Objectives

- Review the brain changes that occur as a result of mental health & addiction disorders
- Review diagnostic categories in the DMS-5 that commonly co-occur with a substance use disorders
- Discuss why substance use disorders commonly co-occur with mental disorders
- Discuss treatment options
Rearranging Dependency

- Taking the substance in larger amounts or for longer than the you meant to
- Wanting to cut down or stop using the substance but not managing to
- Spending a lot of time getting, using, or recovering from use of the substance
- Cravings and urges to use the substance
- Not managing to do what you should at work, home or school, because of substance use
- Recurrent use in physically hazardous situations
Rearranging... Continued

- Needing more of the substance to get the effect you want (tolerance)
- Development of withdrawal symptoms, which can be relieved by taking more of the substance.
- Continued use despite social or interpersonal problems
- Continued use despite negative health consequences
- Two or three symptoms indicate a milд substance use disorder, four or five symptoms indicate a moderate substance use disorder, and six or more symptoms indicate a severe substance use disorder
Changes in the DMS-5

- Gambling Disorder has been added to the Substance Abuse Disorder
- Polysubstance Dependence has been eliminated
Change in the DSM-5

- Now named Substance Use Disorders
- Physically hazardous, health & interpersonal consequences - from substance abuse to SUD
- Legal consequences have been removed because law enforcement varies widely
- “Craving, strong desire, or urge to use” has been added as a criteria
- *Craving* as a symptom is more valid based on brain imagining data.
## Comparing DSM IV to DSM 5

<table>
<thead>
<tr>
<th>DSM IV- Dependence</th>
<th>DSM 5 -Substance Use Disorder no substance abuse diagnosis</th>
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<tbody>
<tr>
<td><strong>3 or more required..</strong></td>
<td><strong>2 of 11 required..</strong></td>
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<tr>
<td><strong>Tolerance</strong> as defined by either increased amounts to obtain intoxication or diminished effect of same amount</td>
<td><strong>Tolerance</strong> (as defined in DSM IV)</td>
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<tr>
<td><strong>Withdrawal Symptoms</strong> typical of the substance or other substance taken to relieve</td>
<td><strong>Withdrawal</strong> (same as DSM IV)</td>
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<td><strong>More taken</strong> than intended-often</td>
<td><strong>More taken</strong> than intended –(often)</td>
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<tr>
<td><strong>Trying to cut back</strong>, but not able</td>
<td><strong>Trying to cut back</strong> but unable</td>
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<td><strong>Much time</strong> spent in substance related activities</td>
<td><strong>Much time</strong> spent in drug related activities</td>
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<td><strong>Important roles</strong> &amp; activities decreased because of use</td>
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<td><strong>Use is continued</strong> despite knowledge of negative health consequences.</td>
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<td><strong>Unable to carry out major obligations</strong></td>
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<td><strong>Use despite interpersonal problems</strong></td>
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<td><strong>Use in physical hazardous conditions</strong></td>
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<td><strong>Craving or a strong desire to use</strong></td>
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<td><strong>Patients placed on continuum</strong></td>
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<td><strong>Mild 2 -3</strong> Moderate 4-5 Severe 6-7</td>
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</tbody>
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- **Mild**: 2-3
- **Moderate**: 4-5
- **Severe**: 6-7
NeuroScience in 30 minutes

- Brain as survival machine - homeostasis
- Diasthesis Stress Model - Soup (epigenetics) and Salt
- Rose buds in a green house + current stress
- Triune Brain
- Mesolimbic or mammalian brain
  - Amy G. Dala
  - Thalmus & bro
  - Nuckle
  - Campus Librarian
- Neurotransmitters serotonin, norepinephrine, dopamine, endorphins, GABA
Brain Changes in Addiction

- Instinct for survival is hi-jacked - brain stem
- Frontal Cortex - loses control to brain stem
- Nucleus accumbens is damaged
- Dopamine - relief substance altered
- Increased receptors – vulnerability
- long term or permanent brain changes
- *Addiction is brain damage*
- The role of stress in relapse - movie clip
Why Do Drug Abuse and Mental Disorders Commonly Co-occur?

- Involvement in similar brain regions: Some areas of the brain are affected by both drug abuse and mental disorders. For example, brain circuits linked to reward processing as well as those implicated in the stress response are affected by abused substances and also show abnormalities in specific mental disorders.
Why Do Drug Abuse and Mental Disorders Commonly Co-occur?

- Overlapping genetic vulnerabilities: there is mounting evidence that suggests that common genetic factors may predispose individuals to both mental disorders and addiction or to having a greater risk of the second disorder once the first appears.

- Overlapping environmental triggers: stress, trauma (physical or sexual abuse) and early exposure to drugs are common factors that can lead to addiction and mental illness, particularly in those with underlying genetic vulnerabilities.
Why Do Drug Abuse and Mental Disorders Commonly Co-occur?

- Drug abuse and mental illness are developmental disorders:
- They often begin in adolescence or even childhood. This is a period when the brain is developing dramatically.
- Early exposure to drugs can change the brain in ways that increases the risk of mental illness just as early symptoms of a mental disorder may increase vulnerability to substance abuse.
Co-Occurring Disorders

- Anxiety Disorders
- Depressive Disorders
- Bipolar and Related Disorders
- Schizophrenia Spectrum and Other Psychotic Disorders
- Obsessive Compulsive, Sterotypic, and Related Disorders
- Trauma and Stressor Related Disorders
- Personality Disorders
Co-Occurring Disorders

- When two primary conditions co-exist, both must be treated if treatment of either is to be effective.
- According to SAMHSA over 8.9 million have addiction co-occurring with mental disorders.
- 7.4% of individuals receive treatment for both, while 55.8% receive no treatment at all.
- Do the Math! 92% don’t get effective treatment.
Co-Occurring Disorders

- 2009 National Survey on Drug Use and Health:
  - 45.1 million adults with any type of mental illness
  - 4% of all adults with mental illness also have co-occurring substance use
  - Adults with any mental illness who reported binge drinking (5 or more drinks)- 30% compared to 24% of adults with no mental illness who reported binge drinking
  - Adults with any mental illness who report heavy alcohol use- 10% compared to 7% for adults without mental illness
Depressive Disorders

- Disruptive Mood Dysregulation Disorder
- Major Depressive Disorder
- Persistent Depressive Disorder (Dysthymia)
- Premenstrual Dysphoric Disorder
- Substance/Medication Induced Depressive Disorder
- Dpz due to another medical condition
Major Depressive Disorder

- Five or more symptoms during the same 2-week period
- Depressed mood most of the day, nearly every day
- Markedly diminished interest or pleasure in all, most all, activities
- Significant weight loss
- Insomnia or hypersomnia nearly every day
Major Depressive Disorder

- Psychomotor agitation or retardation observable by others
- Fatigue or loss of energy
- Feels of worthlessness or excessive guilt
- Diminished ability to think or concentrate or indecisiveness
- Recurrent thoughts of death
Major Depressive Episode

- 5 or more during the same 2-week period:
- Depressed mood most of the day nearly every day
- Diminished interest or pleasure in all or almost all activities most days/every day
- Significant weight loss when not dieting or weight gain (5% of body wt)
- Increased/decreased appetite nearly everyday
- Insomnia/hypersomnia
- Psychomotor agitation or retardation nearly every day and observable by others
- Fatigue or loss of energy
- Worthlessness or inappropriate guilt
- Diminished ability to think or concentrate, indecisiveness
- Recurrent thoughts of death, suicidal ideations (active or passive) or suicide attempt
Brain Changes in Depression

● Structural
  - Pre frontal cortex
  - Decreased blood flow
  - Slowed metabolism
  - Anterior cingulate
  - Reward system de-activated

● Neurotransmitters
  - Homeostatic imbalance
  - Tryptophan to serotonin to family history
  - Best stability with both Therapy & Med
Animal Models and Stress

- Learned helplessness
- Early life stressors
- Chronic unpredictable stress
- Stress sensitive
- Similar brain changes
- Similar behavior
- Respond to anti depressants
Addiction and Depression

- Statistics
- Alcohol as a depressant
- Withdrawal symptom
- Family history of both
- Time prior to antidepressant use?
- CBT (memory aids)
- Relapse of both
- Role of Stress
- Client Education
Bipolar and Related Disorders

- Between psychotic and depressive disorders in the DSM-5.
- A bridge between the two disorders in terms of symptoms, family history and genetics.
- A large number of substances of abuse, some medications, and several medical conditions are associated with manic-like behaviors. i.e substance/medication induced bipolar
Manic Episode

- Abnormally and persistently elevated, expansive, or irritable mood
- Increased goal directed activity or energy
- Lasting at least one week
- 3 or more are present:
  - Inflated self-esteem or grandiosity
  - Decreased need for sleep
  - More talkative than usual or pressure to keep talking
  - Flight of ideas or racing thoughts
  - Goal directed activity or psychomotor agitation
  - Excessive involvement in activities that have a high potential for painful consequences
Manic Episode

- Caused marked impairment in social or occupational function or required hospitalization to prevent harm to self/others or there are psychotic features
- Not attributable to the physiological effects of a substance
- At least one lifetime truly manic episode is required for the diagnosis of Bipolar I Disorder
Hypomanic Episode

- Lasts at least 4 days
- Distractibility
- Unequivocal change in functioning
- Observable by others
- Not severe enough to cause marked impairment in social/occupational functioning

- Does not necessitate hospitalization
Bipolar and Related Disorders

- Onsets can occur throughout the lifecycle to include people in their 60’s & 70’s
- Onset starting late mid-life should prompt consideration of medical conditions to include substance ingestion or withdrawal
- 90% who have a single manic episode go on to have recurrent mood episodes
- 60% manic episodes occur immediately before a depressive episode.
- Mania can be characterized by angry energy
- Bipolar I with 4 or more mood episodes within a year are specified as “with rapid cycling.”
Bipolar and Related Disorders

- More common in high-income than low-income countries
- Separated, divorced or widowed people have higher rates of bipolar I
- A family history is one of the strongest and most consistent risk factors
- Female with the disorder have a higher lifetime risk of alcohol use disorder than males.
- The risk of suicide is 15 times that of the general population.
- Co-occurring disorder are common. Any substance use disorder occur in over half of the individuals with Bipolar I disorder. Those who have both disorders are at greater risk for suicide attempt.
Substance/Medication Induced Bipolar

- PCP/XTC induced mania usually presents with delirium with affective features.
- Follows the ingestion or inhalation quickly, usually within hours or at most a few days.
- Stimulant induced occurs in minutes to 1 hour after ingestion or injection with a short episode that resolve in 1-2 days
- Corticosteroids, some immunosuppressant medications. Symptoms of mania may follow several days of ingestion and are usually with higher doses.
Brain Changes in Bipolar

- Only 1-2% of population suffers from bipolar
- Strong family history correlation
- Smaller nucleus accumbens
- Structural deficits in dorsal raphe nucleus (manufacturing) related to serotonin deficits
- Dramatic increase of glucose metabolic rate in mania
- Lithium influence on homeostasis of serotonin
Bipolar and Addiction

- Family History
- Self medication
- Similar symptoms
- Quicker to develop addiction after casual use
- Increased suicide rate
- Psychiatric treatment essential
- Effective treatment takes longer
Bipolar

- 61% of individuals with bipolar disorder have a substance abuse disorder
  - This is more than five times as likely as the general population
- An estimated 50% of homeless adults with serious mental illnesses have a co-occurring substance abuse disorder
- 16% of jail and prison inmates are estimated to have severe mental and substance abuse disorders
- Among detainees with mental disorders, 72% also have a co-occurring substance abuse disorder.
Anxiety Disorders

- Separation Anxiety
- Selective Mutism
- Specific Phobia
- Social Anxiety
- Panic Disorder
- Agoraphobia
- Generalized Anxiety

- Substance Induced Anxiety
- Anxiety D/O Due to Another Medical Condition
- Other Specified Anxiety
Social Anxiety

- Marked fear or anxiety in social situations
- Fears of showing anxiety symptoms that will be negatively evaluated
- Social situations (esp. Performance) almost always provoke fear or anxiety
- Social situations are avoided or endured with intense fear or anxiety
- Is disproportionate to actual threat imposed
- Last 6 months or more
- Causes impairment in social or occupational areas of life
Social Anxiety

- Self-medication is common with this disorder
- Alcohol is common among people with this disorder. Many report that alcohol lessens the anxiety; however, it often makes it worse. Alcohol abuse usually develops after the onset of this disorder
- Difficulties with common treatment modalities
Panic

- Palpitations, pounding heart, accelerated heart rate
- Sweating
- Trembling or shaking
- Shortness of breath
- Feelings of choking
- Chest pain
- Nausea or abdominal distress

- Feeling dizzy, light-headed
- Chills or heat sensation
- Paresthsias (numbness or tingling)
- Derealization (unreality) or Depersonalization (Detached)
- Fear of losing control or going crazy
- Fear of dying
Panic

- Persistent concern or worry about additional panic attacks
- Significant maladaptive change in behavior related to the attacks (avoidance)
- Not attributable to the physiological effects of substances
- Not attributable to another mental disorder
Panic

- Not diagnosed if the attacks are judged to be a direct physiological consequence of a substance
- Intoxication of central nervous system stimulants (cocaine, amphetamines, caffeine) can cause attacks.
- Withdrawal from central nervous system depressants (alcohol, barbiturates) can cause attacks.
- Panic attacks must occur beyond the context of substance use
Panic

- Alcohol abuse commonly begins before or at the same time as panic disorder.
- Is a risk factor for a relapse among people with a substance abuse disorder.
Generalized Anxiety

- Excessive anxiety and worry occurring more days than not, for 6 months or more, about a number of events or activities and causes impairment
- Difficult for the person to control the worry
- Experiences three or more of the following
  - Restlessness or feeling keyed up or on edge
  - Being easily fatigued
  - Difficulty concentrating or mind going blank
  - Irritability
  - Muscle tension
  - Sleep disturbance
Brain Changes and GAD

- Gender
- Limbic system assesses for danger/detects/activates/deactivates
- Genetic predisposition + stress during early development = vulnerability to stress
- Decreased nucleus accumbens
- Abnormally low GABA levels
- Increase startle response
Anxiety and Addiction

- 25% diagnosed with alcohol addiction also have anxiety
- Short term exposure to alcohol increases GABA effect, long term decreases it
- Reciprocal causal relationship
- Confusion with withdrawal
- Simultaneous treatment
- Serotonergic antidepressants more effective than benzos
Anxiety Disorders

- Treating substance abuse will not eliminate an anxiety disorder
- It is usually necessary to treat both together to lessen the chance of relapse
- People with co-occurring disorders are at an increased risk for abuse as well as potentially dangerous interactions when they use prescription medications. Doctors should prescribe medications with low abuse potential that are considered safe if relapse occurs.
Obsessive-Compulsive and Related Disorders

- OCD
- Hoarding Disorder
- Trichotillomania (hair pulling)
- Excoriation (Skin picking)
OC and Related Disorders

- Obsessions: recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted
- Compulsions: repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession or according to rules that must be rigidly applied
OCD

- Presence of obsessions, compulsions or both
- Obsessions or compulsions are time consuming (take more than 1 hour per day) or cause clinically significant distress or impairment
- Not better explained by symptoms of another mental disorder, substance use, or medical condition.
Hoardding

- Persistent difficulty discarding possessions regardless of their actual value
- Perceived need to save items and to distress associated with discarding
- Results in accumulation of possession that congest and clutter active living areas
- Causes distress or impairment
Brain changes in OCD

- OCD loop: Frontal cortex - thalamus - striatum & back, like a heater with a faulty thermostat
- Automatic movements related to survival connected with striatum
- Structures in the circuit have different shapes and volumes than in normal controls
- Similar to behavioral addictions?
OCD and Addiction

- Addiction and obsessive compulsive disorder share many similarities in terms of brain and cognitive impairment.
- Chemical similarities between OCD and alcoholism and even higher similarities between OCD and opiate addiction.
- Treatment-changing the thought processes that accompany the compulsive behaviors or addictions, which is known as cognitive restructuring.
Trauma and Stressor-Related Disorders

- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Adjustment Disorders
Posttraumatic Stress Disorder

- Exposure to actual or threatened death, serious injury, or sexual violence by:
  - Directly experiencing the traumatic event
  - Witnessing in person as it occurs to others
  - Learning the event has occurred to a close friend
  - Experiencing repeated exposure to averse details of the traumatic event (first responders or police)
Intrusive symptoms associated with the trauma:

- Recurrent, involuntary, and intrusive memories of the trauma
- Distressing dreams related to the trauma
- Dissociative reactions (flashbacks)
- Prolonged psychological distress at exposure to cues that symbolize the trauma
- Marked psychological reactions to the cues related to the trauma
Posttraumatic Stress Disorder

- Persistent avoidance of stimuli associated with the trauma
- Negative alterations in cognitions and mood
  - Inability to remember certain aspects of the event
  - Exaggerated negative beliefs about oneself or others
  - Distorted cognitions about the cause or consequences that cause the person to blame him/herself or others
  - Persistent negative emotional state
  - Diminished interests in activities
  - Feeling of detachment or estrangement from others
  - Inability to experience positive emotions
Posttraumatic Stress Disorder

- Marked alterations in arousal and reactivity:
  - Irritable behavior or angry outbursts
  - Reckless or self-destructive behavior
  - Hypervigilance
  - Exaggerated startle response
  - Problems with concentration
  - Sleep disturbance
Posttraumatic Stress Disorder

- PTSD and substance abuse commonly occur together.
- Many mental health professionals treat PTSD and substance abuse together because the symptoms of PTSD (intrusive thoughts and sleep disturbance) can cause a substance abuse relapse.
46% of individuals with schizophrenia also have a substance abuse disorder.

- This is more than four times as likely as likely is the general population.
Hallucinations

- Perception-like experiences that occur without external stimulus
- Auditory is the most common but any sensory experience (tactile, visual, olfactory) can be included.
- Must occur when the person is fully awake
Delusions

- Fixed beliefs that are not amenable to change in light of conflicting evidence
- Persecution: harming, harassing by others
- Referential: gestures, comments, environmental cues are directed at oneself
- Grandiose: exceptional abilities, wealth, fame
- Erotomanic: falsely believing another person is in love with you
Delusions

- Nihilistic: a major catastrophe will occur
- Somatic: preoccupations with health
- Bizarre: implausible i.e. organs removed without scars
- Delusions of control: manipulation by outside force, thought insertion/deletion.
Negative Symptoms

- Diminished emotional expression
- Avolition: decrease in motivated self-initiated purposeful activities
- Alogia: diminished speech output
- Anhedonia: decrease ability to experience pleasure from positive experiences
- Asociality: lack of interest in social interactions
Disorganized Thinking (Speech)

- Is typically inferred from the person’s speech
- Derailment or loose association: switching from one topic to another
- Tangential: obliquely related or completely unrelated to topic
- Incoherence or Word Salad: Must be severe enough to impair effective communication
Grossly Disorganized or Abnormal Behavior

- Ranging from childlike “silliness” to unpredictable agitation
- Must impair goal directed activities
- Catatonia: decreased reactivity to the environment ranging from resistance to instruction to maintaining rigid, inappropriate or bizarre postures; to lack of verbal and motor responses
Personality Disorders

- Paranoid
- Schizoid
- Schizotypal
- Antisocial
- Borderline
- Histrionic
- Narcissistic
- Avoidant
- Dependent
- Obsessive Compulsive
Borderline

- Pervasive pattern of instability of interpersonal relationships, self image, and affects, and marked impulsivity, as indicated by 5 or more:
  - Frantic efforts to avoid real or imagined abandonment
  - Unstable and intense interpersonal relationships alternating between idealization and devaluation.

- Identity disturbance: markedly and persistently unstable self-image or sense of self

- Impulsivity in at least two areas that are potentially self damaging (spending, sex, substance abuse, reckless driving, binge eating)

- Recurrent suicidal behavior, gestures, or threats or self-mutilating behavior
ADHD (Attention-Deficit/Hyperactivity Disorder)

- A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by:
  - Inattention: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:
ADHD

- Hyperactivity and impulsivity: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities.

- Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
ADHD

- Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).
- There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
Oppositional Defiant Disorder

- Often loses temper
- Touchy or easily annoyed
- Often angry or resentful
- Argues with authority figures
- Actively defies or refuses to comply with rules
- Deliberately annoys others
- Often blames others for his/her mistakes or behavior
- Often precedes a diagnosis of Conduct Disorder
- Show a higher rate of substance abuse
Conduct Disorder

- Repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms are violated. At least 3:15 criteria in the past 12 months:
Conduct Disorder

- Aggression to People and Animals:
  - Bullies, threatens or intimidates others
  - Initiates physical fights
  - Used a weapon that can cause serious physical harm to others
  - Physically cruel to people or animals

- Stolen while confronting a victim
- Forced someone into sexual activity
- Destruction of Property:
  - Deliberately engaged in fire-setting
  - Deliberately destroyed others’ property
Conduct Disorder

- Deceitfulness or Theft:
  - Broken into someone else’s house, building, or car
  - Lies to obtain goods or favors or to avoid obligations
  - Stolen items of nontrivial value without confronting the victim

- Serious Violation of Rules:
  - Stays out at night despite parental prohibitions
  - Run away from home overnight at least twice
  - Is often truant from school beginning before age 13 years
Antisocial

- Pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 yrs, as indicated by three of the following:
  - Failure to conform with respect to lawful behaviors
  - Deceitfulness, repeated lying, use of aliases, conning others for profit or pleasure
  - Impulsivity or failure to plan ahead
  - Irritability or aggressiveness (physical fights or assaults)
  - Reckless disregard for the safety of self or others
  - Consistent irresponsibility (failure to sustain consistent work or honor financial obligations)
  - Lack of remorse
“Scientists have come across a man who’s addicted to brake fluid. Apparently, he says he can stop any time.”
CASE STORY of Luis Martinez

- Gender MALE
- Ethnicity LATINO
- Occupation - was a delivery truck driver, Has been on disability since his AIDS diagnosis.
- Residence - most recently welfare hotel.
CASE STORY OF Luis Martinez

- **Diagnosis** - Major Depressive Disorder- Substance Dependent (crack cocaine, THC, alcohol, was once heroin needle user but has denied any involvement in recent years)

- **Family of Origin Information** - Raised by an emotionally and physically abusive alcoholic father. Youngest of 5 siblings. Only male child. Mother left family when Luis was 5. Allegedly went to live with another man. Drug addiction may have been involved. Luis never saw his mother again. Oldest sister was mother-substitute. Father is now deceased. Two of his sisters (including oldest) try to be supportive but are often exasperated by his addiction and seeming refusal to take care of himself.
CASE STORY OF Luis Martinez

- **Current Family Information**: Luis has an ex-wife and a 12 year old son. He reports that he keeps trying to be a father to his son but his ex blocks his attempts. His ex-wife is HIV positive and asymptomatic. She blames Luis and remains angry.
CASE STORY OF Luis Martinez

- Reason for Referral: Luis became suicidally depressed while in the hospital with *Pneumocystis carinii*. Was referred for case management thru hospital social worker. He had completed detox while in the hospital. He has refused admission to residential treatment for dual diagnosis mentally ill and substance dependent clients. Case manager has set him up for outpatient treatment with your agency.
CASE STORY OF Luis Martinez
Narrative of information from first session

- Luis recognizes that he is likely to die in the next few months and feels a need for his family more than ever. He reports that he became suicidal because everyone in his family had turned against him in the time of his greatest need. He says his son only loves him when he buys him things.

- Luis vacillates between being furious at his family for not coming to see him in the hospital and deeply disgusted with himself for the horrible behavior that drove them away. He admits to leaving his sister’s house after stealing her new TV to finance a crack binge. He reports that he keeps saving up money to buy promised gifts for his son but when ex refuses or delays the visit he ends up spending his money on drugs and disappoints his son and further alienates him.
Luis reports that before he met his wife he had been a street drug user and traces his infection with the virus back to that time. His life changed when his older sister found him and took him home with her. She insisted that he go to church with her and in church he was ‘delivered from addiction’. He met his wife in church. When he married her, he had a good job and had bought a home with her. He lived a good life, he reports for 10 years, never knowing he was infected.
Narrative of information from first session {final}.

- He began to drink after he learned of the HIV 3 years ago, when he was hospitalized with an unexplained fever. He explains that he refused residential treatment because he understands that he is dying anyway and can see no reason for spending his last few months in drug rehab. He has never before been treated for either drug addiction or depression.
How the story ended

- Luis lived 2 years longer. For 20 months of this time he had been relatively well. His decline was rapid. He died in his sister’s home with his reconciled family around him. His funeral was attended by more than 50 NA and AA friends who spoke of the powerful way ‘he carried the message’
CASE STORY of Alvin Washington

- **Gender**: MALE
- **Age**: 31
- **Ethnicity**: African American
- **Occupation**: self described drug dealer
- **Residence**: homeless
- **Diagnosis**: Adjustment Disorder with Depressed Affect - Substance Dependent (crack cocaine)
Family of Origin Information- estranged from family. Raised in the projects by as an only child by a single mother and his grandmother. Mother had several brothers who were in gangs and Mother and Grandmother were determined that Alvin not go down that path. He has never met his father. Mother asked him to leave the house when he had come home high 7 years ago. He went home recently to see Mom, hoping she would welcome and care for him, but she refused to allow him in the house.
CASE STORY of Alvin Washington

- Current Family Information: none. No significant other. Alvin identifies as a gay male.

- Reason for Referral: Alvin was taken to the hospital via ambulance after he had passed out in a downtown McDonalds. He was treated for dehydration and released with a referral to a mental health treatment clinic. When he went to his second appointment at the clinic high on crack, he was also referred to your agency.
CASE STORY of Alvin Washington

- **Narrative of information from first session** Alvin says he is done with drugs. He wants to get and stay healthy. He wants to make his Mom and Grand mom proud. He wants to go back to school. He does not want to waste anymore of his life. He subsequently missed the next two appointments. He came to the third appointment disappointed in himself and clueless as to why he had gone out on a binge after such determination to quit. He re-stated the goals that he had stated in his first session.
CASE STORY of Alvin Washington

- How the story ended: It hasn’t ended yet. Alvin continues in treatment After several relapses, he had achieved a full year of sobriety, but recently had a 2 week relapse. He is currently sober and clean and proudly has the UA to prove it.
CASE STORY of Sandra Williams

- Age-18
- Ethnicity- African American
- Occupation- college student
- Residence- dorm
CASE STORY of Sandra Williams

- **Diagnosis**: Adjustment Disorder with Depression Substance Abuse (THC)

- **Family of Origin Information**: her mother, Edith, a long term crack user, is dying of cancer. She is in a nursing home, emaciated, constantly in pain and with a failing mind. There are two younger sisters aged 9 and 11. Edith’s plan for the care of the 2 little girls after her death is that Sandra will raise them.
CASE STORY of Sandra Williams

- **Current Family Information** - Sandra is engaged to a 22 year old college senior who plans to go to law school.

- **Reason for Referral** - Sandra has self-referred to the counseling center at the college. Reports unbearable anxiety.

- **Where do you go with this case?**
Case Story of Bobby Harrison

- Gender: male
- Age: 16
- Ethnicity: Caucasian
- Occupation: self-described ‘hustler’
- Residence: homeless
Case Story of Bobby Harrison

- Diagnosis: Oppositional Defiant Disorder/Substance Use Disorder- Moderate (THC)
- Mental Exam: presented as well groomed, sharply dressed in urban hip fashion. Affect- Alert and restless. Denies Suicidal or homicidal ideation. Denies Hallucinations. Coherent and oriented to time and place.
- Substance Use History: has used THC since 12, tried alcohol, opiate pills and OTC but prefers weed and sticks to it, for the last 3 years. Smokes weed daily, in the morning to get started and then again before settles down for sleep.
Case Story of Bobby Harrison

- Family History: Estranged from family. Raised in poverty by single Mom and her mother. He is the only child. He has never met his father. Mom has 3 brothers who are all in and out of prison. Mom and grandmother have decided he WILL NOT go down that path. About a year ago Mom confronted him about stolen merchandise in his room. He flew into a rage and he admits to pushing her, denies the assault that Mom claims. Mom made him leave the house. He went home recently to apologize, hoping she would take him in, but she refused to talk to him.
Case Story of Bobby Harrison

- Current Family Situation: lives with whatever buddies he can talk into letting him stay or camps out. Has no significant other – identifies as a gay male.
- Reason for Referral: Bobby was taken to the hospital via ambulance when he passed out in a downtown McDonalds. He was treated for dehydration and released to an adolescent group home. Group home brings him to you for individual assessment and treatment.
Case Story of Bobby Harrison

- Narrative of information given in first session: Bobby immediately agrees that he needs help. He wants to get healthy and strong and wants to work out and be muscular. He wants to go get his GED and wants to ‘make his and Mom and MeMaw proud’ and then live at home while he learns a trade. He tells you that he got into an argument with a male teacher over a grade on a paper.
Case Story of Bobby Harrison

- He admits that he got loud but says that the teacher cussed him. He reports that he just walked away from the teacher and never went back. He reports that he got a job in a service station right after his Mom kicked him out, but was fired for stealing although he never took anything of any value. He tells you he is ready to change and not get into anymore trouble. He subsequently missed the next 2 appointments. He dropped into the agency and you saw him for a few minutes to re-schedule. He told you that he ran away from the group home because he ‘can’t stand the staff or the punks that live there’.
Case Story of Bobby Harrison

- How the story ends… At his 18 month follow-up interview, Bobby reports that he is living in the group home and getting along better with the guys, but still has conflict with some of the staff. He is proud though that he ‘hasn’t got kicked out yet!’ He goes home to stay with his family every other week-end.
Case Story of Bobby Harrison

- He is working on his high school diploma at community college and is thinking he would like to go to college. He is thinking he would rather live in a dorm than live at home. He wants to have a career as a stock broker. He was clean for 4 months but recently had a relapse when he was out of group home on pass.
Bobby Harrison

- He is clean now and thinks he has a ‘better chance at a good life’ if he doesn’t smoke as much weed.
- What is your next action?
ready for jokes:

- What do engineers use for birth control?
- Why do sharks never bite lawyers?
- Why do golfers wear 2 pairs of underwear?
Case Story for Regina Adams

- Female
- Age - 46
- Ethnicity - Caucasian
- Occupation - published writer
- Residence - owns her own home in Fayetteville
- Diagnosis - Generalized Anxiety Disorder, Panic Disorder, Substance Dependence (alcohol)
Case Story for Regina Adams

- **Family of Origin Information**- Father was a military man who was away from the family a great deal. Regina assumed it was because of his military commitments but when she was a teenager she and her sister discovered that their Dad was constantly involved in affairs. Mom was a college English instructor and Regina and her sister tried to convince her to leave father. Regina sees her Mom as ‘a hopeless romantic who was too dependent to see the truth’. Regina is the oldest sibling, her sister is only a year younger. She reports that she and her sister are like twins. Their father finally left Mom in the last year and Regina’s mom and her sister now live with Regina.
Case Story for Regina Adams

- **Current Family Information**: lives with Mom, her sister and her sister’s 2 daughters aged 6 and 8 in a home that Regina bought with the income from her last book (7 years ago). Regina has never been married and never wants to be.

- **Reason for Referral**: Regina has been referred to your agency for Intensive Outpatient Treatment. She made the call herself.
Case Story for Regina Adams

- **Narrative of information from first session**

  Regina reports that she is happy with her current living situation. She is delighted to have her sister come home from California and bring the girls to live with her. She is loving being an aunt and the girls are loving her. She has agreed to seek treatment because her sister is very concerned about Regina’s drinking. The sister has recently come to live with her and is looking for a full time job. Regina wants to be the after school care-giver to the girls. The sister is insistent that Regina cannot be taking care of the girls unless she is clean and sober.

- Regina is frightened by the idea of giving up her drugs of choice because she is sure that she will never sleep and will have continuous panic attacks. Regina has not been able to write for sometime and has been living off of dwindling investment income. She is anxious about her finances and hopes the incomes of the 3 women will make it possible to keep the house.