Co-occurring Disorders Treatment Manual

Department of Mental Health Law & Policy
Louis de la Parte Florida Mental Health Institute
University of South Florida

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SUNCOAST PRACTICE RESEARCH COLLABORATIVE (SPARC)
TRAINING INFORMATION

For information regarding this publication, please contact:

Kathleen Moore, Ph.D., Project Manager, SPARC Project
Phone: (813) 974-2295
e-mail: kamoore@fmhi.usf.edu

For information regarding the SPARC project, please contact:

Carrie Wagner, B.A., Training Manager, SPARC Project
Phone: (813) 974-9337
e-mail: cwagner@fmhi.usf.edu

Roger Peters, Ph.D., Principal Investigator, SPARC Project
Phone: (813) 974-9299
e-mail: peters@fmhi.usf.edu

Holly Hills, Ph.D., Co-Investigator, SPARC Project
Phone: (813) 974-1923
e-mail: hills@fmhi.usf.edu

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Suncoast Practice and Research Collaborative (SPARC)/Tampa Bay
Practice Improvement Collaborative (PIC):
Enhancing coordination for substance-involved individuals in the
criminal justice system

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The University of South Florida's (USF) Louis de la Parte Florida Mental Health Institute is the state's primary university research and training center for public mental health services. Nationally recognized for its innovative research and training, the de la Parte Institute is an integral part of USF's optimism, vitality and can-do attitude. The 18th largest university in the United States and still growing, USF has built a solid reputation as a leader in learning, offering comprehensive, state-of-the-art programs.

Located on the Tampa campus of USF, the de la Parte Institute's multidisciplinary training programs serve thousands of professionals in mental health and related fields throughout Florida every year. The Institute's three-fold mission of training, research and demonstration services is carried out by three departments. Each department provides in-depth research and training with a focus on the mental health needs of specific populations and service systems:

- *Department of Aging and Mental Health*
- *Department of Child and Family Studies*
- *Department of Mental Health Law & Policy*

The de la Parte Institute is an official practicum and intern site for a growing number of university undergraduate and graduate programs. It also offers a pre-doctoral internship in clinical psychology and a multicultural training program to involve minority students in the mental health field.

Founded in 1956, USF opened its doors in 1960 to 2,000 students. Created by Florida's state legislature in 1969 to help strengthen the state's mental health care services, the Florida Mental Health Institute became part of USF in 1984. In 1996, the Institute was renamed the Louis de la Parte Florida Mental Health Institute in honor of Louis de la Parte, former Florida Senate President and lifetime proponent of "lost children."

Department of Mental Health Law & Policy

The Department of Mental Health Law & Policy is a one of three departments of the Louis de la Parte Florida Mental Health Institute at the University of South Florida. The Department's mission is to conduct research and training on the relationship between the legal and mental health systems.

The Department is also host to the Professional Development Center, which under contract to the Florida Department of Children and Families, provides training to employees working in child welfare and juvenile justice.

Department faculty work with a variety of state agencies, including the Department of Children and Families, the Office of Court Administration, the Department of Juvenile Justice, and the Department of Corrections. Faculty members also teach courses in forensic assessment; law and ethics of mental health practice; health care law; cultural competency; and mental disability law at the University of South Florida and at Stetson University College of Law. The Department offers a variety of training programs throughout Florida, including forensic training. Faculty are available to provide training on criminal forensic issues, civil commitment, civil competencies and informed consent, co-occurring disorders and substance abuse treatment, assessment of malingering, violence risk assessment, and a variety of other disability law issues.

Those interested in such training should contact Kelly Lyon at 813-974-4510.

Department of Mental Health Law & Policy
Louis de la Parte Florida Mental Health Institute at USF
13301 Bruce B. Downs Blvd.
Tampa, Florida 33612-3899
813/974-4510, SunCom 574-4510
FAX 813/974-9327

Mission

The Suncoast Practice and Research Collaborative (SPARC)/Tampa Bay Practice Improvement Collaborative (PIC), is designed to bridge gaps in communication and collaboration among the research community, substance abuse prevention and treatment service providers, criminal justice professionals, policymakers, and service recipients in the Tampa Bay area. The goal of this project is to improve service coordination for substance-involved individuals in the criminal justice system and to implement evidence-based practices that address service delivery needs.

Key Stakeholders

- The Louis de la Parte Florida Mental Health Institute (FMHI), University of South Florida
- Agency for Community Treatment Services, Inc. (ACTS)
- Drug Abuse Comprehensive Coordinating Office, Inc. (DACCO)
- Operation PAR, Inc.
- Hillsborough County Sheriff's Office
- The Florida Alcohol and Drug Abuse Association (FADAA), a statewide advocacy organization
- Criminal justice agencies
- Service recipients

Practice Improvement Activities and Studies

Targeted Evidence-Based Practices

- Integrated mental health and substance abuse (MH/SA) treatment for people with co-occurring disorders in the criminal justice system
- Gender-sensitive treatment interventions for women in the criminal justice system

Implementation Strategies

- Expert panel review of evidence-based practices, treatment and training protocols for co-occurring disorders and gender-sensitive treatment
- Identifying peer opinion leaders and providing an initial and follow-up training on the integrated MH/SA treatment protocol
- Conducting workshops for opinion leaders and practitioners at four local treatment agencies on an integrated MH/SA treatment protocol
- Similar training in use of a gender-sensitive treatment protocol for staff at the four local treatment agencies.

Implementation Studies

- Evaluate the effectiveness of standard versus peer training methods in implementing integrated treatment for co-occurring MH/SA disorders
- Evaluate the effectiveness of standard versus peer training methods to implement gender-sensitive treatment interventions for women
- Assess organizational readiness to implement evidence-based treatment protocols

Florida Research to Practice Consortium

The SPARC project hosts the Florida Research-to-Practice Consortium meetings three times each year and sponsors an ongoing series of best practices seminars, research colloquia, and other workshops and policy forums. In the past, these events have addressed such topics as the use of cognitive-behavioral treatment with criminal justice clients, treatment of co-occurring disorders, and gender-sensitive treatment. The collaborative also publishes a quarterly newsletter, develops and distributes practice briefs on evidence-based practices, and maintains a website and member listserv.

For more information on the SPARC project/Tampa Bay PIC, contact Carrie Wagner, B.A., at (813) 974-9337 or *cwagner@fmhi.usf.edu*, or visit the SPARC website at http://www.fmhi.usf.edu/mhlp/sparc/statement.html.

CONTRIBUTING AUTHORS:

Kathleen Moore, Ph.D., Project Manager SPARC
Department of Mental Health Law and Policy
University of South Florida

Chad Matthews, Ph.D., Post-Doctoral Fellow
Department of Mental Health Law and Policy
University of South Florida

W. Michael Hunt, M.A., Graduate Research Associate
Department of Mental Health Law and Policy
University of South Florida

Laura Pape, B.S., Research Assistant
Department of Mental Health Law and Policy
University of South Florida

In Collaboration with:

Melinda Fox, MA, LADC, New Hampshire - Dartmouth Psychiatric
Research Center

Kim Mueser, Ph.D., New Hampshire - Dartmouth Psychiatric
Research Center

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Betty Buchan, Ph.D., DFTCB, Operation PAR
Keith Carpenter, M.S., CAP, DACCO, Inc.
Richard Dembo, Ph.D., University of South Florida
Liz Harden, LMHC, CAP, CCSAP, DACCO, Inc.
W. Michael Hunt, M.A., University of South Florida
Julius James, M.S.W., Mental Health Care, Inc., ACTS Transitional Housing Program
Miguel Messina, Operation PAR
Kathleen Moore, Ph.D., University of South Florida
Roger Peters, Ph.D., University of South Florida
Joel Pietsch, M.S.W., Hillsborough County Sheriff's Office, Substance Abuse Unit
Michelle Smith, M.A., ACTS, Inc.

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W. Michael Hunt, M.A., University of South Florida
Miguel Messina, Operation PAR, Inc.
Laura Pape, B.S., University of South Florida
Carrie Wagner, M.A., University of South Florida

TO OBTAIN ADDITIONAL COPIES OF THIS MANUAL

This manual may be downloaded for free from the Tampa PIC/Suncoast Practice and Research Collaborative website: http://www.fmhi.usf.edu/sparc/statement.html.

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ABOUT THIS MANUAL:

This manual was created over a period of several months through the efforts of a working group comprised of substance abuse treatment practitioners and researchers affiliated with the Tampa PIC/Suncoast Practice and Research Collaborative project. The manual was field tested in several treatment agencies in the Tampa Bay area, and was then refined through feedback received by practitioners and clients regarding the manual's utility, ease of comprehension, and perceived relevance of the material to their needs.

This manual provides a guide for conducting treatment groups related to co-occurring substance use and mental health disorders. Counselors should feel free to adapt the modules (e.g., format, information, and exercises) to the particular needs of their groups. In some settings, groups are shorter in length and may necessitate that modules be split in two or condensed. In other settings, groups are longer and may allow for coverage of two modules in a single session. The manual is designed to provide an interactive approach to addressing co-occurring disorders. Counselors should familiarize themselves with the material in each module in advance of group sessions, and use the manual as a foundation for organizing the sessions, rather than reading material verbatim to their clients.

In the course of field-testing this manual, several issues arose that appear to merit special attention. A number of group participants reported feeling uncomfortable in discussing their own mental health issues within the group. As a result, it may be helpful to focus on the case stories as a means of discussing mental health issues, and then providing group members an opportunity to self-disclose information as they see fit. Even if this disclosure does not occur, participants who have mental health problems can still apply information from group sessions in their subsequent work with treatment staff.

A second issue is that clients may not understand the relevance of discussing mental health problems that are perceived as occurring among others and not themselves. There are a number of reasons why individuals who are not currently suffering from a particular mental health problem should learn more about it. For example, although a person does not *currently* suffer from a particular disorder, he or she may develop it at some point in the future. A second reason for discussing mental health issues is that clients who have mental health problems may not feel comfortable initiating these topics with the group. Finally, although individuals in the group may not directly experience mental health problems, it is likely that someone they know or will know will suffer from these problems. As such, clients may gain a certain amount of understanding and empathy with regard to the experiences of these individuals.

Client Workbook:

Based on the overwhelming number of requests by both counselors and clients, a companion client workbook has been created that contains much of the same material that the manual does. Both clients and counselors believed that it would be beneficial for the clients to have information to refer to between groups and to have access to the case stories and exercises to review and complete on their own if necessary. As a result, the main text, case stories, tables, summaries, and exercises appear in both the manual and workbook. The questions, counselor notes and directions, scoring protocols for the assessments at the end of the mental health oriented chapters, and the medication charts have been omitted from the client workbook in an attempt to insure that the more technical information is discussed in the groups (i.e., with a trained counselor) rather than left for review by the clients on their own.

Suggestions for running groups:

Most counselors find it helpful to establish a set of rules or guidelines for group participation. The following are a few that we believe help create a productive group environment:

Group confidentiality – Group members should refrain from discussing personal information about other members outside of group. Without confidentiality, members may be reluctant to share in group. (Group leaders should also review the limits to confidentiality established by the ethical codes of their profession and/or the law. For example, the duty to report child abuse.)

Respect – Group members should treat each other with the respect they themselves would like to be treated. This includes listening attentively when others are sharing and recognizing the rights of others to hold beliefs they do not share. Disagreeing with each other about particular issues is acceptable, but attacking another member personally (e.g., insults) is not acceptable.

Pay Attention – Sharing may or may not be required by group leaders; however, paying attention is.

Food for thought:

Embrace the silence – Give group members a chance to digest and process information before moving on to the next topic. This technique improves comprehension, and it often increases participation by allowing members a chance to "fill the void".

Accentuate the positives – Focus on members' personal responsibility, freedom of choice, and the ability to make positive changes in their lives. This may include encouraging them to seek helpful information relevant to their problems, to problem solve, and to acknowledge the need for help.

Module 1:

What is The Connection Between Substance Use and Mental Health?

MODULE 1: WHAT IS THE CONNECTION BETWEEN SUBSTANCE USE AND MENTAL HEALTH ?

DIRECTIONS: Try to make this group interesting to the group members by welcoming their input and discussion and using the exercises and discussion questions. Present the material in an interactive format. Don't simply read the material. Say it in your own words in a way that you know the participants will understand. It will be helpful to review the material prior to presenting it. At that time you can underline key points and make notes in the text that you want to emphasize to your particular group. In this way, when presenting the material to the group, you can reference your notes and focus on making the group session more interactive.

One of the main goals of this module is set the stage for the remaining modules by emphasizing the connection between substance use and mental health issues and explaining how risk factors and protective factors interact to make one more or less likely to experience mental health and substance use issues. You can break this module up into more than one part or skip some exercises if you cannot fit it all into one group session. Another idea would be to have participants complete some of the exercises as homework or with their counselors. You can also skip or modify exercises if they are not appropriate for your program or treatment population. Feel free to modify the way you use this material to meet the needs of your program and group participants.

Overview

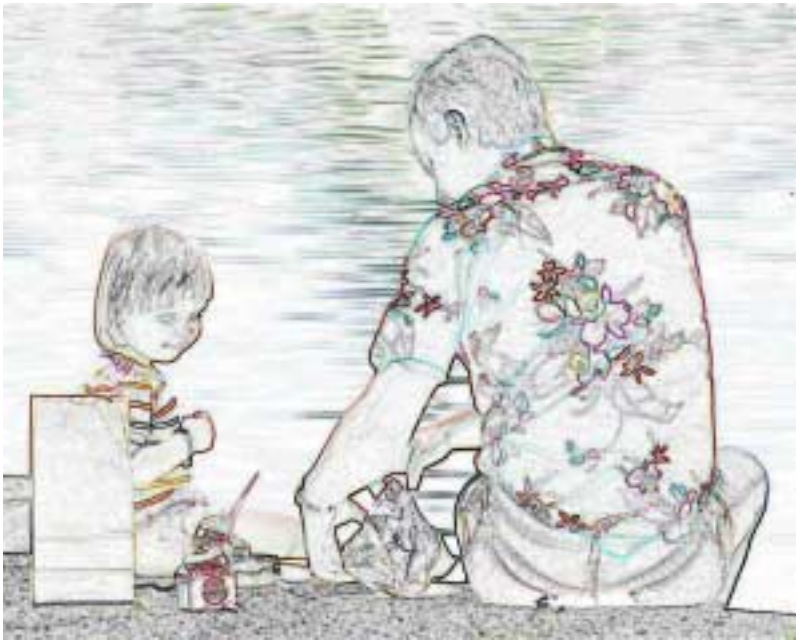
A number of factors contribute to whether people develop substance use and mental health issues and to how severe these issues may become if they are developed. People's biology (i.e., genetic makeup) and the environments in which they live affect their functioning and well-being throughout their lives.

Biology and Environment:

- Interact to create risk factors and protective factors
- Exist in different combinations for every person, resulting in greater or lesser chances of experiencing substance use and mental health difficulties and resolving them successfully

Biological Factors

People's biology can affect how likely they are to develop substance use or mental health issues and how severe these issues can become. Biology refers to people's genes that are inherited from their parents at conception. Just like eye color, height, and whether people are likely to get certain illnesses such as heart disease, people also inherit a tendency toward certain personality traits or ways of thinking, feeling, and acting that make them more or less likely to develop substance use and mental health issues.



Examples of Biological Factors Affecting Mental Health & Substance Use:

- Some people may inherit a tendency to become more anxious than most people do, putting them at greater risk for developing anxiety-related mental health problems.

- Some people may be biologically predisposed to personality traits or ways of behaving that make it harder for them to stop drinking once they have begun using alcohol.

People cannot change the genes they inherit from their parents. However, the effect that genes have on people's lives is influenced by the environment. As a result, while it is more likely that people will develop difficulties that are similar to those of their parents, it is by no means a certainty.

Question 1: ***Do people have control over their biological risks for developing mental health or substance use problems?***
Answer: No, but they can affect these risks through environmental changes.

Environmental Factors

The tendency to develop certain substance use and mental health issues can also be affected by the environment in which people live. The environment can be defined as the world around us and the effects it has upon us. Where we live, the people with whom we come in contact, nutrition, and injuries are all environmental factors. Just as genetic traits vary from person to person, every person experiences a unique combination of environmental factors as well.

Examples of Environmental Factors Affecting Mental Health & Substance Use:

- Injury to the brain in the womb or during birth
- Exposure to drugs in the womb
- Exposure to toxins in the environment like lead in lead paint
- Nutrition and health while growing up
- Where people live, work, or go to school
- Familial and social relationships

Environments that are unhealthy or stressful, for whatever reason, often put people at greater risk for developing substance use or mental health difficulties. They can also make it more difficult to deal with mental health and substance use issues successfully.

Question 2: ***Why would it be important for women to make sure they eat healthy foods and not use alcohol or drugs during pregnancy?***

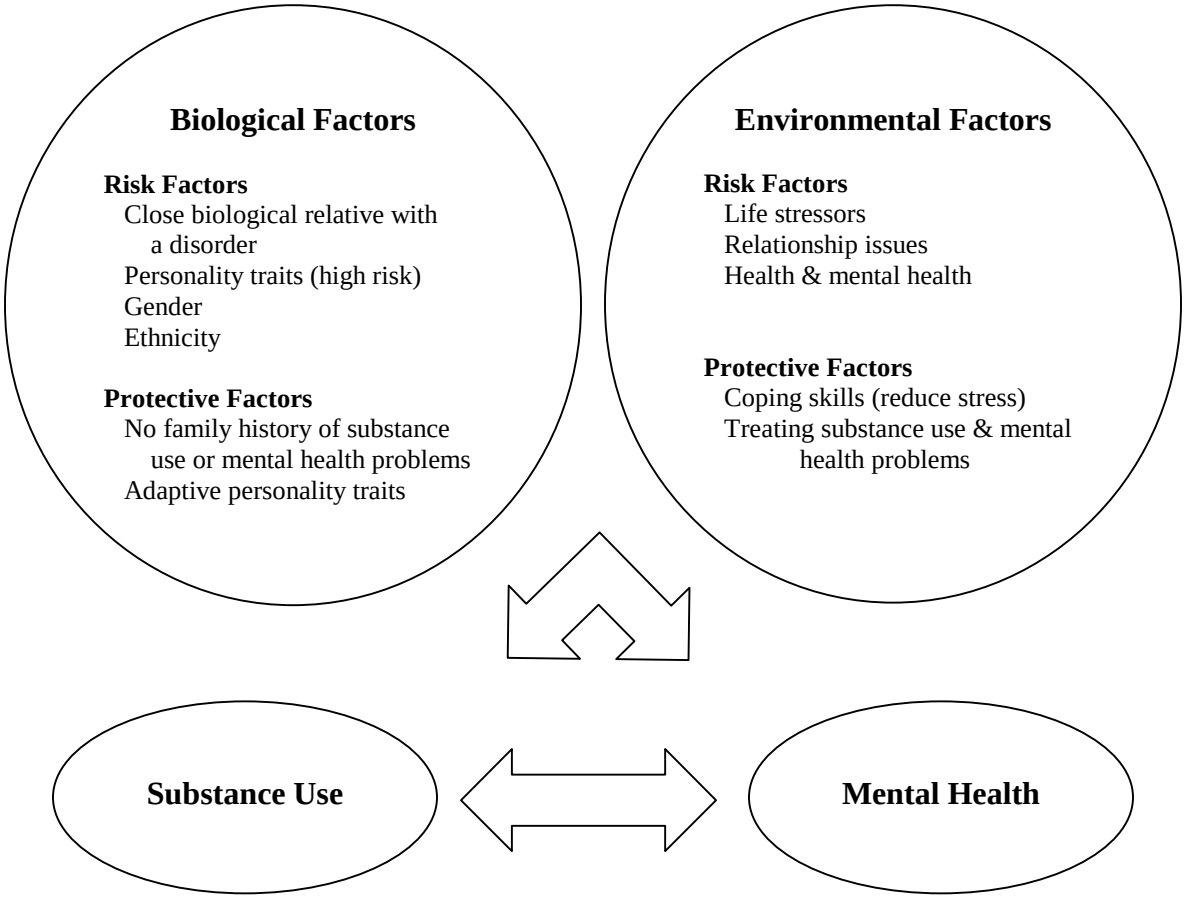
Answer: To avoid potential environmental risks to the fetus.

Question 3: ***What are some ways stress could increase the chances someone began using drugs?***

Answer: A person could use drugs to relax, cope, or improve performance or functioning.

As the figure below shows, people's biology and their environments combine to influence the ways they think, feel, and behave. This creates risk factors and protective factors that in turn have an impact on how likely people are to develop substance use and mental health issues and how severe these issues may become if they are developed. Risk and protective factors and the ways they affect substance use and mental health are discussed next.

Relationship Between Substance Use and Mental Health



Risk Factors

Just as genetic makeup (biology) and environment vary from person to person, the way they interact creates a unique combination of risk factors for individuals. Although the genes people inherit are out of their control, it is possible for people to take control of the environment and how they deal with that environment. Addressing risk factors can reduce chances of developing or worsening substance use and mental health issues.

Biological Risk Factors

People can inherit from their parents' genes that make them more or less likely to develop substance use or mental health problems. Although the likelihood of developing one of these problems if one or both parents have the problem is not 100%, people whose parents have substance use or mental health problems may be at greater risk for developing them themselves. The American Psychiatric Association's Diagnostic and statistical manual of

mental disorders, fourth edition (1994) provides information regarding the increased risk for developing the mental health and substance use problems that will be discussed in this manual. As can be seen in the table below, there is an increased occurrence of these disorders for individuals who have a **first-degree biological relative (i.e., close relatives like parents and siblings) with the disorder** as compared with people in the general population (i.e., who do not have first-degree biological relatives with the disorder).

DISORDER OF 1ST DEGREE RELATIVE (E.G., PARENTS, SIBLINGS)	INCREASED CHANCE TO DEVELOP DISORDER
Major Depressive Disorder	1.5 to 3 times more likely to develop Major Depressive Disorder
Panic Disorder	4 to 7 times more likely to develop Panic Disorder
Bipolar I Disorder	4% to 24% more likely to develop Bipolar I Disorder
Bipolar I Disorder	4% to 24% more likely to develop Major Depressive Disorder
Schizophrenia	10 times more likely to develop Schizophrenia

Although the relationship is somewhat less clear for substance use, close relatives of people with Alcohol Dependence seem to be 3 to 4 times more likely to develop Alcohol Dependence themselves. One example of a biological factor that might contribute to risk for developing a substance use problem is differences in brain chemistry that make certain people more vulnerable to the effects of drugs or alcohol.

Other biologically influenced characteristics such as **personality traits**, **gender**, and **ethnicity** also may affect how susceptible people are to substances of abuse and how likely they are to become addicted to them. For example, some personality traits such as antisocial personality and sensation seeking are associated with increased risk for alcohol and drug problems. Females tend to be affected more by alcohol and/or drugs because of their body size and composition. In terms of ethnicity, many people of Asian descent tend to have negative reactions to alcohol and, therefore, tend not to drink it as much. As a result, they have reduced risk for alcohol problems when compared to other ethnic groups.

Although it is not possible to choose one's parents and the genes inherited from them, it is important to remember that genes are not everything a person is. People may inherit a predisposition to thinking, acting, and feeling certain ways, but it is possible that people can change the ways they behave and feel and think. Additionally, people can exert a great deal

of control over the environments in which they live and work, and, as the next section discusses, the environment can play a large role in how likely people are to develop mental health and substance use issues.

Question 4: ***If people cannot change the genes they inherit, how can society expect them to take personal responsibility for treating mental health or substance use problems they may inherit from their parents?***

Answer: They still have control over their environmental risk and protective factors. Both greatly affect the extent to which someone suffers from substance use or mental health problems.

Environmental Risk Factors

Most often, environmental risks involve some kind of stressor for the individual. Stress may include life stressors, the relationships people maintain, and their health. Stress can influence how likely it is that people will develop substance use and mental health issues. Likewise, substance use and mental health problems can become risk factors for each other. In other words, using substances can influence mental health, and mental health can influence how likely people are to use substances.

Stress

In a more general sense, stress can be the result of trying to deal with negative things in the environment. When people cannot adapt to stress, they become more prone to developing, or making worse, substance use or mental health difficulties, particularly if they are also at risk biologically. Types of stress include the following:

Life stressors:

- *Work (loss of employment, problems at work, new job)*
- *Moving to a new place*
- *Money (being unable to pay bills or having more money than usual)*
- *Being a victim of a crime*
- *Housing problems (losing one's home)*
- *Legal problems*

Relationships:

- *Death of a loved one*
- *Divorce, separation, remarrying*
- *Parenting (difficulties raising/caring for one's children or having unresolved parent/child issues)*

- *Frequent arguments among family members and spouse/significant other*
- *Having few or no friends (lack of social support)*
- *Having friends who use drugs or alcohol*
- *Grief*

Health and Mental Health:

- *Illness, injuries, or accidents*
- *Not getting enough rest or eating well*
- *Caring for a sick relative or friend*
- *Not dealing with feelings*
- *Abusing substances*
- *Experiencing mental health symptoms*

An example of a risk factor leading to mental health difficulties is the death of a spouse causing someone to feel depressed. It is completely normal to feel depressed from time to time, especially after the loss of a loved one. However, as will be discussed in upcoming modules, mental health issues that become too severe or last longer than is normal can sometimes become mental health problems that may require treatment. An example of a risk factor leading to substance abuse is drinking to avoid dealing with emotional problems such as feelings of depression.

Question 5: ***Give another example of an environmental risk factor leading to mental health difficulties.***

Question 6: ***Give another example of an environmental risk factor leading to substance use difficulties.***

Protective Factors

While risk factors make people more prone to experiencing substance use and mental health issues, protective factors serve to help buffer or shield people from the effects of negative things going on in their lives. As a result, protective factors can help prevent or lessen substance use or mental health issues.

Biological Protective Factors

Just as the genes people inherit from their parents can make them more susceptible to mental health and substance use issues, people's genes can also make them less susceptible. Also, people may inherit **adaptive personality traits** that serve to help them "bounce back" faster after depressing events happen to them. Likewise, people also could inherit a tendency to deal more successfully with anxiety-provoking situations, thus helping to protect them from developing anxiety-related disorders.

Environmental Protective Factors

There are many beneficial things one can do to reduce the impact of negative life circumstances. As described below, protective factors can include actions taken to increase coping with life stressors, avoiding substance use, and seeking treatment for problematic mental health issues. Just as substance use and mental health problems can be risk factors for each other, avoiding substance use and maintaining good mental health can help prevent problems in these areas as well.

Coping Skills

One category of protective factors involves developing good ways of ***coping*** with stress and improving overall emotional well-being. In general, coping involves creating a supportive and nurturing environment for oneself, developing skills for interacting effectively with people, and maintaining a stable living and working situation. Good coping mechanisms include:

- *Learning effective communication skills*
- *Learning problem-solving skills*
- *Developing a good support system*
- *Learning to take responsibility for one's actions and well-being*
- *Maintaining employment and a meaningful day-to-day routine*
- *Participating in recovery/support groups (for substance use and mental health problems)*
- *Practicing relaxation skills and enjoying life*

Treating Substance Use and Mental Health Problems

As previously discussed, some people may have a biological predisposition toward abusing substances while others may be living in environmental circumstances that make it more likely they begin to abuse substances. Still other people may have both biological and environmental factors that increase the likelihood they will become substance abusers.

Regardless of the causal factors, people can seek treatment from a variety of sources. Many times, they will combine two or more treatment modalities to increase their chances of breaking their additions. The most common types of addiction treatment are listed below:

- *Individual psychotherapy*
- *Group psychotherapy*
- *Support groups (e.g., AA and NA)*

Once they have become addicted to alcohol or drugs, people often find it very difficult to become and remain clean and sober. Many times they become clean and sober for a while only to start using again later. This cycle of active addiction – recovery – back to active addiction is not uncommon and should not be taken to mean that someone cannot stay clean. Instead, someone who has experienced a relapse should try to become clean again as soon as possible and restart the recovery process. It may take several attempts at becoming and remaining clean, but people's chances of staying clean increase each time they make a wholehearted attempt to recover or quit. The old adage is true: practice makes perfect.

Sometimes people begin experiencing mental health issues that become difficult for them to handle. For example, what started out as normal amounts of depression or anxiety become larger amounts, or the symptoms last for longer periods of time than people normally experience. When this occurs, it may be beneficial for the person to seek treatment. Much like treatment for substance use issues, treatment for mental health issues often involves the following:

- *Individual psychotherapy*
- *Group psychotherapy*
- *Support groups*
- *Taking medication*

Medications tend to correct chemical imbalances in the brain and are generally not addictive. Therapy and support groups help people deal with difficult emotions and learn new ways of thinking and acting that improve coping with life. One type of therapy that has been shown to be effective in treating mental health problems (and substance abuse) is cognitive-behavioral therapy. Cognitive-behavioral therapy (CBT) focuses on a client's thoughts and behaviors. Much time is spent in therapy examining and changing inaccurate thoughts the client has about himself or herself, about relationships, and about the world in general. These inaccurate (or maladaptive) thoughts often lead to or worsen mental health issues. Cognitive-behavioral therapy also involves changing the behaviors of a client that might be causing problems in his or her life. One example of such behavioral change would be to decrease or discontinue problematic drug or alcohol use.

Other types of effective psychotherapy focus on interpersonal relationships, understanding difficulties in psychological development clients may have had while growing up, and the way relationships with family members affect a client's life. Different therapists may prefer one type of therapy to the others. It is the client's responsibility to "shop around" and find a type of therapy and a therapist with whom he or she will be comfortable.

When seeking help through therapy and support groups, it is important to know that they take time to work. People often attend therapy or support groups for several months. They also benefit more from treatment if they are honest and work hard during treatment.

Similarly, finding the right medication for a mental health problem involves a certain amount of trial and error. Medication that works for one person may not work for another, and effective dosages will vary across individuals as well. To be effective, most mental health medications also should be taken regularly (or as directed by a physician), not only when one experiences mental health symptoms. For example, unless directed by a doctor, people should not stop taking anti-depressants as soon as they start feeling less depressed. In summary, the key to successful treatment of mental health problems with medication is patience and perseverance while finding and taking the right medication and dosage.

Question 7: ***List 3 specific things someone can do to increase his/her protective factors (i.e., increase coping or obtaining help for a substance use or mental health issue).***

Connection Between Substance Use and Mental Health

People who are experiencing mental health difficulties sometimes self-medicate with drugs or alcohol. That is, they turn to substances to help them deal with their mental health difficulties. For example, people who experience anxiety may seek refuge in alcohol. People may also use drugs to elevate their mood or use drugs or alcohol to make them feel mellow and relaxed. However, self-medication is often ineffective and can lead to other life and mental health issues such as getting into trouble with the law or becoming depressed after repeated use of alcohol to calm one's nerves.

Instead of self-medicating with drugs or alcohol, a more effective way of dealing with mental health issues would be to seek counseling, a support group, or medications prescribed by a physician. These treatments have more long-lasting results and are much safer than abusing drugs or alcohol. For instance, the quality of medications is assured by the government, and they have been proven to reduce mental health symptoms. On the other hand, drugs bought on the street are often from an unknown source, and there is no way to know for sure what is in them or what effect they will have on mental health symptoms. The following chart lists various psychoactive (mind affecting) substances and their short term and long-term effects on the user.

Effects of Different Psychoactive Substances

Substance Type	Specific Substances	Long Term Effects of Abuse	Short Term Effects of Abuse
Alcohol	Beer, wine, "hard liquor" (E.g., vodka, scotch, whiskey, gin, rum, tequila)	*Alcoholism/unmanageable life *Increased risk of liver disease, brain damage, car accidents, other diseases *Risk of Death from Alcohol Poisoning *Decreased Sex Drive *Impotence *Depression *Sleep problems	*Relaxation, sedation *Slowed reaction time *Impaired judgment *Loss of inhibition
Cannabis	Marijuana, hashish	*Addiction/unmanageable life *Brain Damage *Decreased Motivation *Difficulty Concentrating *Mood Swings *Decreased Sex Drive *Impotence *Interferes with conception of children	*Relaxation *Mild euphoria *Altered sensory experiences *Fatigue *Anxiety *Panic *Increased appetite *Paranoia
Stimulants	Cocaine Amphetamines (and related compounds)	*Addiction/unmanageable life *Unmanageable life *Brain Damage *Difficulty Concentrating *Mood Swings *Increased risk of fatal heart attack or stroke *Increased risk of lung disease, other diseases	*Increased alertness and energy *Decreased appetite *Positive feelings *Anxiety *Tension, feeling jittery, heart racing *Paranoia
Sedatives	Anxiolytic (anxiety lowering) medications (e.g., Xanax, Klonopin, Ativan, Valium) Barbiturates	*Addiction *Risk of Death from Overdose *Depression *Decreased Motivation *Increased risk of HIV/AIDS, hepatitis, other diseases *Decreased Sex Drive *Impotence	*Sleepiness *Relaxation *Loss of motor coordination *Loss of inhibition *Dulled sensory experiences
Narcotics	Heroin Morphine Opium Codeine	*Addiction/unmanageable life *Risk of Death from Overdose *Depression *Decreased Motivation *Decreased Sex Drive *Impotence	*Euphoria *Pain relief *Sedation *Slowed reaction time *Impaired judgment
Inhalants	Glue Aerosols Nitrous oxide (laughing gas) Freon	*Addiction/unmanageable life *Severe Brain Damage *Death, Liver/ Kidney Failure	*Altered perceptions *Disorientation
Over-the-counter medications	Antihistamines and related compounds (e.g., benadryl, other cold tablets)	*Addiction *Greatly Increased risk of heart disease, lung diseases, all types of cancer, other diseases. *Increased risk of death *Decreased Immune Function *Decreased Sex Drive *Impotence	*Sedation
Tobacco	Cigarettes Pipe tobacco Chewing tobacco Snuff		*Alertness *Relaxation
Caffeine	Coffee Tea Chocolate		*Increased alertness
Anti-parkinsonian Agents	Cogentin, Artane, Symmetrel		*Confusion *Mild euphoria

Sometimes people are afraid of using medications prescribed by physicians to treat mental health issues because they worry about becoming addicted to them or worry about the side effects. They may also be concerned about the risks of taking medications while they are still using drugs or alcohol. Under a physician's care many psychotropic medications (i.e., medications for dealing with mental health issues) are very safe and have little risk for addiction. It is important to note, however, that use of drugs or alcohol can change how effective these medications are. Certain drugs or alcohol may increase the effect of the medications to dangerous levels, or they may decrease the effectiveness of the medications to the point that taking them has no beneficial effect. While many medications are not addictive and do not interact negatively with drugs and alcohol, there are some important exceptions. For example, there is the potential for addiction when taking benzodiazepines as well as for adverse side effects when they are combined with drugs or alcohol. Thus, while most psychotropic medications are safe, that does not mean that using drugs or alcohol while on the medications will not result in negative consequences. There is always a risk of adverse consequences for people on psychotropic medications who have not successfully abstained from alcohol or drugs. As such, when being prescribed medications, it is important to be open and honest with your physician about ALL medications you are or may be taking as well as the drugs – legal or not – that you are or may be using while on the medications.

Just as mental health problems can be a risk factor contributing to substance use, substance use can be a risk factor for mental health problems. In this case, however, people who abuse drugs or alcohol may cause or worsen already existing mental health problems. One way this can occur is by drugs permanently altering brain chemistry. For example, use of marijuana or the designer drug ecstasy can make people more likely to experience mood disorders like depression later in life.

Other ways that drug and alcohol use can affect mental health is through the added life stress that users often experience. Legal problems, family conflict over drug use, job loss, and money difficulties are just a few of the ways that drug and alcohol use can disrupt people's lives. These disruptions, just like any other stressors, increase the risk of developing or worsening mental health issues.

To decrease the chances of substance use causing or worsening mental health problems, people who abuse alcohol or drugs should seek addiction treatment through counseling, support groups, or medication prescribed by a physician. If they are experiencing mental health problems in addition to addiction, people can often obtain mental health care at the same time.

Summary

- People's biology and the environments in which they live and work interact to make them more or less likely to develop substance use and mental health issues.

- Biology and environment also affect how severe these issues can become.

- Specific combinations of biology and environment influence how people think, feel, and act and are called risk factors or protective factors, depending on whether they increase or decrease people's well-being and functioning.

- Substance use and mental health issues can be the results of other risk factors and can themselves be risk factors for each other or other problems.

- Seeking treatment for substance use or mental health problems can reduce people's risk for further problems and would be considered a protective factor.

- Effective treatments for substance use and mental health problems include individual and group therapy, support groups, and medication.

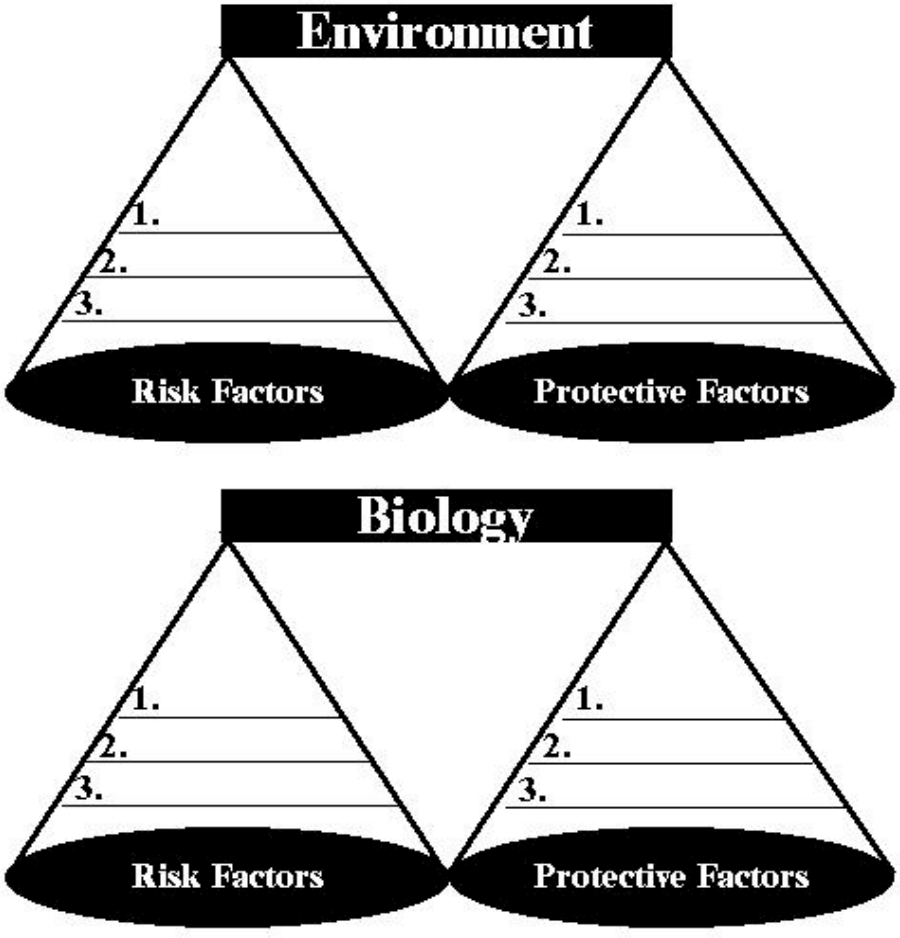
References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Exercises

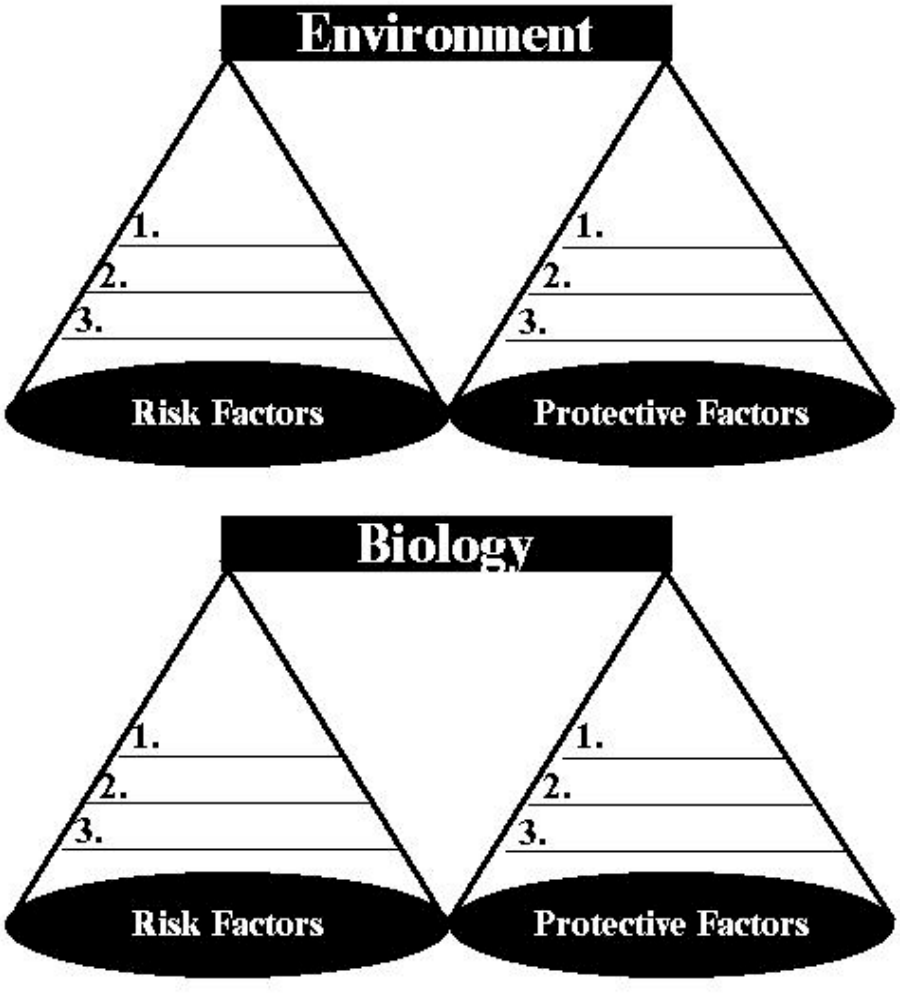
1. Imagine that risk factors and protective factors for substance use problems are on competing sides of a scale. Create two scales, one for biological factors and one for environmental factors. For each one, make a list of your risk and protective factors. See which side is heavier (i.e., which side has the greatest number of factors). What does this tell you about your level of risk for substance use problems?

List your risk and protective factors below:



2. Which is stronger for you right now, risk or protective factors?
3. What are some things you can do to reduce your risk factors and enhance your protective factors?
4. Do exercises 1-3 for mental health problems.

List your risk and protective factors below:



Assessment of Substance Abuse

This information is adapted from the DSM-IV (1994) and applies to both alcohol and drug use

People may meet criteria for substance abuse if their use of alcohol or drugs causes significant impairment or distress in their lives in one or more of the following ways within a 12-month period.

1. Repeated substance use resulting in failure to fulfill major obligations at work, school, or home (e.g., repeated absences or poor work performance related to the substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)

2. Repeated substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by the substance)

3. Repeated substance-related legal problems (e.g., arrests for substance-related disorderly conduct)

4. Continued substance use despite having persistent or repeating social or interpersonal problems caused or worsened by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

Module 2:

Depression and Substance Abuse

MODULE 2: DEPRESSION AND SUBSTANCE ABUSE

DIRECTIONS: Remember to make this group interesting to the group members by welcoming their input and discussion and using the exercises and discussion questions. Present the material in an interactive format. Don't just read the material but say it in your own words in a way that you know the participants will understand.

You can break this module up into more than one group or skip some exercises if you cannot fit it all into one group. Another idea would be to have participants complete some of the exercises as homework or with their counselors. You can also skip or modify exercises if they are not appropriate for your program or treatment population. Feel free to modify the way you use this material to meet the needs of your program and group participants.

Overview

Depression is a psychiatric disorder in which a person experiences a very low or depressed mood. At the same time the person may also experience changes in other areas such as sleep and appetite. Depression differs from normal sadness or "feeling blue" in that it causes severe enough problems to interfere with a person's day-to-day functioning. People's experience with depression varies. Some people describe it as a total loss of energy or enthusiasm to do anything. Others may describe it as always feeling like something very bad is about to happen.

Depression is a common psychiatric disorder. About 15-20% of people experience an episode of depression during their lifetimes. Depression may occur at any point in a person's life. Some people experience depressions that last weeks, months, or even years but then fully recover from the disorder. Other people struggle with depression throughout their lives. Many famous people have struggled with depression such as *Abraham Lincoln*, *Tipper Gore*, and *Anthony Hopkins* and have managed to lead very fulfilling lives.

Question 1: ***What are the symptoms of depression?***

(You may want to refer clients to the workbook page "Assessment for Depression" to help them review the symptoms but have them wait to fill it out later at the end of the module.)

Symptoms of Depression (taken from the DSM-IV, 1994)

- ***Depressed Mood –*** mood is depressed most of the day, nearly every day.

- ***Diminished Interest or Pleasure*** – person takes little interest or pleasure in almost all activities, most of the day, nearly every day.

- ***Change in Appetite and/or weight*** – person has lost appetite or lost weight (when not dieting), or has an increased appetite or has gained weight.

- ***Change in Sleep Pattern*** - insomnia (difficulty falling asleep, staying asleep, or waking early in the morning and not being able to get back to sleep) or sleeps too much.

- ***Change in Activity Level*** – a decreased activity level and is moving or thinking slower, or person has been feeling agitated, "on edge," and restless and having difficulty being still.

- ***Fatigue or Loss of Energy*** – feeling tired and seems to have no energy nearly every day.

- ***Feelings of Worthlessness, or Inappropriate Guilt*** – person feels worthless or has been feeling inappropriately or excessively guilty nearly every day.

- ***Decreased concentration or ability to make decisions*** – trouble concentrating, thinking, or making decisions, nearly every day.

- ***Recurrent thoughts about death*** – thinking about death a great deal, has been thinking about attempting suicide, or has actually attempted suicide.

A diagnosis of depression requires that a person experience at least five of these symptoms for at least two weeks, and one of these symptoms must be either depressed mood or diminished interest or pleasure in daily activities. Also, the person must experience either distress from these symptoms or experience impaired functioning at work, socially, or in another important area of his or her life.

In order to be diagnosed with depression, a person needs to have ***five*** of these symptoms for at least two weeks and at least one of these symptoms must be depressed mood or diminished interest or pleasure in daily activities. Additionally, the person has to have either distress from these symptoms or have impaired functioning at work, socially or in another important area of his or her life. Theories suggest there are more than one cause for depression:

- Biochemical theories suggest it may be caused by a chemical imbalance in the brain, particularly the chemicals norepinephrine and serotonin. These imbalances may be caused by genetic factors, early effects of the environment on the developing brain (such as when the baby is in the womb or during birth), or both.

- Someone who suffers the loss of a significant person (such as a parent) early in life may be more vulnerable to depression later in life.

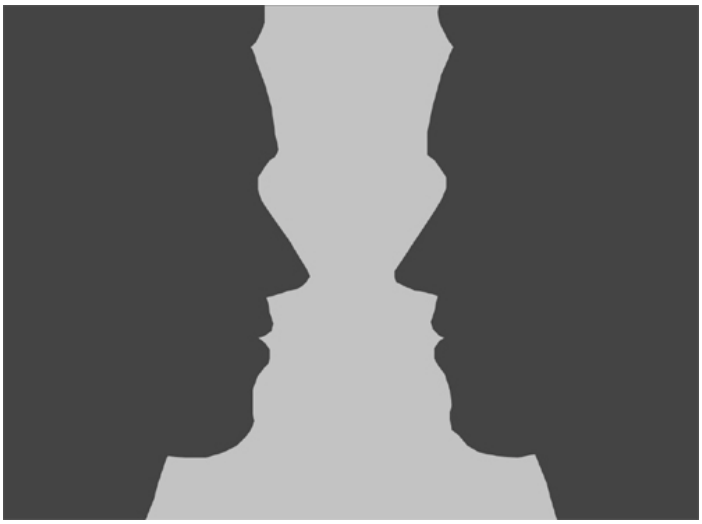
- Depression is more likely to happen after someone has a major loss in his or her life, such as the death of a loved one, divorce, losing a job, or when under a great deal of stress.

- People are more likely to get depressed if they have few friends or family members they can turn to for support.

Question 2: ***Which of the 4 theories are biological? Which are environmental?***
Answer: Biochemical – biological
Early loss – environmental
Major loss/stress – environmental
Lack of support -- environmental

Connection Between Depression and Substance Abuse

Using alcohol or drugs also can cause a person to become depressed, either while drunk or high or during withdrawal from alcohol or other drugs. For instance, it is common for people to become depressed when drinking, and it is also common for people who are withdrawing from cocaine to become depressed. Because of this, treatment professionals may decide that people who are going through withdrawal from alcohol or drugs need to be abstinent for at least a month to see if their depressive symptoms need additional treatment or if the depression will lift by itself after withdrawal is over. A good way to determine whether depression is caused by drugs and



alcohol is to observe a client's mood during abstinence. If mood continues to improve the longer the client is abstinent, the depression was likely a result of the drugs or alcohol. If the person becomes more depressed or stays the same, the drugs or alcohol were not likely to be the cause of the depression.

Another way that depression may interact with substance abuse is that people are more likely to use or relapse when they are experiencing negative feelings. Because depression includes negative feelings, being depressed may make some people more likely to use alcohol or other drugs in an attempt to make themselves feel better. The problem with this strategy is that even if alcohol or other drugs make someone feel better for a little while, they almost always make the depression worse after the initial rush.

Case Story 1

Bennie had been feeling depressed for the past two months. He lost his job in construction because he missed too much work from getting drunk and high. When he got a positive urine screen for cocaine at work that was the final straw and he got fired. After that, he had given up on trying to get another job or doing much of anything. He also began drinking more heavily and smoking even more crack cocaine, which made his depression seem to get better at first, but each morning he felt worse than ever. He began lying around his apartment all day, sleeping or trying to watch TV, but he couldn't even concentrate long enough to make it through a video. He just kept getting drunk and high every night and came close to trying to kill himself several times. He thought about death a lot.

After about a month of this behavior, his girlfriend left him. Being alone made him feel more depressed and so he drank and smoked more to try to feel better. It just made him feel more depressed. He also had been having difficulty getting to sleep at night, so he began drinking each night until he passed out. No matter when he passed out, he always woke up early in the morning feeling exhausted. He felt more and more worthless because he was unemployed and started feeling guilty over how his behavior drove his girlfriend away. He lost his appetite for food and rarely ate, and he had lost 20 pounds in the last 2 months alone.

Question 3: ***Identify Bennie's symptoms of depression.***

Question 4: ***What is the connection between Bennie's depression and his substance abuse?***

Case Story 2

Tanya was abused physically and sexually when she was growing up, which caused her to feel depressed and anxious a lot of the time. She experimented with drugs and alcohol to try to feel better. Sometimes this would help for a little while, but she always felt worse when she came down from drugs. When she was a teenager, she ran away to get away from the abuse. She had no way to support herself so she ended up exchanging sex for money. She did not like the way this made her feel, but she did not know how else to support herself. People also would pay her with drugs or alcohol, which she would use to try to get rid of her bad feelings. Soon she got hooked on crack and would do anything to get high. Whenever she wasn't high, she felt very depressed, and this seemed to get worse every time she came down. She also started to need more and more crack to get high, and the highs seemed to be shorter each time. She hardly ever ate and became very skinny. She often had to use alcohol or heroin to get to sleep because she was so wired from the cocaine. She often got beat up or abused by her clients or pimps, which made her even more anxious and depressed, and she started to feel like everyone was out to get her.

Soon she turned to dealing drugs herself because it seemed an easier way to get money, but she got arrested for possession. Withdrawal in jail felt like hell at first, and she became so depressed that she felt like dying sometimes. Her body was a mess and her mind just didn't seem to work right at first. Her memory of the past several years just seemed like a blur, and she could not figure out how she had ended up so messed up.

Question 5: ***Identify Tanya's symptoms of depression.***

Question 6: ***What is the connection between Tanya's depression and her substance abuse?***

Treatment

There are several good treatments for depression. They include medications, psychotherapy, and other complementary treatments.

Medication

Special medications called antidepressants are used to treat the symptoms of depression. More severe cases of depression may require antidepressant medication in combination with psychotherapy. Antidepressants may also be helpful in preventing future relapses into depression. The following table lists the most common antidepressant medications, average dosages, and their possible side effects.

Antidepressant Medications

Type of Drug	Brand Name	Chemical Name	Average Dosage Range (mg/day)	Possible Side Effects
Tricyclic(s)	Anafranil	climipramine	25-250	Dry mouth, dizziness, sedation or agitation, weight gain, constipation, heart palpitations or abnormalities
	Elavil	amitriptyline	100-300	
	Norpramin	desipramine	100-300	
	Pamelor, Aventyl	nortriptyline	50-150	
	Sinequan, Adapin	doxepin	75-300	
	Tofranil	imipramine	100-300	
	Vivactil	protriptyline	10-60	
MAO Inhibitors	Marplan	isocarboxazid	10-50	Insomnia, dizziness, weight gain, sexual difficulties, confusion, memory problems, overstimulation, hypertensive crisis
	Nardil	phenelzine	45-90	
	Parnate	tranylcypromine	30-60	
Selective Serotonin Reuptake Inhibitors (SSRI's)	Paxil	paroxitine	20-50	Nausea, vomiting, excitement, agitation, headache, sexual problems (delayed ejaculation, not experiencing orgasm)
	Prozac	flouxetine	20-80	
	Zoloft	sertraline	50-200	
	Luvox	fluvoxamine	50-300	
Serotonin and Norepinephrine Reuptake Inhibitors (SNRI's)	Effexor	venlafaxine	75-375	Same as SSRI's plus potential to elevate blood pressure
Other Compounds	Desyrel	trazadone	150-600	Sedation or agitation
	Wellbutrin	buproprion	75-450	
	Ludiomil	maprotiline	75-225	
	Remeron	mirtazapine	15-45	
	Serzone	nefazodone	200-600	

Basic Facts about Antidepressants

- Antidepressants need to be taken daily as prescribed for at least 2-4 weeks to start being effective. Typically, they are taken continually to maintain their effect. When used as prescribed, they are very safe.

- Some people have side effects from antidepressants, but there are several new medications that have far fewer side effects.

- If a person has any side effects from an antidepressant medication, his or her doctor or nurse should be told right away. They may be able to adjust the dosage or switch the person to a different antidepressant to get rid of the side effects. On occasion, the side effects simply go away over time. Not all people experience the same side effects.

- Antidepressants are not addictive but usually should be stopped gradually (by taking a lower dose each day) when they are discontinued. It is important to follow a doctor's directions for tapering off medications. A client should not do it on his or her own.

- Although the 12-step philosophy states that it is fine to take antidepressants or other non-addictive medications for psychiatric disorders, not everyone in 12-step groups will understand someone in recovery taking any drug even if it is medication. As a result, people taking such medications may want to keep that private.

- Once a person is taking an adequate dose of these medications, he or she does not always need to increase the amount taken over time. People do not always develop a tolerance to antidepressants, requiring higher doses over time.

- Antidepressant medications are more effective when combined with other effective treatments such as counseling or psychotherapy, getting social support, and other positive changes in behavior and lifestyle.

- For many antidepressants, it may be better to continue taking them even during a relapse into using alcohol or drugs. This is because the antidepressant can still help to control the depression. However, continuing the use of antidepressants while using drugs or alcohol should be discussed with a doctor because the safety and effectiveness of the antidepressant may depend on which antidepressant (or other medications) is being taking.

- Other commonly used treatments for mild depression include exercise, both aerobic and strength training, and St. John's Wort, an herbal supplement. One should check with a doctor about using herbal supplements because, like medications, they can have side effects and may affect the outcome of other prescribed medications.

(Refer detailed questions about antidepressants to their doctors.)

Psychotherapy

Most people with depression have mild to moderate depression. For these people, individual psychotherapy, counseling, or "talk therapy" may be effective in treating depression, even without medication. Psychotherapy helps the depressed person deal with social, relationship, or work problems as well as change negative patterns of thinking and behavior. Group or family therapy can also play important roles in helping the person overcome depression. If a person is recovering from an addiction and is depressed, the most effective treatments combine treatment for both depression and substance abuse in one program.

One type of therapy that has been shown to be effective in treating depression (and substance abuse) is cognitive-behavioral therapy. Cognitive-behavioral therapy (CBT) focuses on a client's thoughts and behaviors. Much time in therapy is spent examining and changing inaccurate thoughts the client has about himself or herself, about relationships, and about the world in general. These inaccurate (or maladaptive) thoughts often lead to depression. Cognitive-behavioral therapy also involves changing the behaviors of a client that might be causing problems in his or her life. One example of such behavioral change would be to decrease or discontinue problematic drug or alcohol use.

Complementary Treatments

In addition to medication and psychotherapy, certain activities can help to lift depression naturally, especially mild to moderate cases. These activities include regular cardiovascular exercise, such as running, swimming, walking, or riding a bicycle. Strength training with weights or exercise machines can also help. Relaxing activities such as yoga stretches, postures, and breathing exercises and meditation or relaxation training can also help to lift depression naturally. Any of these activities can be added to psychotherapy and/or medication to help treat depression. Severe depression may not respond to any of these activities alone, in which case medication and psychotherapy should be pursued.

Summary

- Depression is a psychiatric disorder in which a person experiences a very low or depressed mood.
- Depression differs from normal sadness or "feeling blue" in that it causes severe enough problems to interfere with a person's day-to-day functioning.
- Between fifteen and twenty percent of people experience an episode of depression during their lifetimes.

- Research suggests that there may be more than one cause for depression. Environmental and biological causes can include chemical imbalances in the brain, experiencing losses early in life, experiencing major losses or stress as adults, and lack of social support.

- Use of alcohol or drugs can be risk factors for depression. A person may become depressed either while drunk or high, or during withdrawal from alcohol or other drugs.

- Depression can also be a risk factor for substance abuse. People are more likely to use or relapse when they are experiencing negative feelings, and because depression includes negative feelings, being depressed may make some people more likely to use alcohol or other drugs in an attempt to make themselves feel better.

- There are several good treatments for depression including medications, psychotherapy, and other complementary treatments. Seeking these treatments could be a protective factor against both substance abuse and mental health problems.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Exercises

1. Think about a time, now or in the past, when you were feeling depressed. Try to identify what was going on in your life that may have made you unhappy (e.g., a death in the family, breaking up a relationship, loss of a job, etc.). If you find that you can't identify a particular event or situation that made you unhappy, try to identify particular "solo" thoughts that you may have been having (e.g., "I'm a bad person", "No one loves me", "I'm a failure").

2. Next, examine the thoughts that went along with the particular situation or examine the "solo" thoughts if there was no identifiable situation.

3. Do these thoughts make sense? Are they logical? What evidence (i.e., proof) do I have to support that belief? Is there anything I can do to change evidence supporting that belief? What evidence do I have that does not support that belief?

Sample 1:

1. I became depressed last month when I got laid off from my job.
2. At the time I became sad because I started thinking that I am a failure and a bad person who can't take care of my family.
3. Am I really a failure because I got laid off from my job?
   Evidence that I'm a failure: I'm out of work.
   Is this proof I'm a failure?: No, it just reflects a worsening economy.
   Evidence that I'm not a failure: I received good employee evaluations on the job. I'm also trying to find another job to help support my family.
   Is this proof I'm not a failure?: It shows that I'm a hard worker and a good employee and that even when laid off I try to find ways to support my family.

Sample 2:

1. I am depressed because I'm an addict.
2. I believe that I am a weak person and a bad person for letting drugs ruin my life.
3. Am I really a weak and bad person?
   Evidence that I'm weak and a bad person: I can't get and stay clean.
   Is this proof I'm weak and a bad person?: It doesn't really mean that I'm weak or a bad person. Like many people, I'm hooked on an addictive substance. Becoming an addict has nothing to do with whether a person is good or bad or is weak or strong. It has to do with biological and environmental risk and protective factors. However, I do need to take responsibility for my actions and try to become and stay clean.

Evidence that I'm not a weak and bad person: I'm showing that I'm strong because I am trying to change the balance of my risk and protective factors and getting help becoming and staying clean.

Is this proof I'm not a weak or bad person?: Yes, I'm showing that I'm strong by taking responsibility for getting off drugs and getting help. Getting off drugs is a very scary process, but I'm strong enough and brave enough to take responsibility for my life and to try to improve it.

Assessment of Depression for People Recovering from Addictions

(adapted from the DSM-IV, 1994)

Directions: This exercise may be completed for the case story character or for yourself. For each of the two time periods (during the time using drugs or alcohol, and during the last 2 weeks), put a check mark next to any symptoms if they existed for at least two weeks during that time period.

Symptoms of Depression	***During the last 2 weeks***	***During the time actively using***
1) *Depressed mood* – Mood is depressed most of the day, nearly every day		
2) *Diminished Interest or Pleasure* – Little interest or pleasure in almost all activities, most of the day, nearly every day.		
3) *Change in Appetite and/or weight* – Has lost appetite or weight (when not dieting) or has increased appetite or gained weight.		
4) *Change in Sleep Pattern* - Difficulty falling asleep, staying asleep, or waking early in the morning and not being able to get back to sleep. Or, is sleeping too much.		
5) *Change in Activity Level* – A decreased activity level and moving and thinking slower. Or, been feeling agitated, "on edge", and restless, and has difficulty being still.		
6) *Fatigue or Loss of Energy* – Been feeling tired and seems to have no energy nearly every day.		
7) *Feelings of Worthlessness, or Inappropriate Guilt* – Feeling worthless or feeling very guilty nearly every day.		
8) *Decreased concentration or ability to make decisions* – Trouble concentrating, thinking, or making decisions, nearly every day.		
9) *Recurrent thoughts about death* – Thinking about death a great deal, thinking about attempting suicide, or has attempted suicide.		

How to Score Answers: If five or more of the above symptoms existed during the last 2 weeks and at least one of them is #1 or # 2 and the individual was in distress or functioning was impaired at work or socially, the individual may have depression. If the individual being assessed is a client (as opposed to the case story character), he or she should tell his or her counselor or doctor right away.

Homework Questions

1) Are there any patterns to when the depressive symptoms occur?
2) Are the symptoms of depression more likely to occur during a particular time period (e.g., before starting to use, during the time period that using occurred, during the first month of abstinence when going through withdrawal, or during the past two weeks)?
3) How has substance abuse interacted with any symptoms of depression that may have existed?

Module 3:

Bipolar Disorder and Substance Abuse

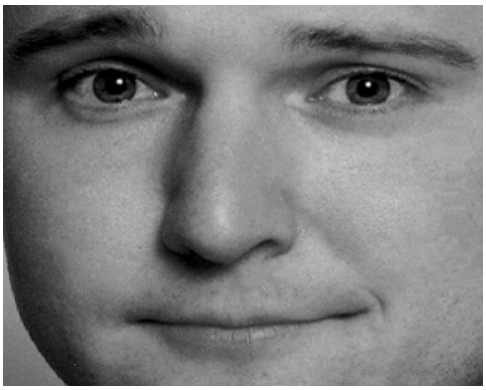
MODULE 3: BIPOLAR DISORDER AND SUBSTANCE ABUSE

DIRECTIONS: Remember to make this group interesting to the group members by welcoming their input and discussion and using the exercises and discussion questions. Present the material in an interactive format. Don't just read the material but say it in your own words in a way that you know the participants will understand.

You can break this module up into more than one group or skip some exercises if you cannot fit it all into one group. Another idea would be to have participants complete some of the exercises as homework or with their counselors. You can also skip or modify exercises if they are not appropriate for your program or treatment population. Feel free to modify the way you use this material to meet the needs of your program and group participants.

Overview

Everyone has ups and downs in mood; happiness, sadness, and anger are normal emotions and are a normal part of everyday life. In contrast, bipolar disorder is a medical condition in which people have mood swings that are out of proportion to things going on in their lives. These mood swings affect a person's thoughts, feelings, physical health, behavior, and functioning. Bipolar disorder is not the person's fault, nor is it the result of a "weak" or unstable personality. It is a treatable medical disorder for which there are specific medications and other therapies that help most people.



Bipolar disorder is the medical name for manic depression. According to the American Psychiatric Association's Diagnostic and statistical manual of mental disorders, fourth edition (1994), a person with this disorder sometimes has:

- ***an extremely elevated mood*** (mania) which may range from mild mania (hypomania) to more severe mania

- ***an extremely low mood*** (depression) which can be very brief to long-lasting

In between the mania and depression, the person's mood may be normal. Sometimes a person with bipolar disorder may have additional psychotic features such as delusions or hallucinations. The symptoms of bipolar disorder can cause considerable disturbance in a

person's life. In fact, the experience has been described as a roller coaster ride that doesn't stop. A person with bipolar disorder doesn't generally have an episode of depression and then an episode of mania in equal amounts. Instead, the cycles are often unpredictable and of different lengths.

Question 1: ***Based on this brief introduction, what might be some symptoms of bipolar disorder?***

Question 2: ***What do you think would happen if someone used drugs or alcohol to cope with depression and mania?***

Bipolar disorder usually develops between the ages of 16 and 35 but may develop in a person's forties or even fifties. It is a lifelong disorder, but in between mood episodes, many people can function normally. Many famous people such as Robert Downey Jr., Jean-Claude Van Damme, Patty Duke, Edgar Allen Poe, and Brian Wilson have had bipolar disorder and still have made significant contributions to society.

Symptoms of Bipolar Disorder **(taken from the DSM-IV, 1994)**

The symptoms of bipolar disorder can be grouped as manic symptoms, depressive symptoms, and other symptoms.

Manic Symptoms

Not all of these symptoms must be present for a person to have had a manic episode.

- ***Euphoric Mood*** - mood is elevated, such as feeling incredibly excited
- ***Irritability*** - easily angered or irritable, especially when others seem to interfere with the person's plans or goals
- ***Inflated Self-Esteem*** - extremely self-confident to the point of being unrealistic about ability to do things (grandiosity)
- ***Decreased Need for Sleep*** - only a few hours of sleep may be needed each night (such as less than four hours) for the person to feel rested
- ***Talkativeness*** - talks excessively and may be difficult to interrupt
- ***Racing Thoughts*** - thoughts come so rapidly that the person finds it difficult to keep up with them or express them
- ***Distractibility*** - attention is easily drawn to other things and can interfere with talking with other people, enjoying an activity, or ability to work

- ***Increased Goal-Directed Activity*** - a great deal of time is spent pursuing specific goals, at work, school, or in sexual activity

- ***Excessive Involvement in Pleasurable Activities*** - common problem areas include sexual indiscretions, spending sprees, increased substance abuse, or making foolish business investments

Depressive Symptoms

Depressive symptoms reflect the opposite of manic symptoms, with a low mood and inactivity as the major features. Not all symptoms must be present for a person to have had a depressive episode.

- ***Depressed Mood*** – most of the day, nearly every day

- ***Diminished Interest or Pleasure – i***n all, or almost all, activities most of the day, nearly every day

- ***Change in Appetite and/or Weight*** – significant weight loss when not dieting, or a weight gain; decrease or increase in appetite nearly every day

- ***Change in Sleep Pattern*** – inability to sleep or sleeping too much nearly every day

- ***Change in Activity Level*** – observable by other people, not just feelings of restlessness or being slowed down

- ***Fatigue and Loss of Energy*** – nearly every day

- ***Feelings of Worthlessness, Hopelessness or Helplessness*** – nearly every day

- ***Inappropriate Guilt*** – not just self-blame or guilt about being sick

- ***Recurrent Thoughts about Death*** – not just fear of dying, but recurring thoughts of suicide without a specific plan, a suicide attempt, or a specific plan to commit suicide

- ***Decreased Concentration or Ability to Make Decisions*** – nearly every day

Other Symptoms

People with bipolar disorder may have other psychiatric symptoms at the same time they experience manic or depressive symptoms. However, not all people experience these symptoms, and they are not needed to make a diagnosis of bipolar disorder. Some of the more common of these other symptoms include:

- ***Hallucinations*** -- false perceptions such as hearing voices
- ***Delusions*** -- false beliefs, such as paranoid thinking

Question 3: ***People often feel great while they are manic (e.g., euphoric mood, inflated self-esteem). If this is the case, why would they, or should they, try to get those symptoms treated?***

Answer: They may feel good but are at risk of engaging in behaviors that are harmful to themselves or others.

Question 4: ***What are some environmental risk factors that might increase the chances someone with a biological predisposition for bipolar disorder would develop it?***

Answer: Stress, drug use, poor diet and sleeping habits.

Connection Between Bipolar Disorder and Substance Abuse

Substance abuse occurs in many patients with bipolar disorder. Abusing drugs or alcohol is not only common among bipolar patients but also may contribute significantly to treatment resistance and poor treatment outcome. Separating the symptoms of bipolar disorder and substance abuse can be difficult because acute intoxications and withdrawal can mimic the illness. How do we know if the symptoms are due to substance use or bipolar disorder? Typically, if manic or depressive symptoms persist or worsen after alcohol or drug detoxification, treatment for a mood disorder may be needed.

Some drugs including marijuana, downers, alcohol, and opiates seem to dull the effects of mood swings temporarily, only to cause other symptoms later. Other drugs such as speed and cocaine can enhance manic depressive symptoms or can cause manic states, which may be followed by deep depression and psychotic symptoms. The continued use of drugs by people with bipolar disorder possibly stems from their discovery of short-term relief from the symptoms of mania or depression. The unfortunate reality is that the relief of symptoms by using drugs or alcohol is short-lived and often begins a cycle of substance abuse. An individual struggling with both bipolar disorder and substance abuse offers this:

"Self-medicating treats the symptoms, not the underlying illness. The more we use a substance other than supervised medication, the worse our symptoms become, and we often find ourselves in a hole which is very difficult to climb out of."

There are many challenges to treatment for those individuals who are struggling with co-occurring disorders. However, if the client takes control and works with a counselor through various treatments, it is possible to find a treatment that fits the client's needs.

Case Story 1

Leo was a young man full of life and potential, but he could never seem to get over that final hurdle in life that would, in his words, "make me a success." Though he was married with two kids and appeared to be happy in his middle-class suburban neighborhood, Leo could never maintain a steady work history. Luckily he had inherited some money and his home from a deceased relative, and his wife worked for a medical clinic. If the family had depended solely on Leo providing for them, they would have been in trouble.

One day while meeting his wife at the clinic for lunch, Leo struck up a conversation with a psychiatrist who worked at the clinic. As usual, Leo was between jobs and began discussing with the psychiatrist how much he hated his previous employer and that in all his years he had yet to find a job that made him happy. He also discussed his history of mood swings that left him depressed and withdrawn from his family and work. During these periods, his alcohol consumption would increase drastically, and his experimentation with hallucinogens got worse, putting a strain on his marriage and usually resulting in another job change. Leo had "tried" over the years to get a grip on his mood swings. Every time he assumed he had things under control, his mood swings would flare up again, his use of alcohol and hallucinogens would increase, and he would change jobs again.

The psychiatrist asked Leo to make an appointment and suggested he bring his wife. At the first appointment, the psychiatrist suggested that Leo try some mental and relaxation exercises. Leo was later diagnosed with bipolar disorder and given medication.

Two years later, Leo's mood swings have subsided, and he no longer uses alcohol and hallucinogens. He started his own business, which is thriving, and his life is finally looking like he had envisioned when he graduated college.

Question 5: ***Why do you think Leo began using alcohol and drugs?***

Question 6: ***What effect did these substances likely have on Leo's mood swings?***

Case Story 2

Lisa had a wonderful life. She had so much going for her. She had three great children and was married to a special man. There was so much to do and so much to live for – and so little time! One day after watching a television show about architects Lisa decided she had found her calling. She would be a cashier by day and an architect by night. She began to create designs of houses and office buildings, often working late into the night. That was no problem, however, because she was so excited about her new calling that she often found she couldn't sleep until quite late anyway.

Lisa had so many good ideas for building designs that she found it hard to finish one design before moving on to the next idea. One evening, while working on a new design, Lisa came to the realization that she could also decorate the insides of the buildings as well as design the outsides. She should become an architect and interior decorator!

Soon, Lisa's husband began to turn into a real pessimist, saying things like she couldn't be an architect without being trained or at the very least finishing her high school degree. That didn't stop Lisa; she knew that she had natural ability and that was all she needed.

After a couple more weeks, Lisa found that she could no longer keep up with the hectic pace she had set for herself. In fact, she began sleeping more and more, sometimes as much as half the day. She also began to feel down on herself, thinking that her husband was right – she couldn't be an architect. What a stupid idea. She began to feel guilty for wasting her time and for neglecting her family. She began to feel that she was a horrible mother and person and didn't deserve such a wonderful family. Maybe she should just put an end to all the foolishness once and for all.

Question 7: ***Identify Lisa's symptoms of bipolar disorder.***

Question 8: ***What drugs might she turn to in order to combat her depressive symptoms?***

Question 9: ***What would be the likely result of using these drugs in the short term?***

Question 10: ***What would be the likely result of using these drugs in the long term?***

Treatment

Clients who have been diagnosed with bipolar disorder may feel they are the only people facing the difficulties of this illness. But in the U.S. alone, more than 2.2 million people have bipolar disorder. There is no cure for bipolar disorder, but very effective treatments are available to stabilize moods and help clients regain and maintain a satisfying and productive life. Some of the most common treatments for bipolar include medication, psychotherapy, and support groups.

Medication

Generally, if the symptoms of bipolar disorder last for 14 days after detoxification, medication can be beneficial. The most common medications used to control the symptoms of bipolar disorder are mood stabilizers, antidepressants, and anticonvulsants. Occasionally, antipsychotics are used (e.g., Zyprexa used as a mood stabilizer). A doctor also may prescribe other medications to help with insomnia, anxiety, restlessness, or psychotic symptoms. It is important that medication be taken as prescribed, usually every day, on a regular basis. A person may need to take medication over the course of his/her lifetime. However, these drugs are not addictive, and people do not develop tolerance to them and require higher doses.

Successful management of bipolar disorder requires a great deal from the client. There will almost certainly be many times when a client will be very tempted to stop medication because: (1) "I feel fine," (2) "I miss the highs," or (3) "I am bothered by side effects." Clients who stop medication probably won't have an acute episode immediately in the next days or weeks but will probably relapse eventually.

Mood stabilizers – Lithium is the most common of these drugs. Specific symptoms may be treated with other medications such as antipsychotics and antidepressants. Many people experience few or no side effects from lithium. Some side effects are temporary and go away after a period of several weeks or months. Examples of common side effects include: nausea, stomach cramps, thirst, fatigue, headache, and mild tremor.

Anticonvulsants – These medications were originally developed for the treatment of seizure disorders and tend to act more rapidly on acute mood disturbances, especially mania. Like lithium, these drugs have some side effects, and certain precautions must be exercised when taking them. Often these side effects are temporary, but sometimes they may continue for longer periods of time. Some of the most common side effects include fatigue, muscle aching or weakness, dry mouth, constipation or diarrhea, loss of appetite, nausea, skin rash, headache, dizziness, decreased sexual interest, and temporary hair loss.

Antidepressants – Although mood stabilizers by themselves can sometimes pull clients out of a depression, they also may need to take a specific antidepressant to treat the depressive episode. However, if given alone, antidepressants can sometimes cause a major

problem in bipolar disorder by pushing the mood up too high. Therefore, antidepressants are sometimes given together with a mood stabilizer to prevent this from happening. Antidepressants usually take several weeks to begin showing full effect, so clients shouldn't get discouraged if they don't feel better right away.

Precautions When Taking Medications

Some of these drugs may cause sleepiness; therefore appropriate precautions must be taken when driving or operating heavy machinery. When a person is taking an anticonvulsant, the use of alcohol is often not advised because the effects of alcohol are greatly increased. The effects of sedative drugs are also enhanced by anticonvulsants. People are usually not prescribed more than one type of anticonvulsant medication at a time.

Mood Stabilizing Medications

Type of Drug	Brand Name	Chemical Name	Average Dosage Range (mg/day)	Possible Side Effects
Lithium	Eskalith Eskalith Controlled Release	lithium carbonate	900-3600	Tremors, dry mouth, muscle weakness, fluid buildup, diarrhea, nausea, vomiting, mental confusion, lack of coordination, drowsiness
Anticonvulsants	Tegretol Depakene, Depakote	carbamazepine valproic acid	100-2000 125-2000	Nausea, vomiting, indigestion, tremors, drowsiness, weight gain, elevated liver enzymes
	Lamictal	lamotrigine	25-500	Skin rashes, sensitivity to the sun, headaches, dizziness, nausea, weakness, tiredness, blurred or double vision

Psychotherapy

Psychotherapy can play an important role in reducing the stresses that can trigger manic and depressive episodes. Sometimes being in therapy helps clients to see warning signs of symptoms before they begin. During depression, psychotherapy usually works more gradually than medication and may take two months or more to show its full effects. However, the benefits are often long lasting.

Support Groups

Support groups can be a valuable part of treatment. These groups provide a forum for mutual acceptance, understanding, and self-discovery. Participants develop a bond with other attendees because they have all lived with mood disorders. People new to mood disorders can talk to others who have learned successful strategies for coping with the illness. Some of the main support groups include:

- **National Depressive and Manic-Depressive Association (National DMDA)** - the largest illness-specific, patient-run organization in the country.

- **National Alliance for the Mentally Ill (NAMI)** - a nonprofit, grassroots, self-help, support and advocacy organization of consumers, families, and friends of people with severe mental illnesses, such as schizophrenia, major depression, bipolar disorder, obsessive-compulsive disorder, and anxiety disorders.

Question 11: ***How do you think having a close friend or family member with bipolar disorder would affect you?***

Summary

- Everyone has ups and downs in mood. Happiness, sadness, and anger are normal emotions and are a normal part of everyday life.

- In contrast, bipolar disorder is a medical condition in which people have mood swings out of proportion to things going on in their lives. These mood swings affect thoughts, feelings, physical health, behavior, and functioning.

- With this disorder a person sometimes has an extremely elevated mood (mania) and sometimes has an extremely low mood (depression).

- In the U.S. more than 2.2 million people have bipolar disorder. Bipolar disorder usually develops between the ages of 16 and 35 but may develop in a person's forties or even fifties. It is a lifelong disorder, but in between mood episodes, many people can function normally.

- Alcohol and other drug abuse are not only common among bipolar patients but also may contribute significantly to treatment resistance and poor treatment outcome.

- Some drugs including marijuana, downers, alcohol, and opiates seem to dull the effects of mood swings temporarily, only to cause other symptoms later. Other drugs such as speed and cocaine can enhance manic depression and send people into manic states, often followed by deep depression and psychotic symptoms.

- The use of drugs by people with bipolar disorder possibly stems from their discovery of short-term release from the symptoms of mania or depression. Unfortunately, the relief of symptoms by using drugs or alcohol is short-lived and often begins a cycle of substance abuse.

- There is no cure for bipolar disorder, but effective treatments are available to stabilize moods and help clients regain and maintain a satisfying and productive life. Some of the most common treatments for bipolar include medication, psychotherapy, and support groups.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Exercises

1. Think about some of the symptoms we have talked about with bipolar disorder. Write down similar symptoms, if any, you have experienced and why you may have used substances to fight off these symptoms.

2. How would a manic episode differ from simply feeling good about oneself?

3. People with bipolar disorder tend to cycle back and forth between mania and depression over time. How do you think taking stimulants while someone is in the depressed phase would affect their cycling process? What about taking depressants while in a manic phase?

Assessment of Manic Episode

(adapted from the DSM-IV, 1994)

Directions: This exercise may be completed for the case story character or for yourself. Read each statement in categories I, II, and III. For each statement, put the appropriate number from the "category options" in the "category scores" section. Sum all the numbers for each category to come up with a category total. Compare the category totals with the chart at the bottom of the page to determine whether a manic episode may have occurred.

Symptoms of Manic Episode		
Category I	***Category I options***	***Category I scores***
Abnormally elevated or expansive mood lasting 1 week or more?	**No=0, Yes=2**	
Abnormally irritable mood lasting 1 week or more?	**No=0, Yes=1**	
		Category I TOTAL
Category II	***Category II options***	***Category II scores***
Inflated self-esteem or grandiosity	**No=0, Yes=1**	
Decreased need for sleep (e.g., feel rested after only 3 hours of sleep)	**No=0, Yes=1**	
More talkative than usual or pressure to keep talking	**No=0, Yes=1**	
Flight of ideas or racing thought	**No=0, Yes=1**	
Distractibility	**No=0, Yes=1**	
Increase in goal-directed activity without direct ways to achieve goals	**No=0, Yes=1**	
Excessive involvement in pleasurable activities that likely have negative consequences (e.g., buying sprees, sexual indiscretions)	**No=0, Yes=1**	
		Category II TOTAL
Category III	**Category III options**	***Category III score***
Mood disturbance causes marked impairment in occupational functioning or in usual social activities or relationships with others	**No=0, Yes=1**	
		Category III TOTAL

SCORING:
1. If **category I** total = 1 AND **category II** total is 4 or more AND **category III** total is 1, there may have been a manic episode.
2. If **category I** total = 2 or more AND **category II** total is 3 or more AND **category III** total is 1, there may have been a manic episode.

If the individual being assessed is a client (as opposed to the case story character), he or she should tell a counselor or doctor right away if there is evidence for a manic episode.

Module 4:

Anxiety Disorder and Substance Abuse

MODULE 4: ANXIETY DISORDER AND SUBSTANCE ABUSE

DIRECTIONS: Remember to make this group interesting to the group members by welcoming their input and discussion and using the exercises and discussion questions. Present the material in an interactive format. Don't just read the material but say it in your own words in a way that you know the participants will understand. It will be helpful to review the material prior to presenting it. At that time you can underline key points and make notes in the text that you want to emphasize to your particular group. In this way, when presenting the material to the group, you can reference your notations and focus on making the group session more interactive.

One of the main goals of this module is to de-stigmatize mental health issues and to normalize them by making it clear that most people experience mental health symptoms to various degrees throughout their lives without ever "having a disorder". Another main goal is to emphasize the connection between substance use and mental health issues.

You can break this module up into more than one group or skip some exercises if you cannot fit it all into one group. Another idea would be to have participants complete some of the exercises as homework or with their counselors. You can also skip or modify exercises if they are not appropriate for your program or treatment population. Feel free to modify the way you use this material to meet the needs of your program and group participants.

Overview

Everyone experiences feelings of anxiety or stress and worry from time to time. Anxiety is a normal part of life and only becomes a problem when it reaches levels that interfere with people's daily lives. Chronic anxiety can have harmful effects on the body, on emotional health, and on the ability to think clearly. In essence, it is maladaptive and should be treated. According to prominent authorities in the field (Zinbarg, Craske, & Barlow, 1993),

Anxiety can be HELPFUL when it:

- Helps motivate people to prepare for important events (e.g., studying for tests or planning ahead for a big event) or to deal with their problems
- Helps prepare the body to deal with difficult or dangerous situations by increasing heart rate and breathing and gearing up for what is known as the "fight or flight response"

Anxiety can be HARMFUL when it:

- Occurs over long periods of time

- Occurs in situations where a person doesn't have control over the stressful situation and worrying about it only puts unnecessary strain on the body

Anxiety problems generally are caused by a combination of biological and environmental risk factors. Some people, as a result of their personality traits, may be more prone to worry or be fearful in situations where other people would not. They may also inherit from their parents a biological vulnerability to the effects of worry on their bodies. Combined with a stressful lifestyle or anxiety-provoking events that happen to occur to them over the course of their lives, these biological vulnerabilities may increase the likelihood that a particular person will experience anxiety-related problems.

Substance use can also be a risk factor affecting the level of anxiety people experience. Some drugs such as cocaine might serve to worsen anxiety, causing it to reach harmful levels. Other drugs such as marijuana might reduce anxiety to the point where it is no longer a positive motivating factor in someone's life (e.g., a marijuana user may lose the motivation to look for a job that worrying about being unemployed might provide).

On the other hand, someone might turn to drugs (e.g., alcohol) to reduce harmful levels of anxiety instead of seeking professional help. Before long the person may develop an addiction to the drug and still experience problems with anxiety. In this case, anxiety would be a risk factor for developing an addiction to drugs or alcohol.

There are a number of very effective treatments for anxiety disorders ranging from medications to psychotherapy. There are also a number of different anxiety-related disorders people may have. Some of them include ***social anxiety disorder (social phobia)***, ***panic disorder***, and ***posttraumatic stress disorder***. In the following three sections, these disorders will be described as they are defined in the American Psychiatric Association's Diagnostic and statistical manual of mental disorders, fourth edition (1994). Afterward, their connection with substance use will be discussed.

Social Anxiety Disorder

Social Anxiety Disorder, also known as social phobia, is a condition in which people experience ***excessive or unreasonable*** amounts of fear in social or performance situations in which

embarrassment may occur. While being in these types of situations is anxiety-provoking for most people, it is so much more anxiety-provoking for people with the disorder that they may avoid such situations, even when doing so interferes with their normal lives.

People with social phobia may even become anxious at just the thought of being in a potentially embarrassing social situation. Some examples of situations where people with social anxiety disorder may become overly anxious can include public speaking, eating in front of others, using a public restroom, attending parties, and speaking to authority figures. Examples of situations that would ***not*** be considered social phobia are ones where the amount of anxiety is ***appropriate*** for the situation and does not interfere with one's daily life (e.g., worrying about your safety in a dangerous neighborhood). A good rule of thumb is to consider whether most other people would be similarly anxious in the same situation.

It has been estimated that social phobia will occur over the course of a person's lifetime in 3% to 13% of the population, with women being slightly more at risk of experiencing it than men. Social phobia tends to run in families (biological risk factor) and typically begins in the mid-teens. It can, however, start in early childhood. Onset may abruptly follow a stressful or humiliating situation (environmental risk factor) or just seem to happen over time for no apparent reason. Duration is frequently continuous over the lifespan.

People may sometimes use drugs or alcohol in order to help "take the edge off" of the anxiety-provoking situations. For example, someone might have a few drinks before trying to meet new people or smoke marijuana before talking to the boss. Alternatively someone could engage in an embarrassing behavior while under the influence of drugs or alcohol and develop a fear of similar future embarrassment.

Question 1: ***Give an example of a social situation in which most people would experience anxiety. Give an example of a social situation where most people would not experience anxiety and where it might be considered excessive if someone did experience it.***

Question 2: ***How do you think substance abuse would affect this disorder? What would be a more effective way of dealing with such anxiety?***

Question 3: ***Discuss some of the biological and environmental risk factors potentially leading to and being caused by social anxiety disorder.***

Panic Attacks

Panic attacks are periods of intense fear or discomfort that occur in the absence of real danger. They are accompanied by a number of the following physical symptoms and thoughts:

- Palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- A feeling of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, lightheaded, or faint
- Feelings of unreality or being detached from oneself
- Fear of losing control or going crazy
- Fear of dying
- Numbing or tingling sensations
- Chills or hot flushes

A panic attack is most often provoked by a situation the individual finds distressing (environmental risk factor). It has a sudden onset and builds to a peak rapidly, usually in 10 minutes or less. It often is accompanied by a sense of looming danger or doom and an urge to escape. People having one of these attacks will describe the fear as intense and will report thinking they were about to die, lose control, have a heart attack or stroke, or "go crazy". They also usually report having had an urgent desire to flee the location where the attack was occurring.

Panic attacks can:

- Be unexpected (i.e., the attack seems to occur spontaneously without any triggering event or thought)

- Always occur in a particular situation (e.g., every time one sees a snake)

- Sometimes occur in a particular situation (e.g., be more likely to occur while driving but not occur every time one drives and sometimes occurring when not driving)

Certain drugs can help cause a panic attack. One common example is when people unintentionally eat or drink too much caffeine. The caffeine makes their hearts race and their bodies tremble. Experiencing these symptoms without realizing what is causing them can be very scary and create a building cycle of anxiety that leads to a full-blown panic attack. People might also mistakenly cause a similar situation to happen by mixing different drugs or combining drugs with medications without knowing how these drugs or medications will

interact. For this reason, when people are speaking to a doctor about taking medication, it is very important to be honest about any other drugs or medications they are using or plan to use while on the new medication.

Sometimes people who have had a panic attack begin to worry about the possibility of having a future panic attack and might use drugs or alcohol in an attempt to prevent the attacks. Again, the most obvious example would be drugs that relax people or "mellow them out" such as marijuana. However, people could also choose to "drown their worries" with alcohol or escape from reality with LSD or heroin.

Question 4: ***What are some biological and environmental risk factors causing or caused by panic attacks?***

Question 5: ***If you ever experience a panic attack, what would be a good way to handle the situation?***

*A: Take deep, slow breaths and calm yourself down. Tell yourself that there is no real danger and that you are safe. Afterward, try to identify any situations or thoughts that may have caused the attack. ***Note: If you have any doubt that you may be having a heart attack or stroke, it is important that you get to a hospital as soon as possible. If it turns out that you were experiencing a panic attack after all, you might still benefit from trying to identify causal situations or thoughts. Once identified, you can look for them if you ever experience these symptoms again.)*

Posttraumatic Stress Disorder (PTSD)

Posttraumatic Stress Disorder (PTSD) may occur when a person has been exposed to a traumatic event such as a physical assault, rape, or witnessing a robbery (environmental risk factor). This event can involve actual or threatened death or serious injury, or it can take the form of a threat to the physical well being of oneself or others. People with PTSD often repeatedly re-experience the trauma by remembering the event, having dreams about it, acting or feeling as if the trauma were reoccurring, or by experiencing intense psychological or physical distress at exposure to reminders of it. While it is common for people to remember a past trauma, people with PTSD often become *very distressed* when they do.

People with PTSD often try to avoid reminders of the trauma or situations associated with the trauma such as doing things to avoid thinking about it or avoiding places that remind them of it. They may also experience feelings of detachment from others, an inability to recall the event, or have a sense of doom about the future. Other symptoms include the following:

- Difficulty falling asleep or staying asleep
- Difficulty concentrating
- Irritability or outbursts of anger
- Always feeling on alert
- An exaggerated startle response

PTSD can occur at any age and to anyone who experiences a severe trauma. Severity and duration of the trauma are the most important factors affecting the development of the disorder.

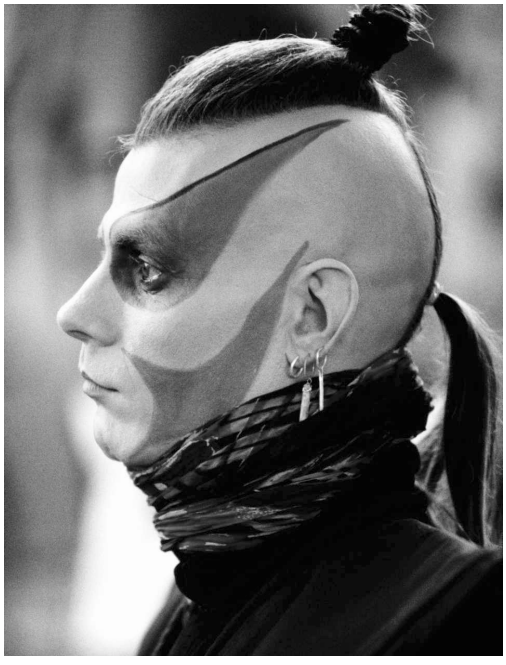
People who experience such traumatic events sometimes turn to drugs or alcohol to help them cope. They may take drugs that relax them such as sedatives or alcohol, or they make take other drugs with the intention of escaping from reality and their fears for a while.

Drugs and alcohol can also put someone at risk for being involved in traumatic experiences. For example, someone could get raped while drunk or under the influence of drugs or could be involved in a driving accident while under the influence.

Question 6: ***How might substance use enhance or make some of these symptoms worse? How else could you deal with these symptoms?***

Question 7: ***What are the biological and environmental risk factors causing or caused by PTSD?***

Case Story 1



James came from a lower middle class family, the younger of two children. From his childhood his chief memories were of his mother and father getting into violent fights, cursing at each other and breaking things, and of his father coming home high on drugs and getting arrested and sent to prison for drug-related and assault charges.

After his father went to prison, James's family could not support themselves and life got even harder to bear. James was very embarrassed about his father but also angry with him for letting down the family. At school, he had a hard time sitting still during class. He found it difficult to concentrate on the work and pay attention. All he wanted to do was talk to girls, crack jokes, or draw – anything but

study and learn. He sought everyone's approval by trying to be the funniest, loudest, craziest person wherever he was. He even tried to be the one to drink the most, use the most drugs, steal the most, and fight the most.

James became obsessed with obtaining the approval of his peers – to the point where he would lie awake at night worrying about fitting in with the crowd and trying to think of new ways to impress people. Dealing seemed to be the best way to fit in.

James started trying to work his way in with the dealers. They had the most money, they got all the pretty women, and they seemed to be the most respected and feared. He had to start at the bottom of the ladder, but James soon began to climb his way to the top. He also found himself constantly on edge, worrying about getting caught and sent to prison, and becoming a failure and embarrassment like his father. One night James woke up in the middle of the night shaking and sweating. His heart was racing, and he couldn't catch his breath. His chest hurt too. He was afraid that he was having a heart attack.

Question 8: ***What symptoms of anxiety is James experiencing?***

Question 9: ***How did his life as a drug user and dealer affect his mental health?***

Question 10: ***What decisions lie ahead for James?***

Case Story 2

Maria grew up in a run down, low rent apartment with her mother and three younger siblings. At the age of fourteen Maria's dad skipped out on them to be with her mother's sister. He never provided much in terms of support anyway, but Maria's mother became depressed. She started sleeping most of the day and spending their welfare money on drugs. It wasn't long before the situation became desperate.

Maria didn't know what to do. She just wanted to get out of the whole situation and forget about it. She wondered if her boyfriend, a boy in a local gang, would be willing to help her get out. He'd said he loved her.

He was reluctant when she first asked him, but he eventually gave in. It would mean her becoming part of his gang, though. Things were fine at first. Maria had a place where she finally fit in.

Most of the gang members used and sold drugs, so it wasn't long before Maria became a pretty heavy user too. Sometimes she would blackout and lose 2 or 3 days of her life at a

time. At other times, she would come to only to find herself in dangerous situations. One night she came to and found that several of the gang members were taking turns having sex with her. She panicked and tried to get away from them, but they held her down and forced her.

Question 11: ***What previously discussed anxiety disorder is Maria at risk of developing?***

Answer: Posttraumatic Stress Disorder

Question 12: ***How did drug use play a role in getting Maria to this point in her life?***

Connection Between Anxiety Disorder and Substance Abuse

Substance abuse occurs in many patients with anxiety disorders. They begin taking the drugs or alcohol to lessen the symptoms they are having and to help them "cope" with their problems. Some of these substances can actually lessen the symptoms of anxiety, but they can also carry negative consequences as well. Many impair judgment or coordination, run the risk of addiction, and may lead to legal consequences. Drugs and alcohol do not treat the anxiety problems directly, but instead they cover up the symptoms so the user doesn't always notice they are there. Taking them is like trying to put out a match with a fire hose. You might hit the match, but you hit a lot of other unintended things as well–possibly with negative consequences.

Anti-anxiety medications are specially intended for reducing the specific symptoms of anxiety disorders and have fewer potentially negative effects on the body than drugs and alcohol. In addition, a number of types of psychotherapy have been shown to be quite effective in treating anxiety disorders.

Question 13: ***What are some specific negative effects that drugs or alcohol could have on someone who was trying to use them to combat an anxiety disorder?***

Question 14: ***Have you or someone you know tried to use substances to treat anxiety? What happened?***

Treatment

Everyone experiences anxiety. Having some anxiety is a good thing. It motivates people to prepare for upcoming events, and it helps them deal with crises when they occur. Anxiety becomes a bad thing when it is so strong or happens so often that it interferes with people's daily lives. When this happens, the anxiety takes its toll on physical, emotional, and mental health. It becomes a disorder at this point.

Many people have anxiety disorders. However, there are very good treatments for anxiety problems. The first step is to speak with a doctor or with a mental health professional. Receiving help in the form of physician-prescribed medications or psychotherapy would be ways to increase one's protective factors for anxiety-related problems.

Psychotherapy

Psychotherapy has also been shown to be quite effective in treating anxiety disorders. People often obtain treatment for these disorders in individual or group therapy. Therapy takes time (often several months) and hard work on the part of the client, but, unlike medications that only work while people are taking them, the gains from therapy are often long term, lasting well after therapy is complete. Sometimes, people will treat anxiety disorders by taking anti-anxiety medications while in psychotherapy.

Medication

Anti-anxiety medications are quite effective in reducing the symptoms of anxiety and often have minimal side effects. These medications can be obtained by prescription from a doctor who should monitors the patient's care while they are in use. Sometimes people with anxiety problems will take anti-anxiety medication once in a while to help them get past periods of intense stress in their lives. Sometimes they will take them for longer periods of time.

One common category of anti-anxiety medication is the benzodiazepines. Due to side effects of using them, it can be dangerous for people taking benzodiazepines to drive or operate some machinery, especially when first beginning the medication. When combined with other medications or drugs, benzodiazepines can present a problem by interacting with them to create undesired and dangerous effects. This interactive effect is most notable when benzodiazepines are taken together with commonly used substances such as alcohol. The interaction of benzodiazepines with alcohol can lead to serious and possibly life-threatening complications. Following a physician's instructions is important, as is being honest about any other drugs or medications (even over-the-counter ones) one is taking or plans to be taking. When combined with alcohol, anesthetics, antihistamines, sedatives, muscle relaxants, and some prescription pain medications, Benzodiazepines depress the central nervous system even more than they do alone. Particular benzodiazepines may influence the action of some anticonvulsant and cardiac medications as well. They have also been associated with abnormalities in babies born to mothers who were taking these medications during pregnancy.

In addition to their interactive properties with other drugs and alcohol, there is the potential for people using benzodiazepines to become addicted to them. Because of this potential for addiction to them, it is very unusual for addicts to be prescribed benzodiazepines. With benzodiazepines there is a potential for development of tolerance and dependence in addition to the possibility of abuse and withdrawal reactions. As such, the medications are generally prescribed for brief periods of time–days or weeks and sometimes

intermittently, for stressful situations or anxiety attacks. It is important to consult with a physician before discontinuing a benzodiazepine because a withdrawal reaction can occur if the treatment is abruptly stopped. Withdrawal symptoms can include anxiety, shakiness, headache, dizziness, sleeplessness, loss of appetite, and, in more severe cases, fever, seizures, and psychosis. In fact, a withdrawal reaction may be mistaken for a return of the anxiety because many of the symptoms are similar. Thus, after benzodiazepines are taken for an extended period, the dosage is gradually tapered off before being completely stopped. The following table lists some common anti-anxiety medications, their average dosage ranges, and their possible side effects.

Antianxiety Medications

Type of Drug	Brand Name	Generic Name	Average Dosage Range (mg/day)	Possible Side Effects
Benzodiazepines	Ativan	Lorazepam	2-10	Drowsiness, loss of coordination, fatigue, mental slowing, and confusion **All benzodiazepines have the potential for addiction**
	Compazine	Prochlorperazine	15-150	
	Klonopin	Clonazepam	0.5-16	
	Librium	Chlordiazepoxide	5-100	
	Valium	Diazepam	2-40	
	Xanax	Alprazolam	0.75-4	
Non Benzodiazepine	Buspar	Buspirone	15-60	Dizziness, nausea, headache, fatigue, nervousness, light-headedness, and excitement
	*Atarax (Vistaril)	Hydroxyzine hydrochloride	200-400	Sleepiness, dizziness, and dry mouth

*Primarily a sleep aid

Alternative Treatments

Exercise, both aerobic and strength training, has been scientifically shown to help reduce the symptoms of anxiety disorders. Yoga, meditation, and participating in relaxing hobbies may also be helpful for some people.

Summary

- It is normal for everyone to experience anxiety and worry.
- In moderate amounts anxiety can be helpful. It is only maladaptive and harmful when it occurs over long periods of time and in situations where there is no benefit to worrying (i.e., when one has no control over a situation).

- People can have biological risk factors for anxiety such as personality traits that cause them to worry easily about things and biological vulnerability to the physical effects of that worry.

- Environmental risk factors for anxiety would include a stressful lifestyle and unexpected events that occur for some people over the course of their lives (e.g., being the victim of a violent crime).

- Anxiety problems can also be caused or worsened by substance use. In this case substance use would be a risk factor for anxiety problems.

- Sometimes people deal with anxiety problems by self-medicating with drugs or alcohol. In this case anxiety problems would be a risk factor leading to substance use.

- More effective ways of dealing with anxiety problems (protective factors) include medications prescribed and monitored by physicians and individual or group psychotherapy.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Zinbarg, R.E., Craske, M. G., & Barlow, D. H. (1993). *Mastery of your anxiety and worry (MAW) program*. Albany, New York: Graywind Publications, Inc.

Exercises

1. Pick three things that cause you anxiety. On a scale from 1 (lowest) to 10 (highest), rate how likely it is that each situation will occur. Also rate how bad things would be if it did occur (exercise adapted from Zinbarg, Craske, & Barlow, 1993).

2. Go back over the three anxiety-provoking things and decide how useful it is to worry about them. (Hint: Lower ratings should elicit less worry.)

3. How useful is it to worry about something over which you have no control?

4. The next time you start feeling anxious, try deep breathing to relax yourself. Deep breathing is breathing from the diaphragm (your stomach should move in and out instead of your chest). Inhale, hold the breath for a few seconds, and then release the breath slowly. Rate your anxiety on a scale of 1 to 10 before and after the deep breathing.

5. If you have panic attacks, list three physical signs that let you know one is about to occur. The next time these symptoms occur, try your deep breathing exercise before the attack begins. Repeat exercises 1 and 2 from above for the worry/fear that is causing the panic attack.

Assessment of Posttraumatic Stress Disorder

(adapted from DSM-IV)

Directions: This exercise may be completed for the case story character or for yourself. Read each statement in categories I through VI. For each statement, put the appropriate number from the "category options" in the "category scores" section. Sum all the numbers for each category to come up with a category total. Compare the category totals with the chart at the bottom of the page to determine whether the individual may have posttraumatic stress disorder.

Symptoms of Posttraumatic Stress		
Category I	***Category I options***	***Category I scores***
Experienced an event involving actual or threatened death or serious injury or threat to the physical safety/health of self or others	**No=0, Yes=1**	
Response to the event involved intense fear, helplessness, or horror	**No=0, Yes=1**	
		Category I TOTAL
Category II	***Category II options***	***Category II scores***
Experienced recurrent and intrusive distressing recollections of the event including images, thoughts, or perceptions	**No=0, Yes=1**	
Experienced recurrent distressing dreams of the event	**No=0, Yes=1**	
Acted or felt as if the event were recurring (including a sense of reliving the experience, hallucinations, and dissociative flashback episodes)	**No=0, Yes=1**	
Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event	**No=0, Yes=1**	
Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event	**No=0, Yes=1**	
		Category II TOTAL
Category III	***Category III options***	***Category III scores***
Efforts to avoid thoughts, feelings, or conversations associated with the trauma	**No=0, Yes=1**	
Efforts to avoid activities, places, or people that arouse recollections of the trauma	**No=0, Yes=1**	
Inability to recall an important aspect of the trauma	**No=0, Yes=1**	
Markedly diminished interest or participation in significant activities	**No=0, Yes=1**	
Feeling of detachment or estrangement from others	**No=0, Yes=1**	
Restricted range of feelings (e.g., unable to have loving feelings)	**No=0, Yes=1**	
Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)	**No=0, Yes=1**	
		Category III TOTAL

Category IV	***Category IV options***	***Category IV scores***
Difficulty falling or staying asleep	**No=0, Yes=1**	
Irritability or outbursts of anger	**No=0, Yes=1**	
Difficulty concentrating	**No=0, Yes=1**	
Hypervigilance	**No=0, Yes=1**	
Exaggerated startle response	**No=0, Yes=1**	
		Category IV TOTAL
Category V	***Category V options***	***Category V scores***
Duration of the disturbance (categories II-IV) is more than 1 month	**No=0, Yes=1**	
		Category V TOTAL
Category VI	***Category VI options***	***Category VI scores***
The disturbance causes significant distress or impairment in social, occupational, or other important areas of functioning	**No=0, Yes=1**	
		Category VI TOTAL

SCORING:
If **category I** total = 2 AND **category II** total is 1 or more AND **category III** total is 3 or more AND **category IV** total is 2 or more AND **category V** total is 1 AND **category VI** total is 1, the individual may have posttraumatic stress disorder.

If the individual being assessed is a client (as opposed to the case story character), he or she should tell a counselor or doctor right away if there is evidence for posttraumatic stress disorder.

Module 5:

Schizophrenia and Schizoaffective Disorder and Substance Abuse

MODULE 5: SCHIZOPHRENIA AND SCHIZOAFFECTIVE DISORDER AND SUBSTANCE ABUSE

DIRECTIONS: Remember to make this group interesting to the group members by welcoming their input and discussion and using the exercises and discussion questions. Present the material in an interactive format. Don't just read the material but say it in your own words in a way that you know the participants will understand. It will be helpful to review the material prior to presenting it. At that time you can underline key points and make notes in the text that you want to emphasize to your particular group. In this way, when presenting the material to the group, you can reference your notations and focus on making the group session more interactive.

One of the main goals of this module is to describe two of the more prevalent psychotic disorders that people may experience and to emphasize the benefits of treatment with prescription medication instead of substances of abuse.

You can break this module up into more than one group or skip some exercises if you cannot fit it all into one group. Another idea would be to have participants complete some of the exercises as homework or with their counselors. You can also skip or modify exercises if they are not appropriate for your program or treatment population. Feel free to modify the way you use this material to meet the needs of your program and group participants.

Overview

This module is intended to provide clients with an overview of ***schizophrenia*** and ***schizoaffective*** disorder, their treatments, and their connection with substance abuse. Basic facts about the disorders from the American Psychiatric Association's Diagnostic and statistical manual of mental disorders, fourth edition (1994) are reviewed, covering prevalence, diagnosis, and symptoms. Antipsychotic medications are also described.

Schizophrenia

Schizophrenia is a major psychiatric disorder that occurs in about 1% of the population. It typically becomes full blown in the late teens or early 20's, often after the individual experiences a period of high stress. The cause is unknown but may be related to changes in the amounts of brain chemicals due to heredity (genetic factors), early effects of the environment on the developing brain (during pregnancy or during birth), or both. Thus, it seems to occur as a result of biological and environmental risk factors.

People who have schizophrenia may experience periods of time where they lose contact with reality in the form of hallucinations (seeing, hearing, or smelling things that do not exist) and/or delusions (erroneous beliefs that are strongly held in spite of contradictory evidence). They may also experience low motivation, poor attention, and inability to experience pleasure. At times, it may be hard for people with schizophrenia to tell the difference between fantasy and reality, and their symptoms may become so severe that they need to be hospitalized. Because there is currently no medical test for schizophrenia, people are diagnosed with the disorder through a clinical interview with a trained mental health professional.

Question 1: ***What are the signs and symptoms of schizophrenia? That is, how might a person with it think, feel, and act?***

Symptoms of Schizophrenia **(adapted from the DSM-IV, 1994)**

A person must experience some decrease in social or occupational functioning for at least a six-month period to be given a diagnosis of schizophrenia. Problems can be experienced in school or work, social relationships, or self-care. The symptoms of schizophrenia can be divided into three broad groups: symptoms ***present*** in people with schizophrenia but ordinarily absent in other people (1-4 below), symptoms displaying an ***absence*** of thoughts, perceptions, or behaviors normally present in other people (5-9 below), and ***other*** symptoms. A person with schizophrenia has some (but not all) of the following:

- ***"Present Symptoms"*** - refer to things that are present in people with schizophrenia but ordinarily absent in other people. The presence of these symptoms varies over time and include:

    1. ***Hallucinations*** -- seeing, hearing, feeling, or smelling things that are not actually there

    2. ***Delusions*** – false beliefs that others clearly realize are not true (e.g., believing the television is talking specifically to them or that the government is after them)

    3. ***Thinking Problems*** – talking in a manner that is hard to follow, making up words, or jumping from one topic to the next

    4. ***Odd Behavior*** – very disorganized or inappropriate behavior (e.g., untriggered agitation, very disheveled appearance, or inappropriate sexual behavior) or very much decreased reactivity to the environment (e.g., maintaining a rigid or bizarre body posture like a mannequin or excessive motor activity without observable cause)

- ***"Absent Symptoms"*** – absence of thoughts, perceptions, or behaviors that are present in other people. These symptoms are often stable over time and include:

    5. ***Blunted Affect*** – reduced expressiveness of the face, tone of voice, and gestures; the person may appear not to be experiencing any emotions

    6. ***Apathy and Low Motivation*** – feeling unmotivated to pursue goals or activities, feeling lethargic or sleepy, and having trouble following through on even simple plans

    7. ***Loss of Pleasure*** – feeling little or no pleasure from activities that used to be enjoyable

    8. ***Poverty of Speech or Content of Speech*** – talking a lot but not conveying much information

    9. ***Problems with Attention*** – being easily distracted

- ***"Other Symptoms"*** can include depression and suicidal thoughts, anger and hostility, and rapidly changing mood.

Schizoaffective Disorder

Schizoaffective disorder is similar to schizophrenia but involves an additional mood component. The symptoms of schizoaffective disorder can be divided into four broad categories: "***present symptoms"*** (see 1-4 from the schizophrenia section above), "***absent symptoms"*** (see 5-9 from the schizophrenia section above), ***depression***, and ***mania***.

Depression is primarily characterized by a period of depressed mood or the loss of interest or pleasure in nearly all activities (see module 2 for a more in depth discussion). Mania (described more fully in module 3) can be described as a period of abnormally and constantly elevated, expansive, or irritable mood. It is important to note that while everyone feels depressed or irritable or "pumped up" from time to time, in both depression and mania, these symptoms are more extreme and last for longer periods of time than is typical for most people.

Question 2: ***What is the difference between schizophrenia and schizoaffective disorder?***

Question 3: ***How do you think substance use might affect the symptoms of someone with these disorders?***

Case Story 1

Barbara had always seemed a bit "odd in her thinking" to many of her friends and family. Her mother had once commented that Barbara reminded her of Barbara's father in that respect. He had been diagnosed with schizophrenia shortly after Barbara was born. Barbara liked being different, though, so she didn't mind being thought of as "out there".

Barbara's mother died of a drug overdose when Barbara was 17, leaving her alone. It was hard trying to support herself because Barbara had trouble keeping a steady job. After a while the bills started to pile up. The stress was too much for her.

Barbara started hearing voices telling her that things were hopeless and that she was a bad person. She was also beginning to suspect that she was under surveillance by the FBI because they had gotten a tip that she was keeping a cat in her apartment without telling her landlord. At any rate, she was certain they were behind her getting fired from her last two jobs.

She was chronically on edge and felt wired all the time. The voices in her head were telling Barbara that she should do awful things to her former boss and then kill herself. She knew she didn't want to do that, but the voices were so loud and constantly there. It was impossible to ignore them. Barbara started taking barbiturates to soothe herself. At least when she slept she couldn't hear the voices.

Question 4: ***What symptoms of schizophrenia can you identify from the story?***

Answer: Auditory hallucinations, bizarre beliefs, and paranoia. Being wired all the time could be a symptom of schizoaffective disorder with a manic component.

Question 5: ***Can you identify any risk factors for schizophrenia from the story?***

Answer: Family history, high stress period, history of low level symptoms all her life – i.e., always having been "odd"

Question 6: ***Complete Barbara's story assuming that she continues to use barbiturates. What alternative paths might Barbara's story take (e.g., if she decides to give up the barbiturates and cope some other way)?***

Case Story 2

Marcus had a miserable life. His father was killed several years ago in a drive-by shooting when Marcus was fifteen. Since then, his mother had brought a string of boyfriends home over the years, insisting that he call them "Dad". The latest one had been a real "piece of work". He would come home drunk and beat Marcus' mother. If he finished with her before passing out, he'd start on Marcus next. A year ago, he'd broken Marcus' jaw with a baseball bat and put Marcus' mother in the hospital.

Not surprisingly Marcus looked for any way to escape that he could. Some kids in the neighborhood had introduced him to a number of different drugs, and he tried them all. His favorite was LSD. He liked watching weird things happen right before his eyes and often thought that he had the power to control what hallucinations he saw. He knew that if he concentrated hard enough he could make them actually happen to his "dad".

During a particularly rough period at home, Marcus stayed on LSD pretty much all day, every day. He started mixing the LSD with other drugs too. One night his "dad" caught Marcus stealing money out of his wallet and threw him down the stairs headfirst. When Marcus woke up he was in a hospital under restraint. The nurse told him that he'd been babbling for several days about melting walls and scooping out his "dad's" brains and feeding them to a dog.

Question 7: ***What symptoms of schizophrenia can you identify from the story?***

Answer: It's unclear whether the hallucinations and his belief about his ability to control them are the result of the drugs, a mental disorder, a head injury, or a combination.

Question 8: ***Can you identify any risk factors for schizophrenia from the story?***

Answer: His age, experiencing high stress, and possibly drug use.

Question 9: ***Why is it hard to determine exactly what is going on in Marcus' case?***

Answer: He started experiencing the symptoms of the mental illness while on drugs.

Question 10: ***How might someone go about figuring out what is going on with Marcus?***

Answer: Get him off the drugs and see if his condition changes.

Connection Between Schizophrenia and Substance Abuse and Schizoaffective Disorder and Substance Abuse

Sometimes people with these disorders start taking street drugs in order to reduce their symptoms. This practice, commonly known as self-medicating, can work in the short-term; however, it may serve to increase or worsen symptoms later on. Additionally, individuals who self-medicate run the risk of becoming addicted to the drugs. In this case, having schizophrenia or schizoaffective disorder can be a risk factor for substance use problems.

Unlike street drugs, the common medications used to treat schizophrenia and schizoaffective disorder are not addictive. Additionally, use of illegal substances can lead to a variety of life problems (e.g., legal problems), which can cause stress for the individual and family and diminish effective coping with the mental health issue. As such, substance use can be a risk factor for the onset or worsening of schizophrenia or schizoaffective disorder in people already at risk for developing the disorders.

Antipsychotic medications are specifically intended to treat schizophrenia and schizoaffective disorder. These medications are legal solutions to the mental health diagnosis that won't set the individual up for a number of other potential problems (e.g., legal problems, risking making symptoms worse in the long term). Although they are better suited to treating schizophrenia and schizoaffective disorder, antipsychotic medications can cause a number of side effects. As such, anyone taking them should be working closely with a doctor who can help treat any side effects that might arise.

Question 11: ***What are the benefits and drawbacks of taking antipsychotic medications versus self-medicating with street drugs?***

Treatment

Psychotherapy & Other Treatments

Both disorders may be treated with a variety of psychotherapies such as social skills training or cognitive-behavioral therapy (described in more detail in module 1), but most likely these treatments would also be combined with medication. Supported employment and case management may also be beneficial. Because this illness affects not only the individual with the disorder but also the whole family, family therapy may help decrease stress and help family members cope as well.

Medication

Although the symptoms for both disorders tend to improve with age, schizophrenia and schizoaffective disorder are life long. As previously stated, they are often treated with medications called *antipsychotics*, which help reduce their symptoms. People with schizoaffective disorder may also receive medications that stabilize their mood fluctuations.

Antipsychotic medications are effective at reducing the "present symptoms" such as hallucinations, delusions, and bizarre behavior. Furthermore, these medications can sometimes reduce the "absent" symptoms such as social withdrawal and poor attention. In addition to lowering their severity, antipsychotics can help to prevent relapses of these symptoms.

Sometimes the effects of these medications are quite rapid, with an improvement in symptoms being noted in a few days; but they need to be taken for several weeks to reduce symptoms significantly. If a person experiences a relapse of symptoms, the dosage of antipsychotic medication may be temporarily increased. Antipsychotics are not addictive. People taking these medications do not develop tolerance, requiring higher doses over time. However, use of these medications should be monitored by a physician because there is the potential for overdose.

Antipsychotic medications, like drugs for treating other illnesses, can cause *undesired side effects*. Although other more serious side effects can occur, the most common side effects of traditional antipsychotics include

- Drowsiness
- Muscle stiffness
- Dizziness
- Dry mouth
- Mild tremors
- Restlessness
- Increased appetite
- Blurred vision
- Sexual difficulties

Not all people taking these medications experience side effects. In many cases the side effects are temporary, especially if they are treated with side effect medications. They also can be addressed by reducing the medication dosage or changing to a different type of antipsychotic.

Like the antipsychotic medications, though, side effect medications are potentially dangerous and should only be taken under the supervision of a physician (e.g., Benadryl, used to treat some side effects, can be addictive.). In any case, the best course of action is to consult with a physician when side effects occur. It is also important to be honest with the physician about any other medications or street drugs that a person is taking or plans to take while using these medications.

The following table lists common antipsychotic medications, their average dosage ranges, and their possible side effects. While these are common antipsychotic medications, they are not always prescribed only for thought disorders. These medications have a variety of other uses and may be prescribed for those purposes as well.

Traditional Antipsychotic Medications

Type of Drug	Brand Name	Chemical Name	Average Dosage Range (mg/day)*	Possible Side Effects
	Clozaril**	clozapine	200-900	Dry mouth, drowsiness, blurred vision, constipation, urinary retention, nose bleeds, dizziness
	Haldol***	haloperidol	1-40	
	Loxitane	loxapine	4-250	
	Mellaril	thioridazine	50-600	
	Moban	molindone	15-250	
	Navane	thiothixene	6-60	
	Prolixin***	fluphenazine	1-40	
	Risperdal**	risperidone	1-8	
	Serentil	mesoridazine	25-300	
	Seroquel	quetiapine	150-750	
	Stelazine	trifluoperazine	4-60	
	Thorazine	chlorpromazine	50-1250	
	Trilafon	perphenazine	8-64	
	Zyprexa	olanzapine	5-20	

* Estimated dosage ratio in relation to Thorazine

** Clozaril and Risperdal have different mechanisms of action than the other antipsychotic medications, and therefore their dosage range is not comparable.

*** Also available in long-acting injections

The table on the following page lists some of the medications used to treat the side effects caused by antipsychotic medications. Often, these side effects are referred to as "extrapyramidal" side effects because of the part of the brain that is affected.

Medications for Extrapyramidal Side Effects of Traditional Antipsychotics				
Type of Drug	**Brand Name**	**Chemical Name**	**Average Dosage Range (mg/day)**	**Possible Side Effects**
Anticholinergic	Artane Benadryl Cogentin Kemadrin	trihexyphenidyl diphenhydramin benztropine procyclidine	5-15 50-300 0.5-8 5-20	Dry mouth, constipation, blurry vision, drowsiness, urinary retention, memory loss
Dopamine agonist	Symmetrel	amatadine	100-400	Increase in "present" symptoms
Benzodiazepines	Ativan Compazine Klonopin Librium Valium Xanax	Lorazepam Prochlorperazine Clonazepam Chlordiazepoxide Diazepam Alprazolam	2-10 15-150 0.5-16 5-100 2-40 0.75-4	Drowsiness, psychomotor impairment, memory loss, **psychological and physiological dependence**,

Summary

- Schizophrenia and schizoaffective disorder are mental health issues that seem to occur as a result of biological and environmental risk factors.

- Both disorders can involve "present symptoms" (e.g., hallucinations and delusions) and "absent symptoms" (e.g., blunted affect and poverty of speech), but schizoaffective disorder has an added mood component (depression or mania).

- Use of street drugs can be a risk factor for developing or worsening schizophrenia and schizoaffective disorder by causing life problems that increase a person's stress level and decrease coping.

- Schizophrenia and schizoaffective disorder can be risk factors for substance use problems if people use street drugs to reduce their symptoms (known as self-medication).

- Medications called antipsychotics are typically prescribed by physicians to treat the symptoms of schizophrenia and schizoaffective disorder.

- Antipsychotic medications are not generally addictive and do not cause the user to develop tolerance to them. However, there is the potential for overdose.

- Antipsychotic medication may cause side effects that are treatable with other medications or by reducing dosage or changing medications.

- Like most medications, antipsychotic medications and side effect medications are still potentially dangerous. Thus, it is important to work with a physician when taking them and to be honest about other medications or street drugs that the patient may be using or plans to use while on these medications.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Exercises:

1. What kind of impact would someone with schizophrenia have on family and friends?

2. Pick a partner from the group. Discuss with your partner ways in which someone with schizophrenia could work together with family and friends to reduce the stress the disorder has on the lives of the family and friends.

3. For people who suffer from auditory hallucinations, sometimes it helps to read out loud to reduce their ability to hear the hallucinations. It sometimes also helps to focus on the characteristics of the voices and their content instead of the anxiety they may provoke in the person. (The voices cannot make the person do anything s/he does not want to do, and the person should not be concerned about any value judgments the voices make.) Imagine that you suffer from auditory hallucinations such as several voices keeping a running commentary while you are conversing with other real people. What might you do to minimize the disruption those voices may have on your socializing? (Hint: Should you include them in the conversation? What would be the pros and cons of telling your real conversation partner about the voices and what they're saying?)

4. Use a phonebook, the internet, or another source to locate some agencies or programs that might be helpful for someone with schizophrenia or schizoaffective disorder (e.g., caseworkers, self-help support groups, treatment centers, crisis centers, or crisis hotlines).

5. If you are working straight through this manual, you have completed over half of the material. Take a few minutes to evaluate your progress in this program. What gains or improvements have you made as a result of your participation in the program? What are your goals for future gains?

Assessment of Schizophrenia for People Recovering from Addictions

(adapted from DSM-IV)

Directions: This exercise may be completed for the case story character or for yourself. For each of the two time periods (during the time using drugs or alcohol, and during the last 6 months), put a check mark next to any symptoms if they existed during that time period.

Symptoms of Schizophrenia	***During the last 6 months***	***During the time actively using***
I) Category I Symptoms		
1) *Delusions* – false beliefs that others can clearly see are not true (e.g., believing the television is talking specifically to them or that the government is after them)		
2) *Hallucinations* – seeing, hearing, feeling, or smelling things that are not actually there		
3) *Thinking Problems* – talking in a manner that is hard to follow, making up words, or jumping from one topic to the next		
4) *Odd Behavior* - very disorganized or inappropriate behavior (e.g., untriggered agitation, very disheveled appearance, or inappropriate sexual behavior) or very much decreased reactivity to the environment (e.g., maintaining a rigid or bizarre body posture like a mannequin or excessive motor activity without observable cause)		
II) Category II Symptoms		
5) *Blunted Affect* – reduced expressiveness of the face, tone of voice, and gestures (e.g., the person may seem like s/he is not experiencing any emotions)		
6) *Apathy and Low Motivation* – feeling unmotivated to pursue goals or activities, feeling lethargic or sleepy, and having trouble following through on even simple plans		
7) *Loss of Pleasure* – feeling little or no pleasure from activities that used to be enjoyable		
8) *Poverty of Speech or Content of Speech* – talking a lot but not conveying much information		
9) *Problems with Attention* – being easily distractible		
III) Disturbance in Social/Occupational Functioning – work, school, interpersonal relations, or self-care are below the normal level for the individual		

How to Score Answers: Score each column separately. Give **one point for EACH symptom** checked in **Category I (maximum = 4 points)**. Give **one point if one or more symptoms** are checked in **Category II (maximum = 1 point).** Add up the points for **Category I** and **Category II**. If the total score is two or more and there is a check in category **III (Disturbance in social/occupational functioning)**, the individual may have schizophrenia. If the individual being assessed is a client (as opposed to the case story character), he or she should tell his or her counselor or doctor right away.

Homework Questions

1) Are there any patterns to when the symptoms occur?
2) Are the symptoms more likely to occur during a particular time period (e.g., before starting to use, during the time period that using occurred, or during the first month of abstinence when going through withdrawal)?
3) How has substance abuse interacted with any of the symptoms that may have existed?

Module 6:

Substance Use: Motives and Consequences

MODULE 6: SUBSTANCE USE: MOTIVES AND CONSEQUENCES

DIRECTIONS: Remember to make this group interesting to the group members by welcoming their input and discussion and using the exercises and discussion questions. Present the material in an interactive format. Don't just read the material but say it in your own words in a way that you know the participants will understand.

You can break this module up into more than one group or skip some exercises if you cannot fit it all into one group. Another idea would be to have participants complete some of the exercises as homework or with their counselors. You can also skip or modify exercises if they are not appropriate for your program or treatment population. Feel free to modify the way you use this material to meet the needs of your program and group participants.

Overview

Alcohol and drugs can have a variety of different effects on people. Individuals with a mental illness tend to be more sensitive to the effects of substances due to their biological vulnerability. This module will focus on understanding the reasons why people use different substances and review some of the consequences of substance use, including the interaction with mental illnesses. Although there may be short-term positive effects of using, the long-term effects are negative.

(Have clients look at "Pay-Off Matrix" in workbook)

Positive Consequences of Using Substances

Question 1: ***What are the positive consequences of using drugs or alcohol in your life? What did you like about getting high or drunk?***

(Write their answers on a board in a pay-off matrix if a board is available. You can fill in examples from below that they don't speak about. Afterward, have participants write their own positive consequences of using in their workbooks.)

Social Interaction - Individuals may feel that using drugs or alcohol helps their social interactions such that they report feeling less anxious around other people. Others use substances with their friends as a way of spending time together or because they feel pressure from their friends to use. Some people use substances to help them feel "normal" and "accepted" by others. Sometimes people feel like they don't have a mental illness or feel less different from others when they are using drugs or alcohol.

Self-Medication - Some people use substances in an attempt to "self-medicate" (reduce the effects of) unpleasant symptoms of mental illnesses. Using alcohol or drugs may provide temporary relief of symptoms, but efforts to self-medicate symptoms almost always make mental illness worse in the long run. Some of the most common symptoms that people report using substances to self-medicate include:

- depression
- medication side-effects
- anxiety/nervousness/tension
- hallucinations
- sleep problems

Pleasure Enhancement - Some individuals use substances because it is one of the few sources of pleasure they experience. Sometimes people use substances because they believe it enhances other enjoyable activities. Using alcohol or drugs for pleasure may be very tempting because it is so easy to get these substances and their effects are so rapid.

Habit – Often, people who have used drugs or alcohol for a long period of time continue to use simply because it has become part of their daily routine - a habit. For these people, substance use becomes second nature. They use substances automatically, without much thought, almost like brushing one's teeth or taking a shower.

Eliminating Cravings & Withdrawal Symptoms - Individuals who use larger quantities of substances may develop cravings for these substances or experience withdrawal symptoms if they stop using suddenly. Substance use for these individuals may be motivated by the desire to eliminate the cravings or withdrawal symptoms.

(Have participants list their own positive consequences of using substances in their workbooks.)

Negative Consequences of Using Substances

Question 2: ***What are the negative consequences of using drugs or alcohol in your life? What don't you like about using?***

(Write their answers on a board in a pay-off matrix if a board is available. You can fill in examples from below that they do not speak about. Afterward, have participants write their own negative consequences of using in their workbooks.)

Social Relationships - Substance use may lead to conflicts in important relationships such as with family members, a spouse, or friends. This can result in tension, arguments, or fighting. For example, a person who frequently uses marijuana may have repeated arguments with relatives about often being high or having money problems.

Work or Role Functioning - The person's substance use may interfere with his or her ability to fulfill important roles such as worker, homemaker, or student. For example, a person may be repeatedly late to work because of drinking the previous night.

Money Problems - Substance use may lead to financial problems such as not having enough money by the end of the month. For example, a person may use up all of his money for the month on a cocaine binge lasting only a few days.

Legal Problems - Substance use may lead to legal problems such as being arrested for drunk and disorderly conduct or possession of an illegal substance. Additionally, people often commit crimes while under the influence of drugs or alcohol.

Housing Instability - People who use substances may experience problems maintaining stable housing. Housing difficulties are often the result of conflicts with family members or being evicted from apartments because of drug deals, loud parties, and inability to maintain the apartment properly. Many housing programs for people with mental illnesses will not accept anyone who is using substances.

Dangerous Situations - Substances may be used in physically hazardous situations such as driving under the influence of alcohol or operating heavy machinery. Such use of substances increases the risk of accidents and injuries.

Mental Illness Symptom Relapses - Substance use tends to worsen mental illness symptoms, leading to relapses and rehospitalizations. For example, cocaine use may trigger psychotic symptoms, requiring hospitalization. People with a psychiatric illness are often more biologically vulnerable to drugs and alcohol than other people are. As a result, they are more sensitive to the effects of even small doses of psychoactive substances. This may also cause some of these individuals to have addiction problems despite relatively low or infrequent use of substances. Also, using drugs or alcohol can cause new mental impairments such as difficulty concentrating, anxiety, depression, dementia, or psychosis.

Health Problems - Drug and alcohol use can lead to a variety of health problems. For example, alcohol can damage the liver, marijuana can cause lung and respiratory problems, and intranasal use of substances (such as snorting cocaine) can damage internal parts of the nose (such as the septum). Also, unprotected sex is more likely to happen when judgment is impaired from being high. This can lead to increased risk of infection from HIV/AIDS, hepatitis, herpes, and other sexually transmitted diseases. Intravenous drug use also puts one at great risk for HIV/AIDS and hepatitis. Use of cocaine, alcohol, inhalants, amphetamines, and other drugs can also cause brain damage. Some drugs such as cocaine and amphetamines can cause strokes or heart attacks. Decreased sex drive or impotence is also caused by many drugs.

Giving Up Important Activities - A person may give up activities he or she used to enjoy in order to spend more time using alcohol or drugs. For example, a person may spend less time listening to music or with family members and more time drinking alcohol.

Cravings - Individuals sometimes experience intense cravings or yearnings for alcohol or drugs. Some individuals may find that their desire for substances is so strong that it cannot be resisted. For example, a person who regularly uses crack cocaine may find that after several days of not using cocaine he or she experiences strong cravings to use this drug.

Withdrawal Symptoms - People who use substances on a regular basis may experience unpleasant symptoms such as nausea, tremors, fatigue, agitation, or sleeping problems if they stop using the substance. When the person uses the desired substance, these withdrawal symptoms go away. For example, someone who has drunk four to six beers per night for a long period of time may experience nausea or tremors if he or she stops drinking suddenly.

(Have participants list their own negative consequences of using substances in their workbooks.)

Positive Consequences of Not Using Substances

Question 3: ***What are the positive consequences of not using drugs or alcohol in your life? What do you like about not using?***

(Write their answers on a board in a pay-off matrix if a board is available. You can fill in examples from below that they don't speak about. Afterward, have participants write their own positive consequences of not using in their workbooks.)

Improved Social Relationships - Substance use may lead to conflicts in important relationships such as with family members, a spouse, or friends. Stopping use can lead to improved social relationships and fewer conflicts.

Improved Work or Role Functioning – A person's substance use may interfere with his or her ability to fulfill important roles such as worker, homemaker, or student. Staying clean allows someone to function much better in all the roles of his/her life.

Fewer Money Problems - Substance use may lead to financial problems such as not having enough money by the end of the month. Staying clean saves a lot of money and allows someone to have a better financial life.

Fewer Legal Problems - Substance use may lead to legal problems such as being arrested for drunk and disorderly conduct or possession of an illegal substance. Staying clean helps keep people from committing crimes and getting arrested.

Increased Housing Stability - People with substance use problems may experience problems maintaining stable housing, and staying clean helps them maintain a stable housing situation.

Less Exposure to Dangerous Situations - Substances may be used in physically hazardous situations such as driving under the influence of alcohol or operating heavy machinery. Staying clean decreases the risk of accidents and injuries.

Clearer Thinking and Memory – Substance use can cloud one's thinking. Staying clean can lead to better attention span and ability to concentrate, better attention to detail, better decision making, and more awareness.

More Stable Mental Illness Symptoms- Substance use tends to worsen mental illness symptoms, leading to relapses and rehospitalizations. Staying clean helps to keep people from relapsing into mental illness.

Better Health - Drug and alcohol use can lead to a variety of health problems. Staying clean keeps the body and brain much healthier.

More Time for Important Activities - A person may give up activities he or she used to enjoy in order to spend more time using alcohol or drugs. Staying clean allows more time for these important activities.

Fewer Cravings or Withdrawal Symptoms - Staying sober for a long period of time helps cravings and withdrawal symptoms eventually go away.

(Have participants list their own positive consequences of not using substances in their workbooks.)

Negative Consequences of Not Using Substances

Question 4: ***What are the negative consequences of not using drugs or alcohol in your life? What have you had to give up or don't you like about not using?***

(Write their answers on a board in a pay-off matrix if a board is available. You can fill in examples from below that they don't speak about. Afterward, have participants write their own negative consequences of not using in their workbooks.)

Decreased Social Interaction – People may feel a sense of loss when they stop using because that was how they used to socialize with others. They need to learn new ways of socializing with others as well as develop a new network of friends.

Increased Mental Illness Symptoms – Sometimes people initially have increased mental illness symptoms when they stop using. These symptoms often include the following:

- depression
- anxiety/nervousness/tension
- sleep problems

Proper treatment for these mental illness symptoms is much more effective than using drugs or alcohol. They will often go away on their own after withdrawal is over.

Loss of Pleasure – Sometimes people feel a loss of pleasure when they quit using. They may need to develop other interests and positive activities that they find pleasurable to replace using.

Disruption of Daily Habits - Some people who have used drugs or alcohol for a long period of time continue to use simply because it has become part of their daily routine - a habit. This means they need to develop new, positive habits.

Cravings & Withdrawal Symptoms - Individuals who use larger quantities of substances may develop cravings for these substances, or they may experience withdrawal symptoms if they stop using suddenly. Proper medical detoxification helps reduce withdrawal and cravings. Over time these symptoms diminish, and cravings can learn to be managed without giving in.

Summary

- Alcohol and drugs can have a variety of different effects on people.

- Individuals with a mental illness tend to be more sensitive to the effects of substances due to their biological vulnerability.

- This module focused on understanding the reasons why people use different substances and reviewed some of the consequences of substance use, including the interaction with mental illnesses.

- The positive and negative consequences of drug or alcohol use or abstinence vary from individual to individual. However, the consequences commonly fall into several main life areas: social interactions and relationships, financial, legal, health, self-medication, and changing how people physically and psychologically feel.

- Although there may be short-term positive effects of using, the long-term effects are most often negative. Thus substance use should be avoided or treated.

Self-Assessment Exercise Directions

- *Have participants list their own negative consequences of not using substances in the Pay-Off Matrix and then transfer their most important four to the left column in the bottom table.*

- *Help the group come up with ways that they can minimize the negative consequences of not using.*

- *If they have difficulty getting to sleep when they are not using, talk about proper sleep habits such as going to bed and getting up at the same time each day, reading something not too interesting before sleep, not watching TV right before bed, not exercising in the evening (exercising earlier in the day helps one to sleep better at night), and using deep breathing and relaxation exercises to help oneself fall asleep.*

- *If they say they are more anxious when they don't use, talk about relaxation exercises and deep breathing.*

- *If they say they feel more depressed when they don't use, talk about getting treatment for depression.*

- *If they say they miss socializing with friends when using, talk about other ways to socialize such as making friends through 12-step meetings.*

- *If they say they miss the pleasure of feeling high, talk about other healthy ways to feel "high" such as through exercise, meditation, prayer, or other positive activities that they find enjoyable.*

- *Encourage group members to share their workbooks with their counselors and get help figuring out how to get their needs met without using substances. Their goal should be to minimize the negative consequences of not using. This goal can be incorporated into their treatment plans to help prevent relapse.*

Self-Assessment Exercises

1. Try anticipating three situations where you might become tempted to use.

2. Try to come up with three ways in each situation to keep from using. Think of three people you could contact if you need help resisting the urge to use. Write their names and phone numbers on a small piece of paper and keep it in your wallet or purse in case you need it in the future.

3. Practice by yourself or role play with others from your group ways you can turn down friends or family who try to get you to use.

Pay-Off Matrix

Name: _____ Date: _____

Please be as specific as possible about the consequences <u>IN YOUR OWN LIFE</u>.

Positive Consequences of Using Substances What are the advantages of using substances? (socializing, coping with symptoms or other problems, pleasure and recreation, something to do, habit)	Positive Consequences of Not Using Substances What are the advantages of *not* using substances? (less conflict with others, fewer mental symptoms and relapses, fewer money problems, housing stability, fewer legal problems, better health)
Negative Consequences of Using Substances What are the disadvantages of using substances? (more mental symptoms and relapses, conflict with others, money problems, legal problems, housing instability, health problems)	Negative consequences of <u>Not</u> Using Substances What did you have to *give up* by not using? (problems socializing, difficulties coping with symptoms or moods, lack of recreation, nothing to do, sleep problems)

Ways that I can minimize the Negative Consequences of Not Using in my life

Negative consequences of <u>Not</u> Using Substances	**Way to Meet That Need Without Using**
1.	1.
2.	2.
3.	3.
4.	4.

HOMEWORK: Share this with your counselor and get his/her help figuring out how to get your needs met without using substances. The goal is to minimize the negative consequences of not using. This goal can be incorporated into your treatment plan to help prevent relapse.

Module 7:

Principles of Treatment

MODULE 7: PRINCIPLES OF TREATMENT

DIRECTIONS: Remember to make this group interesting to the group members by welcoming their input and discussion and using the exercises and discussion questions. Present the material in an interactive format. Don't just read the material but say it in your own words in a way that you know the participants will understand.

You can break this module up into more than one group or skip some exercises if you cannot fit it all into one group. Another idea would be to have participants complete some of the exercises as homework or with their counselors. You can also skip or modify exercises if they are not appropriate for your program or treatment population. Feel free to modify the way you use this material to meet the needs of your program and group participants.

Overview

Substance abuse often leads to worsening of a person's mental illness, and more severe mental health symptoms sometimes lead to greater substance abuse. There are many different strategies that can be used to treat co-occurring disorders and help clients regain control of their lives and make progress toward important goals. Treatment strategies may involve medication, working with professionals and family members, self-help, or other natural supports. We will be discussing some of the principles of treatment and common strategies for people who have co-occurring disorders.

The treatment of co-occurring disorders must blend both ***substance use*** and ***mental health issues***, with each applied at appropriate times and situations according to the clients' needs. Sometimes the attempt to obtain professional help can be bewildering and confusing for people who have co-occurring disorders. For example, a client may need services but lack knowledge about the different goals and processes of various types of available services. Sometimes mislabeling, rejecting, or failing to recognize a person has co-occurring disorders can result in inadequate treatment. As a result, the treatment system itself may be a stumbling block for some people attempting to receive ongoing, appropriate, and comprehensive treatment. Providing treatment for both substance use *and* mental health disorders increases the chance that treatment will be successful.

Question 1: ***What might be some stumbling blocks people can come across when they seek treatment for both mental health and substance use problems?***

Medication

Medication is more often used in psychiatric treatment than in addiction treatment, especially for severe disorders. Medications used to treat psychiatric symptoms include psychoactive and non-psychoactive medications. Psychoactive medications cause an acute change in mood, thinking, or behavior such as euphoria, sedation, or stimulation.

Psychoactive medications prescribed to the average patient with psychiatric problems are generally taken in an appropriate fashion and pose little or no risk of abuse or addiction. (One possible exception is the class of drugs known as benzodiazepines, which are discussed in more detail in module 4.) In contrast, the use of psychoactive medications by patients with a personal or family history of substance abuse disorder can be associated with an increased risk of abuse or addiction. Some medications used in psychiatry that have mild psychoactive effects (such as some tricyclic antidepressants with mild sedative effects) appear to be misused more by patients with substance abuse disorder than by others.

Question 2: ***Have you had similar problems taking medication? If so, what problems did you encounter?***

Psychotherapy

Many health insurance plans cover psychotherapy. Additionally, to help make therapy more affordable, a number of mental health care providers have sliding fee scales based on income or some other types of payment plans available for clients. When looking for mental health care providers, it is important that clients protect themselves from fraud by making sure the providers are licensed to practice in the state. A family doctor should be able to provide referrals as well. Remember that people can react differently to psychotherapy, just as they do to medicine. To get the most out of psychotherapy a client should:

- Keep appointments
- Be honest and open
- Do the homework assigned as part of the therapy
- Give the therapist feedback on how the treatment is working

Group Therapy – Clients may find that participating in groups with other people who have co-occurring disorders is very helpful. These groups may focus on exploring the role that substance use has played in a person's life and on developing strategies for cutting down or stopping substance use. Important parts of these groups include social support, sharing personal experiences, and exchanging ideas about personal goals.

Individual Therapy – Each client is a unique individual who has personal strengths that are an important part of treatment. Understanding these strengths and needs is important for developing a treatment plan that is most helpful.

Family Therapy – Family members (and other persons) can help by providing support, recognizing small positive steps, and assisting with problem solving for difficult issues. By working together, clients and their families can often come up with creative solutions for solving important problems or achieving desired goals. Recovery touches the lives of many other people, including family, friends, and co-workers. Collaboration between clients and other supportive people is essential to meet the challenges of treatment.

Self-Help Groups

One adjunct to treatment that might help some patients is self-help groups. These groups can provide needed support and encouragement for some patients in treatment. For example, some of these groups include:

- Alcoholics Anonymous (AA)
- Narcotics Anonymous (NA)
- Cocaine Anonymous (CA)

Importantly, these services are widespread nationally and internationally. Although self-help programs are not considered treatment per se, they are important additions to professional treatment services. Self-help organizations have helped millions of people with addictive disorders and are widely available in most communities. Groups such as Al-Anon are also available for concerned family members of individuals with addictions.

Other Treatment Strategies

Recovery from a substance use disorder occurs over a series of stages. Individuals progress from one stage to the next as they recover from their substance abuse. Sometimes people move back and forth between stages. Each stage is different in terms of the person's awareness of substance abuse as a problem and motivation to address substance use. Understanding the different stages of substance abuse treatment can be helpful in deciding what goals to be working toward. The following table provides a brief description of each stage and the goal of each stage.

Ways to Look at Stages of Recovery

Stage of Recovery	Description	Goal	Equivalence in Prochaska and DiClemente's (1986) Transtheoretical Model
Engagement	The client does not see a professional on a regular basis and has no working relationship with a professional	To establish a working alliance (therapeutic relationship) with a professional	*Precontemplation* – the client has no intention to take action within the next 6 months
Persuasion	Client has a working alliance with a professional but is not convinced that substance abuse is a problem	To help the client view substance abuse as a problem that should be worked on	
Active Treatment	The client is motivated to work on substance abuse and has discontinued use	To help the client discontinue substance use so that it is no longer a problem	*Contemplation* – client intends to take action within the next 6 months *Preparation* – client intends to take action within the next 30 days and has taken some behavioral steps in this direction *Action* – client has changed overt behavior for less than 6 months
Relapse Prevention	The client has stopped using substances (or experiences no consequences from substance use) for a significant period of time	To maintain awareness that relapse of substance abuse could happen and to extend recovery to other areas (such as work)	*Maintenance* – client has changed overt behavior for more than 6 months

Treatment Engagement

In general, treatment engagement refers to the process of initiating and sustaining the client's participation in the ongoing treatment process. Engagement can involve such enticements as providing help by procuring social services such as food, shelter, and medical services. Engagement can also involve removing barriers to treatment and making treatment more accessible and acceptable. For example, it can entail providing day and evening treatment services. Engagement can be enhanced by providing adjunctive services that may appear to be related indirectly to the disorders such as childcare services, job skills counseling, and recreational activities. It may also be coercive such as through involuntary commitment or a designated payee.

Engagement begins with efforts that are designed to enlist people into treatment, but it is a long-term process with the goals of keeping clients in treatment and helping them manage ongoing problems and crises. Essential to the engagement process is: (1) a personalized relationship with the individual, (2) over an extended period of time, (3) with a focus on the stated needs of the individual.

For clients with co-occurring disorders, engagement in the treatment process is essential, although the techniques used will depend upon the nature of, severity of, and disability caused by, an individual's co-occurring disorders. An employed person with panic disorder and episodic alcohol abuse will require a different type of engagement than a homeless person with schizophrenia and polysubstance dependence. With respect to severe conditions such as psychosis and violent behaviors, therapeutic coercive engagement techniques may include involuntary detoxification, involuntary psychiatric treatment, conditions of probation or parole, or court-mandated acute treatment.

In terms of Prochaska and DiClemente's (1986) Transtheoretical Model of Behavior Change, a client in the engagement stage of recovery may be considered to be in the "precontemplation" stage of behavior change. In this model the client has no intention to take action within the next 6 months and the goal is to help the client her begin to consider the merits of changing an undesirable behavior.

Persuasion

At the persuasion stage, the client is having regular contact with a counselor, but there is no shared agreement to work on substance-use related issues. Before the counselor can begin to work on discontinuing the substance use, the client must decide that using substances has negative consequences and that discontinuing is an important goal. Therefore, the goal of this stage is to persuade the client that substance use is a problem and to obtain agreement to work together on treating it. For example, this may include helping the client see that substance use interferes with the ability to pursue and achieve personal goals. Like the engagement stage of recovery, a client in the persuasion stage would still be considered to be in the "precontemplation" stage of behavior change (Prochaska & DiClemente).

Active Treatment

In this stage, the client realizes that substance use is a problem and is interested in working on discontinuing use of substances. The goal here is to help the client eliminate substance use. Common strategies include participation in self-help groups and developing alternative activities to substance use such as leisure activities, exercising, and working.

This stage of recovery is similar to three stages of behavior change in the Transtheoretical Model (Prochaska & DiClemente). The first one, "contemplation", occurs when the client intends to take action within the next 6 months. The client moves into the "preparation" stage when he or she intends to take action within the next 30 days and has taken some behavioral steps toward achieving this end. The final stage, "action", occurs when the client has recently changed his or her overt behavior (for less than 6 months).

Relapse Prevention

In this stage (which will be discussed in Module 8 in more detail) the client has achieved abstinence for at least six months. As relapse of substance use disorders is common, one important goal is to help maintain an awareness that relapse is possible and to take steps to minimize the chances of relapse occurring. A second goal of this stage is to expand the client's recovery to other areas of functioning such as social relationships and health. Common strategies include developing a relapse prevention plan, participating in self-help groups, and working on rehabilitation.

This stage of recovery corresponds to the "maintenance" stage of behavior change in the Transtheoretical Model (Prochaska & DiClemente). In this stage, the client has changed the unwanted behavior for more than 6 months and is working to prevent returning to the old behavior.

Summary

- Substance abuse often worsens mental illness, and having more severe symptoms of mental illness sometimes leads to greater substance abuse.
- There are many different strategies that can be used to treat co-occurring disorders and help clients regain control of their lives and make progress toward important goals.
- The treatment of co-occurring disorders must blend both substance use and mental health issues, with each applied at appropriate times and situations according to the clients' needs.
- Treatment strategies may involve medication, working with professionals and family members, self-help, or other natural supports.
- Recovery from a substance use disorder occurs over a series of stages. Each stage is different in terms of the person's awareness of substance abuse as a problem and motivation to address substance use. Understanding the different stages of substance abuse treatment can be helpful in deciding what goals to be working toward.
- In the engagement stage, the client does not see a professional on a regular basis and has no working relationship with a professional.
- In the persuasion stage, the client has a working alliance with a professional but is not convinced that substance abuse is a problem.

- During the active treatment stage, the client is motivated to work on substance abuse and has discontinued use.

- In the relapse prevention stage, the client has stopped using substances (or experiences no consequences from substance use) for a significant period of time.

References

Prochaska, J. O., & DiClemente, C. C. (1986). Toward a comprehensive model of change. In W.R. Miller & N. Heather (Eds.), *Treating addictive behaviors: Processes of change. Applied clinical psychology* (pp. 3-27). New York, NY: Plenum Press.

Module 8:

Relapse Prevention

MODULE 8: RELAPSE PREVENTION

DIRECTIONS: Remember to make this group interesting to the group members by welcoming their input and discussion and using the exercises and discussion questions. Present the material in an interactive format. Don't just read the material, but say it in your own words in a way that you know the participants will understand.

You can break this module up into more than one group or skip some exercises if you cannot fit it all into one group. Another idea would be to have participants complete some of the exercises as homework or with their counselor. You can also skip or modify exercises if they are not appropriate for your program or treatment population. Feel free to modify the way you use this material to meet the needs of your program and group participants.

Overview

The last seven modules have discussed how people with addictive and mental disorders likely have a greater number of risk factors than protective factors. As such, these people need to work to change the balance in favor of protective factors. If they don't, they are more likely to relapse into substance abuse or mental illness symptoms, even after receiving treatment.

Additionally, having a mental illness puts one at higher risk for developing an addiction, and having an addiction puts one at higher risk for worsening mental illness symptoms. The research has shown that untreated mental illness is the main cause of relapse into substance abuse, and untreated substance abuse is the main cause of relapse into mental illness. This means that, in order to maintain recovery and prevent relapse, it is necessary to pay attention to and get help for both addictive and mental disorders.

This module covers the most common high-risk situations for substance abuse and mental illness relapse and can be used to help people identify their own high-risk situations. This module also can be used to help people learn to identify their early warning signs for relapse. Knowledge of early warning signs for relapse and high-risk situations aids in the development of a relapse prevention plan.

High-Risk Situations

The most common high-risk situations for relapse into ***substance abuse*** are as follows:

- ***Feeling Down*** (or Feeling Bad) – the most common time for people to relapse is when they feel angry, sad, scared, bored, stressed, embarrassed, guilty, or when they have mental illness symptoms like depression or strong anxiety.

- ***Social Pressure*** – the second most common situation for people to relapse is when they are around others who are using. The social pressure can be indirect (which is what happens when one is simply around others who are using), or the social pressure can be direct (when others offer a drink or drug and try to encourage its use). People might even make fun of others for not using.

- ***Fights*** – (or arguments) the third most common situation for people to relapse is after they have been in an argument or have been criticized by someone else.

Other relapse situations that are not as common but that are still important to be aware of are

- ***Positive Emotions*** – using substances to "celebrate" or try to get more of a good feeling

- ***Urges and Cravings*** – having a sudden strong desire to use

- ***Testing Personal Control*** – when people try using to see if they can now control their use or "handle" it this time

- ***Feeling Bad Physically*** - when people try to reduce their physical pain or discomfort through using

When people drink or use drugs, they probably do so in specific places, at certain times of the day or week, and with certain people. They probably also use certain things to get high. These old cues for using can make them vulnerable to relapse if they come into contact with the cues later. If people in recovery can identify their old patterns of use and cues for using, then they can know what their own high-risk situations are likely to be. Once they are aware of these high-risk situations, they can anticipate when they may come into contact with them and plan for ways of keeping themselves from falling off the wagon. Additionally, even if they are placed in a high-risk situation unexpectedly, it will be helpful to have a plan for what to do to keep from using.

Some common high-risk situations for ***mental illness*** relapse include the following:

- ***Stopping Medications or Changing How They are Taken*** – without checking with a doctor or nurse first. Stopping medications before they have had time to be effective (or because one thinks they are no longer needed) can cause mental illness symptoms to come back. Sometimes people stop their medications due to unpleasant side effects. However, if they talk with their doctors, the doctors may be able to change the medication or dosage to get rid of the side effects and still treat the mental illness.

- ***Missing Mental Health Appointments*** – with counselor, doctor, or group therapy. These appointments can be very important in getting help to keep mental illness symptoms away.

- ***Drinking or Using Drugs*** – even just a little bit of drugs/alcohol can cause a mental illness relapse. People with a mental illness are usually much more sensitive to drugs/alcohol, and using even just a little bit can destabilize their mental health. Also, alcohol and drugs can interfere with the effectiveness of certain mental health medications.

Stressful events and situations can contribute to mental illness relapse:

- ***Stressful Life Situations*** – money problems, legal problems, housing problems, work problems

- ***Relationship Problems*** – arguments, breaking up with someone, divorce, family difficulties

- ***Grief or Loss*** – death of a loved one, loss of a job, health problems

The best way to prevent relapse into substance use and mental illness is to be careful to avoid one's high-risk situations. However, sometimes people get surprised by high-risk situations, so they also need to be ready to cope with them and get out of them as quickly as possible in order to prevent relapse.

Instructions to Group Leader (See page 96 in this manual)
*Have clients look at the page in the workbook "Identifying High Risk Situations for Substance Abuse/Mental Illness Relapse**". Have clients fill out 1a) and 1b) of the handout and then ask people to give examples of their 3 highest risk situations for substance abuse and mental illness relapse. Try to generate discussions of what are the best ways to avoid and cope with these situations. Have clients write down their own answers to these questions on 2) and 3) in their workbooks.*

Early Warning Signs

A relapse is usually the end result of a whole chain of bad decisions. Some of these decisions may seem harmless at the time, or at least that's what people tell themselves as they are making them. This is how they trick themselves and set themselves up for relapse - by making a series of bad choices that put them in one of their high-risk situations. One of the best ways to keep themselves from making these bad decisions is through knowing which early warning signs tell them that they are heading toward relapse. If they know what their early warning signs are, they can get extra help or make changes to prevent themselves from relapsing.

Instructions to Group Leader
The following are directions you may read aloud to clients to get them started on the 'Early Warning Signs for Substance Abuse and Mental Illness Relapse' exercise page.

(Read aloud to group) (See page 97 in this manual)
"For the exercise called 'Early Warning Signs for Substance Abuse and Mental Illness Relapse', think of a time in your past when mental illness symptoms may have led to relapse into substance abuse or when substance abuse may have led you to a mental illness relapse. Keep in mind what was going on with you in your life that led up to your addiction or mental disorder, or both."

"Put a check mark next to the early warning signs you have experienced in the past that happened before and during your relapse into substance abuse or mental illness. There is one column for those that led to a substance use relapse and one for those that led to a mental illness relapse. Go ahead and check both columns if a particular early warning sign applies to both."

"Write other ones in the blanks and make them as specific as possible for what your own personal Early Warning Signs were. Go ahead and put checks next to the appropriate columns for ones that you write in."

Instructions to Group Leader
Now ask clients to share their answers and identify common themes for them by writing them on the board.

Take a quick look at the exercises to see if there are any problematic early warning signs that need to be dealt with right away (like wanting to commit suicide or hurt others) and take appropriate action either in group or afterwards, or both.

Use the group as necessary to help individuals who need immediate assistance.

(Read aloud to group)
"Remember, the reason we are figuring out these early warning signs is so that we can recognize them when they come up next time and do something to stop them from becoming a full-blown relapse to substance abuse or mental health problems."

"Now, what should you do when you notice that you are having early warning signs? As homework, you can use this next assignment to figure out the best ways to prevent yourself from having a substance abuse or mental illness relapse when you see your early warning signs coming up."

(Look at page "Preventing Substance Abuse and Mental Illness Relapse", page 98 in this manual.) *"Use the workbook exercise from 'Early Warning Signs for Substance Abuse and Mental Illness Relapse' and write your early warning signs from the old assignment in the first column of the new assignment."*

"Remember, there are four categories of early warning signs that you identified on your last handout: (1) attitude and thinking changes, (2) mood and emotional changes, (3) behavior changes, and (4) changes in daily living and physical changes. Within each of these four categories, write in the ones that you put a check next to."

"Now take this assignment with you and do your best to fill out the second column as homework. Remember, preventing a relapse into substance abuse or mental illness will require you to do regular self-monitoring and asking for help when you need it. As you write down ideas for how to handle your different warning signs, ask yourself these questions:"

Question 1: ***What did I do in the past that kept me from relapsing to substance abuse or mental illness*****?**

Question 2: ***How did I successfully handle this sign in the past*****?**

Question 3: ***Whom do I need to ask for help when I have this kind of early warning sign*****?**

(Read aloud to group) (See page 99 in this manual.)
"Here is another homework assignment that will help you to develop a comprehensive and complete Relapse Prevention Plan. This plan can help guide you in every part of your recovery from substance abuse and mental illness. You may want to share this with your counselor and get help in completing it."

Instructions to Group Leader (See page 101 in this manual.)
Review page in workbook on "Coping with Cravings and Urges" and have people share how they coped successfully with cravings to use in the past.

Identifying High Risk Situations for Substance Abuse/Mental Illness Relapse

The Top Three High-Risk Situations for Substance Abuse Relapse

Feeling Bad – mental illness symptoms like depression or excess anxiety or feeling other unpleasant emotions including angry, sad, scared, bored, stressed, embarrassed, or guilty.
Social Pressure
Indirect Social Pressure - when you are simply around others who are using.
Direct Social Pressure - when others offer you a drink, drugs, or get you to use.
Fights – getting in an argument or being criticized by someone else.

Other common high-risk situations for substance abuse relapse:
Positive emotions – drinking/using drugs to "celebrate" or to get more of a good feeling.
Urges and Cravings – having a sudden strong desire to drink or use drugs.
Testing Personal Control – drinking/using drugs to see if one can control or "handle" it.
Feeling Bad Physically - trying to lessen physical pain or discomfort by using.

Things to keep in mind when identifying my high risk situations:
What people or kinds of people did I drink/use drugs with?
In what places and social situations did I drink/use drugs the most?
What things did I use to get high (drug paraphernalia, alcohol bottles, etc.)
What were the times of the day or week that I tended to drink/use drugs?

Common High Risk Situations for Mental Illness Relapse

Stopping Medications or Changing How You Take Them – without checking with doctor/nurse
Missing Mental Health Appointments – with counselor, doctor, or group therapy
Drinking or Using Drugs – even just a little bit of drugs/alcohol can cause a mental illness relapse

Stressful Events and Situations Can Contribute to Mental Illness Relapse

Stressful Life Situations – money problems, legal problems, housing problems, work problems
Relationship Problems- arguments, breaking up with someone, divorce, family difficulties
Grief/Loss –death of a loved one, loss of a job, health problems

1a) What are my high-risk situations for substance abuse relapse?
1b) What are my high-risk situations for mental illness relapse?
2) How will I **AVOID** my high-risk situations in the future to help prevent relapse?
3) How will I **COPE** with my high-risk situations in the future when I can't avoid them?

Early Warning Signs for Substance Abuse and Mental Illness Relapse

Read through the following common Early Warning Signs for Substance Abuse and Mental Health Relapse. Put a check mark next to those you have experienced in the past that happened before and during your relapse into substance abuse and/or mental health problems. Write in other ones in the blanks from your life.

Substance Relapse	***Attitude and Thinking Changes***	**Mental Health Relapse**
	Losing interest in your recovery or treatment plan	
	Thinking that you can use some alcohol or drugs and stay in control	
	Urges and impulses to use drugs or alcohol	
	Remembering only the pleasurable part of addiction & forgetting about the pain	
	Making decisions that put you in high risk situations for relapse	
	Not caring about yourself and what happens in your life	
	Thinking that counseling and/or medication is not needed anymore	
	Thinking of hurting yourself or someone else	
	Having difficulty thinking or speaking clearly	
	Seeing or hearing things that others can't see or hear	
	Others:	
	Mood or Emotional Changes	
	Feeling sad, depressed, or hopeless- feeling like giving up	
	Becoming too energetic, excited, and feeling "on top of the world"	
	Feeling anxious, nervous, restless, or "on edge"	
	Feeling bored, empty, or lonely	
	Feeling lost, aimless, or without any direction	
	Feeling angry and hating other people	
	Feeling distrustful and suspicious of others	
	Feeling negative, cynical, or pessimistic	
	Others:	
	Behavior Changes	
	Cutting down/ stopping AA, NA, dual recovery, or support group meetings	
	Cutting down/stopping regular contact with your sponsor/ recovery group	
	Missing counseling appointments without calling in	
	Missing other appointments or work without calling in	
	Withdrawing from other people and keeping to yourself	
	More arguing and getting into fights with others	
	Putting yourself in high risk situations where there is pressure to drink or use	
	Stopping exercise or meditation program; stopping healthy hobbies	
	Cutting down/stopping medications without discussing with your doctor/nurse	
	Others:	
	Others:	
	Changes in Daily Living or Physical Changes	
	Trouble falling asleep or staying asleep; starting to sleep too much	
	Changes in appetite; weight loss or weight gain	
	Changes in personal hygiene habits (stop showering, brushing teeth, or shaving)	
	Changes in energy level (much higher or lower than usual)	
	Others:	

Preventing Substance Abuse and Mental Illness Relapse

What did I do in the past that kept me from relapsing into substance abuse or mental illness? How did I successfully handle this early warning sign in the past? Whom do I need to ask for help when I have this kind of early warning sign?

My Early Warning Signs of Relapse to Substance Abuse and/or Mental Illness	**My Prevention Plan (how I will deal with my Early Warning Signs to prevent Substance Abuse and/or Mental Illness relapse)**
Attitude and Thinking changes	
Mood or Emotional Changes	
Behavior Changes	
Changes in Daily Living/Physical Changes	

My Relapse Prevention Plan

Remember this plan should help you avoid relapse into substance abuse and mental illness. Summarize the most important parts of your previous work in recovery to answer each question below. Get help from your counselor to complete this and share it with him/her.

1. **Goals, Time Management, and Lifestyle Balance**
   a. What are my life goals that will help me maintain my recovery after leaving this program? What steps am I going to take to work toward achieving my goals?

   b. How do I plan to live a **balanced lifestyle** to maintain my recovery? What areas of my life do I want to balance?

   c. How do I plan to **manage my time** after my release? What daily/weekly activities am I going to do to maintain my recovery, and how often will I engage in them?

2. **Coping with Stress** - What positive activities will I do to **cope with stress**?

3. **Early Warning Signs**
   a. My early warning signs for relapse into **substance abuse**.

   b. What will I do to avoid relapse when I notice these warning signs?

   c. My early warning signs for relapse into **mental illness**.

   d. What will I do to avoid relapse when I notice these warning signs?

4. **Managing Cravings and Urges**
   a. What things trigger my **cravings/urges** to relapse? How can I avoid those triggers?

   b. Which techniques work best for me to **manage my cravings/urges** when they arise?

5. **My emergency plan to prevent a lapse (or slip) from becoming a full-blown relapse?**

6. **Coping with high-risk situations for relapse into substance abuse or mental illness**:
   a. What are my personal **high-risk situations for relapse?** How do I plan to avoid them and cope with them?

   b. How do I plan to cope with **feeling bad** so that I do not relapse?

   c. How do I plan to resist **social pressure** to use drugs or alcohol?

7. **Coping with Conflict**:
   a. How do I plan to **change my thinking** to cope with conflict and not relapse?

   b. How do I plan to **communicate more effectively** to cope with conflict?

8. How do I plan to **maintain treatment** for my mental health, substance abuse, and physical health needs after I leave this program?

9. What is my **housing plan** for after I leave this program?

10. What is my **employment plan** for after I am released?

11. How do I plan to develop a **recovery network** (a social group of people who will help with my recovery) after I am released?

Coping with Cravings and Urges

Remember: the first line of defense against cravings and urges is avoiding the triggers and high risk situations that give rise to them! Don't go into that old neighborhood where you used to use or commit crimes, avoid bars, don't keep any alcohol or drug paraphernalia around you, avoid interacting with people who are still using, don't go to parties where people use, etc.

Even if you do your best to avoid external triggers, some cravings and urges will still arise. Do your best to avoid your triggers, but be prepared to come across unexpected triggers. Even if you avoid all external triggers, you can still have internal triggers, such as thoughts, feelings, or memories, that can bring up cravings and urges.

Cravings and urges are a normal part of recovery. Everyone in recovery experiences these at times. You don't need to feel bad about yourself or your recovery just because you have a craving or urge. The important thing is to be aware of them and decide on a coping strategy so that you can stop yourself from giving in to them.

Cravings and urges grow weaker the longer you "starve" them. Giving in to them makes them stronger! Over time, as you maintain your recovery, cravings and urges will continue to get less and less, as long as you don't give in to them. Giving in to cravings and urges may decrease the unpleasant sensations associated with them for a short time, but giving in to them only makes them stronger the next time!

Coping Strategies: What to do when Cravings and Urges Arise

Try out different coping strategies from the list below and see what works best for you. Practice them ahead of time so that you are prepared and know what to do when an urge does arise. When an urge does arise, keep trying different ones until one works, you may need to use different ones at different times. Underline those that work best for you, and write out others that work well for you that are not on this list (on bottom of second page, or on back of page). Keep these two pages with you in your wallet to refer to in an emergency.

Distraction - Do something else that is not a trigger, such as reading, exercise, take a shower, hobbies or sports, take a fast 10 min walk (only in a non-trigger neighborhood!) watching TV (be careful of beer commercials or shows/movies that glamorize drug or alcohol use or crime, maybe only watch PBS).

Talking - Calling or talking to a trusted friend who is a positive person and does not use or commit crimes, or call a counselor or sponsor. Ask for help. Talking about your urge may help you to get over it. Ask the person to let you talk about your reasons for not giving in to the urge, and ask them to remind you of the consequences of your behavior.

Consequences - Remind yourself of your reasons for not giving in, and the good consequences of not giving in (staying out of incarceration, feeling good about yourself, making the urge get weaker the next time, etc.), as well as the possible bad consequences of giving in (incarceration, death, making the urge stronger next time, could lead to full relapse).

Substitution – Instead of giving in to the urge, substitute a pleasant activity that is not harmful and is not one of your triggers, such as receiving a massage, giving yourself a massage, eating or drinking something you enjoy, chew gum, hard candy, etc.

Wait it out - Remember that most cravings and urges only last for a few minutes, and simply wait it out.

Urge Surfing - Use "urge surfing" by watching the urge and noticing it, and detaching yourself from it by realizing that it is not you, you don't have to act on it, and it will decrease soon.

Remove yourself from the situation that brought on the craving; leave the party or neighborhood, retreat to a safe drug free place. One way to do this temporarily in work or social situations is to excuse yourself to go to the bathroom.

Self talk - Tell yourself positive messages, "This will be over soon"; "I can do this", "I can get help if I need it"; "I don't have to give in to this", etc.

Get Angry and Fight with Your Urge – Fight against the urge like the enemy it is, and tell it; "Go away, I won't let you trick me into hurting myself and ruining my life anymore" or similar statements.

Support Groups - Go to a 12-step meeting or other support group. Being with others in recovery can help you to remember that you can get through this. Get other people's names and numbers to call in case of future cravings and urges. Try to get a positive person to be a temporary sponsor, and eventually try to get a long-term sponsor. Develop a positive social network of people to spend time with that don't use or commit crimes.

Breathe - Take 10 – 20 slow, deep breaths; the urge may be gone after only a few minutes of this. If it is not, then keep going with breathing and use urge surfing, meditation, prayer, visualization, or positive self - talk; whatever works for you!

Meditation - meditating regularly will make that a pleasant, positive addiction and give you a natural, beneficial "high". Then when you have an urge, you can meditate instead of using.

Visualize the positive consequences of not giving in to the urge and the negative consequences of giving in to the urge. See what it would be like to be rearrested, feel how you would feel having to go back to prison. Now visualize how much stronger you will feel if you don't give in to the urge, and how you will be happier in the long run.

Pray - ask for help from your Higher Power.

Reward yourself with something pleasant and not harmful when you have successfully resisted the urge. Give yourself some praise, and tell yourself "Good Job!"

Others – write out other specific coping strategies not in this list, especially ones that work well for you (such as what kind of exercise, sports, reading, food, or hobbies help). You can also use the back of this page for this._____
_____
_____

APPENDIX A: INTERNET RESOURCES

Module 1: Connection Between Substance Use and Mental Health

Dual Diagnosis

Dual Diagnosis: Resources for Co-occurring Addiction & Personality Disorders. This site is maintained by Robert Ekleberry, Jr., MA, and Sharon Ekleberry, LCSW, CSAC, BCD. Bibliography that includes book reviews, links to CSAT TAPS and TIPS, links to NIDA articles on dual diagnosis, full text training manual, The Drug Description Modules include neurotransmitters involved, Pharmacology, Effects, Tolerance, Withdrawal, Detoxification, Abuse & Dependence. Last accessed: January 31, 2002. http://www.toad.net/~arcturus/dd/ddhome.htm.

Dual Diagnosis Recovery Network. This site is partially funded by the Tennessee Department of Mental Health and Developmental Disabilities and the Tennessee Department of Health Bureau of Alcohol and Drug Abuse Services. Although the self-help and advocacy services are for Tennessee residents, the site has a comprehensive online bookstore, several full text articles, and the Dual Network Magazine. Last accessed: January 31, 2002. http://dualdiagnosis.org/

Dual Diagnosis Website. From the website: "This site is designed to provide information and resources for service providers, consumers, and family members who are seeking assistance and/or education in this field." The site is maintained by Kathleen Sciacca, MA, and has a glossary, several full text articles, links to other sites, bibliography of relevant materials, bulletin board, and a chat room. Last accessed: January 31, 2002. http://users.erols.com/ksciacca/

Dual Disorder Study. Results of the four-year Australian study *Coffs Harbour Project: A violence prevention program for substance misusing mentally ill*, by Adrian Bradley and Barry Toohey. -The study included development and evaluation of a training package for police officers in the management of violent mentally ill offenders, and the evaluation of an experimental treatment intervention targeting dually disordered outpatients to reduce psychiatric relapses and violence. The entire 331-page report is available in Adobe Acrobat format. Last accessed: January 31, 2002. http://www4.tpgi.com.au/users/bradles/

National Association for the Dually Diagnosed (NADD). From the website: "NADD is a not-for-profit (501C3) membership association established for professionals, care providers and families to promote understanding of and services for individuals who have developmental disabilities and mental health needs. NADD is recognized as the world's leading organization in providing educational services, training materials and conferences. NADD has been influential in the development of appropriate community based policies, programs and opportunities in addressing the mental health needs of persons with mental retardation. Last accessed: January 31, 2002. http://www.thenadd.org/ or http://63.107.112.208/cgi-in/router.pl?SESSION=!SESSION!

National Center for PTSD. This site has full-text information about PTSD and substance use for clinicians, family members, policy makers, researchers, journalists and attorneys, reviews and descriptions of assessment instruments, and links to other Internet resources. Last accessed: January 31, 2002. http://www.ncptsd.org/

The Online Recovery Resource Directory. Over 2,300 recovery resources for alcoholism and addiction, dual disorders, mental health, sober living, treatment resources, etc. The site contains links for information, treatment resources, and self help. Links also provided for alcohol detoxification, alcoholism, Cocaine Anonymous, crystal meth referrals, depression, drug addiction, drug testing, dual diagnosis programs, eating disorders, heroin detoxification, inpatient and outpatient hospital programs and rehabilitation centers, marijuana addiction, mental health, message boards, Nar-Anon, online counseling, oxycontin addiction, sober chat rooms, sober housing, and speed addiction. Last accessed: January 31, 2002.
http://soberrecovery.com/

Mental Health

Knowledge Exchange Network. This site is maintained by the Center for Mental Health Services and provides information for consumers and their families, the general public, policy makers, and providers. Last accessed: January 31, 2002.
http://www.mentalhealth.org/aboutken/

Mental Health Source. This site provides information for patients and caregivers, links to other Internet sources, and continuing education courses. Last accessed: January 31, 2002.
http://www.mhsource.com/

National Alliance for the Mentally Ill. From the site: "The National Alliance for the Mentally Ill (NAMI) is a nonprofit, grassroots, self-help, support and advocacy organization of consumers, families, and friends of people with severe mental illnesses, such as schizophrenia, major depression, bipolar disorder, obsessive-compulsive disorder, and anxiety disorders." Last accessed: January 31, 2002. http://www.nami.org/

National Institute of Mental Health. This is a government site that provides information about a variety of mental illnesses for the general public, practitioners, and researchers. Visitors can join a listserv to receive email announcements about changes to the site. Information is provided in English and Spanish. Last accessed: January 31, 2002.
http://www.nimh.nih.gov/

National Mental Health Association. From the site: "The National Mental Health Association (NMHA) is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. With more than 340 affiliates nationwide, NMHA works to improve the mental health of all Americans, especially the 54 million individuals with mental disorders, through advocacy, education, research and service. Last accessed: January 31, 2002.
http://www.nmha.org/

National Mental Health Consumers' Self-Help Clearinghouse. From the site: "a consumer-run national technical assistance center serving the mental health consumer movement. We help connect individuals to self-help and advocacy resources, and we offer expertise to self-help groups and other peer-run services for mental health consumers. Last accessed: January 31, 2002. http://www.mhselfhelp.org/

PsychologyNet. From the site: "PsychologyNet is a non profit organization to promote Mental Health Services and Mental Health Service Providers on the Internet and to provide valuable mental health services and resources for people in need." Last accessed: January 31, 2002.
http://www.psychologynet.org/

Module 2: Depression

Depression. These sites provide information on depression, and the opportunity to sign up for email notification of clinical trials of new treatments for depression. Last accessed: January 31, 2002.
http://www.symptoms-of-depression.com/
http://www.learn-about-depression.com/
http://www.treatments-for-depression.com/

Dr. Ivan's Depression Central. This site is maintained by Dr. Ivan Goldberg as a clearinghouse for information on all types of depressive disorders, and has a searchable database. Last accessed: January 31, 2002. http://www.psycom.net/depression.central.html

Focus on Depression. This site is part of MedicineNet.com, and provides information on depression, medication, and other treatment, and includes full text articles by physicians. Last accessed: January 31, 2002.
http://www.focusondepression.com/Script/Main/hp.asp

HealingWell.com. This site provides articles and news, community bulletin boards and chats, reviews on the newest books on depression, and links to other Internet resources. Last accessed: January 31, 2002. http://www.healingwell.com/depression/

Hypericum & Depression Home Page. This site is maintained by Harold Bloomfield, MD, and provides information about St. John's Wort and depression, and also has links to National Institute of Health information on St. John's Wort. Last accessed: January 31, 2002.
http://www.hypericum.com/

Suite101. This site has full text articles on depression, including a new article every week, and links to other Internet resources. Last accessed: January 31, 2002.
http://www.suite101.com/welcome.cfm/depression

Wings of Madness. This site is primarily an online chat and message board community, and also has information on depression with links to other sites on depression. Last accessed: January 31, 2002. http://www.wingofmadness.com/

Module 3: Bipolar Disorder

Bipolar Significant Others. This site provides support and information for families and friends of people diagnosed with bipolar disorder, and links to other Internet resources. Last accessed: January 31, 2002. http://www.bpso.org/

Harbor of Refuge Organization, Inc. This site provides peer-to-peer support for people who are receiving treatment for bipolar disorder, and is not appropriate for those who are untreated. Last accessed: January 31, 2002. http://www.harbor-of-refuge.org/

The Ultimate Source for Information on Bipolar Disorder. This site is maintained by a person diagnosed with bipolar disorder and provides links to information on the disorder. Last accessed: January 31, 2002. http://www.courtcastle.com/bpd3m/

Winds of Change. This is a self-help site and has an online support group. Last accessed: January 31, 2002. http://www.thewindsofchange.org/

Module 4: Anxiety Disorder

Anxiety Disorders Association of America. Last accessed: January 31, 2002. Anxiety Disorders Association of America. This site provides treatment referrals, education for the general public, support for research, and an online bookstore. Last accessed: January 31, 2002. http://www.charitablechoices.org/adaa/

Anxiety Disorders Education Program. This site is maintained by the National Institute of Mental Health and contains information for the general public and mental health professionals. Information is provided in English and Spanish. Last accessed: January 31, 2002. http://www.nimh.nih.gov/anxiety/

Childhood Anxiety Network. From the site: “A professional and practical guide into the world of Childhood Anxiety and related Childhood disorders. Our Goal is to keep you up to date with the newest research and information about: OCD, Panic, Selective Mutism, Separation Anxiety, Generalized Anxiety Disorder (GAD), Social Anxiety, PTSD, Trichotillomania, Specific Phobia, and conditions that can occur with childhood anxiety - Depression, ADHD, DSI. Last accessed: January 31, 2002. http://www.childhoodanxietynetwork.org/htm/td1.htm

Module 5: Schizophrenia and Schizoaffective Disorder

The Huxley Institute for Biosocial Research. This site has information on natural treatment for schizophrenia. Last accessed: January 31, 2002. http://www.schizophrenia.org/

National Alliance for Research on Schizophrenia and Depression. This site provides information on research and online continuing education credits. Last accessed: January 31, 2002. http://www.mhsource.com/narsad/

Schizophrenia.com. This is a non-profit site that provides information, support, educational material, chat rooms, book reviews, and free email updates. Last accessed: January 31, 2002. http://www.schizophrenia.com/

World Fellowship for Schizophrenia and Allied Disorders. From the site: "Through education internationally the WFSAD strives to increase understanding and compassion and reduce the fear, stigma, discrimination and abuse that accompany these difficult conditions. The site has many full text pamphlets, a discussion group, and links to other Internet resources. Last accessed: January 31, 2002. http://www.world-schizophrenia.org/

Module 6: Substance Use: Motives and Consequences

Addiction Science Network. This site has the full text version of the book *Methods of Assessing the Reinforcing Properties of Abused Drugs*, published by Springer-Verlag and edited by M. A. Bozarth. Last accessed: January 31, 2002. http://www.addictionscience.net/

Drugstory. This site is sponsored by the Office of National Drug Control Policy, and is an informational resource for entertainment writers and journalists. The site has information on different drugs, links to other Internet resources, and a searchable database. Last accessed: January 31, 2002. http://www.drugstory.org/

Motherisk. This site provides information for pregnant women and substance use, HIV, other diseases during pregnancy, and environmental risks during pregnancy. The site is searchable and publishes a semiannual newsletter. Last accessed: January 31, 2002. http://www.motherisk.org

Module 7: Principles of Treatment and Module 8: Relapse Prevention

The Addiction Web Site of Terence T. Gorski. This site contains a full-text article by Gorski explaining his research-based treatment model, and other material relevant to substance abuse treatment. Last accessed: January 31, 2002. http://www.tgorski.com/

American Society of Addiction Medicine. From the website: "The nation's medical specialty society dedicated to educating physicians and improving the treatment of individuals suffering from alcoholism and other addictions." This site has an extensive list of links to other Internet resources in all areas of substance use and treatment. Last accessed: January 31, 2002. http://www.asam.org/Frames.htm

Focus Adolescent Services. This site is a clearinghouse of information and resources for substance-using adolescents and their families, and has full text articles, a nationwide directory of adolescent treatment facilities, and online bookstore with book reviews. Last accessed: January 31, 2002. http://www.focusas.com/

Motivational Interviewing. This site is maintained by the Mid-Atlantic Technology Transfer Center and has information for clinicians and researchers, full-text material explaining motivational interviewing, and abstracts of empirical work. Last accessed: January 31, 2002. http://www.motivationalinterview.org/

Treatment Improvement Exchange. This site is funded by SAMHSA and contains full-text TIPS and TAPS as well as links to other Internet resources for researchers and clinicians. Last accessed: January 31, 2002. http://www.treatment.org/

APPENDIX B: SUGGESTED READINGS

Dual Diagnosis, 2nd Edition

Katie Evans, J. Michael Sullivan
Guilford Publications, January 2001
Table of Contents: The Nature of the Problem; Models of Treatment; An Integrated Model of Dual Recovery; Assessing Chemical Dependency in the Dually Diagnosed Client; Assessing the Psychiatric Disorder and Planning the Appropriate Level of Care; The Psychotic and Cognitive Disorders; The Affective and Anxiety Disorders; Antisocial and Borderline Personality Disorders; Working with Adolescents; Working with Families; Enhancing the Motivation of Clients (and Counselors, Too!).

Dual Diagnosis: Essentials for Assessment and Treatment

David F. O'Connell, Ph.D.
Haworth Press, December 1997
Table of Contents: Overview; Assessment; Mood Disorders; Anxiety Disorders; Schizophrenia; Cognitive Disorders; Eating Disorders; Antisocial Personality Disorder Psychopathy); Borderline Personality Disorder; Other Personality Disorders; Sexual Abuse; Cognitive Therapy Approaches; Medications Used to Treat Dual Disorders; Selected Sample Treatment Plan Activities; Theory and practice.

Dual Diagnosis: An Integrated Approach to Treatment

Ted R. Watkins, Ara Lewellen, Marjie Barrett
Sage Publications, December 2001
Table of Contents: Introduction; Issues and Problems With Dual Diagnosis; Assessment and Differential Diagnosis of Dual Disorders; Schizophrenia and Substance-Related Disorders; Depression and Substance-Related Disorders; Bipolar Disorders; Severe Personality Disorders; Anxiety Disorders and Substance-Related Disorders;
Primary Substance Abuse Disorders; Conclusion and Treatment Grid.

Dual Diagnosis Recovery SourceBook

Dennis O. Ortman
McGraw Hill Professional, April 2001
From the Publisher: For those who suffer from a combined psychiatric illness and chemical dependency. The six out of one hundred people diagnosed with the dual disorders of addiction and mental disorder face unique challenges on the road to recovery. With comprehensive information and illustrative, inspiring case studies, the Dual Diagnosis Recovery Sourcebook explores the physical, psychological, social, and spiritual approaches to recovering from this often misunderstood and yet surprisingly common condition.

Dual Diagnosis: Substance Misuse and Psychiatric Disorders

G. Hussein Rassool
Blackwell Science, Inc., November 2001
Table of Contents: Dual Diagnosis - an Overview: Fact or Fiction?; Substance Use and Dual Diagnosis: Concepts, Theories and Models; Problems and Issues of Conceptualisation; Psychiatric Disorders and Substance Misuse: Psychopathology;

European Dimension of Dual Diagnosis; Misperceiving Complex Behaviour: A Psychological Research Model; The Challenge of Shared Care; A Synthesis of Addiction & Mental Health Nursing: An Approach to Community Interventions; Enhancing the Social Service Response; Treatment Strategies and Interventions; Nursing Interventions in the Care of Dually Diagnosed Clients; Brief Strategic Therapy - Working with the Patient's Motivation for Change; Assessing Health and Social Needs and Develop Appropriate Services; A Public Health Perspective; Development of a Community Based Model of Service Provision for Dual Diagnosis Patients; A Model of Treatment for Dual Diagnosis (The Greenbank Model); Dual or Separate Services?; Professional Education in Addiction and Mental Health Issues: A Case for Less Diagnosis and More Action?

The Dually Diagnosed: A Therapist's Guide to Helping the Substance Abusing, Psychologically Disturbed Patient

Dennis C. Ortman

Jason Aronson Publishers, March 1997

Table of Contents: Introduction; The Outpatient Setting; The Relationship of the Disorders; Modifying Therapeutic Techniques; Shifting the Therapeutic Focus; Assessing the Disorders; Addressing Denial; Making Referrals; Prescribing Medications; Encouraging Participation in Twelve Step Programs; Requiring Abstinence; Responding to Relapses; Involving the Family; Initiating Termination; Measuring Success; The Inpatient Setting.

The Living Skills Recovery Workbook

Pat Precin

Butterworth-Heinemann, February 1999

From the Publisher: This workbook provides clinicians with the tools necessary to help patients with dual diagnoses acquire basic living skills. Focusing on stress management, time management, activities of daily living, and social skills training, each living skill is taught in relation to how it aids in recovery and relapse prevention for each patient's individual lifestyle and pattern of addiction. This form of treatment allows mentally ill chemically addicted patients to learn and use the skills necessary to remain drug free. It also instructs recovering addicts on how to manage their psychiatric symptoms to promote the highest level of integration into their community. Easy-to-use exercises and instructions provide time-limited, cost-effective treatment that can be used in a variety of settings by patients, occupational therapists, psychologists, and managed care companies. The workbook includes 70 forms that can be filled out by patients to help them learn about themselves and the ways they can manage their problems. In addition, this book can also be used by students in the classroom to help bridge theory and practice.

Today I Will Do One Thing: Daily Readings for Awareness and Hope for Those of Us with Addiction and Emotional Illness

James Jennings

Hazelden Information & Educational Services, September 1995

From the Publisher: A groundbreaking meditation book, this unique volume integrates addiction recovery with the recovery from an emotional or psychiatric illness, develops self-awareness, and nurtures self-acceptance with small, practical steps.