caffeine containing soft drinks will flush psychoactive drugs out of the body and may have a strong effect on the person's ability to sleep normally. Asking about how much and what kind of soft drinks that they are consuming is part of a good assessment process. Reduction of consumption of caffeine and or nicotine may need to be part of some individual's treatment plan at some point in time for the person to make further progress with their illness and recovery. This needs to be assessed on an individual basis.

We will be learning about the other drugs of abuse and discussing which ones most frequently co-occur.

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## SLANG TERMS FOR DRUGS OF ABUSE

- Large group exercise:  
Which ones are familiar to you?  
List them on the flip chart.  
Which are most prevalent in your area?
- There is a complete list available at:  
[www.whitehousedrugpolicy.gov](http://www.whitehousedrugpolicy.gov)

### EXERCISE

The trainer will ask the large group to share slang terms for each drug of abuse and ask for a volunteer to write them on the flip chart or blackboard.

This list is not meant to be comprehensive, but should reflect the main drugs of abuse in the participant's part of the country. Direct the participants to the website for further information: [www.whitehousedrugpolicy.gov](http://www.whitehousedrugpolicy.gov)

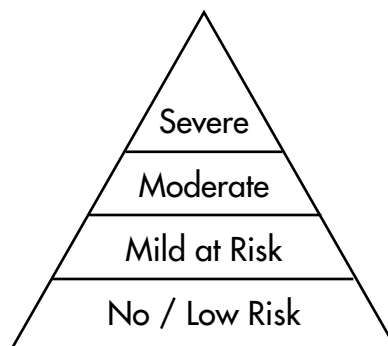


**57**

## CONTINUUM OF ALCOHOL PROBLEMS

National Institute on Alcohol Abuse and Alcoholism-2003

Total U.S. Population







## CONTENT

Although Alcohol is a legal drug for adults, it is a primary drug of abuse and we encounter it frequently with persons with co-occurring disorders.

Some forms of it can be very inexpensive and it is readily available in the USA. We are bombarded by commercials for beer, especially related to viewing sporting events on TV, and it is part of our American “youth culture”. The information in this next section is from the National Institute of Health, National Institute on Alcohol Abuse and Alcoholism, 2003.

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### **AT RISK: “RISKY DRINKING”**

- A. Current drinking patterns (amount or situation of drinking) place drinker at risk for adverse consequences.
- B. Is not already experiencing consequences due to drinking behavior.
- C. Does not meet criteria for Alcohol Dependence



## CONTENT

National survey data from NIAAA shows that nearly a third of all adults in the USA engage in risky drinking, some only occasionally and others frequently. As a group, nearly one in four of these risky drinkers already meet the criteria for alcohol abuse or dependence and the rest have substantially increased chances of developing these disorders. If left untreated, these alcohol problems can cause or worsen other health conditions and lead to social, work related and legal troubles.

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### **MILD TO MODERATE ALCOHOL PROBLEMS: “PROBLEM DRINKING”**

- A. Experiencing adverse consequences due to drinking behavior.
- B. Does not meet criteria for Alcohol Dependence.

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### **MODERATE TO SEVERE ALCOHOL PROBLEMS: “ALCOHOL ABUSE”**

- DSM-IV Criteria: One or more of A-D in the past 12 months plus E.
  - A. Role Impairment
  - B. Hazardous use
  - C. Recurrent legal problems related to Alcohol
  - D. Social/interpersonal problems due to Alcohol
  - E. Does not meet criteria for Alcohol Dependence

Refer to the DSM-IV criteria.



## SEVERE ALCOHOL PROBLEMS: “ALCOHOL DEPENDENCE”

- DSM-IV Criteria: Three or more of A-G during the same 12 month period.
  - A. Tolerance
  - B. Alcohol withdrawal signs or symptoms
  - C. Drinking more or longer than intended
  - D. Persistent desire or unsuccessful attempts to control use
  - E. Excessive time related to alcohol
  - F. Reduction in social, recreational, or work activities due to alcohol
  - G. Use despite knowledge of physical or psychological consequences

Refer to the DSM-IV criteria.



## EARLY RESEARCH ON ALCOHOLISM AS A DISEASE

Jellinek Studies 1946

James Studies 1975

### CONTENT

Dr. E. M. Jellinek 1946 Studies: these were the first studies to indicate that Alcoholism is a disease and has a progressive development that leads to death if untreated. Jellinek went on in the 1960's to further refine his definitions of alcoholism and proposed that it was not just one disease, but perhaps several and some were not “diseases”.

Between 1956 and 1965, there was an increased acceptance of the disease concept of alcoholism by major medical and public health groups. In 1946, only 20% of Americans agreed that alcoholism was a disease (Riley, 1946) while in 1964, that percentage increased to 93% (Mulford & Miller, 1964). In the 1960's models of addiction treatment emerged that could be widely replicated throughout the United States such as: a clinic model for outpatient alcoholism counseling, therapeutic communities, the development of methadone blockade therapy and the development of outpatient drug free counseling approaches.

The Jellinek Curve also introduced the concept of a person needing to “bottom out” before they could enter treatment for alcoholism. This concept lingers but is in dispute today since recent research indicates that coerced treatment does work. This is especially important for persons with co-occurring disorders since persons with mental illness have a much better outcome and can regain better levels of recovery if they are aggressively treated early in their illness. Each major episode/relapse of major mental illness makes it more difficult for the person to regain their previous level of functioning without further permanent impairment of the brain.

Jane E. James study 1975: This is important because it was the first study to target women alcoholics and compare their disease experiences to Jellinek's model which was solely based upon male alcoholics. James drew up a parallel but slightly different progression of symptomology for women. James classified women's symptoms into the following stages: Prodromal, Early, Middle and Late. Further information on the Jellinek and James symptoms models can be found at: [www.whatsdrivingyou.org/resources/reading\\_room/stages.html](http://www.whatsdrivingyou.org/resources/reading_room/stages.html)

People have been drinking alcohol for over 15,000 years. Just drinking steadily and consistently over time can produce dependence and cause withdrawal symptoms during periods of abstinence. This physical dependence is not the sole cause of alcoholism. Other factors such as genetics, culture and psychology also come into play. In 2001, one study found that the amygdala part of the brain is smaller in subjects with family histories of alcoholism, suggesting that inherited differences in brain structure may affect risk. The



amygdala is an area of the brain thought to play a role in the emotional aspects of craving, which can lead to addiction. Some people with alcoholism may have inherited dysfunction in the transmission of serotonin, which is an important neurotransmitter that is important for well-being and associated behaviors (eating, relaxation and sleep). Abnormal serotonin levels are associated with high tolerance for alcohol. Serotonin abnormalities can also develop from environmental pressures such as early loss in childhood. Inheriting genetic traits does not doom a person to an alcoholic future since other factors also play a strong role. (www.reutershealth.com)

Severely depressed or anxious people are at high risk for alcoholism, smoking and other forms of addiction. According to one 2000 study, the risk for heavy drinking in women who are depressed was 2.6 times greater than the risk in women who are not depressed. Major depression accompanies about one third of all cases of alcoholism. (www.reutershealth.com)

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## **ALCOHOL CONSUMPTION NORMS FOR US ADULTS**

- See the handout “Alcohol Consumption Norms for U.S. Adults (%)”
- Define “at risk” drinking levels for men and women (next slides)

Resource: Alcohol Problems in Intimate Relationships: Identification and Intervention, NIAAA, 2003

### **TRAINER NOTE**

Review Handout 3.18 Teach the participants how to read it and use it with their clients.



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## **“AT RISK” DRINKING PATTERNS**

**NIAAA, 2003**

- High Volume Drinking:
  - 14 or more drinks per week for males under age 65
  - 7 or more drinks for females under 65 and males over age 65

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## **“AT RISK” DRINKING PATTERNS**

**NIAAA, 2003**

- High Quantity Consumption
  - 5 or more drinks on any given day for males under age 65
  - 4 or more drinks on any given day for females and males age 65 and older

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## **“AT RISK” DRINKING PATTERNS**

**NIAAA, 2003**

- Any consumption within certain contexts:
- When drinking poses a danger; even if a small amount is consumed.
- During pregnancy
- In combination with certain medications
- Against medical advice
- Operating dangerous machinery or driving a vehicle if result is impairment (DUI)

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## WHAT IS A STANDARD DRINK?

A standard drink contains 0.6 fluid ounces of pure alcohol.

- Equivalent drinks:
  - 12 oz. beer or wine cooler
  - 8-9 oz. malt liquor (Usually sold in 16, 22 & 40 oz sizes)
  - 5 oz. table wine
  - 3-4 oz. fortified or dessert wine
  - 2-3 oz. cordial, liqueur, or aperitif
  - 1.5 oz. brandy
  - 1.5 oz distilled spirits (single jigger of gin, whisky, vodka, Scotch, etc.)

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## VIDEO "DIAGNOSIS ACCORDING TO THE DSM-IV" TAPE 3

Substance Dependence Alcohol

(10 minutes, Client interview / 8 minutes, Clinician discussion, if time permits)

### TRAINER NOTE

Show video clip if time permits and if the group is interested in seeing it. The client interview only is 10 minutes. The Clinical discussion is another 8 minutes.

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## DRUGS OF ABUSE GROUP EXERCISE

- Divide the participants into 9 Groups.
- Each group will prepare a 10 minute presentation on the assigned substance of abuse using the latest materials distributed from the NIDA website.
- Each group will need to select a presenter or co-presenters. Low tech visual aids are encouraged and materials will be provided to make your own.

### TRAINER NOTE EXERCISE

Trainer will divide the group of participants into 9 smaller groups. Each group will be given a folder of the latest information from the NIDA website about a drug of abuse. The groups will have the task to develop a presentation based upon the material, with visual aids if desired, to the large group. Presentations will be limited to 10 minutes and will address the following topics:

1. Prevalence of use
2. Target population of use, including age, gender and cultural differences
3. Method of use
4. Cost of substance
5. Is it a legal substance or an illegal one?
6. What are the treatments most effective for this substance?
7. Do you need to be hospitalized if you are going through withdrawal?
8. How does this substance affect pregnancy?
9. Short term effects of using this substance
10. Long term effects of using this substance

Give them this time to prepare their presentations.



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## **DRUGS OF ABUSE GROUP EXERCISE**

- Presentations should cover the following topics:
- Prevalence of use
- Target population of use, including age, gender and cultural differences
- Method of use
- Cost of substance

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## **DRUGS OF ABUSE GROUP EXERCISE**

- Presentations should cover the following topics (continued) :
- Is it a legal substance or an illegal one?
- What are the treatments most effective for this substance?
- Do you need to be hospitalized if you are going through withdrawal?
- How does this substance affect pregnancy?
- Short term effects of using this substance
- Long term effects of using this substance

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## **~AFTERNOON BREAK~**

Please return in 15 minutes

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## **DRUGS OF ABUSE GROUP EXERCISE CONTINUED**

- Small groups to make presentations to entire large group of participants
- Limit to 10 minutes per small group



### **TRAINER NOTE**

Watch the time on these presentations to make sure that they do not go over 10 minutes. Allow a minimum of 20 minutes to complete the day's topics and complete the wrap up activities.

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## **THE BRAIN ON DRUGS**

- Distribute the handout, "The Brain on Drugs". If there is time, touch on some highlights in the information.
- Distribute "Psychotherapeutic Medications 2004: What Every Counselor Should Know", Mid-America ATTC



### **TRAINER NOTE**

Distribute the Handout 3.22

If time permits, you can review some of the highlights of this material.

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## TASKS OF ADDICTION TREATMENT

(Carroll & Rounsaville, 1990)

- Ask for help to:
  - Control Stimulus to Use
  - Develop Coping Strategies in High Risk Situations
  - De-condition Cues that Lead to Craving
  - Avoid Apparently Irrelevant Decisions that Lead to Use

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## TASKS OF ADDICTION TREATMENT

(Carroll & Rounsaville, 1990)

- Ask for help to:
  - Prevent Abstinence Violation Effects (Lapse vs. Relapse)
  - Address Ambivalence/Resistance to Sobriety
  - Modify Lifestyle to Support Abstinence

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## WRAP UP ACTIVITIES

- Final Questions and Answers
- Post-test (optional)
- Evaluation of module and distribution of continuing education certificates for today

### TRAINER NOTE

Trainer will take about 10-15 minutes to wrap up the session, distribute and collect the evaluation and distribute continuing education certificates, if available. Each participant should also receive a copy of “Psychotherapeutic Medications 2004: What Every Counselor Should Know” and point out the bibliography in their materials.

### Topical Summary

In this module we have reviewed the following subjects:

- Definitions and considerations of substance disorder categories
- Prevalence and demographic considerations of substance disorders
- Treatment selection and modalities, including family, group and individual
- The effect of various substances on the brain
- Substance Disorder criteria and diagnosis

### Post-Test (Optional)

- Administer the post-test Handout 3.24 if required and collect. Participants should not put their names on the post- test.

### What’s Next?

### TRAINER NOTE

- Make an announcement here of upcoming trainings that are being sponsored, if any. If nothing is planned, then skip this section.



Evaluation

**TRAINER NOTE**

- Distribute evaluations Handout 3.25. or the evaluation you require. To ensure anonymity, collect evaluations in large manila envelope.
- Distribute continuing education certificates, if available.
- Thank the participants and end the module.

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**WHERE TO GET MORE INFORMATION**

- See the bibliography at the end of this module.
- Websites:
  - [www.whitehousedrugpolicy.gov](http://www.whitehousedrugpolicy.gov)
  - [www.alcoholics-anonymous.org](http://www.alcoholics-anonymous.org)
  - [www.al-anon.org](http://www.al-anon.org)
  - [www.na.org](http://www.na.org)
  - [www.coce.samhsa.gov](http://www.coce.samhsa.gov)
  - [www.niaaa.nih.gov](http://www.niaaa.nih.gov)
  - [www.nida.nih.gov](http://www.nida.nih.gov)

Make sure that participants have all the handouts including “Psychotherapeutic Medications 2004: What Every Counselor Should Know” and the bibliography for this module. Please feel free to add more information as it becomes available.

Remind participants to take all their personal property, including their DSM-IV manuals.



## MODULE III: REFERENCES

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- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental health disorders, fourth edition*. Washington, DC: Author.
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- Carpenter, S. (2001). Cognition is central to drug addiction. *Monitor on Psychology*, 32-6, p. 34-37.
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- Department of Mental Health Law & Policy, Louis de la Parte Florida Mental Health Institute (2002). *Co-occurring Disorders Treatment Manual*, University of South Florida, Suncoast Practice Research Collaborative, Tampa Bay, FL.
- Joseph, H. & Stimmel, B. (Eds.) (1996). *The neurobiology of cocaine addiction*. New York: The Haworth Medical Press.
- Marieb, E.N. (2000). *Essentials of human anatomy & physiology* (6th ed.) New York: Addison Wesley Longman, Inc.
- Maxmen, J.S. & Ward, N.G. (1995). *Essential psychopathology and its treatment* (2nd ed.). New York: W.W. Norton & Company.
- Milkman, H. & Sunderwith, S. (1998). *Craving for ecstasy: How our passions become addictions and what we can do about them* (2nd ed.). New York: Josey-Bass.
- ONDCP Drug Policy ClearingHouse (1998). *Street terms: Drugs and the drug trade*. NCJ-157020. Rockville, MD: National Criminal Justice Reference Service.
- Plotnik, R. (1999). *Introduction to psychology* (5th ed.). New York: Brooks/Cole Wadsworth.
- Roth, A. & Fonagy, P. (1996). *What works for whom: A critical review of psychotherapy research*. New York: The Guilford Press.
- Stilen, P., Card, A.E., Fields, M.D. (2000). *A collaborative response: Addressing the needs of consumers with co-occurring substance use and mental health disorders*. Kansas City, MO: Mid-America Addiction Technology Transfer Center.

## WEBSITES FOR FURTHER INFORMATION

- National Institute on Drug Abuse. (2001). *Prescription drugs: Abuse and addiction*. Research Report Series. Bethesda, MD: National Institute of Mental Health. Updated as of 1/22/04 at: <http://www.nida.nih.gov/drugpages/prescription.html>. Also available in Spanish.
- National Institute on Drug Abuse. (2001). *Nicotine addiction*. Research Report Series. Bethesda, MD: National Institute of Mental Health. Updated as of 1/22/04 at: <http://www.nida.nih.gov/drugpages/nicotine.html>. Also available in Spanish.
- National Institute on Drug Abuse. (Revised 2002). *Methamphetamine: Abuse and addiction*. Research Report Series. Bethesda, MD: National Institute of Mental Health. Updated as of 1/22/04 at: <http://www.nida.nih.gov/drugpages/methamphetamine.html>. Also available in Spanish.
- National Institute on Drug Abuse. (2001). *Heroin: Abuse and addiction*. Research Report Series. Bethesda, MD: National Institute of Mental Health. Updated as of 1/22/04 at: <http://www.nida.nih.gov/drugpages/heroin.html>. Also available in Spanish.
- National Institute on Drug Abuse. (2000). *Anabolic steroid abuse*. Research Report Series. Bethesda, MD: National Institute of Mental Health. Updated as of 1/22/04 at: <http://www.nida.nih.gov/drugpages/steroids.html>. Also available in Spanish.
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National Institute on Drug Abuse. (2002). *MDMA (Ecstasy) abuse and addiction*. Research Report Series. Bethesda, MD: National Institute of Mental Health. Updated as of 1/22/04 at: <http://www.nida.nih.gov/drugpages/mdma.html>. Also available in Spanish.

National Institute on Drug Abuse. (2002). *Marijuana abuse and addiction*. Research Report Series. Bethesda, MD: National Institute of Mental Health. Updated as of 1/22/04 at: <http://www.nida.nih.gov/drugpages/marijuana.html>. Also available in Spanish.

National Institute of Alcohol Abuse and Alcoholism (2004). Updated as of 1/22/04 at: <http://www.niaaa.nih.gov>

Street Slang Terms for Drugs of Abuse: go to [www.whitehousedrugpolicy.gov](http://www.whitehousedrugpolicy.gov) Updated as of 1/22/04.