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8 A Brief Overview of Specific Mental Disorders and Cross-Cutting Issues

This chapter provides a brief overview for working with substance abuse treatment clients who also have specific mental disorders. It is presented in concise form so that the counselor can refer to this one chapter to obtain basic information. Appendix D contains more in-depth information on suicidality, nicotine dependence, and each of the disorders addressed in this chapter. The material included is not a complete review of all disorders in the *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition (DSM-IV), but updates the material from TIP 9 (Center for Substance Abuse Treatment 1994*a*) (i.e., personality disorders, mood disorders, anxiety disorders, and psychotic disorders), adding other mental disorders with special relevance to co-occurring disorders (COD) not covered in TIP 9 (i.e., attention deficit/hyperactivity disorder, posttraumatic stress disorder, eating disorders, and pathological gambling). The consensus panel acknowledges that people with COD may have multiple combinations of the various mental disorders presented in this chapter (e.g., a person with a substance use disorder, schizophrenia, and a pathological gambling problem). However, for purposes of clarity and brevity the panel chose to focus the discussion on the main disorders and not explore the multitude of possible combinations.

The chapter begins with a brief description of cross-cutting issues—suicidality and nicotine dependency. While suicidality is not a DSM-IV diagnosed mental disorder per se, it is a high-risk behavior associated with COD. Nicotine dependency is recognized as a disorder in DSM-IV, and as such a client with nicotine dependency and a mental disorder could be considered to have a co-occurring disorder. Though this is the case, an important difference between tobacco addiction and other addictions is that tobacco's chief effects are medical rather than behavioral, and, as such, it is not conceptualized and presented as a typical co-occurring addiction disorder. However, because of the high proportion of the COD population addicted to nicotine, as well as the devastating health consequences of tobacco use, nicotine dependency is treated as an important cross-cutting issue for people with substance use disorders and mental illness.

The discussions of suicidality and nicotine dependency highlight key information counselors should know about that disorder in combination with substance abuse. This section offers factual information (e.g., prevalence data), commonly agreed-upon clinical practices, and other general information that may be best characterized as “working formulations.”

A brief description of selected disorders and their diagnostic criteria follows. This material has been extracted from DSM-IV-TR (Text Revision, American Psychiatric Association [APA] 2000) and highlights the descriptive features, diagnostic features, and symptom clusters of each mental disorder. The consensus panel elected to take this material directly from DSM-IV-TR to provide easy access to the material that is not typically available in the substance abuse treatment field. Use of a specialized dictionary that includes terminology related to mental disorders may be needed to understand terms in the quoted material from DSM-IV-TR, though the main features of each disorder should still be clear.

Because of the greater availability of case histories from the mental health literature, the illustrative material in the next section has a greater emphasis on the mental disorder. Wherever possible case histories were selected to illustrate the interaction of the mental and substance use disorders. Finally, each section contains an *Advice to the Counselor* box.

The consensus panel recognizes that no one chapter can replace the comprehensive training necessary for diagnosing and treating clients with specific mental disorders co-occurring with substance use disorders and that the Advice to the Counselor understates the complexity involved in treating clients with these disorders. The Advice to the Counselor boxes are designed to distill for the counselor the main actions and approaches that they can take in working with substance abuse treatment clients who have the specific mental disorder being discussed (see the table of contents for a full listing of these boxes throughout the TIP).

The consensus panel also recognizes the chapter cannot possibly cover each mental disorder exhaustively and that addiction counselors are not expected to diagnose mental disorders. The limited goals of the panel in providing this material are to increase substance abuse treatment counselors' familiarity with mental disorders terminology and criteria, as well as to provide advice on how to proceed with clients who demonstrate these disorders. It is also the purpose of this chapter and appendix D to stimulate further work in this area and to make this research accessible to the addiction field.

Overview

Cross-Cutting Issues

Suicidality

Suicidality is not a mental disorder in and of itself, but rather a high-risk behavior associated with COD, especially (though not limited to) serious mood disorders. Research shows that most people who kill themselves have a diagnosable mental or substance use disorder or both, and that the majority of them have depressive illness. Studies indicate that the most promising way to prevent suicide and suicidal behavior is through the early recognition and treatment of substance abuse and mental illnesses. This is especially true of clients who have serious depression (U.S. Public Health Service 1999). Substance-induced or exacerbated suicidal ideations, intentions, and behaviors are an ever-present possible complication of substance use disorders, especially for clients with co-occurring mental disorders.

The topic of suicidality is critical for substance abuse treatment counselors working with clients with COD. Substance use disorders alone increase suicidality, while the added presence of some mental disorders doubles an already heightened risk. Counselors should be aware that the risk of suicide is greatest when relapse occurs after a substantial period of abstinence—especially if there is concurrent financial or psychosocial loss. Every agency that offers counseling for substance abuse also must have a clear protocol in place that addresses the recognition and treatment (or referral) of persons who may be suicidal.

What counselors should know about suicide and substance abuse

Counselors should be aware of the following facts about the association between suicide and substance abuse:

- Abuse of alcohol or drugs is a major risk factor in suicide, both for people with COD and for the general population.
- Alcohol abuse is associated with 25 to 50 percent of suicides. Between 5 and 27 percent of all deaths of people who abuse alcohol are caused by suicide, with the lifetime risk for suicide among people who abuse alcohol estimated to be 15 percent.
- There is a particularly strong relationship between substance abuse and suicide among young people.
- Comorbidity of alcoholism and depression increases suicide risk.
- The association between alcohol use and suicide also may relate to the capacity of alcohol to remove inhibitions, leading to poor judgment, mood instability, and impulsiveness.
- Substance intoxication is associated with increased violence, both toward others and self.

Advice to the Counselor: Counseling a Client Who Is Suicidal

• Screen for suicidal thoughts or plans with anyone who makes suicidal references, appears seriously depressed, or who has a history of suicide attempts. Treat all suicide threats with seriousness.

• Assess the client's risk of self-harm by asking about what is wrong, why now, whether specific plans have been made to commit suicide, past attempts, current feelings, and protective factors. (See the discussion of suicidality in appendix D for a model risk assessment protocol.)

• Develop a safety and risk management process with the client that involves a commitment on the client's part to follow advice, remove the means to commit suicide (e.g., a gun), and agree to seek help and treatment. Avoid sole reliance on “no suicide contracts.”

- Assess the client's risk of harm to others.
- Provide availability of contact 24 hours per day until psychiatric referral can be realized. Refer those clients with a serious plan, previous attempt, or serious mental illness for psychiatric intervention or obtain the assistance of a psychiatric consultant for the management of these clients.
- Monitor and develop strategies to ensure medication adherence.
- Develop long-term recovery plans to treat substance abuse.
- Review all such situations with the supervisor and/or treatment team members.
- Document thoroughly all client reports and counselor suggestions.

Case study: counseling a substance abuse treatment client who is suicidal

Beth M., an American-Indian woman, comes to the substance abuse treatment center complaining that drinking too much causes problems for her. She has tried to stop drinking before but always relapses. The counselor finds that she is not sleeping, has been eating poorly, and has been calling in sick to work. She spends much of the day crying and thinking of how alcohol, which has cost her her latest significant relationship, has ruined her life. She also has been taking painkillers for a recurring back problem, which has added to her problems. The counselor tells her about a group therapy opportunity at the center that seems right for her, tells her how to register, and makes arrangements for some individual counseling to set her on the right path. The counselor tells her she has done the right thing by coming in for help and gives her encouragement about her ability to stop drinking.

Beth M. does not arrive for her next appointment, and when the counselor calls home, he learns from her roommate that Beth made an attempt on her life after leaving the substance abuse treatment center. She took an overdose of opioids (painkillers) and is recovering in the hospital. The emergency room staff found that Beth M. was under the influence of alcohol when she took the opioids.

Discussion: Although Beth M. provided information that showed she was depressed, the counselor did not explore the possibility of suicidal thinking. Counselors always should ask if the client has been thinking of suicide, whether or not the client mentions depression. An American-Indian client, in particular, may not answer a very direct question, or may hint at something darker without mentioning it directly. Interpreting the client's response requires sensitivity on the part of the counselor. It is important to realize that such questions do not increase the likelihood of suicide. Clients who, in fact, are contemplating suicide are more likely to feel relieved that the subject has now been brought into the light and can be addressed with help from someone who cares.

It is important to note that the client reports taking alcohol and pain medications. Alcohol impairs judgment and, like pain medications, depresses brain and body functions. The combination of substances increases the risk of suicide or accidental overdose. Readers are encouraged to think through this case and apply the assessment strategy included in the discussion of suicidality in appendix D, imagining what kind of answers the counselor might have received. Then, readers could consider interventions and referrals that would have been possible in their treatment settings.

Nicotine Dependence

In 2003 an estimated 29.8 percent of the general population aged 12 or older report current (past month) use of a tobacco product (National Survey on Drug Use and Health 2003*c*). The latest report of the Surgeon General on the Health Consequences of Smoking (U.S. Public Health Service Office of the Surgeon General 2004) provides a startling picture of the damage caused by tobacco. Tobacco smoking injures almost every

organ in the body, causes many diseases, reduces health in general, and leads to reduced life span and death. Tobacco dependence also has serious consequences to nonsmokers through environmental tobacco smoke (secondhand smoke) and the negative effects on unborn children. Fortunately quitting smoking has immediate as well as long-term benefits (U.S. Public Health Service Office of the Surgeon General 2004).

Evidence suggests that people with mental disorders and/or dependency on other drugs are more likely to have a tobacco addiction. In fact, most people with a mental illness or another addiction are tobacco dependent—about 50 to 95 percent, depending on the subgroup (Anthony and Echeagaray-Wagner 2000; Centers for Disease Control and Prevention 2001; National Institute on Drug Abuse 1999*a*; Richter 2001; Stark and Campbell 1993*b*). Smokers with mental disorders consume nearly half of all the cigarettes sold in the United States (Lasser et al. 2000). A study of individuals doing well in recovery from alcohol dependence found that those who smoked lived 12 fewer years because of their tobacco dependence and the quality of their lives was affected by other tobacco-caused medical illnesses (Hurt et al. 1996).

There is increasing recognition of the importance of integrating tobacco dependence treatment and management into mental health services and addiction treatment settings. Although tobacco dependence treatment works for smokers with mental illness and other addictions, only recently have clinicians been given training to address this serious public health and addiction treatment concern. It is increasingly recognized that all clients deserve access to effective treatments for tobacco addiction, and that smokers and their families should be educated about the considerable risks of smoking as well as the benefits of tobacco dependence treatment. All current tobacco dependence clinical practice guidelines strongly recommend addressing tobacco during any clinical contact with smokers and suggest the use of one or more of the six Food and Drug Administration (FDA)-approved medications as first-line treatments (e.g., bupropion SR/zyban and the nicotine patch, gum, nasal spray, inhaler, and lozenge).

Tobacco use and dependence should be assessed and documented in all clinical baseline assessments, treatment plans, and treatment efforts. A motivation-based treatment model allows for a wider range of treatment goals and interventions that match the patient's motivation to change. Like other addictions, tobacco dependence is a chronic disease that may require multiple treatment attempts for many individuals and there is a range of effective clinical interventions, including medications, patient/family education, and stage-based psychosocial treatments. Recent evidence-based treatment guidelines have been published for the management of tobacco dependence and this information can be a primary guide for addressing tobacco. Few recognize how ignoring tobacco perpetuates the stigma associated with mental illness and addiction when some ask, “Why should tobacco be addressed in mental health or addiction settings?” or “Other than increased morbidity and mortality, why should we encourage and help this group to quit?” or “What else are they going to do if they cannot smoke?”

What counselors should know about nicotine dependence

- Tobacco dependence is common in clients with other substance use disorders and mental illnesses.
- Like patients in primary care settings, clients in mental health services and addiction treatment settings should be screened for tobacco use and encouraged to quit.
- The U.S. Public Health Service Guidelines encourage the use of the “5 A's” (Ask, Advise, Assess, Assist, Arrange Followup) as an easy road map to guide clinicians to help their patients who smoke:
    - **A**sk about tobacco use and document in chart.
    - **A**dvise to quit in a clear, strong, and personal message.

- **A**ssess willingness to make a quit attempt and consider motivational interventions for the lower motivated and assist those ready to quit.

- **A**ssist in a quit attempt by providing practical counseling, setting a quit date, helping them to anticipate the challenges they will face, recommending the use of tobacco dependence treatment medications, and discussing options for psychosocial treatment, including individual, group, telephone, and Internet counseling options.

- **A**rrange followup to enhance motivation, support success, manage relapses, and assess medication use and the need for more intensive treatment if necessary.

- Assessment of tobacco use includes assessing the amount and type of tobacco products used (cigarettes, cigars, chew, snuff, etc.), current motivation to quit, prior quit attempts (what treatment, how long abstinent, and why relapsed), withdrawal symptoms, common triggers, social supports and barriers, and preference for treatment.

- Behavioral health professionals already have many of the skills necessary to provide tobacco dependence psychosocial interventions.

- Smokers with mental illness and/or another addiction can quit with basic tobacco dependence treatment, but may also require motivational interventions and treatment approaches that integrate medications and psychosocial treatments.

- Tobacco treatment is cost-effective, feasible, and draws on principles of addictions and co-occurring disorders treatment.

- The current U.S. Clinical Practice Guidelines indicate that all patients trying to quit smoking should use first-line pharmacotherapy, except in cases where there may be contraindications (Fiore 2000).

- Currently there are six FDA-approved treatments for tobacco dependence treatment: bupropion SR and five Nicotine Replacement Treatments (NRTs): nicotine polacrilex (gum), nicotine transdermal patch, nicotine inhaler, nicotine nasal spray, and nicotine lozenge.

- Tobacco treatment medications are effective even in the absence of psychosocial treatments, but adding psychosocial treatments to medications enhances outcomes by at least 50 percent.

- Specific coping skills should be addressed to help smokers with mental or substance use disorders to cope with cravings associated with smoking cues in treatment settings where smoking is likely to be ubiquitous.

- When clients with serious mental illnesses attempt to quit smoking, watch for changes in mental status, medication side effects, and the need to lower some psychiatric medication dosages due to tobacco smoke interaction.

Program-level changes

As with other COD, the most effective strategies to address tobacco include both enhancing clinician skills and making program and system changes. Effective steps for addressing tobacco at the treatment program level are listed in an outline in the text box below. These steps have been developed at the University of Medicine and Dentistry of New Jersey Tobacco Program and used effectively to address tobacco in hundreds of mental health and addiction treatment settings (Ziedonis and Williams 2003*a*). The necessary steps

include developing comprehensive tobacco dependence assessments; providing treatment, patient education, and continuing care planning; making self-help groups such as Nicotine Anonymous available to clients and their families; providing nicotine dependence treatment to interested staff; and making policy changes related to tobacco. Such changes should include documentation forms in clinical charts that contain more tobacco related questions, labeling smoker's charts, not referring to breaks in the program's schedule as "smoking breaks," forbidding staff and patients to smoke together, providing patient education brochures, and providing NRT for all clients in smoke-free residential treatment settings (Ziedonis and Williams 2003*a*).

Steps for Addressing Tobacco Within Treatment Programs

1. Acknowledge the challenge.
2. Establish a leadership group and commit to change.
3. Create a change plan and implementation timeline.
4. Start with easy system changes.
5. Assess and document in charts nicotine use, dependence, and prior treatments.
6. Incorporate tobacco issues into client education curriculum.
7. Provide medications for nicotine dependence treatment and required abstinence.
8. Conduct staff training.
9. Provide treatment and recovery assistance for interested nicotine-dependent staff.
10. Integrate motivation-based treatments throughout the system.
11. Develop addressing tobacco policies that are site specific.
12. Establish ongoing communication with 12-Step recovery groups, professional colleagues, and referral sources about system changes.

Source: Ziedonis et al. 2003.

Case study: addressing tobacco in an individual with panic disorder and alcohol dependence

Tammy T. is a 47-year-old widow who has been treated in a substance abuse outpatient program for co-occurring alcohol dependence and panic disorder. She is about 9 months abstinent from alcohol and states that she is now ready to address her tobacco addiction. When she first entered treatment she was not ready to quit tobacco. Her substance abuse counselor recognized her ambivalence and implemented some motivational interventions and followup on this topic over the course of the 9 months of her initial recovery. This persistence was perceived as expressing empathy and concern, and Tammy T. eventually recognized the need to quit smoking as part of a long-term recovery plan. She was now ready to set a quit date.

Tammy T. started smoking at age 17. Her only period of abstinence was during her pregnancy. She quickly resumed smoking after giving birth. She cut back from 30 cigarettes per day (1.5 packs) to 20 cigarettes per day (1 pack) in the last year but has been unable to quit completely. She lives with her brother, who also smokes. Her panic disorder is well controlled by sertraline (Zoloft), and she sees a counselor monthly and a psychiatrist four times a year for medication management. She works full time in a medical office as an office manager and must leave the building to smoke during work hours. Tammy T. drank alcohol heavily for many years, consuming up to 10 beers 3 to 5 times per week until about 1 year ago. At the advice of her physician, who initiated treatment for panic attacks, she was able to quit using alcohol completely. She was encouraged by her success in stopping drinking, but has been discouraged about continuing to smoke.

In creating a quit plan for Tammy T., it was important for the counselor to determine what supports she has

available to help her to quit. Encouraging her brother to quit at the same time was seen as a useful strategy, as it would help to remove smoking from the home environment. Tammy T. was willing to attend a 10-week group treatment intervention to get additional support, education, and assistance with quitting. Some clients may desire individual treatment that is integrated into their ongoing mental health or addiction treatment, or the use of a telephone counseling service might be explored since it is convenient and is becoming more widely available. In discussing medication options, Tammy T. indicated that she was willing to use the nicotine inhaler. Medication education enhanced compliance with the product and increased its effectiveness. She was encouraged to set a quit date and to use nicotine replacement starting at the quit date and in an adequate dose.

Tammy T. was taking sertraline for her panic disorder (a selective serotonin reuptake inhibitor [SSRI]) and therefore another medication option might be to add bupropion SR (not an SSRI) to her current medications for a period of 12 weeks, specifically to address smoking if another quit attempt is needed in the future. If she had not been successful in this attempt, it would have been important to motivate her for future quit attempts and consider increasing the dose and/or duration of the medication or psychosocial treatment. In this case the group treatment, 6 months of NRT inhaler, and eliciting her brother's agreement to refrain from smoking in the house resulted in a successful quit attempt, as well as continued success in her recovery from co-occurring panic disorder and alcohol dependence.

Personality Disorders

These are the disorders seen most commonly by addiction counselors and in quadrant II substance abuse treatment settings.

Personality disorders (PDs) are rigid, inflexible, and maladaptive behavior patterns of sufficient severity to cause internal distress or significant impairment in functioning. PDs are enduring and persistent styles of behavior and thought, rather than rare or unusual events in someone's life. Furthermore, rather than showing these thoughts and behaviors in response to a particular set of circumstances or particular stressors, people with PDs carry with them these destructive patterns of thinking, feeling, and behaving as their way of being and interacting with the world and others.

Those who have PDs tend to have difficulty forming a genuinely positive therapeutic alliance. They tend to frame reality in terms of their own needs and perceptions and not to understand the perspectives of others. Also, most clients with PDs tend to be limited in terms of their ability to receive, accept, or benefit from corrective feedback.

A further difficulty is the strong countertransference clinicians can have in working with these clients, who are adept at “pulling others' chains” in a variety of ways. Specific concerns will, however, vary according to the specific PD and other individual circumstances.

Diagnostic Features of Personality Disorders

The essential feature of a personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture and is manifested in at least two of the following areas: cognition, affectivity, interpersonal functioning, or impulse control (Criterion A). This enduring pattern is inflexible and pervasive across a broad range of personal and social situations (Criterion B) and leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood (Criterion D). The pattern is not better accounted for as a manifestation or consequence of another mental disorder (Criterion E) and is not due to the

direct physiological effects of a substance (e.g., a drug of abuse, a medication, exposure to a toxin) or a general medical condition (e.g., head trauma) (Criterion F).

General diagnostic criteria for a personality disorder

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:

(1) Cognition (i.e., ways of perceiving and interpreting self, other people, and events)

(2) Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response)

(3) Interpersonal functioning

(4) Impulse control

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.

F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 686, 689).

Borderline Personality Disorder

What counselors should know about substance abuse and borderline personality disorders

The essential feature of borderline personality disorder (BPD) is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, along with marked impulsivity, that begins by early adulthood and is present in a variety of contexts. Counselors should be aware that

- People with BPD may use drugs in a variety of ways and settings.
- At the beginning of a crisis episode, a client with this disorder might take a drink or a different drug in an attempt to quell the growing sense of tension or loss of control.
- People with BPD may well use the same drugs of choice, route of administration, and frequency as the individuals with whom they are interacting.
- People with BPD often use substances in idiosyncratic and unpredictable patterns.
- Polydrug use is common, which may involve alcohol and other sedative-hypnotics taken for self-medication.
- Individuals with BPD often are skilled in seeking multiple sources of medication that they favor, such as benzodiazepines. Once they are prescribed this medication in a mental health system, they may demand to be continued on the medication to avoid dangerous withdrawal.

Diagnostic Features of Borderline Personality Disorder

The essential feature of borderline personality disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, along with marked impulsivity that begins by early adulthood and is present in a variety of contexts. Individuals with borderline personality disorder make frantic efforts to avoid real or imagined abandonment (Criterion 1). Individuals with borderline personality disorder have a pattern of unstable and intense relationships (Criterion 2). There may be an identity disturbance characterized by markedly and persistently unstable self-image or sense of self (Criterion 3). Individuals with this disorder display impulsivity in at least two areas that are potentially self-damaging (Criterion 4). Individuals with borderline personality disorder display recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior (Criterion 5). Individuals with borderline personality disorder may display affective instability that is due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days) (Criterion 6). Individuals with borderline personality disorder may be troubled by chronic feelings of emptiness (Criterion 7). Individuals with borderline personality disorder frequently express inappropriate, intense anger or have difficulty controlling their anger (Criterion 8). During periods of extreme stress, transient paranoid ideation or dissociative symptoms (e.g., depersonalization) may occur (Criterion 9), but these are generally of insufficient severity or duration to warrant an additional diagnosis.

Diagnostic criteria for borderline personality disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

(2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

(3) Identity disturbance: markedly and persistently unstable self-image or sense of self.

(4) Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

(5) Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.

(6) Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

(7) Chronic feelings of emptiness.

(8) Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).

(9) Transient, stress-related paranoid ideation or severe dissociative symptoms.

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 706–708, 710).

Advice to the Counselor: Counseling a Client With Borderline Personality Disorder

- Anticipate that client progress will be slow and uneven.
- Assess the risk of self-harm by asking about what is wrong, why now, whether the client has specific plans for suicide, past attempts, current feelings, and protective factors. (See the

discussion of suicidality in appendix D for a risk assessment protocol.)

- Maintain a positive but neutral professional relationship, avoid overinvolvement in the client's perceptions, and monitor the counseling process frequently with supervisors and colleagues.
- Set clear boundaries and expectations regarding limits and requirements in roles and behavior.
- Assist the client in developing skills (e.g., deep breathing, meditation, cognitive restructuring) to manage negative memories and emotions.

Case Study: Counseling a Substance Abuse Treatment Client With Borderline Personality Disorder

Ming L., an Asian female, was 32 years old when she was taken by ambulance to the local hospital's emergency room. Ming L. had taken 80 Tylenol capsules and an unknown amount of Ativan in a suicide attempt. Once medically stable, Ming L. was evaluated by the hospital's social worker to determine her clinical needs.

The social worker asked Ming L. about her family of origin. Ming L. gave a cold stare and said, “I don't talk about that.” Asked if she had ever been sexually abused, Ming L. replied, “I don't remember.” Ming L. acknowledged previous suicide attempts as well as a history of cutting her arm with a razor blade during stressful episodes. She reported that the cutting “helps the pain.”

Ming L. denied having “a problem” with substances but admitted taking “medication” and “drinking socially.” A review of Ming L.'s medications revealed the use of Ativan “when I need it.” It soon became clear that Ming L. was using a variety of benzodiazepines (anti-anxiety medications) prescribed by several doctors and probably was taking a daily dose indicative of serious dependence. She reported using alcohol “on weekends with friends” but was vague about the amount. Ming L. did acknowledge that before her suicide attempts, she drank alone in her apartment. This last suicide attempt was a response to a breakup with her boyfriend. Ming L.'s insurance company is pushing for immediate discharge and has referred her to the substance abuse treatment counselor to “address the addictions problem.”

The counselor reads through notes from an evaluating psychiatrist and reviews the social worker's report of his interview with Ming. She notes that the psychiatrist describes the client as having a severe borderline personality disorder, major recurrent depression, and dependence on both benzodiazepines and alcohol. The counselor advises the insurance company that unless the client's co-occurring disorders also are addressed, there is little that substance abuse treatment counseling will be able to accomplish.

Discussion: While it is important not to refuse treatment for clients with co-occurring disorders, it is also important to know the limits of what a substance abuse treatment counselor or agency can and cannot do realistically. A client with problems this serious is *unlikely* to do well in standard substance abuse treatment unless she also is enrolled in a program qualified to provide treatment to clients with borderline personality disorders, and preferably in a program that offers treatment designed specially for this disorder such as Dialectical Behavior Therapy (Linehan et al. 1999) (although substance abuse treatment programs are increasingly developing their capacities to address specialized mental disorders). She is likely to need complicated detoxification either on an inpatient basis or in a long-term outpatient program that knows how to enclose the kinds of behavioral chaos that borderline clients often experience.

Antisocial Personality Disorder

The two essential features of antisocial personality disorder (APD) are: (1) a pervasive disregard for and violation of the rights of others, and (2) an inability to form meaningful interpersonal relationships.

What counselors should know about substance abuse and APD

The prevalence of antisocial personality disorder and substance abuse is high:

- Much of substance abuse treatment is particularly targeted to those with APD, and substance abuse treatment alone has been particularly effective for these disorders.
- The majority of people with substance use disorders are not sociopathic except as a result of their addiction.
- Most people diagnosed as having APD are not true psychopaths—that is, predators who use manipulation, intimidation, and violence to control others and to satisfy their own needs.
- Many people with APD use substances in a polydrug pattern involving alcohol, marijuana, heroin, cocaine, and methamphetamine.
- People with APD may be excited by the illegal drug culture and may have considerable pride in their ability to thrive in the face of the dangers of that culture. They often are in trouble with the law. Those who are more effective may limit themselves to exploitative or manipulative behaviors that do not make them as vulnerable to criminal sanctions.

Diagnostic Features of Antisocial Personality Disorder

The essential feature of antisocial personality disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. This pattern also has been referred to as psychopathy, sociopathy, or dyssocial personality disorder. Because deceit and manipulation are central features of antisocial personality disorder, it may be especially helpful to integrate information acquired from systematic clinical assessment with information collected from collateral sources. For this diagnosis to be given, the individual must be at least age 18 (Criterion B) and must have had a history of some symptoms of conduct disorder before age 15 (Criterion C).

Diagnostic criteria for antisocial personality disorder

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15, as indicated by three (or more) of the following:

(1) Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest

(2) Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure

(3) Impulsivity or failure to plan ahead

(4) Irritability and aggressiveness, as indicated by repeated physical fights or assaults

(5) Reckless disregard for safety of self or others

(6) Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations

(7) Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

B. The individual is at least age 18.

C. There is evidence of Conduct Disorder (see APA 2000, p. 98) with onset before age 15.

D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 701, 702, 706).

Case study: counseling a substance abuse treatment client with antisocial personality disorder

Mark R., a Hispanic/Latino male, was 27 years old when he was arrested for driving while intoxicated. Mark R. presented himself to the court counselor for evaluation of the possible need for substance abuse treatment. Mark R. was on time for the appointment and was slightly irritated at having to wait 20 minutes due to the counselor's schedule. Mark R. was wearing a suit (which had seen better days) and was trying to present himself in a positive light.

Mark R. denied any "problems with alcohol" and reported having "smoked some pot as a kid." He denied any history of suicidal thinking or behavior except for a short period following his arrest. He acknowledged that he did have a "bit of a temper" and that he took pride in the ability to "kick ass and take names" when the situation required. Mark R. denied any childhood trauma and described his mother as a "saint." He described his father as "a real jerk" and refused to give any other information.

In describing the situation that preceded his arrest, Mark R. tended to see himself as the victim, using statements such as "The bartender should not have let me drink so much," "I wasn't driving that bad," and "The cop had it in for me." Mark R. tended to minimize his own responsibility throughout the interview. Mark R. had been married once but only briefly. His only comment about the marriage was, "She talked me into it but I got even with her." Mark R. has no children and lives alone in a studio apartment. Mark R. has attended two meetings of Alcoholics Anonymous (AA) "a couple of years ago before I learned how to control my drinking."

The counselor coordinates closely with the parole officer and arranges several three-way meetings. He carefully reviews details of the court contract and conditions of parole and keeps court records up to date. His work with Mark R. centers on clarifying expectations.

Discussion. It is likely that Mark R. has antisocial personality disorder. Clients with this disorder usually are very hard to engage in individual treatment and are best managed through strict limits with clear consequences. With such an individual, it is important to maximize the interaction with the court, parole officers, or other legal limit setters. This enforces the limits of treatment, and prevents the client from criticizing and blaming one agency representative to the other. People with this disorder are best managed in group treatment that addresses both their substance abuse and antisocial personality disorder. In such groups the approach is to hold the clients responsible for their behavior and its consequences and to confront dishonest and antisocial behavior directly and firmly and stress immediate learning experiences that teach corrective responses.

It is important to differentiate true antisocial personality from substance-related antisocial behavior. This can best be done by looking at how the person relates to others throughout the course of his or her life. Persons with this disorder will have evidence of antisocial behavior preceding substance use and even during periods of enforced abstinence. It also is important to recognize that people with substance-related antisocial behavior may be more likely to have major depression than other typical personality disorders. However, the type and character of depressions that may be experienced by those with true APD have been less well characterized, and their treatment is unclear.

Mood Disorders and Anxiety Disorders

Because of the striking similarities in understanding and serving clients with mood and anxiety disorders, the sections have been combined to address both disorders. (It should be noted, however, that two disorder types

are separated in DSM-IV-TR [APA 2000].)

What Counselors Should Know About Mood and Anxiety Disorders and Substance Abuse

Counselors should be aware of the following:

- Approximately one quarter of United States residents are likely to have some anxiety disorder during their lifetime, and the prevalence is higher among women than men.
- About one half of individuals with a substance use disorder have an affective or anxiety disorder at some time in their lives.
- Among women with a substance use disorder, mood disorders may be prevalent. Women are more likely than men to be clinically depressed and/or to have posttraumatic stress disorder.
- Certain populations are at risk for anxiety and mood disorders (e.g., clients with HIV, clients maintained on methadone, and older adults).
- Older adults may be the group at highest risk for combined mood disorder and substance problems. Episodes of mood disturbance generally increase in frequency with age. Older adults with concurrent mood and substance use disorders tend to have more mood episodes as they get older, even when their substance use is controlled.
- Both substance use and discontinuance may be associated with depressive symptoms.
- Acute manic symptoms may be induced or mimicked by intoxication with stimulants, steroids, hallucinogens, or polydrug combinations.
- Withdrawal from depressants, opioids, and stimulants invariably includes potent anxiety symptoms. During the first months of sobriety, many people with substance use disorders may exhibit symptoms of depression that fade over time and that are related to acute withdrawal.
- Medical problems and medications can produce symptoms of anxiety and mood disorders. About a quarter of individuals who have chronic or serious general medical conditions, such as diabetes or stroke, develop major depressive disorder.
- People with co-occurring mood or anxiety disorders and a substance use disorder typically use a variety of drugs.
- Though there may be some preference for those with depression to favor stimulation and those with anxieties to favor sedation, there appears to be considerable overlap. The use of alcohol, perhaps because of its availability and legality, is ubiquitous.
- It is now believed that substance use is more often a cause of anxiety symptoms rather than an effort to cure these symptoms.
- Since mood and anxiety symptoms may result from substance use disorders, not an underlying mental disorder, careful and continuous assessment is essential.

Diagnostic Features of Mood Disorders

The mood disorders are divided into the depressive disorders ("unipolar depression"), the bipolar disorders, and two disorders based on etiology—mood disorder due to a general medical condition and substance-induced mood disorder. The depressive disorders (i.e., major depressive disorder, dysthymic disorder, and depressive disorder not otherwise specified) are distinguished from the bipolar disorders by the fact that there is no history of ever having had a manic, mixed, or hypomanic episode. The bipolar disorders (i.e., bipolar I disorder, bipolar II disorder, cyclothymic disorder, and bipolar disorder not otherwise specified) involve the presence (or history) of manic episodes, mixed episodes, or hypomanic episodes, usually accompanied by the presence (or history) of major depressive episodes.

The section below describes mood episodes (major depressive episode, manic episode) which are not diagnosed as separate entities, but serve as the building block for the mood disorder diagnoses.

Major Depressive Episode

Episode features

The essential feature of a Major Depressive Episode is a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities. In children and adolescents, the mood may be irritable rather than sad. The individual also must experience at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. To count toward a Major Depressive Episode, a symptom must either be newly present or must have clearly worsened compared with the person's pre-episode status. The symptoms must persist for most of the day, nearly every day, for at least 2 consecutive weeks. The episode must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning. For some individuals with milder episodes, functioning may appear to be normal but requires markedly increased effort.

Criteria for major depressive episode

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.

(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

(3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

(4) Insomnia or hypersomnia nearly every day.

(5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

(6) Fatigue or loss of energy nearly every day.

(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a Mixed Episode (see APA 2000, p. 365).

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

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one; the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Manic Episode

Episode features

A Manic Episode is defined by a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood. This period of abnormal mood must last at least 1 week (or less if hospitalization is required) (Criterion A). The mood disturbance must be accompanied by at least three additional symptoms from a list that includes inflated self-esteem or grandiosity, decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor agitation, and excessive involvement in pleasurable activities with a high potential for painful consequences. If the mood is irritable (rather than elevated or expansive), at least four of the above symptoms must be present (Criterion B). The symptoms do not meet criteria for a Mixed Episode, which is characterized by the symptoms of both a Manic Episode and a Major Depressive Episode occurring nearly every day for at least a 1-week period (Criterion C). The disturbance must be sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalization, or it is characterized by the presence of psychotic features (Criterion D). The episode must not be due to the direct physiological effects of a drug of abuse, a medication, other somatic treatments for depression (e.g., electroconvulsive therapy or light therapy), or toxin exposure. The episode also must not be due to the direct physiological effects of a general medical condition (e.g., multiple sclerosis, brain tumor) (Criterion E).

Criteria for manic episodes

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

(1) Inflated self-esteem or grandiosity

(2) Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)

(3) More talkative than usual or pressure to keep talking

(4) Flight of ideas or subjective experience that thoughts are racing

(5) Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

(6) Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

(7) Excessive involvement in pleasurable activities that have a high potential for painful

consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The symptoms do not meet criteria for a Mixed Episode (see APA 2000, p. 365).

D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 349, 356, 357, 362).

Diagnostic Features of Generalized Anxiety Disorder

The essential feature of generalized anxiety disorder is excessive anxiety and worry (apprehensive expectation), occurring more days than not for a period of at least 6 months, about a number of events or activities (Criterion A). The individual finds it difficult to control the worry (Criterion B). The anxiety and worry are accompanied by at least three additional symptoms from a list that includes restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension, and disturbed sleep (only one additional symptom is required in children) (Criterion C). The focus of the anxiety and worry is not confined to features of another Axis I disorder such as having a panic attack (as in panic disorder), being embarrassed in public (as in social phobia), being contaminated (as in obsessive-compulsive disorder), being away from home or close relatives (as in separation anxiety disorder), losing weight (as in anorexia nervosa), having multiple physical complaints (as in somatization disorder), or having a serious illness (as in hypochondriasis), and the anxiety and worry do not occur exclusively during posttraumatic stress disorder (Criterion D). Although individuals with generalized anxiety disorder may not always identify the worries as "excessive," they report subjective distress due to constant worry, have difficulty controlling the worry, or experience related impairment in social, occupational, or other important areas of functioning (Criterion E). The disturbance is not due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or toxin exposure) or a general medical condition and does not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder (Criterion F).

Diagnostic criteria for generalized anxiety disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The person finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). Note: Only one item is required in children.

(1) Restlessness or feeling keyed up or on edge

(2) Being easily fatigued

(3) Difficulty concentrating or mind going blank

(4) Irritability

(5) Muscle tension

(6) Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), losing weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.

E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 472, 473, 476).

Advice to the Counselor: Counseling a Client With a Mood or Anxiety Disorder

- Differentiate among the following: mood and anxiety disorders; commonplace expressions of anxiety and depression; and anxiety and depression associated with more serious mental illness, medical conditions and medication side effects, and substance-induced changes.
- Although true for most counseling situations, it is especially important to maintain a calm demeanor and a reassuring presence with these clients.
- Start low, go slow (that is, start "low" with general and nonprovocative topics and proceed gradually as clients become more comfortable talking about issues).
- Monitor symptoms and respond immediately to any intensification of symptoms.
- Understand the special sensitivities of phobic clients to social situations.
- Gradually introduce and teach skills for participation in mutual self-help groups.
- Combine addiction counseling with medication and mental health treatment.

Case Study: Counseling a Substance Abuse Treatment Client With Bipolar Disorder

John W. is a 30-year-old African-American man with diagnoses of bipolar disorder and alcohol dependence. He has a history of hospitalizations, both psychiatric and substance-related; after the most recent extended psychiatric hospitalization, he was referred for substance abuse treatment. He told the counselor he used alcohol to facilitate social contact, as well as deal with boredom, since he had not been able to work for some time. The counselor learned that during his early twenties, John W. achieved full-time employment and established an intimate relationship with a nondrinking woman; however, his drinking led to the loss of both.

During one of his alcohol treatments, he developed florid manic symptoms, believing himself to be a prophet with the power to heal others. He was transferred to a closed psychiatric unit, where he eventually stabilized on a combination of antipsychotic medications (risperdal) and lithium. Since that time he has had two episodes of worsening psychiatric symptoms leading to hospitalization; each of these began with drinking, which then led to stopping his medications, then florid mania and psychiatric commitment. However, when he is taking his medications and is sober, John W. has a normal mental status and relates normally to others. Recently, following a series of stressors, John W. left his girlfriend, quit his job, and began using alcohol heavily again. He rapidly relapsed to active mania, did not adhere to a medication regimen, and was

rehospitalized.

At the point John W. is introduced to the substance abuse treatment counselor, his mental status is fairly normal; however, he warns the counselor that after manic episodes he tends to get somewhat depressed, even when he is taking medications. In taking an addiction history, the counselor finds that though John W. has had several periods of a year or two during which he was abstinent from both alcohol and drugs of abuse, he has never become involved with either ongoing alcohol treatment or AA meetings. John W. replies to his questions about this with, “Well, if I just take my meds and don't drink, I'm fine. So why do I need those meetings?”

Using a motivational approach, the counselor helps John W. analyze what has worked best for him in dealing with both addiction and mental problems, as well as what has not worked well for him. John W. is tired of the merry-go-round of his life; he certainly acknowledges that he has a major mental disorder, but thinks his drinking is only secondary to the mania. When the counselor gently points out that each of the episodes in which his mental disorder led to hospitalization began with an alcohol relapse, John W. begins to listen. In a group for clients with co-occurring disorders at the substance abuse treatment agency, John W. is introduced to another recovering manic patient with alcohol problems who tells his personal story and how he discovered that both of his problems need primary attention. This client agrees to be John W.'s temporary sponsor. The counselor calls John W.'s case manager, who works at the mental health center where John W. gets his medication, and describes the treatment plan. She then makes arrangements for a monthly meeting involving the counselor, case manager, and John W.

Discussion: The substance abuse treatment counselor has taken the wise step of taking a detailed history and attempting to establish the linkage between co-occurring disorders. The counselor tries to appreciate the client's own understanding of the relationship between the two. She uses motivational approaches to analyze what John W. did in his previous partially successful attempts to deal with the problem and helps develop connections with other recovering clients to increase motivation. Lastly, she is working closely with the case manager to ensure a coordinated approach to management of each disorder.

Schizophrenia and Other Psychotic Disorders

What Counselors Should Know About Substance Abuse and Psychotic Disorders

There are different types of psychotic disorders or disorders that have psychotic features. Schizophrenia, a relatively common type of psychotic disorder, is featured in this section.

Counselors should be aware of the following:

- There is evidence of increasing use of alcohol and drugs by persons with schizophrenia (from 14 to 22 percent in the 1960s and 1970s to 25 to 50 percent in the 1990s) (Fowler et al. 1998).
- There is no clear pattern of drug choice among clients with schizophrenia. Instead, it is likely that whatever substances happen to be available or in vogue will be the substances used most typically.
- What looks like resistance or denial may in reality be a manifestation of negative symptoms of schizophrenia.
- An accurate understanding of the role of substance use disorders in the client's psychosis requires a multiple-contact, longitudinal assessment.
- Clients with a co-occurring mental disorder involving psychosis have a higher risk for self-destructive

and violent behaviors.

- Clients with a co-occurring mental disorder involving psychosis are particularly vulnerable to homelessness, housing instability, victimization, poor nutrition, and inadequate financial resources.

- Both psychotic and substance use disorders tend to be chronic disorders with multiple relapses and remissions, supporting the need for long-term treatment. For clients with co-occurring disorders involving psychosis, a long-term approach is imperative.

It is important that the program philosophy be based on a multidisciplinary team approach. Ideally, team members should be cross-trained, and there should be representatives from the medical, mental health, and addiction systems. The overall goals of long-term management should include (1) providing comprehensive and integrated services for both the mental and substance use disorders, and (2) doing so with a long-term focus that addresses biopsychosocial issues in accord with a treatment plan with goals specific to a client's situation.

Descriptive Features

The term "psychotic" historically has received a number of different definitions, none of which has achieved universal acceptance. The narrowest definition of psychotic is restricted to delusions or prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature. A slightly less restrictive definition also would include prominent hallucinations that the individual realizes are hallucinatory experiences. Broader still is a definition that also includes other positive symptoms of schizophrenia (i.e., disorganized speech, or grossly disorganized or catatonic behavior). Unlike these definitions based on symptoms, the definition used in earlier classifications (e.g., DSM-II and ICD-9) probably was far too inclusive and focused on the severity of functional impairment. In that context, a mental disorder was termed "psychotic" if it resulted in "impairment that grossly interferes with the capacity to meet ordinary demands of life." The term also has previously been defined as a "loss of ego boundaries" or a "gross impairment in reality testing."

Schizophrenia is a disorder that lasts for at least 6 months and includes at least 1 month of active-phase symptoms (i.e., two or more) of the following: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms. Definitions for the schizophrenia subtypes (paranoid, disorganized, catatonic, undifferentiated, and residual) are also included in this section.

Diagnostic criteria for schizophrenia

A. *Characteristic symptoms:* Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

(1) Delusions

(2) Hallucinations

(3) Disorganized speech (e.g., frequent derailment or incoherence)

(4) Grossly disorganized or catatonic behavior

(5) Negative symptoms, i.e., affective flattening, alogia, or avolition

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

B. *Social/occupational dysfunction:* For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in

childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. *Duration:* Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. *Schizoaffective and Mood Disorder exclusion:* Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. *Substance/general medical condition exclusion:* The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. *Relationship to a Pervasive Developmental Disorder:* If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations also are present for at least a month (or less if successfully treated).

Classification of longitudinal course (can be applied only after at least 1 year has elapsed since the initial onset of active-phase symptoms):

- Episodic With Interepisode Residual Symptoms (episodes are defined by the reemergence of prominent psychotic symptoms); *also specify if:* With Prominent Negative Symptoms
- Episodic With No Interepisode Residual Symptoms
- Continuous (prominent psychotic symptoms are present throughout the period of observation); *also specify if:* With Prominent Negative Symptoms
- Single Episode In Partial Remission; *also specify if:* With Prominent Negative Symptoms
- Single Episode In Full Remission
- Other or Unspecified Pattern

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 298–302, 312–313).

Advice to the Counselor: Counseling a Client With a Psychotic Disorder

- Obtain a working knowledge of the signs and symptoms of the disorder.
- Work closely with a psychiatrist or mental health professional.
- Expect crises associated with the mental disorder and have available resources (i.e., crisis intervention, psychiatric consultation) to facilitate stabilization.
- Assist the client to obtain entitlements and other social services.
- Make available psychoeducation on the psychiatric condition and use of medication.
- Monitor medication and promote medication adherence.
- Provide frequent breaks and shorter sessions or meetings.
- Employ structure and support.
- Present material in simple, concrete terms with examples and use multimedia methods.
- Encourage participation in social clubs with recreational activities.

- Teach the client skills for detecting early signs of relapse for both mental illness and substance abuse.
- Involve family in psychoeducational groups that specifically focus on education about substance use disorders and psychosis; establish support groups of families and significant others.
- Help the client obtain needed housing and vocational services.
- Monitor clients for signs of substance abuse relapse and a return of psychotic symptoms.

Case Study: Counseling a Substance Abuse Treatment Client With Schizophrenia

Adolfo M. is a 40-year-old Hispanic male who began using marijuana and alcohol when he was 15. He was diagnosed as having schizophrenia when he was 18 and began using cocaine at 19. Sometimes he lives with his sister or with temporary girlfriends; sometimes he lives on the street. He has never had a sustained relationship, and he has never held a steady job. He has few close friends. He wears long hair, tattoos, torn jeans, and t-shirts with skulls or similar images. Although he has had periods of abstinence and freedom from hallucinations and major delusions, he generally has unusual views of the world that emerge quickly in conversation.

Adolfo M. has been referred to the substance abuse treatment counselor, who was hired by the mental health center to do most of the group and individual drug/alcohol work with clients. The first step the counselor takes is to meet with Adolfo M. and his case manager together. This provides a clinical linkage as well as a method to get the best history. The clinical history reveals that Adolfo M. does best when he is sober and on medications, but there are times when he will be sober and not adhere to a medical regimen, or when he is both taking medications and drinking (though these periods are becoming shorter in duration and less frequent). His case manager often is able to redirect him toward renewed sobriety and adherence to medications, but Adolfo M. and the case manager agree that the cycle of relapse and the work of pulling things back together is wearing them both out. After the meeting, the case manager, counselor, and Adolfo M. agree to meet weekly for a while to see what they can do together to increase the stable periods and decrease the relapse periods. After a month of these planning meetings, the following plan emerges. Adolfo M. will attend substance abuse treatment groups for persons with COD (run by the counselor three times a week at the clinic), see the team psychiatrist, and attend local dual disorder AA meetings. The substance abuse treatment group he will be joining is one that addresses not only addiction issues, but also issues with treatment follow through, life problems, ways of dealing with stress, and the need for social support for clients trying to get sober. When and if relapse happens, Adolfo M. will be accepted back without prejudice and supported in recovery and treatment of both his substance abuse and mental disorders; however, part of the plan is to analyze relapses with the group. His goal is to have as many sober days as possible with as many days adhering to a medical regimen as possible. Another aspect of the group is that monthly, 90-day, 6-month, and yearly sobriety birthdays are celebrated with both AA coins and refreshments. Part of the employment program at the center is that clients need to have a minimum of 3 months of sobriety before they will be placed in a supported work situation, so this becomes an incentive for sobriety as well.

Discussion: Substance abuse treatment counselors working within mental health centers should be aware of the need not only to work with the client, but also to form solid working relationships with case managers, the psychiatrist, and other personnel. Seeing clients with case managers and other team members is a good way to establish important linkages and a united view of the treatment plan. In Adolfo M.'s case, the counselor used his ties with the case manager to good effect and also is using relapse prevention and contingency management strategies appropriately (see chapter 5 for a discussion of these techniques).

Attention Deficit/Hyperactivity Disorder (AD/HD)

What Counselors Should Know About Substance Abuse and AD/HD

The essential feature of AD/HD is a persistent pattern of inattention and/or hyperactivity-impulsivity that is displayed more frequently and more serious than is observed typically in individuals at a comparable level of development (APA 2000). Counselors should be aware of the following:

- Studies of the adult substance abuse treatment population have found AD/HD in 5 to 25 percent of persons (Clure et al. 1999; King et al. 1999; Levin et al. 1998; Schubiner et al. 2000; Weiss et al. 1998).
- Approximately one third of adults with AD/HD have histories of alcohol abuse or dependence, and approximately one in five has other drug abuse or dependence histories.
- Adults with AD/HD have been found primarily to use alcohol, with marijuana being the second most common drug of abuse.
- The history of a typical AD/HD substance abuse treatment client may show early school problems before substance abuse began.
- The client may use self-medication for AD/HD as an excuse for drug use.
- The most common attention problems in substance abuse treatment populations are secondary to short-term toxic effects of substances, and these should be substantially better with each month of sobriety.
- The presence of AD/HD complicates the treatment of substance abuse, since clients with these COD may have more difficulty engaging in treatment and learning abstinence skills, be at greater risk for relapse, and have poorer substance use outcomes.

Diagnostic Features of AD/HD

The essential feature of attention-deficit/hyperactivity disorder is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development (see Criterion A below). Some hyperactive-impulsive or inattentive symptoms that cause impairment must have been present before age 7, although many individuals are diagnosed after the symptoms have been present for a number of years, especially in the case of individuals with the predominantly inattentive type (Criterion B). Some impairment from the symptoms must be present in at least two settings (e.g., at home and at school or work) (Criterion C). There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning (Criterion D). The disturbance does not occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder and is not better accounted for by another mental disorder (e.g., a mood disorder, anxiety disorder, dissociative disorder, or personality disorder) (Criterion E).

Diagnostic criteria for AD/HD

A. Either (1) or (2):

(1) Six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

• *Inattention*

(a) Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities

(b) Often has difficulty sustaining attention in tasks or play activities

(c) Often does not seem to listen when spoken to directly

(d) Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)

(e) Often has difficulty organizing tasks and activities

(f) Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)

(g) Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)

(h) Is often easily distracted by extraneous stimuli

(i) Is often forgetful in daily activities

(2) Six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

• *Hyperactivity*

(a) Often fidgets with hands or feet or squirms in seat

(b) Often leaves seat in classroom or in other situations in which remaining seated is expected

(c) Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)

(d) Often has difficulty playing or engaging in leisure activities quietly; is often "on the go" or often acts as if "driven by a motor"

(e) Often talks excessively

• *Impulsivity*

(a) Often blurts out answers before questions have been completed

(b) Often has difficulty awaiting turn

(c) Often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school or work and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

• *Code based on type:*

• Attention-Deficit/Hyperactivity Disorder, Combined Type: if both Criteria A1 and A2 are met for the past 6 months

• Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type: if Criterion A2 is met but Criterion A1 is not met for the past 6 months

Coding note: For individuals (especially adolescents and adults) who currently have symptoms that no longer meet full criteria, "In Partial Remission" should be specified.

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 85–87, 92–93).

Advice to the Counselor: Counseling a Client Who Has AD/HD

- Clarify for the client repeatedly what elements of a question he or she has responded to and what remains to be addressed.
- Eliminate distracting stimuli from the environment.
- Use visual aids to convey information.
- Reduce the time of meetings and length of verbal exchanges.
- Encourage the client to use tools (e.g., activity journals, written schedules, and "to do" lists) to organize important events and information.
- Refer the client for evaluation of the need for medication.
- Focus on enhancing the client's knowledge about AD/HD and substance abuse. Examine with the client any false beliefs about the history of both AD/HD and substance abuse difficulties.

Case Study: Counseling a Substance Abuse Treatment Client With AD/HD

John R., a 29-year-old African-American man, is seeking treatment. He has been in several treatment programs but always dropped out after the first 4 weeks. He tells the counselor he dropped out because he would get cravings and that he just could not concentrate in the treatment sessions. He mentions the difficulty of staying focused during 3-hour intensive group sessions. A contributing factor in his quitting treatment was that group leaders always seemed to scold him for talking to others. The clinician evaluating him asks how John R. did in school and finds that he had difficulty in his classwork years before he started using alcohol and drugs; he was restless and easily distracted. He had been evaluated for a learning disability and AD/HD and took Ritalin for about 2 years (in the 5th and 6th grades), then stopped. He was not sure why, but he did terribly in school, eventually dropping out about the time he started using drugs regularly in the 8th grade.

Discussion: The substance abuse treatment clinician reviewed John R.'s learning history and asked about anxiety or depressive disorders. The clinician referred him to the team's psychiatrist, who uncovered more history about the AD/HD and also contacted John R.'s mother. When the clinician reviewed a list of features commonly associated with AD/HD, she agreed that John R. had many of these features and that she had noticed them in childhood. John R. was started on bupropion medication and moved to a less intensive level of care (1 hour of group therapy, 30 minutes of individual counseling, and AA meetings three times weekly). Over the next 2 months, John R.'s ability to tolerate a more intensive treatment improved. Although he was still somewhat intrusive to others, he was able to benefit from more intensive group treatment.

Posttraumatic Stress Disorder (PTSD)

What Counselors Should Know About Substance Abuse and PTSD

PTSD is classified in DSM-IV-TR as one type of anxiety disorder. It is treated separately in this TIP because of its special relationship to substance abuse and the growing literature on PTSD and its treatment.

The essential feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (APA 2000, p. 463). Counselors should be aware that

- The lifetime prevalence of PTSD among adults in the United States is about 8 percent.
- Among high-risk individuals (those who have survived rape, military combat, and captivity or ethnically or politically motivated internment and genocide), the proportion of those with PTSD ranges from one-third to one-half.
- Among clients in substance abuse treatment, PTSD is two to three times more common in women than in men.
- The rate of PTSD among people with substance use disorders is 12 to 34 percent; for women with substance use disorders, it is 30 to 59 percent (Brown and Wolfe 1994).
- Women with substance abuse problems report a lifetime history of physical and/or sexual abuse ranging from 55 to 99 percent (Najavits et al. 1997).
- Most women with this co-occurring disorder experienced childhood physical and/or sexual abuse; men with both disorders typically experienced crime victimization or war trauma.
- Clinicians are advised not to overlook the possibility of PTSD in men.
- People with PTSD and substance abuse are more likely to experience further trauma than people with substance abuse alone.
- Because repeated trauma is common in domestic violence, child abuse, and some substance-using lifestyles (e.g., the drug trade), helping the client protect against future trauma may be an important part of work in treatment.
- People with PTSD tend to abuse the most serious substances (cocaine and opioids); however, abuse of prescription medications, marijuana, and alcohol also are common.
- From the client's perspective, PTSD symptoms are a common trigger for substance use.
- While under the influence of substances, a person may be more vulnerable to trauma—for example, a woman drinking at a bar may go home with a stranger and be assaulted.
- As a counselor, it is important to recognize, and help clients understand, that becoming abstinent from substances does not resolve PTSD; both disorders must be addressed in treatment.

Diagnostic Features of PTSD

The essential feature of posttraumatic stress disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior) (Criterion A2). The characteristic symptoms resulting from the exposure to the extreme trauma include persistent reexperiencing of the traumatic event (Criterion B), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (Criterion C), and persistent symptoms of increased arousal (Criterion D). The full symptom picture must be present for more than 1 month (Criterion E), and the disturbance must cause clinically significant distress

or impairment in social, occupational, or other important areas of functioning (Criterion F).

Diagnostic criteria for PTSD

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

(2) The person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

(3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.

(4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) Efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) Inability to recall an important aspect of the trauma

(4) Markedly diminished interest or participation in significant activities

(5) Feeling of detachment or estrangement from others

(6) Restricted range of affect (e.g., unable to have loving feelings)

(7) Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) Difficulty falling or staying asleep

(2) Irritability or outbursts of anger

(3) Difficulty concentrating

(4) Hypervigilance

(5) Exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: duration of symptoms is less than 3 months

Chronic: duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: onset of symptoms is at least 6 months after the stressor

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 463, 467, 468).

Advice to the Counselor: Counseling a Client With PTSD

• Anticipate proceeding slowly with a client who is diagnosed with or has symptoms of PTSD. Consider the effect of a trauma history on the client's current emotional state, such as an increased level of fear or irritability.

• Develop a plan for increased safety where warranted.

• Establish both perceived and real trust.

• Respond more to the client's behavior than her words.

• Limit questioning about details of trauma.

• Recognize that trauma injures an individual's capacity for attachment. The establishment of a trusting treatment relationship will be a goal of treatment, not a starting point.

• Recognize the importance of one's own trauma history and countertransference.

• Help the client learn to de-escalate intense emotions.

• Help the client to link PTSD and substance abuse.

• Provide psychoeducation about PTSD and substance abuse.

• Teach coping skills to control PTSD symptoms.

• Recognize that PTSD/substance abuse treatment clients may have a more difficult time in treatment and that treatment for PTSD may be long term, especially for those who have a history of serious trauma.

• Help the client access long-term PTSD treatment and refer to trauma experts for trauma exploratory work.

Case Study: Counseling a Substance Abuse Treatment Client Who Binge Drinks and Has PTSD

Caitlin P. is a 17-year-old American-Indian female who was admitted to an inpatient substance abuse treatment program after she tried to kill herself during a drunken episode. She has been binge drinking since age 12 and also has tried a wide variety of pills without caring what she is taking. She has a history of depression and burning her arms with cigarettes. She was date-raped at age 15 and did not tell anyone except a close friend. She was afraid to tell her family for fear that they would think less of her for not preventing or fighting off the attack.

In treatment, she worked with staff to try to gain control over her repeated self-destructive behavior. Together they worked on developing compassion for herself, created a safety plan to encourage her to reach out for help when in distress, and began a log to help her identify her PTSD symptoms so that she could recognize them more clearly. When she had the urge to drink, drug, or burn herself, she was guided to try to “bring down” the feelings through grounding, rethink the situation, and reassure herself that she could get through it. She began to see that her substance use had been a way to numb the pain.

Discussion: Counselors can be very important in helping clients gain control over PTSD symptoms and self-destructive behavior associated with trauma. Providing specific coping strategies and a lot of encouragement typically are well received by PTSD/substance abuse treatment clients, who may want to learn how to be able to overcome the emotional roller coaster of the disorders. Notice that in such early-phase treatment, detailed exploration of the past is not generally advised.

Eating Disorders

What Counselors Should Know About Substance Abuse and Eating Disorders

The essential features of anorexia nervosa are that the individual refuses to maintain a minimal normal body weight, is intensely afraid of gaining weight, and exhibits a significant disturbance in the perception of the shape or size of his or her body. The essential features of bulimia nervosa are binge eating and inappropriate compensatory methods to prevent weight gain. In dealing with persons who have either disorder, counselors should be aware of the following:

- The prevalence of bulimia nervosa is elevated in women presenting for substance abuse treatment.
- Studies of individuals in inpatient substance abuse treatment centers (as assessed via questionnaire) suggest that approximately 15 percent of women and 1 percent of men had a DSM-III-R eating disorder (primarily bulimia nervosa) in their lifetime (Hudson et al. 1992).
- Substance abuse is more common in bulimia nervosa than in anorexia nervosa.
- Individuals with eating disorders are significantly more likely to use stimulants and significantly less likely to use opioids than other individuals undergoing substance abuse treatment who do not have a co-occurring eating disorder.
- Many individuals alternate between substance abuse and eating disorders.
- Alcohol and drugs such as marijuana can disinhibit appetite (i.e., remove normal restraints on eating) and increase the risk of binge eating as well as relapse in individuals with bulimia nervosa.
- Individuals with eating disorders experience craving, tolerance, and withdrawal from drugs associated with purging, such as laxatives and diuretics.
- Women with eating disorders often abuse pharmacological agents ingested for the purpose of weight loss, appetite suppression, and purging. Among these drugs are prescription and over-the-counter diet pills, laxatives, diuretics, and emetics. Nicotine and caffeine also must be considered when assessing substance abuse in women with eating disorders.
- Several studies have suggested that the presence of co-occurring substance-related disorders does not affect treatment outcome adversely for bulimia nervosa.
- Further studies are required to assess how the presence of an eating disorder affects substance abuse treatment and how best to integrate treatment for those with both conditions. This condition is quite serious and can be fatal. Treat it accordingly.
- Individuals with eating disorders experience urges (or cravings) for binge foods similar to urges for drugs.

Anorexia Nervosa

Diagnostic features

The essential features of anorexia nervosa are that the individual refuses to maintain a minimally normal body weight, is intensely afraid of gaining weight, and exhibits a significant disturbance in the perception of the shape or size of his or her body (see below Criterion A). In addition, postmenarcheal females with this disorder are amenorrheic. (The term anorexia is a misnomer because loss of appetite is rare.) Individuals with this disorder intensely fear gaining weight or becoming fat (Criterion B). This intense fear of becoming fat is usually not alleviated by the weight loss. In fact, concern about weight gain often increases even as actual weight continues to decrease. The experience and significance of body weight and shape are distorted in these individuals (Criterion C). In postmenarcheal females, amenorrhea (due to abnormally low levels of estrogen secretion that are due in turn to diminished pituitary secretion of follicle-stimulating hormone and luteinizing hormone) is an indicator of physiological dysfunction in Anorexia Nervosa (Criterion D).

Diagnostic criteria for anorexia nervosa

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85 percent of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85 percent of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

Specify type:

• **Restricting Type:** During the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

• **Binge-Eating/Purging Type:** During the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Bulimia Nervosa

Diagnostic features

The essential features of bulimia nervosa are binge eating and inappropriate compensatory methods to prevent weight gain. In addition, the self-evaluation of individuals with bulimia nervosa is excessively influenced by body shape and weight. To qualify for the diagnosis, the binge eating and the inappropriate compensatory behaviors must occur, on average, at least twice a week for 3 months (Criterion C). An episode of binge eating is also accompanied by a sense of lack of control (Criterion A2). Another essential feature of bulimia nervosa is the recurrent use of inappropriate compensatory behaviors to prevent weight gain (Criterion B).

Individuals with bulimia nervosa place an excessive emphasis on body shape and weight in their self-evaluation, and these factors are typically the most important ones in determining self-esteem (Criterion D). However, a diagnosis of bulimia nervosa should not be given when the disturbance occurs only during episodes of anorexia nervosa (Criterion E).

Diagnostic criteria for bulimia nervosa

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

(1) Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances

(2) A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Specify type:

•**Purging Type:** during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

•**Nonpurging Type:** during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 583, 584, 589–591, 594)

Advice to the Counselor: Counseling a Client With an Eating Disorder

• Where possible, work closely with a professional who specializes in eating disorders.

• Document through a comprehensive assessment the individual's full repertoire of weight loss behaviors since people with eating disorders will often go to dangerous extremes to lose weight.

• Conduct a behavioral analysis of the foods and substances of choice; high-risk times and situations for engaging in disordered eating and substance abuse behaviors; and the nature, pattern, and interrelationship of disordered eating and substance use.

• Develop a treatment plan for both the eating and substance use disorder.

• Employ psychoeducation and cognitive-behavioral techniques for bulimia nervosa.

• Use adjunctive strategies such as nutritional consultation, the setting of a weight range goal, and observations at and between meal times for disordered eating behaviors.

• Incorporate relapse prevention strategies to plan for a long course of treatment and several treatment episodes.

Case Study: The History of a Substance Abuse Treatment Client With an Eating Disorder

Mandy H. was 28 years old, Caucasian, 5'10" and 106 pounds when she first presented to the eating disorders service. She reported 4 years of untreated bingeing and self-induced vomiting. In the months prior to presentation she had quit her job and was spending days locked in her mother's house doing nothing but bingeing and vomiting, up to 20 times per day. She had large ulcers and infected scrapes in her mouth as a

result of inserting objects down her throat to induce vomiting. She denied the use of alcohol, drugs, or other substances to induce purging. Her mother and boyfriend had substantial difficulties with alcohol abuse. She was admitted to the hospital and had great difficulties complying with unit rules. Vomitus was found hidden in her room and other clients' rooms; she was caught smoking numerous times in the nonsmoking ward. She stole objects from staff and other clients to insert down her throat to induce vomiting.

Although she was able to gain 10 pounds during her hospital stay, very little progress was made with the cognitive features of her bulimia nervosa. During subsequent outpatient followup, she managed to normalize her eating and reach a high weight of 125; however, she soon dropped out of treatment. One year later she presented again to the emergency room, this time weighing 103 pounds and intoxicated. Although she had managed to stop bingeing and purging, she had been restricting her food intake severely to about 250 calories per day from food (not including the amount of calories she took in the form of alcohol). She had been drinking excessively and smoking marijuana with her boyfriend. Her therapist searched for a treatment program for uninsured individuals that specialized in substance abuse and that could address the added complexity of co-occurring disordered eating.

Mandy H.'s therapist found a residential substance abuse treatment program that considered itself to have a balanced substance abuse and mental health approach, with a specialized dual disorders program for women who met American Society of Addiction Medicine Dual Diagnosis Enhanced criteria. The program offered group and individual counseling using the Dialectical Behavior Therapy (DBT) method. The therapist's use of DBT included psychosocial groups for skills training, individual psychotherapy to strengthen individual skills and increase motivation, and telephone contact with the therapist when needed to foster generalization of skills to everyday life outside the treatment context (Linehan et al. 1999). The woman in charge of the DBT component of the treatment services was delighted to form a collaborative relationship with Mandy H.'s eating disorder therapist. Once during Mandy H.'s treatment (with Mandy H.'s permission, and the permission of the DBT group), Mandy H.'s eating disorders therapist sat in on the substance abuse treatment agency's team treatment meeting and observed the DBT group counseling session that day. Mandy H.'s eating disorders therapist also was able to help Mandy H. get Medicaid coverage for her residential substance abuse treatment under the State's program for clients with severe and persistent mental illness by demonstrating the persistence of Mandy H.'s COD based on her hospital stay the prior year and her current severe, complex, co-occurring conditions.

Mandy H. did very well during her residential stay, and she responded positively to AA. From the extensive intake information and collateral reports from relatives, Mandy H.'s substance abuse treatment counselor learned that Mandy H.'s family tree was filled with people who had developed alcoholism, including a grandmother who might well have developed an addiction to sleeping pills and/or tranquilizers in the 1960s. Since the substance abuse treatment counselor also had a family tree with many people with chemical dependencies, the counselor could understand how Mandy H. could identify closely with what people had to say at AA meetings, even without a lengthy history of heavy alcohol use. Mandy H. found that the strong attachment to alcohol expressed by others was what she was already experiencing, including her finding that until she knew where her drinking would be able to occur during the day, not much else could keep her attention. Mandy H. felt she had a similar addictive response to marijuana.

The substance abuse treatment program directed Mandy H. to AA meetings that other people with co-occurring disorders attended. Mandy H. was able to find a sponsor who herself had a co-occurring depressive disorder, one that had been handled successfully with maintenance antidepressant medication.

Mandy H. did well throughout treatment, and by the time she was in her sixth month of outpatient continuing care, she had gained 12 pounds. At that point Mandy H. began to struggle with urges to binge and thoughts of inducing vomiting. Her eating disorders therapist contacted her continuing care substance abuse treatment counselor (the same woman who handled the DBT parts of the residential program). After discussing Mandy

H.'s situation and improvement, the substance abuse treatment counselor agreed with the eating disorders counselor's recommendation that Mandy H. see the substance abuse treatment program's psychiatric consultant for possible use of an antidepressant to help with the emerging bingeing and purging concerns. The psychiatrist consultant saw Mandy H. and then called another psychiatrist who Mandy H.'s eating disorder therapist used regularly. After a brief discussion with the other psychiatrist, the psychiatrist treating Mandy H. prescribed 20 mg of fluoxetine and discussed with Mandy H. what to expect.

It was helpful to Mandy H. to see the medication as part of how she could be empowered to take care of herself and to take care of her recovery. Mandy H. fully embraced the idea of being powerless over her use of alcohol, marijuana, or euphoria-producing drugs, as she saw that as a great help to her both in terms of averting thoughts about her weight and in terms of thoughts about whether just to smoke marijuana or have just a little wine, Mandy H.'s sponsor was able to share with Mandy H. her "research" with "just a little wine."

Mandy H.'s COD were a diagnostic challenge for the treatment team. Her DBT counselor thought she had an additional borderline personality disorder, but the treatment team thought she should be re-evaluated after 3 to 6 months of both sobriety and healthy eating, especially as Mandy H. had had regular but slow progress the prior year until she dropped out of treatment and began to drink and smoke marijuana.

Indeed, with a year of sobriety and strong feelings of a new lease on life through 12-Step living, Mandy H. was eligible for State vocational rehabilitation assistance and entered college. Mandy H. still went to AA once a month, or more if she or her sponsor thought it wise, and she stayed in touch about once a week with her sponsor. Mandy H. attended monthly continuing care groups, and she saw her eating disorders therapist every other month. Mandy H. also continued to see the psychiatrist for medication management, and she had unproblematic increases in her medication to a full therapeutic dose appropriate for her. On rare occasions Mandy H. had thoughts about foregoing her medication, but with her counselor's help she realized that such thoughts were akin to "stinking thinking" and often connected to some other reactions or concerns going on in other areas of her life.

Discussion: How would Mandy H. have fared without comprehensive and integrated treatment? Mandy H.'s case history highlights the importance of assisting clients in therapeutic and extra-therapeutic ways, such as assisting with Medicaid and vocational rehabilitation eligibilities. Also, the importance of Mandy H.'s particular background and the reactions it engendered to AA is taken into consideration, while nonacute concerns about diagnostic concerns were put in abeyance. Last, the united front between the substance abuse counselor and persons involved in treatment of her mental disorder regarding medications and other aspects of treatment was helpful to Mandy H. maintaining her dual recovery.

Pathological Gambling

What Counselors Should Know About Substance Abuse and Pathological Gambling

The essential feature of pathological gambling is persistent and recurrent maladaptive gambling behavior that disrupts personal, family, or vocational pursuits. Counselors should be aware that

- Prevalence data for gambling regularly makes distinctions among "pathological" gamblers (the most severe category) and levels of "problem" gambling (less severe to moderate levels of difficulty). Recent general estimates (Gerstein et al. 1999; Shaffer et al. 1997) indicate about 1 percent of the U.S. general population could be classified as having pathological gambling, according to the diagnostic criteria below. Cogent considerations regarding prevalence are given in the DSM-IV-TR regarding variations due to the availability of gambling and seemingly greater rates in certain locations (e.g.,

Puerto Rico, Australia), which have been reported to be as high as 7 percent. Higher prevalence rates also have been reported in adolescents and college students, ranging from 2.8 to 8 percent (APA 2000). The general past-year estimate for pathological and problem gambling combined is roughly 3 percent. This can be compared to past year estimates of alcohol abuse/dependence of 9.7 percent and drug abuse/dependence of 3.6 percent.

- The rate of co-occurrence of pathological gambling among people with substance use disorders has been reported as ranging from 9 to 30 percent and the rate of substance abuse among individuals with pathological gambling has been estimated at 25 to 63 percent.

- Among pathological gamblers, alcohol has been found to be the most common substance of abuse. At minimum, the rate of problem gambling among people with substance use disorders is four to five times that found in the general population.

- It is important to recognize that even though pathological gambling often is viewed as an addictive disorder, clinicians cannot assume that their knowledge or experience in substance abuse treatment qualifies them automatically to treat people with a pathological gambling problem.

- With clients with substance use disorders who are pathological gamblers, it often is essential to identify specific triggers for each addiction. It is also helpful to identify ways in which use of addictive substances or addictive activities such as gambling act as mutual triggers.

In individuals with COD, it is particularly important to evaluate patterns of substance use and gambling. The following bullets provide several examples:

- Cocaine use and gambling may coexist as part of a broader antisocial lifestyle.

- Someone who is addicted to cocaine may see gambling as a way of getting money to support drug use.

- A pathological gambler may use cocaine to maintain energy levels and focus during gambling and sell drugs to obtain gambling money.

- Cocaine may artificially inflate a gambler's sense of certainty of winning and gambling skill, contributing to taking greater gambling risks.

- The gambler may use drugs or alcohol as a way of celebrating a win or relieving depression.

- One of the more common patterns that has been seen clinically is that of a sequential addiction. A frequent pattern is that someone who has had a history of alcohol dependence—often with many years of recovery and AA attendance—develops a gambling problem.

Diagnostic Features of Pathological Gambling

The essential feature of pathological gambling is persistent and recurrent maladaptive gambling behavior (Criterion A) that disrupts personal, family, or vocational pursuits. The diagnosis is not made if the gambling behavior is better accounted for by a manic episode (Criterion B).

Diagnostic criteria

A. Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:

(1) Is preoccupied with gambling (e.g., preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble)

(2) Needs to gamble with increasing amounts of money in order to achieve the desired excitement

(3) Has repeated unsuccessful efforts to control, cut back, or stop gambling

(4) Is restless or irritable when attempting to cut down or stop gambling

(5) Gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)

(6) After losing money gambling, often returns another day to get even ("chasing" one's losses)

(7) Lies to family members, therapist, or others to conceal the extent of involvement with gambling

(8) Has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling

(9) Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling

(10) Relies on others to provide money to relieve a desperate financial situation caused by gambling

B. The gambling behavior is not better accounted for by a Manic Episode.

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 671, 674).

Advice to the Counselor: Counseling a Client With Pathological Gambling Disorder

- Carefully assess use and frequency of sports events, scratch tickets, games of chance, and bets.
- Ask if the client is at any physical risk regarding owing money to people who collect on such debts.
- Treat the disorders as separate but interacting problems.
- Become fluent in the languages of substance abuse and of gambling.
- Understand the similarities and differences of substance use disorders and pathological gambling.
- Utilize all available 12-Step and other mutual support groups.
- Recognize that a client's motivation level may be at different points for dealing with each disorder.
- Use treatments that combine 12-Step, psychoeducation, group therapy and cognitive-behavioral approaches.
- Use separate support groups for gambling and for alcohol and/or drug dependence. While the groups can supplement each other, they cannot substitute for each other.

Case Study: Counseling a Substance Abuse Treatment Client With a Pathological Gambling Disorder

Louis Q. is a 56-year-old, divorced Caucasian male who presented through the emergency room, where he had gone complaining of chest pain. After cardiovascular problems were ruled out, he was asked about stressors that may have contributed to chest pain. Louis Q. reported frequent gambling and significant debt. However, he has never sought any help for gambling problems.

The medical staff found that Louis Q. had a 30-year history of alcohol abuse, with a significant period of meeting criteria for alcohol dependence. He began gambling at age 13. Currently, he meets criteria for both alcohol dependence and pathological gambling. He has attended AA a few times in the past for very limited periods.

He was referred to a local substance abuse treatment agency. Assessment indicated that drinking was a trigger for gambling, as well as a futile attempt at self-medication to manage depression related to gambling losses. The precipitating event for seeking help was anxiety related to embezzling money from his job and fear that his embezzlement was going to be found by an upcoming audit.

During the evaluation, it became clear that treatment would have to address both his gambling as well as his alcohol dependence, since these were so intertwined. Education was provided on both disorders, using standard information at the substance abuse treatment agency as well as materials from Gamblers Anonymous (GA). Group and individual therapy repeatedly pointed out the interaction between the disorders and the triggers for each, emphasizing the development of coping skills and relapse prevention strategies for both disorders. Louis Q. also was referred to a local GA meeting and was fortunate to have another member of his addictions group to guide him there. The family was involved in treatment planning and money management, including efforts to organize, structure, and monitor debt repayment. Legal assistance was obtained to advise him on potential legal charges due to embezzlement at work. He began attending both AA and GA meetings, obtaining sponsors in both programs.

Discussion: The counselor takes time to establish the relationship of the two disorders. He takes the gambling problem seriously as a disorder in itself, rather than assuming it would go away when the addiction was treated. Even though his agency did not specialize in gambling addiction treatment, he was able to use available community resources (GA) as a source of educational material and a referral. He recognized the importance of regular group involvement for Louis Q. and also knew it was critical to support the family in working through existing problems and trying to avoid new ones.

Conclusion

The information contained in this chapter can serve as a quick reference for the substance abuse counselor when working with clients who have the mental disorders described or who may be suicidal. As noted above, appendix D provides more extensive information. The limited aims of the panel in providing this material are to increase substance abuse treatment counselors' familiarity with mental disorders terminology and criteria, as well as to provide advice on how to proceed with clients who demonstrate these disorders. The panel encourages counselors to continue to increase their understanding of mental disorders by using the resource material referenced in each section, attending courses and conferences in these areas, and engaging in dialog with mental health professionals who are involved in treatment. At the same time, the panel urges continued work to develop improved treatment approaches that address substance use in combination with specific mental disorders, as well as better translation of that work to make it more accessible to the substance abuse field.