

Managing Multiple Diagnoses

Diagnosis and Treatment of Co-occurring Mental Health Problems

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MULTIPLE DIAGNOSIS

- Most adults we work with have more than one presenting problem.
- Highly correlated with addiction, domestic violence, and dependency problems.
 - **About 50% of individuals with severe mental health disorders are affected by substance abuse (JAMA).**

CO MORBIDITY CONSEQUENCES

- Compared to those with one disorder, people with severe mental illness and substance abuse are statistically at greater risk:
 - Violence
 - Overall poorer functioning
 - Medication noncompliance
 - Failure to respond to treatment
 - **Greater chance of relapse**

SHARED RISK FACTORS

- These disorders have shared risk factors:
 - Overlapping genetic vulnerabilities
 - Overlapping environmental triggers
 - Involvement of similar brain regions
 - Early exposure
 - Developmental disorders often begin in teen years
 - Early exposure to drugs may change the brain to increase risk of mental disorders.

NIDA

WHERE TO BEGIN

- Every single encounter you have with the defendant is an opportunity to do relationship/attachment repair.

THE LABEL

- Sometimes folks avoid having an evaluation or seeking services because they are afraid of being given a label.
- Normalize this fear, discuss the pros and cons, talk about what it might mean, affirm that they deserve to get the help they need.

GENERAL BARRIERS

- Lack of psychiatric care and evaluations
- Long waiting list
- Client resistance
- Transportation – time and distance
- Cultural and language barriers

OVERCOMING RESISTANCE

- Join with the client
- Make a connection
- Don't judge
- Do evaluate

INTERNAL BARRIERS

- The defendant's internal working model of how the world works and how they see themselves is the primary barrier to recovery.
- This model is formed very early in life and will only shift over time and with considerable effort.

SHAME

- Mental illness carries a nasty social stigma.
- They often feel responsible but project this onto others (children, helpers, spouses).
- They often feel alone and isolated.
- **Early trauma creates an embedded sense of unworthiness.**

GUILT

- They often blame themselves and think they are deficient, weak, or bad.
- They have been told they could change if they wanted to badly enough.
- They have had repeated failure experiences and feel inferior.
- **Early trauma leaves a person feeling as though they should have been able to stop the abuse, or that they ‘deserved it’.**

DENIAL

- It is very important to help the person come to grips with their struggle.
- They often normalize and minimize their troubles and have lost perspective about what they miss in daily life and relationships.
- **Early trauma has created defense mechanisms to shut down and shut off emotional experiences.**

GRIEF

- What has the person lost due to mental illness?
- Have they named, acknowledged, and mourned these losses?
- **Early trauma is an experience of loss. Loss of safety, loss of comfort, loss of joy, loss of self, and loss of control.**

ACCEPTANCE

- They understand they have an illness.
- They recognize it has cost them.
- They know it is not “normal”.
- They don't blame themselves.

WHAT TO TREAT FIRST?

- Addressing mental health and trauma issues first is often necessary to help the defendant relinquish their dependency on drugs/alcohol.
- **An altered physical and emotional state is why they use. They need another option of how to find that.**
- **Go for the most impact. Treat what you can, first.**

EXTERNAL BARRIERS

- Housing
- Work
- Job
- Relationships
- Parenting – ability to facilitate attachment
 - These all affect the parent-child relationship.

NEEDED INFORMATION

- Previous history of abuse and/or neglect of self
- Substance abuse – duration and episodes of previous treatment
- Cognitive or physical deficits
- Involvement with criminal justice system
- Military service

PROPER DIAGNOSIS

- Identify and evaluate each disorder concurrently:
 - Broad assessment tools are less likely to result in a missed diagnosis.
 - Those entering drug treatments should be screened for mental illness and vice versa.

EARLY ASSESSMENTS

- Does the defendant need a **neuropsychological** exam to determine any brain injury, memory loss, learning deficits, or cognitive impairment?
- Are there any serious traumatic events that would have been a contributing factor for the defendant to use/abuse drugs?

GET SOME HISTORY-PSI

- How long has the condition been present?
- Is there a pattern? Is the client doing better or worse than in the past?
- Have treatments or services been used in the past, and what, if any, worked?
- Are they able to admit/recognize they have impaired mental health/addiction?

QUESTIONS TO ASK

- Were your needs met as a child?
- Were you raised by your parents most of the time?
- Who was the person you could count on?
- Can you still count on them?
- Are you connected to your family yet?
- Have you had services before, in this county/state/country?
- Why was that?
- Have you ever been told that you have a diagnosis or been on medication to help you out?

WHAT DOES MENTAL HEALTH MEAN TO THEM?

- Do they know the jargon?
- Do they have a sense of what the paper trail may say about them?
- Can they reliably or honestly report?

SEVERITY OF ILLNESS

- **Get some history**
- How long has the condition been present, what is its pattern, is the client doing better or worse than in the past?
- Have treatments or services been used in the past, and what if any, worked?
- Does the client even admit/recognize they have impaired mental health?

CHRONIC OR ACUTE

- It is important to try and figure out if the situation is a chronic, reoccurring pattern, or an acute attack, onset of symptoms that could go away with intervention.
- Acute is more readily treated.

WHAT YOU NEED TO KNOW

- Previous history of abuse
- Substance abuse.
- Cognitive deficits.
- Involvement with criminal justice system.

CRITICAL PROGNOSTIC INDICATORS

- Can the client empathize?
- Does the client accept responsibility (even some) for the circumstances they are in?
- Does the client have a support system?

THEN WHAT?

- You know where the defendant has to start from – usually the beginning, and you know if there were periods of success.
- You know what their triggers might be.
- You know what they missed out on.
- **Start where the defendant is stuck, developmentally.**

HIGH RISK FACTORS

- Failure to take medications
- Hallucinations that involve the child
- Frequent police contact due to violence
- Failure to work with mental health professional
- Termination of Parental Rights cases upheld by MN Supreme Court

INTERNAL RESOURCES

- Intellect
- Periods of reasoning
- Children who can cope
- Insight into the problem
- Past success

IS THERE A RELAPSE PLAN?

- Relapse is a predictable part of the process.
- It needs to be discussed.

WHAT YOU OFTEN SEE

- PTSD
- DEPRESSION/ANXIETY
- PERSONALITY DISORDERS
- BIPOLAR
- ADHD

PTSD

It is an **anxiety disorder** that occurs after a person experiences or witnesses a traumatic event that they perceive as life-threatening to self or others.

- Sometimes we see extreme or layered trauma, one after the other.

PTSD SYMPTOMS

- Intense fear, sleeplessness, can't sleep or can't stay asleep – bad dreams, terror
- **Anxiety** and hyper vigilance or dissociation
- **Startle** response and **arousal** response are exaggerated
- Frequent physical complaints
- **Anger/irritability**
- Trouble concentrating, confusion

PTSD TREATMENT

- Cognitive Behavioral Therapy
- EMDR
- Desensitization
- Bio feedback/relaxation
- Group therapy
- Couples/family therapy
- Individual therapy
- Medication for depression/anxiety

PROGNOSIS

- This is a disorder that can be treated, managed and sometimes, be put to rest. It is possible, even expected, that a person will re-experience the trauma throughout one's life span, thus requiring episodic treatment.

THE PTSD DEFENDANT

- Returning military personnel
- The parent with a traumatic childhood.
- The older child who never received services.
- The immigrant who survived starvation/genocide.
- The chronic addict who cycles through programs.

ADD DRUGS TO THE MIX

- They will provide some regulation and lessen anxiety.
- They can be a sleep aid; it provides comfort.
- Drugs change how the brain processes data, so their ability to gauge crisis or fear is skewed.

MESSAGE OF AFFIRMATION

- Its not your fault.
- You are not weak, stupid, or bad.
- It does not mean you do not love your family.
- It will get better.
- You do not have to live like this; you and your family deserve and need support.
- Your family needs you to address this.

DEPRESSION/ANXIETY

- These are brain based illnesses.
- There is no one single cause of either.
- It is not necessarily related to major life event or stressor, but may be triggered or exacerbated by trauma or distress.
- They are often misdiagnosed.
- Symptoms can vary greatly based on developmental stage of person.

DIAGNOSING

- A complete **history**
- Onset and **severity**
- Prior **treatment**
- Physical **health**
- Family history
- **CD evaluation**, if needed
- **Thoughts about suicide**

SYMPTOMS OF DEPRESSION

- Changes in **sleep** and **appetite**
- Impaired **concentration**, short-term memory, focus and decision making
- Loss of energy
- Loss of interest and **friends**
- Low self-esteem
- Feelings of hopelessness

SYMPTOMS OF ANXIETY

- Moody
- Irritable
- Sullen, withdrawn
- Frequent crying or outbursts
- Lack of ability to regulate emotions
- Loss of **friends** and lack of pleasure
- **Panic attacks** and intense worry

TREATMENT

- Most effectively treated with **medication and therapy**.
- Accurate and early diagnosis.
- **Individual and group therapy** that focused on adaptive skills and disturbance in emotional and relationship disturbance.

ADD DRUGS TO THE MIX

- They take the edge off.
- They make it possible to talk to people.
- They add a point of pleasure to the day.
- They speed up or slow down the person's ability to manage the next task.
- They lessen feelings of guilt about what/who is being neglected.

MESSAGE OF AFFIRMATION

- You can't "decide" to get better.
- It is not a matter of attitude.
- Medication will probably be necessary.
- These conditions improve over time, if you take care of yourself.
- Your child needs you every day—you must think of them, not your own pride.

PERSONALITY DISORDERS

- Emerging research describes these disorders in a similar fashion to children with severe **attachment problems**.
- Lack of **interpersonal relationship** health.
- Lack of child-centered thinking
- **Push me/pull me** dynamic: too close or too far away
- Impossible to please in the long haul

FEATURES

- These folks have a history of failed relationships and **little insight** into why.
- They have **unclear boundaries** between adults and children in their families of origin that will repeat themselves.
- They almost always have a trauma story.

TREATMENT

- This population is **treatment-resistant** and not prone to use insight-oriented therapy.
- Group work is good to build social networks.
- DBT and Cognitive Behavioral can help.
- They tend to fire therapists over time.
- They do not have a sense of empathy for the distress they cause others and must learn attunement and empathy.
- Individual therapy.

ADD DRUGS TO THE MIX

- It creates a more acceptable ‘normal’
- It enhances their capacity to pretend
- It is a substitute for dissociation
- It is a way to be loyal to their parent
- Drugs help blur boundaries, so ‘anyone’ will do

MESSAGES OF AFFIRMATION

- Your child needs you to do better.
- You can offer a better legacy to your child than you had.
- You have the power to make the change.
- You must know who to ask for help when you are overwhelmed.
- Practice a safety plan with parent/child.
- Your child needs professional support.

BIPOLAR DISORDER I and II

- Symptoms include some occurrence of manic and hypo manic with depressive state preceding or following. It may be a **one time episode, or reoccurring**, and may be mild, moderate or severe.
- Often **associated with alcohol** and other substance abuse.
- Some family history is helpful.

SYMPTOMS

- **Presence or history** of a major depressive or manic/hypo manic episode.
- Symptoms cause distress or impairment in social, occupational or other life domains.
- Lethargy, catatonia can both be present.
- Sleepless, restless energy.
- **Unpredictable**, moody, can't regulate.

TREATMENT

- Individual and group work
- Medication
- Family therapy
- Supportive systems in place
- **Most can return to normal functioning in between episodes.**

ADD DRUGS TO THE MIX

- Alcohol and other drugs level the playing field.
- It is the one factor they feel they can control.
- It takes the edge off or gives them one.
- Drugs may enhance the mania which feels scary but good.
- Drugs dull the horror of when they crash.

ADHD

- THIS IS A PRIMARY PROBLEM BUT OFTEN NOT IDENTIFIED.
- If you have severe ADHD, marijuana is your very best friend. Alcohol is a close second.
- <http://minnesota.publicradio.org/display/web/2011/06/20/midmorning1/>

APPROPRIATE PROGRAMS

- Interventions are bundled together
 - Same professionals in one setting
- Gradual approach
- Accepts denial as inherent part of the problem
- Realizes patients lack insight into seriousness of problem
- Abstinence is not a precondition for treatment
- Counseling/Therapy

THE RIGHT APPROACH

- Clients proceed at own pace
- Recovery is long-term and community-based
- Convey understanding of client's difficulty
- Credit is given for any accomplishment
- Clients have opportunity to develop social supports, which serve as reinforcement

TREATMENT STAGES

TRUST

is established to...



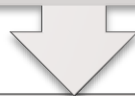
MOTIVATE

the client to learn the skills to...



ACTIVELY CONTROL

their illness and focus on goals to...



PREVENT RELAPSE

by staying on track.

THERAPIES

- Therapeutic Communities (TC)
- Assertive Community Treatment (ACT)
- Dialectical Behavior Therapy (DBT)
- Exposure Therapy
- Integrated Group Therapy

THERAPY OR SERVICES?

- Concrete services such as supportive living, transportation, budgeting, daycare, medication management are often more useful when offered with psychological services such as counseling, psychotherapy or group work.

WHAT IS THERAPY?

- Building a relationship
- Identifying problems and competencies
- Understanding the functional impairment
- Developing treatment goals
- Offering strategies or interventions for change
- Providing emotional and social supports to sustain change

HOW DOES IT WORK?

- Good therapy opens the door to either restoring or developing coping skills to alleviate distress, symptoms, impairments.
- It is more than a feel good experience, as it needs to leave the client with increased capacity to make healthy choices.
- It builds confidence and self worth by offering encouragement, skills and affirmation.

INTERVENTIONS AND SERVICES

- Know **what you are trying to fix** or address.
- Are they custodial tasks?
- What risk factors are you trying to **soften or eliminate?**
- What is the **scope** of the service (chronic or acute)?

SKILLS VS VALUES/BELIEFS

- We can teach skills.
- We can shift thinking and offer insight.
- We can offer incentives or consequences.
- We seldom are able to change a persons morals or values.
- We can seldom teach good judgment or common sense.

WHEN IT HELPS

- The presenting problems will appear more manageable by the client.
- There will be some relief from the emotional distress and turmoil that had been reported.
- The client will report some sense of mastery over the symptoms and some increased sense of well being.
- There are measurable outcomes.

A GOOD REPORT

- Offers background
- Summary of treatment
- Diagnosis
- Has some collateral
- States treatment goals
- States progress made and work that remains
- Offers some prognosis for outcomes

WHAT YOU CAN REQUEST

- Treatment plan
- Frequency and duration
- Goals of therapy
- Progress and concerns
- Who is included and attendance rate
- Risk features
- Professional opinions

NEUTRALITY

- We are never value neutral.
- We can be asked to give an opinion and then to back it up.
- We can disagree and still not be wrong.
- We can avoid taking sides and still do the job.

WORKING WITH THE THERAPIST

- They are trained and Experienced.
- Knows what they are good at.
- Will listen to your perspective.
- Will return your phone calls.
- Is willing to collaborate for the client.

TYPES OF THERAPIES

- EMDR – eye movement desensitization reprocessing
- DBT – didactical behavioral therapy
- PCIT – parent child interaction therapy
- CBT – cognitive behavioral therapy
- Biofeedback
- Psychodynamic
- Play therapy, directed or self directed
- Family, group, individual, couples

MEDICATION

- Medication is/can be therapeutic.
- Medication is often used for Axis I diagnosis.
- It can make a tremendous difference.
- Often hard to monitor and to encourage compliance and follow through.
- Paying for meds is getting harder.
- Finding a psychiatrist is even harder.

ASSISTANCE

- Services beyond therapy and medication:
 - Assertive outreach
 - Intensive case management
 - Job/housing assistance
 - Family counseling and education
 - Relationship management
 - Stress management
 - Social networking

MAKE A CONNECTION

- Affirm their need to have help.
- Affirm how hard things have been for them.
- Tell them something good about them.
- Normalize their experience.
- Send a message of confidence

DON'T JUDGE

- Mental illness carries with it a nasty social stigma.
- They often feel responsible and blame themselves but project this onto others (their children).
- They often feel alone and isolated.
- They feel deeply ashamed.

THE REPLACEMENT PARENT

- Become the firm, caring grown up they never had.
- Remember that developmentally they are very young, they missed out on a lot.
- They benefit from structure, expectations, clarity and connection.

SUCSESSES

- My probation officer gave me a lot of chances.
- My judge really cared about me.
- My attorney took the time to talk to me.
- My therapist taught me new skills.
- No one accepted excuses.
- They treated me with respect.
- I am better, not fixed, but better.

RESOURCES

- "Comorbidity: Addiction and Other Mental Illnesses" *National Institute on Drug Abuse: Research Report Series*. Revised September 2010. Department of Health and Human Services. Print.
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