1. Understanding Substance Abuse and Mental Illness
2. Dual Disorders: Concepts and Definitions
   * Establishing an accurate diagnosis for patients in addiction and mental health settings is an important and multifaceted aspect of the treatment process. Clinicians must discriminate between acute primary psychiatric disorders and psychiatric symptoms caused by ***alcohol and other drugs (AODs).*** To do so, clinicians must obtain a thorough history of ***AOD*** use and psychiatric symptoms and disorders.

1) ***AOD*** use can cause psychiatric symptoms and mimic psychiatric disorders. Acute and chronic ***AOD*** use can cause symptoms associated with almost any psychiatric disorder. The type, duration, and severity of these symptoms are usually related to the type, dose, and chronicity of the ***AOD*** use.

2) Acute and chronic ***AOD*** use can prompt the development, provoke the reemergence, or worsen the severity of psychiatric disorders.

3) ***AOD*** use can mask psychiatric symptoms and disorders. Individuals may use ***AOD’s*** to purposely dampen unwanted psychiatric symptoms and to ameliorate the unwanted side effects of medications. ***AOD*** use may inadvertently hide or change the character of psychiatric symptoms and disorders.

1. For example, patients with anxiety and phobias may fear and resist attending Alcoholics Anonymous or group meetings. Depressed people may be too unmotivated and lethargic to participate in treatment. Patients with psychotic or manic symptoms may exhibit bizarre behavior and poor interpersonal relations during treatment, especially during group-oriented activities. Such behaviors may be misinterpreted as signs of treatment resistance or symptoms of addiction relapse.
2. The Terminology of Dual Disorders
3. The term ***dual diagnosis*** *is* a common, broad term that indicates the simultaneous presence of two independent medical disorders.
4. The equivalent phrase ***dual disorders***also denotes the coexistence of two independent (but invariably interactive) disorders.
5. The acronym ***MICA****,* which represents the phrase *mentally ill chemical abusers,* is occasionally used to designate people who have an AOD disorder and a markedly severe and persistent mental disorder such as schizophrenia or bipolar disorder.
6. Other acronyms are also used: ***MISA***(mentally ill substance abusers), ***CAMI***(chemical abuse and mental illness), and ***SAMI***(substance abuse and mental illness).

C. Mood Disorders

1. The term ***mood***describes a pervasive and sustained emotional state that may affect all aspects of an individual's life and perceptions. *Mood disorders*are pathologically elevated or depressed disturbances of mood, and include full or partial episodes of depression or mania.
2. A ***mood episode***(for example, major depression) is a cluster of symptoms that occur together for a discrete period of time.
3. A ***major depressive episode*** involves a depression in mood with an accompanying loss of pleasure or indifference to most activities, most of the time for at least 2 weeks. These deviations from normal mood may include significant changes in energy, sleep patterns, concentration, and weight. Symptoms may include psychomotor agitation or retardation, persistent feelings of worthlessness or inappropriate guilt, or recurrent thoughts of death or suicide.
4. The diagnosis of ***major depression***requires evidence of one or more major depressive episodes occurring without clearly being related to another psychiatric, AOD use, or medical disorder. Major depression is sub classified as major depressive disorder, *single episode*and *recurrent.*
5. ***Dysthymia***is a chronic mood disturbance characterized by a loss of interest or pleasure in most activities of daily life but not meeting the full criteria for a major depressive episode. The diagnosis of ***dysthymia*** requires mild to moderate mood depression most of the time for a duration of at least 2 years.
6. A ***manic episode***is a discrete period (at least 1 week) of persistently elevated, euphoric, irritable, or expansive mood. Symptoms may include hyperactivity, grandiosity, flight of ideas, talkativeness, a decreased need for sleep, and distractibility. Manic episodes, often having a rapid onset and symptom progression over a few days, generally impair occupational or social functioning, and may require hospitalization to prevent harm to self or others. In an extreme form, people with mania frequently have psychotic hallucinations or delusions. This form of mania may be difficult to differentiate from schizophrenia or stimulant intoxication.
7. A ***hypomanic episode***is a period (weeks or months) of pathologically elevated mood that resembles but is less severe than a manic episode. ***Hypomanic episodes*** are not severe enough to cause marked impairment in social or occupational functioning or to require hospitalization.
8. ***Cyclothymia***can be described as a mild form of bipolar disorder, but with more frequent and chronic mood variability. ***Cyclothymia*** includes multiple hypomanic episodes and periods of depressed mood insufficient to meet the criteria for either a manic or a major depressive episode.
9. ***Substance-induced mood disorder*** *is*described in the DSM-IV according to the following criteria:

A. A prominent and persistent disturbance in mood characterized by either (or both) of the following:

1) depressed mood or markedly diminished interest or pleasure in all, or almost all, activities,

2) elevated, expansive, or irritable mood.

B. There is evidence from the history, physical examination, or laboratory findings of substance intoxication or withdrawal, and the symptoms in criterion ***A*** developed during, or within a month of, significant substance intoxication or withdrawal.

C. The disturbance is not better accounted for by a mood disorder that is not substance induced.

* + Evidence that the symptoms are better accounted for by a mood disorder that is not substance induced might include:

1) the symptoms precede the onset of the substance abuse or dependence

2) they persist for a substantial period of time (e.g., about a month) after the cessation of acute withdrawal or severe intoxication

3) they are substantially in excess of what would be expected given the character, duration, or amount of the substance used

4) there is other evidence suggesting the existence of an independent non-substance-induced mood disorder (e.g., a history of recurrent non-substance-related major depressive episodes) .

D. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance does not occur exclusively during the course of delirium

1. ***Medical conditions*** that can either precipitate or mimic mood disorders include the following:
   * Malnutrition
   * Anemia
   * Hyper- and hypothyroidism
   * Dementia
   * Brain disease
   * Lupus
   * HIV/AIDS
   * Post cardiac condition
   * Stroke, especially among elderly people.
   * Medications, including reserpine and other medications that treat hypertension and hypotension, can cause conditions that may be confused with psychiatric or ***AOD*** disorders. Both prescribed and over-the-counter (OTC) medications can precipitate depression. Diet pills and other OTC medications can lead to mania. Patients treated with neuroleptic (antipsychotic) drugs may have a marked constriction of affect that can be misinterpreted as a symptom of depression.

II. Clinical Competence

1. Person-Centered Therapy

* Based on a philosophy of human nature as an innate striving for self-actualization
* Self-actualization: developing to one’s fullest potential
* Reaction to directive therapies (e.g., psychoanalysis, behavior therapy)
* Based on the ideas of self-empowerment, self-actualization, freedom, choices, values, purpose, meaning
* Carl Rogers: humanist

**THEORY**

* People are honest, smart, and have ability to understand themselves
* People have the ability to solve their own problems
* People are capable of self-directed growth

**GOAL OF COUNSELING**

* Set clients free to engage in self exploration
* Positive view of human nature
* Focus on what is right about someone
* Look at positive side of people
* Clients work on moving forward, positively, in their world

**THREE ATTITUDES THERAPIST MUST CONVEY**

* Genuineness: open, real, honest
* Unconditional positive regard and acceptance: value and accept client as they are
* Empathetic understanding

**EMPATHY**

* Experiencing others feelings and thoughts while remaining objective
* Communicate to someone your understanding of his/her thoughts and feelings
* Helps clients understand themselves
* Understand clients world as they see and feel it

**STRENGTHS**

* Empathy
* Phenomenological approach
* Reflection
* Increase self-understanding
* Genuine
* Unconditional positive regard and acceptance

**WEAKNESSES**

* Client is not challenged
* Too simplistic
* No interventions/techniques
* Undirected
* Not all clients are able to find their own answers

**GENUINESS**

* Honest
* Real and True
* Acceptance (regardless of personal values and beliefs)
* The clinician must embody the attitudinal quality of genuineness and to experience empathic understanding from the client’s internal frame of reference and to experience unconditional positive regard towards the client. When the client perceives the therapist’s empathic understanding and unconditional positive regard, the actualizing tendency of the client is promoted.

1. **Communication Skills**

**ACTIVE LISTENING**

* Active listening involves paraphrasing/summarizing the person's emotions back to them, asking questions to help them express what they feel or believe or asking questions to achieve a better understanding of what they’re saying. Client needs is to know that they are being heard.

**Attending Behaviors**

* You can use certain key nonverbal skills to visibly tune into clients.
* These skills can be summarized in the acronym S.O.L.E.R.
* S: Face the client **S**quarely.
* O: Adopt an **O**pen posture.
* L: **L**ean toward the other.
* E: Maintain good **E**ye contact.
* R: Try to be **R**elaxed

III. Crisis Intervention and Management

Managing Aggression

The effective handling of aggression is one of the most demanding

aspects of working in Behavior Health. It is an area where good interaction and communication skills are required.

**Aggression**:

any behavior that is perceived by the victim as being deliberately harmful and damaging either psychologically or physically.

1. **People may become aggressive for a number of**

**reasons, including**:

* + - Frustration
    - Unfairness
    - Humiliation
    - Immaturity
    - Excitement
    - Learned Behavior (it get results)
    - Reputation
    - Means to an end
    - Decoy
    - Duty
    - Mental Illness (i.e. Paranoia, psychosis, delusions)

1. **Signs of Aggression**:
   * Standing tall
   * Red faced
   * Raised voice
   * Rapid breathing
   * Direct, prolonged eye contact
   * Exaggerated gestures
   * Tensing of muscles

**Additional signs of aggression**:

* Any major change in behavior that varies from what is normal for the person
* Clenched fists
* Focusing/narrowing of the gaze
* Tight jaw/facial muscles
* Increased agitation and disturbance in behavior (e.g. pacing)

1. **If faced with an aggressive person, assess the**

**risk of violence by considering:**

* Is the person facing a high level of stress? (e.g. recent bereavement, pending court date)
* Does the person seem to be drunk or on drugs?
* Does the person have a history of violence?
* Does the person have a history of psychiatric illness?
* Has the person verbally abused staff in the past?
* Has the person threatened staff with violence in the past?

1. **Communication**

Two-way process that relates to verbal interaction (listening,

speaking, and hearing), and non-verbal interaction (interpretation and observational skills – looking and seeing).

**To Minimize Communication Problems:**

1. Use language appropriate to the person (his/her language if possible; use interpreter where necessary)
2. Take time to communicate
3. Check that you are understood
4. Encourage and give feedback
5. Conversation should take place at an appropriate time and place (whenever possible)

**Common inhibitions to effective communication**:

1. **Noise**
   * Major distraction
   * Hard to hold a discussion against noisy background
   * Speaking loudly can be misinterpreted as yelling
2. **Language (native language/demeaning language)**
   * Express yourself in as direct and explicit manner as possible
   * Avoid emotive language (Words used deliberately to create an emotional impact or response)
   * Avoid demeaning language/belittling
   * Find assistance for a person who does not speak the same language as you.
3. **Perception and prejudice**

Everybody has a unique background and history with influences and experiences that form our way of looking at the world.

* + Recognize our prejudices
  + Work around prejudices of others
  + Maintain professional attitude (not allowing our perceptions to get in the way of duties and responsibilities to others, particularly in promoting equal opportunities)
  + Not to let our prejudices influence the way we communicate

1. **Intrusion of personal space**
   * Avoid standing too close to the person
   * Amount of space required for a person differs based on gender, familiarity, culture, mood, etc.
   * In addition, standing too close to an angry individual can make the person feel unsafe, and make YOU unsafe.
   * Step-Kick distance
2. **Non-verbal communication**
   * Staff should be aware of non-verbal messages that show how a person is feeling or may respond, and should apply the techniques of non-verbal communication they are taught in training to help defuse potentially violent situations.
3. **De-escalation Prevention Steps**
4. **Recognize**

* That anger is a choice of a range of behaviors that could be used to get what one needs in a situation.
* It is a behavior that has benefit for its user.
* Anger can get people the attention they need, escape things they don’t want to do, gain control over another person/situation
* Pump them up when they are feeling small/insignificant

1. **Identify**

The person interacting with the angry person must identify his/her own emotion at any given point in time. If the helper is also angry, then that person will not be effective in assisting the person to manage his/her anger.

1. **Change**

When potential interveners are experiencing anger, they must be able to change what they are doing or thinking to get their emotions under control, or seek assistance to manage the situation.

1. **Perform a quick self-assessment**

* Can I avoid criticizing and finding fault with the angry person?
* Can I avoid being judgmental?
* Can I keep myself removed from the conflict?
* Can I try to see the situation from the angry person’s pt of view or understand the need s/he is trying to satisfy?
* Can I remember that my job is to keep the peace and protect the client and staff?

1. **Early Warning Signs**

* Recognize Early Warning Signs: Many incidents can be prevented by recognizing subtle changes in behavior.

-Quiet people may become agitated

-Loud, outgoing people may become quiet

* Commenting on the changes may open up conversation and minimize frustration/buildup

1. **Defusing Strategies**
2. Appear confident
3. Display calmness
4. Create some space
5. Speak slowly, gently and clearly
6. Lower your voice
7. Avoid staring
8. Avoid arguing and confrontation
9. Show that you are listening
10. Calm the person and assure s/he feels heard before trying to solve the problem

**Adopt a non-threatening body posture**

1. Use a calm, open posture (sitting or standing)
2. Reduce direct eye contact (may be taken as a confrontation) without affirmative acknowledgment
3. Allow the person adequate personal space
4. Keep both hands visible
5. Avoid sudden movements that may startle or be perceived as an attack
6. Avoid audiences (when possible) – an audience may escalate the situation
7. **De-Escalation Techniques**
   1. **Simple Listening**

Sometimes all an angry person needs is for someone to take the time to allow them to vent his/her anger and frustrations. Simply listen to what he/she is saying, give encouragers (i.e. uh-huh, yes, go on, etc.).

* 1. **Active Listening**

Really attempting to hear, acknowledge and understand what a person is saying. A genuine attempt to put oneself in the other’s situation. LISTENING…not only to the words, but the underlying emotion as well as the body language.

* 1. **Acknowledgement**

Occurs when the listener is attempting to sense the emotion underlying the words a person is using and then comments on that emotion. Relaying that you understand what a person is feeling helps the person to release that feeling.

* 1. **Allow Silence**

Although many find silence unbearable, sometimes the angry person may need the time to reflect or think.

* 1. **Agreeing**

Often when people are angry about something, there is something true in what they are saying. When attempting to diffuse someone’s anger, it is important to find that truth and agree with it.

* 1. **Apologizing**

An excellent de-escalation skill! …Not for an imaginary wrong, but a sincere apology for anything in the situation that was unjust; a simple acknowledgment that something occurred wasn’t right or fair. It is possible to apologize without accepting blame. Apologizing can have the effect of letting angry people know that the listener is empathetic for what they are going through, and they may cease to direct their anger toward the person attempting to help

* 1. **Inviting Criticism**

The listener should simply ask the angry person to voice his/her criticism of the listener (What am I doing wrong that makes you so angry at me? Tell me, I can take it. Don’t hold anything back. I want to hear about everything you’re angry about.).

* 1. **Develop a Plan**

Have a plan before one is needed. Think about options of what you could do before such a circumstance occurs. Decisions made before a crisis occurs are more likely to be more effective/rational than those thought of “on the fly”.

* 1. **De-escalation Closure**
* De-escalation is a very difficult and humbling skill
* You cannot be unsure of your own pride or self-esteem
* You must be able to control your own anger
* You must be able to see the bigger picture
* You must be willing to practice what you’ve learned