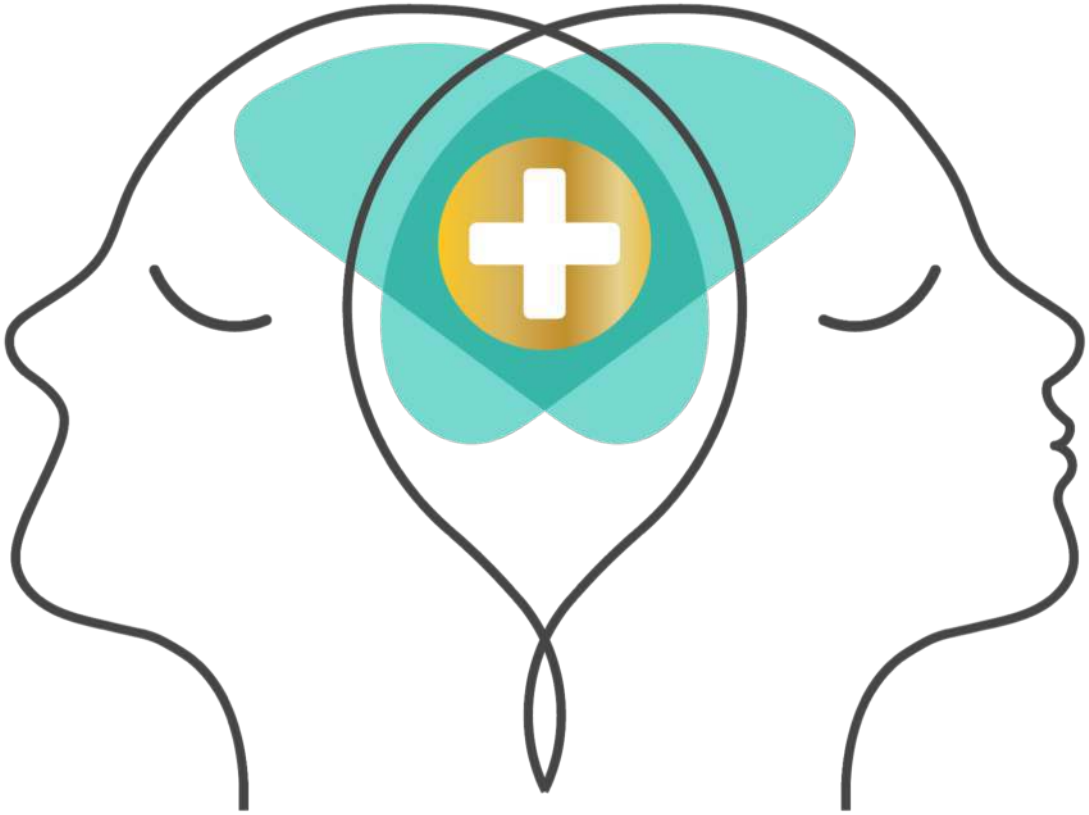
Dual Diagnosis:

The Chicken & Egg Relationship Between Mental Illness & Addiction



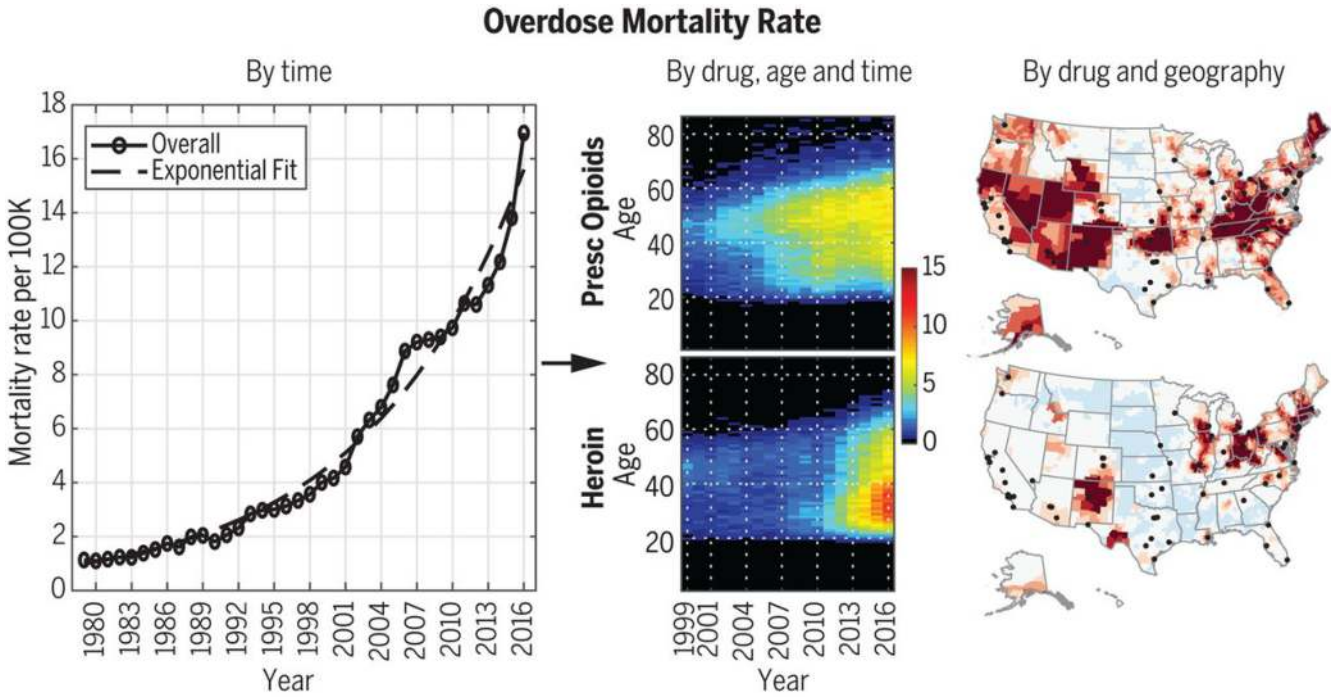
By Joyce Marter, LCPC

CEO & Psychotherapist

My Background

- CEO of Urban Balance (www.UrbanBalance.com)
- Chair of the Midwest Region of the American Counseling Association
- Author/Blogger for The Huffington Post & PsychCentral
- Speaker for the National Alliance on Mental Illness

Exponential Growth in Overdose Deaths



Hawre Jalal et al. Science 2018;361:eaau1184

What is Narcan?

- https://www.addictionhope.com/blog/demi-lovato-heroin-overdose-narcan/
- Because of the surge in opioid overdose-related mortality, considerable resources have been devoted to emergency response.
- Naloxone (Narcan) is a “rescue” medication
- Naloxone is analogous to CPR or cardioversion in acute cardiovascular compromise: it provides acute rescue and is lifesaving – but does not change the chronic, underlying pathology that led to the acute event in the first place.
- In other words, Naloxone use has been successful in saving lives, but does not treat the underlying OUD; hence, overdose prevalence continues to increase. In fact, opioid overdose deaths are skyrocketing.
- The number of deaths due to an opioid overdose quadrupled between 1999 and 2015 then further increased to over 60,000. Drug overdose is now the leading cause of accidental death in the United States.

Clinical Psychiatry News

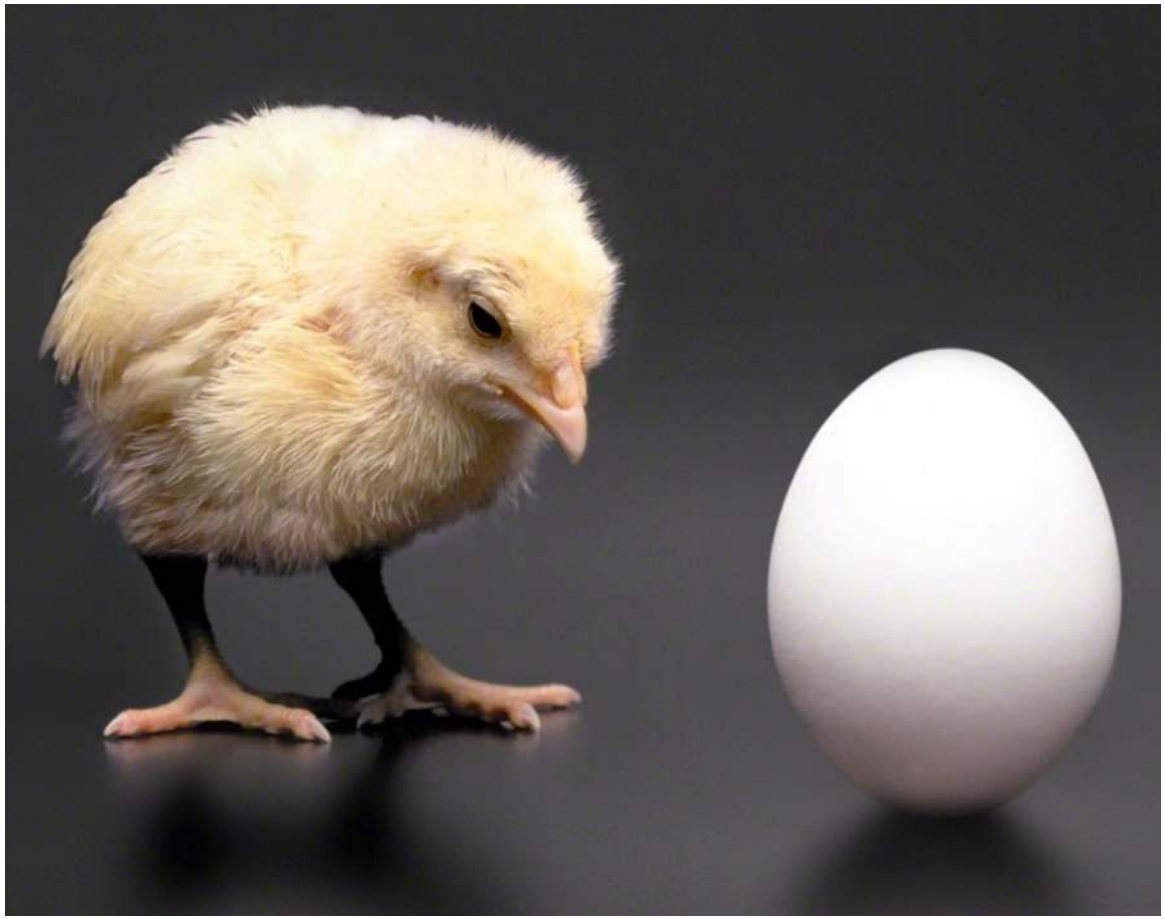
August 20,2017

"Missed Opportunities: Opioid Overdoses and Suicide"

A. Benjamin Srivastava MD & Mark S. Gold, MD

- ..more than 50% of patients with opioid use disorder have histories of major depressive disorder, which, when untreated, may further drive suicidal thoughts and behavior.10,11Maria A. Oquendo, MD, PHD, immediate past president of the American Psychiatric Association, wrote in a guest post on the blog of Nora D. Volkow, MD, director of the National Institute on Drug Abuse, about the strong link between opioid use disorders and suicidal thoughts and behavior Furthermore, a 2004 literature review on substance use disorders and suicide found that individuals with opioid use disorders had a 13 times greater risk of completed suicide, compared with the general population.12
- A recent study of nearly 5 million veterans enrolled in the Veterans Health Administration demonstrated that, even when adjusted for age and comorbid psychiatric diagnoses, opioid use disorder was associated with an increased risk for suicide; particularly striking was that this risk was doubled in women
- A survey of 40,000 subjects from the 2014 National Survey on Drug Use and Health demonstrated that prescription opioid misuse was associated with an increased risk of suicidal ideation, and weekly misuse was associated with increased suicide planning and attempts.

What is dual diagnosis?



- The disorders feed off one another - Chicken & Egg Phenomena
- Which comes first in terms of treatment?
- Who are the dually diagnosed?

Why is this important?

- It is a responsibility as a therapist to be informed
- No population is exempt from addiction
    - Any age, background, income level, sexual orientation, social or ethnic group

1 out of 10
Americans have a drug or alcohol problem

1 out of 7
of us have a family member with a problem

1 out of 3
people who present for therapy have a substance abuse problem

Relationships between addiction and psychological issues

- Self-medication or maladaptive coping mechanism to manage:
  - Mood disorders
  - Anxiety disorders
  - Trauma/abuse
  - Grief/loss
- Drugs and alcohol exacerbate depression & anxiety
- Sometimes the addictive symptoms look like a psych diagnosis until the person gets clean
- Prescription drug abuse:
  - Benzodiazepines (Xanax, Valium, Klonopin, etc.)
  - Opiates (Codeine, Vicodin, Tylenol 3's, etc.)
  - ADD medications (Ritalin, Adderall, Concerta, etc.)

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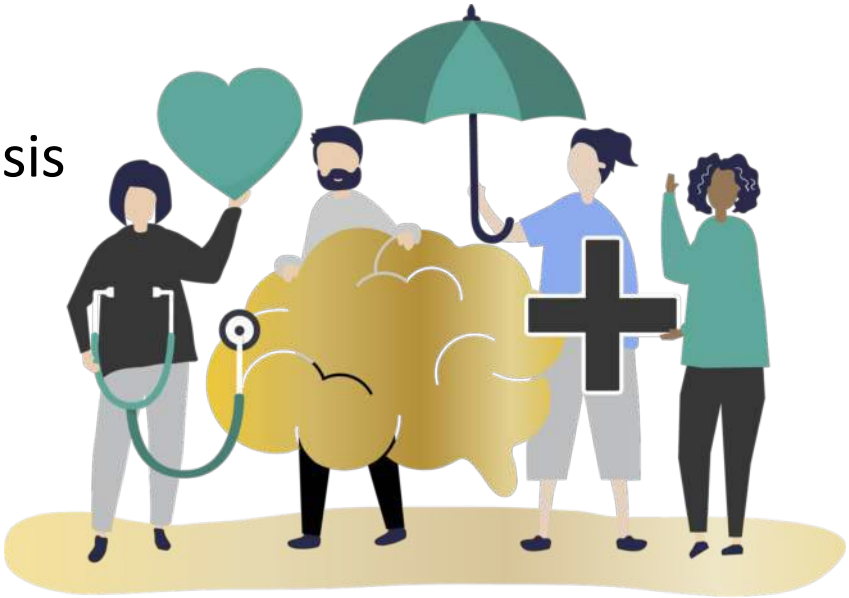
Assessing for the Diagnoses

- Straight psych (no addiction)
- Straight addiction (no psych—does this exist?)
- Dual diagnosis
  - Addiction in addition to psych diagnosis
  - Substance use in relation to grief
  - Which is the primary diagnosis?
  - Which do you treat first?
  - How does this affect treatment?



Alcohol Assessment — What should you ask?

- What's their relationship with alcohol?
  - How many days a week do they drink?
  - What/why/when do they typically drink?
  - How many do they have when going out?
  - Blackouts? Frequency?
  - DUI'S or accidents/injuries?
  - High risk behaviors when drinking?
  - Vomiting? Frequency? Alcohol poisoning?
  - Have they or anyone ever been concerned they might have a problem?
  - What is their alcohol use history?
  - Age at first use?
  - Withdrawal symptoms like shakes or delirium tremens?
  - Prior AA or treatment? Have they ever tried to quit?

Alcohol Assessment (Continued)

- Family history of alcoholism, DUI's?
- Lifestyle/alcohol use of friends/family
- Psychosocial history (trauma, abuse, etc.)
- Medical history (liver disease, etc.)
- Do they look healthy?
  - skin, eyes, hair, weight, hygiene, grooming, etc.
- Drinking style
  - Dependency (withdrawals, obsessive use)
  - Binge (5 or more drinks, 5 or more times per month)
  - Episodic (once they start they can't stop, quit for periods, etc.)
- There are different stages of the disease of alcoholism
  - Stages 1, 2 (intense need to drink), 3 (loss of control) & 4 (advanced)
  - www.about-alcoholism-info.com/Stages_of_Alcoholism.html

Assessing Drug History

- What have they tried?
- At what ages?
- How many times?
- Frequency and quantity of use?
- What drugs did they like or dislike?
- How did they do their drugs? (smoke, inject, inhale, etc.)
- Drug of choice or polysubstance abuse?
- Have they ever abused prescription drugs or took medications that weren't theirs?
- Did they ever deal drugs?
- Legal consequences?
- Caffeine & tobacco use?
- Did they ever over dose?
- Prior 12-step or treatment?
- Family history of addiction or abuse?

Emotional Relational Behavioral Factors

- Lying/secrecy
- Denial/rationalization/minimizing
- Inconsistency
- Not morning people/high absenteeism
- Financial/legal consequences
- Relational problems
- Chaos, behavioral cycles
- Denying responsibility
- People around who enable them
- Problems handling conflict
- Physical complaints
  (due to withdrawal, etc.)
- Sleep disturbance
- Job/academic problems

Etiology of Addiction

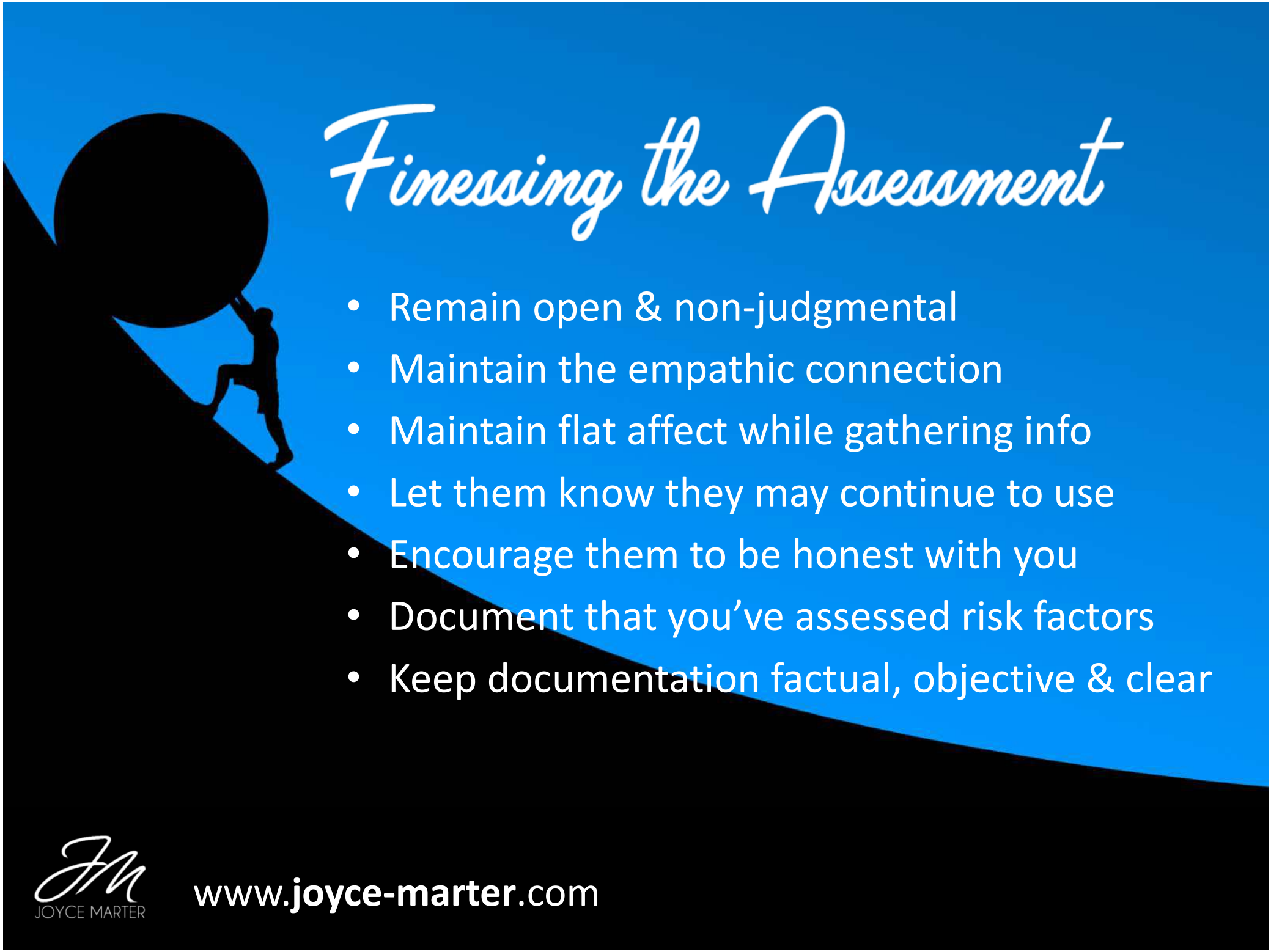
- Discussion—is addiction/alcoholism a disease?
- Why does addiction happen to some and not others?
  - Genetic predisposition, trauma history, etc.
- Why do people say it is a family disease?
- Why do people say it is a spiritual disease?
- Addiction as an attachment disorder?
- When does addiction appear?
  - For some, almost at first use
  - For others, addiction triggered by event

Nature of Addiction

- It is an obsessive-compulsive disorder
- The drug becomes primary focus (even over love)
- Irrational “stinking” thinking
- High rate of recidivism/relapse
- They are not going to get better for somebody else---they have to do it for themselves
- Journal of Addiction Medicine as resource

Knowing the Jargon

- Know the classes of drugs (hallucinogens, opiates, benzodiazepines, stimulants, etc.)
- Know the street names/slang: www.whitehousedrugpolicy.gov/StreetTerms/ByType
- Know how they are used (smoked, shot, snorted, etc.)
- Know the dosages ($ or amount)
- Know the slang for use
- Admit what you don't know


Finessing the Assessment
• Remain open & non-judgmental
• Maintain the empathic connection
• Maintain flat affect while gathering info
• Let them know they may continue to use
• Encourage them to be honest with you
• Document that you've assessed risk factors
• Keep documentation factual, objective & clear
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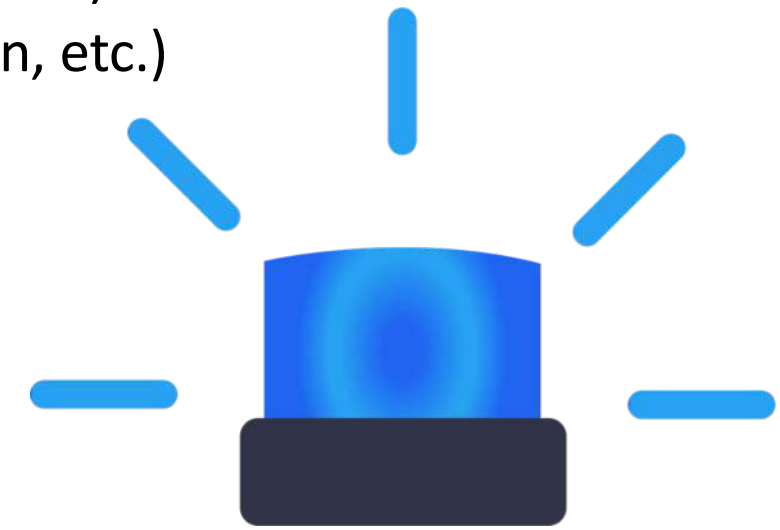
Finessing the Intervention/Treatment

- Provide education, information and resources
- Remain non-judgmental & open
- Ask them questions to break through denial
- Address the defense mechanisms
- Might have to begin with harm reduction
- Use behavioral predictions to increase insight
- Maintain the therapeutic relationship
- Start where they are at
- Professional interventionists are available

Assessing the Level of Care

- Are they an alcoholic/addict or an abuser?
- When is medical detoxfication required?
  - When dependent on:
  - Alcohol (most serious, dangerous withdrawal)
  - Opiates (heroine, methadone, pain pills, etc.)
  - Benzodiazepines (Xanax, Valium, Klonopin, etc.)
- Use DSM-V criteria
  - For abuse or dependency
- Use ASAM Criteria (www.asam.org)
  - Dependency (medical detox, inpatient)
  - Abuse (residential, PHP, IOP)
  - Problem (OP, therapy, 12-step like AA)
- Client may step down to a lower level of treatment as progress is made



Referring to a Treatment Program

- If client wants to use insurance, have them check their substance abuse benefits
- Contact the Intake Coordinator to schedule an intake
- If emergency detoxification, they can go to ER of hospital.
- Resource lists?

Finessing Communication with Collaterals

- Get reciprocal releases that last a year
- Treatment Program
  - Facilitate treatment coordination
  - Discuss discharge plan
- Psychiatrist or Addictionologist
  - Make sure doctor is knowledgeable of addiction
  - Facilitate treatment coordination
  - Reduce ability of client to abuse medications
  - Establish a safety plan
- Sponsor
  - For emergency if no other sober support
- Family
  - For emergency contact

Codependency—What is it?

- The people in a relationship with an addict
  - Often had an alcoholic parent
- Term can apply to being in a relationship with somebody who is depressed, narcissistic, etc.)
  - Book, “The Wizard of Oz & Other Narcissists”
  - “The Human Magnet Syndrome”
- Traits
  - Enabling, controlling, caretaking, over-functioning, poor boundaries, poor self care, rage, low self-esteem, checking behaviors, martyr behavior, feel responsible for others, etc.
- The cycle (anger, control, disempowerment, rationalization, sadness and repeat)

Assessing for Codependency

- Family/relationship history of addiction
- Seeing the symptoms
  - Even if there is no report of drug or alcohol abuse
- Seeing the cycle
  - Drama Triangle (persecutor, rescuer, victim)
- Comorbidity with depression
- Alcoholics and addicts can also be codependent and vice versa
  - Some attend AA & Al-Anon


Recovery from Codependency
• 12-Step Support
o Al-Anon, CODA, ACOA, & Ala-teen
o Handout of the steps of Al-Anon
o Serenity Prayer
• Psychotherapy
• Self care, detachment, unplug, setting limits and boundaries, & breaking the cycle
• Melody Beattie & Al-Anon Books
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12-Step Program Criticisms

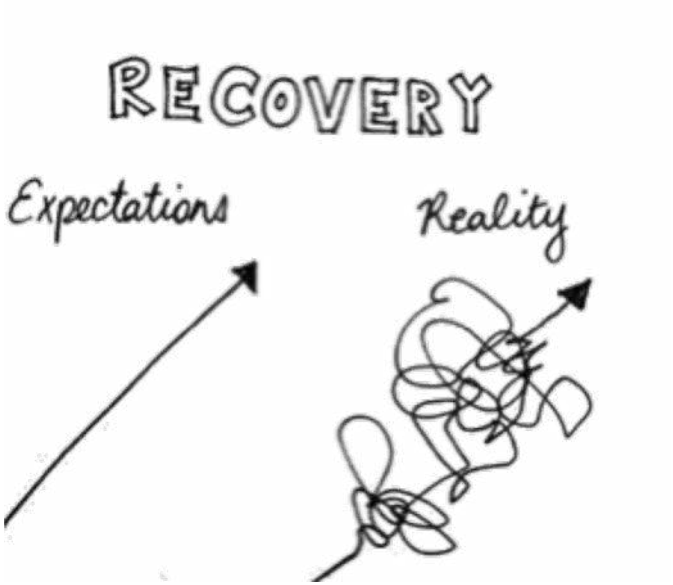
- The criticisms/excuses
  - Not comfortable with the higher power/God stuff
  - “These people are really sick”
  - “I don’t like groups”
  - It is like a cult
  - Replacing one addiction for another
  - “I don’t have time for meetings”
  - Not ready for abstinence, want to try moderation
- Tell your clients the criticisms up front so they can’t use them later.

12-Step Program Strengths

- Psychological tools (like CBT)
  - "Take it one day at a time"
  - "Going in your head is going into a bad neighborhood"
  - "Gratitude is an attitude"
- Sober social support
  - Fellowship
  - Sponsor
- Being of service/volunteering
- Spiritual support
- Normalization/validation
- Information & education
- There is nothing better
  - Moderation programs (www.moderation.org) not effective for addicts, just abusers
- Handout of the 12 steps of AA (same for NA, CA, etc.)
- Best shot: sponsorship, working steps, 90 meetings/90 days

Supporting Recovery in Therapy

- Identifying triggers for use
  - people, places, things, feelings, events, etc.
- Develop Relapse Prevention Plan
- Work on CBT to rework “alcoholic thinking”
- Encourage the creation of a sober support network
- Creating drug free activities/hobbies
- Understand progress is not linear
- Increase healthy coping skills
- Encourage appropriate expression of emotion
- Teach conflict resolution and communication skills
- Support developmental growth
  - Clients return to emotional age of first use once sober
  - Promote responsibility
  - Promote self care (being own good parent)



For the Therapist

- Be aware of your own abuse/addiction
- Be aware of your own codependency
- Be aware of your countertransference
- Do not enable, collude or go into denial
- Practice self-care
- Practice detachment
- Maintain good boundaries
- Get consultation and peer support
- Be authentic & direct
- Stay open & non-judgmental
- Remember you are not responsible for their sobriety
- Have a sense of humor
- Could consider addictions certification

Suggestions for Continued Learning

- Alcoholics Anonymous Big Book
- The 12 Steps & Twelve Traditions
- The Thinking Person's Guide to Sobriety
- Hazelden books (www.hazelden.org)
- Codependent No More/Beyond Codependency (must read)
- The Language of Letting Go

- The Glass Castle: A Memoir (must read)
- A Drinking Life: A Memoir
- Angela's Ashes

- Attend an open AA & Al-Anon meeting
- Continuing ed

Thank You!

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