

## Substance Abuse and Common Mental Health Disorders

### Slide 1

An individual with mental illness wants to be seen for something other than his mental illness. At the same time, the health care setting often wants the individual to “accept” his diagnosis in order to receive service. This poses some challenges for you: the individual will expect you to see him or her for *whom* they are, not what they have; the healthcare professional may expect you to see what they *have* as determining who they are. In order to advocate with confidence, you need to know something about diagnoses, but more importantly, you need to know the language.

(\*Click)

Goals

Slide 2

This session is designed to provide you with the terminology and common diagnoses used by psychiatrists and mental health professionals to describe and discuss mental illness.

It is intended to further increase your personal comfort and confidence in your abilities to work effectively with residents with multiple, chronic health problems (both mental and physical) living in adult homes

It is not intended to promote labeling of individuals or to encourage ombudsmen to make their own diagnoses. Remember,

(\*Click)



Remember

Slide 3

(Click)

Classification is for disorders, not for people!

(\*Click)

## Objectives

### Slide 4

At the end of this module, you will be able to

(Click)

Define terms commonly used to describe disorders of mood, thinking, behaving

(Click)

Name the common disorders of mood, cognition, behavior (click) and,  
Describe some of the features of each disorder covered and its possible impact on function.

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## Overview

### Slice 5

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Historically, classifications systems were concerned with distinctions such as neurotic versus psychotic,

(Click)

Major versus minor or,

(Click)

Situational versus biological, which you will sometimes hear referred to as endogenous. These dichotomies (or distinctions) are no longer helpful.

Today, we know the mind/body split is an artificial one which has more to do with the state of our *knowledge* about how we function than with how we're actually put together (or fall apart!).

Today, when we talk about mental illness, we know that we are talking about brain disorders, which like any disorder, are influenced by genes AND by early development AND by the environment.

Domains

Slide 6

As you learned in Module I, mental illnesses are those disorders of *thought, feeling* and/or *behavior* which result in an inability to cope with life's ordinary demands and routines

From this vantage point, I think it is fairly clear why *I* include the dementias and substance abuse when I talk about mental health issues. Bear in mind however that this is a **CLINICAL** vantage point. Most systems of care – entitlements - resources and statutes- continue to split off the dementias and substance abuse from the “mental health” domain.

(\*Click)

## Common Terms

### Slide 7

[The animation is set up on this slide to have one word appear at a time. If not using power point, the instructor may wish to either write down one word at a time on a flip chart, or uncover one word at a time if using an overhead].

Before we begin describing the individual disorders, let's take a moment to make sure we all understand the terms I'll be using. All of these terms are included in the glossary which you were encouraged to read for today's session. Let's see how much you can remember: (\* Click first word: psychosis. Click again each time you wish to display a new word)

What is psychosis? Give participants a few seconds to respond then offer some prompts if no one responds: [prompt]: What are some examples of psychosis? Hallucinations, delusions, right? And what are they?

Ask some one to give an example of a hallucination (participants will have had the simulated experience of auditory hallucinations in an earlier module). Remind the group that hallucinations are disturbances of perception when a person sees, hears, taste, smells, feels something that isn't there. Then define a delusion: a fixed false belief in something that is not shared by others.

So we could say about psychosis that it represents: "a break with reality" or "an inability to be sure about what is real or not real"

[It is important to cover all the terms on this slide. Depending on how quickly the audience is able to define them, the instructor may wish to let this remain interactive, or after going over a few terms, may simply wish to give a brief definition of each remaining term. All of these terms are defined in the glossary. If the instructor is not confident about the meaning of these terms, she or he may wish to make notes in this section before the lecture].

(\*Click)

## Thinking – Diagnostic Categories

### Slide 8

What are the disorders or diseases that have their greatest impact on thinking?

Quite arbitrarily, this category is usually divided into two groups: thought disorders and cognitive disorders. This is a hold over from the days when we thought of dementia, but not schizophrenia, as a brain disorder. Now we know they are all disorders of the brain. Today we will only talk about schizophrenia. Dementia is covered in another part of your ombudsman training.

(\*Click)

## Schizophrenia

### Slide 9

Schizophrenia is a disorder that usually begins in the teens or twenties. Although we classify it as a thought disorder it is important to remember that it also affects a person's ability to manage their feelings and relate to other people. Schizophrenia is often thought of as the "prototypic" psychotic illness.

(Click)

You will often hear the terms "positive" and "negative" symptoms with respect to schizophrenia. This does not mean some symptoms are "good" or better to have than others. What it really means is the presence (+) of something overt, like hearing voices,

(Click)

rather than the absence (-) of something like motivation or feeling.

(Click)

Disorganization, the third category of symptoms in schizophrenia, is responsible for the difficulties in communication that we commonly see in people who have schizophrenia.

Hallucinations can affect any of the senses but the most common in schizophrenia, are auditory hallucinations or hearing voices. Delusions, or fixed false ideas, can be about any subject, but paranoid and persecutory themes are the most common. You may have observed loosening of associations in conversation with some one who had a thought disorder. It would be something like this:

**(Read at average or slow speed)**

"I thought we would get a cigarette break but I didn't cause that break-in. I was walking that way but did you want to take me to the canteen I can't go to the canteen if I had a dollar I would have taken the red bus my father's favorite color was red but my red car had no brakes."

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## Schizophrenia

### Slide 10

Schizophrenia used to be thought of as an illness with an inevitable downhill course. As you learned during module II on recovery, we no longer think this is true. Schizophrenia is a highly treatable and manageable illness. Like most chronic illnesses however, including diabetes and heart disease, there is as yet no cure.

The primary medications for schizophrenia are the anti-psychotics which you learned about in module IV. The other elements of treatment were touched on in module I. There is a complete description of each aspect of treatment in the recovery pamphlet as well as in the NAMI handout.

(\*Click)

## Schizophrenia

### Slide 11

Even with treatment, people with schizophrenia encounter challenges related to residual symptoms and the stigma that still attaches to this condition:

(Click)

Often, they have trouble paying attention. This may be because of hearing voices, feeling anxious or having disorganized thoughts.

(Click)

Others are anxious around them. (Cite your own experience or ask the ombudsmen to share theirs)

(Click)

If the person has been ill a long time, and has not had adequate treatment, it is not uncommon for their social network, including family support to have unraveled.

Many may not be receiving benefits for which they are eligible or the benefits may not have kept pace with the cost of care and the cost of living.

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## Feeling – Diagnostic Categories

### Slide 12

The next major category is the mood disorders.

Many of you are probably somewhat familiar with depression. For review, I have included a few slides on depression but we are not going to talk much about it unless you have some questions. It is covered in your handouts.

Today I want to focus on “depression plus mania” or bipolar disorder and, anxiety disorders.

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## Bipolar Disorder Depression

### Slide 13

First, bipolar disorder. This is what used to be called, manic-depressive disorder. This disorder causes significant shifts in mood, as well as in energy and function.

Depression in bipolar disorder does not look different from major or unipolar depression. We recognize it by the sad affect and the loss of interest from usual activities, the pessimism, sense of worthlessness, hopelessness and preoccupation with death and maybe suicide. The depressed person is often unkempt in appearance, cares little about eating, has difficulty sleeping, has little energy and is unable to derive pleasure from life.

(\*Click)

## Bipolar Disorder Mania

### Slide 14

(Click once – the words will appear one by one automatically)

Mania is the other part or pole of bipolar disorder. Mania is usually manifested by euphoria, expansiveness and grandiosity but can also show up as irritability. When an individual is manic she not only feels “on top of the world” in the sense of “really happy” but feels like they ought to stay there do great things. For the person who has bipolar disorder the distinction is lost between “I feel great” (which all of us have felt) and “I am great.” The “feeling good” feeling is momentarily “so good”, that the person becomes out of touch with the situation or her own real potential.

In the manic state, a person takes on a lot of different projects. Can't finish them. Starts spending money excessively. May engage in multiple sexual encounters. There is a loss of judgment and a kind of recklessness.

Typically the person also stops sleeping. But unlike in depression, the person in a manic state never complains about not sleeping. The feeling of needing sleep disappears.

Now, the first couple days of this feels pretty good. We all like feeling “up”. Wouldn't it be nice to always feel invincible? Or like you could do anything; like you had all the energy you wanted and more? Mania can be a very seductive state, and as a result, many individuals with bipolar disorder frequently reduce their medications to trying to get into that almost manic state where they jus feel good and don't swing too high.

(\*Click)

## Bipolar Disorder Mania

### Slide 15

(Click once: the words will appear automatically)

The problem with the disorder is they can't stop there. If a person is heading into a manic episode and stops taking medication or stops participating in any treatment and is not sleeping, she'll likely swing too high (and just as quickly, may swing low) It's a brain disorder. The person talks very fast. The words gush forth under pressure, almost like from a fire hose. The person is difficult to interrupt. Thinking becomes disorganized, just like in schizophrenia. Often though, instead of the associations simply becoming loose, the thought processes spin out into punning and word play and rhyming so that the connection between words is actually by their sound rather than by their meaning.

If normal speech is like an old 45 (record) then flight of ideas is like listening to a 45 at 78 rpms. If you have seen the movie, Good Morning Vietnam, Robin Williams's opening monologue is a good example of what I mean.

Mania is not an exaggerated feel-good state. In a manic episode, the person loses control of the state.

(\*Click )

## Bipolar Disorder Mania

### Slide 16

A major part of the treatment of bipolar disorders is medication. The major class of drugs used for bipolar disorders are the mood stabilizers which you learned about last time. Illness self-management is also key. These approaches are described in more detail in the NAMI and NIMH handouts.

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## What Have You Learned

### Slide 17

[To the instructor: If using an animated power-point presentation, This “drill” can be played like the game show Jeopardy<sup>®</sup>. with two categories: disorders and definitions. If not, you may just wish to prepare a flip chart in advance, or simply call out definitions and let individuals - or teams - call out the answer]

(\*Click)

Terms

Slide 18

(Click once for the answer to appear) What are hallucinations?

(\*Click)



Terms

Slide 19

(Click for the answer to appear) What is a delusion?

(\*Click)

Terms

Slide 20

(Click for the answer to appear) What is affect?

(\*Click)



Terms

Slide 21

What is apathy? (Click for the answer to appear) What is apathy?

(\*Click)



Terms

Slide 22

(Read this as fast as you can)

“I saw a cat with a hat and a bat but where oh where has my little dog gone oh where what should I wear” is an example.

(Click: answer: flight of ideas)

(\*Click)



Back to Disorders

Slide 23

(\*Click)

## Anxiety

### Slide 24

Anxiety disorders include both the feeling states of anxiousness or nervousness and dread or being afraid. Sometimes people will describe anxiousness as somewhat amorphous (meaning without shape) or as what happens in your body, and fear as having a focus, a shape. That is, people are usually afraid of something.

In everyday usage, we speak of fear, nerves, and anxiety interchangeably. The point I wish to make here, is that when a person has an anxiety *disorder*, it is something more than what we all experience everyday. Like depression, which we have all felt at one time or another, these feeling states are called disorders when they interfere with function. Anxiety disorders can be very crippling and are not simply a sign of not being able to “get a grip”.

The category of anxiety disorders is an extensive one and of course we cannot go into all of them today.

I encourage you to read the very good summaries of the major anxiety disorders in your NAMI or NIMH handouts if you have not already done so.

(\*Click)

## Anxiety

### Slide 25

What I want to focus on in this module are panic disorders and post-traumatic stress disorders.

Imagine pushing a grocery cart through an aisle in the supermarket and suddenly, without warning, without reason, being gripped by an awful fear that something catastrophic is going to occur. Your heart starts pounding and beating very fast. Your hands get clammy. You feel like you can't breathe and start hyperventilating as you run from the store, certain that if you don't you will die. It's an awful feeling. It typically lasts from 5-10 minutes and then goes away.

Wherever that first panic attack happened becomes associated with the attack and the person is afraid to go back there. This is how people start curtailing their activities. In this case, this first panic attack happened in the grocery store and so the person does not want to go shopping. If the first panic attack occurs crossing a bridge, the person might drive home in a round about way to avoid driving over bridges. If a panic attack occurs on the top of a tall building, the person may refuse to go up a flight of stairs. It's that type of thing. The problem with panic attacks is that there is no warning.

Stress disorders, which you probably have heard referred to as PTSD, are different. PTSD is an anxiety disorder that can occur after a person experiences a traumatic event caused intense fear, helplessness or horror. This can be from a direct experience – assault, abuse, rape, and natural disasters - or from witnessing a violent event. Although symptoms can vary, the core features of this disorder are a state of heightened arousal: poor sleep, startle responses, irritability and watchfulness; re-experiencing of the trauma in daytime flashbacks or in dreams AND avoidance of the place or situations reminiscent of the situation which the trauma occurred.

(\*Click)

## Anxiety

### Slide 26

One positive aspect about anxiety disorders is that good treatments exist. (Click)  
The mainstays of treatment are education,

(click)

cognitive behavioral therapy and (click)medication.

For example, in the case of panic disorder, one of the major crippers of panic disorder is the constant fear it will happen again. So individuals with this disorder are reminded that, yes, it may recur, but they can do something about it. Most individuals can learn to manage even their worst attacks through breathing and progressive muscle relaxation. The SSRIs can also be used to good effect.

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Behaving & Relating – Diagnostic Categories

Slide 27

Now let's wrap-up by looking at the domain of behavior. This is always a challenging category to describe because I don't want to suggest that there are "good" ways to behave and "bad" ways to behave. This domain is used more in the sense of classifying those disorders that have the most impact on our judgment, our interactions with others, in managing our affairs and so forth.

First, I want to remind you that we all have a personality; and, that not all personalities "click". This may be particularly true in group living situations, where you're dealing with not just resident but also staff personalities. They don't always mesh. It doesn't mean anyone has a disorder.

So, what do we mean by "personality"?

[Encourage a few responses before moving on]

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## Personality Disorders

### Slide 28

My definition of personality is this: it is a person's way of being in the world. It includes patterns of relating, of responding to stress, of communicating. These are patterns which endure. When we talk about personality *disorders* we're really talking about the way of being in the world *not working* at all. That, in fact, the way of being in the world interferes with your ability to love, to work, to play, and to get a job.

Some personality disorders, frankly, are as crippling as the so-called major mental illnesses. The personality disorder you are most likely to hear about in this regard is something called borderline personality disorder. Now, the caveat about borderline personality disorders is that it is *way, way, way*, over diagnosed. Frankly, that diagnosis is used today the way hysteria was used to describe women in the 1950's. It often seems to be used as a way of dismissing people who are difficult. Not as a way of understanding them. On the other hand, there are characteristic *maladaptive* patterns, that some women (and men, though in fewer numbers) who have suffered severe trauma as children often develop that have been grouped under this term borderline personality disorder. If you hear a person described as having borderline personality disorder, insist that the staff describe the behaviors or challenges they are talking about. You will often hear staff say: "Oh, she's just a borderline" as though it explains everything. It explains nothing. People with borderline personality disorder really suffer a tremendous amount of stigma within institutions because, in fact, many behaviors they share in common are pretty maddening.

One of the most maddening is that there is this kind of *all good/all bad* way of relating to the world. The world is very black and white and you can be highly valued and then totally devalued. And this can be very confusing. This is something that you need to understand. If you encounter somebody who has a borderline personality disorder, you will come to appreciate that some days you are the best thing that's ever happened to him or her. They love you; you're the greatest; , you can do no wrong. And a month later, even though you haven't changed, as far as you can tell, you haven't done anything differently, you're a traitor, and you're useless and told never to return. And you'll have no idea how it's happened. This can be maddening.

If you're working for a resident in an adult home that's making everybody angry and it's a woman, I guarantee you that person will be called "borderline" at some point during his or her stay. What to do? Listen. Validate feelings. Set clear limits on what you can and can't do. Be straightforward. Be consistent. Don't make promises you can't keep to try to placate (anyone). Avoid labeling. And read the NIMH handout on this disorder.

(\*Click)

## Substance Use Disorders

### Slide 29

Drug abuse is the final disorder to describe. First a definition:

For our purposes, I'll be using the terms, substance use disorders and drug abuse interchangeably. In this series, the distinctions between drug dependency and drug abuse are not important. What is important is that you understand the magnitude of the problem of substance abuse in group homes and what you can do.

For our purposes, Drug abuse is simply **the continued use of a substance despite negative consequences**. It doesn't matter if it's one beer, a six pack, a twelve pack, and a case. It doesn't matter if it's whiskey, wine. It doesn't matter if it's marijuana or cocaine or heroin. If it's causing a problem and the individual can't or doesn't stop using it, it's likely a substance use disorder.

Drug abuse is the continued use of a substance despite negative consequences.

The most commonly abused drugs in the community setting are:

Alcohol Stimulants Marijuana Prescription drugs, especially the benzodiazepines or valium type drugs and heroin

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## Substance User Disorders

### Slide 30

Why talk about substance abuse? Substance abuse is a major source of disability, particularly for the population living in adult homes. It is a problem that has long been problem underestimated or minimized.

And yet, substance abuse complicates almost every aspect of care

(Click)

There are four key points:

- 1) Half of all individuals with one mental illness also have a problem with substance abuse but usually only one problem is identified.

(Click)

- 2) Resources for substance use disorders in most communities lag far behind services for other mental health disorders.

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- 3) Many of the problems with aggressive behavior in adult homes arise in the context of substance abuse: either in violence towards others or toward the self , in other words suicide.

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## Dual Disorders

### Slide 31

The most commonly used drug by individuals with another mental illness is alcohol, followed by marijuana and cocaine. Prescription drugs such as tranquilizers and sleeping medicines may also be abused.

Mental health services are often not well prepared to deal with patients having both afflictions . If both are recognized, the individual may bounce back and forth between services for mental illness and those for substance abuse and be refused treatment by each service until the other problem is addressed. Why are they so common?

(\*Click)

Dual Disorders

Slide 32

There are a number of reasons individuals with mental illness (or without ) use substances:

(Click)

One common use is recreation. People like the way drugs make them feel.

(Click)

A second reason is to “self-medicate”. This may be an attempt to reduce anxiety or depression, or in the case of someone with a mental illness, a misguided attempt to treat symptoms of the illness or to treat side effects of other medications.

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## Dual Disorders

### Slide 33

Substance use disorders can be manifested in a number of ways and it is sometimes difficult to separate the behaviors due to mental illness from those due to drugs.

Substance Use can:

- cause psychiatric symptoms
- mimic psychiatric disorders
- initiate a psychiatric disorder
- provoke re-emergence
- exacerbate/worsen a psychiatric disorder or
- mask psychiatric symptoms and syndromes

But the problems that you will encounter in adult homes, are not just the result of the direct effect of the drug on the person. One of the biggest problems related to substance abuse in group homes is related to the buying and selling of substances. It is a real problem. Female residents in group homes often are induced to trade sexual favors for drugs (or cigarettes). Others residents may be intimidated or bullied into obtaining drugs or giving over resources. When confronted with the problem of substance abuse, make sure you know what problem it is. IS the problem that the drug use interferes with the person's ability to function in the home because they are intoxicated all the time? Is the problem that they are buying and selling a drug? Is the problem that they are not motivated for treatment? Naming the problem about drug abuse will help you frame the solution a lot more easily.

Let's talk about treatment.

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## Dual Disorders

### Slide 34

Individuals with substance use disorders either as a primary or co-occurring disorders are often difficult to engage in treatment.

In addition, individuals with dual disorders may find they are not welcome in community residences because of their substance use or tolerated in rehabilitation programs because of their mental illness.

Not uncommonly, individuals have lost their support system and suffer frequent relapses and hospitalization

As advocates, the most important intervention you can make is to insist on making integrated treatment in your community.

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## Integrated Treatment

### Slide 35

Integrated treatment is an approach to providing services that has come out of years of research. In this model, the same team provides services for both conditions at the same time in the same setting.

At the foundation of this approach is the restoration of hope, positivity and optimism.

Treatment is recognized as occurring in stages over the long term and in the community. You can read more about it in your handout on dual diagnoses.

Now let's review what you've learned, with another quick round of Jeopardy®

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## Disorders

### Slide 36

(\*Click)

Signs and Symptoms

Slide 37

(Click)

What are hallucinations and delusions?

(\*Click)



Signs and Symptoms

Slide 38

(Click)

What is sleep? What is money? would also be an ok answer)

(\*Click)

Signs and Symptoms

Slide 39

(Click)

What are negative symptoms?

(\*Click)



Signs and Symptoms

Slide 40

(Click)

What is tardive dyskinesia?

(\*Click)



Signs and Symptoms

Slide 41

Smoking marijuana everyday and not being able to work is an example

(Click)

What is drug abuse) or what is a substance use disorder

At the end of this one, tell the group it is time to add up the scores. There were ten questions in all. Ask the scorekeeper to announce the scores...

(\*Click )

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And the Winner is .....

Slide 42

Congratulate the winners! It's a wrap!

Thank everyone for his or her participation in the series and pass out the evaluation form.