

Providing Chemical Dependency Treatment to the Deaf or Hard of Hearing Mentally Ill Client

At the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals (hereafter referred to as "The Program"), over 75% of admitted clients have issues that relate to chemical dependency and additional psychiatric disorders. The Program opened in March of 1989 at Fairview Riverside Medical Center in Minneapolis, Minnesota. The Program serves individuals sixteen years of age and older and is one of the only hospital-based inpatient programs in the United States providing chemical dependency treatment for this population. The Program is specifically designed and staffed to meet the needs of Deaf and Hard of Hearing individuals. The staff, fluent in American Sign Language and respectful of Deaf Culture, include: counselors, nurses, interpreters, drug unit assistants, a communication specialist, a chaplain, a certified teacher of Deaf and Hard of Hearing students, an occupational therapist, a secretary, and a program director.

For the purpose of this paper, *chemical dependency* will be defined as a primary chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations which are progressive and potentially fatal. The state of chemical dependency is characterized by impaired control, increased tolerance, distorted thinking (most notably denial), and continued use of mood-altering chemicals despite negative consequences. Each of these symptoms may be continuous or periodic. Individuals who are deaf or hard of hearing, chemically dependent, and seeking treatment often have additional mental health issues. When a person has one or multiple diagnosable psychiatric disorders present in addition to the chemical dependency, it is referred to as a "dual diagnosis." Dual diagnosis is defined as the concurrent diagnosis of chemical dependency plus a psychiatric diagnosis.

According to a 1992 article by Williams and Wilkins published in *The Journal of*

Nervous and Mental Disease, over one-quarter of the individuals with psychiatric disorders also had substance use disorders, and over-half of the substance abusers had a diagnosable psychiatric disorder. These rates of dual diagnosis were further elevated for patients seen within mental health or substance abuse treatment settings. Thus, clinicians within these settings must be prepared to accurately diagnose the dual conditions of substance abuse and psychiatric disorders in order to initiate effective treatment or evaluate treatment outcomes.

Dually diagnosed clients are often dealt with inadequately in both the mental health and addiction settings. They tend to be treated for their multiple problems sequentially and are likely to be seen in numerous programs. Managing this population is further complicated because of the lack of appropriate programs and service providers that can address the mental health, chemical dependency, and deafness issues. The question continuously being raised for counseling consideration--and often financial reasons--is which condition (substance abuse or mental illness) is primary. Difficulties in establishing the role of the secondary psychiatric or substance use disorder in the treatment setting may lead to inaccurate comorbid diagnoses. The psychiatric diagnosis of chemically-dependent individuals may also confound (a) the ability and motivation of the chemically-dependent person to recall this information accurately; (b) the wide variety of mood states induced by drug use; or (c) the onset of mood states relative to the drug use. Moods that are induced by chemical dependency may include anxiety, depression, and psychosis and can be difficult to distinguish from symptoms associated with other mental disorders. Likewise, chemical dependency may mask symptoms of the primary psychiatric disorder. A client may use alcohol or other drugs to reduce general anxiety or to relieve dysphoria associated with cocaine withdrawal. Additionally, psychologically-related disorientation from a current psychotic disorder may impair an individual's ability to accurately report psychoactive substance use patterns. Some experts feel that psychiatric issues should be treated first, while others feel that chemical dependency is the central problem and should be treated first. Untreated chemical dependency may contribute to the exacerbation of a psychiatric

disorder, while an untreated psychiatric disorder may impact on the relapse into active addiction.

Although the focus of The Program is chemical dependency, a flexible treatment model is necessary for individuals who present with dual diagnosis issues. At any given time, contingent upon the manifestation of their mental illness, the focus may need to divert from a strict chemical dependency model to an approach designed to meet an individual's psychiatric needs. Thus, a client whose presentation indicates mental illness as the primary condition at one time may later be in crisis with behaviors related to chemical dependency. A drug addict in an open treatment setting may begin to experience intense feelings related to a traumatic event and require a temporary transfer to a secure mental health setting. Professionals must be prepared for this oscillation of presenting problems with dual-disordered individuals.

Professionals also face a dilemma with regard to the use of medication for dual diagnosis clients in a chemical dependency setting. On the one hand, treatment for chemical dependency focuses on abstinence from mood-altering chemicals and development of alternative methods of coping with life situations. On the other hand, some mentally ill clients function better under medication or even require medication to cope with their psychiatric illness. These individuals may be inappropriately seeking medication rather than learning to utilize alternative coping methods. The multi-disciplinary team needs to be cautious when determining if medication is clinically appropriate, and actively involved in the case management of these individuals.

In clinical settings, the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)* criteria is used to classify the type of psychiatric disorder that exists within a client. The classification system uses a multi-axial system that can be used to classify a person's diagnosis. The information is recorded on five axes in the following manner: Axes I & II - Mental Disorders; Axis III - Physical Disorders and Conditions; and Axes IV & V - Severity of Psychosocial Stressors and Global Assessment of Functioning. The majority of clients served within The Program have an Axis I diagnosis of chemical dependency and an Axis III diagnosis

of deafness. Axis I includes affective diagnoses while Axis II relates to personality disorders or characteristics. Individuals served at The Program present with a variety of psychiatric disorders, the most common of which are depicted in Appendix A.

Efforts to point to an underlying psychopathology as the precipitant or cause of drug dependence have proven simplistic and misleading. Likewise, the wide range of psychopathology exhibited by substance-abusing clients cannot be explained as merely a consequence of the abuse or dependence. The probability is that both Axis I and Axis II disorders may be risk factors for substance abuse and may modify the features of the addiction. They may be exaggerated by chronic abuse or may coexist without any consequential relationship. Personality is profoundly affected by dependence, and the risk of dependence is greater in the presence of a disturbed personality.

This population represents a difficult challenge to treatment professionals on both sides of the dual diagnosis track. The mental health professional is often exasperated by the patient's alcohol or other drug abuse and the chemical dependency treatment staff are equally frustrated by the manifestation of mental illness into the already difficult process of recovery from alcohol and/or other drug dependency. Experts agree that the ideal situation is to treat both the mental health issues and chemical dependency concurrently. The quandary is that we have a difficult time in the field of deafness finding qualified professionals in mental health settings or chemical dependency settings--and when we seek expertise in both areas, the task is even more complex. Professionals need to work together in a coordinated approach to best meet the needs of each client.

Throughout the remainder of this paper, the focus will be on some of the more frequently seen psychiatric disorders. Each disorder will be defined and may be followed by case studies which will review diagnostic criteria, counseling strategies, assignments given while in chemical dependency treatment, and examples of client work. The psychiatric disorders which will be

covered include antisocial personality disorder, depression, borderline personality disorder, post-traumatic stress syndrome, and developmental disorder.

Personality Disorders

The coexistence of substance abuse and a personality disorder, particularly borderline and antisocial personality disorder, is relatively common (13% to 61%, depending on the environment and the study) and therefore merits special attention. (Walker,223-232) A recent review of the literature on the prevalence of Axis II disorders in alcohol or other drug-abusing populations showed a wide range (from 14% to 55%) depending on the setting, gender, and type of drug used. These statistics are similar to those found within the deaf chemically-dependent population when using the 250 clients that have been treated at The Program. This category also includes passive-aggressive and narcissistic personality disorders. Characteristics of passive-aggressive would include a pattern of passive resistance to demands for adequate social and occupational performance beginning by early adulthood and presenting in a variety of contexts. Narcissistic personality disorder includes a pattern of grandiosity in both fantasy and behaviors and a lack of empathy that begins by early adulthood and also presents in a variety of contexts. This paper will focus primarily on antisocial and borderline personality disorders. (For more information on passive-aggressive and narcissistic personality disorders, see Appendix A.) These disorders present a challenge to service providers because of the tendency for individuals to act out. Acting-out behaviors are manifestations of the personality disorder and may appear in the form of threats or intimidation or as flattery and subtle coercion. Many acting-out behaviors, including those mentioned above, reflect socially inappropriate ways of relating to others. The use of mood-altering chemicals among these individuals may further exacerbate the acting-out behaviors. Personality-disordered and drug-dependent persons seem to be attracted to quick fixes that elicit feelings of well-being to their intensely dissatisfying lives. The presence of both disorders produces a magnified compulsion toward seeking the "high" provided by alcohol and other drugs. These individuals find the high and/or the drug use powerfully compelling because the achieved mental state satisfies the patient's craving for a desired feeling or mood. In

addition, the high includes a brief generalized feeling of well-being or "all rightness," mastery, and power. These clients have a history of persistent and pervasive anger and resentment. When they experience a loss, instead of being aware of sadness, they express anger; when frightened they do not show fear but hostility. Anger tends to be used for all the feelings that would reflect vulnerability.

Antisocial

Antisocial personality disorder is characterized by behavior in which the rights of others are violated to meet one's own needs. The patterns of behavior discussed often begin before age fifteen and persist into adult life. These people have difficulty maintaining a lasting, close, warm relationships with family or friends. They usually have low frustration tolerance, seek immediate pleasure, are narcissistic, and become restless or bored easily. People in this group may seem charming and appear to be mature and sincere, but they are more prone to be pathological liars and are highly skilled at deceiving other people. The person with antisocial personality disorder usually shows a lack of foresight and judgement and tends to use reckless behavior. Individuals with this disorder may fail to become a responsible functioning adult and spend time incarcerated.

These clients will need structure and firm limits. They will challenge staff and try to find exceptions to program rules and regulations. Because of this, close staff collaboration is essential with expectations clearly defined. Contracts should be used to manage manipulative and immature behavior with concrete consequences if expectations are not met.(See Appendix B for contract philosophy and examples.) Sometimes therapeutic discharges are necessary to convey the message that disruptive or manipulative behavior and violation of the rights of others will not be tolerated. This also can help to maintain the integrity of The Program. These discharges should only occur after giving the client sufficient education, along with the

opportunity and support to change problematic behaviors. These individuals will often minimize or deny any role in these behaviors, so they need to be held accountable. It is important to use collateral data from the family, legal personnel, or other professionals involved, because information from the individual is often minimized or incomplete. Clients may also try to divert attention to external matters to avoid having to focus on themselves. A reality-oriented approach emphasizing the nature of current behaviors and feelings is often successful.

In summary, the counselor should provide structure during treatment through continuous feedback on behavior; confront problematic behavior; hold clients accountable for their behavior; collaborate closely with staff and external resources; use the client's self-report to point out behaviors which need to be modified and to reinforce more responsible actions; and be aware that these individuals may attempt to dictate their own treatment without appropriate collaboration from staff.

The following is a case study outlining treatment approaches used at The Program with an individual diagnosed with an antisocial personality disorder.

Case Study: Antisocial Personality Disorder

Tim

Background Information

Tim is a 35-year-old deaf male from a deaf family. He was referred to treatment from the criminal justice system and was offered treatment as an alternative to incarceration in prison. The most recent treatment is his fourth treatment and the second in this facility. He communicates fluently in American Sign Language. He attended and graduated from a residential School for the Deaf. He reports being abused as a child by his father and also at the residential school. He was employed briefly as a carpenter. His current drug of choice is cocaine which he prefers to use intravenously. He has also used intravenous heroin, alcohol, pot, PCP, speed, crank, sedatives, and stimulants. His initial treatment placement at this program ended with discharge due to repeated rule violations and intimidation of peers on the unit. At the time of his second admission to treatment approximately six months later, he was divorced from his wife and separated from his two children. He has been out of work for an extended period of time. He has also spent periods of time, up to three months, living on the streets. Tim displays a flat affect, is well defended, and throughout treatment intentionally omitted information about his consequences.

Assessment

In addition to the chemical dependency, Tim presents as having an antisocial personality disorder. The following features indicate that diagnosis:

- * use of alcohol and other drugs early in adolescence
- * impaired capacity to sustain lasting, close, warm, and responsible relationships with family and friends
- * complaints of tension, inability to tolerate boredom, and depression
- * conviction that others are hostile toward him
- * failure to honor financial obligations
- * failure to conform to social norms with respect to lawful behavior
- * has no regard for truth indicated by repeating lying, or conning for personal gain or pleasure
- * is reckless about personal safety of self and children
- * suicide attempts
- * lack of remorse

Life Area Consequences

Physical

*40 lb. weight loss
hypertension
three overdoses
knee injury while high
poor quality of sleep
suicide attempts
poor eating patterns*

Legal

*theft charges
forgery charges
facing 3-year prison term
several other arrests over 13 yrs.
multiple jail placements
speeding tickets
possession and dealing charges*

Social

*lost friends due to use
lived on the streets
repeated law violations
most friends are users
involved with biker gang*

Family

*divorce
neglected children
abusive to family members
lost custody of children
used needles in front of children*

Financial

*owes about \$10,000
used SSDI checks for drugs
borrowed and stole money
sold/pawned personal items*

Work/School

*called in sick to work
fired from job
work injury while high
school suspensions*

Counseling Strategies

Tim came to us with a long history of legal involvement prior to his admission. Staff collaborated with the criminal justice system to establish a clear set of expectations for Tim's treatment and aftercare to include specific consequences should he not comply with the treatment process. Upon Tim's arrival, staff entered into a treatment contract with him which clearly outlined expectations as well as the implications of non-compliance. For the contracting process it was important to encourage Tim's active involvement in establishing limits and consequences. This seemed to offer Tim some sense of ownership in the process and staff could refer back to his participation as a means of holding him more accountable.

It was essential for staff to communicate and be consistent from one shift to the next to minimize Tim's opportunity to play staff against staff and manipulate unit rules. Demonstration of staff consistency seemed to offer Tim clear boundaries and limits. When Tim deviated from established limits, staff responded in a non-reactive way matching the level of intervention with the severity and frequency of the acting out behavior. When Tim arrived late for group, staff would remind him that he was accountable to be on time. When he became involved in the violation of a peer's rights, staff initiated a Behavior Contract. And when Tim did not respond to the Behavior Contract it was replaced with a Probation Contract. Tim was able to comply with the Probation Contract and actually seemed to function more appropriately when serious consequences were impending. Through the course of Tim's treatment, several such contracts were used.

Tim seemed to respond to a straight forward reality based therapeutic approach which focused on his self-defeating behaviors. He was provided with support and education regarding more effective ways of getting his needs met. For this process, we asked him to identify things that were important to him. He seemed to want an ongoing relationship with his children. Tim had marital and legal difficulties as a consequence of his use. Because of this, he had been unable to have contact with his two children for a significant period of time. We were able to use his desire to regain family relationships as a goal to motivate and encourage him to change his behavior. We generalized this philosophy to emphasize other "pay offs" for a chemical free lifestyle.

Throughout the treatment process, an emphasis was placed on educating Tim regarding his responsibility for past, present, and future behaviors and potential consequences. The combination of Tim's previous therapeutic discharge from The Program and the clinical approach described seemed to offer Tim the structure necessary to successfully complete primary treatment.

Step Work Approaches

In his second placement, Tim was able to complete Steps One through Five of the Twelve Step program of AA. The following assignments were given to Tim:

- * *Instead of the usual Drug Chart, Tim was asked to write an autobiography covering the time period since he had left treatment until his return. The autobiography was to include the specific details of his relapse, all consequences, and associated feelings.*
- * *His Step One assignment focused on the period of time between his therapeutic discharge and readmission. Tim was asked to identify fifteen examples of ways his life had been powerless, and fifteen examples of how it was unmanageable. He was asked to describe how his most recent use had negatively impacted his life as well as the lives of those around him.*
- * *Tim's Step Two assignment was given in two parts. In part one, he was asked to identify places to avoid, safe places, people who can help him stay sober, times people have helped him, and how he had experienced both. He was also asked to identify feelings he hides, how he hides those feelings, and ways he can build healthy relationships.*
- * *Step Three involved interviewing other people about their Higher Power and explaining how he communicates with his Higher Power and vice versa.*
- * *Steps Four and Five were done with The Program chaplain. (In these steps, the patient does an inventory of his past life looking at both positive and negative aspects. Once this is complete, the patient makes an appointment with the chaplain to talk about the inventory. This constitutes Steps Four and Five.)*

It was felt that Tim had a successful treatment experience. He appeared to understand the concepts involved and seemed to be attempting to make changes in his behavior based on those concepts. Tim's aftercare recommendations include attendance at a minimum of three AA/NA meetings per week, securing a sponsor, pursuing an opening in a sober house, weekly counseling sessions, and adherence to any and all conditions of his probation.

Borderline Personality Disorder

Borderline personality disorder is more common in women and often accompanied by other personality disorders. They are characterized by instability in a variety of life areas, including interpersonal behavior, impulse control, mood, self-image, and dependency on others. These individuals seem to be in a constant state of crisis begging or demanding immediate attention. Initially they appear to be needy and attention-seeking, but they will act out if their needs aren't met. Their relationships are often intense and chaotic, and clients may present as depressed, suicidal, or in a relationship crisis. Persons with this disorder tend to be in and out of hospitals on a regular basis and typically will attempt suicidal or dramatic self-harm behaviors (cutting themselves or other self-damaging or acting-out behaviors). They may also show negative emotions such as bitterness and sarcasm, or they may appear to be demanding. These individuals have poor boundaries and self-identity and may have brief psychotic episodes.

These individuals tend to use flattery to control or manipulate the counselor, and their dependency issues may result in acting-out behaviors if perceived needs aren't met. Borderline individuals may sign themselves out against medical advice or try to get medication. Counselors should set limits and expect that the client will use numerous urgent physical or psychosocial problems to try to deflect from dealing with his/her substance abuse issues. Counseling should focus on a "here and now" approach minimizing the opportunity for the client to get involved with fabricating or exaggerating past experiences, thereby avoiding the focus of current consequences related to their alcohol and/or other drug use. Limit-setting is another successful approach to use with these individuals. Staff should collaborate due to the client's attempts to "split" or "polarize" staff. Clients will go from one staff member to another to get their needs met. Neediness shows up in their constant requests to staff for help with "unsolvable" problems. The assignment of a primary counselor for these clients, and redirection to that person, is essential. This may assist in being consistent and avoiding the tendency to split or polarize staff.

For example, if the client is preoccupied with health concerns, give them a contract (see Appendix B) assigning a specific time of day when a designated staff member is available to discuss these concerns. Give the client positive reinforcement for following the contract, and modify it as appropriate. The client may view specific counselors as sensitive and understanding one day and cold and uncaring the next day. A gentle, non-threatening intervention or counseling style using ongoing reality checks should be used. In group, clients may attempt to monopolize, so you may want to consider using more one-to-one settings. An additional issue dealt with by this population is the anxiety related to leaving treatment. This separation anxiety may lead to the decompensation of the individual and the associated acting-out behaviors. Additional education and support may be necessary at this time. Clients may elicit negative responses from their peers or may contribute to splitting in the therapeutic group setting. If these situations occur, the clinician needs to focus on process rather than content. Some clients may decompensate due to the stresses and may need to be transferred to a secure psychiatric unit if their condition cannot be stabilized.

In summary, help borderline clients understand and reevaluate their anger by teaching management techniques and reducing the negative impact their anger has on others. Often counselors will need to focus on crisis management, helping clients tolerate emotions and conflict without the use of mood-altering chemicals or self-destructive behavior. Due to these clients' poor impulse control, they are at risk for prematurely terminating treatment; the counselor should not focus on the crisis, but on the client's thoughts and feelings about leaving treatment. Limit contact from family and friends if needed because this may mean more crisis with outside contacts. Remember to focus on chemical dependency, which should be the primary emphasis of treatment.

Affective Disorders

The American Psychiatric Association defines the essential feature of this group of disorders as a disturbance of mood, accompanied by a full or partial manic or depressive syndrome that is not due to other physical or mental disorders. Included under affective disorders are depression, bipolar, and dysthymia disorders. Features of depression may include a depressed mood, and the loss of interest or pleasure in all or almost all activities. Symptoms must have existed for at least two weeks and are subclassified as a single major depressive episode or recurrent. Bipolar disorders include one or more manic episode which is either an elevated or irritable mood with disturbances in functioning and other thought or behavior changes. The manic occurrence is usually accompanied by one or more major depressive episodes. Dysthymia involves a chronic disturbance of mood involving depression or irritation which has lasted for the majority of a two year period of time. These individuals can also have a poor appetite or overeat; insomnia or hypersomnia; low energy or fatigue; low self-esteem; poor concentration or difficulty making decisions and feelings of hopelessness.

The most common psychiatric problems treated are mood disorders--primarily depression--and anxiety disorders. Depression is present in more than 50% of heroin addicts, or about five times the prevalence seen in the population as a whole (Batki,1990). Dr. Marie Schuckit, in her 1985 book, *Drug and Alcohol Abuse: Clinical Guide to Diagnosis and Treatment*, talks about the confusion between alcoholism and affective disorders. She discusses how alcohol can cause depressive symptoms and how temporary depression can follow prolonged drinking. She correctly observes that drinking can escalate during primary affective episodes in clients. Clients may also be depressed due to guilt over drinking or using behaviors and the loss of things of importance in their lives. After these alcohol/drug-dependent individuals sober up and evaluate their lives, they become depressed. It seems that a small proportion of clients have independent alcoholism and affective disorders. When clients drink to lessen their feelings of depression, it actually worsens the depressive symptoms. It is

important to remember that clinical depression is very prevalent in this population. This paper we will focus on major depressive disorder and will include a case study outlining treatment approaches used with an individual who had this diagnosis. (For more information on bipolar or dysthymia disorders, see Appendix A.)

Major Depressive Disorder

The main characteristic of this disorder is a depressed mood or loss of interest in usual activities. It is accompanied by appetite disturbance, change in weight, sleep disturbance, decreased energy, worthlessness, suicidal ideation, and difficulty concentrating.

When attempting to complete an assessment of a potential client, counselors should gather the family history and try to determine if depression occurred during abstinence or before the alcohol and/or other drug problem. Stabilize the client and their mood and complete a suicide assessment upon admission. If actively suicidal, these clients may need short-term care in a locked psychiatric unit prior to receiving chemical dependency treatment. The counselor working with this kind of client needs to instill a sense of hopefulness. Counselors should be supportive and talk about improvements in life, once sober. Encourage clients to express their feelings related to sadness, guilt, powerlessness, and anger. Treatment staff may want to assign specific times of the day for clients to have permission to depart from their chemical dependency treatment focus in order to "feel bad" or vent their intense feelings. These sessions should be done in one-to-one time with staff. Assist the client in connecting feelings between unpleasant emotions, thoughts, and attitudes that occurred prior to the one-to-one meetings with staff. Try to reduce a client's guilt and shame through the use of affirmations. An example of this would be: "I feel bad about what I have done, but I am working hard to make things better." At that point the counselor would assist the client in developing specific examples to solidify the affirmations. Work with the client on developing anger management and positive coping skills.

Education is a vital component of the clinically-depressed individual's treatment. An understanding of the disease, the impact on day to day mood states, as well as the role of therapeutic medication for the client, is critical to their ongoing recovery. Counselors may need to remind clients that if anti-depressant medication is being used, there will still be times where they may feel sad, but staff will be there to provide support.

Daley, Moss, and Campbell(1985) found that a cognitive behavioral therapy approach can be effective with these clients when attempting to assist them in modifying maladaptive thoughts, assumptions, or beliefs and teaching specific problem-solving skills. Often clients think that in order to be happy they have to be accepted by all people at all times and that if somebody disagrees with them, they are not liked by that person. Cognitive interventions are aimed at helping them identify and change distorted thoughts and assumptions.

In summary, counselors working with clinically-depressed clients should remember to find out about suicidal ideation and gather as much family history as possible. Counselors should initially stabilize the client and her or his mood, and there should be an attempt to instill hope in the client. Remember to be supportive and keep a positive focus. Encourage the client's expression of feelings in general and those related to grief issues, and teach anger identification and management as well as positive coping skills. A cognitive behavioral approach has worked well with this type of client and should be attempted. Medication should be considered with these clients as their depression may be organically or situationally based. Often this type of intervention can be very successful.

Case Study: Depression

Jerry

Background Information

Jerry is a 35-year-old Caucasian male born deaf with hearing parents and a deaf sister. He was self-referred to treatment. He had one previous treatment experience with hearing people which he reports as unsuccessful. Jerry attended an oral school from age two to age thirteen and then attended a residential school for the deaf but quit at age sixteen. His parents were divorced when he was two years old and his mother has remarried five times. He was raised by his father who is an alcoholic. He was physically abused and cruelly treated by his father and suffered sexual abuse from an undisclosed perpetrator. The family has experienced ongoing turmoil for a number of years and Jerry currently has contact only with his deaf sister. He reports his first sexual experience and his first use of drugs in the form of alcohol at age twelve. His chemical use also includes cocaine (IV and sniffing), crack, marijuana, codeine, PCP, mushrooms, acid, speed, IV amphetamines, Valium, Xanax, Ativan, quaaludes, and pain killers. His drug of choice is alcohol. He has been prostituting for drugs since age sixteen. Jerry has been homeless and transient for the past two years moving from the streets to his friends' or sister's homes.

Assessment

In addition to chemical dependency, Jerry presents as being clinically depressed. The following features indicate that diagnosis:

- * depressed mood*
- * significant weight loss*
- * flashbacks*
- * diminished interest in almost all activities*
- * insomnia and disrupted sleep*
- * flat affect*
- * fatigue, loss of energy*
- * suicidal thoughts*

Life Area Consequences

Financial

*unpaid bills-collection agency
car repossessed
utilities cut off
borrowed money to use
spending \$600+/week on drugs*

Work/School

*quit school
did not graduate
missing work due to use
fired from 3 jobs due to use*

Legal

*Federal investigation for dealing
theft
prostitution
minor consumption
multiple DWIs*

Social

*loss of friends
socialization focus on use
isolation
"friends" take advantage of him*

Physical

*nasal damage from cocaine
liver damage
memory loss
blackouts
hallucinations
dental problems
tolerance
withdrawal symptoms*

Family

*broken relationships
abuse related to drug use*

Counseling Strategies

Upon arrival, Jerry was assessed for current suicidal ideation and staff began to monitor him for signs of depression following a thorough nursing admission. It became evident early in his treatment that Jerry presented with a diagnosis of Major Depression. After consulting with the program medical director, a decision was made for a trial period of antidepressant medication. Counseling and education was done with Jerry to help him understand the therapeutic implications of a trial on medication. Emphasis was placed on pharmacological effects of the medication to include time necessary for the medication to reach a therapeutic blood level. He was offered further education related to the difference between antidepressant medication and the chemicals he had been abusing. Jerry responded well to this information and appeared to clearly understand the purpose for a trial on medication.

Staff educated Jerry about the disease of depression and how it could impact his day to day living including his chemical dependency treatment. He was encouraged to seek out one to one staff time to discuss issues related to his presenting depression but it was emphasized that chemical dependency would be the primary focus of his treatment.

Early on in the treatment process, Jerry was provided with clinical tasks designed to assist in the process of gaining insight into his chemical dependency and allowing him to experience small successes. Assignments were short and clear to allow for his attention span and difficulty staying focussed on tasks. As Jerry began to experience multiple successes he seemed to gain a degree of confidence in himself and his ability to do chemical dependency treatment related work. Staff noted him responding and the tasks assigned were focused more on his ability to complete complex tasks. This process continued developing throughout his treatment stay. Case management was vital, concurrently matching Jerry's therapeutic tasks while monitoring his depressive symptoms seemed to effectively meet his special needs.

Jerry's affect began to improve and he became more responsive to all aspects of his chemical dependency treatment experience. This accumulative change could be attributed to the combination of medication and appropriate treatment approaches along with counseling and education.

Many depressed individuals present as survivors of abuse and Jerry was no exception. Jerry was able to successfully enter into a therapeutic relationship with several staff members. Jerry had the opportunity to process some abuse related issues as they presented during his work on Step Four.

Although the primary focus was kept on chemical dependency, he was given the opportunity to process appropriate abuse related issues with the treatment staff of his choice. Ongoing recovery particularly for a dually diagnosed client may depend on their opportunity to process these issues in what they perceive as a safe place.

There were times when Jerry became overwhelmed with emotions or feelings of depression. At these times he seemed willing to seek out appropriate peer and staff support.

Step Work Approaches

During his treatment stay, Jerry was able to complete Steps One through Five of the Twelve Steps. The assignments he completed include the following:

- * Standard Drug Chart including naming all drugs used, a description of his most recent use and identifying consequences in all life areas.*
- * Step One assignment included pictures of unmanageable, pictures of powerlessness, pictures of how each of these feels, and problems he caused himself and others.*
- * Step Two work included identifying reasons he needs people to help him stay sober, people with whom he could build a trusting relationship, things he could do when tempted to use, safe places, ways he can take care of himself, and a picture of himself in one year if he stays sober.*
- * He was given an assignment to identify fifteen things he likes about himself.*
- * A Step Two additional assignment asked him to identify twenty skills he has and how they can help him stay sober.*
- * In Step Three he was asked to identify his Higher Power, explain how his Higher Power can help him stay sober, ways he gets answers from his Higher power, ways he is willing to change to stay sober, risks he is willing to take to stay sober, and twenty things his Higher Power wants for him.*
- * He also completed Step Four (moral inventory) and Step Five (sharing of Step Four work). Because Jerry had a history of traumatic stressors in the form of abuse, there was discussion about whether assigning Step Four would further traumatize him. A decision was made to go ahead with a modified inventory asking him to confine it to his dependency.*

After completing treatment, Jerry was referred to a halfway house program where he resides and receives aftercare services, including counseling. It was also recommended that he attend a minimum of three AA/NA meetings per week.

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is a psychological reaction to overwhelming traumatic events or stress that is far beyond normal human experiences. The disorder has two common features that can occur separately or concurrently. The first is a general emotional numbing and loss of normal affective responsiveness to life situations and to interpersonal relations. The second is that victims reexperience the event in a number of ways, in the form of painful and fearful recollections, intrusive thoughts, recurrent dreams and nightmares, chronic anxiety states, and dissociative episodes(Blair,1991). Many believe that post-traumatic symptoms are normal responses to horrible events that are prolonged, and they cause serious dysfunction. These observations are derived from a wide variety of trauma victims--survivors of disasters, personal violence, sexual abuse, and combat. In 1980, the American Psychiatric Association officially recognized the disorder and included the new diagnostic category "PTSD" in the *DSM-III* which listed five diagnostic criteria (APA,1980). The *DSM-III-R* (1987) clarified and redefined the *DSM-III* criteria and included the following: the exposure to a traumatic event that is outside the range of normal human experience; the reexperiencing of the traumatic event in various ways; the persistent avoidance of stimuli associated with the trauma; the persistent symptoms of increased arousal; and the duration of symptoms of at least one month and that occur at least six months after the traumatic event. The most serious symptom is depression and a drastic increase in risk of suicide(Hickman,1987). Many sufferers have difficulty holding a job and have a history of multiple employments over the years. Many complain of attention and concentration deficits, impaired memory, hyperalertness, chronic anxiety states, and survival guilt.

Because chemical dependency is a common symptom in PTSD, it often becomes the focus of treatment, leaving other symptoms and issues overlooked. Agosta and McHugh(1987) studied rape victims, battered women, and incest victims and found that self-medication for

anxiety using alcohol or other drugs is very common. These clients have a poor self-image and exhibit a lack of trust. Those clients who may belong to gangs and either observed or been involved with numerous violent acts on the streets or at home may have difficulty with authority figures and may have a chip-on-the-shoulder attitude. These conditions make for emotional distancing, an aggressive interpersonal style, and a tendency to antagonize and alienate others.

Counselors will need to establish trusting relationships with these clients in order for them to have a successful treatment experience. It is important to remember that the primary focus of treatment is for chemical dependency, but recollections of traumatic events may surface and these will need to be addressed. Counselors may want to establish specific one-to-one counseling times where clients can focus on the traumatic events in a safe, private environment. Focusing on these issues in a group setting may be discouraged in lieu of the formal one-to-one settings. Clients tend to be overwhelmed easily, and because of the lack of trust will establish relationships easier in one-to-one settings. Staff may want to assign a specific counselor to be the primary therapist involved in meeting with these clients throughout their stay in treatment. Upon discharge, referrals for additional counseling and other therapeutic support should be made. Often, long-term counseling is recommended for this clientele.

Developmental Disorder

The essential feature of this group is that the predominant disturbance is in the acquisition of cognitive, language, motor, or social skills. The disturbance may involve a general delay or a failure to progress in a specific area of skill acquisition or in multiple areas in which there are qualitative distortions of normal development. These clients often have difficulty in areas related to social skills, communication, and daily living skills. In addition,

personal independence and social responsibility is often an area that may be lacking. Individuals may be passive, overly dependent, have low self-esteem, low frustration tolerance, aggressiveness, poor impulse control, or self-injurious behavior. In some cases these behaviors may be learned and conditioned by environmental factors; in other cases they may be linked to an underlying physical disorder. Clients often have suffered social deprivation and are communicatively isolated resulting in maladaptive behaviors, cognitive abilities, and social skills. Due to multiple disabilities, poor or nonexistent verbal skills, impaired performance on intelligence tests, and language and learning deficits, it is often difficult to determine appropriate functioning levels and approaches to use with clients. Individuals with developmental disorders may have normal intelligence, but because of social deprivation they have not reached their potential. Many become classified as borderline retarded, developmentally delayed, low functioning, or traditionally underserved. The increased vulnerability of this population is related to the lack of opportunities to learn adaptive ways of dealing with daily coping skills. Symptomatic behavior such as aggression, destructive behavior, and emotional disturbance actually may be the consequence of poor coping and self-regulatory abilities.

When working with developmentally-delayed clients, it is important to be black and white regarding expectations. Consequences should be very clear and art therapy and the use of gesturing or other nonverbal activities or role playing should be utilized. Flexibility is essential when working with this population. Staff should be consistent and present a structured, firm, but nurturing approach with clients. Various behavioral approaches may need to be utilized, such as using a star system to reward appropriate attendance and participating behavior, based on an incremental system determined by staff. Time-out systems are effective strategies to utilize when these clients exhibit difficulty with impulse or aggressive control issues. When introducing new concepts, staff should utilize a task-oriented approach. First, model the task for

the client and give him/her an opportunity to imitate the modeled behavior. These modeled behavioral tasks should be saved by the clients and stored in a notebook so they can be used in place of written directions for future related assignments. An example of this would be discussing with a client the following: The staff would say to the client in American Sign Language, "Drinking bad happens." Staff would give examples such as "Mother yells me." Staff would draw a picture of the client's mother yelling at him/her. Staff would say to the client "Other bad happens, what?" At this point, staff would wait for a client response which may be examples such as fights, jail, etc. Staff would then assist the client in drawing the examples. The client is given an assignment to draw five examples of when bad things happened related to their chemical use. The counselor's directions should be put on the paper utilizing drawings and one-or-two word sentences. The mode of communication the staff person uses with the client may include pictures, gesturing, role playing, or other appropriate sign communication modes. The client's examples and the counselor's directions would be saved in a notebook so the client can refer to this as a model of the assignment. When introducing new concepts and tasks, present one new idea at a time and always remember to use concrete examples. In this process, staff should create small successful experiences for clients, allowing them to develop self-confidence and progress to more complex tasks while gaining insight during the process.

In summary, counselors working with this population need to be creative and flexible with the therapeutic approaches they choose. Non-verbal activities, role playing, and art therapy are recommended techniques. Staff should remember to be consistent, firm, but nurturing when providing intervention. Behavior approaches, which may include a star system, time-outs, and contracts, may be used. Concrete tasks should be given which are black and white, in small increments with modeling and repetition provided by the counselor. These clients often will require long-term care and will always be especially vulnerable in unstructured settings.

Deaf or hard of hearing individuals who are chemically dependent and mentally ill pose a significant challenge for mental health/substance abuse professionals. Determination of the primary problem and the medication dilemma are complicating factors as are the communication issues associated with hearing loss. While dual treatment is an overwhelming task, the sequential treatment of chemical dependency and mental illness seem to be ineffective in meeting the needs of these clients. In a chemical dependency treatment setting, a very large number of deaf and hard of hearing clients present with such dual disorders. Professionals are challenged to be familiar with a range of mental illness disorders that may co-occur with alcohol and other drug dependency. Specific strategies and approaches should be prescribed with these individuals to address their dependency and psychiatric issues. Counselors and staff will need to be proficient with the specifics of culture and language, and these professionals must have competence in chemical dependency and mental health services. The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals, by using a balanced, flexible, multi-disciplinary approach, has shown that clients with chemical dependency and additional psychiatric disorders can be treated in a successful, nurturing manner.

Appendix A

Definitions: Psychological Disorders

I. Personality Disorders

Enduring patterns of perceiving, relating to, and thinking about the environment and oneself, exhibited in a wide range of important social and personal contexts, that are inflexible and maladaptive causing either significant functional impairment or subjective distress.

A. Antisocial Personality Disorder

The essential feature of this disorder is a pattern of irresponsible and antisocial behavior beginning in childhood or early adolescence and continuing into adulthood.

B. Borderline Personality Disorder

The essential feature of this disorder is pervasive pattern of instability of self-image, interpersonal relationships, and mood, beginning by early adulthood and present in a variety of contexts.

C. Passive-Aggressive Personality Disorder

The essential feature of this disorder is a pervasive pattern of passive resistance to demands for adequate social and occupational performance, beginning by early adulthood and present in a variety of contexts.

D. Narcissistic Personality Disorder

The essential feature of this disorder is a pervasive pattern of grandiosity (in fantasy or behavior), hypersensitivity to the evaluation of others, and lack of empathy that begins by early adulthood and is present in a variety of contexts.

II. Affective (Mood) Disorders

The essential feature of this group of disorders is a disturbance of mood, accompanied by a full or partial Manic or Depressive Syndrome that is not due to any other physical or mental disorder.

A. Depression

The essential feature is one or more Major Depressive Episodes (depressed mood or loss of interest or pleasure in all or almost all activities and associated symptoms for at least two weeks) without a history of either a Manic Episode or an unequivocal Hypomanic Episode. It is subclassified to indicate single episode or recurrent and further subclassified to indicate the current state of the disturbance.

B. Bipolar Disorders

The essential feature is one or more Manic Episodes (distinct period during which the predominant mood is either elevated, expansive or irritable and associated symptoms of disturbance in functioning and other thought or behavior changes) usually accompanied by one or more Major Depressive Episodes (see above). It is subclassified to indicate the clinical features of the current episode and further subclassified to indicate the current state of disturbance.

C. Dysthymia

The essential feature of this disorder is a chronic disturbance of mood involving depressed mood (or possibly an irritable mood in children or adolescents), for most of the day more days than not, for at least two years (one year for children and adolescents). In addition, there are some of the following symptoms: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self esteem, poor concentration or difficulty making decisions, and feelings of hopelessness.

III. Anxiety Disorders

The characteristic features of this group are symptoms of anxiety and avoidance behavior.

A. Post-Traumatic Stress Disorder

The essential feature of this disorder is the development of characteristic symptoms following a psychologically distressing event that is outside the range of usual human experience. The stressor producing this syndrome would be markedly distressing to almost anyone, and is usually experienced with intense fear, terror and helplessness.

B. Obsessive Compulsive Disorder

The essential feature of this disorder is recurrent obsessions or compulsions sufficiently severe to cause distress, be time-consuming, or significantly interfere with the person's normal routine, occupational functioning or usual social activities or relationships with others.

IV. Organic Mental Disorder

The essential feature is a psychological or behavioral abnormality associated with transient or permanent dysfunction of the brain. The organic factor responsible for an Organic Mental Disorder may be a primary disease of the brain

V. Developmental Disorders

The essential feature of this group is that the predominant disturbance is in the acquisition of cognitive, language, motor, or social skills. The disturbance may involve a general delay or a delay or failure to progress in a specific area of skill acquisition or in multiple areas in which there are qualitative distortions or normal development.

VI. Schizophrenia

The essential features of this disorder are the presence of characteristic psychotic symptoms during the active phase of the illness and functioning below the highest level previously achieved, and a duration of at least six months that may include characteristic prodromal or residual symptoms.

Psychoactive Substance Dependence

The essential feature of this disorder, which is an Axis I disorder, is a cluster of cognitive, behavioral, and physiologic symptoms that indicate that the person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences. This includes:

Alcohol Dependence
Amphetamine Dependence
Cannabis Dependence
Cocaine Dependence
Hallucinogen Dependence
Inhalant Dependence
Nicotine Dependence
Opioid Dependence
Phencyclidine Dependence
Sedative, Hypnotic or Anxiolytic Dependence
Polysubstance Dependence
Polysubstance Dependence Not Otherwise Specified

Multiaxial Evaluation System

The DSM-III-R has a multiaxial system for evaluation to assist in treatment planning and outcome expectations. This information is recorded on five axes in the following manner:

Axes I & II - Mental Disorders

Axis III - Physical Disorders and Conditions

Axes IV & V -Severity of Psychosocial Stressors and Global Assessment of Functioning

Appendix B

Behavior Contracts

Behavior Contracts are tools that may be used when behavior becomes inappropriate or in some way negatively affects the treatment process. Behavior Contracts are used to help clients identify and change behavior. Contracts may be used with any behavior that is of concern. Some examples of behavior that might be addressed in a Behavior Contract are:

- *Violation of unit rules
- *Power struggling with staff
- *Procrastinating in completion of work
- *Caretaking peers
- *Failing to focus on personal needs
- *Not focusing on treatment

Behavior Contracts are not to be viewed or used as a punishment. The Behavior Contract should specify the behaviors for which it is being given and the changes that are expected. Behavior Contracts, like other treatment techniques, are best formulated by the treatment team. Communication to all staff about the Behavior Contract and its terms is essential. Typically the Behavior Contract would be implemented by having one or more members of the treatment team meet with the client to explain the purpose and terms of the contract.

Behavior Contract

Your behavior has become a concern to the staff. The purpose of this contract is to help you change your behavior. If you have any questions about this contract, please ask a staff member.

Specific Behavior Concerns:

1. _____
2. _____
3. _____
4. _____
5. _____

Expected Changes:

1. _____
2. _____
3. _____
4. _____
5. _____

This contract will be reviewed on or before: _____

Patient signature

Staff signature

Date

Probation Contract Philosophy

The Probation Contract is a tool used to help a client recognize behaviors which seriously threaten the success or quality of his/her treatment experience. The Probation Contract is used as a follow-up to the Behavior Contract in the event that the client does not respond positively or is openly defiant to the Behavior Contract. The contract identifies specific problem behaviors and changes that are expected. The Probation Contract may also include an assignment which helps the client identify and change his/her self-defeating-behavior. Failure to adhere to the Probation Contract may result in the client being asked to leave the program.

Probation Contract

I, _____, agree to the following as a part of my probation beginning on _____
_____ and ending on _____.

Complete the attached Probation assignment.

If I choose to not follow these guidelines, I understand that I will receive a consequence. One possible consequence will be that I may be asked to leave the program.

I understand and agree to follow the terms of this probation contract.

Client Signature

Staff Signature

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