APPENDIX B

Educational Handouts

B.1. Understanding Bipolar Disorder
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HANDOUT B.1

Understanding Bipolar Disorder

Bipolar disorder is a major psychiatric illness, also known as *manic–depressive disorder.* People with this illness sometimes experience extremely high moods (*mania*) and sometimes extremely low moods (*depression*). Symptoms of mania and depression usually occur at different times, but they may exist together in what is called a *mixed episode*. A person may also have normal moods.

The cause of bipolar disorder is unknown. Scientists believe the disorder may be caused by an imbalance in brain chemicals, particularly the chemical *norepinephrine*. This imbalance may be due to genetic factors. About 1% of people develop bipolar disorder in their lifetime.

Bipolar disorder usually develops between the ages of 16 and 35, but may develop in a person's 40s or even 50s. Bipolar disorder is a lifelong disorder, but between mood episodes many people can function well. Many famous people have had bipolar disorder and contributed greatly to society, such as the artist Vincent Van Gogh, the writer Edgar Allen Poe, and the actress Patty Duke.

Bipolar disorder is diagnosed with a clinical interview. The interviewer checks to see whether the person has experienced specific symptoms for a period of at least 2 weeks. The clinician must also make sure that the person has no physical problems that could cause symptoms like those of bipolar disorder, such as thyroid gland disease.

> Bipolar disorder is a major psychiatric illness that is diagnosed with a clinical interview.
>
> About 1% of people develop bipolar disorder.

SYMPTOMS OF MANIA

The symptoms of mania involve a change in mood states (usually irritability or euphoria), increased self-esteem and confidence, and increased goal-directed activity (for example, the person spends an excessive amount of time and energy on work, school, or other activities). Some of these symptoms will affect how people perform their daily activities. A person does not have to have all of the following symptoms to be diagnosed with mania.

Common symptoms of mania include the following:

- Euphoria
- Irritability
- Reduced need for sleep

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- Increased talkativeness
- Inflated self-esteem
- Grandiosity
- Increased goal-directed activity
- Racing thoughts
- Distractibility

The term *hypomanic symptoms* refers to manic symptoms that are less severe and less disruptive.

SYMPTOMS OF DEPRESSION

Depressive symptoms are the opposite of manic symptoms, with low mood and inactivity as the major features. A person does not need to have all of the following symptoms to be diagnosed with depression.

Common symptoms of depression include the following:

- Depressed mood or sadness
- Decreased interest or pleasure
- Feeling worthless, hopeless, or helpless
- Guilt
- Suicidality
- Change in appetite and/or weight
- Sleep disturbances
- Lethargy or agitation
- Fatigue
- Problems with attention, concentration, and making decisions

> Common symptoms of bipolar disorder include:
> - Mania (euphoria, irritability, etc.)
> - Depression (low mood, etc.)

FREQUENTLY ASSOCIATED SYMPTOMS

Some people with bipolar disorder may experience other psychiatric symptoms when they have a manic or depressive episode, although these symptoms are not among those used to diagnose the disorder. Such symptoms include *hallucinations* (hearing, seeing, feeling, or smelling things that aren't there) and *delusions* (unusual beliefs that other people don't have—for example, paranoia or fear of being persecuted).

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SIMILAR PSYCHIATRIC DISORDERS

Bipolar disorder shares some symptoms with other major psychiatric disorders, including schizophrenia and schizoaffective disorder. There are differences between bipolar disorder and these other disorders, however. The primary difference is that when a person with bipolar disorder has a stable mood, he or she usually does not experience hallucinations or delusions, while a person with schizophrenia or schizo- affective disorder may have these symptoms even during periods when his or her mood is stable. People with posttraumatic stress disorder (PTSD) or personality disorders also experience intense mood shifts. The mood shifts in bipolar disorder typically last for weeks to months, while mood shifts among people with PTSD or personality disorder may last only minutes or hours.

> The symptoms of bipolar disorder
> overlap with those of other psychiatric disorders.

TREATMENT

Medications are used to treat the symptoms of bipolar disorder. Lithium, carbamazepine, and valproic acid are effective medications. Antipsychotic medications like olanzapine can also treat the symptoms of bipolar disorder. Antidepressant medications are sometimes used to treat depression in bipolar disorder, but they may increase the frequency of hypomanic or manic episodes.

Many people with bipolar disorder also use supportive counseling and family treatment to help them cope with the disruptive aspects of the disorder.

> Bipolar disorder is treated
> with medication, as well as other services
> (such as counseling and family treatment).

FURTHER READING

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Jamison, K. R. (1995). *An Unquiet Mind: A Memoir of Moods and Madness*. New York: Vintage.

Miklowitz, D. (2002). *The Bipolar Disorder Survival Guide: What You and Your Family Need to Know.* New York: Guilford Press.

Mondimore, F. M. (1999). *Bipolar Disorder: A Guide for Patients and Families*. Baltimore: John Hopkins University Press.

HANDOUT B.2

Understanding Major Depression

Major depression is a psychiatric disorder in which a person experiences a very low mood, or *depressed mood*. The person may also have a loss of interest in activities and low energy. Depression differs from feeling "blue," in that it causes severe enough problems to interfere with a person's day-to-day functioning.

The cause of major depression is unknown. Theories suggest that there may be more than one cause. Biochemical theories suggest that two chemicals, *norepinephrine* and *serotonin*, play an important role in depression. Imbalances of these chemicals may be caused by genetic factors, early experiences (such as the loss of a parent at an early age), or both. Between 10% and 15% of people experience an episode of depression during their lifetime.

Depression can happen at any point in a person's life. Some people experience depression but then fully recover from the disorder. Other people struggle with depression throughout much of their lives. People struggling with depression can nevertheless lead very useful and successful lives, as President Abraham Lincoln and the writer Ernest Hemingway did.

Major depression is diagnosed with a clinical interview. The interviewer checks to see whether the person has experienced severe symptoms for at least 2 weeks. Less severe symptoms over a more extended period of time may be diagnosed as *dysthymic disorder*.

> Major depression is a psychiatric illness
> that is diagnosed with a clinical interview.
> Major depression occurs in 10–15% of people.

SYMPTOMS OF DEPRESSION

The primary symptoms of depression include low mood, as well as problems with activity level, sleep, appetite, and thinking. A person does not have to have all the symptoms listed below to receive a diagnosis of major depression.

Common symptoms of depression include the following:

- Depressed mood
- Decreased interest or pleasure
- Feeling worthless, hopeless, or helpless
- Guilt
- Suicidality
- Change in appetite and/or weight
- Sleep disturbances (too much or too little)

(continued)

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- Lethargy or agitation
- Fatigue
- Problems with attention, concentration, and making decisions

FREQUENTLY ASSOCIATED SYMPTOMS

Some people with depression may experience other psychiatric symptoms, although these symptoms are not among those used to diagnose depression. They may include *hallucinations* (hearing, seeing, feeling, or smelling things that aren't there) or *delusions* (unusual beliefs that other people don't have, such as persecutory delusions), when their mood is depressed. These symptoms usually go away when their mood is normal.

> Common symptoms of depression include:
> - Depressed mood
> - Weight/appetite and sleep changes
> - Changes in energy and activity level
> - Feeling worthless, helpless, hopeless, guilty, suicidal
> - Concentration/attention problems

SIMILAR PSYCHIATRIC DISORDERS

Major depression shares symptoms with other major psychiatric disorders. People with bipolar disorder, schizoaffective disorder, or schizophrenia may experience symptoms of depression, but there are important differences as well. People with bipolar disorder also have manic episodes, whereas people with major depression do not. People with schizophrenia or schizoaffective disorder may experience depression, but when their mood is normal they may continue to experience hallucinations and delusions.

> The symptoms of major depression
> may overlap with those of other psychiatric disorders.

TREATMENT

Special medications called *antidepressants* are often used to treat major depression. For depressions that don't respond to medication, sometimes *electroconvulsive therapy* (*ECT*) can be an effective treatment.

Many people with depression may also benefit from psychotherapy and family treatment to help them deal with the disruptive aspects of the disorder.

> Effective treatments for major depression include
> medication, counseling, and sometimes ECT.

(continued)

FURTHER READING

Burns, D. (1999). *Feeling Good: The New Mood Therapy* (rev. ed.). New York: Bantam.

Copeland, M. E. (1992). *The Depression Workbook: A Guide for Living with Depression and Manic Depression*. Oakland, CA: New Harbinger.

DePaulo, J. R., Jr. (2002). *Understanding Depression: What We Know and What You Can Do about It*. New York: Wiley.

Papolos, D. F., & Papolos, J. (1997). *Overcoming Depression* (3rd ed.). New York: HarperPerennial.

HANDOUT B.3

Understanding Obsessive–Compulsive Disorder

Obsessive–compulsive disorder (OCD) is a major psychiatric disorder. People with OCD may have anxiety related to severe *obsessions* (repeated worries that are difficult to stop thinking about) or *compulsions* (recurrent behaviors or thoughts that must be repeated over and over to reduce anxiety). People with OCD often recognize that their obsessions and compulsions are not normal or rational, but they can't seem to stop them.

The cause of OCD is unknown, but there are several theories. One theory is based on learning. A person experiences a minor distressing thought, image, or impulse, which causes anxiety. The person tries to use thoughts or behaviors to dispel the anxiety, and these are temporarily successful. However, over time the anxiety gets worse as the obsessions increase, and the person develops elaborate thinking strategies or compulsions as attempts to lower the anxiety. There are also biological theories of OCD that focus on an imbalance of brain chemicals, particularly the neurotransmitter (brain chemical) *serotonin*.

Between 2% and 3% of people develop OCD in their lifetime. OCD often develops in late adolescence or early adulthood, although it may occur at any time in a person's life. For some people, OCD is a chronic lifelong disorder. Others may achieve complete recovery.

OCD is diagnosed with a clinical interview. The interviewer checks to see whether the person has experienced specific symptoms for a period of time.

> OCD is a major psychiatric illness that is diagnosed with a clinical interview.
> OCD occurs in 2–3% of people.

OBSESSIVE SYMPTOMS

A person with obsessions has disturbing recurrent thoughts, impulses, or images that cause a great deal of anxiety, such as thoughts of hurting a loved one or thoughts of having been exposed to a fatal disease. Sometimes people realize these obsessions aren't real, but other times they do not. These obsessions lead to efforts to avoid, suppress, or neutralize the thoughts.

COMPULSIVE SYMPTOMS

A person with compulsions repeats behaviors or thoughts to reduce the anxiety related to obsessions, or does so because he or she can't resist doing it. The person may spend several hours a day engaging in these compulsions.

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Common compulsions include the following:

- Checking things, such as making sure doors and windows are locked, lights are turned off, and appliances are turned off
- Washing and cleaning, such as repeated hand washing
- Repeating behaviors over and over, such as dressing and undressing
- Ordering, such as having objects line up
- Hoarding things like old newspapers
- Thinking rituals, such as repeating prayers over and over

FREQUENTLY ASSOCIATED SYMPTOMS

For some people with OCD, the obsessions and compulsions may take over their lives and lead to depression. When a person develops obsessions that are bizarre and strong, the obsessions can become *delusions* (or false beliefs). The diagnosis of OCD is not based on depression or delusions, however.

> Common symptoms of OCD include:
> - Obsessions (recurrent thoughts, etc.)
> - Compulsions (checking, washing, etc.)

SIMILAR PSYCHIATRIC DISORDERS

OCD shares some symptoms with other psychiatric disorders. The pervasive anxiety in OCD can be similar to that in posttraumatic stress disorder, and the depression can be similar to major depression. Obsessions that become delusional may be difficult to distinguish from the delusions that are present in schizophrenia or schizoaffective disorder. A person may have OCD and one of these other disorders, or the symptoms may only be related to the obsessions and compulsions.

> The symptoms of OCD overlap
> with those of other psychiatric disorders.

TREATMENT

Two types of treatment for OCD are effective: *behavior therapy* and *medication*. Behavior therapy works by employing two therapeutic principles: *exposure* and *response generation*. In exposure, people learn to confront their fears rather than escaping from them and over time their anxiety decreases. In response prevention, people are taught to stop compulsions and break the cycle of repeated behaviors. Family treatment can also help to reduce the stress a person with OCD experiences.

Antidepressant medications can help to alleviate the symptoms of OCD as well. These medications are believed to change levels of the neurotransmitter (brain chemical) serotonin, leading to improvements in OCD symptoms.

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Effective treatments for OCD
are behavior therapy and medication.

FURTHER READING

Foa, E. B., & Wilson, R. (2001). *Stop Obsessing!: How to Overcome Your Obsessions and Compulsions* (rev. ed.). New York: Bantam.

Goodman, W. K., Rudorfer, M. V., & Maser, J. D. (Eds.). (2000). *Obsessive-Compulsive Disorder: Contemporary Issues in Treatment.* Mahwah, NJ: Erlbaum.

Rapoport, J. L. (1989). *The Boy Who Couldn't Stop Washing: The Experience and Treatment of Obsessive-Compulsive Disorder.* New York: Dutton.

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HANDOUT B.4

Understanding Posttraumatic Stress Disorder

Posttraumatic stress disorder (PTSD) is a major psychiatric disorder that may occur when a person experiences or witnesses a traumatic, often life-threatening event. Examples of common traumatic events that may cause PTSD are combat, sexual abuse, assault or rape, accidents, natural disasters, and the sudden, unexpected death of a loved one. People with PTSD experience high levels of anxiety, arousal, and avoidance due to recurrent memories of the traumatic event.

It is not clear why some people develop PTSD after a trauma and others do not. Theories suggest that both learning and biological factors may contribute to the cause of PTSD. The number of traumas a person experiences is also important. The effects of repeated traumas may be cumulative and result in increased severity of symptoms. From 1% to 10% of people develop PTSD at some point in their lives.

PTSD may develop anytime in a person's life, after experiencing a traumatic event. For some people, the symptoms of PTSD gradually disappear over weeks or months, but for other people they may get worse over time. With treatment a person may fully recover from PTSD, although some people may continue to experience symptoms after treatment.

PTSD is diagnosed with a clinical interview. The interviewer checks to see whether the person has experienced specific symptoms for more than a month.

> PTSD is a major psychiatric illness
> that is diagnosed with a clinical interview.
> PTSD occurs in 1–10% of people at some point in their lives.

SYMPTOMS OF PTSD

PTSD is diagnosed based on the presence of three types of symptoms: reexperiencing the trauma, avoidance of stimuli associated with the trauma, and increased arousal. People do not have to have all of the following symptoms to be diagnosed with PTSD, but they need to have at least some of each type of symptom.

Reexperiencing the Trauma

- Recurrent nightmares of the event
- Recurrent and intrusive memories of the event
- Distress at events that are reminders of the trauma
- Suddenly acting or feeling as if the event were recurring

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Avoidance of the Stimuli Associated with the Trauma

- Efforts to avoid thoughts, feelings, situations, or activities that trigger memories of the trauma
- Feeling detached or estranged from others
- A sense of foreshortened future
- Inability to recall an important aspect of the trauma
- Diminished interest in significant activities

Increased Arousal

- Hypervigilance (e.g., always "looking over one's shoulder")
- Increased arousal in situations that remind the person of the trauma
- Difficulty sleeping
- Difficulty concentrating
- Exaggerated startle response
- Irritability or anger outbursts

Common symptoms of PTSD include:
- Reexperiencing the trauma
- Avoidance of stimuli associated with the trauma
- Feeling emotionally numb
- Overarousal

FREQUENTLY ASSOCIATED SYMPTOMS

People with PTSD often experience other psychiatric symptoms, although these are not among the symptoms used to diagnose PTSD. Depression is a very common problem. Some people may experience *hallucinations* (hearing, seeing, feeling, or smelling things that aren't there) or *delusions* (unusual beliefs that other people don't have—for example, persecutory delusions) related to their traumatic experience.

SIMILAR PSYCHIATRIC DISORDERS

PTSD shares some symptoms with other psychiatric disorders. The anxiety, anger, and overarousal of PTSD may seem like the mania of bipolar disorder. Some of the symptoms of PTSD may overlap with those of schizophrenia or schizoaffective disorder. For example, people with PTSD may reexperience the trauma to the point of hallucinations. Their avoidance of people who remind them of their trauma may lead to social withdrawal, and their emotional numbing may resemble the blunted (or flattened) affect often present in schizophrenia or schizoaffective disorder. People with PTSD may also experience symptoms of major depression or obsessive–compulsive disorder. A person may have PTSD and also one of these other disorders, or the symptoms may only be related to the traumatic event.

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TREATMENT

Several different treatments are effective for people with PTSD. *Behavior therapy* is a very effective treatment approach for PTSD. Two types of behavior therapy are used to treat PTSD: *exposure therapy* (also called *flooding*) and *cognitive restructuring* (also called *cognitive therapy* or *cognitive processing therapy*). In exposure therapy, the client is helped to confront feared memories and safe situations that remind him or her of the trauma, rather than avoiding them, in order to learn that feared memories and situations cannot hurt him or her. In cognitive restructuring, the client is helped to challenge distorted beliefs about him- or herself and the world that are related to the trauma in order to develop more realistic and cognitive beliefs. Behavior therapy for PTSD may involve exposure therapy, cognitive restructuring, or a combination of the two.

In addition to behavior therapy, medication and supportive counseling may improve the symptoms of PTSD. Antidepressant and antipsychotic medications can decrease symptoms. Supportive counseling, in which the person can talk about feelings and get help resolving problems, can also be helpful.

There are several treatments for PTSD, which include:

- Behavior therapy
- Supportive counseling
- Medication

FURTHER READING

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Rosenbloom, D., & Williams, M. B., with Watkins, B. E. (1999). *Life after Trauma: A Workbook for Healing.* New York: Guilford Press.

Schiraldi, G. R. (2000). *The Post-Traumatic Stress Disorder Sourcebook: A Guide to Healing, Recovery, and Growth.* Los Angeles, CA: Lowell House.

HANDOUT B.5

Understanding Schizoaffective Disorder

Schizoaffective disorder is a major psychiatric disorder that is similar to schizophrenia. People with this illness may experience *hallucinations* (hearing, seeing, feeling, or smelling things that aren't there) or *delusions* (unusual beliefs that other people don't have, such as paranoid beliefs that others are against them), as well as low motivation and poor attention. Unlike schizophrenia, people with schizoaffective disorder may also experience extremely high moods (*mania*) or extremely low moods (*depression*) for prolonged periods of time.

The cause of schizoaffective disorder is unknown. Scientists believe the disorder may be caused by an imbalance in neurotransmitters (brain chemicals), particularly the neurotransmitter *dopamine*. These imbalances may be due to genetic factors, early effects of the environment on the developing brain (such as when the baby is in the womb or during birth), or both.

About 0.5% of people (1 in 200) develop schizoaffective disorder in their lifetime. Schizoaffective disorder is diagnosed with a clinical interview. The interviewer checks to see whether the person has experienced specific symptoms over a long enough period of time. The clinician must also make sure that the person has no physical problems that could cause symptoms like those of schizoaffective disorder, such as a brain tumor.

> Schizoaffective disorder is a major psychiatric illness
> that is diagnosed with a clinical interview.
> Schizoaffective disorder occurs in 0.5% of people (1 of 200).

SYMPTOMS OF SCHIZOAFFECTIVE DISORDER

Four broad types of symptoms are very common in schizoaffective disorder: *psychotic symptoms*, *negative symptoms*, *mania*, and *depression*. Psychotic symptoms are thoughts, perceptions, and behaviors that are present in people with schizoaffective disorder (and also schizophrenia), but not in other people. These symptoms often reflect difficulties distinguishing between what is real and not real. Negative symptoms are the absence of thoughts, perceptions, and behaviors that are usually present in other people. Manic symptoms reflect heightened mood states (especially euphoria and irritability), increased self-esteem and confidence, and increased goal-directed activity (such as spending an excessive amount of time and energy on work, school, or other activities). Depressive symptoms are the opposite of manic symptoms, with low mood and inactivity as the major features.

A person does not have to have all of these types of symptoms to be diagnosed with schizoaffective disorder.

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Common Psychotic Symptoms

- Hallucinations
- Delusions
- Bizarre, disorganized, or strange behaviors
- Disorganized speech

Common Negative Symptoms

- Flattened affect
- Apathy and low motivation
- Loss of pleasure
- Lack or low amount of speech, or limited content of speech

Common Symptoms of Mania

- Euphoria
- Irritability
- Reduced need for sleep
- Increased talkativeness
- Inflated self-esteem
- Grandiosity
- Increased goal-directed activity
- Racing thoughts
- Distractibility

Common Symptoms of Depression

- Depressed mood or sadness
- Decreased interest or pleasure
- Feeling worthless, hopeless, or helpless
- Guilt
- Suicidality
- Change in appetite and/or weight
- Sleep disturbances (too much or too little)
- Lethargy or agitation
- Fatigue
- Problems with attention, concentration, and making decisions

Common symptoms of schizoaffective disorder include:

- Psychotic symptoms
- Negative symptoms
- Mania
- Depression
- Disorganization

(continued)

FREQUENTLY ASSOCIATED SYMPTOMS

Some people with schizoaffective disorder may also experience thinking problems, though these are not among the symptoms used in making a schizoaffective diagnosis. These may include difficulties with memory, trouble with abstract reasoning, difficulty planning, and attention problems.

SIMILAR PSYCHIATRIC DISORDERS

Schizoaffective disorder shares some symptoms with other major psychiatric disorders, such as schizophrenia, bipolar disorder, and major depression. However, there are some important differences. People with schizoaffective disorder or schizophrenia often have hallucinations or delusions even when their mood is stable, whereas people with major depression or bipolar disorder do not have these symptoms when their mood is stable. People with schizoaffective disorder often experience mood symptoms such as mania or depression, while people with schizophrenia usually experience less severe mood symptoms.

> The symptoms of schizoaffective disorder overlap with those of other psychiatric disorders.

TREATMENT

As in schizophrenia, antipsychotic medications are effective in treating the symptoms of schizoaffective disorder. Mood-stabilizing medications and antidepressant medications are sometimes used to treat the mood symptoms of this disorder. It is very important that medications be taken regularly to decrease symptoms, to prevent relapses, and to make sure that the illness does not become more severe.

Many people with schizoaffective disorder also benefit from social skills training, supported employment, case management, family treatment, and learning illness management techniques (such as how to prevent relapses and cope with symptoms).

> Schizoaffective disorder is treated with medication, as well as other services (including family treatment, vocational rehabilitation, and skills training approaches).

FURTHER READING

Mueser, K. T., & Gingerich, S. L. (in press). *Coping with Schizophrenia: A Guide for Families* (2nd ed.). New York: Guilford Press.

Schiller, L., & Bennett, A. (1994). *The Quiet Room: A Journey Out of the Torment of Madness*. New York: Warner Books.

Torrey, E. F. (2001). *Surviving Schizophrenia: A Family Manual* (4th ed.). New York: HarperTrade.

HANDOUT B.6

Understanding Schizophrenia

Schizophrenia is a major psychiatric illness. People often experience symptoms such as *hallucinations* (hearing, seeing, feeling, or smelling things that aren't there) or *delusions* (unusual beliefs that other people don't have, such as paranoid beliefs that others are against them). They may also have other symptoms, such as low motivation, poor attention, and inability to experience pleasure. Sometimes it is hard for people with schizophrenia to distinguish fantasy from reality.

The cause of schizophrenia is unknown. Scientists believe it may be caused by an imbalance in neurotransmitters (brain chemicals), especially the chemical *dopamine*. Imbalances of these neurotransmitters may be caused by genetic factors, early effects of the environment on the developing brain (such as when the baby is in the womb or during birth), or both.

About 1% of people develop schizophrenia during their lifetime. Schizophrenia usually develops between the ages of 16 and 30, but may develop after that. It is a lifelong disorder.

Schizophrenia is diagnosed with a clinical interview. The interviewer checks to see whether a person has experienced symptoms and, if so, for how long. To be diagnosed with schizophrenia, a person must experience a decrease in social functioning (school, work, social relationships, or self-care) for at least 6 months. The clinician must also make sure that the person has no physical problems that could cause problems like those of schizophrenia, such as a brain tumor.

> Schizophrenia is a major psychiatric illness that is diagnosed with a clinical interview. Schizophrenia occurs in 1% of people.

SYMPTOMS OF SCHIZOPHRENIA

Two broad types of symptoms are very common in schizophrenia: *psychotic symptoms* and *negative symptoms*. Psychotic symptoms are thoughts, perceptions, and behaviors that are present in people with schizophrenia, but not in other people. These symptoms often reflect difficulties distinguishing between what is real and not real. Negative symptoms are the absence of thoughts, perceptions, and behaviors that are present in other people. A person does not have to have all of the following symptoms to be diagnosed with schizophrenia.

Common Psychotic Symptoms

- Hallucinations
- Delusions
- Bizarre, disorganized, or strange behaviors
- Disorganized speech

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Common Negative Symptoms

- Flattened affect (diminished expressiveness)
- Apathy and low motivation
- Loss of pleasure
- Lack or low amount of speech, or limited content of speech

> Common symptoms of schizophrenia include:
> - Psychotic symptoms (hallucinations, delusions, etc.)
> - Negative symptoms (apathy and low motivation, loss of pleasure, etc.)
> - Disorganization

FREQUENTLY ASSOCIATED SYMPTOMS

Some people with schizophrenia may also experience cognitive problems and other symptoms, though these are not used in making the diagnosis of schizophrenia. Cognitive problems include difficulties with memory, trouble with abstract reasoning, difficulty planning, and attention problems. Some other associated symptoms are depression, fluctuating mood, anxiety, and anger or hostility.

SIMILAR PSYCHIATRIC DISORDERS

Schizophrenia shares some symptoms with other major psychiatric disorders, such as bipolar disorder, major depression, and schizoaffective disorder. However, there are important differences between schizophrenia and these other disorders. People with bipolar disorder or major depression sometimes experience hallucinations or delusions when their mood is abnormal (depressed or manic). In contrast, people with schizophrenia or schizoaffective disorder often continue to experience hallucinations or delusions even when their mood is normal. People with schizoaffective disorder experience prolonged or frequent problems with their mood (either depression, mania, or both), whereas people with schizophrenia tend to have less severe problems with their mood.

> The symptoms of schizophrenia overlap with those of other psychiatric disorders.

TREATMENT

Antipsychotic medications are used to treat schizophrenia. Sometimes antidepressant and mood-stabilizing medications are used as well. It is very important that medications are taken regularly to decrease symptoms, to prevent relapses, and to make sure that the illness does not become more severe.

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Many people with schizophrenia also benefit from social skills training, supported employment, case management, family treatment, and learning illness management techniques, such as how to prevent relapses and cope with symptoms.

Schizophrenia is treated with medication, as well as other services (including family treatment, vocational rehabilitation, and skills training approaches).

FURTHER READING

Mueser, K. T., & Gingerich, S. L. (in press). *Coping with Schizophrenia: A Guide for Families* (2nd ed.). New York: Guilford Press.

Schiller, L., & Bennett, A. (1994). *The Quiet Room: A Journey Out of the Torment of Madness*. New York: Warner Books.

Torrey, E. F. (2001). *Surviving Schizophrenia: A Family Manual* (4th ed.). New York: Harper Trade.

HANDOUT B.7

Understanding Antidepressant Medications

Antidepressant medications are primarily used to treat depression, but they may also be used to treat other symptoms, such as anxiety and chronic pain. Antidepressant medications were first discovered in the 1950s, and new ones continue to be developed.

> Antidepressant medications are effective in reducing depression and anxiety.

Antidepressant medications are frequently used in the treatment of major depression and some anxiety disorders, such as posttraumatic stress disorder, obsessive–compulsive disorder, panic disorder, and social phobia. Sometimes these medications are also used to treat bipolar disorder.

> Antidepressant medications are used in the treatment of major depression and other psychiatric disorders.

Antidepressant medications work by affecting neurotransmitters (chemicals in the brain). Two neurotransmitters that are important include *serotonin* and *norepinephrine*. Some antidepressant medications mainly affect serotonin; others mainly affect norepinephrine; and others affect both neurotransmitters.

> Antidepressant medications work by altering chemicals in the brain called *neurotransmitters*.

FACTS ABOUT ANTIDEPRESSANT MEDICATIONS

- Antidepressant medications are usually taken by mouth.
- They are not addictive.
- The medications may work in a few days, but they usually require 4–6 weeks to become completely effective.

(continued)

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- Taking antidepressant medications has two main effects:
  - They reduce the severity of depression and anxiety.
  - They lower the chances of relapses of depression and anxiety in the future.
- If symptom relapses occur, a temporary increase in antidepressant medication dosage may be helpful.

COMMON ANTIDEPRESSANT MEDICATIONS

Following is a table of the most common antidepressants. They are divided into four major groups: *tricyclic antidepressants*, *monoamine oxidase inhibitors* (*MAOIs*), *selective serotonin reuptake inhibitors (SSRIs)*, and *other compounds*.

Antidepressant Medications

Type of drug	Brand name	Chemical name
Tricyclics	Anafranil	Clomipramine
	Elavil	Amitriptyline
	Norpramin	Desipramine
	Pamelor, Aventyl	Nortriptyline
	Sinequan, Adapin	Doxepin
	Tofranil	Imipramine
	Vivactil	Protriptyline
MAOIs	Marplan	Isocarboxazid
	Nardil	Phenelzine
	Parnate	Tranylcypromine
SSRIs	Celexa	Citalopram
	Lexapro	Escitalopram
	Luvox	Fluvoxamine
	Paxil	Paroxtine
	Prozac	Fluoxetine
	Zoloft	Sertraline
Other compounds	Desyrel	Trazodone
	Effexor	Venlafaxine
	Ludiomil	Maprotiline
	Remeron	Mirtazapine
	Serzone	Nefazodone
	Wellbutrin, Zyban	Bupropion

There are four major groups of antidepressant medications: *tricyclics, MAOIs, SSRIs,* and *other compounds*.

(continued)

SIDE EFFECTS

Antidepressant medications can have some unpleasant side effects. To reduce these side effects, either the dosages or the medications themselves can be changed.

There are particular risks for people with bipolar disorder taking antidepressants. These medications may cause hypomania or mania. If this occurs, the dosages may need to be reduced or the medications stopped.

Antidepressant medications can also occasionally cause hypomanic or manic symptoms (such as increased irritability or euphoria, decreased need for sleep, inflated self-esteem, or grandiosity) in people with depression who have no prior history of such symptoms. If hypomanic or manic symptoms are observed in someone who is being treated with antidepressant medications for depression, the prescribing physician should be consulted immediately. Again, these symptoms can usually be resolved by stopping the antidepressant medications or adjusting the dosages.

The MAOIs have side effects with the chemical tyramine, which is found in certain foods and drinks. People taking MAOIs should get a complete list of the foods and beverages to be avoided from their doctor.

Following is a table of common side effects.

Side Effects of Antidepressant Medications

Drug group	Side effects
Tricyclics	Dry mouth, dizziness, sedation or agitation, weight gain, constipation, heart palpitations, cardiac abnormalities
MAOIs	Insomnia, dizziness, weight gain, sexual difficulties, confusion, memory problems, overstimulation, hypertensive crisis
SSRIs	Nausea, vomiting, excitement, agitation, headache, sexual problems (delayed ejaculation, not experiencing orgasm)
Other compounds	Same as SSRIs, plus potential to elevate blood pressure, sedation, or agitation

Antidepressant medications can have some unpleasant side effects.

The dosages can be adjusted or the medications can be changed to relieve these side effects.

HANDOUT B.8

Understanding Antipsychotic Medications

Antipsychotic medications (also called *major tranquilizers* or *neuroleptics*) were first discovered in the 1950s. Many antipsychotic medications have been developed since then. Antipsychotic medications are effective in treating *psychotic symptoms*, such as hallucinations, delusions, and disorganized thinking. They can also be helpful in reducing *negative symptoms*, such as apathy and social withdrawal. In addition, antipsychotic medications are useful in controlling mood swings.

> Antipsychotic medications are effective
> in reducing psychotic symptoms and other symptoms.

Antipsychotic medications are frequently used in the treatment of schizophrenia and schizoaffective disorder. They are also often used to treat bipolar disorder. Sometimes these medications are used to treat major depression and other disorders as well.

> Antipsychotics are used to treat
> schizophrenia and other psychiatric disorders.

Antipsychotic medications work by affecting the neurotransmitter (brain chemical) *dopamine*. Some of the newer antipsychotic medications (called *second-generation, atypical,* or *novel antipsychotics*) also affect the neurotransmitter *serotonin*.

> Antipsychotic medications work by altering chemicals
> in the brain called *neurotransmitters*.

FACTS ABOUT ANTIPSYCHOTIC MEDICATIONS

- Antipsychotic medications are usually taken by mouth, but some short-acting and long-acting injectable forms exist.
- They are not addictive.
- The medications may work in a few days, but they usually require several weeks to become completely effective.
- Taking antipsychotic medications has two main effects:
    - They reduce the severity of symptoms.
    - They lower the chances of symptom relapses in the future.
- If symptom relapses occur, a temporary increase in antipsychotic medication dosage may be helpful.

(continued)

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NOVEL ANTIPSYCHOTIC MEDICATIONS

The novel antipsychotics, mentioned above, work differently than the conventional antipsychotics do. They appear to affect different neurotransmitters in the brain. The novel antipsychotics include Clozaril, Risperdal, Zyprexa, Seroquel, Geodon, and Abilify. More novel antipsychotics are currently being developed. Some of these medications may be effective when the conventional medications have only been partially effective. Novel antipsychotics may also be more effective in treating the negative and cognitive symptoms than the conventional medications.

COMMON ANTIPSYCHOTIC MEDICATIONS

A table of commonly used antipsychotic medications (both conventional and novel) follows.

Antipsychotic Medications

Type of medication	Chemical name
Conventional	
Haldol**	Haloperidol
Loxitane	Loxapine
Mellaril	Thioridazine
Moban	Molindone
Navane	Thiothixene
Prolixin**	Fluphenazine
Serentil	Mesoridazine
Stelazine	Trifluoperazine
Thorazine	Chlorpromazine
Trilafon	Perphenazine
Novel	
Abilify	Aripiprazole
Clozaril	Clozapine
Geodon	Ziprasidone
Risperdal	Risperidone
Seroquel	Quetiapine
Zyprexa	Olanzapine

**Medications available in long-acting, injectable preparations.

> There are both conventional and novel antipsychotics, with many new medications currently under development.

(continued)

SIDE EFFECTS OF CONVENTIONAL ANTIPSYCHOTIC MEDICATIONS

The conventional antipsychotic medications have a number of side effects, some mild and some serious. These include the following:

- Drowsiness
- Muscle stiffness
- Dizziness
- Dry mouth
- Mild tremors
- Restlessness
- Increased appetite, weight gain
- Blurred vision
- Sexual difficulties
- Heart rhythm abnormalities

Tardive dyskinesia is a serious side effect that occurs in 10–20% of people taking conventional antipsychotics. Higher rates of tardive dyskinesia may occur in people taking these medications over very long periods of time. This is a neurological syndrome that causes involuntary muscle movements, usually in the tongue, the mouth or lips, the trunk, or the extremities (such as hands, fingers, or toes). It is usually mild, but sometimes may be severe and disfiguring. It usually does not go away, but reducing the dose of the conventional antipsychotic or switching to a novel antipsychotic may improve it.

> Antipsychotic medications cause several side effects.
> Tardive dyskinesia is one of the serious side effects.

MEDICATIONS FOR SIDE EFFECTS

Two types of medications (called *anticholinergics* and *dopamine agonists*) are used to treat side effects like muscle stiffness, tremors, and increased salivation. These are called *extrapyramidal side effects*.

Medications for Extrapyramidal Side Effects of Antipsychotics

Type of drug	Brand name	Chemical name
Anticholinergic	Akineton	Biperiden
	Artane	Trihexyphenidyl
	Cogentin	Benztropine
	Kemadrin	Procyclidine
Dopamine agonist	Symmetrel	Amantadine

(continued)

Another side effect of antipsychotics is *akathisia*, which is restlessness, agitation, or trouble sitting still. Medications like *beta-blockers* (such as Inderal, Tenormin, or Corgard) or *benzodiazepines* (such as Ativan or Valium) may help with akathisia. Unfortunately, there are also side effects associated with these medications.

Possible Side Effects of Side Effect Medications

Drug class	Side effects
Anticholinergics	Dry mouth, constipation, blurry vision, drowsiness, urinary retention, memory loss
Dopamine agonists	Increase in psychotic symptoms
Beta-blockers	Fatigue, depression
Benzodiazepines	Drowsiness, psychological or physiological dependence, psychomotor impairment, memory loss

There are medications to treat side effects of conventional antipsychotics, but they have side effects of their own.

SIDE EFFECTS OF NOVEL ANTIPSYCHOTICS

Common side effects of Clozaril include drowsiness, increased salivation, dizziness, a slight increase in body temperature, changes in blood pressure, constipation, weight gain, *tachycardia* (rapid heart rate), *cataplexy* (sudden loss of muscle tone), and seizures. *Agranulocytosis* is a dangerous drop in a person's white blood cell count. This occurs less than 1% of the time with people taking Clozaril. To detect this problem, weekly blood tests are done so that the medication can be stopped if agranulocytosis occurs. Clozaril is also rarely associated with myocardia, or inflammation of the heart, which can be fatal.

Novel antipsychotic medications can cause some of the same side effects as the conventional antipsychotics, but usually they are much less severe and side effect medications are often not required to treat them. However, novel antipsychotics may cause some other side effects, which are listed below.

- Risperdal: Elevation of the hormone prolactin, sexual side effects, sedation, weight gain
- Zyprexa: Sedation, weight gain
- Seroquel: Dizziness, sedation, increased risk for cataracts
- Geodon: Possible heart rhythm abnormalities, sedation, nausea, constipation, dizziness
- Abilify: Headache, insomnia, nausea, vomiting, lightheadedness

Novel antipsychotics tend to cause different side effects from conventional antipsychotics.

HANDOUT B.9

Understanding Mood-Stabilizing Medications

Mood-stabilizing medications are primarily used to treat the symptoms of bipolar disorder, including mania and depression, but they may also be used to treat other disorders, such as schizoaffective disorder. Several mood-stabilizing medications have been discovered over the past century, including lithium (the 1940s), carbamazepine and valproic acid (1970s and 1980s), and olanzapine (2000).

> Mood-stabilizing medications are effective in reducing episodes of mania and depression. They are used to treat bipolar disorder (and sometimes other disorders).

FACTS ABOUT MOOD-STABILIZING MEDICATIONS

- Mood-stabilizing medications are believed to work by affecting levels of neurotransmitters (chemicals in the brain).
- The medications are taken by mouth.
- They are not addictive.
- The medications may work in a few days, but they usually require several weeks to become completely effective.
- Mood-stabilizing medications can affect other symptoms, such as impulsiveness, agitation, hallucinations, delusions, and anxiety.
- Taking these medications has two main effects:
  - They reduce the severity of symptoms.
  - They lower the chances of symptom relapses in the future.
- If symptom relapses occur, a temporary increase in mood-stabilizing medication dosage may be helpful.

> Mood stabilizers affect certain neurotransmitters in the brain.

(continued)

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TYPES OF MOOD STABILIZERS

There are three broad categories of mood-stabilizing medications: lithium, anticonvulsants (medications originally used to treat seizure disorders), and antipsychotics. See the following table.

Mood Stabilizers

Type of drug/brand name	Chemical name	Side effects
Lithium		*Common side effects*
Eskalith, Eskalith Controlled Release, Lithobid, Lithonate	*Lithium carbonate*	Nausea, weight gain, slowed thinking, fatigue, tremor
		Serious side effects
		Vomiting, diarrhea, slurred speech, confusion
Anticonvulsants		*Common side effects*
Depakote, Depakene	Valproic acid	Fatigue, weight gain, nausea, headache, decreased sexual desire
Tegretol	Carbamazepine	
		Serious side effects
		Confusion, vomiting, abdominal pain, vision problems, fever, jaundice or liver damage, abnormal bleeding or bruising, blood cell count abnormalities, swelling lymph glands
Antipsychotics		*Side effects*
Zyprexa	Olanzapine	See "Understanding Antipsychotic Medications" handout
Clozaril	Clozapine	

There are three categories of mood stabilizers:

- Lithium
- Anticonvulsants
- Antipsychotics

SPECIAL ISSUES WITH LITHIUM

If any of the serious side effects are experienced, clients should contact their doctor. High doses of lithium can be harmful to the brain; therefore, regular blood levels of lithium are routinely checked when someone is taking lithium. Low-salt diets and diuretic medications should be avoided, as they lower lithium levels. Anti-inflammatory drugs may increase lithium levels.

Consult a physician if lithium causes side effects.

(continued)

SPECIAL ISSUES WITH ANTICONVULSANTS

Again, if any of the serious side effects are experienced, clients should contact their doctor. Anticonvulsants can be sedating, and alcohol may increase this sedation, so people using these medications should be careful when driving or operating machinery. Routine blood levels are conducted in order to monitor how the medication is affecting blood cells and the liver.

> Consult a physician if anticonvulsant medications cause side effects.

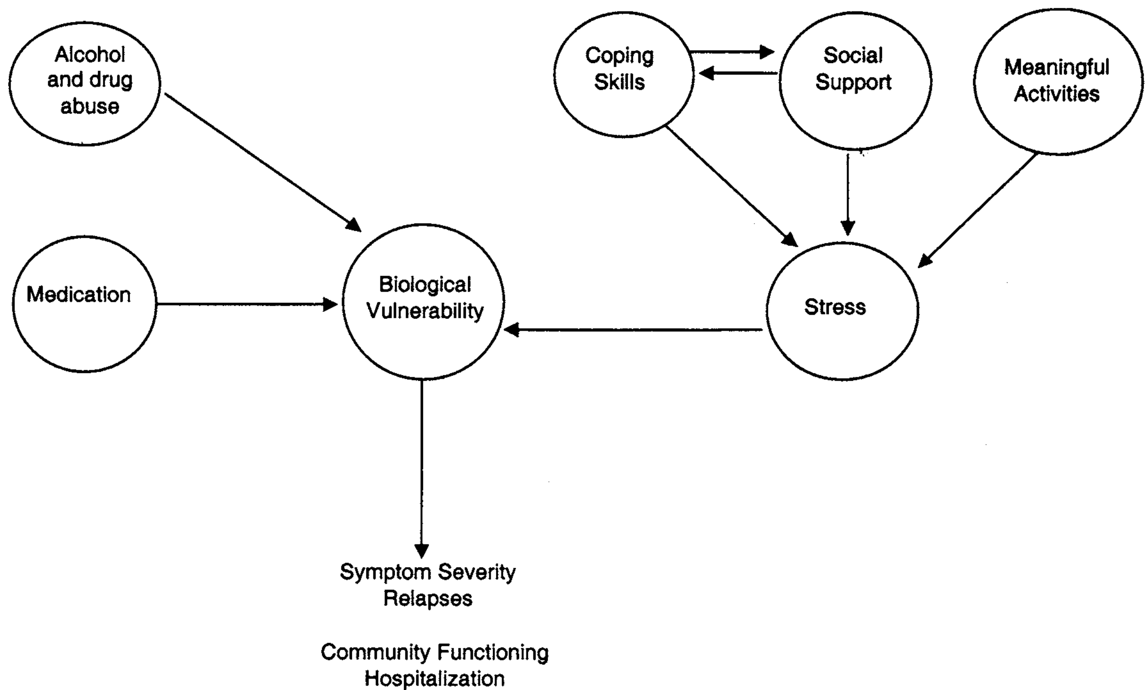
HANDOUT B.10

The Stress–Vulnerability Model of Psychiatric Disorders

Psychiatric illnesses tend to fluctuate over time, with their severity increasing and decreasing at different points in time. An episode of an illness (or a relapse) occurs when symptoms are severe and functioning is impaired. Understanding what factors contribute to relapses can help people learn how to manage their illness more effectively, and to prevent relapses or decrease their severity.

Psychiatric illnesses fluctuate over time in their severity.

The *stress–vulnerability model of psychiatric disorders* provides a useful way of understanding how different factors influence the course of mental illness. According to this model, the course of a psychiatric illness is influenced by several factors: biological vulnerability, stress, medication, drugs and alcohol, coping skills, and social support. Each of these factors is described below, and illustrated in the accompanying diagram.



A diagram of the stress–vulnerability model.

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BIOLOGICAL VULNERABILITY

Each person has *biological vulnerability* to different diseases. This vulnerability is determined by a combination of genetic and other biological factors. For example, some people have a biological vulnerability to cardiac disease; some people have a vulnerability to specific types of cancer; and some people have a vulnerability to specific psychiatric disorders. Common psychiatric disorders to which people are biologically vulnerable include schizophrenia, schizoaffective disorder, bipolar disorder, major depression, and anxiety disorders.

Once a person has a biological vulnerability to a mental illness, that mental illness may either develop spontaneously or be triggered by stress. Even among people who have a psychiatric illness, vulnerability may differ from one person to another. On average, people who have a greater biological vulnerability to an illness experience more severe symptoms and difficulties.

STRESS

Stress refers to something in the environment that forces the person to adjust or adapt in some way. Stress can take the form of specific life events, such as the death of a loved one, a major move, or being a victim of crime. Stress can also be caused by living in difficult conditions, such as living with people who are hostile and critical, living in an unpredictable and dangerous environment, or living in poverty.

People who are biologically vulnerable to a psychiatric disorder and who are exposed to stress are more likely to develop that disorder. Once people have a psychiatric disorder, stress can cause relapses and worsen the course of the illness.

> Stress can affect biological vulnerability,
> leading to symptom relapses.

FACTORS THAT AFFECT BIOLOGICAL VULNERABILITY AND STRESS

Although biological vulnerability and stress influence the course of the psychiatric disorder, they can be affected by several factors. Those factors include medication, drugs and alcohol, coping skills, and social support.

Factors That Affect Biological Vulnerability

Biological vulnerability can be affected both by medications and by drugs and alcohol.

Medications

Medications for psychiatric disorders can decrease biological vulnerability. Medications are effective at both decreasing the severity of symptoms and preventing symptom relapses. People who take medications regularly and do experience relapses tend to have less severe relapses.

(continued)

Alcohol and Drugs

Alcohol and drug use can increase biological vulnerability. Some substances can directly increase biological vulnerability, while other substances can decrease the beneficial effects of medications on vulnerability. People with psychiatric disorders who use alcohol and drugs regularly are prone to more frequent relapses of their symptoms.

> Medications decrease biological vulnerability.
> Alcohol and drugs increase biological vulnerability.

Factors That Affect Stress

Stress can be decreased by coping skills, social support, and engaging in meaningful activity.

Coping Skills

Coping skills are strategies that people use to minimize the effects of stress. Examples of coping skills include relaxation, positive self-talk, problem solving, talking out one's feelings with a friend or support person, exercising, journal writing, and artistic expression. People who have several different coping skills are less susceptible to the negative effects of stress.

> Coping skills decrease
> the negative effects of stress.

Social Support

Social support refers to the help and caring that people feel they can count on from other people. Supportive persons can include family members, friends, members of the treatment team, a clergy member, or anyone else with whom a person has a close relationship. Good social support can decrease the effects of stress. Supportive people can sometimes solve problems with a person and decrease stress. For example, if a man feels criticized by his supervisor at work, a supportive person can help him identify strategies for learning more specifically about his supervisor's concerns. Supportive people can also help a person deal with the negative effects of stress. For example, if a woman has been a victim of crime, she can talk it over with a supportive person, and benefit from that person's concern and empathy.

Social support and coping skills can interact with one another. People with good coping skills can obtain more social support by reaching out and engaging with other people. Supportive people can also improve others' coping skills by helping them develop more effective strategies for dealing with stress. People who have more social support tend to experience fewer and less severe relapses.

> Social support decreases
> the negative effects of stress.

(continued)

Meaningful Activities

Meaningful activities are tasks that provide a strong sense of purpose and gratification to a person. Being involved in meaningful activities helps people to structure their time and gives them something to look forward to every day. Examples of meaningful activities include work, going to school, parenting a child, doing volunteer work, caring for someone else, and being a regular participant at a peer support program. Having meaningful activities to engage in reduces susceptibility to stress, because people are actively pursuing their goals and are less focused on stress.

Engaging in meaningful activities decreases the negative affects of stress.

TREATMENT IMPLICATIONS OF THE STRESS–VULNERABILITY MODEL

The stress–vulnerability model points to five ways people with psychiatric illness (and their families) can improve the course of their illness:

1. Take psychiatric medications as prescribed.
2. Avoid alcohol and drug use.
3. Increase coping skills.
4. Increase social support.
5. Engage in meaningful activities, such as work, school, and parenting.

Taking these steps can help reduce relapses or lessen the severity of relapses, and therefore can help people make progress toward their personal goals.

The stress–vulnerability model points to specific steps for reducing relapses and rehospitalizations.

HANDOUT B.11

Role of the Family

Family members can play an important role in reducing stress in an ill person's life and helping him or her achieve personal goals. Using good communication and problem-solving skills, creating a role for the ill family member that recognizes the person as the expert on the illness, and helping to monitor symptoms are all ways to enhance the family's role and improve everyone's life.

> Family members can help improve the outcome of a psychiatric disorder by participating in treatment.

EARLY WARNING SIGNS

Relapse is a part of any chronic illness. People with psychiatric disorders often experience small changes in thinking and behavior days or even weeks before a relapse or episode of illness. When family members are able to observe these early warning signs, and then help a client to recognize them and seek an appropriate intervention, it can make a dramatic difference in the outcome of the relapse. Early intervention can often prevent relapses and rehospitalizations, or minimize the severity of a relapse. Here are some examples of common early warning signs:

- Tension or agitation
- Eating problems
- Concentration problems
- Sleeping too little or too much
- Depression
- Social withdrawal
- Irritability
- Decreased compliance with treatment
- Anxiety
- Hallucinations or odd beliefs (delusions)

It is often helpful for the family members to make a list of the early warning signs they have noticed over time with their ill relative. Once they have that list, they should sit down with the client and draw up a list of actions everyone agrees to take once some of the early warning signs occur. This action plan should be agreed upon by client, family, and treatment providers, and signed by all parties.

> Recognizing early warning signs and developing early intervention strategies can help prevent relapse.

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In developing a plan, everyone should sit down and discuss past relapses, and the early warning signs noticed before. The family should also discuss the types of situations that have been stressful to the ill person in the past, and how to avoid them. A strategy for getting the family members together for a meeting should be put in place. Lastly, actions to be taken should be agreed upon by all family members.

> An action plan needs to include recognizing early warning signs, avoiding stressful situations, and holding a family meeting.

EFFECTS OF MENTAL ILLNESS ON THE FAMILY

Mental illness in a relative can have a major effect on all members of the family. Common reactions to mental illness include anxiety, fear, depression or sadness, guilt, frustration, and anger. In addition, relatives often devote considerable amounts of time and financial help to the ill family member. The net result of these emotional and other consequences of mental illness can be higher levels of stress on family members.

> Common reactions in family members to mental illness include:
> - Anxiety
> - Depression
> - Guilt
> - Frustration
> - Anger

When a person has a mental illness, relatives often change their roles to adjust to it. Some family members become very involved in assisting the ill member in meeting his or her day-to-day needs, spending large amounts of time with the person, and devoting much of their lives to helping him or her. Sometimes the level of involvement is so great that although the person appreciates it, he or she finds the attention is more than is truly wanted. Other family members can react to the mental illness by withdrawing from the person and becoming more emotionally distant. These relatives may feel that they don't have anything to offer, may be afraid of mental illness, or may be concerned that they may make matters worse. These changes in family roles are all normal reactions of concerned relatives trying to cope with mental illness.

> Family roles often change when relatives try to adjust to mental illness in a member.

(continued)

THE FAMILY SYSTEM

When one thing in a system changes, other things shift to accommodate the change. This is a very normal response. The family system is transformed when one member becomes mentally ill. Family members redefine their roles, so that they can maintain a safe environment and continue to get their needs met. Relatives can be supportive of an ill family member and still take care of themselves. Family members can get support for themselves by learning about mental illness, developing a relationship with treatment providers, and participating in support groups for families with a mentally ill member. Family members can also support their ill member in several ways. They can encourage taking medications and attending treatment, can help monitor the illness, can provide a low-stress environment, can help monitor substance use, and can encourage independent living. Providing support and being supported helps families regain their balance.

> Family members can both get support for themselves and provide support to their mentally ill relative.

FURTHER READING

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HANDOUT B.12

Basic Facts about Alcohol and Drugs

People sometimes use different substances to change the way that they feel, think, or experience the world. Examples of substances commonly used in this way include alcohol, marijuana, and cocaine. These and other substances can have a variety of effects on people. This educational handout reviews the different types of substances commonly used by people and the effects of these substances. In addition, the interactions between substance use and mental illness are discussed.

This handout reviews the effects of different types of commonly used substances.

WHAT ARE PSYCHOACTIVE SUBSTANCES?

Psychoactive substances are substances that have a major effect on the mind. These effects may include the way people feel, how they think, or how they perceive the world around them. Any substance that affects a person's mind this way is a psychoactive substance.

Psychoactive substances affect the way people feel, think, or perceive things.

HISTORY OF PSYCHOACTIVE SUBSTANCE USE

Since earliest civilization, people have used psychoactive substances for a number of different reasons, including medicinal, recreational, and spiritual purposes. For example, the Hittites in central Turkey discovered how to make beer around 7000 B.C., and in the Middle Ages it was a major source of nutrition. Hemp, the plant from which marijuana is derived, has a long history of use in countries in the Far East (such as India). In South America, farmers used to chew leaves of coca, the plant from which cocaine is derived, because of its stimulating properties. Some Indian tribes in Mexico and Central America have used the plant peyote, a powerful substance that can cause hallucinations, as part of religious and spiritual ceremonies.

Psychoactive substances have been used from earliest civilization for medicinal, recreational, and spiritual purposes.

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DIFFERENT TYPES OF PSYCHOACTIVE SUBSTANCES

There are many different types of psychoactive substances. In order to discuss their effects, it is helpful to consider different types or groups of substances which are commonly used. The table below summarizes broad types of substances, and provides examples of specific substances in each broad category. In addition to describing the specific substances in each broad category, this table also gives examples of slang words for each substance, indicates how each substance is taken ("route of administration"), and describes the effects of the substance.

Different Psychoactive Substances and Their Effects

Substance type	Specific substances	Slang words	Route of administration	Effects
Alcohol	Beer, wine, "hard liquor" (e.g., vodka, Scotch, whiskey, gin, rum, tequila)	Booze; brew (beer)	Oral (drinking)	Relaxation, sedation Slowed reaction time Impaired judgment Loss of inhibition
Cannabis	Marijuana, hashish	Pot, reefer, weed; joint (marijuana cigarette); dope, grass	Smoking (most common), ingestion (eating)	Relaxation Mild euphoria Altered sensory experiences Fatigue Anxiety Panic Increased appetite Paranoia
Stimulants	Cocaine, amphetamines (and related compounds)	Coke, crack, rock (cocaine); crank, speed, crystal meth (amphetamines)	Intranasal (snorting), smoking, injection (cocaine); oral (eating pills), intranasal, injection (amphetamines)	Increased alertness and energy Decreased appetite Positive feelings Anxiety Tension, feeling jittery, heart racing Paranoia
Sedatives	Anxiolytic (anxiety-lowering) medications (e.g., Xanax, Klonopin, Ativan, Valium, barbiturates)	Downers (barbiturates), sleeping pills	Oral	Sleepiness Relaxation Loss of motor coordination Loss of inhibition Dulled sensory experiences
Hallucinogens	LSD, PCP, peyote, mescaline, MDMA	Acid, window pane (LSD); angel dust (PCP); buttons (peyote); magic mushrooms	Oral; smoking (PCP)	Enhanced or altered perceptions Hallucinations Disorientation Psychosis
Narcotics	Heroin, morphine, opium, codeine	Smack, horse, H (heroin)	Injection, intranasal (heroin); oral (morphine, codeine, and related substances)	Euphoria Pain relief Sedation Slowed reaction time Impaired judgment

(continued)

Substance type	Specific substances	Slang words	Route of administration	Effects
Inhalants	Glue, aerosols, nitrous oxide (laughing gas), freon		Inhalation (includes sniffing)	Altered perceptions Disorientation
Over-the-counter medications	Antihistamines and related compounds (e.g., Benadryl, other cold tablets)		Oral	Sedation
Tobacco	Cigarettes, pipe tobacco, chewing tobacco, snuff	Casket nails, smokes, cigs, butts (cigarettes)	Smoking; under the tongue (chewing tobacco, snuff)	Alertness Relaxation
Caffeine	Coffee, tea, chocolate		Oral	Increased alertness
Antiparkinsonian agents	Cogentin, Artane, Symmetrel		Oral	Confusion Mild euphoria

INTERACTIONS BETWEEN SUBSTANCE USE AND MENTAL ILLNESS

Substances such as alcohol, marijuana, and cocaine can have a wide range of effects on people (see the table above). These and other substances can produce even more dramatic effects in persons with a mental illness. The key to understanding the interactions between substance use and mental illness lies in the stress–vulnerability model of psychiatric illness.

According to this model (see "The Stress–Vulnerability Model of Psychiatric Disorders," Handout B.10), psychiatric illnesses are caused by biological factors determined very early in life. Although this biological vulnerability must be present for a mental illness to develop, the severity of the illness and course of symptoms are influenced by other factors as well. One factor that can worsen vulnerability, leading to symptom relapses, is stress from the environment. On the other hand, if a person has good coping skills, he or she will be less vulnerable to the negative effects of stress.

In addition to stress and coping skills, medications and psychoactive substances can have an effect on vulnerability. Prescribed medications can help correct some of the chemical imbalances in the brain believed to cause mental illnesses. However, just as medications can reduce vulnerability, psychoactive substances, such as alcohol, marijuana, and cocaine, can increase vulnerability. These substances can have a negative effect on mental illness in two ways. First, they can directly affect the brain chemicals responsible for the illness, worsening the illness. Second, psychoactive substances can interfere with medications used to treat mental illness, making them less effective.

The stress–vulnerability model explains why persons with a mental illness are highly sensitive to the effects of psychoactive substances. These individuals have a biological vulnerability that is the cause of their mental illness. This vulnerability makes them highly sensitive ("supersensitive") to the effects of psychoactive substances such as alcohol and cocaine. This is the reason why people with a mental illness are often affected by even small quantities of alcohol or drugs.

> Persons with a mental illness are supersensitive to small amounts of substances.

(continued)

CONSEQUENCES OF SUBSTANCE USE IN MENTAL ILLNESS

Substance use can cause a variety of different negative effects in persons with mental illness. The specific consequences depend on the individual and the type of substance used. Some of the most common consequences experienced by persons with a mental illness include the following:

- Symptom relapses and rehospitalizations
- Depression and increased risk of suicide
- Housing instability and homelessness
- Family conflict
- Anger and violence problems
- Money difficulties
- Becoming a target for predators
- Legal problems
- Risky sexual behavior
- Infectious diseases

> Substance use can cause a variety of negative consequences for persons with mental illness.

SUMMARY AND CONCLUSIONS

Many different psychoactive substances are used in the general population. These substances can have a variety of different effects. People with mental illness are more sensitive to the effects of alcohol and drugs than the general population. Their higher sensitivity to the effects of these substances can be explained by their biological vulnerability to mental illness. Because of this vulnerability, they may experience consequences from using even very small amounts of alcohol and drugs.

HANDOUT B.13

Alcohol and Drugs: Motives and Consequences

Alcohol and drugs can have many different effects on people. Individuals with mental illness tend to be more sensitive to the effects of substances, due to their biological vulnerability. This handout focuses on understanding the reasons why people with mental illness use different substances, and it reviews some of the consequences of substance use.

This handout discusses motives of substance use and the consequences of use.

COMMON MOTIVES FOR ALCOHOL AND DRUG USE

People with mental illness give a number of different explanations for their use of substances. Some of the most common reasons for using substances are described below.

Socializing

Individuals may feel that using drugs or alcohol helps their social interactions with others. People give several different reasons why they think using substances may be helpful. Some people report feeling less anxious around other people when they use alcohol or drugs. Others use substances with their acquaintances as a way of spending time together. Some people use substances because they feel pressured by others to use. Yet another reason why some persons use substances is that it helps them feel "normal" and "accepted" by others; sometimes people don't feel they have a mental illness or are different from others when they are using drugs or alcohol.

Self-Medication

Some people use substances in an attempt to *self-medicate* (reduce the effects of) unpleasant symptoms. Although efforts to self-medicate symptoms are usually unsuccessful in the long run, they may be temporarily effective. Here are some of the most common symptoms that people report using substances to self-medicate:

- Depression
- Anxiety
- Sleep problems
- Nervousness
- Tension
- Hallucinations
- Medication side effects
- Loss of interest

(continued)

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Pleasure Enhancement

Some individuals use substances because it is one of the few sources of pleasure they experience. Sometimes people use substances because they believe it enhances other enjoyable activities. Using alcohol or drugs may be very tempting for some individuals, because it is so easy to get these substances and their effects are so rapid.

Habit or Routine

Some people who have used drugs or alcohol for a long period of time continue to use them simply because it has become part of their daily routine—a habit. For these people, substance use becomes second nature. They use substances automatically, without much thought, almost like brushing their teeth or taking a shower.

Relieving Cravings or Withdrawal Symptoms

Individuals who use larger quantities of substances may develop cravings for these substances, or they may experience withdrawal symptoms if they stop using suddenly. Substance use for these individuals may be primarily motivated by the desire to avoid the cravings or withdrawal symptoms.

Common motives for using substances include:

- Socializing
- Self-medication
- Pleasure enhancement
- Habit or routine
- Relieving cravings or withdrawal symptoms

CONSEQUENCES OF SUBSTANCE USE

The consequences of substance use can be divided into two broad categories: *behavioral* and *physical* consequences. Examples of each category are provided below.

Behavioral Consequences

Social Relationships

Substance use may lead to conflicts in important relationships, such as with family members, a spouse, or friends. This can result in tension, arguments, or conflicts. For example, a person who frequently uses marijuana may have repeated arguments with relatives about often being high or having money problems.

(continued)

Work or Role Functioning

A person's substance use may interfere with his or her ability to fulfill important roles, such as worker, homemaker, or student. For example, a person may be repeatedly late to work because of drinking the night before, leading to job losses.

Money Problems

Substance use may lead to financial problems, such as not having enough money by the end of the month. For example, a person may use up all of his or her money for the month on a cocaine binge lasting only a few days.

Legal Problems

Substance use may lead to legal problems, such as being arrested for drunk and disorderly conduct or for possession of an illegal substance.

Housing Instability

People with substance use problems may experience problems maintaining stable housing. Housing difficulties are often the result either of conflicts with family members or of eviction from an apartment because of drug deals, loud parties, or inability to maintain the apartment properly. Many housing programs for persons with mental illness will not accept anyone who is using substances.

Dangerous Situations

Substances may be used in physically hazardous situations. Examples include driving under the influence of alcohol or operating heavy machinery after taking drugs. Such use of substances increases the risk of accidents and injuries.

Common behavioral consequences of substance use include:

- Poor social relationships
- Poor work or role functioning
- Money and legal problems
- Housing instability
- Exposure to dangerous situations

Physical Consequences

Symptom Relapses

Substance use may worsen psychiatric symptoms leading to relapses and rehospitalizations. For example, cocaine use may trigger psychotic symptoms, requiring hospitalization.

(continued)

Health Problems

Drugs and alcohol use can lead to a variety of health problems. For example, alcohol can damage the liver; marijuana can cause lung and respiratory problems; and intranasal use of substances (such as cocaine) can damage internal parts of the nose (such as the septum).

> Common physical consequences of substance use include symptom relapses and health problems.

SUBSTANCE ABUSE

A person who experiences negative consequences due to substance use has a *substance use disorder*. A *disorder* is just like a psychiatric diagnosis; it is a term used to describe common symptoms or problems. Individuals whose substance use results in problems in the areas described above (such as problems with social relationships, work, legal consequences, or use in dangerous situations) have a diagnosis of *substance abuse*. Substance abuse is simply a term describing people who experience negative consequences from their use of psychoactive substances.

> *Substance abuse* refers to experiencing common negative consequences from substance use.

LONG-TERM CONSEQUENCES OF SUBSTANCE USE

Individuals who use alcohol or other drugs over long periods of time sometimes experience other consequences as well. Two broad categories of these of consequences include *psychological* consequences and *physical* consequences. Examples of each category are discussed below.

PSYCHOLOGICAL CONSEQUENCES

Giving Up Important Activities

A person may give up activities he or she used to enjoy in order to spend more time using alcohol or drugs. For example, a person may spend less time playing sports or with family members, and more time drinking alcohol.

Spending Large Amounts of Time Getting or Using Substances

Over time, some people spend more and more of their time involved in substance-use-related activities. As an example, much of a person's day may be spent finding money (for instance, through panhandling), finding a person from whom to buy cocaine, and using the cocaine.

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Using More of a Substance Than Planned

A person may drink more alcohol or use a greater amount of drugs than he or she planned on using. For example, someone might go to a party planning on drinking just one beer, but end up drinking four or five beers.

Repeated Attempts to Cut Down or Quit

Someone who uses alcohol or drugs may attempt on several occasions to cut down on his or her use or to quit altogether, without success each time. This can be frustrating and lead to feelings of hopelessness. For example, an individual who smokes marijuana several times a week may have tried on many occasions to stop smoking altogether, but each time returns to his or her habit.

Long-term psychological consequences of substance use include:

- Giving up important activities
- Spending large amounts of time getting or using substances
- Using more of a substance than planned
- Repeated attempts to cut down or quit

Physical Consequences

Tolerance

An individual may find that he or she needs to use larger quantities of a substance in order to achieve a desired effect. For example, an individual who used to feel a "buzz" after two or three beers may find over time that seven or eight beers is needed to experience the same "buzz."

Cravings

Individuals sometimes experience intense cravings or yearnings for alcohol or drugs. Some individuals may find that their desire for substances is so strong that it cannot be resisted. For example, a person who regularly uses crack cocaine may find that after several days of not using cocaine, he or she experiences strong cravings to use this drug.

Withdrawal Symptoms

People who use substances on a regular basis may experience unpleasant symptoms (such as nervousness, nausea, tremors, fatigue, agitation, or sleeping problems) if they stop using the substance. When the person uses the desired substance, these withdrawal symptoms go away. For example, someone who has drunk four to six beers per night for a long period of time may experience nausea or tremors if he or she stops drinking suddenly.

(continued)

Physical consequences of long-term substance use include:

- Tolerance
- Cravings
- Withdrawal symptoms

SUBSTANCE DEPENDENCE

Substance dependence is a term used to describe individuals who experience long-term consequences of substance use. An individual who experiences either the long-term psychological or physical consequences of using substances (described above) can be described as having substance dependence.

Substance dependence refers to long-term psychological and physical consequences of substance use.

WHAT CAUSES ADDICTION?

A person who has a substance abuse or substance dependence diagnosis is said to have an *addiction*. (The term *substance abuse* is also used in the more general way, in addition to the diagnosis of substance abuse as described above.) People often ask about the causes of addiction. There is no simple answer to this question. Different causes may be responsible for addiction in different people. In addition, more than one factor can lead to an addiction in some individuals. Two important explanations for addiction in psychiatric clients are described below. However, other explanations are also possible.

Supersensitivity to Substances

People with psychiatric illness are more biologically vulnerable than other people. As a result of this, they are more sensitive to the effects of even small doses of psychoactive substances. The result of this vulnerability is that psychiatric clients are "supersensitive" to alcohol and drugs, even in small amounts. This may cause some of these individuals to have addiction problems, despite relatively low or infrequent use of substances.

Family History

Research has found that persons with substance use problems are more likely to have relatives with similar problems than individuals who do not have such problems are. This tendency is true even for those who are raised apart from their families. Many scientists believe that genetic factors play a role in increasing vulnerability to substance use problems. Therefore, if a psychiatric client has a relative who has had problems with substances, he or she may be more likely to experience similar problems.

Two common causes of addiction in psychiatric clients are supersensitivity to substances and family history of addiction.

HANDOUT B.14

Treatment of Dual Disorders

People who have problems with both mental illness and substances can be described as having a *dual diagnosis*, *dual disorders*, or *co-occurring disorders*. There are many different ways of helping people with a dual diagnosis regain control over their lives and make progress toward important goals. Treatment strategies may involve self-help, working with professionals, and working with family members or other natural supports. This handout discusses some of the principles of treatment and common strategies for people with dual disorders.

> Many different treatments can help people with a dual diagnosis.

STAGES OF TREATMENT

Recovery from a substance use disorder occurs over a series of stages. Individuals progress from one stage to another as they recover. Sometimes people move back and forth between stages. Each stage is different in terms of the person's awareness of substance use as a problem and motivation to address it. Understanding the different stages of substance abuse treatment can be helpful in deciding what goals to be working toward. A brief description of each stage and the goal of each stage is provided in the table below.

Stage	Description	Goal
Engagement	The client does not see a professional on a regular basis and has no working relationship with a professional.	To establish a working alliance (therapeutic relationship) with a professional.
Persuasion	The client has a working alliance with a professional, but is not convinced that substance abuse is a problem.	To help the client view substance abuse as a problem that should be worked on.
Active treatment	The client is motivated to work on substance abuse and is decreasing use or has stopped briefly.	To help the client decrease (or stop) substance use so that it is no longer a problem.
Relapse prevention	The client has stopped using substances (or experiences no consequences from substance use) for a significant period of time.	To maintain awareness that relapse of substance abuse could happen, and to extend recovery to other areas (such as work).

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Stages of recovery from substance abuse include:

- Engagement
- Persuasion
- Active treatment
- Relapse prevention

PRINCIPLES OF TREATMENT

The treatment of a person with a dual diagnosis is guided by five basic principles. Following these principles increases the chance that treatment will be successful. These principles are described below.

Medication Adherence

Medication for a psychiatric disorder can help to correct the imbalance in the brain chemicals responsible for the mental illness. Taking medication regularly can decrease symptoms and relapses, stabilizing a client's psychiatric illness. Encouraging medication adherence can decrease substance use that occurs as a result of problematic symptoms.

Decreased Stress

Stress resulting from tense relationships with others, upsetting life events, or other factors can worsen symptoms and lead to more severe substance abuse. Minimizing stress and bolstering clients' ability to manage stress are important goals of dual-diagnosis treatment.

Treatment of Both Mental Illness and Substance Abuse

Substance abuse often worsens mental illness and more severe symptoms sometimes lead to greater substance abuse. In order for dual-diagnosis treatment to be effective, both substance abuse *and* mental illness need to be addressed.

Individualized Treatment

Every client is a unique individual with personal strengths that are an important part of treatment. Understanding the individual strengths and needs of each client is important for developing a treatment plan that is specific for that person.

Collaboration

The lives of clients with dual disorders touch the lives of many other people, including their families, friends, and professionals. Collaboration and teamwork among clients, professionals, and other supportive persons is essential to meet the challenges of dual-disorder treatment.

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The principles of dual-diagnosis treatment include:

- Medication adherence
- Decreased stress
- Treatment of both mental illness and substance abuse
- Individualized treatment
- Collaboration

TREATMENT STRATEGIES

Many different strategies can be used in the treatment of dual disorders. The specific strategies used for a particular client will depend on that person's specific needs and goals. Several of the most commonly used strategies are described below.

Dual-Diagnosis Groups

Clients often find participating in groups with other people who have dual disorders helpful. These groups may focus on exploring the role that substance use has played in each person's life, and developing strategies for cutting down or stopping substance use. Important parts of these groups include social support, sharing personal experiences, and exchanging ideas about personal goals.

Increased Structure

Sometimes clients tend to use substances when they have nothing else to do. Increasing daily structure and meaningful activities can help clients decrease their opportunities to use substances. For example, working at a part-time job can decrease substance abuse and increase self-esteem.

Rehabilitation

Clients may use substances in order to achieve such goals as socializing, pleasure enhancement, or coping with symptoms. Participation in rehabilitation activities, such as social skills training, can help clients develop skills for achieving these goals in more effective ways than using substances.

Self-Help Groups

Self-help organizations, such as Alcoholics Anonymous or Double Trouble in Recovery, offer peer-supported sponsorship for individuals who wish to remain abstinent from alcohol and drug use. Self-help organizations have helped millions of people with addictive disorders, and are widely available in most communities. Self-help groups, such as Al-Anon, are also available for concerned family members of individuals with addictions.

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Motivational Strategies

Sometimes a client does not believe that his or her substance abuse is a problem, although other people think that it is a problem. With such clients, it is sometimes helpful to explore what their personal goals are, and to help them make progress toward achieving these goals. Often in this process, these clients become aware that their use of substances interferes with achieving goals that are important for them.

Family Support and Problem Solving

Family members (and other persons) can help clients with dual disorders by providing support, recognizing small positive steps, and engaging in problem solving about difficult issues. By working together, family members and clients can often come up with creative solutions for solving important problems or achieving desired goals.

Keeping Hope Alive

Some individuals with dual disorders feel discouraged about their chances for recovery. They may have battled their problems for many years and feel that there is little hope for improvement. However, there are good reasons for being optimistic about getting better. Research on the treatment of clients with a dual diagnosis indicates that most such clients *do* recover. Furthermore, once clients stop using substances, their outlook and their ability to pursue personal goals improve. For these reasons, optimism is warranted for clients with dual disorders who become involved in treatment.

Strategies for treating dual disorders include:

- Dual-diagnosis groups
- Increased structure
- Rehabilitation
- Self-help groups
- Motivational strategies
- Family support and problem solving
- Keeping hope alive

HANDOUT B.15

Communication Skills

Good communication skills are important to all families. There is a wide range of topics families discuss—such as running the household, meals, recreation, and money, as well as expressing feelings (happiness, sadness, anger, etc.). Effective communication can help families cope with day-to-day situations as they come up. Good communication can also help family members solve problems together and work toward goals.

Good communication is helpful for families.

COMMUNICATION AND MENTAL ILLNESS

When a family member has a mental illness, the person may have trouble communicating because of difficulties with concentration, memory, or processing information. This can cause stress for everyone in the family. Stress can have a negative effect on the person with the mental illness by increasing symptoms. So improving communication skills in the family may decrease stress for the ill member, and for other family members as well.

Good communication skills can decrease stress in families.

HOW TO IMPROVE COMMUNICATION

Many family members are good communicators, but almost everyone can benefit from reviewing and practicing the basics of effective communication. The following are specific suggestions to improve communication:

- *Get to the point.* People with mental illness sometimes get confused easily. It is best to avoid long-winded statements and to keep communications brief and to the point.
- *Keep communications focused.* When people have trouble concentrating, it is helpful to focus on one subject at a time.
- *Speak clearly.* The more specific the statement, the more likely it is to be understood by others.
- *Use feeling statements.* Let people know how you feel in a noncritical way. Using "I" statements ("I feel . . . ") and verbal feeling statements ("angry," "upset," "happy," "pleased," "concerned," "disappointed," "sad") can let other people understand your feelings.

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• *Speak for yourself, not others.* Family members sometimes speak for each other because they think they know how other persons think or feel. This can lead to confusion and misunderstandings. Speaking only for oneself can prevent the problems that occur when one person speaks for another.

• *Focus on behavior.* It is easier for a person to change a behavior than his or her personality, attitudes, or feelings. Focusing communications on behavior, especially when you are upset, can make it clear to the other person what you are talking about. Consider these examples:

Less specific	*More specific*
"I am concerned about your health."	"I am concerned about your health because you have been drinking a lot recently."
"You bothered me last night."	"I was annoyed when you woke me up last night coming home. Please be more quiet next time."
"That was thoughtful of you."	"I really liked that you remembered my birthday by getting me flowers."

Ways to improve communication:
- Get to the point.
- Keep communication focused.
- Speak clearly.
- Use feeling statements.
- Speak for yourself, not others.
- Focus on behavior.

OTHER COMMUNICATION TOOLS

How a person communicates can be just as important as what the person actually says. The following are some tools for improving communication:

• *Listening.* Use small comments like "uh-huh" or "okay" to let the person know you are listening. Repeating back what you heard shows the other person that you are paying attention.

• *Eye contact.* Look the person in the eye (or close to the eyes) when you talk, to focus his or her attention.

• *Tone of voice.* People respond better to a calm tone of voice. Your voice tone should be consistent with the feeling message you are communicating.

• *Facial expression.* Like voice tone, use a facial expression that matches the feeling message you are saying.

Other communication tools:
- Listening
- Eye contact
- Tone of voice
- Facial expression

(continued)

KEY COMMUNICATION SKILLS

Expressing Positive Feelings

It is always helpful to be able to tell a person in an effective way what the person did that pleased you. Follow these steps:

- Look at the person.
- Tell the person exactly what he or she did that pleased you—be specific.
- Tell the person how it made you feel—be specific.

Here is an example:

"I really enjoyed the meal you cooked tonight."

Making a Positive Request

It is important to be able to ask someone to do something for you in an effective and positive way. Follow these steps:

- Look at the person.
- Tell him or her what you are requesting—be specific.
- Tell the person how it would make you feel if the request were met—be specific.

Here are examples:

"I would appreciate it if you would cook dinner tonight."
"I would like it if you could come to my doctor's appointment with me next Monday, so you can help me talk with him about my medication side effects."

Expressing a Negative Feeling

It is helpful to express a negative feeling in a way that increases the chances that the person will hear what you have to say.

- Look at the person who displeased you.
- Tell the person exactly what he or she did to displease you—be specific.
- Tell the person how it made you feel—be specific.
- Make a positive request for change, if possible.

Here are examples:

"I am mad that you spent the money I gave you for clothes on alcohol. When you need clothes, perhaps we should go shopping together."
"I was worried when you didn't come home last night. The next time you are going to stay out I would appreciate it if you would give me a call."

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Compromise and Negotiation

When you would like someone to change something, it is important to have an effective way to discuss how it might work out.

- Look at the person.
- Explain your viewpoint.
- Listen to the other person's viewpoint.
- Repeat back what you heard.
- Suggest a compromise (more than one may be necessary).

Requesting a Time-Out

Sometimes when you are in a stressful situation, you need a break, and it is important to communicate that.

- Indicate that the situation is stressful.
- Tell the person that the stress is interfering with constructive communication.
- Say that you must leave temporarily.
- State when you will return and be willing to problem-solve.

Here is an example:

"I'm feeling stressed out by this conversation. I'd like to take a break now, and discuss this with you again later on when I'm feeling calmer."

Key communication skills:

- Expressing positive feelings.
- Making a positive request.
- Expressing a negative feeling.
- Compromise and negotiation.
- Requesting a time out.

SUMMARY

Communication is sometimes stressful in families. However, all family members need to be able to communicate with each other. By following the guidelines of good communication, family members can share their thoughts and feelings, and be effective in working together toward solving problems and achieving goals.

HANDOUT B.16

Infectious Diseases

Infectious diseases are illnesses that can easily be spread from one person to another. There are many different kinds of infectious diseases, and they can be spread in different ways. This educational handout describes three infectious diseases that are caused by viruses: the *hepatitis B virus*, the *hepatitis C virus*, and the *human immunodeficiency virus (HIV)*. These diseases are spread by contact with contaminated blood or other body fluids. Each of these diseases is serious, can harm a person's health and well-being, and can even result in death. This handout explains the following:

- How to avoid contact with these viruses
- Whether a person should be tested for the diseases
- The treatment options for the diseases
- If someone has a disease, how to avoid spreading it to others

> Infectious diseases are illnesses that can be easily spread from one person to another.

HOW COMMON ARE INFECTIOUS DISEASES?

Infectious diseases are more common in some places than others, and in some years compared to others. In the United States, about 5% of people are infected with hepatitis B virus, and about 2% have hepatitis C virus. HIV is less common; about 1 person in 200 (0.5%) is infected with HIV.

Some people are more likely to get infectious diseases than others. People who have severe mental illness and alcohol or drug problems (that is, dual disorders) are more likely to have an infectious disease than people who do not have dual disorders. Among people with dual disorders, almost 25% have hepatitis B virus, about the same percentage have hepatitis C virus, and about 5% have HIV.

> People with dual disorders are more likely to have hepatitis B virus, hepatitis C virus, or HIV.

HEPATITIS

Hepatitis hurts the liver. To understand hepatitis, it is helpful to know what the liver does. The liver is a very important organ of the body. The liver is part of the digestive tract. It helps filter out toxic materials; builds proteins for the body; and stores vitamins, minerals, and carbohydrates. A person needs a functioning liver to stay alive.

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When a person has hepatitis, the liver becomes sick or inflamed because it has been infected with a virus. This sickness or inflammation can cause more serious liver problems, including *cirrhosis* (permanent scarring of the liver reduces blood flow), *liver failure* (the liver is unable to function), and *liver cancer* (cancer cells attack the liver). Any of these diseases can make the person sick and cause him or her to die.

There are many kinds of hepatitis viruses, but the most common and most serious ones are hepatitis B and hepatitis C. Preventing hepatitis B virus and hepatitis C virus, or taking care of oneself if one has either virus, is important to prevent damage to the liver.

- The liver is an important organ of the human body.
- Hepatitis is a disease of the liver.
- Hepatitis B virus and hepatitis C virus are the most common and serious types of hepatitis.

HIV AND AIDS

HIV is a virus that attacks and destroys special white blood cells in the body, called *T*-cells. T-cells are a part of the immune system, which helps the body fight infection and stay healthy. When HIV destroys these cells, the immune system breaks down and is unable to fight infections. This means that normally mild infections can grow to be very serious, causing the person to get very sick and even to die. *Acquired immunedeficiency syndrome (AIDS)* is the disease someone gets after HIV has destroyed the immune system and the body cannot fight infections.

HIV is a virus that attacks the immune system, leading to AIDS.

TRANSMISSION OF HEPATITIS B VIRUS, HEPATITIS C VIRUS, AND HIV

All three of these viruses pass from one person to another through exposure to infected or contaminated blood. For an uninfected person to get hepatitis B virus, hepatitis C virus, or HIV, the blood of an infected person needs to enter his or her bloodstream. HIV can also be transmitted from the sex fluids (such as semen or vaginal secretions) of an infected person into the bloodstream of an uninfected person when the two people have sex.

Here are some of the ways people get exposed to the contaminated blood of other people and develop these infectious diseases:

- Sharing injection needles with other people
- Sharing a straw for snorting cocaine, amphetamine, or heroin with others
- Having unprotected sex (without a condom) with many partners or with people they do not know well
- Having had a blood transfusion, hemodialysis, or organ transplant from an infected source before 1992 (for hepatitis B virus or hepatitis C virus) or before 1985 (for HIV)
- Having body piercings or tattoos with improperly sterilized needles

(continued)

- Using personal articles (such as a razor, toothbrush, nail file, or nail clippers) that have been used by someone else with the infection
- Being born to a mother with the infection

None of these three viruses can be spread through insect bites, kissing, hugging, or using public toilet seats, unless there is direct contact with other people's body fluids.

> Hepatitis B virus, hepatitis C virus, and HIV are transmitted by exposure to infected blood.

TESTS FOR HEPATITIS B VIRUS, HEPATITIS C VIRUS, AND HIV

Most people who have one of these three viruses do not have symptoms until a long time after they get the virus. People who have chronic hepatitis B virus or hepatitis C virus infection may experience tiredness (fatigue), loss of appetite, abdominal pain, nausea or vomiting, dark urine, or jaundice (yellow skin). People who have early symptoms of AIDS may experience sores and difficulty fighting off infections, such as a cough that will not go away.

Blood tests can tell whether a person has hepatitis B virus, hepatitis C virus, or HIV. Since most infected people have no symptoms, who should be tested for the viruses? A person should get tested if he or she has had any of the risk factors listed in the previous section, such as sharing needles or having unprotected sex with multiple partners.

> Blood tests can detect hepatitis B virus, hepatitis C virus, and HIV.

TREATMENT

Hepatitis B Virus

A vaccine can prevent hepatitis B virus if the person gets the vaccine before he or she is exposed to the virus. This vaccine is free and widely available.

Most people who get hepatitis B virus recover on their own. However, about 1 in 10 people (10%) get a chronic illness. People who have chronic hepatitis B virus may improve from treatment with *interferon*, a medicine that boosts the body's ability to fight the infection. Interferon is given in a series of injections into the muscles over a 16-week period.

People infected with hepatitis B virus who are then infected with a different virus, the hepatitis A virus, can then get sick with *fulminant hepatitis*—a very serious disease that can be fatal. To prevent this, people with hepatitis B virus need to get a vaccination for hepatitis A.

> - A vaccine can prevent hepatitis B.
> - Most people with hepatitis B virus recover on their own.
> - Interferon treatment helps people infected with chronic hepatitis B virus.
> - Vaccination for hepatitis A can prevent fulminant hepatitis in people infected with chronic hepatitis B.

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Hepatitis C Virus

There is no vaccine that protects a person from getting hepatitis C virus, unlike hepatitis B virus. Another difference from hepatitis B virus is that about 85% of people with hepatitis C virus carry the virus for life unless they are treated.

Some treatments help people with hepatitis C. One treatment is taking interferon for up to 48 weeks. Another treatment is taking interferon with another medication (a combination of drugs called *Rebetron*) over 6 months. These treatments completely get rid of hepatitis C virus for some infected people (between 20% and 50%).

Treatments for hepatitis C virus can cause side effects, such as flu-like symptoms or depression. Therefore, the decision to treat hepatitis C virus is based on how sick someone is. Researchers are developing new medications for treating hepatitis C virus.

Similar to people with hepatitis B virus, people with hepatitis C virus who are then infected with the hepatitis A virus can develop *fulminant hepatitis*, a deadly disease. This can be prevented by taking a vaccine for hepatitis A.

- Most people with hepatitis C virus do not get well on their own.
- Treatment is helpful for hepatitis C virus.
- Vaccination for hepatitis A can prevent fulminant hepatitis in people infected with chronic hepatitis C.

HIV and AIDS

No vaccine or cure exists for HIV or AIDS. However, medications can slow down the illness. In addition, new medications are being developed and tested for HIV and AIDS that may help in the future.

- There is no cure for HIV or AIDS.
- Different medications are effective in managing HIV and AIDS.

TAKING CARE OF ONESELF

When a person has one of these viruses, good self-care can help the person stay well. Alcohol is toxic, or poisonous, to the liver. Since hepatitis also harms the liver, people infected with hepatitis B virus and hepatitis C virus should avoid drinking alcohol, or drink as little as possible.

There are several other things people with hepatitis B virus, hepatitis C virus, and HIV can do to help themselves:

- Getting a medical care provider (such as a doctor) who can monitor health and discuss treatment options
- Taking medication as prescribed
- Getting enough rest
- Eating healthy foods
- Avoiding using street drugs

(continued)

- People with hepatitis B virus and hepatitis C virus should avoid alcohol.
- Taking care of oneself can lessen the effects of all three viruses.

HOW TO AVOID SPREADING HEPATITIS B VIRUS, HEPATITIS C VIRUS, AND HIV TO OTHERS

There are several ways people can avoid spreading these infectious diseases:

- Not sharing needles with other people
- If a person *has* to share needles with other people, sterilizing the "works" by immersing them in bleach for 30 seconds at least three times
- Always using a latex condom when engaging in sexual relations
- Not sharing personal items (such as a razor, toothbrush, nail file, or nail clippers) with others

People can take steps to avoid giving others hepatitis B virus, hepatitis C virus, or HIV.

APPENDIX C

Assessment Instruments and Other Forms

C.1. Dartmouth Assessment of Lifestyle Instrument (DALI)
C.2. Alcohol Use Scale—Revised (AUS-R)
C.3. Drug Use Scale—Revised (DUS-R)
C.4. Functional Assessment Interview
C.5. Drug/Alcohol Time-Line Follow-Back Calendar (TLFBC)
C.6. Payoff Matrix
C.7. Functional Analysis Summary
C.8. Substance Abuse Treatment Scale—Revised (SATS-R)
C.9. Individual Dual-Disorder Treatment Plan
C.10. Individual Treatment Review
C.11. Mental Illness Relapse Prevention Worksheet
C.12. Substance Abuse Relapse Prevention Worksheet
C.13. Pleasant Activities Worksheet
C.14. Recovery Mountain Worksheet
C.15. Orientation to Behavioral Family Therapy
C.16. Family Member Interview
C.17. Summary of Family Assessment
C.18. Family Treatment Plan
C.19. Family Treatment Review
C.20. Problem-Solving or Goal-Setting Sheet

FORM C.1

Dartmouth Assessment of Lifestyle Instrument (DALI)

Client name: ____________________________

Date: __________

INSTRUCTIONS

The DALI is a brief screening instrument, based on a client interview, for the detection of recent (past 6 months) substance use disorders in persons with severe mental illness. The DALI identifies three types of substance use disorders: alcohol, cannabis, and cocaine.

Reference: Rosenberg, S. D., Drake, R. E., Wolford, G. L., Mueser, K. T., Oxman, T. E., Vidaver, R. M., Carrieri, K. L., & Luckoor, R. (1998). The Dartmouth Assessment of Lifestyle Instrument (DALI): A substance use disorder screen for people with severe mental illness. *American Journal of Psychiatry, 155*, 232–238.

Circle the answer under each question as you ask it. At the end of the interview, select the corresponding DALI score and circle that on the right. List your scores on the last page and total them. (In the response options below, Ref = refused; NA = not applicable; DK = don't know.)

Question	Alcohol DALI score	Drug DALI score
1. Do you wear seatbelts while riding in the car? Yes = 0 No = 1 Ref = .41 NA = .41 DK = .41 Missing = .41	1a | 0 1 .41	
2. How many cigarettes do you smoke each day? Not scored		
3. Have you tried to stop smoking cigarettes? Not scored		
4. Do you control your diet for total calories (amount you eat)? Not scored		
5. How much would you say you spent during the past 6 months on alcohol? <$49 = 0 >$49 = 1 and –1 Ref = 1 and –1 NA = 0 DK = 1 and –1 Missing = .26 and –.26	5a | 0 1 .26	5d | 0 –1 –.26
6. How many drinks can you hold without passing out? (Interviewer note: If patient does not know, ask, "How many do you think it would take?") 0 drinks = 0 1–5 drinks = 1 >5 drinks = 2 Ref = 1.61 NA = 0 DK = 1.61 Missing = 1.61	6a | 0 1 2 1.61	
7. Have close friends or relatives worried or complained about your drinking in the past 6 months? Yes = 0 No = –1 Ref = –.78 NA = –1 DK = –.78 Missing = –.78	7a | 0 –1 –.78	

(continued)

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	Alcohol DALI score	Drug DALI score
8. Have you ever attended a meeting of Alcoholics Anonymous (AA) because of your drinking? Yes = 0 No = –1 Ref = –.53 NA = –1 DK = –.53 Missing = –.53	8a: 0 –1 –.53	
9. Do you sometimes take a drink in the morning when you first get up? (Interviewer note: If client asks, specify alcohol.) Yes = 0 No = –1 Ref = –.83 NA = –1 DK = –.83 Missing = –.83	9a: 0 –1 –.83	
10. How long was your last period of voluntary abstinence from alcohol (or most recent period when you chose not to drink)? (Interviewer note: 2 weeks or more equals a month. Exclude periods of incarceration or hospitalization.) 0–59 months = 1 >60 months = 0 Ref = .76 NA = 0 DK = .76 Missing = .76	10a: 0 1 .76	
11. How many months ago did this abstinence end for alcohol (or when did you start drinking again)? 0 month = 0 >0 months = 1 Ref = .40 NA = 0 DK = .40 Missing = .40	11a: 0 1 .40	
12. Have you used marijuana in the past 6 months? Yes = 0 No = –1 Ref = –.70 NA = –1 DK = –.70 Missing = –.70	12a: 0 –1 –.70	12d: 0 –1 –.70
13. Have you lost a job because of marijuana use? Yes = 0 No = –1 Ref = –.93 NA = –1 DK = –.93 Missing = –.93		13d: 0 –1 –.93
14. How much would you say you spent in the past 6 months on marijuana? $0 = 0 >$0 = 1 Ref = 1 NA = 0 DK = 1 Missing = .18		14d: 0 1 .18
15. How troubled or bothered have you been in the past 6 months by marijuana problems? Not at all (1) — Slightly (2) — Moderately (3) — Considerably (4) — Extremely (5) 1 = 0 2–5 = 1 Ref = 1 NA = 0 DK = 1 Missing = .19		15d: 0 1 .19
16. Has cocaine abuse created problems between you and your spouse/partner or your parents? Yes = 0 No = –1 Ref = –.82 NA = –1 DK = –.82 Missing = –.82		16d: 0 –1 –.82
17. How long was your last period of voluntary abstinence from cocaine (or most recent period when you chose not to use)? (Interviewer note: 2 weeks equals a month. Exclude periods of incarceration or hospitalization.) 0–59 months = 1 >60 months = 0 Ref = .19 NA = 0 DK = .19 Missing = .19		17d: 0 1 .19
18. Do you ever use cocaine when you're in a bad mood? Yes = 0 No = 1 Ref = 0 NA = 1 DK = 0 Missing = 0		18d: 0 1

(continued)

The eight alcohol questions have possible scores ranging from –4 to +6. Anyone scoring +2 or higher on the Alcohol scale is at high risk for having a current alcohol use disorder. The six drug questions have possible scores ranging from –4 to +4. People scoring above –1 on the Drug scale are at high risk for cannabis and/or cocaine use disorders.

Alcohol scores		Drug scores	
1a	______	5d	______
5a	______	12d	______
6a	______	13d	______
7a	______	14d	______
8a	______	15d	______
9a	______	16d	______
10a	______	17d	______
11a	______	18d	______
12a	______		
Total Alcohol score:	______	Total Drug score:	______

FORM C.2

Alcohol Use Scale—Revised (AUS-R)

Client name: ____________________

Rater: ________________________

Date: _________________________

INSTRUCTIONS

This scale pertains to your client's use of alcohol over the past 6 months. Rate the *worst* period of alcohol use during this interval. If the client is in an institution, the reporting interval is the time period prior to institutionalization. Complete the information-gathering portion of this form, and then rate your client on the 5-point Rating Scale at the end of this form.

Use

Inquire whether the client has used alcohol over the past 6 months.

____ No

____ Yes

If no, give the client a 1 on the Rating Scale and complete the "Sources of Information" section at the end of this form. If yes, complete the rest of the form.

Abuse

Consequences of use in past 6 months. Check all recurrent problems related to the alcohol use that have persisted for *at least 1 month*. Use client report, plus any other sources of information (i.e., urine screens, collateral reports).

Social functioning and legal status

____ Family problems

____ Housing instability

____ Social difficulties (e.g., arguments, threats of violence, or violent behavior)

____ Social isolation

____ Difficulty budgeting funds

____ Prostitution

____ Other legal problems

(continued)

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Role functioning

____ Employment difficulties (e.g., loss of job, accidents on the job)

____ Difficulty attending or keeping up in school

____ Parenting difficulties (e.g., failure to care for children)

Physical status

____ Hygiene problems

____ Change in physical appearance

____ Health problems

____ Injuries

Psychiatric status

____ Treatment nonadherence

____ Suicidal thoughts

____ Cognitive impairment

____ Symptom relapses

____ Sudden mood shifts

____ Appearance of new symptoms

Use in dangerous situations

____ When driving

____ When operating machinery

If no problems are noted for abuse, stop here and rate client a 2 on the Rating Scale. If problems are noted, check for dependence (below).

Dependence

The client needs to have at least one symptom present in three out of the following seven categories to meet criteria for dependence. If not, rate the client a 3 on the Rating Scale for abuse.

1. Greater amounts or intervals of use than intended

____ Drinking more than planned

____ Drinking longer than planned

____ Repeated unsuccessful attempts to cut down

2. Frequent intoxication, or withdrawal, interferes with other activities

____ Spending most of the time drinking

____ Frequent hangovers

(continued)

3. Important activities given up because of alcohol use

____ Drinking instead of working

____ Drinking instead of spending time on leisure activities

____ Drinking instead of spending time with family or friends

4. Continued use despite knowledge of alcohol-related problems

____ Drinking is causing problems, but client continues to drink

5. Marked tolerance

____ Needing to drink a lot more to get high

____ Diminished effect with use of same amount of alcohol

6. Characteristic withdrawal symptoms

____ Sweating

____ Racing heart

____ Hands shaking

____ Trouble sleeping

____ Feeling nauseated or vomiting

____ Feeling agitated

____ Feeling anxious

7. Alcohol taken to relieve or avoid withdrawal symptoms

____ Drinking to keep from getting sick from withdrawal symptoms

____ Drinking to stop the shakes or other withdrawal symptoms

If the client meets the criteria for dependence, move on to see whether the client has severe dependence, where problems are so severe that living in the community is difficult.

DEPENDENCE WITH INSTITUTIONALIZATION

____ Psychiatric hospitalization(s)

____ Inpatient treatment(s) for substance abuse

____ Incarceration(s)

If the client has had more than one psychiatric hospitalization, inpatient treatment for substance abuse, or incarceration, or if the client has spent 3 or more months of the past 6 institutionalized, rate the client a 5 on the Rating Scale. If none of these apply, rate the client a 4.

(continued)

Rating Scale

Based on the information summarized on the previous pages, rate your client's use of alcohol during the worst period over the past 6 months, according to the following scale.

____ **1 = Abstinence.** Client has not used alcohol over the past 6 months.

____ **2 = Use without impairment.** Client has used alcohol over the past 6 months, but there is no evidence of persistent or recurrent problems in social functioning, legal status, role functioning, psychiatric status, or physical problems related to use, and no evidence of recurrent dangerous use.

____ **3 = Abuse.** Client has used alcohol over the past 6 months, and there is evidence of persistent or recurrent problems in social functioning, legal status, role functioning, psychiatric status, or physical problems related to use, or evidence of recurrent dangerous use. For example, recurrent alcohol use leads to disruptive behavior and housing problems. Problems have persisted for at least 1 month.

____ **4 = Dependence.** Client meets criteria for abuse, plus at least three of the following: greater amounts of use than intended; much of time spent obtaining or using alcohol; frequent intoxication or withdrawal interferes with other activities; important activities given up because of alcohol use; continued use despite knowledge of alcohol-related problems; marked tolerance; characteristic withdrawal symptoms; or alcohol taken to relieve or avoid withdrawal symptoms. For example, drinking binges and preoccupation with drinking have caused client to drop out of job training and non-drinking-related social activities.

____ **5 = Dependence with institutionalization.** Client meets criteria for dependence, plus related problems are so severe that they make noninstitutional living difficult. For example, constant drinking leads to disruptive behavior resulting in incarceration.

Sources of Information

____ Client self-report
____ Observations by clinician(s)
____ Lab tests
____ Collateral sources (specify):
    ____ Mother
    ____ Father
    ____ Sibling
    ____ Spouse/boyfriend/girlfriend
    ____ Child
    ____ Other relative
    ____ Friend
    ____ Landlord
    ____ Police/probation/parole officer
    ____ Other (______________)

FORM C.3

Drug Use Scale—Revised (DUS-R)

Client name: ____________________

Rater: ____________________

Date: ____________________

INSTRUCTIONS

This scale pertains to your client's drug use over the past 6 months. Rate the *worst* period of drug use during this interval. If the client is in an institution, the reporting interval is the time period prior to institutionalization. Complete the information-gathering portion of this form, and then rate your client on the 5-point Rating Scale at the end of this form.

Use

Inquire whether the client has used drugs (other than as prescribed) over the past 6 months.

____ No

____ Yes

If no, give the client a 1 on the Rating Scale and complete the "Sources of Information" section at the end of this form. If yes, complete the rest of the form.

Mark drugs used:

____ Sedatives/hypnotics/anxiolytics

____ Cannabis

____ Stimulants

____ Opioids

____ Cocaine

____ Hallucinogens

____ Over-the-counter (specify) ____________________

____ Other (specify) ____________________

____

See last page of form for specific drugs within each category and slang words.

(continued)

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Abuse

Consequences of use in past 6 months. Check all recurrent problems related to the drug use that have persisted for *at least 1 month*. Use client report, plus any other sources of information (i.e., urine screens, collateral reports).

Social functioning and legal status

____ Family problems
____ Housing instability
____ Social difficulties (e.g., arguments, threats of violence, or violent behavior)
____ Social isolation
____ Prostitution
____ Difficulty budgeting funds
____ Other legal problems

Role functioning

____ Employment difficulties (e.g., loss of job, accidents on the job)
____ Difficulty attending or keeping up in school
____ Parenting difficulties (e.g., failure to care for children)

Physical status

____ Hygiene problems
____ Change in physical appearance
____ Health problems
____ Injuries

Psychiatric status

____ Treatment nonadherence
____ Suicidal thoughts
____ Cognitive impairment
____ Symptom relapses
____ Sudden mood shifts
____ Appearance of new symptoms

Use in dangerous situations

____ When driving
____ When operating machinery

If no problems are noted for abuse, stop here and rate client a 2 on the Rating Scale. If problems are noted, check for dependence (below).

(continued)

Dependence

The client needs to have at least one symptom present in three out of the seven categories to meet criteria for dependence. If not, rate the client a 3 on the Rating Scale for abuse.

1. Greater amounts or intervals of drug use than intended

____ Using more drugs than planned

____ Using drugs longer than planned

____ Repeated unsuccessful attempts to cut down use of drugs

2. Frequent drug use or withdrawal interferes with other activities

____ Spending most of the time using drugs

____ Lengthy time spent recovering from effects

3. Important activities given up because of drug use

____ Using drugs instead of working

____ Using drugs instead of spending time on leisure activities

____ Using drugs instead of spending time with family or friends

4. Continued use despite knowledge of drug-related problems

____ Drug use is causing problems, but client continues to use

5. Marked tolerance

____ Needing to use a lot more drugs to achieve desired effect

____ Diminished effect with use of same amount of drug

6. Characteristic withdrawal symptoms

Sedatives/hypnotics/anxiolytics

____ Sweating or increased pulse rate

____ Increased hand tremor

____ Insomnia

____ Nausea or vomiting

____ Transient visual, tactile, or auditory hallucinations or illusions

____ Anxiety

____ Grand mal seizures

Stimulants/cocaine

____ Dysphoric mood

____ Fatigue

____ Vivid, unpleasant dreams

____ Insomnia or hypersomnia

____ Increased appetite

____ Psychomotor retardation or agitation

(continued)

Opiates

____ Dysphoric mood
____ Nausea or vomiting
____ Muscle aches
____ Pupillary dilation
____ Diarrhea
____ Fever
____ Insomnia
____ Sweating

7. Drug taken to relieve or avoid withdrawal symptoms

____ Use to keep from getting sick from withdrawal symptoms
____ Use when feeling sick with withdrawal symptoms

If the client meets the criteria for dependence, move on to see if the client has severe dependence, where problems are so severe that living in the community is difficult.

Dependence with Institutionalization

____ Psychiatric hospitalization(s)
____ Inpatient treatment(s) for substance abuse
____ Incarceration(s)

If the client has had more than one psychiatric hospitalization, inpatient treatment for substance abuse, or incarceration, or if the client has spent 3 or more months of the past 6 institutionalized, rate the client a 5 on the Rating Scale. If none of these apply, rate the client a 4.

Rating Scale

Based on the information summarized on the previous pages, rate your client's use of drugs during the worst period over the past 6 months according to the following scale.

____ **1 = Abstinence.** Client has not used drugs over the past 6 months.

____ **2 = Use without impairment.** Client has used drugs over the past 6 months, but there is no evidence of persistent or recurrent problems in social functioning, legal status, role functioning, psychiatric status, or physical status related to use, and no evidence of recurrent dangerous use.

____ **3 = Abuse.** Client has used drugs over the past 6 months, and there is evidence of persistent or recurrent problems in social functioning, legal status, role functioning, psychiatric status, or physical status related to use, or evidence of recurrent dangerous use. For example, recurrent drug use leads to disruptive behavior and housing problems. Problems have persisted for at least 1 month.

(continued)

____ **4 = Dependence.** Client meets criteria for abuse, plus at least three of the following: greater amounts of use than intended; much of time spent obtaining or using drugs; frequent intoxication or withdrawal interferes with other activities; important activities given up because of drug use; continued use despite knowledge of substance-related problems; marked tolerance; characteristic withdrawal symptoms; or drugs taken to relieve or avoid withdrawal symptoms. For example, binges and preoccupation with drugs have caused client to drop out of job training and non-drug-related social activities.

____ **5 = Dependence with institutionalization.** Client meets criteria for dependence, plus related problems are so severe that they make noninstitutional living difficult. For example, constant drug use leads to disruptive behavior resulting in incarceration.

Sources of Information

____ Client self-report

____ Observations by clinician(s)

____ Lab tests

____ Collateral sources (specify):

- ____ Mother
- ____ Father
- ____ Sibling
- ____ Spouse/boyfriend/girlfriend
- ____ Child
- ____ Other relative
- ____ Friend
- ____ Landlord
- ____ Police/probation/parole officer
- ____ Other (______________)

(continued)

DRUG NAMES AND SLANG WORDS

Sedatives/hypnotics/anxiolytics:
"Downers," Quaalude ("ludes"), Seconal ("reds"), Valium, Xanax, Librium, barbiturates ("barbs"), Miltown, Ativan, Dalmane, Halcion, Restoril, Klonopin, "Special K," "roofies," "tranks."

Cannabis:
Marijuana ("pot," "grass," "weed," "reefer," "smoke," "dope," "joint," "ganga," "doobie," "wacky tobacky," "Mary Jane"), hashish ("hash"), THC.

Stimulants:
"Uppers," amphetamine, "speed," "crystal meth," Dexedrine, Ritalin, "ice," "crank," "black beauties," "crosses," "hearts," STP, Ecstasy ("XTC," "X-file"), MDMA, MOA, DOM, DOB.

Opiates:
Heroin ("smack," "horse," "H"), morphine, opium (laudanum, paregoric, "Dover's powder"), methadone, Darvon, codeine, Percodan, Demerol, Dilaudid.

Cocaine:
"coke," "crack," "speedball," "freebase," "rock," "snow," "8-ball," "flake"

Hallucinogens ("psychedelics"):
LSD ("acid," "windowpane," "blotter," "microdot"), mescaline (peyote, "buttons," "cactus," "mesc"), psilocybin (mushrooms, "shrooms," "purple passion").

Over-the-counter:
Sleeping pills, diet pills, antihistamines.

Other:
PCP ("angel dust," "boat," "hog," "love boat"), steroids, "glue," ethyl chloride, paint, inhalants, nitrous oxide ("laughing gas"), amyl or butyl nitrate ("poppers"), White-Out, cough medicine.

FORM C.4

Functional Assessment Interview

Client name: ____________________

Dates of assessment: ______________

Check sources of information used. (*Note:* If respondent is someone other than the client, substitute the client's name for "you" in questions below.)

____ Client

____ Significant other (specify: ____________________)

____ Treatment provider (specify: ____________________)

____ Other informant (specify: ____________________)

____ Medical records

I. Background information

A. Address ____

____

____

B. Telephone number: ______________________________________

C. Gender: ____ Male _____ Female

D. Date of birth: ____________

E. Ethnicity: ____________

F. Marital status: ____________

G. Names and ages of siblings:

Name	Age

H. Children

1. Do you have any children? ____ Yes ____ No
2. Names and ages of children:

Name	Age

(continued)

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3. Living situation for children: ____

____

____

4. Contact with children: ____

____

____

I. Living situation

1. Where do you live (e.g., with relatives, supervised residence, independently)? ________

____

2. Do you do your own:

Cooking? ____ Yes ____ No

Cleaning? ____ Yes ____ No

Shopping? ____ Yes ____ No

Laundry? ____ Yes ____ No

3. Are you satisfied with your living arrangement? ____ Yes ____ No

4. If no, why? ____

____

5. If no, what other living arrangement would you prefer?

____

____

J. Education

1. How far did you go in school? ____ years high school ____ High school diploma or (GED) ____ years college ____ College diploma

2. Are you interested in returning to school? ____ Yes ____ No

3. If yes, have you made previous efforts to return to school? ____ Yes ____ No

If yes, describe: ____

____

4. What would you like to do in school? ____

____

____

II. Psychiatric illness

A. DSM psychiatric diagnosis (from medical records or structured interview)

1. Axis I: ____

2. Axis II: ____

B. Understanding of psychiatric illness (from client self-report)

1. Do you think you have a psychiatric illness? ____

Ask questions 2–6 if client either acknowledges having a psychiatric illness, or admits some kinds of difficulty (such as problems functioning, problems with "nerves," etc.).

(continued)

2. What is it called? ______________________________

____

3. What are some of the symptoms of the illness (problem)? ______________________________

____

____

4. What do you think caused this illness (problem)? ______________________________

____

____

5. What have you noticed makes your illness (problem) better? ______________________________

____

____

6. What have you noticed makes your illness (problem) worse? ______________________________

____

C. History of illness

1. Age at illness onset (first symptoms): ______________________________
2. Age at first hospitalization: ______________________________
3. Number of psychiatric hospitalizations: ______________________________
4. Date and duration of most recent psychiatric hospitalization: ______________________________
5. Circumstances that led up to most recent hospitalization: ______________________________

____

____

D. Medication

1. Psychiatric medications and dosages: ______________________________

____

____

2. Do you take medications regularly? ____ Yes ____ No
3. If no, why not? ______________________________

____

____

Probe for client concerns about substance–medication interactions.

4. Do your medications seem to help? ____ Yes ____ No

Please specify: ______________________________

____

____

5. Side effects of medications: ______________________________

____

____

____

(continued)

6. How have you coped with these side effects?: ______________________________

____

____

____

Were these coping efforts effective? ____ Yes ____ No

E. Symptoms

Which of the following symptoms have you experienced over the past month? For each symptom, indicate how distressed you have felt by it, using the following scale: 1 = "not at all," 2 = "a little," 3 = "somewhat," 4 = "quite a bit," 5 = "extremely."

	Yes/no	Severity
1. Depression (sadness, feeling blue, low self-esteem)	________	________
2. Anxiety (worry, fear, panic attacks)	________	________
3. Sleep problems (falling asleep, awakenings, nightmares, sleeping too much)	________	________
4. Anger (irritability, outbursts)	________	________
5. Cognitive problems (poor attention, memory problems)	________	________
6. Apathy/anhedonia (not caring about anything, difficulty initiating action, lack of pleasure)	________	________
7. Hallucinations (hearing or seeing things others don't)	________	________
8. Delusions (unusual thoughts or ideas)	________	________
9. Other symptoms (specify: ____________)	________	________

III. Physical Health and Safety

A. Do you have any major physical illnesses that interfere with your life (e.g., diabetes, heart disease)? ______________________________

B. When was the last time you saw a doctor for a physical reason, and what was the reason? __

____

C. Do you take any medications on a regular basis for physical problems? ____ Yes ____ No

If yes, describe: ______________________________

____

D. Have you been physically assaulted over the past year? ____ Yes ____ No

If yes, describe: ______________________________

____

____

E. Has anyone forced you or coerced you to have sexual relations against your will in the past year? ____ Yes ____ No

If yes, describe: ______________________________

____

(continued)

IV. Psychosocial Adjustment

A. Family functioning

1. Which members of your family do you have contact with (e.g., parents, siblings, spouse, children, grandparents, aunts, uncles)?

Relationship	Contact (daily, weekly, etc.)
______	______
______	______
______	______
______	______
______	______
______	______

2. What types of situations or problems are sources of conflict between you and your family members? Describe: ______

3. How do you and your relatives deal with these situations? Are you satisfied with how you cope with these stresses? ______

4. Does anyone in the family yell, threaten, or hit each other during conflict?
   ____ Yes ____ No
   If yes, describe: ______

5. What do you see as the major stressors that your family has to deal with?

6. What are some of the ways you help out in your family?

7. What do you see as the major strengths of your family?

8. Overall, how satisfied are you with the support you receive from you family? ______

   Which family members do you find most supportive? ______

(continued)

Which family members are least supportive? ____________________

____

How would you like things to be different? ____________________

____

(Probe for desire for more contact with family.)

B. Friendship and romantic relationships

1. Whom do you consider your friends? ____________________

   ____

2. How often do you get together with your friends? ____________________

   ____

3. What do you like to do with your friends? ____________________

   ____

4. Are you satisfied with your friends and the amount of contact you have with them? ____ Yes ____ No
5. Do you have a romantic relationship? ____ Yes ____ No
6. If no, would you like one? ____________________
7. If yes, are you satisfied with it? ____________________

C. Leisure and recreation

1. How do you spend your free time? ____________________

   ____

2. Whom do you spend it with? ____________________
3. Would you like to do more with your spare time? ____ Yes ____ No
4. If yes, what would you like to do? ____________________

   ____

5. Are there activities you used to do but don't do any more? ____ Yes ____ No

   If yes, describe: ____________________

   ____

6. Would you like to start doing them again? ____________________

   ____

7. What gets in the way of doing those activities? ____________________

   ____

   ____

D. Work

1. Are you working? ____ Yes ____ No
2. If yes, where and doing what? ____________________
3. How many hours per week? ____________________
4. If not working, are you interested in work? ____ Yes ____ No
5. Have you made any recent efforts to find work? ____ Yes ____ No

   If yes, describe: ____________________

   ____

(continued)

6. If no, what gets in the way of finding work? ____________________

____

7. When was the last time you worked? ____________________

E. Spirituality

1. What are your spiritual beliefs? ____________________

____

2. Are you involved with a religious group (e.g., church)? ____ Yes ____ No
3. Did you used to belong to a religious group that you are no longer an active participant in? ____ Yes ____ No
4. Do you seek more spiritual meaning in your life? ____ Yes ____ No
5. If yes, please explain: ____________________

____

F. Financial matters

1. What are your sources of income (e.g., SSI, SSDI, family)? List all sources and approximate income from each.

Source	Monthly income
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

2. Who controls your money? ____________________

____

3. How satisfied are you with this current arrangement?

____

4. Have you experienced any problems when you control your own money?
____ Yes ____ No
If yes, explain: ____________________

G. Legal problems

1. Have you ever been in trouble with the law? ____ Yes ____ No
2. Have you ever been arrested? ____ Yes ____ No
3. If yes, what were you arrested for? ____________________

____

4. Are you awaiting charges, trial, or sentencing? ____ Yes ____ No
5. Have you ever spent time in jail? ____ Yes ____ No
6. Are you on probation or parole? ____ Yes ____ No
If yes, explain: ____________________

V. Substance Use

A. Alcohol

1. Do you drink alcohol? ____ Yes ____ No
2. If yes, what types of beverages? ____________________

____

(continued)

How much at a time? ______________________

How often do you drink? ______________________

3. Complete the Drug/Alcohol Time-Line Follow-Back Calendar (Form C.5) for alcohol use.
4. In what situations do you drink (e.g., alone, with friends, etc.)?

____

5. Motives for alcohol use
   a. What are the positive things you get from drinking?

   ____

   b. What do you like about the effects of alcohol?

   ____

   ____

   c. Which of the following is true about alcohol for you?

Drinking . . .	Not true	Sometimes true	Often true
• is important to socializing with friends	____	____	____
• helps me meet and get to know people	____	____	____
• lowers my anxiety when I'm with people	____	____	____
• makes me feel less depressed	____	____	____
• makes me feel less anxious	____	____	____
• helps me forget my problems	____	____	____
• helps me sleep better	____	____	____
• helps reduce boredom	____	____	____
• is an important source of pleasure to me	____	____	____
• gives me something to look forward to	____	____	____
• is one of the only things that makes me feel good	____	____	____
• is chiefly a habit	____	____	____

B. Drugs

1. Which of the following drugs have you used?

	Ever	Recently (past 6 months)
Marijuana	____	____
Cocaine	____	____
Hallucinogens (e.g., LSD, PCP, mescaline)	____	____
Sedatives (not prescribed or misused, e.g., Klonopin, Valium)	____	____
Stimulants (e.g., amphetamines)	____	____
Opiates (e.g., heroin, Darvon)	____	____
Over-the-counter (specify: ________)	____	____
Other (specify: ________)	____	____

Indicate with an asterisk (*) which substances are most preferred.

2. How do you use those drugs (route of administration)? ______________________
3. How often do you use them? ______________________

(continued)

4. How much do you use at a time? ____________________
5. Complete the Drug/Alcohol Time-Line Follow-Back Calendar (Form C.5) for drug use.
6. Motives for drug use
   a. What are the positive things you get from using drugs?

      ____

   b. What do you like about the effects of drugs?

      ____

      ____

   c. Which of the following is true about drugs for you?

Using drugs . . .	Not true	Sometimes true	Often true
• is important to socializing with friends	____	____	____
• helps me meet and get to know people	____	____	____
• lowers my anxiety when I'm with people	____	____	____
• makes me feel less depressed	____	____	____
• makes me feel less anxious	____	____	____
• helps me forget my problems	____	____	____
• helps me sleep better	____	____	____
• helps reduce boredom	____	____	____
• is an important source of pleasure to me	____	____	____
• gives me something to look forward to	____	____	____
• is one of the only things that makes me feel good	____	____	____
• is chiefly a habit	____	____	____

C. Problems and desire to change
1. What problems have you had because of drinking/using drugs?

   ____

2. What would happen if you stopped using alcohol/drugs?

   ____

3. Has your use of alcohol or drugs led to any family problems or conflict?
   ____ Yes ____ No
   If yes, describe: ____________________

   ____

   ____

4. Do you see your alcohol/drug use as a problem? ____________________
5. Are you interested in stopping or cutting down on your alcohol/drug use?
   ____ Yes ____ No
6. If yes, why? ____________________
7. What do you think gets in the way of stopping or cutting down on your use of substances? ____________________

   ____

(continued)

VI. Goals

A. What would you like to see changed in your life? (Probe for work, school, social, leisure, living arrangements, independent living skills, coping with mental illness.)

____

____

____

B. Is substance use something you need to work on? ____ Yes ____ No

If yes, why? ______________________________

____

C. What would you like to see changed in your relationships with your family members or others? ______________________________

____

____

D. What things have you done to try to achieve these goals? ____________________

____

____

What has worked? ______________________________

____

What has not worked? ______________________________

____

VII. Strengths

A. What do you see as your own personal strengths or abilities? ____________________

____

____

B. What things about yourself are you most proud of? ____________________

____

____

C. What do other people say are your positive qualities? ____________________

____

____

D. How have you used your personal strengths and abilities to achieve goals or deal with challenges in the past? ______________________________

____

____

E. How do you think you could use your strengths to help you achieve your current goals?

____

____

FORM C.5

Drug/Alcohol Time-Line Follow-Back Calendar (TLFBC)

Client name: ______________________ Date : __/__/__

Instructions to interviewers: The TLFBC summarizes the current month and the previous 6 months of the client's substance use. Start by asking about alcohol use, month by month, and then ask about drug use. Focus on an estimation of monthly use and the pattern of use. (More detailed instructions follow the chart below.)

Ask: For each month--(1) How many days have you used alcohol (or drugs)? (2) What kind of alcohol (or drugs) did you use? (3) How much did you use each day (on those days you drank or used drugs)? (4) What is the total number of days in ________ (month) that you drank (or used any drug at all)?

Alcohol	**Current month 1** (# days: ___)	**Previous month 2**	**Previous month 3**	**Previous month 4**	**Previous month 5**	**Previous month 6**	**Previous month 7**
Kind							
How much (per day)							
How often (days/month)							
Total days/month alcohol used							
Drugs							
Kind (+ abused meds)							
How much (per day)							
How often (days/month)							
Total days/month drugs used							

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FURTHER INSTRUCTIONS

First, fill in today's day and month, and each of the previous 6 months.
Make note of key events in client's life during these months, such as hospitalizations and jail time.

Alcohol Use

Start with the current month. Ask this series of questions for the current month:

1. "Today is September 15th." (First month is usually a *partial* month.)
2. "How many days, in the 15 days of September, did you use any alcohol?"
3. "What kind of alcohol did you use?" (Beer, wine, hard liquor?)
4. "How much did you drink each day, on the days you used?" (Ask for *each kind* used. If client used more than one kind per day, see notes on recording different kinds, below.)
5. "How many days in this month did you drink any kind of alcohol?" (Ask only if client used *more than one kind* of alcohol. You are looking for the total number of days of use.)

Then go back in time, month by month, using the technique described above for each month (except that questions should cover the whole month). Probe for *patterns* of use, particularly when going further back in time (when recall is more difficult). Ask: "Was your use this month the same as last month, or different?"

Drug Use

Start with the current month. Ask this series of questions for the current month:

1. "Today is September 15th."
2. "What kinds of drugs did you use in September?"
3. Ask the next questions for each kind used. (If client used more than one kind per day, see notes on recording different kinds, below.)
   - "How many days, in the 15 days of September, did you use this drug?"
   - "How much did you use each day you used?"
   - "Were there any days this month when you took more of your medications than you were supposed to?"
   - "What is the total number of days, this month, you took *any* kind of drug?"

Then go back in time, month by month, using the technique described above for each month (except that questions should cover the whole month). As for alcohol use, probe for *patterns* of drug use, particularly when going back in time (when recall is more difficult). Ask: "Was your use this time the same as last month, or different?"

OTHER NOTES

Recording different kinds of substances: For more than one kind of drug (or alcohol) used in the same month, you will need to divide up the available box and create a kind of code for each substance so you can keep track of each substance, differentiating it from the others, within the same month (see Figure 4.2 in Chapter 4).

When you are finished with the drug section, ask: "Was there any drug you used any time during the past 6 months—even once—that we haven't yet recorded here?" With drug use, also ask: "Was there any time you took more of your medications, even once, in the past 6 months?"

Nondirective questioning is useful when clients have a problem remembering their use over the past 6 months: "Did you use more than half the month or less than half the month?" will get you started.

FORM C.6

Payoff Matrix

Client name: ______________________ Date: ______________

Instructions: Instructions for completing each quadrant appear below. For all quadrants, please be as specific as possible about the consequences.

Advantages of Using Substances Consider possible motives for using substances, such as socializing; coping with symptoms or other problems; pleasure and recreation; or something to do.	**Advantages of Not Using Substances** Consider potential advantages of not using, such as less conflict with others; fewer symptoms and relapses; fewer money or legal problems; more stable housing; and improved ability to work, go to school, or parent.
Disadvantages of Using Substances Consider common negative consequences of using substances, such as more severe symptoms; more frequent relapses; conflict with others; money or legal problems; loss of housing; and problems with working, going to school, or parenting.	**Disadvantages of Not Using Substances** Consider the potential costs of becoming sober, such as more problems socializing; difficulties coping with symptoms or negative moods; lack of recreation and fun; or having nothing interesting to do.

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FORM C.7

Functional Analysis Summary

Client name: ______________________________

Date: ______________________________

A. Complete a Payoff Matrix (see Form C.6) that identifies the advantages and disadvantages of using substances, and the advantages and disadvantages of not using substances. For a client who is currently using substances, the perceived advantages of using substances (and disadvantages of not using substances) should *outweigh* the perceived advantages of not using substances (and the disadvantages of using substances). The short-term advantages of using substances (and disadvantages of not using) often maintain substance use behavior, despite the long-term disadvantages of using substances and (advantages of not using).

B. Based on the perceived advantages of using substances, and the disadvantages of not using substances, what factors seem to be most critical in maintaining the client's use of substances (or, if the client is not abusing substances, what factors pose the greatest risk for relapse)?

____

____

____

C. What strategies might be used to *reduce* some of the negative consequences (or the "costs") of the client's not using substances? Consider rehabilitation-based interventions, such as teaching the client skills to cope with symptoms; providing social skills training to improve social competence and ability to make friends; assisting the client in developing new social outlets and new recreational activities; and helping the client find something meaningful to do (such as employment, supported education for school, or increased parenting responsibilities).

____

____

____

D. What strategies might be used to *increase* the advantages of not using substances? Consider motivation-based interventions, such as motivational interviewing and contingency contracting.

____

____

____

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FORM C.8

Substance Abuse Treatment Scale—Revised (SATS-R)

Client name: ______________________________

Date: ______________________________

Is client currently in an institution? ____ Yes ____ No

If yes, what institution? ______________________

Date of hospitalization or incarceration: __________

Instructions: This scale is for assessing a person's stage of substance abuse treatment, not for determining diagnosis. The reporting interval is the last 6 months. If the person is in an institution, the reporting interval is the time period prior to institutionalization. Check which stage of treatment the client is in.

____ 1. *Preengagement.* The person (not yet a client) does not have contact with a case manager, mental health counselor, or substance abuse counselor, and meets criteria for substance abuse or dependence.

____ 2. *Engagement.* The client has had only irregular contact with an assigned case manager or counselor, and meets criteria for substance abuse or dependence.

____ 3. *Early Persuasion.* The client has regular contacts with a case manager or counselor; continues to use the same amount of substances, or has reduced substance use for less than 2 weeks; and meets criteria for substance abuse or dependence.

____ 4. *Late Persuasion.* The client has regular contacts with a case manager or counselor; shows evidence of reduction in use for the past 2–4 weeks (fewer substances, smaller quantities, or both); but still meets criteria for substance abuse or dependence.

____ 5. *Early Active Treatment.* The client is engaged in treatment and has reduced substance use for more than the past month, but still meets criteria for substance abuse or dependence during this period of reduction.

____ 6. *Late Active Treatment.* The person is engaged in treatment and has not met criteria for substance abuse or dependence for the past 1–5 months.

____ 7. *Relapse Prevention.* The client is engaged in treatment and has not met criteria for substance abuse or dependence for the past 6–12 months.

____ 8. *In Remission or Recovery.* The client has not met criteria for substance abuse or dependence for more than the past year.

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FORM C.9

Individual Dual-Disorder Treatment Plan

Client: ______________________________ Date: ______________

Primary clinician: ______________________________

Psychiatric disorder (Axis I): ______________________________

Psychiatric disorder (Axis II): ______________________________

Alcohol Use Scale—Revised: ______________________________

Drug Use Scale—Revised: ______________________________

Substance Abuse Treatment Scale—Revised: ______________________________

Stage-Wise Goals

Problem	Goal	Intervention	Treatment modality	Responsible clinician(s)
1.				
2.				
3.				

Goals Based on Functional Analysis

Problem	Goal	Intervention	Treatment modality	Responsible clinician(s)
1.				
2.				
3.				

Date of treatment plan meeting with client: ________

Date of treatment plan meeting with family: ________

Date of next review of treatment plan: ________

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FORM C.10

Individual Treatment Review

Client: ______________________________ Date: ______________

A. Implementation of Planned Interventions

For each planned intervention, indicate whether the intervention was fully implemented, partially implemented, or not implemented.

	Fully implemented	Partially implemented	Not implemented
1. ______________________________	☐	☐	☐
2. ______________________________	☐	☐	☐
3. ______________________________	☐	☐	☐
4. ______________________________	☐	☐	☐

B. Implementation Obstacles or Problems

For each intervention not implemented or partially implemented, describe obstacles or problems encountered in attempting to implement it.

Intervention	Obstacle or problem
1. ____________________	______________________________
2. ____________________	______________________________
3. ____________________	______________________________
4. ____________________	______________________________

C. Goals Achieved

For each intervention that was implemented or partially implemented, indicate which of the goals (from prior Individual Dual-Disorder Treatment Plan) of that intervention were achieved.

Intervention 1

	Fully achieved	Partially achieved	Not achieved
Goals: 1. ______________________________	☐	☐	☐
2. ______________________________	☐	☐	☐
3. ______________________________	☐	☐	☐

(continued)

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Intervention 2

	Fully achieved	Partially achieved	Not achieved
Goals: 1. ______	☐	☐	☐
2. ______	☐	☐	☐
3. ______	☐	☐	☐

Intervention 3

	Fully achieved	Partially achieved	Not achieved
Goals: 1. ______	☐	☐	☐
2. ______	☐	☐	☐
3. ______	☐	☐	☐

Intervention 4

	Fully achieved	Partially achieved	Not achieved
Goals: 1. ______	☐	☐	☐
2. ______	☐	☐	☐
3. ______	☐	☐	☐

D. Changes in Substance Abuse

Briefly describe any changes in substance abuse since the last treatment plan. Describe which interventions seem to have worked and which ones seem not to have worked.

______

______

______

______

______

______

FORM C.11

Mental Illness Relapse Prevention Worksheet

A. Early warning signs that I may be about to experience a relapse of my mental illness (e.g., trouble sleeping, being isolated from others, confused thinking):

1. ______________________________
2. ______________________________
3. ______________________________

B. Feelings I experience when I'm about to have a relapse of my mental illness (e.g., paranoia, nervousness, sadness):

1. ______________________________
2. ______________________________
3. ______________________________

C. Plan to be implemented when early warning signs or feelings appear (e.g., call my doctor, call my case manager, call a support person, go to a Twelve-Step meeting):

1. ______________________________
2. ______________________________
3. ______________________________

Doctor's name: ____________________ Phone number: ____________

Therapist's/case manager's name: ____________________ Phone number: ____________

Support person's name: ____________________ Phone number: ____________

Support person's name: ____________________ Phone number: ____________

Support person's name: ____________________ Phone number: ____________

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FORM C.12

Substance Abuse Relapse Prevention Worksheet

A. Early warning signs that I may be about to experience a relapse of my substance abuse (e.g., going to places where I used to drink or use drugs, hanging out with people I used to drink or use drugs with, cravings, decreased need for sleep, becoming more isolated):

1. ______________________________
2. ______________________________
3. ______________________________

B. Feelings I experience when I want to start using substances again (e.g., angry, sad, bored, nervous, anxious, guilty, excited, self-confident):

1. ______________________________
2. ______________________________
3. ______________________________

C. Plan to be implemented when early warning signs or feelings appear (e.g., call my doctor, call my case manager, call a support person, go to a Twelve-Step meeting):

1. ______________________________
2. ______________________________
3. ______________________________

Doctor's name: ______________________ Phone number: ______________

Therapist's/case manager's name: ______________ Phone number: ______________

Support person's name: ______________________ Phone number: ______________

Support person's name: ______________________ Phone number: ______________

Support person's name: ______________________ Phone number: ______________

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FORM C.13

Pleasant Activities Worksheet

1. List pleasant activities that do not depend upon others, are noncompetitive, and have some physical, mental, or spiritual value for you. You can improve your level of performance in these activities, and you can accept your level of performance without criticizing yourself.

______	______	______
______	______	______
______	______	______
______	______	______

2. Schedule 30–60 minutes of "personal time" at least three times per week to engage in these activities. Set aside the time each day. You do not have to select which activity you will do ahead of time. Select the activity from your list above.

	Appointment for personal time	Activity you choose to do
Monday	______	______
Tuesday	______	______
Wednesday	______	______
Thursday	______	______
Friday	______	______
Saturday	______	______
Sunday	______	______

3. At the end of the week, look back and note which activities you most enjoyed:

______

______

______

4. Are there any other activities not on your list that you would like to add to this list?

______

______

______

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FORM C.14

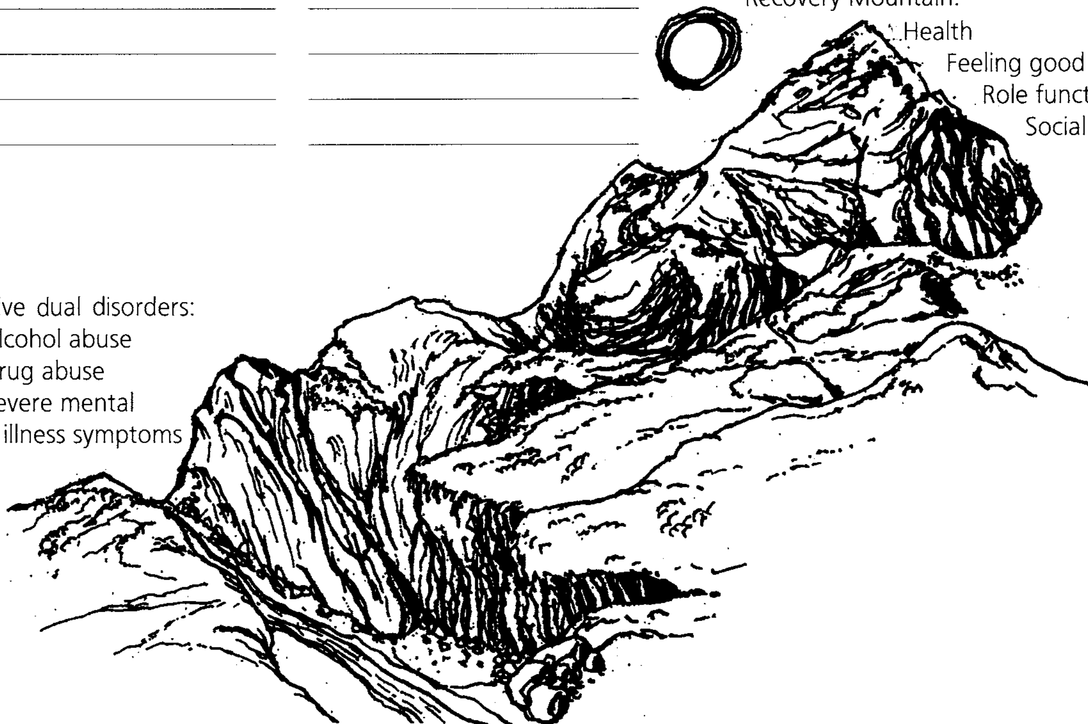
Recovery Mountain Worksheet

Instructions: Recovery from dual disorders is like climbing a mountain, *Recovery Mountain*. The process of recovery involves overcoming different obstacles and challenges, and dealing with various setbacks. You make progress on your personal journey of recovery by learning your warning signs of mental illness and substance abuse, and developing effective coping skills.

Use this worksheet to identify your warning signs and the coping skills you have found most helpful.

Warning signs of mental illness	Coping skills

Warning signs of substance abuse	Coping skills



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FORM C.15

Orientation to Behavioral Family Therapy

Role of the Therapist

- Coordinate, guide, and assist family members in learning new information and coping skills.

Goals

- Reduce tension in family relationships.
- Improve communications between family members.
- Increase the family's understanding and acceptance of the illness.
- Assist the family in developing more satisfactory problem-solving strategies.

Format of the Program

- Assessment of each individual family member.
- Assessment of the family's strengths and weaknesses as a unit.
- Education about the nature of the illness and its treatment.
- Communication skills training.
- Problem-solving training.
- Development of new strategies for specific problems.

What Is Expected of Family Members

- Regular attendance.
- A quiet working environment (if therapy is conducted at home).
- Active role playing.
- Completion of all homework assignments.
- Cooperation with each other and the therapist.

What the Family Can Expect the Therapist to Provide

- Regular attendance.
- A comfortable working environment (if therapy is conducted in clinic).
- Thoughtful, systematic intervention
- Strict confidentiality (except with treatment team and when obligated to report).
- Homework materials.
- Crisis counseling (if applicable).

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FORM C.16

Family Member Interview

Date: ____________________

I. Background Information

A. Name: ____________________

B. Relationship to client: ____________________

C. Age: ____________________

D. Marital status: ____________________

E. Address: ____________________

____

____

F. Telephone number: ____________________

G. How far did you go in school? ____________________

H. Occupation: ____________________

I. Have you ever had any psychiatric treatment? ____ Yes ____ No
If yes, what? ____________________

II. Knowledge of Mental Illness

A. Do you think ____________ has a mental illness? ____ Yes ____ No

B. If yes, what is it called? ____________________

C. What do you think caused it? ____________________

____

D. Is there anything that makes it better? ____________________

____

E. Is there anything that makes it worse? ____________________

____

F. Does ____________ take medication? ____ Yes ____ No

G. Do you know what he or she takes? ____________________

H. Is the medication helpful? ____ Yes ____ No
How? ____________________

____

(continued)

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I. Does the medication have side effects? ____ Yes ____ No
If yes, what are they? ______________________________

____

____

J. Does ______________ take the medication regularly? ____ Yes ____ No
If no, is it a problem? ______________________________

____

III. Problem Behaviors

A. How has ______________'s disorder changed the family? ______________________________

____

B. Has ______________'s disorder caused any problems? ____ Yes ____ No
If yes, what are they? ______________________________

____

C. How do you cope with these problems? ______________________________

____

D. What types of situations or problems are the source of conflict between you and ______________? ______________________________

____

____

E. How do family members deal with these situations? ______________________________

____

____

Are you satisfied with how you and other family members cope with these stresses?
____ Yes ____ No
If no, why not? ______________________________

____

F. What do you see as the family's major stressors? ______________________________

____

IV. Substance Use

A. Does ______________ use alcohol? ____ Yes ____ No

B. If yes, could you tell me a little bit about that (frequency, type, situation)? ______________

____

C. If yes, is this a problem (for you or other relatives, for him or her, or for everyone)? ________

____

(continued)

D. If yes, what specific kinds of problems does it cause? ____________________

____

E. Do you know whether ____________ has used any of the following substances?

Substance	Ever	Recently (past 6 months)
Marijuana	________	________
Cocaine	________	________
Hallucinogens (e.g., LSD, PCP, mescaline)	________	________
Sedatives (not prescribed) (e.g., Valium)	________	________
Stimulants (e.g., amphetamines)	________	________
Opiates (e.g., heroin, Darvon)	________	________
Over-the-counter (specify: ____________)	________	________
Other (specify: ____________)	________	________

F. Do you use alcohol? ____ Yes ____ No

G. If yes, in what situations do you use alcohol? ____________________

____

H. Do you use any of the other substances listed above? ____ Yes ____ No

I. If yes, in what situations have you used these substances? ____________________

____

J. Have you experienced any problems related to your substance use (i.e., relationship, job, legal, financial)? ____________________

____

____

V. Leisure/Social Activities

A. How do you spend your free time? ____________________

____

B. With whom do you spend it? ____________________

C. Would you like more activities? ____ Yes ____ No

D. If yes, what would you like to do? ____________________

____

E. Are there activities you used to do but don't do any more? ____ Yes ____ No
If yes, describe: ____________________

F. Would you like to do them again? ____ Yes ____ No

G. What gets in the way of doing those activities? ____________________

____

(continued)

VI. Goals

A. What would you like to see change? ______________________________

____

B. Name two things you would like to get out of these family meetings (for yourself):

____

____

C. What are obstacles to achieving these goals? ______________________________

____

D. What are supports to achieving these goals? ______________________________

____

____

VII. Strengths

A. What do you see as your own personal strengths? ______________________________

____

B. What do you see as the major strengths of your family? ______________________________

____

C. In what ways does ____________ help out the family? ______________________________

____

____

D. How do you think your and your family's strengths can help you achieve your personal goals and the goals of your family? ______________________________

____

____

VIII. Clinical and Other Observations

____

____

____

____

____

____

____

____

____

____

FORM C.17

Summary of Family Assessment

Client: ______________________

Date: ______________________

Instructions: Summarize and integrate the pertinent information from the functional assessment interview (with the client) and individual family member interviews on this form.

Description of family (e.g., living arrangement and family contacts):

Client's psychiatric disorder and substance abuse problems:

Impact of substance abuse on client and relatives:

Critical factors identified on functional analysis:

(continued)

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Degree of supportiveness or tension among family members:

Client and relatives' motivation to improve management of psychiatric disorder:

Description of family's strengths (as gathered from individual interviews and observations of the family):

Client's stage of treatment (from the Substance Abuse Treatment Scale—Revised):

___ Preengagement
___ Engagement
___ Early Persuasion
___ Late Persuasion
___ Early Active Treatment
___ Late Active Treatment
___ Relapse Prevention
___ Remission/Recovery

Overall family stage of treatment (taking into consideration all family members):

___ Preengagement
___ Engagement
___ Early Persuasion
___ Late Persuasion
___ Early Active Treatment
___ Late Active Treatment
___ Relapse Prevention
___ Remission/Recovery

FORM C.18

Family Treatment Plan

I. Client's Individual Goals

1.
2.
3.

II. Family Member 1's Individual Goals

1.
2.
3.

III. Family Member 2's Individual Goals

1.
2.
3.

IV. Family Member 3's Individual Goals

1.
2.
3.

V. Shared Family Goals

1.
2.
3.

VI. Factors Identified by Functional Analysis

1.
2.
3.

VII. Stage-Wise Treatment Goals

1.
2.
3.

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FORM C.19

Family Treatment Review

Client/family: ________________________________ Date: ____________

A. Implementation of Family Therapy Sessions

Were regular behavioral family therapy sessions fully implemented, partially implemented, or not implemented?

____ Fully implemented
____ Partially implemented
____ Not implemented

B. Number of Family Sessions

How many family sessions were held since the last treatment plan? ____

C. Implementation Obstacles or Problems

Describe obstacles or problems encountered in attempting to implement family sessions.

____
____
____
____

D. Goals Achieved

Indicate goals achieved or progress made toward goals for each individual family member and the family as a unit.

		Successfully achieved	Partially achieved	Not achieved
Client Goals:	1. ____________	☐	☐	☐
	2. ____________	☐	☐	☐
	3. ____________	☐	☐	☐

		Successfully achieved	Partially achieved	Not achieved
Family Member 1 Goals:	1. ____________	☐	☐	☐
	2. ____________	☐	☐	☐
	3. ____________	☐	☐	☐

(continued)

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Family Member 2 Goals:		Successfully achieved	Partially achieved	Not achieved
	1. ________	☐	☐	☐
	2. ________	☐	☐	☐
	3. ________	☐	☐	☐

Family Member 3 Goals:		Successfully achieved	Partially achieved	Not achieved
	1. ________	☐	☐	☐
	2. ________	☐	☐	☐
	3. ________	☐	☐	☐

E. Changes in Substance Abuse

Briefly describe any changes in substance abuse since the last treatment plan. Describe which interventions seem to have worked and which ones seem not to have worked.

____

____

____

____

____

____

FORM C.20

Problem-Solving or Goal-Setting Sheet

1. **Discuss the problem or goal.** Get everyone's opinion. Try to reach agreement on exactly what the problem/goal is. Write down *specifically* what the problem/goal is.

____

2. **Brainstorm at least three possible solutions.** Do not evaluate these at this time—wait till step 3.

(a) ____________________

(b) ____________________

(c) ____________________

(d) ____________________

(e) ____________________

3. **Briefly evaluate each solution.** List major advantages and disadvantages.

Advantages	Disadvantages
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________

4. **Choose the best solution(s).** Consider how easy it would be to implement the solution, and how likely it is to be effective. ____________________

5. **Plan the implementation.** When will it be implemented? ____________________

What resources are needed ,and how will they be obtained? ____________________

Who will do what to implement the solution? ____________________

List what might go wrong in the implementation and how to overcome it. ____________________

____

Practice any difficult parts of the plan.

Who will check that all the steps of the plan have been implemented? ____________________

6. **Review implementation at next family meeting.** (Date: ________) Revise as needed.

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