Intervention and Treatment Strategies for Resistant Clients with Mental Health and Substance Abuse Disorders

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Training Agenda

- **Identify what resistance is in the therapeutic process and specific signs of resistance.**
  Review the principles for assessing and treating clients with co-occurring disorders, highlighting evidence-based practices.
- **Will identify specific strategies to enhance client engagement in the treatment process.**
- **Will process how specific diagnoses can influence resistance and the importance of utilizing consultation and the referral process to improve outcomes**
- **What else_____??**

What is Resistance??

- What does it look like?
- What does it sound like?
- What does it feel like?

Resistance

- "A process of avoiding or diminishing the self-disclosing communication requested by the interviewer because of its capacity to make the interviewee uncomfortable or anxious." (Pope, 1979, P. 74)
- An active process that has the potential to become a fundamental obstacle to positive counseling.

Resistance

- The initial process lends itself to resistance!!
- The client, the counselor, and the client's social environment all have the capability of enhancing resistance!!

The Client

- If they don't do what we want, they are resistant, oppositional, reactionary, non-compliant, intractable, and unmotivated!!
- Often times people do not change because of the logic of the situation; people change when they have an emotionally compelling reason!!

The Counselor

- Did we establish rapport?
- Failure to establish a mutually agreed upon objective/goals.
- Are we taking them where they really are?
- Are we cognizant of the interventions that we typically use?

The Social Environment

- Changes in the living situation.
- Deliberate sabotage from others.
- Friends and family foster. dependency/dysfunction!
- Lack of support in the healing process.

Signs of Resistance

- You feel like you are arguing or fighting with the client.
- You feel stressed and/or drained.
- You are working harder in your sessions then your client is.
- You are feeling burned out

Signs of Resistance

Relax……sometimes resistance means that you and the client are really working hard!!

Resistance in therapy is a natural, necessary part of every client's problems. It is neither good nor bad, and the effective therapist neither abandons, rescues, nor attacks clients because of their resistance.
(Clifton Mitchell, 2006)

Why Resistance with Co-occurring Disorders?

- Denial??
- Significance?
- A specific type of diagnoses?
- Treatment providers?
- What else?_____

Prevalence

- **The National Survey on Drug Use and Health in 2002 reported:**
- **4 million adults met the criteria for both serious mental illness (SMI) and substance dependence and abuse.**
- **Based on a sample of 67,500 American civilians aged 12 or older in non-institutionalized settings**
- **(Office of Applied Studies [OAS] 2003b).**

Prevalence

- Among adults with SMI in 2002, 23.2 percent were dependent or abused alcohol or illicit drugs
- Adults without SMI was only 8.2 percent.
- Among adults with substance dependence or abuse, 20.4 percent had SMI
- The rate of SMI was 7 percent among adults who were not dependent on or abusing a substance (OAS, 2003b).

Prevalence

- Among adults who used an illicit drug in the past year, 17.1 percent had SMI in that year, while the rate was 6.9 percent among adults who did not use an illicit drug
- Among adults with SMI, 28.9 percent used an illicit drug in the past year while the rate was 12.7 percent among those without SMI
- SMI was correlated with binge alcohol use. Among adults with SMI, 28.8 percent were binge drinkers (OAS, 2003b).

Prevalence

- **National Co-occurring Disorders Survey:**
- **8-11 million have at least 1 mental health and 1 substance-related disorder**
- **89% developed mental illness first**
- **9% developed substance abuse first.**
- **Median age of onset for mental illness-11**
- **Median age of onset for SA- 17-21**
- **(Kessler, et al. 1994)**

Prevalence

- **While people with co-occurring disorders are more likely to seek treatment, research consistently shows a gap between the number of people who are identified in a survey as having a disorder and the number of people receiving any type of treatment.**
- **Some find that a troubling 60 percent never received any treatment! (SAMHSA, 2005, TIP 42).**

Prevalence

- 2002 National Survey on Substance Abuse Treatment found:
- 49 percent of 13,720 facilities nationwide reporting substance abuse services offered programs/groups for COD.

Prevalence

- 63% of the 1,126 responding mental health services that offered substance abuse services offered COD programs/groups
- About 70 % of the 3,440 facilities that have a mix of MH/SA treatment services offer COD programs/groups

Interesting Statistics

- Rates of co-occurring Axis I and substance use disorders among females who are homeless increased from 14.3 percent in 1990 to 36.7 percent in 2000
- Rates among men increased from 23.2 percent in 1990 to 32.2 percent in 2000.
- In 2000, 84 percent of the men and 58 percent of the women who were homeless had a substance use disorder
- Major depression accounted for the majority of all Axis I non-substance disorders
- (North et al. 2004).

Interesting Statistics

- **In 1955, the nation's number of psychiatric hospital beds: 560,000.**
- **In 2002-60,000 We had however a population increase of 100 million in that period of time!**

Interesting Statistics

- In 1972, the number in jail and prison: 196,000
- In 2003: 2,078,570!!
- 6.9 million, 3.2 % of the adult population is under court supervision,
- Over 500,000 felons are released from prison each year, many with COD!!

What's the History?

- 1979- Woody and Blaine looked at "Substance Abuse and Depression"
- 1981- Bert Pepper- 'The Chronic Young Adult"
- Kenneth Minkoff, M.D.-"Integrated Treatment"
- Kessler- National Comorbidity Survey

What's the History

- Sequential Treatment: I'm referred to one form of treatment, and once addressed, I'm referred to another form of treatment. Failed, but common even today.
- Parallel Treatment: Treat them at the same time, in two different agencies or sights. If they attempt to talk, it's called collaborative. This can be productive if everybody stays in consistent contact!!

What's the History

- "When substance disorder and psychiatric disorder co-exist, each disorder should be considered primary, and integrated dual primary treatment is recommended, where each disorder receives appropriately intensive diagnosis specific treatment."
- (K. Minkoff-"An Integrated Model for the Treatment of People with Co-Occurring Disorders in Managed Care Systems").

What's the History

- Integrated Treatment:
- Provide for both in one place.
- Treatment team has varied backgrounds.
- Ideally provided by a cross-trained clinician.
- Responsive to the many changing symptoms and disorders of the patient

What's the History?

- No Treatment- Worst!
- Treat one disorder- Bad!
- Sequential Treatment- Bad!
- Parallel/Collaborative Treatment- Not as Bad/Better!
- Integrated Treatment- Best!

Why Integrated Treatment?

- Among those with co-occurring disorders:
- The most common cause of psychiatric relapse is resumption of alcohol or drug USE, not necessarily abuse.
- The most common cause of relapse to alcohol and other drugs is untreated psychiatric disorders, especially depression and anxiety (Kessler, 1996.)

Four Quadrants of Co-occurring Disorders

- **Category I:** Less severe mental disorder/Less severe substance abuse disorder.
- Locus of care: Primary health care settings-Outpatient treatment MH/SA.

Four Quadrants

- **Category II:** More severe mental illness/Less severe substance use disorder.
- Locus of care: Mental health system/integrated case mgt.

Four Quadrants of Co-occurring Disorders

- **Category III:** Less severe mental disorder/More severe substance abuse disorder.
- Locus of Care: Substance abuse system/Coordination and collaboration with affiliated mental health programs.

Four Quadrants

- **Category IV:** More severe mental disorder/More severe substance abuse disorder.
- Locus of care: State hospitals, modified therapeutic communities, jails/prisons, emergency rooms, etc.

Why was the Co-occurring Matrix developed?

- Most early "dual disorder" research dealt only with those with severe and persistent Mental Illnesses in MHC's
- A method and graphic was needed to describe other populations in MH and Addictions settings
- The "Matrix" is simple and relates two Illnesses/Systems
  Mental Health vs. Addictions
  At two severities....Low vs. High

Six Guiding Principles in Treating Clients with COD

- 1. Employ a recovery perspective
- Recovery is a long-term process of internal change, and it recognizes that these changes proceed through various stages (Prochaska et al, 1992).
- Develop a treatment plan that provides for continuity of care over time.

Employ a Recovery Perspective

- **Devise treatment interventions that are specific to the tasks and challenges faced at each stage of the co-occurring disorder recovery process.**
- **It is important to engage the client in defining markers or progress meaningful to the individual and to each stage of recovery.**
- **(SAMHSA, 2005 TIP 42)**

Six Guiding Principles

- 2. Adopt a multi-problem viewpoint:
- Clients typically have an array of problems.
- May need to address housing, work, health care, supportive network, treatment, etc
- Substantial rehabilitation and habilitation!

Six Guiding Principles

- **3. Develop a phased approach to treatment:**
- **Clients typically progress through phases; Engagement, stabilization, treatment, aftercare/continuing care, etc.**
- **Use of these phases enables the clinician to develop and use effective, stage-appropriate treatment protocols (SAMHSA, 2005 TIP 42).**

Six Guiding Principles

- 4. Address specific real-life problems early in treatment:
- Specialized interventions that target important areas of client need.
- Psychosocial rehabilitation, which helps the client develop specific skills and approaches she needs to perform chosen roles.
- Solving problems reinforces engagement, a critical part of MH/SA treatment.

Six Guiding Principles

- 5. Plan for the client's cognitive and functional impairments:
- Patients with COD often have difficulty comprehending information or completing tasks.
- Gradual pacing, visual aids, and repetition are beneficial.
- Important to assess for these deficits and treatment plan accordingly.

Six Guiding Principles

- 6. Use support systems to maintain and extend treatment effectiveness:
- AA/NA/Double Trouble groups.
- Family, faith community.
- COD issues can "burn bridges" with family, community, etc
- Clinicians play a role in educating patients of available support systems.

Utilize Empathy

- **An essential component to breaking through resistance is maintaining a foundation of understanding through a dialogue that engages the client's experience with empathic comments (Clifton Mitchell, Ph.D.)**
- **Again, people change when they have an emotionally compelling reason….empathy can help get them there.**
- **Empathy can foster the emergence of emotionally compelling reasons to change.**

Parallel Phases of Recovery

- Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" (Minkoff, 1989).
- With parallel phases of recovery
  -Acute stabilization
  -Motivational enhancement
  -Active treatment
  -Relapse prevention
  -Rehabilitation (recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change

It gets us back to Integrated Treatment!!

- The client participates in one program that provides treatment for both disorders
- The client's mental and substance use disorders are treated by the same clinicians.
- The clinicians are trained in psychopathology, assessment, and treatment strategies for both mental and substance use disorders.

Integrated Treatment

- The clinicians offer substance abuse treatments tailored for clients who have severe mental disorders
- The focus is on preventing anxiety rather than breaking through denial
- Emphasis is placed on trust, understanding, and learning
- Treatment is characterized by a slow pace and a long-term perspective
- Providers offer stragewise and motivational counseling.

Integrated Treatment

- Supportive clinicians are readily available
- 12-Step groups are available to those who choose to participate and can benefit from participation
- Neuroleptics and other pharmacotherapies are indicated according to client's psychiatric and other medical needs. (Adapted from Drake et al 1998b, p591).

Assessment Process

- Goals of Assessment:
- To obtain a more detailed chronological history of past mental symptoms, diagnosis, treatment, and impairment, particularly before the onset of substance abuse, and during periods of extended abstinence.

Assessment Process

- To obtain a more detailed description of current strengths, supports, limitations, skill deficits, and cultural barriers related to following the recommended treatment regimen for any disorder or problem
- To determine the stage of change for each problem, and identify external contingencies that might help to promote treatment adherence. (SAMHSA, 2005, TIP 42)

12 Steps in the Assessment Process

- 1. Engage the client
- 2. Identify and contact collaterals
- 3. Screen for and detect COD
- 4. Determine quadrant and locus of responsibility
- 5. Determine level of care
- 6. Determine diagnosis

12 Steps in the Assessment Process

- 7. Determine disability and functional impairment
- 8. Identify strengths and supports
- 9. Identify cultural and linguistic needs and supports
- 10. Identify problem domains
- 11. Determine stage of change
- 12. Plan treatment

Case Example

- **Tony is a 38 year old African American married man with cocaine dependence, alcohol abuse and bipolar disorder (stabilized on lithium). He has been mandated to see you by his employer as an EAP referral for failing a drug screen last week. Both Tony and his family agree that he needs help with his cocaine use. The alcohol consumption is not seen as a "big deal". He does agree that his mood swings intensify when he is using cocaine.**

Evidence-Based Practices

- Provide motivational enhancement to increase motivation for treatment.
- Motivation Interviewing (MI) is a "client-centered, non-directive, method for enhancing intrinsic motivation to change by exploring and resolving ambivalence (Miller & Rollnick, 2002).
- Shows so much promise it is one of two treatments being sponsored in multi-site trials in the NIDACTN program (CSAT, 2005).

(MI)

- 1. Expressing empathy: Skillful reflective listening, ambivalence is normal
- 2. Developing discrepancies: Change is motivated by a perceived discrepancy between present behavior and future goals
- 3. Rolling with resistance: Avoid arguing, new perspectives are invited, resistance is a signal to respond differently, client is a resource in finding answers
- 4. Supporting self-efficacy: A person's belief in the possibility of change is an important motivator, validation of client's effort.

Motivational Strategies Matched to Stages of Change

- **PRE-CONTEMPLATION:**
- Express concern about their use, or their mood, anxiety, etc.
- State non-judgmentally that drug use/mood is a problem
- Explore client's perception of drug or psychiatric problem
- Emphasize importance of seeing the client again
- Consider a trail of abstinence for clarification

Contemplation

- **Elicit positive and negative aspects of drug use or psychological symptoms.**
- **Summarize the patient's comments on these issues.**
- **Make explicit discrepancies between values and actions.**
- **Consider a trial of abstinence and/or psychological evaluation.**
- **Ask about +/- aspects of past sobriety, drug use, depression, mania, etc.**

Preparation

- **Acknowledge the significance of making the decision to seek treatment**
- **Help the client decide on appropriate, achievable action for each of the CODs**
- **Caution that the road ahead is tough but very important.**
- **Explain that relapse should not disrupt the client-clinician relationship.**

Action

- **Be a source of encouragement and support.**
- **Recognize that the client can be in different stages of change with different problems.**
- **Reinforce the importance of remaining in recovery from both problems.**
- **Acknowledge the uncomfortable aspects of withdrawal and/or psychological symptoms.**

Maintenance

- **Anticipate and address difficulties as a means of relapse prevention.**
- **Support the client's resolve.**
- **Recognize the client's troubles with either or both problems.**
- **Reiterate that relapse or psychological symptoms should not disrupt the counseling relationship.**

Relapse

- Explore what can be learned from a return to drug use/exacerbation of symptoms.
- Express concern about relapse.
- Emphasize the positive aspect of the effort to seek care.
- Support the client's self-efficacy so that recovery seems achievable.

Brief Strategic Interventions

- **F**eedback-Personal Risk or impairment.
- **R**esponsibility-For change, its up to you!
- **A**dvice-The essence of brief intervention.
- **M**enu-Of alternative change options.
- **E**mpathy-Warm, reflective vs. authoritarian.
- **S**elf-efficacy-Optimism regarding the possibility of change vs. powerlessness.

Evidence-Based Practices

- **Design Contingency Management techniques to address specific target behaviors.**
- **Contingency Management (CM) maintains that the form or frequency of behavior can be altered through a planned and organized system of positive and negative consequences.**

CM

- **Housing and employment contingent upon abstinence.**
- **Regular drug testing to monitor targeted substance**
- **Clinic attendance/group participation**
- **Medication adherence/Attaining particular goals**
- **A lot of the patients we see our motivated by contingencies!!**

Evidence-Based Practices

- Use **Cognitive Behavioral** therapeutic techniques to address maladaptive thinking and behavior.
- An underlying assumption is that the client systematically and negatively distorts her view of the self, the environment, and the future.
- Use cognitive and or behavioral strategies to identify and replace irrational beliefs with rational beliefs/new behaviors the client can practice.

Evidence-Based Practices

- Employ **Relapse Prevention** techniques to reduce psychiatric and substance use symptoms.
- Have a broad repertoire of cognitive and behavioral coping strategies.
- Make appropriate lifestyle changes.
- Increase healthy activities.
- Prepare for interrupting lapses, so that they don't end up in full blown relapse.
- Learn specific skills to identify and cope effectively with drug urges and craving.

Evidence-Based Practices

- Apply **Repetition and Skill-Building** to address deficits in functioning:
- Be more concrete and less abstract
- Use simpler concepts
- Repeat the core concepts many times
- Present info. in multiple formats: verbally, visually or through stories and experiential activities.
- Role-playing is useful!

Evidence-Based Practices

- Facilitate client participation in mutual **Self-Help groups:**
- Helping them locate an appropriate mtg.
- Assist with finding a sponsor, preferably someone with similar issues and long-term recovery.
- Helping them prepare to participate appropriately in the group.
- Help them overcome barriers to group participation.
- Debriefing after meetings.

Back to Tony!

- Cocaine Dependence
- R/O Alcohol Abuse
- Bipolar Disorder
- Quadrant?
- Goals/Interventions?

Ask about medications!

- Reinforce taking care of mental health will help prevent relapse.
- Ask how psychiatric medication is helpful/Acknowledge it can be a hassle
- Ask “How many doses have you missed?”
- Ask if they felt different when they missed a dose. Was it in relation to drug/alcohol use
- Without judgment, ask “why did you miss the medication?” “Did you forget or did you choose not to take it?”
- Don’t accept “I just don’t like pills!”

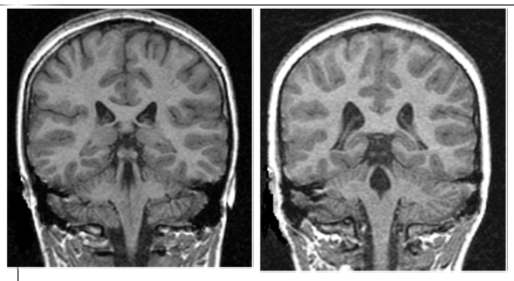
Specific Populations

- **SUICIDE and SUBSTANCE ABUSE:**
- **Abuse of alcohol or drugs is a major risk factor in suicide, both for people with COD and for the general population.**
- **Alcohol abuse is associated with 25%-50% of suicides. Between 5%-27% of all deaths of people who abuse alcohol are caused by suicide, with the lifetime risk for suicide among people who abuse alcohol estimated to be 15%**
- **Co-morbidity of alcoholism and depression increases suicide risk.**

Suicide and Substance Abuse

- Consistently screen for thoughts/plans.
- Develop a safety and risk mgt. process with the client (follow advice, remove guns, complete ROI).
- Don't hesitate to refer for psychiatric intervention.
- Monitor medication adherence.

Lateral Ventricles Measures in an 11 Year Old Maltreated Male with Chronic PTSD, Compared with a Healthy, Non-Maltreated Matched Control



(De Bellis et al., 1999)

Posttraumatic Stress Disorder (PTSD)

- Involves direct personal experience or witnessing an event that includes death, injury, or threat to personal integrity of self or another person.
- Learning of unexpected violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.
- The person's response involved intense fear, helplessness or horror.

PTSD

- Intrusion: A persistent re-experiencing of the trauma in the form of intrusive images, thoughts, nightmares, flashbacks
- Avoidance: Persistent avoidance of stimuli related to the trauma such as activities, feelings, and thoughts associated with the traumatic event.
- Arousal: Persistent symptoms of increased arousal such as insomnia, irritability, hypervigilance, and exaggerated startle response. (SAMHSA, 2005, TIP 42).

PTSD

Lifetime prevalence in US-8%

- Among high-risk groups- one third to one half!!
- The rate of PTSD among people with substance use disorders is 12 to 34 percent: for women who abuse substances, it is 30 to 59 percent
- Most women with this co-occurring disorder experienced childhood physical and/or sexual abuse: men with both disorders typically experienced crime victimization or war trauma.

Key Issues With PTSD

- People with PTSD tend to abuse the most addictive substances as well prescription meds and alcohol!
- Patients can be prescribed several meds at once to treat panic/anxiety, dysthymia, bipolar
- It is recommended that benzodiazepines be avoided. Prazocin and propranolol may hold great promise.

Key Issues with PTSD

- Develop a plan for safety and establish trust
- "Listen" to a client's behavior even more than words.
- Recognize that a client with PTSD and substance use disorders may have a more difficult time in treatment.
- Help the client access treatment for PTSD.
- Help the client learn to de-escalate intense emotions.
- Teach "grounding" techniques!
- Provide lots of education to break through shame!

Key Issues With PTSD

- Teach "grounding" techniques
- Provides lots of education to brake through shame!
- Recognize that becoming abstinent does not resolve PTSD, some symptoms might become worse with abstinence at first.
- Education on the link between PTSD and substance use is essential.

Anti-Social Personality Disorder

- A pervasive disregard for and violation of the rights of others.
- An inability to form meaningful interpersonal relationships.
- Deceitfulness, impulsivity, lack of remorse.

Anti-Social Personality Disorder

- Many people with APD are not true psychopaths.
- People with APD typically use substances in a poly-drug pattern.
- Important to differentiate between true anti-social and substance related antisocial behavior!

Anti-social Personality Disorder

- Individuals with both APD and substance use disorders have been perceived as hard to treat, have poor prognosis, and exclusion.
- Research though shows otherwise!
- Vaillant (1995) found that after 10 years, 48% of men from an inner city env. that were alcoholic and APD were abstinent. Significantly higher than the 28% that were alcoholic but did not have APD

Key Issues With APS

- Counter-transference and transference
- Counselor well-being
- Resistance: The 4 'd"s-Dangerous, Difficult, Demanding, or Drug-seeking
- Contracting: It is essential to reiterate clear expectations of the who, what , when, how... and get it in writing!
- The 3 "C's": Corral, Confront, Consequences.

A History of Barriers to Integrated treatment

- Managed Care
- Peer Counseling vs. Medical/Professional Model
- Self-Help vs. Medication
- Recovery ideology vs. Deinstitutionalization ideology
- Psychopathology is secondary to Addiction and vice versa.

Barriers to Integrated Treatment

- Cultural and linguistic service barriers
- Financial (Cross training, on site Psychiatry, transportation, etc.)
- Abstinence-oriented vs. Abstinence-mandated

Closing Thoughts

- **First and foremost is the simple fact that people of all ages who have COD are people first, fully deserving of respect.**
- **At the same time, consumers, recovering persons and their families need to be involved in all aspects of their treatment and recovery.**
- **People with co-occurring disorders can and do recover.**
- **People with co-occurring disorders deserve access to the services they need to recovery. (David Mee-Lee,M.D., 2006).**

Resistance

- What is the opposite of resistance?
- Think of a client you had that got better as a result of working with you. How did they do that??

Resources

- Dual Diagnosis: An Integrated Model.. Kenneth Minkoff, M.D., 2002
- Co-occurring Disorders: A current review. Kessler, et al., 1994 Archives of General Psychiatry
- SAMHSA's Co-Occurring Center for Excellence, June 2008.
- SAMHSA/CSAT: Substance Abuse Treatment for Persons With Co-Occurring Disorders TIP 42, 2005
- Pope, 1979., P.74
- Clifton Mitchell, 2006

Questions, comments, concerns??

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