Subject One:

Subject Review & Training/Teaching Guide

The Link Between Psychiatric and Substance Disorders: An Integrated Treatment Approach

Subject Review Developed By:
Rhonda McKillip, LLC
Text: THE BASICS, Second Edition:
A Curriculum for Co-Occurring Psychiatric and Substance Disorders
© McKillip & Associates; rhondamckillipandthebasics.com; Review Revision May 2021
Author: Rhonda McKillip, M.Ed., LMHC, MAC, CCDCIII, CDP
Foreword: Kenneth Minkoff, MD

1

Purpose of the Subject Review & Teaching Guide

1. Cross-train staff on Co-Occurring Psychiatric and Substance Disorders using *THE BASICS, Second Edition* as the text. Training, study, or review by treatment providers of the curriculum/subjects in *THE BASICS, Second Edition* either individually or by the entire staff.
2. Provide discussion and teaching format for Universities and Colleges using *THE BASICS* as their course work text.
3. Assist professionals in Subject Review for Credentialing Exams offered by the International Certification & Reciprocity Consortium (IC&RC) and other national boards.

❖ **NOT**E: These PowerPoint presentations are **NOT** the officially endorsed "Study Guides" for the IC&RC and other National Exams recommending *THE BASICS, Second Edition* as material to be studied for their exams. *THE BASICS, Second Edition – the two volume set* – **IS** the recommended Study Guide for the credentialing exams. These Subject Reviews are overviews that I created to give professionals a way of reviewing subject material or training presentations *on THE BASICS*. These are not sufficient or intended to be the sole credentialing preparation for any credentialing, CEU, or licensing exams as they are only an overview.

2

Bibliographies/References/Resources

- *THE BASICS, Second Edition* is supported by thousands of professional research studies, references, and resources…over 1,600 of these are listed in the curriculum.
- In each of the eight subjects and six appendices there are sources/references listed within the subject text itself.
- At the end of each of the eight subjects and six appendices you will find extensive bibliographies of the references and resources.
- An enormous gratitude is extended to the treatment participants who – while being taught the psychoeducation in this curriculum – commented and shared what was helpful. They contributed through their responses (without knowing I had written the curriculum) what I needed to add, eliminate, or explain differently.
- Much appreciation to the thousands of professionals who contributed to the psychoeducation found in *THE BASICS, Second Edition* through their trainings, research studies, books, mentoring, collegial support, and sharing their vast experience and knowledge with me.

3

Putting Evidence Based Practice (EBP) into Action

1. ***PURPOSE**: THE BASICS eliminates the "gap" between the system and the professionals providing the services; between the evidence based practices and the person seeking services. THE BASICS is a compendium of materials designed to help clinicians teach the evidence based practice skills to persons with co-occurring disorders. It is designed to ensure the continuity of care.*
2. ***EBP:** Integrated System of Care; Universal Dual Diagnosis Capabilities; Principles of Empathy and Hope; Motivational Interviewing Approach; Stages of Change Model Design; Strength Based; Skill Building; Solution Focused; Neurochemistry Based Disorders of the Brain; Symptom Identification; Symptoms Management; Best Practices Curriculum Topics, i.e. Nutrition, Stress Management, Cognitive Behavioral, and much more…*

4

Scope of the SUBJECT REVIEWS & DSM-5 UPDATE INFO

1. The Subject Reviews for each of the eight subjects in *THE BASICS, Second Edition* is meant to provide bullets of the curriculum content and examples.
2. It is *not*, of course, intended to present the entire curriculum in this PowerPoint format.
3. Please refer to the actual curriculum for the complete list of the examples, explanations, and psychoeducation on all the topics in these Subject Reviews.
4. Also please take a look at the *LESSON PLANS* located on my website for detailed group lesson plans to put the curriculum into action.
5. *THE BASICS* was never written with the intention of making a diagnosis either by professionals or treatment participants. It was purposely written without sufficient information available to make a diagnosis possible. There are other forms, evaluations, and specifically trained professionals to make diagnoses.
6. Yet symptom identification and discussion is extremely important.
7. During the printing of *THE BASICS, Second Edition* the format of the *Diagnostic and statistical manual of mental disorders*, originally published by the American Psychiatric Association in1952, was the DSM-IV-TR, 2000.
8. So this was my dilemma as the author of the curriculum…

5

9. Do I publish a *Third Edition* for the sole purpose of updating the limited amount of diagnostic criteria to align with the DSM-5? Or do I find a way to update the material that would be available at no cost on my website?
10. I chose the latter…no additional cost to current owners and purchasers.
11. The limited references to the DSM on the symptoms of psychiatric disorders are primarily located in *Subject Two: Psychiatric Disorders Within A Co-Occurring Diagnosis*. This subject, of course, does not cover all of the psychiatric disorders. It includes only the ones typically found among co-occurring psychiatric and substance use orders like Depression, Anxiety, Mood Disorders, Thought Disorders, Personality Disorders, etc.
12. The limited references to the DSM on Substance Disorders are located in *Subject Three, Substance Disorders Within a Co-Occurring Diagnosis*.
13. The updates from the DSM-IV-TR to the DSM-5 (American Psychiatric Association, 2013) are located in Subject Two & Subject Three of these Reviews.
14. You will find extensive lists of symptoms from other sources on Psychiatric Disorders in APPENDIX II and Substance Disorders in APPENDIX III.
15. These Appendices are worded in everyday language and are by far the very best way for individuals to understand their symptoms or identify those they may wish to discuss further with their group or individual counselor.

6

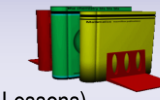
Lesson Plan Exercises

1. Each one of the lesson plans on my website have at least one exercise. None of these are in *THE BASICS, Second Edition* curriculum.
2. I developed the lesson plans to put the curriculum into action by dividing subject material into 6 - 10 pages.
3. The exercises were developed so each group includes an opportunity for treatment participants to internalize the material and transform the psychoeducation into actual practice.
4. The result is 103 detailed lessons and exercises with complete instructions, suggested processing questions, and time-frames.

7

Curriculum Development and Lesson Plans
rhondamckillipandthebasics.com

1. Integrated Treatment Recovery & Approach (6 lessons)
2. Symptom Identification & Symptom Management of Psychiatric Disorders (9 lessons)
3. Moving Toward Change (6 lessons)
4. Life Skills (6 Lessons)
5. Progression of Untreated Disorders (5 Lessons)
6. Symptoms Identification & Symptom Management of Substance Use Disorders (9 Lessons)
7. Recovery & Health (6 Lessons)
8. Physical Self-Care (4 Lessons)
9. Stress Identification & Management (2 Lessons)



8

Curriculum Development and Lesson Plans…continued
rhondamckillipandthebasics.com

10. Neurochemistry of Substance Dependence (3 Lessons)
11. Emotional Recovery & Health (9 Lessons)
12. Preventing Relapse in Substance Use Disorders & Recurrence of Symptoms in Psychiatric Disorders (8 Lessons)
13. Family and Social Recovery & Health (3 Lessons)
14. Thinking/Cognitive Recovery & Health (2 Lessons)
15. Personal Development & Recovery (6 Lessons)
16. Self-Help & Twelve Step Groups (2 Lessons)
17. Spiritual Recovery (2 Lessons)
18. Maintaining Recovery (3 Lessons)

9

SUBJECT ONE The Link Betweeen Psychiatric and Substance Disorders, An Integrated Approach

OVERVIEW OF TOPICS

Psychiatric, Substance & Co-Occurring Disorders Defined · The Brain-Body Connection· Causes of Psychiatric & Substance Disorders · Bio-Psycho-Social-Cultural-Environmental-Spiritual Approach · Recovery and Wellness · Focusing on Similarities and *NOT* Differences · History, Philosophies, and Barriers to Treatment · The Integrated Treatment Approach · Ethnic, Cultural, and Personal Identity · Cultural Diversity · How People Change Behaviors · Stages of Change · Motivation & Working Through Ambivalence · Personal Motives · Choices · Fear in Early Recovery · The Group Process · Good Communication Skills and Group · Listening Skills · Passive, Aggressive, Passive-Aggressive & Assertive Communication Skills · Getting the Most Out of Group · Group Guidelines…more

10

Subject One Presentation Guide

The Link Between Psychiatric and Substance Disorders, An Integrated Treatment Approach

Presentation Subject Guide Example Located at the Beginning of Each Subject

PRESENTATION GUIDE: SEGMENTS				
	A	*Prepare*	Professionals	Goal, Objectives, and Methods
				Subject Sections
				Appendices
				Handouts
			Group	Beginning: Reading, Phrase, or Relaxation
				Introductions
				Overview of Format & Subject
	B	*Present*	Subject Material	Time Frames Separate Sections
				Sections of Subject
			Appendices	Appendices Related to Specific Subject
	C	*Practice*	Handouts	Subject Handouts & Discussion
			Group Closure	Group Closure & Support

11

Subject One Goal and Objectives

Goal:
Identify the link between Psychiatric and Substance Disorders as the foundation of the integrated treatment approach.

Objectives for Professionals:

1. Discuss the similarities of Psychiatric and Substance Disorders in "illness" and in "health."
2. Detail the effects of Alcohol and Other Drugs on Mental Health, as well as in the Withdrawal Process.
3. Discuss ethnic, cultural, personal, as well as recovery identities of people who are attending treatment for co-occurring Psychiatric and Substance Disorders.
4. Summarize how people change behaviors.
5. Review the skills that help people get the most out of group.

12

Today's Subject and Why It's Important

"I believe we have two lives, the one we learn with and the one we live with after that." (MGM, Glenn Close, The Natural, 1984)

- A person with *any* illness needs to learn as much as possible about that disorder. Education on Psychiatric and Substance Disorders is an essential part of the treatment process.
- It is not important to remember the specific facts of any lesson. Facts are simply statements of something that is real and can be verified or backed up. The goal is to gain an understanding of the material. *Understanding* means a person is grasping the overall *meaning* of the facts.
- The goal of today's subject is to provide education on the link between Psychiatric and Substance Disorders, as well as an overall understanding of the importance of an integrated treatment approach.

From THE BASICS, Second Edition, Page Subject 1-1

13

PSYCHIATRIC, SUBSTANCE, AND CO-OCCURRING DISORDERS DEFINED

Substance Disorders Are Linked With Psychiatric Disorders and Symptoms in Ways That Can:

- *Mask* or cover up a mental illness.
- *Mimic* or imitate a psychiatric disorder.
- *Worsen* mental health disorders by increasing symptoms.
- *Complicate* the treatment of a psychiatric disorder.

14

MEDICAL DISORDERS OF THE BRAIN

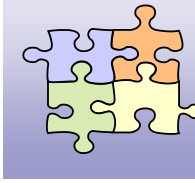
First,
it is true that these disorders are medical disorders of the brain.

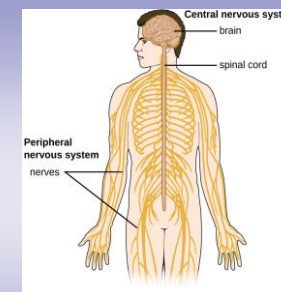
Second,
it helps a person to understand *they* are *not* their illness.

Third,
identifying these disorders as *medical disorders* leads to acceptance.

15

THE BRAIN – BODY CONNECTION





16

The Effects of *Untreated* Psychiatric Disorders on the Brain and Body Like Depression often includes:

Brain	Body
• Depressed Mood • Inappropriate Guilt • Negative Thinking • Sense of Hopelessness	• Insomnia • Significant Weight Loss or Gain • Fatigue or Loss of Energy • Impaired Immune System and Increased Risk of Illness

17

The Effects of *Untreated* Substance Disorders on the Brain and Body often includes:

Short-Term *Desired* Effects of Cocaine		*Undesired* Long-Term Effects	
Brain	**Body**	**Brain**	**Body**
• Euphoria • Self-Confidence • Enhanced Thinking	• Increased Sense of Energy • Decreased Fatigue • Decreased Appetite	• Depression • Delusions • Paranoia	• Extreme Fatigue • Strokes • Heart Failure

18

The Effects of *Untreated* Co-Occurring Disorders on the Brain and Body often includes:

Continued Substance Abuse + Mental Health Disorder
(i.e. long-term Crack Cocaine can mimic Paranoid Schizophrenia)

Brain	Body
• Chemical Changes • Hallucinations • Delusions (False Beliefs)	• Impaired Immune System • Possible Heart Damage • High Risk of Death to Self or Others

19

CAUSES OF PSYCHIATRIC AND SUBSTANCE DISORDERS

Psychiatric Illnesses =
Biology (primary influence) + Psychology + Social or Environment + Stress

Addictive Illnesses =
Biology (primary influence) + Psychology + Social or Environment + Stress + Alcohol and Other Drugs

Daley, 1994

20

Bio-Psycho-Social-Cultural-Environmental-Spiritual *Approach*

- "Bio" or Biological Component
  - ✓ Biochemistry
  - ✓ Addictive Disorders and Biochemistry
  - ✓ Heredity
  - ✓ Genetics
- "Psycho" or Psychological Component
- "Socio" or Social-Cultural-Environmental Components
- Spiritual Component
- Weighing the Components of Risk

21

Bio-Psycho-Social-Cultural-Environmental-Spiritual *Recovery*

Biological Wellness

1	Getting rest, sleep, and developing relaxation skills.
2	Maintaining nutrition and proper body fat.
3	Avoiding abuse of drugs, alcohol, or tobacco.
4	Achieving fitness.
5	Practicing positive life-style habits.
6	Carrying out daily tasks.

22

Bio-Psycho-Social-Cultural Environmental-Spiritual Recovery

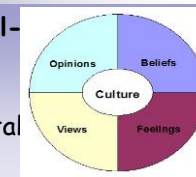
Psychological Wellness

1	Learning and using information effectively for personal, family, and career development.
2	Recognizing, accepting, and expressing feelings, emotions, and thoughts appropriately.
3	Managing stress, structuring time, accepting one's personal limitations, and striving for balance in work, play, and rest.
4	Learning to deal with new challenges effectively and striving for continued growth.

23

Bio-Psycho-Social-Cultural-Environmental-Spiritual *Recovery*

Socio-Cultural-Environmental Wellness



1	Interacting successfully with people and the environment.
2	Developing and maintaining intimacy with significant others.
3	Developing respect and tolerance for those with difference opinions and beliefs.

24

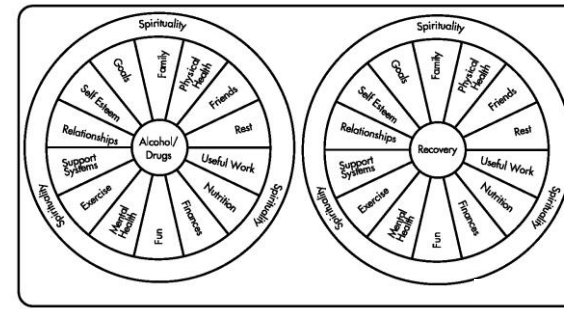
Bio-Psycho-Social-Cultural-Environmental-Spiritual *Recovery*

Spiritual Wellness

1	Believing in some force, nature, science, religion, or a "Higher Power" that serves to unite human beings and provide meaning and purpose to life.
2	Defining and living within personal morals, values, and ethics.

25

Specific Areas of Life Are Affected Either in the *Disease* Process or the *Recovery* Process



26

FOCUSING ON SIMILARITIES AND *NOT* DIFFERENCES

Similarities of Psychiatric and Substance Disorders

No Fault Illnesses	Brain Disorders	Parallel Phases of Treatment & Recovery
Stigmatized Illnesses	Chronic Illnesses	Each Illness is Primary
Illnesses of Isolation	Disease & Recovery Model	Each Illness Proceeds Independently

27

Subgroups of *Co-Occurring* Disorders

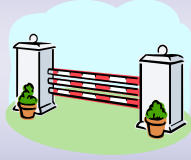
- Quadrant I: SUBSTANCE ABUSE AND NON-SEVERE PSYCHOPATHOLOGY (PSYCH-LOW; SUBSTANCE-LOW)
- Quadrant II: SUBSTANCE ABUSING MENTALLY ILL (PSYCH-HIGH; SUBSTANCE-LOW)
- Quadrant III: COMPLICATED CHEMICAL DEPENDENCY (PSYCH-LOW; SUBSTANCE-HIGH) (PSYCHIATRICALLY-COMPLICATED SUBSTANCE DEPENDENCE)
- Quadrant IVA and IVB: SUBSTANCE DEPENDENT MENTALLY ILL (PSYCH-HIGH; SUBSTANCE HIGH) (Quadrant IVA: SPMI- high; substance high) (Quadrant IVB: non-SPMI; high substance high)

Sources: Richard Ries, M.D., Director, Outpatient Psychiatry, Harborview Medical Center, Department of Psychiatry and Behavioral Sciences, Seattle, WA; Kenneth Minkoff, M.D., 2002, *Quadrants of Sub-Groups of People with Co-Existing Disorders*. Medical Director of Arbour-Choate Health

28

Prevalence of Co-Occurring Disorders

Increasing Number of Individuals With Co-Occurring Disorders



HISTORY, PHILOSOPHIES, AND BARRIERS TO TREATMENT

History of Mental Health Treatment

History of Substance Disorders Treatment

29

SEPARATE SYSTEMS CREATE BARRIERS TO TREATMENT

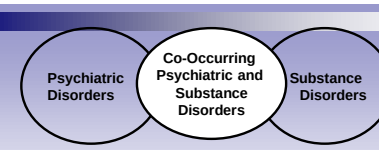
- Barriers in a *Non*-Integrated Mental Health Facility
- Barriers in a *Non*-Integrated Addiction Treatment Facility
- Separate Funding and Reimbursement Creates Barriers to Treatment

30

BARRIERS TO TREATMENT RESULT IN "PING-PONG" THERAPY

People "Ping-Pong" Themselves From One System to Another
(or the "system" ping-pongs them)

31



The Integrated Treatment Approach

- Benefits for the Individual With a Single Disorder
- Accepting a Dual Diagnosis Can Be Difficult, Even Distressing
- The "Recovery Model" for Co-Occurring Disorders
- Co-Occurring Disorders and Dual Recovery

32

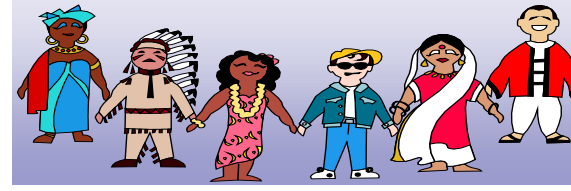
Recovery = Abstinence + Specific Treatment + Change
(Daley, 1994)

Specific treatment that addresses psychiatric *and* substance disorders often includes:

Gain Education	Get Support
Design & Implement a Plan	Identify Relapse Triggers
Cope with Emotions	Establish Healthy Behaviors
Manage Cravings	Cope with Symptoms
Change Thinking	Work a Program

33

Ethnic, Cultural, and Personal Identity



34

Ethnic and Cultural Diversity

- Frustration
- Health Issues
- Cultural "Shock"
- Isolation
- Stress & Depression

Cultural Diversity

Views on Psychiatric & Substance Disorders	Ideas on Illness & Healing
Attitudes on Seeking Counseling	Views on Communication
Opinions on Self-Reliance	Thoughts on Time
Thoughts on Competition	Beliefs on Spirituality
Beliefs About Family Systems	Opinions on Gender

35

Personal Identification With a Specific Group

(sexual orientation example)

Pre-Encounter Stage	Internalization Stage
Encounter Stage	Internalization - Commitment Stage
Immersion Stage	

- Diversity of Individuals
- Breaking Down Stereotypes and *Not* Judging Others
- Identifying With a Recovery Group

36

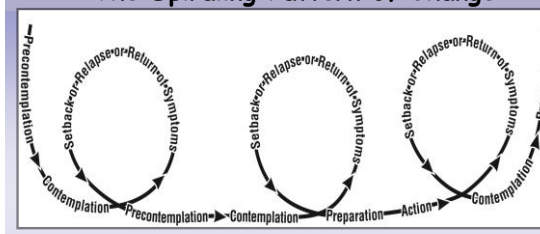
HOW PEOPLE CHANGE BEHAVIORS

Stages of Change

- Pre-Contemplation Stage of Change
- Contemplation Stage of Change
- Preparation Stage of Change
- Action Stage of Change
- Maintenance Stage of Change

37

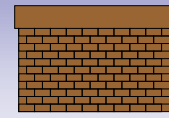
The Spiraling Pattern of Change



- Different Stages of Change at the Same Time
- Discomfort and Mistakes Can Lead to Change
- Depression and Anxiety Can Help Lead to Change

38

Barriers to Change



- Old Attitudes and Beliefs
- Difficulty in Relating to Later Stage Symptoms
- The "Yeah Buts"
- The "Yets"
- The "I'm Really, Really Going to Try…*Really*" Syndrome
- Putting Off Making a Decision for Change
- Not Putting The "Action" Into Change
- Discounting or Finding a "Reason" to Leave Treatment
- Trying To Do It "Perfectly"

39

Change Takes Practice and Occurs From the Inside - Out

Motivation and Working Through Ambivalence

40

Weighing the "I Want To" & the "I Don't Want To"

"I Want To" Finding Personal Reasons to Change		"But I Don't Want To" Reasons I Don't Want to Change
What images come to mind when you think about having a better life without alcohol and drugs, or making changes to reduce psychiatric symptoms?		I'm afraid to really try to quit using or begin treatment for a Psychiatric Disorder because I might fail.
How would quitting substance abuse or working a program of recovery for Psychiatric and Substance Disorders pay off immediately in your relationships?		I think the positive effects I get from substances outweigh the negative effects, even though they worsen my psychiatric symptoms.

41

Personal Motives & Choices

42

Fears in Early Recovery
can include a person fearing…

someone will find out about substance abuse	diagnosis of a psychiatric or substance disorder	punishment or retaliation from family, friends, or employers
DUI, incarceration, or institutionalization	losses like custody of children, relationships, family, job, housing, health, or mental capacity	physical harm due to risky behaviors or dangerous situations
failure, crisis, or relapse	treatment, making changes, or the unknown	life without the use of alcohol and/or drugs

43

Fears in Early Recovery …continued

- Fear of Living Life Without Substances
- Fear in The Group Process
- Acknowledging Fear
- Working Through Fear By Living in Today

44

The Group Process

45

Increasing Self-Awareness With the Johari Window

	Area Known to You or What You See in Yourself	Area Not Known to You or What You Do *Not* See In Yourself
Area Known To Others or What Others *See* in You	**Window Pane 1** Open, Public, Conscious Self	**Window Pane 2** Blind Self
Area Not Known to Others or What Others Do Not See or Know about You	**Window Pane 3** Private, Hidden, or Avoided Self	**Window Pane 4** Unknown or Unconscious Self

46

The Window Panes Change With Self-Disclosure and Feedback

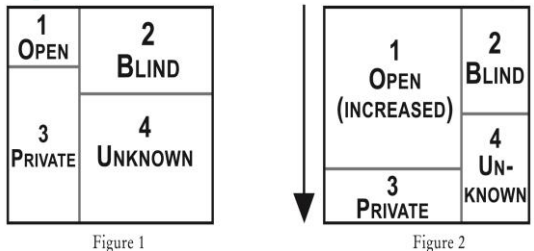


Figure 1 Figure 2

47

Self-Disclosure Defined

- What Self-Disclosure Is *Not*
- What Self-Disclosure *Is*

Feedback Defined

- What Feedback Is *Not*
- What Feedback *Is*

48

Difficulty Trusting Self and Others

- Unhealthy Family Systems and Sexual Abuse
- "Family Secrets"
- Breaking Promises to Self
- Untrustworthy Behavior & Unhealthy Relationships

49

Developing Trust Through Self-Disclosure

- Risks of Self-Disclosure
- Benefits of Self-Disclosure
- Benefits of The Group Process
- Moving From "Victim" to "Survivor"
- Don't Let Fear Be In Charge

50

Sharing Personal Experiences in a Support or Recovery Group

- Keeps Honesty & Accountability
- Gives New Perspectives
- Breaks Through Isolation & Shame
- Gets the Story Right
- Sheds Illusions
- Produces Lasting Benefits of Telling a Truthful Story

Learning to Value the Perspective of Others

51

Good Communication Skills and Group Listening Skills

Listen From the Heart	Use Silence When You Do Not Know What to Say
Focus Fully on What Someone is Saying	Listen for Details
Listen for More Than Words	Listen to What Is *Not* Being Said
Listen Objectively	Use Short Responses
Listen for the Main Idea	Listen Twice as Much
Pay Attention If the Person Is Expressing Facts or Feeling	

52

Communication Styles

Passive	**Aggressive**
Passive-Aggressive	**Assertive**

53

A person communicates in one style more than another for reasons that can include:

- Past Experiences
- Habit
- Defenses
- Control or Manipulation

54

Passive Communication Style

- Goal
- Techniques
- Beliefs
- Body Language or Tone
- Results

55

Aggressive Communication Style

- Goal
- Techniques
- Beliefs
- Body Language or Tone
- Results

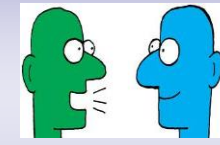
56

Passive-Aggressive Communication Style

- Goal
- Techniques
- Beliefs
- Body Language or Tone
- Results

57

Assertive Communication Style



- Goal
- Techniques
- Beliefs
- Body Language or Tone
- Results

58

Challenged in the Area of Assertiveness?

Do you?

1. Express anger and annoyance appropriately?
2. Ask for help if you need it?
3. Express your feelings and preferences clearly to others?
4. Say "no" when you don't want to do something?
5. Ask questions when you're confused?
6. Volunteer your opinions when you think or feel differently from others?
7. Speak with a generally confident manner, communicating strength and caring?
8. Tell people when they hurt your feelings?
9. When you hear a person say something mean about someone you know, do you disagree or stick up for the person?

59

Benefits of Assertive Communication

- Indicates an effort at creating mutually satisfying solutions.
- Diffuses anger, reduces guilt, faces problems, and gains respect of others.
- Strengthens relationships, reduces stress, improves a person's self-image, and increases their ability to succeed.

60

Individual Rights of Being Assertive

You have the right, just like everyone else, to be heard.
Your thoughts, opinions, ideas, and feelings are important.
You can say what you feel without hurting other people's feelings.
You can be firm, direct, and honest about your thoughts and opinions.
You don't have to agree with other people if you feel they're wrong, especially if they're putting someone down!
You can state your opinions, stand up for others, and ask for something you want or need without apologies. You don't have to be aggressive.
You have the right to express your perspective.
You have the right to assume *personal* responsibility and to decline responsibility *for* others.

61

Reasons People Are Not Assertive

assertive skills have not been learned	afraid of reprisals	don't want to rock the boat
fear of hurting someone's feelings	trying to please others	low self confidence
fear of displeasing others	fear of not being liked	fear of being abandoned

62

How to Be Assertive

- Assertive Techniques
- Use "I" Statements to Take Responsibility
- Clarify
- Be Aware of Body Language
- Role-Play
- Watch Your Timing
- Avoid Pushing The "Hot Buttons"
- Think About Feelings
- Encourage Your Partner to Describe Real Feelings
- Evaluate How You Are Doing as You Practice Communicating Assertively

Practice, Practice, Practice!

63

Getting The Most Out Of The Group Process

SKILLS

- Listening
- Clarifying
- Saying
- Feedback
- Direct Communication

VALUES

- Openness
- Taking Responsibility
- Trust
- Involvement
- Staying in the Here & Now
- Give and Take

64

TECHNIQUES

- Awareness of My Own Behavior
- Applying Insight Of Own Behavior
- Experiment With Own Behavior
- Contribute to The Group's Awareness of Itself
- Problem Solving Effectiveness
- Helping Group Maintenance
- Making The Group a Part of Life
- Contribute to Others Sharing
- Contribute to the Process of Group
- Group Diagnostic Ability
- Overall Effectiveness as a Group

65

Group Guidelines

- Group Facilitator Responsibilities
- Belonging to The Group
- Safety of the Group
- Responsibilities of Each Group Member to The Group

66

Co-Occurring Disorders *Without* Recovery often includes

1	Unmanaged stress.
2	Weakened immune system.
3	Decline in health with illness and disease.
4	Progression of Substance Disorders.
5	Increased problems with *life*: family, financial, legal, and health.
6	Worsening of anxiety, depression, or paranoia.
7	Increased intensity of Thought Disorders.
8	Deteriorating mental condition or mental decompensation.

67

Co-Occurring Disorders *With* Recovery often includes:

1	Working a program of recovery.
2	Reduced substance abuse or abstinence.
3	Improved clearing of brain processes and thinking.
4	Decreased health problems as the brain and body heal.
5	Reduction in frequency, length, and intensity of mood swings.
6	Strengthening of immune system and prevention of future illnesses.
7	Improved mental and emotional stability.
8	Connection with spirituality and hope for recovery.

68

APPENDIX IA — Effects of Alcohol And Other Drugs On Mental Health

Drug Category Section

Effects of The Following Drugs in The Areas Of:
Brain & Thinking-Personality & Mood-Behavior

- **Alcohol**
- **Barbiturates, Major Tranquilizers, or Benzodiazepines**
- **Heroin, Morphine, Opium, or Codeine**
- **Amphetamine, Methamphetamine, Cocaine, or Crack Cocaine**
- **Nicotine/Smoking**
- **Caffeine**
- **Cannabis Sativa (Marijuana, ,Hashish, or Hash Oil)**
- **LSD, PCP, Peyote, Mescaline, Psilocybin, MDMA (Ecstasy), or "designer drugs"**
- **Inhalants**
- **Anabolic Steroids**

69

Brief Examples of APPENDIX IA

Effects of Alcohol and Other Drugs on Mental Health
Brain and Thinking - Personality and Mood - Behavior

Effects of Alcohol on *Brain and Thinking*

Cognitive Impairments and Deficits: caused by damage to the liver that damages the brain and results in a lower capacity to learn and store information; 75% of alcoholics report some form of cognitive impairment; recall of information is disrupted in all aspects of everyday life.

Effects of Cannabis on *Brain and Thinking*

Marijuana Psychosis or Hemp Psychosis: break with reality; onset of psychosis can be sudden usually lasting 24-48 hours; symptoms including rambling speech, impaired memory, clouded consciousness, disorientation, hallucinations, and delusions.

70

Examples: Effects of Sedative-Hypnotics on *Personality and Mood*

Severe Depressive Symptoms: in individuals with no previous depression and worsened depression in those who have had prior Depressive Episodes.

Examples: Effects of LSD, PCP, Peyote, Mescaline, Psilocybin, MDMA, or "Designer Drugs" on *Personality and Mood*

Acute Anxiety: sense of impending doom, fearfulness, and paranoia; panic attacks.

Prolonged Depression and Prolonged Anxiety: test scores showed ecstasy users had slipped into deeper depression and were 50% more restless and irritable three days after "clubbing" as opposed to alcohol abusers.

71

Example: Effects of Opiates (Narcotics) on *Behavior*

"On The Nod" alternately wakeful & drowsy state; Indifference to Environment and People; Loss of Self Control; Psychosocial Problems; Accidental Drug Overdoses; Antisocial and Criminal Behavior; Suicide Attempts.

Example: Effects of Inhalants on *Behavior*

Marked Changes in Behavior; Lack of Concern about Appearance; Restless Activity; Impaired Coordination; Aggressive, Violent, or Impulsive Behavior; Drunken Behavior; Diminished Social and Occupational Functioning; Reduced Inhibitions.

72

APPENDIX IB Acute Withdrawal Symptoms Of Alcohol And Other Drugs

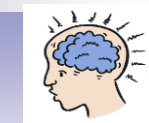
- The Brain During The Withdrawal Process
- Co-Occurring Disorders and Withdrawal
- Severity of Withdrawal Symptoms Vary
- Withdrawal Can Be Serious, But It *Is* Manageable
- Benefits of Recovery Versus Discomfort of Withdrawal

Drug Category Section: Withdrawal Process Of: Alcohol • Barbiturates, Major Tranquilizers, Benzodiazepines • Heroin, Morphine, Opium, Codeine • Amphetamine, Methamphetamine, Cocaine, or Crack Cocaine • Nicotine/ Smoking • Caffeine • Cannabis Sativa (Marijuana, Hashish, or Hash Oil) • LSD, PCP, Peyote, Mescaline, Psilocybin, MDMA (Ecstasy), or "Designer Drugs" • Inhalants • Anabolic Steroids

Withdrawal Areas Include:
Psychomotor Retardation or Agitation • Physical Discomfort • Cognitive or Thinking Difficulties • Emotional Discomfort….more

73

The Brain During the Withdrawal Process



- Changes in the brain during the withdrawal process from *depressants* push the brain toward over-activity or *anxious* symptoms.
- Changes in the brain during the withdrawal process from *stimulants* can push the brain toward depression or *depressive* symptoms.

74

Acute Withdrawal Symptoms

Range - Onset – Duration – Severity - Symptoms

***Partial* Example: Alcohol Withdrawal**

- Range of Symptoms
- Onset of Phase I
  1. Milder symptoms of discomfort or hangover
  2. Usually begins within 12 hours after the last drink, but may begin within 3-4 hours.
  3. Some symptoms, such as irritability, may peak in 24 hours while others peak in the 48-72 hour range.
  4. Symptoms last approximately 3-5 days, but may last 7-10 days depending on how much alcohol has been used and for how long use persisted prior to abstinence.
  5. Symptoms: increased over-activity of the automatic system (Hypertension of increased blood pressure along with emotional tension or agitation).....etc.
- Onset of Phase II.....

75

Subject One Handouts

Worksheet Handout

PERSONAL ASSESSMENT:
The Link Between Mental Health and Substance Use Disorders

Inspirational Handouts

1. "Change"
2. The Rules for Being Human
3. *You* May Be Strong

76

Example of a Inspirational Handout

You May Be Strong

Pray don't find fault with the man who limps…Or stumbles along the road,
Unless you have worn the shoes *he* wears…Or struggled beneath *his* load.

There may be tacks in *his* shoes that hurt…Tho' hidden away from view;
Or the burden *he* bears, placed on *your* back,
Might cause *you* to stumble too.

Don't sneer at the man who's down today, Unless you have felt his blow
That caused *his* fall or felt the shame…That only the fallen know.

You may be strong, but still the blows…That were *his*, if dealt to *you*
In the selfsame way, at the selfsame time…Might cause *you* to stagger *too*.

Author: Rama Muthukrishman

77

THE END: Subject One Review and Training/Teaching Guide

- I am deeply honored to have worked with hundreds upon hundreds of the millions of individuals who have struggled and continue to struggle with Co-Occurring Psychiatric and Substance Disorders.
- Their courage and strength in pushing ahead toward health, in spite of seemingly insurmountable obstacles, is nothing short of amazing.

- I am sometimes asked why this is the *Second Edition*.
- The first printing (250 pages) was distributed without charge to agencies to receive feedback from *treatment participants* – many of which I sat in or taught across the country without them knowing I was connected to the curriculum in any way.
- When we listen and ask – treatment and therapy participants will tell us what is working, what is not helpful, and what they need.
- Thank you for your input which is the heart of this curriculum.

78