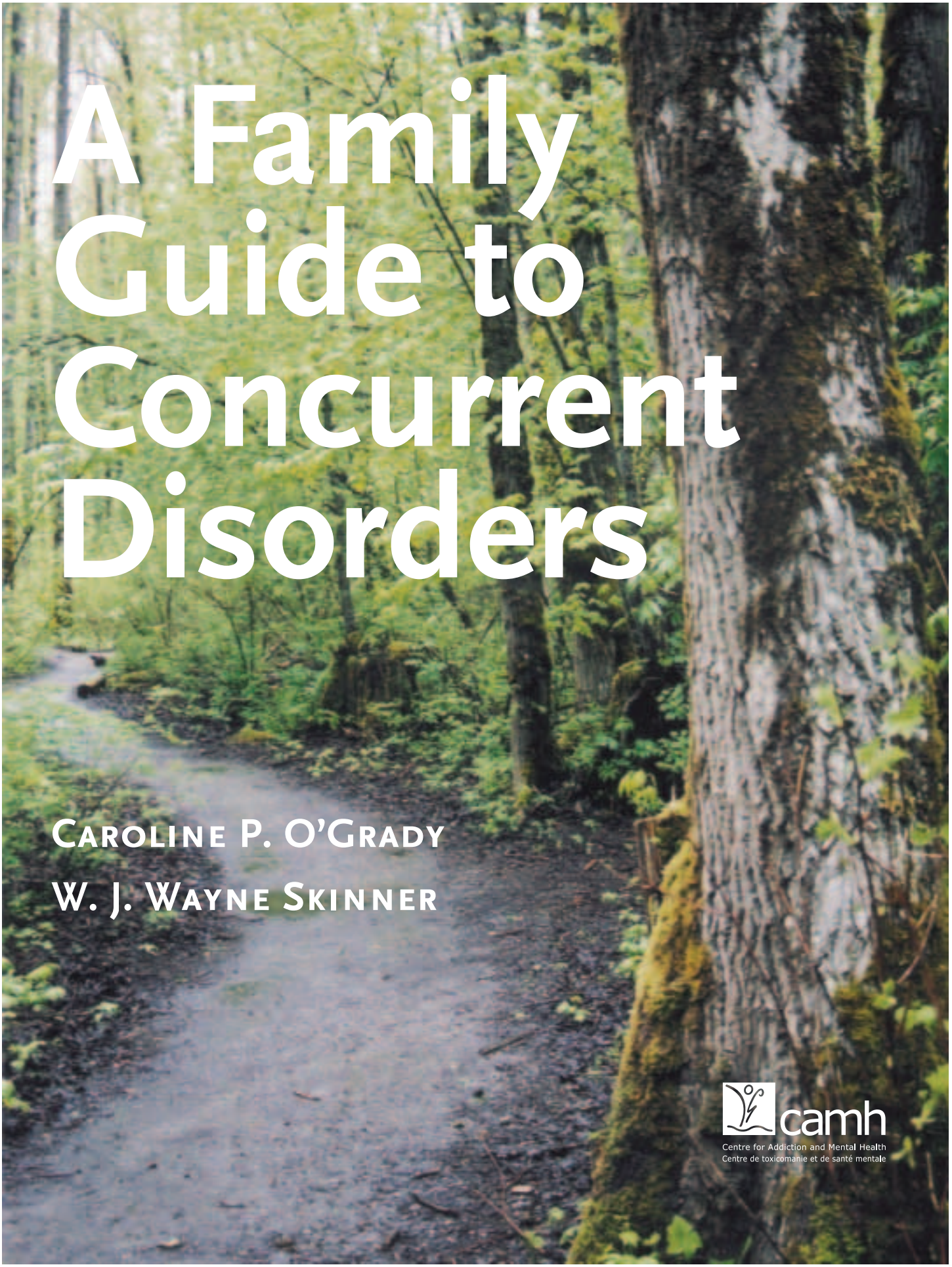
A Family Guide to Concurrent Disorders
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We are fortunate to work in an organization that has an explicit priority commitment to concurrent disorders and to families. We have also benefited from the opportunity to work with talented and passionate colleagues who helped to sustain and expand the scope of our project. Christine Bois has been a true champion of concurrent disorder capacity building in Ontario. Monique Bouvier is co-ordinating an ambitious provincial dissemination effort, supported by a great team in CAMH's provincial services. A special thanks goes to editors Martha Ayim and Jacquelyn Waller-Vintar and designer Eva Katz.

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Contents

Preface

DEALING WITH THE IMPACT OF CONCURRENT DISORDERS

Over the past few years, we have received numerous calls from family members of people who have co-occurring substance use and mental health problems. The family members were often overwhelmed as they tried to cope with difficult issues.

We know that the mental health and substance use systems could be better at helping families become more resilient, at recognizing the work that family members do every day to find solutions and resources for problems related to concurrent disorders. Families need help to deal with the impact of concurrent disorders, but families are also a key to finding effective solutions. To help their relatives on the journey to recovery, families need:

- information about substance use and mental health problems—and above all, to know that families do not cause the problems
- a common language with treatment providers—to make it easier to collaborate
- strategies to cope with issues associated with concurrent disorders
- strategies to look after themselves and reduce the impact of their relatives' problems on their own lives.

HISTORY OF THE PROJECT

In 2004–05, we offered a support and education group to help family members:

- learn about concurrent disorders
- develop skills that would help them deal with the impact of concurrent disorders on their family life
- collaborate with their relatives with concurrent disorders as well as treatment providers to find ways to manage substance use and mental health problems.

The feedback we have received—both directly from family members and indirectly from the research measures we took before and after the project—has been extremely positive, and has motivated us to make our work available to a broader audience.

This resource is based on the package of materials that we created for the group. We designed this version so that family members can also use it on their own. It includes:
- information and educational material
- quotations from family members
- resources and contact information
- tip lists
- activities.

USING THIS RESOURCE

How you use this resource will depend on how long you have been coping with concurrent disorders in your family, on how well your relative is doing and on your learning style.

You can look up specific information that will help you with current concerns. Or you can read the resource chapter by chapter. If you read through the entire guide, you will get a good overall understanding of key ideas and of the challenges and opportunities that are part of dealing with a family member who has concurrent disorders.

This resource is divided into four parts:

Part I: What are concurrent disorders? provides an overview of concurrent disorders, an introduction to treatment options and information about substance use and mental health problems and how they interact.

Part II: The impact on families focuses on the impact of concurrent disorders on family life. It includes information on experiencing, understanding and coping with the effects of stigma and on self-care strategies for family members.

Part III: Treatment explores treatment and support for people affected by concurrent disorders. It includes strategies for navigating the mental health and substance use treatment systems and information about psychosocial and medication treatment options, recognizing and planning for relapses, and anticipating and coping with crisis situations.

Part IV: Recovery talks about the journey to recovery.

As you use this resource, you join a host of wonderful people who are committed to playing a positive role in the life of a family member who is affected by substance use and mental health problems. We have learned a lot from them—they share their insights throughout. We are delighted to have this chance to present what we have learned.

Part I:
What are concurrent disorders?

Introduction to concurrent disorders

1

Outline

- How common are concurrent disorders?
- The relationship between substance use and mental health problems
- The impact of concurrent disorders
- An introduction to treatment

We were just like any other family with teenagers, except that while our daughter was a real extrovert—she had so many friends, did well in school, never caused us any problems—you know, the kind of kid who can do no wrong . . . our son was so different, the complete opposite. He had friends growing up, but then it seemed like, out of the blue, he didn't want to be around anyone, including his own family. He just got so isolated, you know? He was always a quiet kid, but this was different. When my husband caught him smoking marijuana, and then found bottles of alcohol in his closet, it suddenly all started making sense . . . booze and drugs were causing him to crawl into his own little world and withdraw from other people. To tell you the truth, we were actually relieved to find out about his drug problem—we had a plan, you know? We could do something concrete to help him, like put him in rehab for teens. The real nightmare started when he wouldn't even go out of the house to see our family doctor. Even when we made sure he wasn't smoking pot or drinking, he still got worse! It was another two years before we found out that he had a mental illness as well as a drug problem. We had never heard of concurrent disorders before then.

The term concurrent disorders describes a situation where someone has both a substance use problem and a mental health problem at some point in their lifetime. It could be in the past. (Has your family member ever had a mental health problem? Has your family member ever had a substance use problem?) Or it could be a current problem. (Does your family member currently have both a mental health problem and a substance use problem?)

Many families share similar experiences to those of the family whose story is introduced this chapter. Substance use and mental health problems can lead to symptoms and behaviours that look very similar, so family members and treatment professionals often find it difficult to determine whether the behaviour they are looking at is due to a substance use problem or a mental health problem—or both. This chapter is an introduction to concurrent disorders:

- how substance use and mental health problems interact
- the impact of concurrent disorders on the family
- how concurrent disorders are detected and treated.

HOW COMMON ARE CONCURRENT DISORDERS?

Having either a substance use or a mental health problem significantly increases the likelihood of having the other. The results of the Epidemiologic Catchment Area Study (Regier et al., 1990) indicate that a person who has a mental health disorder is almost three times more likely to have a substance use disorder at some time in his or her life than is a person who does not have a mental health disorder. A person who has a substance

(other than alcohol) use disorder is about 4.5 times more likely to have a mental health disorder at some point in his or her life than a person who does not have a substance use disorder.

The prevalence of combinations of substance use and mental health disorders varies depending on the disorder:

- Among people who have had an anxiety disorder in their lifetime, 24 per cent will have a substance use disorder in their lifetime.
- Among people who have had major depression in their lifetime, 27 per cent will have a substance use disorder in their lifetime.
- Among people who have had bipolar disorder in their lifetime, 56 per cent will have a substance use disorder in their lifetime. This is more than three times the average rate.
- Among people who have had schizophrenia in their lifetime, 47 per cent will have a substance use disorder in their lifetime. This is nearly three times the average rate.

People who work in substance use agencies should assume that someone who comes for help with a substance use problem might also have a mental health problem, until they have information that indicates that this is not the case. Similarly, mental health workers should assume that clients might also have a substance use problem, until they have information that rules out this possibility.

Understanding the terminology

People often have substance use and mental health problems that have a significant impact on their daily lives, but are not severe enough or do not last long enough to meet the criteria for a diagnosis of any disorder. So, we will usually use the broader term "mental health and substance use problems," unless we are talking about a specific DSM IV-based (*Diagnostic and Statistical Manual of Mental Disorders, 4th ed.*) diagnosis of a disorder.

These are terms you will probably hear used in some parts of the substance use and mental health systems.

Mental disorders

Mental disorders (including substance use disorders) are health conditions that are characterized by changes in thinking, mood or behaviour (or some combination of the three) associated with distress and/or impaired functioning (American Psychiatric Association, 1994).

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is used in North America to diagnose mental health disorders. The fourth and most recent edition, the DSM-IV, organizes mental disorders into 16 major diagnostic classes—for example, mood disorders and substance-related disorders. Within these diagnostic

classes, disorders are further broken down—for example, depressive disorders and bipolar disorders are included in the mood disorders class. For each disorder, the DSM-IV lists specific criteria for making a diagnosis.

While we will use the terms co-occurring problems and concurrent disorders in this manual, there are other terms that you may have heard:

Dual diagnosis is often used in the United States. It implies that a person has just two problems. However, evidence suggests that there may well be more. In Ontario, this term is used to refer to people with serious developmental delay and severe, persistent mental illness.

Co-occurring disorders (COD) is another way of describing a situation where someone has one or more mental health disorders and one or more substance use disorders.

THE RELATIONSHIP BETWEEN SUBSTANCE USE AND MENTAL HEALTH PROBLEMS

Do the substance use behaviours cause psychiatric symptoms? Do the mental health issues lead people to use substances to relieve troubled mental states? The relationship is usually much more complicated than simple cause and effect. Researchers have suggested four types of interaction:

- substance use and mental health problems may be triggered by the same factor
- mental health problems may influence the development of substance use problems
- substance use problems may influence the development of mental health problems
- substance use and mental health problems may not interact.

The way substance use and mental health problems interact is specific to the person, the mental health problem and the substance being used, and may change over time.

SUBSTANCE USE AND MENTAL HEALTH PROBLEMS MAY BE TRIGGERED BY THE SAME FACTOR

Both substance use and mental health problems could be caused by a common factor, that could be genetic, developmental or environmental. For example, traumatic events (an environmental factor) can lead to both mental health and substance use problems.

MENTAL HEALTH PROBLEMS MAY INFLUENCE THE DEVELOPMENT OF SUBSTANCE USE PROBLEMS

Severe mental health problems, such as schizophrenia or bipolar disorder, may leave people more vulnerable to developing substance use problems; they tend to develop substance use problems with lower amounts of alcohol or other drug use than people who don't have mental health problems.

People may use substances in the hope of relieving the symptoms of mental health problems. For example, someone with an anxiety disorder may use alcohol to feel more at ease in social situations. This is called self-medication.

SUBSTANCE USE PROBLEMS MAY INFLUENCE THE DEVELOPMENT OF MENTAL HEALTH PROBLEMS

Substance use can induce psychiatric symptoms. For example, a person using significant amounts of cocaine could become paranoid to the point of being psychotic.

Substance use can not only induce psychiatric symptoms, but can also lead to psychosocial problems that may in turn lead to mental health problems. Severe paranoia could lead to psychosocial problems such as trouble in family relationships, trouble at work and trouble with the law. These problems could lead to a mental health problem such as depression.

SUBSTANCE USE AND MENTAL HEALTH PROBLEMS MAY NOT INTERACT

Sometimes, both mental health and substance use problems are present, but do not interact, so that even when one problem area is addressed, the other problem area is still active.

For some people, getting substance use under control will produce immediate positive changes in mental health symptoms. For others, it can mean that their mental health symptoms become more active. Understanding the relationship between the substance use and mental health problems is key to working successfully with people to choose treatment strategies and anticipate outcomes.

THE IMPACT OF CONCURRENT DISORDERS

Co-occurring substance use and mental health problems affect people differently, and depend on factors such as the combination and severity of the problems. For example,

people with severe mental illness who also have substance use problems tend to experience a wide range of serious problems. Common issues include:
- more severe psychiatric symptoms, such as depression and hallucinations
- more dramatic effects after using substances, including more blackouts
- a greater chance of not following treatment plans
- physical health problems
- increased experiences of stigma
- financial problems
- housing instability and homelessness
- poorer management of personal affairs
- serious relationship problems with family members
- more verbal hostility, tendency to argue, disruptive behaviour, aggression
- violence or crises that may end up involving the police
- a greater likelihood of ending up in jail
- increased suicidal feelings and behaviours.

IMPACT ON THE FAMILY

Having concurrent disorders obviously affects the person experiencing the disorders directly, but they also have powerful effects on family members and friends. As problems become more complex, family members are often confused about which problems are causes, and which are results. They are often puzzled and frustrated if their relative continues to use alcohol or other drugs when the consequences are so severe. We discuss the impact on the family in Chapter 4 and talk about coping strategies in Chapter 5.

AN INTRODUCTION TO TREATMENT

Detecting substance use and mental health problems

Because of the overlap of symptoms between mental health and substance use disorders, it is often difficult to make a firm diagnosis in the early stages of treatment. For example, symptoms resulting from intoxication and withdrawal can look a lot like symptoms of mood and anxiety disorders. A period of stopping, or cutting down on, substance use is often necessary before therapists can say whether a client has a substance use problem or a mental health problem—or both.

The best way to tell the difference between the symptoms caused by substance-related and other mental health problems is to observe the person when no substances are being used. However, experts don't agree on how long the person needs to stop using substances before a separate problem can be identified. Usually, the required period of abstinence depends on the substances being used and the suspected mental health problem. For example, drugs that stay in the body for a long time (e.g., long-acting ben-

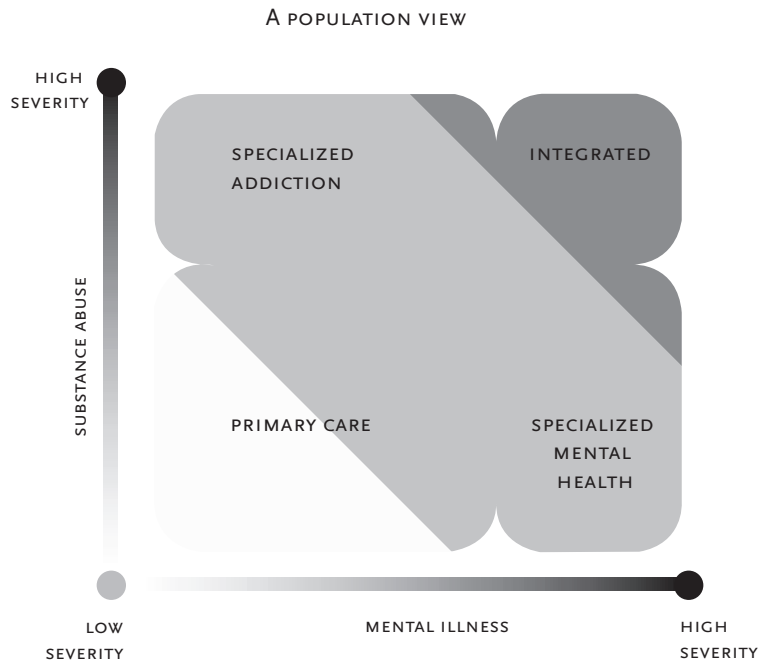
zodiazepines) may need many weeks of abstinence for withdrawal symptoms to taper off so that an accurate diagnosis can be made. For drugs that stay in the body for a shorter period of time (e.g., alcohol, cocaine), both the intoxication and the withdrawal stages will likely be briefer. In this case, it may be possible to make a firm diagnosis with shorter periods of abstinence.

Where do people find treatment?

Substance use services range from withdrawal management services, through community-based assessment and treatment, to short- and long-term residential resources. Mental health services include psychiatric emergency rooms, outpatient mental health clinics, acute-stay hospital beds, extended residential care and assertive community outreach teams for people who previously could only be supported in institutions. Many people get treatment for substance use and mental health problems from family doctors or other primary care services.

A framework (developed in the United States) illustrates where people are most likely to look for treatment. People may move back and forth among the quadrants at various stages of recovery from substance use and mental health problems.

Figure 1-1: The Quadrant Framework



The quadrant framework suggests that where a person has:

- **both substance use and mental health problems of low to moderate severity,** primary health care (e.g., family doctors) and community health resources are the core resources to draw on
- **a substance use problem of high severity, with a mental health problem of mild to moderate severity,** specialized substance use services are the lead resources, with mental health services providing collaborative care
- **a mental health problem of high severity, with a substance use problem of mild to moderate severity,** specialized mental health services are the lead resources, with substance use services providing collaborative care
- **both substance use and mental health problems of high severity,** strong evidence suggests that integrated care by a single, multidisciplinary team is the most effective way to provide continuing care and support.

CO-ORDINATED CARE

In the past, mental health and substance use services have not been well connected. They have tended to concentrate on one set of problems and view the other as a secondary problem that will clear up once the core problem is addressed. However, we know that if one of the co-occurring problems is not addressed, both problems usually get worse, and additional complications often arise.

Most communities have resources that could provide collaborative programming. In some cases, this already happens. In others, services in both systems need to work together more effectively to provide client-centred care for people with complex needs. We discusss strategies for navigating the treatment system in Chapter 7.

Treatment principles

When care for substance use and mental health problems is more co-ordinated and integrated, people do better. Concurrent disorder treatment initiatives focus on improved screening and assessment, more specialized programming, and co-ordination (by one person, or a treatment team) of substance use and mental health treatment. Five principles guide how to care for people with co-occurring problems:

1. People with co-occurring disorders are people *first*. Too often, these individuals pay too high a price for co-occurring disorders (SAMHSA, 2003).
2. Co-occurring problems are under-identified but common.
3. Co-occurring problems are complex but understandable.
4. Co-occurring problems are challenging but responsive to care.
5. Co-occurring problems require responses that go beyond separate addiction and mental health treatment.

People who have co-occurring substance use and mental health problems are some of the most vulnerable people in our society and in our health care system. Evidence suggests that if we address their problems in more co-ordinated and collaborative ways, they are more likely to reduce their substance use and improve their mental functioning. For many people, this is a long, complex process. Often family members are the most constant companions in the journey to recovery. At points in the journey, the family may be called on to be advocate, support person and sometimes case manager. In the rest of the guide we offer tools and strategies to help you do this.

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Substance use problems

2

Outline

- Substance-related disorders
- What is the risk of addiction?
- Why do people develop addictions?
- Types of substances

Many people use substances such as alcohol in moderate amounts and don't experience any problems. However, some people may start using larger amounts regularly, or using substances to get intoxicated. These behaviours can lead to problems with a person's job, family and health. After repeated abuse, some people may become dependent on the substance.

SUBSTANCE-RELATED DISORDERS

There is no clear line that indicates when substance use becomes a problem that is severe enough to need treatment. However, the *DSM-IV* includes substance-related disorders as one of the classes of mental health disorders. Many clinicians use the DSM's diagnostic criteria for *substance abuse* and *substance dependence* to help screen and assess people for concurrent disorders.

Substance Abuse

People who abuse substances regularly may have ongoing serious problems without being dependent on the substance. Some of these problems are:

- inability to fulfil responsibilities (e.g., being absent from work, doing poorly in school or neglecting duties at home)
- dangerous use (e.g., using substances in physically dangerous situations, such as when driving a car)
- legal problems (e.g., being arrested for disorderly conduct following substance use)
- social and family problems (e.g., arguing with family members about being intoxicated).

If one or more of these problems has a significant impact on a person's life, the person may be diagnosed with a substance abuse disorder.

Substance Dependence

People who are dependent on substances have major physical, mental and behaviour problems that can have serious effects on their lives. Some of the signs of substance dependence are:

- tolerance: the need to use larger and larger amounts of the substance to get the desired effect, such as intoxication
- withdrawal: having unpleasant symptoms if substance use stops; continued substance use with the same or similar drugs to avoid or reduce withdrawal symptoms
- desire to cut down or quit: many unsuccessful attempts to reduce or stop using the substance
- time investment: a great deal of time spent getting the substance, using it or recovering from its effects

- retreat from usual activities: giving up or reducing work, social or recreational activities, and withdrawing from family and friends to use the substance privately or to spend more time with friends who use substances
- ongoing use: substance use continues despite the negative effects.

If three or more of these problems are ongoing during a 12-month period, a person may be diagnosed with a substance dependence disorder.

A person does not need signs of tolerance or withdrawal to be dependent. For example, people who are dependent on marijuana show a pattern of compulsive use without any signs of tolerance or withdrawal. *Compulsive use* means people keep using substances in spite of the negative consequences, even though they want to stop and have tried to stop. Many people who are substance dependent also experience cravings. A *craving* is an urge or a longing for a substance.

Addiction

Addiction has been defined in many ways. Some of the technical definitions are similar to the way in which substance dependence is defined (see above). Most people use the term more broadly to refer to compulsive behaviours, including substance use, that cause problems. People persist with these behaviours in spite of strong negative consequences.

If we use this definition, addiction can be thought of as existing on a continuum. Substance abuse is a less severe form of addiction than substance dependence. Other forms of addictive behaviour include smoking, problem gambling and compulsive sexual behaviours.

WHAT IS THE RISK OF ADDICTION?

Research suggests that the risk of addiction varies across behaviours and substances:
- about two per cent of people who gamble meet diagnostic criteria for problem gambling
- between five and seven per cent of people who drink alcohol meet diagnostic criteria for alcohol dependence
- about 10 per cent of people who use cocaine meet diagnostic criteria for cocaine dependence
- about 80 per cent of smokers meet diagnostic criteria for nicotine dependence—the highest rate of substance dependence.

Addictive behaviours are difficult to change because they are activities to which the person becomes strongly attached. They also tend to have immediate positive consequences (this is known as *positive reinforcement*). People who have stopped an addictive

behaviour sometimes compare it to saying goodbye to a very close friend or leaving a relationship that was very important to them.

When helping someone with an addictive behaviour, it is important to understand how attractive the behaviour is to the person. As the behaviour intensifies, it increasingly preoccupies the person. Other interests and needs tend to become less important, and the behaviour becomes the primary or only way that the person gets satisfaction, even as the negative consequences grow.

WHY DO PEOPLE DEVELOP ADDICTIONS?

Not everyone who engages in a pleasurable behaviour ends up becoming addicted. At many levels, behaviours that can become addictive are either encouraged or discouraged by larger social forces (think of advertising) or by factors that are within the person (biological or psychological). If we understand the ways that behaviours can be powerfully rewarding for people, instead of viewing addictive behaviour as inherently bad or totally negative, we can begin to have a more sympathetic understanding of the problems of substance dependence and other addictive behaviours.

As the biopsychosocial model suggests, the causes of addictive behaviours are complex, and can include the following:

- A person usually perceives the behaviour itself as being strongly rewarding in some way. The nature of the reward, however, may vary from person to person, and may change over time. Some individuals may be rewarded by the energizing, exciting or pleasurable effects of a substance or of a behaviour such as gambling.
- Some people may engage in addictive behaviours because the physiological or psychological effects relieve physical or emotional suffering.
- Addictive behaviours may divert attention from distressing or overwhelming life circumstances. For example, some substances may temporarily lessen the symptoms associated with anxiety, depression or chronic frustration. Unfortunately, many of the destructive consequences associated with addictive behaviours—for example, damage to relationships, finances, self-esteem and emotional and physical health; development of physiological tolerance and ultimately increased anxiety, depression and other symptoms—may draw the person even deeper into his or her addiction. As the consequences associated with the behaviour grow more severe, a person feels less able to address the problem. Even when it reaches the point where the person is not getting any positive rewards, the person may keep using to avoid the distress of having to quit the behaviour. For example, many people dependent on substances report using substances long after they stop experiencing any pleasant effects.

The biopsychosocial approach to understanding substance dependence

BIOLOGICAL FACTORS

There is evidence that some people inherit a higher risk of dependent behaviours than others. To have a sibling or a parent with a history of dependence is to be at higher risk. We are learning more about the biological dimensions of addictions. These behaviours themselves might produce biological changes that make the person more vulnerable to relapsing (returning to the behaviour).

PSYCHOLOGICAL FACTORS

Any powerfully rewarding experience encourages a person to repeat the experience. There are many aspects of addictive behaviours—including the rituals, the environmental factors, and the thoughts and feelings that are involved—that can help us understand addictive behaviours. Usually the rewards from these behaviours show up first, while the costs tend to follow later or gradually build up over time. When someone feels a powerful urge, and the reward is immediate, while the negative consequences are nowhere in sight, it is tempting to give in to the power of the moment.

SOCIAL FACTORS

Addictions are strongly shaped by our relationships with other people and by interpersonal processes.

Peer factors help to determine if someone will experiment with a behaviour such as using tobacco, alcohol, marijuana or other drugs that may cause dependency.

Availability affects the risk of a behaviour becoming addictive. The increase in opportunities to gamble in the western world has led to an increase in the number of people with gambling problems in the region. Making cigarette smoking in public spaces illegal, along with higher prices through taxation, has led to significant decreases in the numbers of people who smoke.

Cultural factors also shape what people consider to be acceptable or unacceptable behaviours.

TYPES OF SUBSTANCES

This section describes three major types of substances[1]:

- depressants: drugs that slow the central nervous system (CNS) functions (e.g., make people feel more relaxed and less conscious of their surroundings)
- stimulants: drugs that increase CNS activity (e.g., speed up mental processes to make people feel more alert and energetic)
- hallucinogens: drugs that alter perceptions and sense of time and place; drugs that can produce hallucinations.

The following drug classification chart shows drugs that fall into each of these categories.

DEPRESSANTS	
Opioids • morphine • heroin • methadone • codeine • pentazocine (Talwin) • oxycodone (in Percocet, Percodan, OxyContin) • hydromorphone (Dilaudid) **Alcohol** **Inhalants** • gasoline • toluene	**Anxiolytics** **Benzodiazepines** • diazepam (Valium) • lorazepam (Ativan) • oxazepam (Serax) • clonazepam (Rivotril) • alprazolam (Xanax) • temazepam (Restoril) **Barbiturates** • secobarbital (Seconal) • butalbital (in Fiorinal)

[1] The Centre for Addiction and Mental Health has published 20 brochures describing substances in the Do You Know…series. For more information, visit www.camh.net/Publications/CAMH_Publications/do_you_know_index.html.

STIMULANTS	
Amphetamines • dextroamphetamine (Dexedrine) • methamphetamine • methylphenidate (Ritalin) **Cocaine/Crack**	**Methylenedioxyamphetamine (MDA)** **3,4-methelynedioxymeth-amphetamine (MDMA) (ecstasy)** (also has hallucinogenic actions) **Nicotine** **Caffeine**
HALLUCINOGENS	
LSD **Mescaline**	**Cannabis (marijuana)** (also has CNS depressant activity) **Phencyclidine (PCP)**

Depressants

Depressants include:
- alcohol (e.g., beer, wine, liquor)
- opiates, sometimes called narcotics (e.g., heroin and pain medication such as demerol, morphine, codeine)
- benzodiazepines, sometimes called tranquillizers (e.g., Valium and Ativan, prescribed to help people sleep or to reduce anxiety)
- barbiturates, sometimes called downers (e.g., Nembutal, Seconal)
- cough and cold remedies (e.g., Benylin with codeine)
- allergy medications (e.g., Benadryl and Sudafed)
- other over-the-counter drugs (e.g., antinausea drugs such as Gravol).

Depressants slow your central nervous system and affect the parts of the brain that control thinking, behaviour, breathing and heart rate. Depressant drugs such as alcohol, opioids and benxodiazepines can make you drowsy, slow your reaction time, and hinder your ability to pay attention or concentrate. The same is true for drugs with depressant side-effects—drugs such as cold remedies, cough medicines, antihistamines to control allergy symptoms, and drugs to prevent nausea or motion sickness.

Mixing any depressant drug with alcohol, which is also a depressant, can be extremely dangerous. The combined effects of the two drugs are sometimes much greater than the effect of either one alone.

ALCOHOL

Alcohol is the depressant that is used and abused most often.

How does alcohol make you feel?

The way alcohol affects you depends on many factors, including:
- your age
- your gender
- your body weight
- how sensitive you are to alcohol
- the type and amount of food in your stomach
- how much you drink
- how often you drink
- how long you've been drinking
- how you expect the alcohol to make you feel
- whether you've taken any other drugs (illegal, prescription, over-the-counter or herbal)
- whether you have certain pre-existing medical or psychiatric conditions.

For many people, a single drink of alcohol releases tension and reduces inhibition, making them feel more at ease and outgoing. Some people feel happy or excited when they drink, while others become depressed or hostile.

Women are generally more sensitive to the effects of alcohol than men, and all adults become increasingly sensitive to alcohol's effects as they age. When someone is more sensitive, it takes less alcohol to cause intoxication, and more time for the body to eliminate the alcohol consumed.

Is alcohol dangerous?

Alcohol can affect judgment, behaviour, attitude and reflexes. The impact of these effects can range from embarrassment to unwanted or high-risk sexual contact to violence, injury or death. Alcohol is involved in more regrettable moments, crimes and traffic fatalities than all other drugs of abuse combined.

Extreme intoxication can kill, often as the result of the person "passing out" while vomiting and choking. Clammy skin, low body temperature, slow and laboured breathing and loss of bladder and bowel control are signs of acute alcohol poisoning, which can be fatal.

Mixing alcohol with other drugs—prescribed or recreational—can have unpredictable results. Alcohol may either block the absorption of the other drug, making it less effective, or it may increase the effect of the other drug, making it dangerous.

Is alcohol addictive?

It can be. Most alcohol-related illnesses, social problems, accidents and deaths are caused by *problem drinking*. This term describes alcohol use that causes problems in a person's life, but does not include physical dependence. Problem drinking is four times as common as severe alcohol dependence.

Physical dependence involves tolerance to alcohol's effects and withdrawal symptoms when drinking is stopped. People who are physically dependent on alcohol can develop withdrawal symptoms, such as sleeplessness, tremors, nausea and seizures within a few hours after their last drink. Even after long periods of abstinence, a person may continue to crave alcohol, and may begin to drink again.

Opiates

Opiates include heroin, codeine and morphine. They may be prescribed by a doctor for severe pain. Under medical supervision, these strong painkillers are safe in the short term.

Opiates not only relieve pain, but in excess amounts can cause intoxication, giving them a high addictive potential. Opiate use is a problem when the person who is using them either has no medical reason to use them, or is using the drug in larger amounts than needed to manage pain. People who are dependent become extremely tolerant to the drug (they need to increase the amount to get the same level of intoxication) and will undergo withdrawal if they stop using abruptly.

Opiate drugs are often bought illegally. People may fake or exaggerate medical problems when talking to doctors to get prescriptions they don't need, or they may get several prescriptions from different doctors. Sometimes these drugs end up on the streets in the hands of drug dealers.

HEROIN

Heroin is a dangerous and illegal drug with high addictive potential.

How does heroin make you feel?

The way heroin, or any drug, affects you depends on many factors, including:
- your age
- how much you take
- how often you take it
- how long you've been taking it
- the method you use to take the drug
- whether you've taken any alcohol or other drugs (illegal, prescription, over-the-counter or herbal)
- whether you have certain pre-existing medical or psychiatric conditions.

When heroin is injected into a vein, it produces a surge of euphoria, or a "rush." This effect is felt in seven to eight seconds, and lasts from 45 seconds to a few minutes. The initial effect with snorting or smoking is not as intense. Following the rush comes a period of sedation and tranquility known as being "on the nod," which may last up to an hour. When heroin is injected under the skin or into a muscle, the effect comes on more slowly, within five to eight minutes.

New users often experience nausea and vomiting. The desired effects include detachment from physical and emotional pain and a feeling of well-being. Other effects include slowed breathing, pinpoint pupils, itchiness and sweating. Regular use results in constipation, loss of sexual interest and libido, and an irregular or a stopped menstrual cycle in women.

Heroin use causes changes in mood and behaviour. People who are dependent on heroin may be docile and compliant after taking heroin, and irritable and aggressive during withdrawal.

How long does the feeling last?

Regardless of how it is taken, the effects of heroin generally last for three to five hours, depending on the dose.

People who are dependent on heroin must use every six to 12 hours to avoid symptoms of withdrawal. The initial symptoms are intense, and include runny nose, sneezing, diarrhea, vomiting, restlessness and a persistent craving for the drug. Also associated with withdrawal are goosebumps and involuntary leg movements, leading to the expressions "cold turkey" and "kicking the habit." Withdrawal symptoms peak within a couple of days, and usually fade within five to 10 days. Other symptoms, such as insomnia, anxiety and craving may continue for some time. Heroin withdrawal is not life-threatening, but can be extremely uncomfortable.

Is heroin dangerous?

Yes. Overdose is the most immediate danger of heroin use. Heroin depresses the part of the brain that controls breathing. In an overdose, breathing slows, and may stop completely. A person who has overdosed is unconscious and cannot be roused, and has cold, moist and bluish skin. A heroin overdose can be treated at a hospital emergency room with drugs, such as naloxone, which block heroin's depressant effects.

The risk of overdose is increased by:

- the unknown purity of the drug, which makes it difficult to determine the correct dose, and harder to protect from overdose (ironically, many overdoses are due to increases in the quality of the drug sold on the street)
- injection, because the drug reaches the brain more quickly than by other ways of taking the drug, and because the dose is taken all at once
- combining heroin with other sedating drugs, such as alcohol, benzodiazepines and methadone.

Other dangers associated with heroin use include the following:
- Consequences of injection: Injection drug use puts the user at high risk not only of overdose, but also of bacterial infection, blood poisoning, abscesses, endocarditis (an infection of the lining of the heart) and collapsed veins. Sharing needles greatly increases the risk of becoming infected with, or spreading, HIV and hepatitis B or C.
- Unknown content of the drug: For example, heroin is often cut with additives that may be poisonous, such as strychnine, or that do not dissolve and can clog blood vessels, such as chalk.
- Combining heroin with other drugs: Taking heroin with another drug such as cocaine (speedballs) results in unpredictable, and sometimes deadly, drug interactions in the body.
- Dependence: The constant need to obtain heroin, and the repeated use of the drug, can result in criminal involvement or other high-risk behaviour, breakdown of family life, loss of employment and poor health.
- Pregnancy: Women who use heroin regularly often miss their periods; some mistakenly think that they are infertile, and become pregnant. Continued use of heroin during pregnancy is very risky for the baby.

Is heroin addictive?

Yes. Regular use of heroin, whether it is injected, snorted or smoked, can lead to physical and psychological dependence within two to three weeks.

Not all people who experiment with heroin become dependent. Some use the drug only on occasion, such as on weekends, without increasing the dose. With regular use however, tolerance to the effects of the drug develops, and more and more heroin is needed to achieve the desired effect. Continuous use of increasing amounts of the drug inevitably leads to dependence.

Once dependence is established, stopping use can be extremely difficult. People who have used heroin for a long time often report that they no longer get any pleasure from the drug. They continue to use heroin to avoid the symptoms of withdrawal, and to control the powerful craving for the drug, which is often described as a "need." Cravings may persist long after the drug is discontinued, making relapse (beginning to use again) difficult to avoid.

Stimulants

Stimulants include:
- cocaine and "crack" (a potent form of cocaine)
- amphetamines such as methamphetamine
- ecstasy
- caffeine in coffee, tea, cola drinks, "power" drinks and "stay-awake" pills
- over-the-counter medications such as allergy medicines (e.g., Sudafed).

Stimulants increase activity in the central nervous system, including the brain. For example, they speed up mental processes and make people feel more alert and energetic. But while a drug such as caffeine may make you more alert, it still leaves you impaired, and when it wears off, sometimes quickly, it leaves you very tired and less alert.

COCAINE

People who use cocaine can become dependent after using it for short periods of time. An early sign of cocaine dependence is when a person finds it harder and harder to resist using cocaine whenever it is available.

Crack is a commonly used form of cocaine. Unlike other types of cocaine, it is easily turned into a vapour and inhaled. As a result, its effects are immediate.

Because cocaine breaks down in the body quickly, people frequently find they need to use cocaine often to maintain a high. People who are dependent can spend huge amounts of money on the drug in a short period. To get the large amounts of money needed, they may become involved in theft, prostitution or drug dealing. A person who is cocaine-dependent may often need to stop using for a few days to find more money to buy the drug.

Tolerance to cocaine occurs after repeated use. Withdrawal symptoms, particularly a poor mood, may occur but they often do not last long.

How does cocaine make you feel?

How cocaine makes you feel depends on:
- your age
- how much you use
- how often you use
- how long you use
- how you take it (e.g., by injection, orally or snorting)
- your mood
- how you expect it to make you feel
- whether you've taken any alcohol or other drugs (illegal, prescription, over-the-counter or herbal)
- whether you have certain pre-existing medical or psychiatric conditions.

Cocaine increases heartbeat, breathing, blood pressure and body temperature. It makes people feel energetic, talkative, alert and euphoric. They feel more aware of their senses, such as sound, touch and sight. Hunger and the need for sleep are reduced. Although cocaine is a stimulant, some people find it calming, and feel increased self-control, confidence and ease with others. Other people may feel nervous and agitated, and can't relax.

Taking high doses of cocaine for a long time can lead to:
- panic attacks
- psychotic symptoms, such as paranoia (feeling overly suspicious, jealous or persecuted), hallucinations (seeing, hearing or smelling things that aren't really there) and delusions (having false beliefs)
- erratic, bizarre and sometimes violent behaviour.

With regular use, people may become tolerant to the euphoric effects of cocaine. This means that they need to take more and more of the drug to get the same desired effect, or that they get less effect from the same amount of the drug. At the same time, people who use the drug regularly may also become more sensitive to its negative effects, such as anxiety, psychosis (hallucinations, loss of contact with reality) and seizures.

Is cocaine dangerous?

Yes. While many people use cocaine on occasion without harm, the drug can be very dangerous. Whether it's used once or often:
- Cocaine causes the blood vessels to thicken and constrict, reducing the flow of oxygen to the heart. At the same time, cocaine causes the heart muscle to work harder, leading to heart attack or stroke, even in healthy people.
- Cocaine raises blood pressure, which can explode weakened blood vessels in the brain.
- A person can overdose on even a small amount of cocaine. Overdose can cause seizures and heart failure. It can also cause breathing to become weak or stop altogether. There is no antidote to cocaine overdose.
- Snorting cocaine can cause sinus infections and loss of smell. It can damage tissues in the nose and cause holes in the bony separation between the nostrils inside the nose (nasal septum).
- Smoking cocaine can damage the lungs and cause "crack lung." Symptoms include severe chest pains, breathing problems and high body temperatures. Crack lung can be fatal.
- Injecting cocaine can cause infections from used needles or impurities in the drug. Sharing needles can also lead to a person getting, or spreading, hepatitis or HIV.
- Chronic use can cause severe psychiatric symptoms, including psychosis, anxiety, depression and paranoia.
- Cocaine use is linked with risk-taking and violent behaviours. It is also linked to poor concentration and judgment, increasing risk of injury and sexually transmitted diseases.
- Chronic use can cause weight loss, malnutrition, poor health, sexual problems, infertility and loss of social and financial supports.
- Cocaine use in pregnancy may increase the risk of miscarriage and premature delivery. It also increases the chance that the baby will be born underweight. Because women who use cocaine during pregnancy often also use alcohol, nicotine and other drugs, we do not fully know the extent of the effects of cocaine use on the baby.
- Cocaine use while breastfeeding transmits cocaine to the nursing child. This exposes the baby to all the effects and risks of cocaine use.

Is cocaine addictive?

It can be. Not everyone who uses cocaine becomes dependent, but if they do, it can be one of the hardest drug habits to break.

People who become dependent on cocaine lose control over their use of the drug. They feel a strong need for cocaine, even when they know it causes them medical, psychological and social problems. Getting and taking cocaine can become the most important thing in their lives.

Smoking crack, with its rapid, intense and short-lived effects, is most addictive. However, any method of taking cocaine can lead to dependence. The amount of drug used, and how often people use the drug, has an effect on whether they become dependent.

Cocaine causes people to "crash" when they stop using it. When they crash, their mood swings rapidly from feeling high to distress. This brings powerful cravings for more of the drug. Bingeing to stay high leads quickly to dependence.

Symptoms of cocaine withdrawal can include exhaustion, extended and restless sleep or sleeplessness, hunger, irritability, depression, suicidal thoughts and intense cravings for more of the drug. The memory of cocaine euphoria is powerful, and carries a strong risk of relapse to drug use.

Hallucinogens

Hallucinogens include:
- cannabis/marijuana (the most common hallucinogen)
- LSD (the best-known hallucinogen)
- ecstasy (sometimes called "the love drug")
- solvents (e.g., glue, paint thinner, gasoline)
- ketamines (a painkiller originally developed to treat animals; sometimes called "special K").

The term hallucinogen is used to describe drugs that produce distortions of reality. Hallucinogens are sometimes called "psychedelic drugs." Hallucinogens dramatically affect perception, emotions and mental processes. They distort the senses and can cause hallucinations. Hallucinations are sensory images similar to dreams or nightmares—a person may see, taste or hear things that are not really present, except they occur when a person is awake.

CANNABIS

Cannabis is the most commonly used illicit drug in Canada (after alcohol and tobacco use by minors). However, most cannabis use is infrequent and experimental.

Research has shown that THC and other pure cannabinoids can relieve nausea and vomiting and stimulate appetite. This can help people who have AIDS or who take drugs used to treat cancer. While there is plenty of anecdotal evidence, further research is needed to establish the medical value of marijuana in relieving pain, reducing muscle spasms and controlling some types of epileptic seizures.

How does cannabis make you feel?

How cannabis makes you feel depends on:
- your age
- how much you use
- how often you use
- how long you've been using it
- whether you smoke it or swallow it
- your mood
- how you expect it to make you feel
- whether you've taken any alcohol or other drugs (illegal, prescription, over-the-counter or herbal)
- whether you have certain pre-existing medical or psychiatric conditions.

At low doses, cannabis mildly distorts perception and the senses. People who use it say the drug makes music sound better, colours appear brighter and moments seem longer. They say it enhances taste, touch and smell and makes them feel more aware of their body.

Smoking large amounts may intensify some of the desired effects, but is also more likely to produce an unpleasant reaction. Too high a dose may induce the feeling of losing control, confusion, agitation, paranoia and severe anxiety attacks that resemble panic attacks. Pseudohallucinations (seeing things such as pattern and colour that you know are not real) or true hallucinations (where you lose touch with reality) can occur.

Is cannabis dangerous?

While no one has ever died of a cannabis overdose, those who use cannabis should be aware of the following possible dangers:
- Cannabis impairs depth perception, attention span and concentration; it slows reaction time, and decreases muscle strength and hand steadiness—all of which may affect a person's ability to drive or operate machinery safely.
- Cannabis and alcohol, when taken together, intensify each other's effects, and cause severe impairment.

- Cannabis intoxication affects thinking and short-term memory.
- Illegal cannabis products are not subject to any health and safety standards and may be contaminated with other drugs, pesticides or toxic fungi.
- Large doses of potent cannabis, especially when swallowed, can cause "toxic psychosis." Symptoms include auditory and visual hallucinations (hearing or seeing thing that are not really there), confusion and amnesia (partial or complete memory loss).

Is cannabis addictive?

It can be. People who use cannabis regularly can develop psychological or mild physical dependence.

People with *psychological dependence* crave the high. The drug becomes overly important to them, they may feel they need it, and if they can't get it, they may feel anxious.

Long-term, frequent use can lead to *physical dependence*. People with physical dependence may experience mild withdrawal symptoms if they suddenly stop using cannabis. Symptoms can include irritability, anxiety, upset stomach, loss of appetite, sweating and disturbed sleep.

Activity 2-1: Identifying substance categories

Some of the substances may fit into more than one category. Match the substances to the primary category in which they belong:

- If you think the substance belongs in the depressant category, write the letter D beside it.
- If you think the substance belongs in the stimulant category, write the letter S beside it.
- If you think the substance belongs in the hallucinogen category, write the letter H beside it.

Substance	*Category*	*Substance*	*Category*
Beer:	_____	Valium:	_____
Heroin:	_____	Benadryl:	_____
Codeine:	_____	Crack:	_____
Ecstasy:	_____	Demerol:	_____
Gravol:	_____	Sudafed:	_____
Cannabis:	_____	Glue:	_____
Morphine:	_____	Methamphetamine:	_____
Liquor:	_____	Wine:	_____
LSD:	_____	Ativan:	_____

Answers: Beer: D; Heroin: D; Codeine: D; Cocaine: S; Ecstasy: H; Gravol: D; Morphine: D; Cannabis: H; Liquor: D; LSD: H; Valium: D; Benadryl: D; Crack: S; Demerol: D; Sudafed: S; Glue: H; Methamphetamine: S; Wine: D; Ativan: D

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Mental health problems

3

Outline

- Why do people develop mental health problems?
- Mental health disorders
- Personality disorders

WHY DO PEOPLE DEVELOP MENTAL HEALTH PROBLEMS?

We don't know exactly what causes mental health problems, nor can we predict who will have a few episodes and who will develop chronic problems. However, it's becoming more apparent that a mix of biological, psychological and social factors influence the development of mental health problems. That is why the biopsychosocial approach can be helpful in understanding key factors in what can be a very complex explanation. One way of explaining how biological, psychological and social factors influence one another is to look at stress and vulnerability.

The stress-vulnerability model

In general, the stress-vulnerability model holds that the greater the number of possible causes that are present, the greater the risk that a person may develop a mental health problem.

Treatment for mental health problems involves decreasing stress factors (e.g., working to develop a strong social network) and finding ways to decrease vulnerability (e.g., developing better coping skills or using medication to help balance chemical processes in the brain.

STRESS

Although stress does not cause mental health problems, it can trigger them, or make them worse.

Social factors

Events, either in childhood or adulthood, can contribute to the onset of a mental health problem. For example, some studies suggest that early childhood trauma and losses, such as the death or separation of parents, or adult events, such as the death of a partner or child or loss of a job, can be precursors to a mental health problem. Other environmental risk factors include:

- living in poverty
- lack of social support.

VULNERABILITY

Biological factors

Biological vulnerability is the tendency to develop problems in a specific area of the body—for example, respiratory system problems such as asthma. Similarly, people can

have a biological tendency to develop mental health problems such as depression, bipolar disorder or schizophrenia.

Vulnerability doesn't mean that problems *will* happen. It means that if certain factors come together, a person has a higher risk of developing a problem, and a higher risk of the problem being more severe.

Genetics
Some mental health problems seem to be genetic, or run in families. For example, the rate of schizophrenia in the general population is about one per cent. That rises to nine per cent for a child with one sibling with the diagnosis, 13 per cent for a child with one parent with the diagnosis and 46 per cent for a child with both parents with the diagnosis.[2]

Brain chemistry
Research indicates that chemical processes in the brain are involved in the development of mental health problems. Recent research has also pointed to abnormalities in brain structure as a possible factor in the development of mental health problems, particularly schizophrenia.[3]

Psychological factors
The temperament a person is born with (e.g., a tendency to internalize feelings) may play a part in increasing the risk of developing mental health problems. Psychological risk factors include:
- poor social skills
- poor coping skills
- problems with communication.

MENTAL HEALTH DISORDERS

As with substance use problems, there is no clear line that indicates when problems become severe enough to warrant treatment. As we explained in Chapter 1, many clinicians use the DSM-IV diagnostic criteria to help screen and assess people for mental health disorders. Most people with mental health problems will receive a specific diagnosis at some point during treatment. However, because the symptoms of many disorders are similar, the diagnosis may change several times during the course of treatment.

[2] You can find more information about research into the role of genetics on the Psychosis Sucks! website, created by the Fraser Health Authority in British Columbia, at www.psychosissucks.ca/epi.

[3] The National Institute of Mental Health in the United States (www.nimh.nih.gov/) is a good source of information about new developments in research into the biological basis of mental health problems.

You may hear mental health and substance use service providers use the terms Axis I disorder and Axis II disorder. The *DSM-IV* uses five axes to help organize information about mental disorders:

- Axis I: all mental health disorders (e.g. schizophrenia, bipolar disorder, substance dependence disorder) except personality disorders and mental retardation (also called intellectual disability)
- Axis II: personality disorders and mental retardation
- Axis III: medical conditions that may be contributing to psychological problems (e.g., infectious diseases)
- Axis IV: psychosocial and environmental problems (e.g., housing problems)
- Axis V: global assessment of functioning (how well a person is coping with daily life).

Axis II disorders are much less straightforward and even harder to diagnose than Axis I disorders.

Dimensional approaches

Another way to understand mental health problems is to divide mental health problems into broad groups based on the behaviours that we see. We did this in Chapter 2 with substance use problems by suggesting that drugs that have psychoactive effects could be divided into three groups: depressants, stimulants and hallucinogens.

We suggest that mental health problems can be divided into four groups:

- anxiety
- mood
- psychosis
- impulsivity (Skinner, 2005).

Mental health problems are described in terms of the severity of behaviours in each of these groups. This dimensional approach is a useful way to begin to organize the observations that indicate that a person has a mental health problem.

Table 3-1: The dimensional approach

DIMENSION	VERBAL BEHAVIOUR	MENTAL HEALTH PROBLEM		SUBSTANCE USE PROBLEM
		Axis I: Mental Health Disorders	**Axis II: Personality Disorders**	**Substance-Induced Disorders**
Anxiety	• "fear talk"	• anxiety disorders (e.g., phobias, obsessive-compulsive disorder)	• avoidant personality disorder • dependent personality disorder • obsessive-compulsive personality disorder	• substance-induced anxiety disorder (e.g., cannabis-induced anxiety disorder)
Mood	• "sad talk" • laconia • "manic or grandiose talk"	• depressive disorders • dysthymia • bipolar disorders	• affective features often present in personality disorders	• substance-induced mood disorder (e.g., heroin-induced depression)
Psychosis	• "weird talk"	• schizophrenia • other psychotic disorders • mania	• schizoid personality disorder • schizotypal personality disorder • paranoid personality disorder	• substance-induced psychotic disorder (e.g. cocaine-induced paranoia) • substance-induced delirium
Impulsivity	• "threat talk"	• impulse control disorders • gambling • bulimia • alcohol or other drug abuse/dependence	• antisocial personality disorder • borderline personality disorder • narcissistic personality disorder • histrionic personality disorder	• substance-induced impulse control disorder (e.g., amphetamine-induced sexual disorder)

ANXIETY

Anxiety disorders take on different forms. They are the most common type of mental health disorder. They have different causes and symptoms, but one thing people with anxiety disorders share is feelings of deep anxiety and fear that affect their mood, thinking and behaviour. When someone has an anxiety disorder, his or her thoughts and feelings may get in the way of taking the actions needed to be healthy and productive. These illnesses are chronic and can get worse over time if they are not treated. The following anxiety disorders:

- posttraumatic stress disorder
- generalized anxiety disorder
- panic disorder
- social phobia
- obsessive-compulsive disorder

are described below.

POSTTRAUMATIC STRESS DISORDER

As we discussed in Chapter 1, many people who develop substance use and/or mental health problems have experienced, or are experiencing, sexual, physical, psychological or emotional trauma.

Experiencing a traumatic event may trigger mental health problems such as anxiety, depression, psychotic symptoms or personality disorders (SAMHSA, 2003). The DSM-IV diagnostic category posttraumatic stress disorder (PTSD) describes a set of symptoms that people may experience following a traumatic event.

Simple posttraumatic stress disorder

PTDS may develop after a person experiences or sees an event where serious physical harm occurred or was threatened. Symptoms include:

- re-experiences of the event through flashbacks, nightmares or memories
- intense anxiety
- intense agitation
- increased heart rate
- tremors
- sweating
- increased awareness of the environment (hypervigilence)
- avoidance of anything associated with the traumatic event.

PTSD is diagnosed when symptoms last more than one month. Simple PTSD accurately describes the symptoms that can result when a person experiences a one-time event such as a car accident or a natural disaster.

Complex posttraumatic stress disorder

Clinicians and researchers have found that the current DSM-IV PTSD diagnosis often does not capture the severe psychological harm that occurs when the traumatic experience continues for a long time. For example, ordinary, healthy people who experience chronic trauma can experience changes in the way they see themselves and in the way they adapt to stressful events. Dr. Judith Herman suggests that a new diagnosis, called "complex PTSD" (sometimes called "disorder of extreme stress"), is needed to describe the symptoms of long-term trauma.

Experiences that can lead to complex PTSD include:
- long-term domestic violence
- long-term, severe physical abuse
- child sexual abuse
- internment in a concentration or prisoner of war camp.

The first requirement for the complex PTSD diagnosis is that the person experienced a prolonged period in a situation in which he or she felt helpless or trapped.

Symptoms include alterations in:
- emotional regulation (e.g., persistent sadness, suicidal thoughts, explosive anger or inhibited anger)
- consciousness (e.g., forgetting traumatic events, reliving traumatic events or having episodes in which one feels detached from one's mental processes or physical body)
- self-perception (e.g., a sense of helplessness, shame, guilt, stigma and a sense of being completely different than other human beings)
- the perception of the perpetrator (e.g., attributing total power to the perpetrator or becoming preoccupied with the relationship to the perpetrator, including a preoccupation with revenge)
- relations with others (e.g., isolation, distrust or a repeated search for a rescuer)
- one's system of meanings (e.g., a loss of sustaining faith or a sense of hopelessness and despair).

Survivors may avoid thinking and talking about trauma-related topics because the feelings associated with the trauma are often overwhelming. Survivors (anywhere from 50 to 90 per cent) may use alcohol and other substances as a way to avoid and numb feelings and thoughts related to the trauma. Survivors may also engage in self-mutilation and other forms of self-harm.

Crises that threaten the safety of the person with PTSD (e.g., talking about suicide) or the safety of others (e.g., reacting violently when they feel threatened), must be addressed first. However, the best treatment results are achieved when both PTSD and the other disorder(s) are treated together rather than one after the other. This is especially true for PTSD and alcohol and other substance use.

GENERALIZED ANXIETY DISORDER

People who have experienced at least six months of ongoing and excessive anxiety and tension may have generalized anxiety disorder. They usually expect the worst and worry about things, even when there is no sign of problems. They often experience the following symptoms:

- insomnia
- fatigue
- trembling
- muscle tension
- headaches
- irritability
- hot flashes.

PANIC DISORDER

Panic disorder occurs when people have repeated panic attacks, the sudden onset of intense fear or terror. During these attacks, people may experience physical symptoms such as:

- shortness of breath
- heart palpitations
- chest pain or discomfort
- choking or smothering sensations
- fear of losing control
- fear of going crazy.

Many people with panic disorder develop anxieties about places or situations in which they fear another attack, or where they might not be able to get help. Eventually this can develop into agoraphobia, a fear of going into open or public spaces. Women are twice as likely as men to develop panic disorder, which usually begins in young adulthood.

SOCIAL PHOBIA

People with social phobia experience a significant amount of anxiety and self-consciousness in everyday social situations. They worry about being judged by others and embarrassed by their own actions. This anxiety can lead them to avoid potentially humiliating situations. Other symptoms such as blushing, sweating, trembling, problems talking or nausea can also occur. Women are twice as likely as men to develop social phobia, which typically begins in childhood and early adolescence.

OBSESSIVE-COMPULSIVE DISORDER

People with this condition have obsessive, unwanted thoughts that cause marked anxiety or distress and/or compulsions to behave in certain ways to manage the anxiety. They

may perform rituals to prevent or make the obsessive thoughts go away (e.g., excessive hand washing or cleaning to prevent or diminish their fear of germs). These behaviours bring only temporary relief. If they are not treated, these obsessions and compulsions can take over a person's life.

Mood

Ordinarily, people experience a wide range of moods. They feel more or less in control of their moods. When the sense of control is lost, people experience distress. Those with an elevated mood (mania) can experience expansiveness, racing thoughts, decreased sleep, exaggerated self-esteem and grandiose ideas. People with depressed mood (depression) can have symptoms such as a loss of energy and interest, feelings of guilt and difficulty concentrating.

Major depressive disorder

Prevalence

Between 15 and 20 per cent of women and between 10 and 15 per cent of men will experience a major depressive episode in their lifetime.

Symptoms

A person who is experiencing at least five of the following symptoms meets the criteria for a diagnosis of a major depressive episode:

- Depressed mood: A depressed mood is much different from sadness. In fact, many people with depression say they cannot feel sadness, and many people cannot cry when depressed. Being able to cry again often means the depression is improving.
- Loss of interest or pleasure: At the start of depression or with mild depression, people can still enjoy and be distracted by pleasurable activities. When people are severely depressed, they lose these abilities.
- Weight loss or gain: Many people lose weight when depressed, partly because they lose their appetite. However, some people feel hungrier and may develop a craving for carbohydrate-rich foods. This causes them to gain weight. Depending on the type of depression, a person's metabolism may speed up or slow down. This can also cause weight loss or gain.
- Sleep problems: Sleep problems are common in depression. Many people have insomnia. They have trouble falling asleep, wake up often during the night, or wake up very early in the morning. They do not find sleep to be restful and may wake up feeling exhausted. Others may find that they sleep too much, especially during the day. This is called *hypersomnia*.

- Physical changes: For some people with depression, their movements, speech and/or thinking slows. In severe cases, they may be unable to move, speak or respond. With other people, the opposite happens. They become agitated and cannot sit still. They may pace, wring their hands or show their agitation in other ways.
- Loss of energy: People with depression find it difficult to complete everyday chores. It takes them much longer to perform tasks at work or home because they lack energy and drive.
- Feelings of worthlessness and guilt: When depressed, people may lack self-confidence. They may not assert themselves and may be overwhelmed by feelings of worthlessness. Many people cannot stop thinking about past events. They obsess about having let others down or having said the wrong things, and they feel guilty. In severe cases, the guilt may cause delusions. (See "Psychotic symptoms," three bullets below.)
- Inability to concentrate or make decisions: People may not be able to do simple tasks or make decisions on simple matters.
- Suicidal thoughts: People with depression often think that life is not worth living or that they would be better off dead. There is a high risk that they will act on these thoughts. Many people do try to kill themselves when depressed.
- Psychotic symptoms: These may include false beliefs, such as believing they are being punished for past sins. People with psychotic symptoms may believe that they have a terminal illness, such as cancer. They may also hear voices that are not there (auditory hallucinations).

Other symptoms may include:
- oversensitivity and preoccupation with oneself
- negative thinking
- little response to reassurance, support, feedback or sympathy
- less awareness of other's feelings because of one's own internal pain
- feeling a need to control relationships
- inability to function in a normal role.

Course

A first episode of depression can occur anytime in a person's life.

Most people struggle for long periods with the symptoms before seeking mental health intervention. They may have undergone several stressful events, and have tried to manage their mood fluctuations, only seeking help when they experience serious difficulties coping at home, at work or in important relationships.

A person may be diagnosed as having had a "single episode" (meaning that this is the first time he or she has experienced a major depression) or "recurrent episode"

(meaning that the person has experienced at least one previous episode of major depression). Different episodes may vary in severity: some episodes may be minor and have less impact on a person's ability to function, while others may be more severe and result in significant disruption to a person's life.

Bipolar disorder

Prevalence

About one to two per cent of the population will develop a bipolar disorder in their lifetime.

Symptoms

There are three major groups of symptoms related to bipolar disorder. These are mania, hypomania and depression.

Mania

If a person's mood is abnormally or persistently high for at least one week, he or she may be in a manic phase of the illness. However, not everyone who enters the manic phase feels euphoric. Some people may feel extremely irritable, behave rudely or become angry, disruptive and aggressive. They can be very impatient with others and make hurtful statements or behave impulsively or even dangerously.

In addition to mood symptoms, people must have at least three of the following symptoms to a significant degree to be diagnosed with bipolar disorder:
- exaggerated self-esteem or grandiosity
- reduced need for sleep
- increased talkativeness
- a flood of ideas or racing thoughts
- speeding up of activities such as talking and thinking, which may be disorganized
- poor judgment
- psychotic symptoms such as delusions (false beliefs) and in some cases hallucinations (mainly hearing voices).

Mania causes people to be emotional and react strongly to situations. For people with poor anger management skills or with low tolerance for frustration, this can lead to violent behaviour.

Hypomania

Hypomania is a milder form of mania with less severe symptoms. However, symptoms can interfere with the person's ability to function. We now recognize that

hypomania has more impact on a person's life and relationships than was previously recognized.

Depression

Depressive episode symptoms are described earlier in this chapter, in the "Major Depressive Disorders" section.

Bipolar I disorder

Some people experience mania or depression, or both, in addition to well phases during their illness.

Bipolar II disorder

Some people experience hypomania, depression and phases without symptoms—with no full manic phases.

Course

The manic/hypomanic, depressive and mixed (both manic/hypomanic and depressive) states usually do not occur in a particular order. How often they occur cannot be predicted. For many people, there are years between each episode, whereas others have episodes more often. Over a lifetime, the average person with bipolar illness experiences about 10 episodes of depression and mania/hypomania or mixed states. As the person ages, the episodes of illness come closer together. Untreated mania often lasts for two or three months. Untreated depression usually lasts longer, between four and six months.

One in five people with bipolar disorder have four or more—sometimes many more—episodes a year and have short phases without symptoms. This is called rapid cycling, and is a subtype of bipolar disorder for which people need specific treatment. The cause of rapid cycling isn't known. Sometimes, it may be triggered by antidepressants, but how this happens is not clear. In some cases, stopping the antidepressant may help the person return to a "normal" cycling pattern.

Psychosis

A psychotic disorder is a severe medical illness that disturbs the way a person acts, thinks, sees, hears or feels, and makes it difficult or impossible for him or her to distinguish between what is real and what is not.

Symptoms of psychosis may be either positive (something "added to" the person, something that is not always present) or negative (something "taken away" or "missing from" the person).

Schizophrenia

Prevalence

About one per cent of the population will develop schizophrenia at some point during their life.

Symptoms

Early warning signs of schizophrenia include:
- withdrawal from regular activities and from family and friends
- problems concentrating
- lack of energy
- confusion
- sleep problems
- unusual speech, thoughts or behaviour (e.g., a person may become intensely preoccupied with religion or philosophy).

This early phase can last weeks or months.

The seriousness of symptoms and chronic nature of schizophrenia can often cause a high degree of disability. Coping can also be difficult for family members who remember the person before the illness.

Positive symptoms (symptoms that appear in a person) include:
- Delusions: A delusion is a false or irrational personal belief. About one-third of people with schizophrenia experience delusions. These can include feelings of being persecuted, cheated or harassed, as well as delusions of grandeur (a false idea of oneself, e.g., as being famous).
- Hallucinations: A hallucination occurs when a person hears, sees, tastes or experiences something that is not really there. Hearing voices is the most common hallucination.
- Disordered thoughts: A person's thoughts may become unconnected, so that conversations no longer make sense. Their thoughts may come and go and they may not be able to focus for long on one thought. This is called thought disorder. It can contribute to a person's isolation.
- Cognitive difficulties: A person may have problems with memory, concentration and understanding concepts.

- Decline in social or occupational functioning: A person may have problems with work or school, or have trouble taking care of him- or herself.
- Disorganized behaviour: A person may seem agitated for no particular reason.

People with schizophrenia often have negative symptoms (elements that are taken away from a person) that include a "blunted affect" or "flat affect." This means they find it hard to show or express feelings. They may feel empty. A person with schizophrenia may appear extremely apathetic, have reduced motivation and withdraw socially.

Course

Men and women are equally likely to develop schizophrenia. However, men tend to have their first episode in their late teens or early twenties. With women, the onset is usually a few years later. In most cases, the illness can start so gradually that people will start to have symptoms, but they and their families may not be aware of the illness for a long time.

Symptoms of schizophrenia tend to vary in intensity over time. Some people have a mild form, and may only have symptoms for a few short periods during their lives. Others experience symptoms almost all the time, and may need to spend time in a hospital to protect themselves or others.

Impulsivity

Impulsivity disorders problems result from behaviour where the urge to do something is greater than the person's ability to understand that the behaviour has a high risk of being harmful to him- or herself or others.

Examples of impulsivity problems include substance use disorders and other behaviours such as problem gambling, antisocial behaviour, and problems related to anger and aggression.

A person with impulsivity problems needs to learn to think before acting. Too often the person reacts to a situation, and the action has consequences that could have been anticipated if her or she had sought more information and reflected more before acting.

Impulsive behaviour is often an attempt to control a situation that feels unsafe or threatening. In a smaller percentage of cases, the person doesn't care about the impact of his or her behaviour on others or even himself or herself. This type of behaviour is likely to be diagnosed as conduct disorder in young people or as antisocial behaviour in adults.

PERSONALITY DISORDERS

Personality is a way of describing how people think, feel and behave: the particular ways in which they understand and react to situations (e.g., their emotional response to an upsetting situation, their usual way of coping with stress, or how they understand and react to the external world).

Certain types of mental health problems are called personality disorders. As we saw when we looked at Table 3-1: The Dimensional Approach on p. 35, personality disorders are Axis II disorders. Axis II disorders are much less straightforward and are even harder to diagnose than Axis I disorders. Many of the features of these diagnoses (such as borderline personality disorder or antisocial personality disorder) overlap with many elements of *anybody's* personality. Personality disorders are often diagnosed when particular elements of a person's behaviours, reactions and perceptions of the world are extreme and lead to significant adverse problems in his or her life.

Personality disorders can have symptoms that are similar to mood, anxiety, psychotic and impulsivity disorders. Diagnosing personality disorders is open to error. The diagnosis is often used to describe a set of symptoms that don't fit into any other category.

Some practitioners do not even consider personality disorders to be mental health problems. Our view is that personality disorders are problems that a person experiences, and need to be seen as problems for which help should be provided.

Clusters of personality disorders

The *DSM-IV* divides personality disorders into three main groups, each of which fits into one of the dimensions we have previously outlined (psychosis, impulsivity and anxiety).

Cluster A (psychosis dimension) consists of schizoid personality disorder, schizotypal personality disorder and paranoid personality disorder. It is characterized by disturbances in cognition and perceptual organization in ways that resemble psychotic processes, although are usually less severe.

Cluster B (impulsivity dimension) includes antisocial personality disorder, borderline personality disorder, narcissistic personality disorder and histrionic personality disorder. This cluster is characterized by impulsive behaviours.

Cluster C (anxiety dimension) includes avoidant personality disorder, dependent personality disorder and compulsive personality disorder.

We are going to provide more information on borderline personality disorder (BPD) because this diagnosis is one of the most stigmatizing. People who are diagnosed with

BPD often have symptoms that make it difficult for them to avoid serious problems in the social world and to get effective help in mental health or social service settings.

Borderline personality disorder

The symptoms of BPD can occur in various combinations. People with the disorder have many, if not all, of the following traits:

- fears of abandonment
- extreme mood swings
- difficulty in relationships
- unstable self-image
- difficulty managing emotions
- impulsive behavior
- self-injuring acts
- suicidal ideation
- transient psychotic episodes.

Many of the characteristics of BPD reflect extreme ways that any person might react to a situation that upsets them. These reactions may be diagnosed as BPD when the person engages in severe self-destructive behaviour when he or she gets angry, or is disappointed, or experiences loss or grief and feels completely abandoned.

Activity 3-1: Identifying mental health problems

Read each of the following descriptions and write down whether mood, anxiety, psychosis or impulsivity describes the situation. More than one dimension may apply.

Tom, 50, and his wife, Laura, 47, have been married for 20 years. They both work full time—Tom as an executive at an architectural firm and Laura as the manager of a large fitness club. They do not have any children, but enjoy the company and companionship of several other couples who have been very good friends for many years. Tom and Laura work hard at their jobs, but also spend a great deal of time together in the evenings and on weekends. About one year ago, Tom began to have difficulty falling asleep at night and therefore waking up in time for work. He also described feeling nervous and jittery, and found it hard to complete work-related tasks that used to be very easy for him. Laura became concerned when Tom began to withdraw from her and to spend increasing amounts of time watching television or simply sitting outside staring into space. Ever since the changes in his behaviour began, Laura also worried about Tom's drinking, which had gradually increased from an occasional glass of wine to several shots of whiskey four to five evenings every week. He was also unable to express his feelings or to explain why his behaviour had changed so dramatically. One evening, when Laura and Tom were expected at a friend's home for a dinner party, Laura found Tom sitting on the floor in the bedroom crying and shaking. He told her that he felt too nervous to go out and that he "couldn't stand feeling like this anymore."

Ben is a 20-year-old, single, second-year university student majoring in biochemistry and living in a student residence on campus. In spite of Ben's characteristically shy and quiet personality, he has developed a close friendship with his roommate, an outgoing student from another province who goes by the nickname "Scat." Ben has even accompanied Scat to a few parties on campus and has been going to classes with Scat and several other students from their residence. Ben's parents live in a nearby city and are delighted that Ben, who was somewhat withdrawn and isolated as a child and teenager, has made new friends. Halfway through the school year, however, Ben suddenly began withdrawing from his new group of friends and refused to join them on outings. He started missing classes and instead stayed in his room in the student residence. Within a few months, Ben stopped eating meals in the cafeteria, complaining that there was "something in the food" and that somebody was trying to poison him. He became increasingly fearful that the other students were talking about him behind his back, and even accused Scat of plotting to harm him. Eventually, he stopped going to his classes altogether and spent his entire day in his room with the lights off, smoking cigarettes and marijuana, and listening to loud music. When Scat came home, Ben would angrily yell at him to get out. Scat reminded Ben that they lived in a non-smoking residence and Ben responded by

throwing a chair at Ben and storming out of the room. When Ben did not come home for three days, Scat contacted his parents. They were shocked with Ben's behaviour, especially his angry outbursts, smoking and use of drugs.

Cassie is a 32-year-old single woman working part-time in a department store. She has become used to living on her own and supporting herself, especially since she left home at age 17 due to her parents' constant fighting and daily drinking. Cassie has felt hopeless and despondent (dejected and sad) about her life for as long as she can remember, and has endured long periods of feeling worthless, useless and lonely. Since the age of 15, Cassie has also experienced bouts of intense anger and urges to harm herself. Her family has been unable to cope with their own emotions and have always turned to alcohol or gambling to deal with such unpleasant feelings as anger, boredom, sadness and anxiety. Cassie did not learn to deal effectively with her own feelings, and since the age of 17 has used various kinds of drugs to numb her psychological pain. She has also found that cutting her arms and legs with sharp objects often helps to get rid of painful emotions quite effectively—although the relief she gets from these self-harm behaviours never lasts very long. The intensity of Cassie's anger and loneliness has been increasing and she has begun to cope by overdosing on pills and then ends up in emergency departments. During one of her emergency admissions to a hospital she disclosed to a nurse that she is contemplating suicide.

Molly is a 35-year-old mother of four living in a subsidized housing complex in a Toronto suburb. Molly collects welfare in addition to financial aid for her children, aged seven years, five years, three years and nine months. Her ex-husband is in jail on a drug-related charge. Since her divorce one year ago, Molly has felt overwhelmed, particularly with finding a job that will pay her enough so that she can support her children. She is also worried about finding appropriate child care services should she find a good job. With four children to care for, Molly has not had time to make friends and she often feels an enormous sense of burden in addition to feeling "down in the dumps," isolated and alone with her responsibilities. She has developed daily episodes of severe nervousness and agitation during which she is completely unable to attend to her children's needs. She finds that as long as she paces around the same rooms in the same order and in the same direction and keeps repeating a particular phrase, her nervousness marginally subsides. Often Molly finds that during these episodes she also experiences shaking hands, shortness of breath, an extremely fast heart rate and profuse sweating. When these symptoms become really bad, Molly takes excessive doses of minor tranquillizers such as Valium, previously prescribed to her for insomnia by her family physician.

Comments

Tom is experiencing problems with *mood* and *anxiety*. Ben appears to be suffering from *psychosis*. Cassie appears to be struggling primarily with an *impulsivity* problem, accompanied by *mood* problems. Molly appears to be experiencing problems with *anxiety* and *mood* (depression).

REFERENCES

Skinner, W.J. (2005). *Treating Concurrent Disorders: A Guide for Counsellors.* Toronto: Centre for Addiction and Mental Health.

Part II:
The impact on families

How concurrent disorders affect family life

4

Outline

- Behaviour changes
- Relationship changes
- Increased responsibility
- Impact on caregivers

When families learn that a relative has both a mental health disorder and a substance use disorder, they often feel shocked and scared. Mental health disorders on their own can overwhelm families. Families who once had a safe and comfortable daily routine may find themselves on an emotional roller coaster.

There are many studies that document the stress families experience when they have a relative with a mental illness. However, few studies have looked at the added impact when that family member with mental illness also has substance abuse problems. One study by researchers in the United States showed what many of these families already know too well: that substance abuse contributes to family conflict and wears away social support (Kashner et al., 1991).

Family members' lives often change dramatically after a family member develops concurrent disorders. Many of these changes create stress. This chapter discusses:
- behaviour changes in the person with concurrent disorders
- relationship changes between family members
- increased responsibility for caregiving
- the impact on the caregivers.

Before we discuss these experiences further, it's important to recognize that some positive changes can and do happen. While family members must acknowledge and cope with the challenges they face, these challenges represent only one aspect of the caregiver experience. Many family members describe a renewed sense of closeness with their loved one and an appreciation for the truly important things in life, such as connecting emotionally with another human being, having hope, overcoming extreme hardships and experiencing the journey of recovery along with their loved one. Many family members find a positive way to think about difficult circumstances—for example, seeing caregiving in terms of hope and personal growth, as an experience that has positively transformed them.

BEHAVIOUR CHANGES

Mental health problems can bring frightening changes in how people experience reality. These changes can affect their relationships and ability to function. Behaviour changes include paranoia and hallucinations, feelings of anger, drastic mood changes or overwhelming anxiety. People with mental health problems may:
- begin to lose trust in close family members
- find it hard to make even simple decisions, to complete plans or to set goals
- stop participating in activities that they once enjoyed
- cut themselves off from the outside world
- find it hard to express their feelings and thoughts
- retreat into their own inner world
- become hostile, even with their families.

> *You have lots of your own feelings about it, and then lots of feelings for your loved one. How is this going to affect their life? What's going to happen to them? There are so many things that just come pouring in. And you have concerns for their siblings, for your other children . . . it can affect so many people.*

Substance use problems can interfere with a person's ability to follow family routines and meet their responsibilities. They may:

- spend more time getting and using substances, and less time or no time in their usual activities
- have financial problems (the cost of using substances can become quite high; in some cases, substance use can lead to job loss, which can create further money problems)
- act out physically.

RELATIONSHIP CHANGES

The family member with concurrent disorders

The person with concurrent disorders will often feel that family members are invading his or her personal life. Resentment about being overprotected may lead to anger, rebellion and acting out. These behaviours may increase the risk that the mental health problems will worsen or that the person will end up in unsafe situations. The cycle of the family's preoccupation and the loved one's reaction then repeats itself. This costs everyone in terms of time, physical and emotional energy, and quality of life.

Parents

Parents of children with mental health disorders often feel a great sense of loss and sadness when they see the changes in their child. Family members may have to change their expectations for their loved one regarding education, career paths, marriage and children. This can involve emotional pain, a sense of loss, grief, sadness and anger. The grieving process is similar to the one experienced by those who have had a loved one die, or who must adjust to a serious chronic physical illness in a loved one.

> *The whole family—we had so many other problems to face, you know? I remember feeling grief and frustration and a sense of tremendous loss, for my daughter and for her potential.*

Siblings

Siblings may worry about developing mental health problems, substance problems or both. They may worry about the stress and strain that their parents are enduring, and may take on the burden of trying to make up for what their parents have lost in their other child. At the same time, brothers or sisters sometimes resent the time that parents spend with their sibling. They may become angry to the point of acting out or distancing themselves from family and friends.

> *I remember being teased as a child because I was so serious, so sombre—and people told me that I acted like a middle-aged woman, a lot older than I actually was. It was impossible to explain to other people—like, you go to school after not sleeping all night, and after the police were at your house because of your sister's psychotic episode, and no one thought of dinner or anything like that because she overdosed and your parents had to go to the emergency room with her, and then you go to school the next day and it's like, all the expectations are still on you. But you don't tell anybody anything, you just carry on as usual. You can't talk to anybody about it. Nobody will understand . . . .*

Siblings may also experience anger, hostility or verbal or physical aggression from their brother or sister. These behaviours can evoke shock, dismay, fear and a sense of abandonment and rejection. Sometimes, children may feel like they have lost their best friend. They may feel guilty that they have a better life than their brother or sister.

HELPING CHILDREN COPE

Parents can help their other children by:

- assuring children that behaviours such as aggression are symptoms of the illness and shouldn't be taken personally
- sharing feelings and encouraging children to talk about how they feel and how their brother's or sister's problems are affecting them
- explaining that family members often feel uncomfortable, embarrassed or ashamed of their relative's behaviours, symptoms and diagnosis
- if appropriate, discussing the issue of stigma and why it happens, as well as effective ways to deal with it (see Chapter 6 for more information about stigma)
- helping siblings learn about substance use and mental health problems and how these interact with and affect each other
- spending time alone with siblings, talking and doing enjoyable activities
- helping children build a new relationship with their brother or sister and creating unique ways of being with their sibling.

INCREASED RESPONSIBILITY

Caring for basic needs

Family members may begin to take on much more responsibility for their relative. In more severe cases, the relative may be unable to care for basic needs such as keeping up with personal hygiene, eating meals or even getting out of bed. If the caregiver is also the family's only source of income, being unable to leave the family member alone can lead to huge financial consequences for the family and more emotional strain for the caregiver.

> *Our son not only has schizophrenia, but he uses drugs, he's been involved with gangs—and with the police. Half the time we're not sure if he's taking his medication—he gets mad if we keep after him to do simple things, like have a shower . . . we're so stressed as it is. We're trying to find out things, how we can resolve some of these problems. Sometimes I think I can't deal with it all.*

People with concurrent disorders often have trouble maintaining stable and decent housing. They may:

- spend their money on substances rather than rent, which can lead to eviction
- become involved in criminal activity such as robbing, property theft, prostitution or the sale of drugs to raise the large amounts of cash needed to buy the substances they use, which can result in loss of supportive housing and sometimes homelessness
- open their home to others involved in problem substance use, then be unable to maintain that home, forget to feed and bathe themselves, pay heat and light bills, and face eviction.

These consequences create even more challenges for the families.

Co-ordinating treatment

Some mental health programs refuse to treat people with concurrent disorders, or only treat the mental health problem. Similarly, some addiction treatment programs and facilities may not address the mental health problem. Families may have to take responsibility for co-ordinating treatment between two or more service providers, as well as caring for their relative.

> *Having a loved one who is suffering from both a mental illness and a substance use disorder can represent a significant disruption in the lives of families and can have an enormous impact on overall family functioning and sense of well-being.*

> *People need to be able to call somebody when their loved one is in the hospital because of a mental illness or a drug problem. They need to be able to touch base and get information from someone. It's hard for people who don't know the system—like, what channels have to be manoeuvred—or who to call when you have specific questions. There are so many roadblocks.*

Some suggestions for navigating the substance use and mental health system are discussed in Chapter 7.

IMPACT ON CAREGIVERS

Family members may be concerned about leaving their relative alone because they are worried that he or she will take harmful drugs, forget to take medications, take part in dangerous or criminal behaviour to get illegal drugs, or harm him- or herself during a serious episode of illness. If family members are constantly watching for symptoms and dealing with the impact of the illness, they may feel overwhelmed.

> *You become extremely protective of [family members who are ill]. It takes incredible emotional energy.*

Some family members may find it almost impossible to soothe their own anxieties, and distract themselves from the strain of coping with their relative. They may feel unable or even guilty to take time for themselves, to relax, care for their own emotional and physical health, and rebuild their own coping resources. Sometimes, family members even feel guilty if they experience resentment or anger. They should admit if they are extremely tired, worn out, angry or bitter. Denying these emotions can lead to exhaustion, depression, isolation and hopelessness.

They may feel isolated from others who were once very good friends. They might feel that they don't have the time to maintain friendships, or they may be embarrassed or ashamed about the concurrent disorders.

Think about your own situation and how your life has been affected. Remember that all family members experience difficult circumstances and negative feelings. It is very common for family members to feel guilty when they are asked to think about how this has affected their own lives. However, before you can begin to take care of yourself and play a positive role in your loved one's recovery, you need to think honestly about the different ways that your life has been changed.

Caregiver burden and compassion fatigue: A note about language

The term **caregiver burden** is used in professional literature to describe the emotional, social and psychological toll on the family that comes from caring for someone with a substance use and/or mental health problem. Many caregivers, while they like others to recognize how difficult it is to care for a family member with concurrent disorders, don't like the term "caregiver burden." They feel it ignores the positive side of looking after the needs of someone important to them and negates the fact that, in spite of the stress, they love the person and would go to the ends of the earth to help and protect them. It also dehumanizes their loved one, and reduces him or her to a "burden," which the caregiver hopes will not always be the case.

The stress and feelings of powerlessness that are such a large part of caring for a family member with concurrent disorders may be better described as **compassion fatigue.** We use compassion fatigue here to describe the overwhelming physical, emotional, social and spiritual exhaustion that can strike family members affected by concurrent disorders. It is a much more user-friendly term for describing the results of ongoing coping with extreme adversity.

You can find some strategies for dealing with compassion fatigue at:

www.mytherapynet.com/Public/ShowText.asp?EUID=&articleid=134&articletype=25

Activity 4-1: Personal impact log

This log will help you think about the effects of your loved one's mental illness and substance use problems on your own physical, emotional, social and spiritual health. It will help you break the overall impact on your life into smaller, more manageable areas of concern.

Below is an example of a personal impact log.

PERSONAL IMPACT LOG	
Physical health	**Emotional health**
• chest pain has returned—too worried about my son • no time to go to my own doctor anymore • no longer exercising • always tired • can't sleep without taking sleeping medication (never used to need anything to sleep) • joint stiffness & neck pain • eat high-sugar foods, don't care about my diet anymore	• constant worrying about Kevin • worrying about everything now • bad anxiety and sadness • I'm always angry or frustrated or depressed these days • I snap at my other children and then feel guilty • I'm angry with my husband—he gets to leave for work all day and leaves me to deal with all of our problems
Social life	**Spiritual life**
• never go out with husband or close friends anymore • never have guests over for dinner or Friday euchre nights • can't concentrate on reading • spend all of our time in emergency rooms or visiting Kevin on psychiatric wards	• do not know what this is anymore! • don't go to church • no time for my daily meditation readings • don't feel like doing my yoga sessions anymore • bitter and resentful about my son's illness—why our family? • angry with God

On the blank personal impact log, write down the ways your life has been affected in the areas that apply to you. You may find that you fill in only some of the areas.

You will use this information again as you work through the self-care plan in the next chapter.

PERSONAL IMPACT LOG	
Physical health	**Emotional health**
Social life	**Spiritual life**

Activity 4-2: Preoccupation and impact

It can be difficult to take even the smallest steps forward if you don't know the source of your worry, preoccupation and distress.

This is an early version of a tool we are calling the family concurrent disorders **Preoccupation and Impact Scale (PAIS).** It'll help you think about how much having a family member with concurrent disorders is affecting your life; specifically, how absorbed you are with thoughts, fears and worries about your family member with these disorders. This scale still needs to be formally tested, so at this point the intention (rather than interpreting your score) is simply to encourage you to consider how much the preoccupation effect has infiltrated which aspects of your life. Completing this quiz may help you realize that you have moved beyond a constant state of preoccupation to an emotionally healthier, calmer, more balanced lifestyle. Indicate how strongly you agree or disagree with each statement. Circle 1 if you strongly agree, 2 if you agree, 3 if you disagree and 4 if you strongly disagree.

How strongly do you agree or disagree with these statements?	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
I can't stop worrying about my family member's illness.	1	2	3	4	9
I am able to maintain a healthy balance in my life.	1	2	3	4	9
I have trouble thinking about anything other than my family member's mental illness and substance use problems.	1	2	3	4	9
I feel that I'm completely preoccupied with my family member's mental illness and substance use problems.	1	2	3	4	9
My daily routine completely centres on my family member's illness.	1	2	3	4	9
I find myself a lot more anxious these days.	1	2	3	4	9
I make sure that I find time to do things for myself and to have fun.	1	2	3	4	9
I never feel that I am doing enough for my ill family member.	1	2	3	4	9

Sometimes I feel that I am drowning in my family member's illness.	1	2	3	4	9
I focus so much on my ill relative's problems that I have difficulty finding time to spend on other members of my family.	1	2	3	4	9
I have very little time and energy to socialize with my friends.	1	2	3	4	9
My physical health (e.g., nutrition, sleep and rest) has been negatively affected since I've been dealing with my family member's mental health and substance use problems.	1	2	3	4	9
I have had a hard time gaining a sense of emotional well-being since my family member developed mental illness and substance use problems.	1	2	3	4	9
I am able to cope with my loved one's mental illness and substance use problems.	1	2	3	4	9
I think it is OK for family members to feel angry with, or resentful of, their ill loved one.	1	2	3	4	9

Activity 4-3: The family concurrent disorders index of concerns quiz

The items included in this quiz may also help you pinpoint your areas of concern. Once you've listed them, you can think about how to resolve them. Think in terms of small steps you can make gradually.

Completing this quiz may also help you to:
- identify personal areas of concern over which you have little control
- consider how you might learn to accept what you cannot change.

For each item, circle the number that best corresponds with *how you are feeling right now.* Once you have completed all of the questions, add them up. The higher your total score, the more uneasy, worried or alarmed you are overall about your situation and the more you need to focus on your own emotional, social and physical health and well-being.

How concerned am I about...

	Not concerned										*Very concerned*
the immediate overall health and well-being of my ill family member?	0	1	2	3	4	5	6	7	8	9	10
the immediate overall health and well-being of the other members of my family?	0	1	2	3	4	5	6	7	8	9	10
my own immediate overall health and well-being?	0	1	2	3	4	5	6	7	8	9	10
the long-term overall health and well-being of my ill family member?	0	1	2	3	4	5	6	7	8	9	10
the long-term overall health and well-being of the other members of my family?	0	1	2	3	4	5	6	7	8	9	10
my own long-term overall health and well-being?	0	1	2	3	4	5	6	7	8	9	10

	Not concerned										*Very concerned*
how much my ill family member is suffering?	0	1	2	3	4	5	6	7	8	9	10
how much the other members of my family are suffering?	0	1	2	3	4	5	6	7	8	9	10
how much I am suffering?	0	1	2	3	4	5	6	7	8	9	10
my ill family member's ability to get through this?	0	1	2	3	4	5	6	7	8	9	10
the ability of my other family members to get through this?	0	1	2	3	4	5	6	7	8	9	10
my own ability to get through this?	0	1	2	3	4	5	6	7	8	9	10
the emotional health of my ill family member?	0	1	2	3	4	5	6	7	8	9	10
the emotional health of the other members of my family?	0	1	2	3	4	5	6	7	8	9	10
my own emotional health?	0	1	2	3	4	5	6	7	8	9	10
whether my ill family member is getting enough social support?	0	1	2	3	4	5	6	7	8	9	10
whether the other members of my family are getting enough social support?	0	1	2	3	4	5	6	7	8	9	10
whether I am getting enough social support?	0	1	2	3	4	5	6	7	8	9	10
my ill family member's physical health?	0	1	2	3	4	5	6	7	8	9	10
the physical health of the other members of my family?	0	1	2	3	4	5	6	7	8	9	10

	Not concerned										*Very concerned*
my own physical health?	0	1	2	3	4	5	6	7	8	9	10
the spiritual health of my ill family member?	0	1	2	3	4	5	6	7	8	9	10
the spiritual health of the other members of my family?	0	1	2	3	4	5	6	7	8	9	10
my own spiritual health?	0	1	2	3	4	5	6	7	8	9	10
my ill family member's financial situation?	0	1	2	3	4	5	6	7	8	9	10
the financial situation of the other members of my family?	0	1	2	3	4	5	6	7	8	9	10
my own financial situation?	0	1	2	3	4	5	6	7	8	9	10
my ill family member's journey of recovery?	0	1	2	3	4	5	6	7	8	9	10
the recovery journey of the other members of my family?	0	1	2	3	4	5	6	7	8	9	10
my own journey of recovery?	0	1	2	3	4	5	6	7	8	9	10

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Self-care

5

Outline

- Resilience
- Short-term self-care strategies
- Long-term self-care goals
- Building a self-care plan

In Chapter 4, we discussed the enormous challenges involved in having a loved one with both mental health and substance use problems. You and your family members should never underestimate the benefits of taking care of yourselves. Taking good care of yourself gives you more physical and emotional energy to deal with the challenges you face, and that will benefit your family member with the illness. Family members will each find their own way to care for themselves. Being able to soothe, relax and calm yourself involves:

- knowing what kinds of thoughts and behaviours make you feel better or worse
- coming up with a self-care plan that helps you to prevent or overcome the negative feelings.

This plan involves following a structured routine each day, engaging in a particular activity, spending time with a good friend, or focusing on a way of thinking—anything that may comfort you and give you a sense of well-being and stability. We will develop a self-care plan later in this chapter.

RESILIENCE

> *The strongest oak of the forest is not the one that is protected from the storm and hidden from the sun. It is the one that stands in the open, where it is compelled to struggle for its existence against the winds and rains and the scorching sun.*
>
> *—Napoleon Hill (1883–1970)*

What is resilience?

Resilience is frequently described as the capacity to thrive and fulfil one's potential despite (or perhaps because of) stressful circumstances. All of us are resilient in one way or another, but some people seem to be more so. They are inclined to see challenges as learning opportunities that can lead to healthy emotional growth and development.

Factors that are characteristic of resilient people include:

- a sense of closeness and connectedness to others
- strong, dependable support from at least one significant other in their lives
- attention to their own personal health and well-being
- high self-esteem
- a strong sense of personal identity
- a realistic and balanced awareness of their strengths and limitations
- the ability to be assertive and emotionally tough when necessary, but also sensitive and compassionate

- a playful, lighthearted approach to life
- a sense of direction and purpose in life
- the ability to turn difficult experiences into valuable learning opportunities
- the capacity to pick themselves up, shake themselves off and keep moving forward after traumatic and upsetting situations
- the ability to adapt to and live comfortably with uncertainty and unpredictability
- the ability to laugh at themselves. Resilient people do not "sweat the small stuff."

> *A sense of humor can help you overlook the unattractive, tolerate the unpleasant, cope with the unexpected and smile through the unbearable.*
>
> *—Moshe Waldoks*

Developing resilience

Ask yourself:
- How resilient am I?
- In what specific ways am I very resilient?
- In what ways am I less resilient and how can I change this?

Activity 5-1: Assessing resilience

Developed by Patricia Morgan

To help you answer these questions, try filling out a resiliency questionnaire or quiz. There are many tools designed to help you assess your personal level of resilience. We have included one of these quizzes in this chapter.

Resilience is the ability to recover or bounce back from and effectively adapt to life changes and challenges. Anyone can strengthen their resiliency. Celebrate the resilient aspects you have in place and take action to improve the rest.

Rate yourself in the following areas:

Never (0) Seldom (1) Sometimes (2) Frequently (3) Always (4)

Attend to Your Body

1. I recognize when my body is feeling distress _____
2. I deliberately relax my body when I realize it is strained _____

3. I eat a wholesome diet _____

4. I get adequate rest _____

5. I routinely exercise _____

Attend to Your Inner Self

6. I take charge of my thoughts in stressful situations _____

7. I recognize when I talk to myself in a criticizing or shaming manner _____

8. I minimize my critical self talk and increase my supportive self talk _____

9. I know what my main strengths or gifts are (example: assertive, disciplined, honest, organized) _____

10. I use and volunteer my strengths or gifts _____

Attend to Your Communication

11. I change negative comments into positive phrasing _____

12. I listen to others and communicate clearly my position _____

13. I work towards finding a mutual agreement in conflicts _____

14. I minimize my criticism of others while offering helpful feedback _____

15. I assert myself by saying "yes," "no" or "I will think it over" _____

Attend to Your Social Support

16. I feel close and connected to significant others _____

17. I give and receive help, support and listening time at home and at work _____

18. I express appreciation to others at home and work _____

19. I encourage and act as a team cheer leader at home and work _____

20. I say, "I am sorry" and make amends when I make mistakes _____

Attend to Giving Your Life Meaning

21. I learn and give meaning to mistakes, hurts and disappointments _____

22. I view work, relationships and life with realistic optimism _____

23. I set and meet realistic goals and expectations _____

24. I laugh at myself while taking my responsibilities seriously _____

25. I find health, optimism, pleasure, gratitude and meaning in my life _____

INTERPRETING YOUR SCORE

Bounce Back Champ (Score from 75 to 100) Congratulations! You have developed a strong resilience factor. You know that it takes daily effort to bounce back from big and little strains. You support yourself with affirming self talk, a healthy lifestyle and a supportive network. You have a sense of humor and an optimistic attitude. Accepting responsibility for your pain, laughter and purpose has strengthened who you are.

Bouncy Challenger (Score from 35 to 74) You have strength in some factors of resilience while other areas need attention. Celebrate what is working and take an inventory of the weaker aspects. Note the answers you scored 0 or 1. Then develop a plan that will address your resiliency needs. Consider reading articles, books, taking a course and finding reasons to smile more often.

Bouncing Low (Score from 0 to 34) Please get yourself some help before you become seriously ill, if you are not already. You are at risk for challenges ranging from depression to migraines to irritable bowel syndrome to heart disease. Make a drastic life change, seek help and put a plan in place. By working on your physical, mental and emotional well-being and resilience you will relieve your loved ones of much worry and create the life you deserve. Please see a doctor, confide in a friend or call your local distress centre if you believe you cannot cope. This will be your first step toward rebuilding your resilience.

Note: Although this tool is based on resilience research, neither it nor the scores have been formally validated. It is intended to provide basic information so you might strengthen your resilience.

For more information see Patricia Morgan's website:
www.lightheartedconcepts.com

Other resiliency assessment tools you may find interesting and helpful include:

- "How Resilient Are You?" by A. Siebert (www.resiliencycenter.com)
- "The Resiliency Quiz" by N. Henderson (www.resiliency.com/htm/resiliencyquiz.htm)

SHORT-TERM SELF-CARE STRATEGIES

Developing a plan of self-care involves thinking about ways to care for yourself on days when you might feel particularly stressed or worn down. Short-term goals focus on the fast and relatively easy ways that you can soothe yourself and replenish your energy. We call these strategies "the quick wins."

Putting the brakes on

Family members identified these short-term strategies that helped them ease their anxiety for a moment so they could face their situation with renewed energy:

- Have your morning coffee.
- Talk to someone you trust.
- Hug your pet.
- Take a deep breath.
- Take a timeout.
- Take a long, hot shower.
- Apply your favourite body lotion.
- Watch your favourite TV show.
- Sit in your backyard after dinner.
- Go for a long walk.
- Become more aware of nature.
- Go to a movie.
- Go shopping and treat yourself to something new.
- Give yourself permission to feel upset and frustrated, and permission to overcome these feelings.
- Structure your day to ensure it includes leisure time.
- Think about things that make you feel happy or soothed or comforted and make a note of them so you can remember to add those things to your list of self-care quick wins.

These short-term strategies will be unique to each family member. List the quick wins that might be most helpful for you, and add to your list when something comes up that you find pleasant or re-energizing, such as visiting a flower market.

Strength and forgiveness

Another self-care strategy involves recognizing and having appreciation for your own personal strengths. This can take a great deal of practice. We can be very hard on ourselves. We can also start to focus on what we think we are doing wrong, instead of right, particularly where it concerns family members who are ill. In fact, it can be much harder to suffer the illness of someone you love than to suffer the illness yourself.

It is essential to keep a sense of yourself as a person independent of your relationship to your relative with the illness. Acknowledging your strengths and giving yourself permission to be human may involve learning to think in new ways about your circumstances. For example, acknowledging positive aspects about yourself—such as intelligence, a good sense of humour, perseverance, motivation, physical abilities—is particularly important when you are stressed. You can practise this type of thinking every time you become overwhelmed with guilt or hopelessness.

Positive self-talk

One way to learn to think about your situation in new ways is by using self-talk. For example, tell yourself, "I am doing the very best I can. I'm only human. I am a caring and loving mother." Letting yourself experience all of your feelings is extremely important when you are coping with difficult circumstances.

Activity 5-2: Quick wins

Strengths

One quick win involves recognizing your strengths. Think about five of your greatest strengths (e.g., the considerate things that you do for yourself or for other people, your sense of humour, your skill in a particular sport).

List them below.

1. _____

2. _____

3. _____

4. _____

5. _____

Role models

Another quick win can involve identifying role models. These could be other people who have overcome adversity and whom you admire because of the way they can take care of themselves, both in calm periods and in crises. Think specifically about why you are choosing these particular people as role models, and identity the characteristics that you appreciate in them.

My role models are:

_____

_____

_____

_____

_____

Activity 5-3: Stop/start/continue

Think about ways of behaving, feeling or thinking that you would like to:
- stop
- start
- continue.

For example:
I would like to **stop** feeling guilty that I am not doing more for my ill family member.

I would like to **start** taking an afternoon time out just for myself, to go shopping or to do yoga or to visit with friends.

I would like to **continue** going to a family self-help group such as the Mood Disorders Association of Ontario when this support group ends.

Write down your wishes.

Stop: _____

Start: _____

Continue: _____

LONG-TERM SELF-CARE STRATEGIES

Recognizing and addressing challenges

There are many challenges in having a relative with concurrent disorders. Try to identify and prioritize these challenges. You may decide that some cannot be dealt with quickly or easily. Others can be addressed immediately and even resolved. It can be difficult for family members when a loved one:

- refuses to take psychiatric medication
- feels severely depressed and suicidal
- lacks motivation and will not get out of bed
- doesn't think it's necessary to go to appointments and groups to solve problems
- uses alcohol or other drugs in your home
- doesn't see the alcohol or other drug use as a problem and, in fact, may tell you that those substances improve the symptoms of the mental health problem
- will not respond to your suggestions or offers for help
- becomes angry, verbally abusive or aggressive toward you and other family members.

It can also be difficult when:

- you or another family member become physically ill and are unable to attend to your relative
- you feel overwhelmed, anxious or depressed yourself, and it begins to affect your ability to care for your loved one
- you are afraid to leave your loved one at home alone, and yet you need to go to work
- another family member develops a mental health or substance problem (or both).

Making a list of your options and possible solutions can help you develop an action plan. Some challenges may require help from other people, such as other family members, friends or health care professionals. You may decide to see a health professional who can help you with your own needs and concerns. You may join a family support group after this one, or even while this one is running. You can make a list of especially close and supportive relatives and friends for help in a crisis. Maybe you can hand over some responsibilities that can be carried out by others, so you can lighten your load in general (e.g., ask for help in car pools, have another family member shop for groceries, simplify the home cleaning schedule, teach everyone the miracle of the microwave!).

Sometimes you need to change the way you think about the problem. Perhaps you need to deal with it differently. For example, you might decide to set limits and clear boundaries with your loved one, so that you do not feel helpless, angry and manipulated. Setting limits also helps your relative because your expectations for his or her behaviour are clearly stated (see Chapter 10: Limit-setting, p.163). Then you must always follow through with the consequences, whatever you decide they will be. Feeling in control is an important part of a long-term self-care strategy.

Understanding problematic thought patterns

Trying to cope with emotions is challenging for many people at the best of times. When faced with severe and persistent stress, you can find it even harder to deal with anger, grief, loneliness, sadness, shame and guilt.

Remember that feelings are intertwined with thoughts, beliefs and behaviours. For example, if caregivers believe that they caused a family member's co-occurring mental health and substance use problems, then they are more likely to feel responsible for their family member's relapses. Such beliefs may then lead to feelings of sadness, guilt and remorse. If caregivers are not able to cope with these emotions constructively, they could avoid seeking help for their family members or for themselves. This may have serious repercussions for their family members and for their own health and well-being. All the self-care morning coffees in the world will not help if you let problematic thinking rule your thoughts.

In *Feeling Good*, David Burns discusses how errors in thoughts and beliefs may lead to negative emotions. Awareness of the types of problematic thinking often helps caregivers to recognize these types of thinking in themselves. They are then in a better position to work on strategies for changing problematic thoughts and beliefs.

OVERGENERALIZATION

This is a common distortion in thinking that leads people to conclude that things are worse than they really are. It occurs when a person exaggerates and therefore inaccurately appraises an event or situation. For example, a family member may think, "I failed to convince my daughter that she needs to take her medication, and she ended up being taken to emergency by the police. Since I failed to help her, that must mean I'm a failure as a person." Mental filter bias is a type of overgeneralization in which a person focuses only on the negative aspects of an experience and downplays or ignores the positive aspects.

MAGNIFICATION

Magnification, or catastrophizing, occurs when a negative event is blown out of proportion. For example, the father of a teenage son with concurrent depression and alcohol abuse thinks "Our neighbours looked at my wife and me in a funny way this morning and didn't even say hello. That must mean they think we're to blame for our son's illness and they want nothing to do with us because they think we're bad parents." This brief encounter is interpreted as something catastrophic.

MINIMIZATION

Minimization occurs when people downplay the meaning and importance of a positive event. "It's great that I was hired for this job after almost 25 people applied for it. It pays more than any job I've ever had before and my new boss said he is looking forward to hearing more about my ideas. I'll get to talk about these ideas in the executive board room meetings . . . but all I can think about now is the increase in taxes I'll have to pay with the higher salary and all the extra meetings I'll have to go to. Besides, I probably won't last long anyway. Once my boss sees that I'm actually underqualified, I'll be fired and then I won't be able to pay any of my bills. And I really only got the job because my cousin worked here for years and put in a good word for me."

DISQUALIFYING THE POSITIVE

Disqualifying the positive occurs when people do pay attention to positive information but then later find a reason to discount it. "It's great to have a friend like Barb call me all the time to talk, but she only calls me because her best friend got a new job now and is busy during the day. She really doesn't even like me."

ALL-OR-NOTHING THINKING

All-or-nothing, or black-and-white, thinking occurs when a person's evaluation of an experience lies at one extreme or the other. For example, a person does not get a job that he or she really wanted. Instead of thinking, "Up until now, I've been hired for most of the jobs that I've ever applied for, so if I keep looking, a great job is bound to turn up," the person thinks, "I was just turned down for the best job I've ever applied for. I'll never have an opportunity like that again—I'm a total failure."

JUMPING TO CONCLUSIONS

This occurs when people jump to (usually negative) conclusions that are not justified by the facts that they have about the situation. "It looks like this is going to be a good day to relax and watch television, but I just know that the minute I sit down, another family crisis will start up."

MIND READING

Mind reading occurs when people assume, without any evidence, that someone is thinking something negative about them. They react based on this conclusion, which is often false. “Why should I bother trying to talk to my co-workers down the hall? They all hate me and think that I should be replaced by somebody who actually knows what they’re doing.”

SHOULD, MUST AND OUGHT BELIEFS

These thoughts and beliefs are often found in people who set unrealistic, often impossible demands on themselves. When they fail to meet these demands, they either punish themselves for their perceived failures or sink into low self-esteem and depression. “I should be a better father”; “I ought to try harder to stop my husband from drinking”; “I should be better looking. I’ll never get ahead in this life being this ugly!”

Some people with perfectionistic tendencies may also hold others to unrealistically high standards. “My mother should learn a lot more about how to deal with my brother. She should kick him out of the house if he refuses to take his medication and clean himself up. And I can’t understand why she doesn’t *demand* that he go to a drug treatment centre. She lets him just sit around the house thinking about whether or not he’s ready to get help. If he were my son instead of my brother, I’d have him whipped into shape in no time. Nobody in this family can do anything right.”

PERSONALIZING AND BLAMING

This happens when a person takes responsibility for something that in reality they had very little control over. “I wasn’t paying enough attention to my son. If I hadn’t been so busy working and doing other things, I would have known that he was planning to hurt himself and I could have stopped him. It’s because of my negligence that he’s back in the hospital.”

Similarly, a person might unfairly assign responsibility to someone else. “You would think my adult children would have noticed how stressed out I’ve been trying to take care of their father and work and manage the whole household at the same time. They can be so selfish and self-centred. If they had been more helpful, I could have paid more attention to my husband and he’d be off the drugs by now. It's really their fault that the whole situation is so out of control.”

Dealing with difficult emotions

Strategies that may help you to deal more effectively with difficult feelings include:
- repeating positive affirmations over and over to yourself such as, "I am doing the best that I can and I am a good and decent person."
- being aware of yourself and any problematic thoughts you might be having about situations, events and other people that might be resulting in negative feelings
- being aware of how you handle stress and what kinds of stressful situations leave you feeling most vulnerable
- developing effective ways of coping with a family member who has concurrent disorders (e.g., finding out how to navigate the treatment system and get help (see Chapter 7, p. 107)
- setting limits and clear boundaries (see Chapter 10, p. 163)
- talking openly and honestly about how you feel, and examining those feelings, either with someone you trust or within a peer or professionally led support group
- talking to other families about effective ways to deal with stress and difficult emotions
- developing and following your own personalized self-care plan.

If you practise these strategies on a regular basis, you can cut down the frequency and intensity of distressing thoughts. They can help prevent negative moods from occurring in the first place, and also help prevent them from getting a lot worse.

In order for many of these strategies to work, it is better if you are calm and thinking logically and rationally. **In a stressful situation, if you find that you are *already* experiencing intensely negative feelings, it might be better to first try calming and soothing yourself before you try to work on any problematic thoughts and beliefs.**

Building social support

Family members often give up their own activities, and can become isolated from their friends and colleagues when caring for a family member with concurrent disorders. Social support is crucial to help you achieve and maintain emotional and even physical health.

FRIENDS AND COLLEAGUES

Some people find it helpful to have a large social network to draw on. Others prefer to have only a few supportive and understanding friends. Participating in a group activity you enjoy, such as a walking club, a sports team, a reading club or church group can help you retain your social network. Old friends and colleagues you've grown apart from may appreciate hearing from you. Being open about your situation will often bring support from the least likely places and people.

SELF-HELP ORGANIZATIONS

Many family members join family self-help / mutual aid support organizations such as the Schizophrenia Society of Ontario (SSO), the Mood Disorders Association of Ontario (MDAO) or the Family Association for Mental Health Everywhere (FAME). While these groups provide support, education and advocacy for family members of people with a mental illness, many of the participants have loved ones with both a mental health problem *and* a substance use problem.

Some of the groups are structured with educational programs or guest speakers from the mental health care system. Other groups are more informal and may involve small group discussions and peer support from other family members struggling with similar issues. Some families also choose to attend self-help groups for family members of people with alcohol or other drug problems. These groups include Al-Anon (for family members of people with alcohol problems), Alateen (for young adults who have siblings with substance use problems) and Nar-Anon (for families of people with substance use problems). (See Tips for Evaluating Self-Help Groups, p. 132.)

Becoming informed

Information is power. Many family members seek both formal and informal opportunities to learn about concurrent mental health and substance use problems. They find it helpful to learn as much as they can about their loved one's particular mental health and substance use problems, including the causes, signs, symptoms and possible treatments.

Believing in yourself and your rights

You have a right to ask questions and to receive attention and respect from health care professionals. Some people with concurrent disorders want their family members to be very involved in their treatment plan, even if they're in hospital. Others may prefer not to involve their families and may want to keep their personal information confidential. Whether or not you are actively involved in the professional care of your family member, you have a right to:

- your own support from health care professionals
- education about mental health and substance use problems
- information about the latest research and most effective treatment options
- respect and validation.

(See Family involvement in Chapter 7, p. 115, and The role of family in chapter 11, p. 190.)

BUILDING A SELF-CARE PLAN

Developing a self-care plan will help you think about the small steps you can take in your own life to build your resilience and reduce your vulnerability to compassion fatigue.

Imagine what your self-care plan might look like. This plan should address all your needs:
- biological self-care (caring for your own physical health)
- psychological self-care (taking care of your emotional health)
- social self-care (taking care of your social needs and networks)
- spiritual self-care (drawing on sources of spiritual help that might comfort and guide you)
- financial self-care.

This plan is called the biopsychosocial-spiritual self-care plan. Just remember to be very specific in your self-care plan. For example, a family member may choose to include something like the following in his or her plan:
- I will work out at the local gym three times a week for 30 minutes each time.
- I will walk reasonable distances instead of taking my car.
- I will go to Pilates classes with my friend Sheila once every week.
- I will eat three fruits a day, and take a B6 multivitamin.
- I will prepare two meatless dinners a week.

Activity 5-4: Self-care plan

Think about how you can take care of your needs. See the following example of a self-care plan:

BIOPSYCHOSOCIAL-SPIRITUAL SELF-CARE PLAN	
Physical health	**Emotional health**
• start daily walks again • return to exercise classes (30 minutes low impact at first; when ready, 45 minutes of high impact & weights) • park my car further away from entrances and walk the remaining distance • use stairs instead of escalators • start shopping for healthy foods that I enjoy and return to healthy eating habits.	• attend family support groups with my husband to help us cope with Kevin's illness • resume my gardening • set limits with Kevin (e.g., practise saying no, allow him to make mistakes) • talk to my husband about stresses instead of having a drink after work • continue attending Al-Anon and MDAO family meetings • set aside daily quiet time to read, garden or write in my journal.
Social life	**Spiritual life**
• go out for dinner with husband at least once per week • resume Friday "euchre nights" with our closest friends, Martha & Harry • go out with my best friend, Sue, at least once per week (shopping/lunch) • resume "family weekend outings" on Sundays.	• take classes on how to meditate • increase awareness of nature (e.g., birds & flowers during day, stars & solitude at night) • return to my readings on Buddhism & serenity • do my yoga sessions every morning when things are quieter around the house • return to my daily meditation readings.

Now write down your ideas so you can take care of your needs.

BIOPSYCHOSOCIAL-SPIRITUAL SELF-CARE PLAN	
Physical health	**Emotional health**
Social life	**Spiritual life**

If one of the areas in your self-care plan looks sparse or empty, you may want to think about whether this is a component of your life that you should work toward expanding. For example, if you have always been an energetic and active person, and in your personal impact log from Chapter 4 you wrote down that you are too busy to exercise and that you feel down and tired all the time, this is an excellent area to begin working on your own health and well-being.

REFERENCES

Burns, D.D. (1999). *Feeling Good: The New Mood Therapy, Revised and Updated*. New York: Avon.

Stigma

6

Outline

- Understanding stigma
- Experiencing stigma
- Surviving stigma
- Combating stigma

Much of this chapter is based on a study of family members in self-help / mutual aid groups (O'Grady, 2004). In this study, family members expressed how deeply stigma had affected them on personal, interpersonal, social and political levels. Some family members had learned to cope very effectively with the pain caused by stigma and discrimination, while others had never experienced stigma. However, most of the family members were not only struggling with the fear of others finding out about their loved one's illness, but were surprised and dismayed to find that they were sometimes blamed for the mental health and/or substance use problems experienced by their loved ones. The quotes included in this chapter come directly from interviews with these family members. Their stories reveal the degree of pain experienced by so many families as a direct result of prejudice, stigma and discrimination.

Families usually experience stigma in four stages:
- **Understanding stigma** refers to the ways in which family members understand and explain stigma to themselves and others.
- **Experiencing stigma** refers to the ways that families experience the consequences of stigma.
- **Surviving stigma** refers to the strategies family members use to cope with stigma.
- **Combating stigma** refers to the decision by some families to fight stigma on a social and political level.

This chapter will help you understand why stigma occurs and how families address these challenges.

UNDERSTANDING STIGMA

> *When I suspected I had cancer, I went for medical help right away. Then, for the first time in my life, I went through a real depression. It took three months before I would go to a psychiatrist's office—and I knew I was depressed. I mean, I was responsible for the care of a very mentally ill person, my husband. I was afraid of being someone who had to go for psychiatric help themselves. It meant that I was weak. I think the fact that we associate mental illness with some kind of weakness—it's going to take a long time to get away from that. I mean, I was asking myself, "Why am I depressed? I should be coping better than this."*

Many societies look down on people with mental health or substance use disorders. They—and their families—face negative attitudes, behaviours and comments. This is known as stigma. Stigma does more than make it more difficult to live with concurrent disorders. Stigma can:

- shame, isolate and punish the people who need help
- reduce the chances that a person will get appropriate help
- reduce social support
- lead to lower self-confidence
- make people feel that they will never be accepted in society.

Fear

Many people are frightened of mental health and substance use problems. One of our deepest fears involves the loss of our abilities to think and communicate, to make our own decisions and to set the course of our own lives. Many people believe that people with mental health and substance use problems and their families may be strange, unpredictable, violent or dangerous.

> *I think a common belief is that people with mental illness are violent—you know how the media sometimes portrays people. And then you think, are my relatives concerned that my daughter will be violent? And let's face it, she is often inappropriate and really angry when she's not well, but she never gets violent with people . . . but a lot of people associate mental illness with criminal behaviour in general.*

In fact, most people who are violent do not have mental illnesses. People who have mental illnesses are more likely to be the victims of violence—about 2.5 times more likely—than other members of society. This violence often occurs among those people who are also experiencing other factors such as poverty, homelessness and substance use. Unfortunately, recent research suggests that the public's perception that people with mental illness are violent and dangerous is actually rising (Canadian Mental Health Association, 2003).

Family members worry about acknowledging their loved ones' concurrent disorders to friends and acquaintances, and fear rejection by those who know. A main concern is that knowledge of the illness will reduce opportunities for their loved one.

> *What comes to mind when I think of stigma? My immediate thought is fear of exposure. You know, fear of people's reactions. I mean, you're very fearful of a change in people's attitudes toward you or toward your family member who's ill—and whatever affects the consumer, affects the family.*

Many people believe there is no hope for recovery or a future for someone with concurrent disorders. Family members often compare concurrent disorders to cancer. In the past, cancer was associated with stigma and avoidance, reactions that typically stemmed from fear. While cancer still arouses anxiety and fear, most people recognize that today many types are curable and others are treatable. Although concurrent disorders are similar to cancer in that a life of meaningful recovery is possible, they are often not seen that way.

The media

The media often misrepresent the link between mental health problems and violence, and present sensationalized, inaccurate and unflattering stereotypes of people with substance use and mental health problems, as well as of their family members.

Studies suggest that some types of discrimination have actually increased in the past 10 years, partly because of media coverage linking mental health disorders with violent murders (Canadian Mental Health Association, 2003). Media portrayals of mental illness emphasize its chronic nature, violence and criminal behaviour, while portrayals of substance use disorders emphasize poor self-control and hopelessness. Such misleading portrayals increase rejection, ostracism, harassment and victimization of people with mental illness, substance use disorders and concurrent disorders. Inappropriate or careless use of stigmatizing language is also common in the media.

> *I think the media is smartening up a little bit, but you still hear stuff all the time. I just heard someone on the news the other day say, "Oh, you'd have to be schizo to do that." Language is tricky, it can really hurt . . . . The media . . . have to be responsible. And we have to make them accountable. I think it's really important to make people be responsible for what they say and for the messages they put out about other human beings.*

The average North American household watches almost five hours of television per day (Nielsen Media Research, 2007). Many viewers don't question the negative images and information that they see.

On a more positive note, the number of documentaries and movies with realistic and sensitive messages is increasing.

> *At least there's more and more accurate information on television about mental illness, about schizophrenia and substance abuse, that at least portrays these people as people, shows their humanity, and the tragedy of their loss.*

Blame

Several years ago, the prevailing explanation for concurrent disorders blamed families for causing and prolonging these disorders. Many parents in the study recalled hearing this from both health care professionals and society in general.

> *I compare mental illness and addiction to Alzheimer's disease because my mother-in-law felt comfortable calling up all her relatives and letting us know that her husband had Alzheimer's. No doctor blamed her. The community offered all kinds of support and I think that's because they had known him to be a valid member of society, as a hard-working, neighbourly person for 75 years. And as people get older, we expect some mental degeneration, right? Whereas with mental illness . . . my mother was partially blamed for my sister's schizophrenia so she started hiding it from people.*

Usually a person with a physical illness is not expected to take on normal responsibilities or to get well purely by an act of will. When the problem is seen as resulting from personal choice, social expectations are often harsher.

> *For the longest time, I understood intellectually what the disease [schizophrenia and problem substance use] was—but deep down I thought it was my sister's fault, and if she really tried, she could have more self-control and could act better. But there comes a point when that way of thinking disappears, and you realize that people with mental illness didn't ask for this. This has to be the most horrible thing—to lose control of your own thoughts.*

EXPERIENCING STIGMA

Stigma by association

> *Some say that stigma is worse than the disease itself.*
>
> *—Torrey (1994)*

We have seen that a combination of biochemical changes in the brain and a wide range of environmental factors can trigger substance use and mental health problems. Yet many people still believe these problems are caused by the behaviours of family members.

Families may be blamed, feared or shunned because of their connection with their relative. Although many parents are reassured when they discover that there are biomedical components to mental health disorders, they continue to feel blamed by

society for their relative's problems. Whether families actually experience discrimination or negative attitudes, or fear that they might, the experience can be stressful. Because of the fear of stigma, people tend to hide the diagnosis. They may start avoiding others and live in fear that the illness will be discovered.

Family members experience the effects of stigma in many ways:
- Their social support network may shrink and they may face negative attitudes if they reveal the disorder.
- They may be disappointed by reactions from mental health care professionals and feel alienated from the treatment process.
- They often have to endure the effects of labelling and the visibility of the disorders.
- They may delay getting treatment due to fears of stigma.

> *As kids, we knew there was something wrong with my mother, but there was never any validation from anyone else about that. We couldn't really tell anybody or go to anybody for help. People that weren't really connected to the family couldn't see what was going on, and so it was just this constant sort of day-in and day-out bizarre inner world that we lived in, that nobody else could really see—and we were alone with it.*

Multiple sources of stigma

Multiple sources of stigma increase the risk of mental, emotional and physical health problems. The more visible a person's differences—for example, physical disability, noticeable developmental delay, non-white skin colour, unconventional dress, low English-language proficiency and accents—the less comfortable they are about accessing mental health care.

Isolation

Many people try to protect themselves from stigma by avoiding certain people or situations. However, limiting social interactions can increase loneliness and psychological distress and lead to social isolation. As a result, people may start to think that they are incompetent, strange or otherwise flawed. **A reduced social support network may actually lower family members' self-confidence and self-esteem, and they may experience depression.** In such cases, people are less likely to seek help.

> *I guess this has something to do with stigma—that you close out people that you could have counted on—people that you really need. And you end up closing them out only because of the stigma—not because you don't trust them or anything, it's just the stigma. And the risk is huge, so you're closing all the doors. You close the doors to any support link.*

Lack of acknowledgment

Families say that health care professionals rarely recognize family members' strengths, value their opinions or acknowledge their efforts to support their loved ones. Family needs are often not considered a priority, and integrated care for mental illness and substance use disorders is not widely available. Family members recount being ignored, patronized and blamed for their loved one's illness. They may feel that they are not being consulted about their relative's treatment.

> *I have felt resentful for all the years I put in before the illness was diagnosed. How much time and how much agony, and how much worry—because this was a child who was not developing normally, and nobody listened to me! I was so angry over that—and I'm still angry.*

CULTURALLY SENSITIVE TREATMENT

Treatment programs based on western philosophical values and assumptions may not be helpful for everyone. Family members comment on the lack of culturally sensitive mental health care services and the lack of families from various minority groups in support groups.

> *People have an opportunity to learn ways of handling problems like stigma, but only if you can actually get people to go to support groups—because that's the other thing—my parents aren't the kind of people to go to these groups. . . . And most of the people in these organizations tend to be Anglo-Saxon, female and mothers of mentally ill people. They're more educated, the kind of people who are likely to do volunteer work, join committees and organizations, and to help counsel others, whereas the average person from some cultures seems to prefer to keep it within the family—to hide the mental illness and the drug problem. They not only have to deal with mental illness—they belong to other ethnic backgrounds, and they may be stigmatized because of that.*

Labelling

Some families are reluctant to accept a formal diagnosis because of the potentially devastating effects of labelling. "Schizophrenic" and "drug abuser" are among the most powerful labels. Other diagnoses such as "depression and tranquillizer abuse" and "anxiety disorder with codeine abuse" can be interpreted as meaning that the person is not able to handle everyday stress. Health professionals may not take the symptoms of these disorders seriously and sometimes see these clients and families as "personality disordered" or "attention-seeking."

A formal diagnosis can be far more difficult to ignore or hide than informal labels. **A family member talked about having difficulty in accepting her brother's diagnosis of schizophrenia, preferring instead to believe that his bizarre and unpredictable behaviour was caused only by drug abuse.** Others may struggle to accept the reality of the diagnosis.

> *It really wasn't until he had a full-fledged psychotic episode that we knew it was more than just the drugs. It was different when the diagnosis became one of drug abuse* and *mental illness. It was really difficult. It was difficult to accept that schizophrenia was a real diagnosis also—it was difficult just to, sort of, rid myself of the feeling that, no, it can't be mental illness. It can't be schizophrenia. I mean, it was that word—just the word, the label itself—that, well, I thought, "That can't be right. It's got to be just, you know, hits of acid," or whatever. It sounds terrible, but that's what I thought then. So yeah, it was hard to accept, for sure.*

When the symptoms are more obvious (e.g., excessive substance use, angry outbursts, talking to oneself), the stigma is usually greater.

> *There is more stigma, I think, when mental illness is more obvious. People can see it. My daughter told me that she smashed a bottle on the ground two weeks ago. She was walking along, she had a juice bottle, and she just got angry—she was very unstable at that time . . . people do get frightened.*

Delayed treatment

When a person receives prompt treatment for concurrent disorders, the course of the illnesses may be changed for the better with greater hopes for recovery. But fear of stigma can discourage families from seeking care for their loved one as well as care and support for themselves.

> *Stigma can make parents hesitate to go for more help. But who can blame them? It only takes one really bad experience in the health care system and you don't want to go through anything like that again. When my husband and I took our son to a child psychiatrist, he blamed the behaviour on our parenting. Now, that sort of thing, being blamed, being told you have bad parenting skills, prevents many people from seeking needed treatment later. People think, well, there's no use going to those guys for help, they're only going to tell us it's our fault! We went away and never came back. We all just lived with it.*

A family member describes the distress she has endured for a number of months over her son's concurrent disorders and his refusal to seek help due to fears of people's negative attitudes.

You know, if you have cancer surgery and you have to take a month off school for that, do you think it would jeopardize somebody's chances of completing their degree? And as his mother, I can't help him—I can't go to bat for him . . . I can't violate my son's privacy and confidentiality. So he's delayed going for help because of what might happen to his job! So, I mean, tell me who would explain it to his supervisor? Give me one *person that would do that for him! One person who would say, "Okay, let's really help this guy. Let's go to bat for this kid."*

SURVIVING STIGMA

Family members have found many ways to cope with stigma and discrimination. Strategies change, depending on the situation, their relative's stage of illness or recovery, and their own stage of self-discovery and healing. Strategies to survive stigma are unique to each family and its members:

- turning to other families in similar situations for support
- keeping the problems private — as a family matter
- sharing their stories with the public
- challenging negative attitudes
- looking at the situation from a different perspective.

Building support networks

Many families turn to community-based services such as the Mood Disorders Association of Ontario, the Schizophrenia Society and Al-Anon for emotional support, information and acceptance. Social support can help families deal with problems and cope with stress, and can even prevent or reduce various health problems.

How many people even know that family support is an avenue to help them cope with things like stigma? I mean, people just don't know. But it's very important for family members to get help. Let me put it this way—if I didn't have the help along the way, my husband and I wouldn't be married, because I wouldn't have been able to cope with his mental illness and alcoholism. Where would society be without help available?

Family support groups also provide the opportunity to develop friendships and social networks that can help build self-esteem and feelings of efficacy. **When family members are in touch with others with the same problems, feelings and experiences, they are less likely to blame themselves for their relative's problems.**

> *Family support groups can be a very big help to people who can actually talk about it. There's a list of possible topics like medication, noncompliance, housing and stigma—topics that in a typical social gathering, they're a real downer—I mean, to start talking about psychiatric medications, nonprofit housing, what drugs do to people with mental illness, and all the rest of it! So it's a relief just to be in a group of people that you know understand, and you don't have to explain your situation to them. You don't have to hide it. Everybody's pretty much tackling the same thing.*

Families also say that providing support and information to others promotes a sense of success and self-esteem.

> *I've advocated for a buddy system. I think each new family should be linked with a more experienced family, to help them through the maze of all this. Many new families come to the support groups because they feel so alone. It's good for the more experienced family, too. They feel good because they're helping someone. It makes them feel like they can do something, make a difference.*

Maintaining privacy

Many family members are uncertain whether or not to tell others about the mental illness and substance abuse. A related issue is the decision about when, how and whom to tell.

> *When you have severe mental illness and drug problems in the family, every time you meet a new person you have to wonder, "Should I tell them? Should I not tell them? What will happen? What will they think if I do tell them? How will they deal with it?" The onus is on you to worry about it—you have to expend the energy.*

If their relative agrees, some families choose to tell their personal story in a public forum. In this environment, family members are often able to be more objective about their experiences. Because the purpose is to educate others, family members say that they have greater control over the emotional aspects and others' reactions.

However, to avoid stigma, some people try to keep the problems a secret or avoid others.

> *There are some days when I drive to my parents' house, and if one of the neighbours comes out of their house, I just keep driving around the block until I know they're gone, because I just can't deal with it—the looks and the questions, that whole reaction you get—so I stay away from it if I can. And I can't force myself to say "hello" just like a normal person because I'm wondering what happened the day before—what did my sister do this time in front of the neighbours? Depending on the situation and how I feel, I handle it in different ways.*

Hiding the problems works only as long as the condition remains invisible or the family member with concurrent disorders is able or willing to help cover things up. If the condition becomes more obvious, it may be necessary to try new strategies. For instance, one woman's husband had major depression and a serious drinking problem, which had led to hospitalizations, many treatments and job loss. After a long period of stability, he experienced a relapse of depression and spent days watching television or lying in bed. His wife told friends that he had worked so hard he needed to slow down. People were sympathetic and didn't question his absences from social events or work.

Some families try to maintain separate public and private identities. Only close, understanding friends or family are trusted with the truth and are allowed to see all aspects of what some family members called their "real" identities.

> *I would never tell any of my co-workers. Never. Because it would hurt me professionally—that's a fact. It's a spillover stigma. So at work, I have a separate circle of friends—and it's like a haven. It's the one place I can go that hasn't been touched by schizophrenia and depression and drugs and alcohol. If I were to tell [co-workers], then mental illness would take over that world as well. So, it's better to just have that barrier there between the two worlds, and then there's a threshold I can step over—to get over to this normal world. It's a refuge and a place of rest.*

Although many family members say that they avoid potential stigma by not disclosing the problems, research has shown that some of these strategies have negative consequences. The question is whether it is actually possible to reduce the effects of stigma by keeping information secret. **One study showed that elaborate coping mechanisms involving secrecy did not reduce the negative consequences associated with stigma, prejudice and discrimination.** Such strategies also did not prevent psychological distress and demoralization. In fact, the tactics that led to avoidance and withdrawal produced more harm than good (Link, Mirotznik, Cullen, 1991).

Challenging negative attitudes

Strategies such as dismissing, downplaying or challenging negative attitudes and beliefs can help to enhance self-esteem and resilience. **For many family members, accepting the idea that they can't control other people's attitudes, beliefs and behaviour is liberating.**

> *You can't let negative people get to you. You just have to put on a suit of armour and face it. Stigma is everywhere—running away won't make it any better, for you or for your family. You have to be tough with things like this.*

> *. . . I don't experience stigma at all. I refuse to. If people have bad attitudes toward my husband's depression, I try to educate them. If they won't hear what I have to say, forget them. I don't waste time on people like that.*

The section below entitled "Combating Stigma" has more information on challenging negative attitudes.

Changing the perspective

Another coping strategy involves thinking positively about difficult circumstances. It may involve seeing caregiving in terms of hope and personal growth, as a journey that has transformed them in a positive way.

> *Any really bad experience in life has the potential for learning, and I think that as a human being, that's what you have to try to do. I mean, you can't approach it intentionally like that, but now I can think to myself, "Yes, this really was a learning experience."*

> *A related strategy is to try to loosen the hold that stigma may have on you.*

> *I think stigma is how a person perceives it and I think if you refuse to let stigma be there, it loses its hold over you. You can't be ashamed. Because there is no shame in this. You start to wonder about yourself—and that's what stigma can do, make you wonder about yourself.*

COMBATING STIGMA

When some families discover that a big part of stigma and rejection is social, not personal, it stimulates them to try and make changes.

> *For years now, I've fought for the rights of those with concurrent mental illness and substance abuse problems, to really legitimize the whole thing. We have to start coming out of the closet. I think we'll have a much stronger position when everybody can finally relate to the reality of concurrent disorders.*

Family members may become involved in social and political action to change conditions and attitudes, to decrease discrimination and increase control over resources. Family support groups are at the heart of this action. Such groups give people a sense of collective power to solve their common problems and improve their lives.

Advocating for change

Stigma has powerful effects that people can't easily overcome on their own. Stigma can prevent legislators from setting aside enough money for mental health care and financial support for caregivers; it can keep insurance companies from providing enough coverage.

For many family members, educating the public about the myths, stereotypes and realities of concurrent disorders helps reduce stigma. Families have worked hard to decrease irrational fears while attempting to humanize and promote acceptance of both the people with these disorders and their families. Family members have recognized that health care workers, educators and the media need to be educated as well.

> *Things will improve, and we're doing our bit out there with education about mental illness and substance abuse. Things really couldn't be much worse than they were 20 years ago. There's a lot of education and good research coming out now. I still feel that education is the best way to combat stigma, but I think it can take a couple of generations to get rid of things like that—so we're only halfway there, if that.*

Family groups are one of the best catalysts for change across the mental health and addiction services system. Members of family self-help support groups can:
- argue for better treatment, planning and accountability
- sponsor conferences
- speak at professional meetings
- lobby legislators and appointed officials.

The family movement, particularly in the United States, has significantly influenced research and treatment for people with concurrent disorders. Family members have developed effective relationships with researchers, mental health professionals, legislators and administrators, without compromising their own independence as advocates.

> *Stigma is nothing like it used to be, say, 18 years ago. It's really gone down, and the reason, I think, is that people are better informed. I like to think that the strongest advocates for concurrent disorders are primarily family members. We were the ones that started talking about it, not hushing up the "S" [schizophrenia] word . . . and I think that has demystified mental illness and substance abuse a lot. It helped with my friends. Quite early on, the friends that I had were not terribly sympathetic. I set about educating them, frankly.*

Advocacy activities can pose a moral dilemma for some families. They need to be sensitive to their relative's desire for privacy or disillusionment with the mental health system. Some may wish to forget or deny their condition and expect their families and others to co-operate. Many families encourage caution in moving forward with lobbying or other public advocacy activities.

ADVOCACY TIPS

1. **Be well informed.**
   As a family member or friend of a person living with substance use and mental health problems, you already know the effects of this illness. Your experience and knowledge is one of the greatest tools you can bring to your advocacy efforts.

2. **Identify your issues.**
   You may have many areas of concern (i.e., access to comprehensive mental health and substance use screening and assessment, access to integrated treatment), but it is best to keep your communication targeted. Focus on one or two issues at a time.

3. **Communicate effectively with government officials.**
   Connect with officials, either in person or by phone, to expand relationships and present your key messages. You can call your local member of Parliament (MP) and review your key issues. If you are able to speak directly with your MP, be specific, persuasive and factual. Keep your conversation short. Ensure you thank the official for his or her time. Finally, follow up with a brief letter reinforcing your key messages. If you cannot speak directly with your MP, leave a message with his or her assistant. Be sure you know what you want to say, say it politely and don't forget to leave your name, address and phone number.

   Send a letter to a federal government ministry such as Health Canada or Justice Canada. Letters, either through Canada Post or e-mail, are powerful ways to get key messages to MPs. When writing a letter, remember to use the correct address, use your own words and personal experiences, identify the issues and key messages and don't forget to say thank you. Letters are a great way for politicians to get to know the real faces of people affected by mental health and substance use problems. You are critical to making this happen.

   Here are some suggestions for preparing to communicate with government officials:
   - If you want to contact provincial or territorial government officials, visit http://canada.gc.ca/othergov/prov_e.html for more information on contacting your member of provincial or territorial parliament.
   - Find your federal MP by entering your postal code at: www.parl.gc.ca/information/about/people/house/PostalCode.asp?lang=E&source=sm.
   - You can find out about the federal ministries and the ministers responsible for each ministry at www.parl.gc.ca/information/about/related/Federal/Agency.asp?Language=E&Agency=M. Further contact information is available at www.parl.gc.ca/information/about/people/key/Ministry.asp?lang=E.
   - For more information on how to communicate with your MP, visit www.vsr-trsb.net/publications/roundeng.pdf.

4. **Communicate effectively with the media.**
   Your local newspaper, television or radio station may be willing to write an article about your experiences and key issues. Be clear and concise when speaking to the media. Be prepared when you speak to a journalist and remember to stick to your key messages. You may also want to contact local, provincial, territorial or national organizations for more information before speaking with the media.

Tip list adapted with permission from Advocacy Tips (Schizophrenia Society of Canada)

The impact of anti-stigma campaigns

Some studies have shown that educational campaigns result in a moderate increase in general knowledge about mental illness and substance abuse, but they actually have little impact on negative attitudes. For example, educating people about the biochemical nature of concurrent disorders hasn't improved attitudes toward people with mental health and substance use problems (Read & Harre, 2001).

However, attitudes did improve when people had personal contact with people who have concurrent disorders. This suggests that educational and anti-stigma campaigns should have a personal element, perhaps with client and family testimonials about their struggles and triumphs.

> *I think the strongest advocates against stigma are family members and the people with the illness themselves. We are now getting people that are willing to stand up and say, yes, I have schizophrenia and, yes, I have used drugs and alcohol. I know three or four people that will actually come with me to high schools and get up and talk about their illness in front of high school students. And I took one young man with me to speak to the first-year medical students last month. That's the kind of thing that people will listen to—the real stories coming from the people themselves.*

Take a look at the following list of well-known public figures who have personally dealt with a mental health problem, a substance use problem or both.

Were you aware that these famous individuals (and this list provides only a few examples!) have struggled or continue to struggle with such problems?

Do any of these names come as a surprise to you? If so, why do you think you are so surprised?

- **Paula Abdul** (singer/dancer) had an eating disorder (bulimia nervosa).
- **Patty Duke Astin** (actress) wrote about her bipolar disorder in a book entitled *A Brilliant Madness: Living with Manic-Depressive Illness.*
- **Drew Barrymore** (actress) has tackled clinical depression and substance use problems from a very young age.
- **Ludwig van Beethoven** (German composer) had bipolar disorder.
- **Jim Carrey** (comedian/actor) has experienced clinical depression.
- **Winston Churchill** (former British prime minister) had bipolar disorder.
- **Francis Ford Coppola** (director, *The Godfather* and *Apocalypse Now*) had bipolar disorder.
- **Patricia Cornwell** (mystery/thriller writer) had bipolar disorder and eating disorders (anorexia and bulimia nervosa).
- **Charles Darwin** (naturalist, author of "The Origin of Species" theory of evolution) had severe panic disorder.
- **Carrie Fisher** (actress—Princess Leia in *Star Wars*) had bipolar disorder and substance use problems.
- **F. Scott Fitzgerald** (writer, *The Great Gatsby*) experienced clinical depression.
- **Judy Garland** (actress, singer, "Dorothy" in the *Wizard of Oz*) had clinical depression and substance use problems.
- **Linda Hamilton** (actress, *Terminator*, *Terminator II*) has bipolar disorder.
- **Sir Anthony Hopkins** (British actor, *Nixon* and *The Silence of the Lambs*) had clinical depression.
- **Margot Kidder** (actress, "Lois Lane" in *Superman*) had bipolar disorder.
- **Marilyn Monroe** (actress) had clinical depression and substance use problems.
- **Alanis Morissette** (singer, musician) has experienced clinical depression.
- **Dolly Parton** (country singer, actress) had clinical depression.
- **George S. Patton** (US general, WWII military leader) experienced clinical depression.
- **Cole Porter** (American lyricist, composer of Broadway scores ["Anything Goes," "Can-Can," "Night and Day"]) experienced clinical depression, alcoholism, paranoid delusions and obsessive-compulsive disorder.
- **James Taylor** (musician, singer) had bipolar disorder.
- **Leo Tolstoy** (writer, *War and Peace*) experienced clinical depression and alcoholism.

- **Barbra Streisand** (singer, actress) has social phobia.
- **Margaret Trudeau Kemper** (wife of former Canadian prime minister, Pierre Trudeau) has bipolar disorder.
- **Robin Williams** (actor) has bipolar disorder.

Burnout

When years of advocacy fail to produce desired results, family members may feel disempowered and burned out.

> *You know, there's a "Cure for Cancer" run—everybody goes to bat for people stricken with cancer. And . . . there are people who go door to door raising money for cancer research and cancer support . . . but compare this to schizophrenia—people will watch the "Walk for Schizophrenia," but they're not exactly supportive. They're not rooting or cheering them on or anything. But then again, with mental illness and substance abuse, it's going to be so much harder. Relatively few people with concurrent disorders or their families have come out in the open, if you consider the percentage of people with these illnesses. We just don't see enough role models and heroes. What we do see are the dedicated family members who have really made a push forward in this area.*

Issues such as lack of housing for relatives with concurrent disorders, lack of acknowledgment of the burden on the family and failure to provide services and respite care for families are consistently raised and ignored. In spite of these barriers, however, family members continue to strive for equality, fairness and justice. Families may need to take a break from advocacy work from time to time to give themselves a chance for rest and renewal.

Despite their negative experiences, family members have found ways to survive and cope with stigma. Many have reflected on their own growth and development as they faced stigmatization and have come to see their experience as a process in which they learned to rise above the effects of prejudice and discrimination.

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Part III: Treatment

Navigating the treatment system

7

Outline

- Is there a system?
- What *should* happen: Integrated treatment
- What *may* happen: Sequential or parallel treatment
- Access points
- Screening, assessment and diagnosis
- Treatment planning
- Treatment approaches
- Co-ordinating treatment
- Continuing care

You have to be active with the health care system when you're trying to get help for your family member . . . the dynamic is not that the system is serving you. The dynamic is that you're getting what you need out of the system—and that takes effort. Trying to deal with the mental health system or the addiction system for that matter . . . can be just as frustrating as dealing with the problems your sick family member has all by yourself—and by that I mean just as soul-devouring and just as hope-destroying . . . because the health care system—well, you think of it as something that's going to help you, and when it doesn't, it's doubly devastating. It feels like you've been let down by your grandma or something . . . the door has been shut in your face by someone you thought was kind and benevolent. So, we have to be strong and knowledgeable . . . people have to become "system navigators"—like a new profession that requires education and training. We have to be proactive and learn what to do, who to call, what kind of program is best and how to find the right spot in the system . . . and we have to develop negotiation skills and talk like we have knowledge.

IS THERE A SYSTEM?

While there are many substance use and mental health resources and services available, what are missing are the threads that would join these resources and services together. If those threads were in place, roles and tasks would be clearly understood, client-centred planning started, and services across programs easily accessed. Connecting services is even more of a concern when clients have complex problems, which is usually the case with concurrent substance use and mental health problems. Though providers will acknowledge that a client has many needs, too often, they aren't willing or able to say, "You've come to the right place, and we are the right people to work with you. If we can't meet all of your needs, we have access to other resources that can."

WHAT *SHOULD* HAPPEN: INTEGRATED TREATMENT

Treatment for concurrent disorders works best if the client has a stable, trusting, long-term relationship with one health care professional—for example, a case manager or therapist.

Integrated treatment means that treatment for substance use and mental health problems are combined and ideally provided in the same treatment setting by the same clinicians and support workers, or same team of clinicians and support workers. This ensures that a client receives a consistent explanation of substance use and mental health problems and a coherent treatment plan. Integrated treatment means that the client gets co-ordinated and comprehensive treatment, as well as help in other life areas, such as housing

and employment. Ongoing support in these life areas helps clients to maintain treatment successes, prevent relapses and meet their basic life needs.

Most integrated programs have been developed for clients who have severe mental health problems. They have common features including:
- staged interventions (see "States of change" and "Stages of treatment" on p. 121–122)
- assertive outreach (see "Assertive community treatment," p. 133–134)
- motivational interventions (see "Motivational approaches to treatment," p. 119–121)
- social support interventions (e.g., housing and employment support).

If integrated care always required that clients be served in a single program, current service systems would have to be completely rebuilt. Fortunately, substance use and mental health service providers are discovering that many people with concurrent disorders can receive well-integrated care from different programs, if:
- links are established among programs
- one person or team takes overall responsibility for ensuring that services are co-ordinated.

Many substance use and mental health service providers have developed collaborative relationships that allow them to offer integrated approaches to treating concurrent disorders.

People with severe mental illness and substance use problems usually respond better when both problems are treated at the same time. However, people with other types of mental health problems may respond better when substance use and mental health problems are treated in sequence (e.g., anxiety problems often improve when substance use is reduced or stopped). In this example, substance use problems are usually addressed first, but within the context of a treatment plan that considers both mental health and substance use problems (Health Canada, 2002).

WHAT *MAY* HAPPEN: SEQUENTIAL OR PARALLEL TREATMENT

In many communities, treatments for substance use and mental health problems are still offered in isolation from one another. This may occur in one of two ways:
- treatment for one problem is only available after the other problem has stabilized (sequential treatment)
- both problems are treated at the same time, but there is little, if any, communication between the mental health and substance use service providers (parallel treatment).

Sequential treatment

In sequential treatment, a client with concurrent disorders is not eligible for treatment in one part of the system (e.g., in the mental health care system) until the other problem (e.g., alcohol or other drug use) is resolved or stabilized.

Drawbacks of sequential treatment include the following:
- The untreated problem continues to affect the problem that is being treated.
- Substance use and mental health providers may not agree about which problem (mental health or substance use) should be treated first.
- It is unclear when one problem has been "successfully treated" so that treatment of the other problem can begin.
- Often the client is not referred for treatment of the other problem.

Parallel treatment

In parallel treatment, mental health and substance use disorders are treated at the same time, but by different professionals or teams (often working for different agencies, but sometimes within the same agency).

Drawbacks of parallel treatment include the following:
- Mental health and substance use treatments are often not integrated into a cohesive treatment package. For example:
  - Many addiction services agree that *reducing* or even *monitoring* substance use is a realistic goal for clients at the beginning of treatment. However, some mental health programs ask clients to stop *all* use of alcohol or other drugs before they can begin treatment.
  - Many mental health problems benefit from treatment with medications. However, some substance use programs may want the client to stop taking all drugs, including those used to treat mental health problems.
- Treatment providers may not talk with each other.
- The job of pulling the substance use treatment plan and the mental health treatment plan together may fall on the client and his or her family.
- Clients may not meet eligibility criteria when trying to access one system or the other. This could mean the client receive no services at all.

ACCESS POINTS

Finding a program that is a good fit for your relative can be a challenge for several reasons:
- Many communities have no specialized, integrated concurrent disorders services to assess and treat complex cases.
- In some communities, the waiting lists for specialized services are too long.

- Substance use and mental health programs and services may have admission criteria that exclude clients with concurrent disorders.
- Finding psychiatrists or clinical psychologists who can provide psychiatric diagnoses can be a challenge in many communities.
- Treatment resources may be lacking, even though you, your relative or your doctor understand what would be most helpful.

But you have to start somewhere, so we begin by talking about the most common entry points into the system.

Family doctors and psychiatrists

Family doctors, or general practitioners (GPs), are often the first professionals that people talk to about a mental health problem. Doctors can examine your relative's physical health and rule out problems that could be adding to or affecting changes in his or her mood, thinking or behaviour. Sometimes doctors can do a full psychiatric assessment, particularly for the more common conditions, such as depression or anxiety. Sometimes, doctors will suggest that a person see a psychiatrist.

Psychiatrists almost always need a referral from a doctor before they can see a client. Family doctors often have a list of psychiatrists they can refer a person to. After booking an appointment, a person often has to wait at least two to three months to see a psychiatrist. **If you and/or your relative don't agree with the diagnosis, your relative should ask the family doctor for a referral to another psychiatrist for a second opinion.** Most doctors are open to clients seeking another perspective and may even suggest it.

Community mental health agencies

Community agencies can also offer assessments. The type of assessment will depend on the health care provider available. Sometimes this may be a doctor, psychologist, social worker or nurse. In smaller cities and rural areas, you are more likely to be seen by a community mental health worker. This person will try to match your needs with the services available.

Substance use agencies

Most substance use agencies accept self-referrals. After an initial assessment, the person will be referred to the level of care (e.g., community-based treatment, residential treatment, withdrawal management) that meets his or her needs at that time. Screening for mental health problems should be part of the assessment process, and referral to a mental health treatment program or a specialized concurrent disorders program is a possibility.

Hospital emergency departments

In a crisis, you and your relative can go to the emergency department of a hospital. If the situation does not require immediate medical care, the next step may be a more in-depth assessment from a crisis worker. This person is often a nurse or social worker. (For more information about emergency treatment, see Chapter 10.)

Access Points is adapted from *Challenges & Choices: Finding Mental Health Services in Ontario*. You can find *Challenges & Choices* at www.camh.net/Publications/CAMH_Publications/challenges_choices.html.

Connex*Ontario*

Connex*Ontario* is a bilingual information and referral service in Ontario for the public and professionals wanting to access addiction and mental health treatment for themselves, family, friends or clients. Information and referral specialists offer education and guidance based on each caller's situation.

Toll-free telephone numbers:

Drug and Alcohol Registry of Treatment: 1 800 565-8603

Mental Health Service Information: 1 866 531-2600

Ontario Problem Gambling Helpline: 1 888 230-3505

These information lines are available 24 hours a day, seven days a week. You can find more information about Connex*Ontario* at www.connexontario.ca.

Questions to ask a treatment agency

- What is your treatment philosophy and method?
- Do you refer clients to other agencies for some substance use and/or mental health services? If so, who is responsible for overall co-ordination of services?
- What percentage of your clients has co-occurring substance use and mental health problems?
- What is your policy about using medication as a treatment option?
- Does the program support a full range of needs (e.g., social and medical)?
- What role do family members play in their relatives' treatment?
- Do you offer services and referrals for family members?

SCREENING, ASSESSMENT AND DIAGNOSIS

Screening

Screening procedures are designed to identify whether someone *might* have a mental health and/or a substance use problem, and whether he or she should have a comprehensive assessment.

People who work in the substance use and mental health fields are encouraged to expect to see concurrent disorders rather than see them as an exception. However, some mental health agencies still don't screen clients for substance use problems, and some substance use agencies don't screen clients for mental health problems. When your family member begins treatment, ask if both problems have been considered.

Assessment

Assessments usually start with a conversation with the health care provider. Questionnaires are often part of the assessment interview. The treatment provider investigates how the substance use and mental health problems interact. During an assessment, people are often asked to discuss things such as:

- why they have come for help, what kind of help they are looking for and what has helped in the past
- their physical condition
- general life problems, troubling thoughts or feelings, substance use problems, as well as how long problems have lasted
- whether they have experienced or seen violence (e.g., physical or sexual assault, war), even if it occurred years before
- whether there is a history of substance use or mental health problems in their family
- what their life is like (e.g., how they feel, what they think, how they sleep, if they exercise and socialize, how they do at school or work, how their relationships with friends and family are)
- whether they've come to Canada in the last few years and/or whether they've come from a war-torn country
- what, if any, medications they take.

The client and the treatment provider use the information from the assessment to develop a treatment plan.

Diagnosis

It is not always necessary to have a diagnosis before starting treatment. However, a diagnosis may help to direct treatment. For example, a diagnosis may determine if a particular kind of therapy would be most helpful and whether there are medications that could help treat the problem.

Even if your relative does receive a preliminary diagnosis, it may change or be interpreted differently by other health care providers over the course of treatment. It is often hard to determine whether symptoms are related to substance use or a mental health problem. The only way to figure out what you are dealing with is to see how the symptoms develop over time.

> *It's very difficult to identify the issues when it comes to mental illness and substance abuse. You know, cancer is much more clear-cut. And I don't think even the psychiatrists are really sure a lot of the time. They may be sure of the diagnosis, but they often don't help very much with the prognosis—and that doesn't help the cause of families, who know this is an illness that can respond to medication. We all need to view mental illness as something that can be treated, so at least there's hope out there! Having hope can make all the difference in the world.*

TREATMENT PLANNING

There is no single, correct intervention or program for people who have concurrent disorders. The treatment plan needs to be customized to address each client's particular needs. Treatment plans should:

- identify issues and problems
- outline short-term and long-term goals
- establish approaches and interventions to meet the goals.

In many cases, treatment includes helping a person with employment, housing, finances, leisure activities and basic daily self-care. The person giving the assessment may recommend your family member see a therapist or that he or she start taking medication. Joining a self-help group is also an important part of treatment for many people. A person may decide he or she simply needs more support during stressful times. The ultimate goal of treatment is for people to decide what a healthy future means for them and to find ways to live a healthy life.

Family involvement

Families often provide the ongoing, day-to-day care, so they should be involved in treatment planning if possible. Families will often have information that should be considered by the treatment team as part of the planning process. Their perspective may be different than that of the client or the treatment team.

The amount of family participation will depend on the client. One barrier to family involvement cited by providers and families is unclear confidentiality policies. **A treatment provider cannot share case-specific information with you without your family member's agreement.** Treatment providers should ask clients if they agree to family members participating in planning and treatment. However, many providers don't ask, so it's best if you talk to your family member and let the treatment team know what you have agreed to. Have this agreement added to your family member's treatment record. If more than one agency is involved in care, make sure each agency is aware of whether your relative has agreed to share information with you and whether the agency has a copy of that agreement in its files. You may need to start the conversation because each agency may assume that the other has talked to your relative.

Learning about substance use and mental health problems will help you recognize what type of information will be useful to the treatment team. It often helps to organize your questions and concerns into a document. Keep the document short and to the point, and keep the tone neutral. If possible, you and your relative should work together to decide what information to include.

IF YOUR RELATIVE DOES NOT WANT YOU INVOLVED

Even if your relative hasn't agreed to share treatment information with you, the treatment team can still talk to you about:

- the nature of substance use and mental health problems
- how to respond to disturbing behaviours
- how to get help in an emergency
- how to get help for yourself.

The treatment provider can also listen to your observations. Avoid making treatment recommendations—remember, you are not the attending physician or psychiatrist!—but allow the treatment team to draw conclusions from the information you present.

Figure 7-1: Sample family information document

Information provided to:

Client's name:

Form completed by:

Relationship to client:

Date:

Issues that I am concerned about:

1.

2.

3.

4.

5.

Recent family or life events that may have contributed to mental health and/or substance use problems.

1.

2.

3.

4.

5.

If your family member doesn't want you to be involved, check periodically to see if he or she has reconsidered or to express your interest in being involved.

Questions to ask about the treatment plan

If your relative has agreed to having you involved, here are some questions to ask about his or her treatment plan:

- What is the provisional diagnosis?
- What are the possible causes of my relative's problems?
- What is the proposed treatment?
- What are the benefits and risks of the treatment?
- Are other treatments available?
- What are the options if this treatment doesn't work?

Tracking treatment

People who have concurrent disorders often have a lengthy treatment history. Try using a chart to track treatment information. This document can be useful when you talk to the treatment team.

TREATMENT LOG

Type of Treatment	Treatment Provider	Contact Person	Issues Addressed	Start Date / End Date	Comments

TREATMENT

In the past, treatment for people with severe mental illness and substance use problems tended to concentrate on the limits and impairments associated with mental health problems, while overlooking the strengths that people can often harness to achieve their personal goals. We have found that treatment is more effective when it focuses on identifying people's personal goals and abilities, and the personal and community resources and opportunities available to help them achieve their goals.

Motivational approaches to treatment

Motivational approaches can be more effective than conventional methods of working with people with concurrent disorders. Motivational approaches are also useful in encouraging people to identify their goals, and in building hope and commitment to change and recovery.

Some people enter therapy determined to change and are ready to talk about their reasons for wanting to change. However, many people are not motivated to change. There are many justifiable reasons for this:

- Some people may not even acknowledge that they have problems.
- People with concurrent disorders are more likely than others to have had previous unsuccessful attempts to change.
- The interaction of their substance use and mental health problems may have made it harder to follow treatment plans.
- They are more likely than other clients to feel discouraged about the prospects of improving their situation.
- They may also feel that substance use gives them relief from other symptoms and from their distress.

Being ambivalent (being of two minds) about a particular behaviour is normal. How people balance the costs and benefits of a behaviour affects whether they'll continue or change the behaviour.

Motivational approaches use the client's perspective on his or her mental health and substance use problems as the starting point for treatment. It requires that therapists get in touch with how the client sees things. This approach often opens a pathway to working on practical issues of concern to the client. This can include issues of health and safety—for example, finding housing—even when the client isn't ready to change behaviours that may actually contribute to the problem. Acknowledging the client's perception and lifestyle doesn't necessarily mean that the therapist agrees with that perception. **The long-term objective is to help the client set goals and recognize that his or her current lifestyle interferes with achieving these goals.** However, in the short-term, the family—or others, such as an employer—may not understand why the client and the therapist are not working directly on the substance use and mental health problems.

Activity 7-1: Exploring ambivalence about change

One of the fundamental techniques of the motivational approach is to look at the benefits and costs of not changing and the benefits and costs of changing. Therapists call this *decisional balance*.

Think about what your relative might see as the benefits and costs of using substances. It may help you understand why your family member uses substances or is reluctant to seek treatment.

The benefits of continuing to use alcohol and/or other drugs for my family member may include:	The costs of continuing to use alcohol and/or other drugs for my family member may include:
The benefits of changing this use of alcohol and/or other drugs for my family member may include:	The costs of changing this use of alcohol and/or other drugs) for my family member may include:

Motivation and substance use goals

When people have concurrent disorders, abstinence is often the best long-term substance use goal. Continued use of alcohol and/or other drugs may worsen emotional and mental health problems and threaten a person's overall physical and psychological well-being. However, many people may, at least at first, lack the confidence and skills to decrease or stop their substance use. So, when clinicians work with someone who is struggling with both major substance use and mental health problems, the short-term goal is often to reduce the most harmful effects of substance use while developing a strong working alliance with the client. This trusting relationship can help clients understand the negative effects of their substance use and develop the motivation to address it. This approach—not requiring the person to commit to abstinence as a condition for help—is called *harm reduction*.

STAGES OF CHANGE

Changes in behaviour occur over a series of stages (Pruchaska et al., 1992). Recognizing what stage a particular a client is at can help clinicians decide which interventions are more likely to be successful at a particular point in treatment and recovery.

The stages of change model outlines five basic stages:
- precontemplation
- contemplation
- preparation
- action
- maintenance.

Some people move steadily through the stages toward recovery. Others move rapidly and then slow down or stop for a while. People often relapse (return to problematic behaviours), move backward through the stages and then move forward again.

Table 7-1: Stages of change

STAGE	EXAMPLE
Precontemplation	"I don't think I have a problem."
Contemplation	"I'm not sure, but I might have a problem."
Preparation	"I think I have a problem, but I am not sure what to do about it."
Action	"I have a problem, and I want to change it. I know where to get help with this change if I need it."
Maintenance	"I have already made changes and I want help to maintain them."

STAGES OF TREATMENT

The stages of change model describes the process of behavioural change. Treatment strategies should be adapted to a person's motivation to change. Researchers have developed a complementary step-wise model of stages of treatment. The model describes four major stages:

- engagement
- persuasion
- active treatment
- relapse prevention.

Table 7-2: Stages of treatment

ENGAGEMENT			
Stage of change	**Current situation**	**Treatment goal**	**Clinical interventions (examples)**
Precontemplation	Person does not have regular contact with a clinician	To establish a trusting therapeutic relationship with the person	• Practical assistance (e.g., food, clothing, financial benefits) • Crisis intervention • Stabilization of psychiatric symptoms (e.g., medication management)

PERSUASION			
Stage of change	**Current situation**	**Treatment goal**	**Clinical interventions (examples)**
Contemplation Preparation	Person has regular contact with a clinician, but does not want to work on reducing substance use	To develop the person's awareness that his or her substance use is a problem and to increase the person's motivation to change	• Individual and/or family education • Motivational interviewing

ACTIVE TREATMENT			
Stage of change	**Current situation**	**Treatment goal**	**Clinical interventions (examples)**
Action	Person is motivated to reduce substance use	To help the client further reduce his or her substance use and, if possible, attain abstinence	• Individual counselling (e.g., cognitive-behavioural therapy) • Peer groups (e.g., group therapy) • Social skills training

RELAPSE PREVENTION			
Stage of change	**Current situation**	**Treatment goal**	**Clinical interventions (examples)**
Maintenance	Person has not experienced problems related to substance use for at least six months (or the person is abstinent)	To maintain awareness that relapse can happen; to extend recovery to other areas of the person's life (e.g., family and other relationships, social activities, work and school)	• Peer groups (group therapy or relapse prevention groups) • Self-help groups (e.g., Alcoholics Anonymous, Mood Disorders Association of Ontario) • Family problem solving

Table 7-3: Stages of treatment and family collaboration

ENGAGEMENT		
Current situation	**Family collaboration goal**	**What family members should expect**
Family members are in contact with a case manager or counsellor and are beginning to develop a working relationship	To establish regular contacts and develop an alliance between the clinician and the family	• Education about substance use and mental health disorders • Encouragement that change is possible • To be heard and supported

PERSUASION		
Current situation	**Family collaboration goal**	**What family members should expect**
Families are engaged in a relationship with a case manager or counsellor, and are discussing their relative's substance use and mental health problems Families may also be participating in monitoring and helping their relative to begin to reduce his or her substance use	• To help family members see that their relative's use of alcohol and/or other drugs is a problem • To help family members see how substance use is interacting with his or her mental health problem • To help families understand that both issues need to be addressed	• More specific education about the effects of substance use on mental illness and how the two illnesses interact • Encouragement and help to develop external social supports • Help with problem-solving on family issues related to substance use and mental health problems

ACTIVE TREATMEMT		
Current situation	**Family collaboration goal**	**What family members should expect**
Families are engaged in treatment, help their relative reduce or stop substance use, follow aspects of their relative's treatment plan, help their relative avoid high-risk situations and reduce stressors	To help family members develop strategies to reduce substance use and follow aspects of their relative's treatment plan	• Help in modifying stressful communication styles that may contribute to relative's substance use • Education about different types of therapy for concurrent substance use and mental health problems and how to access these services

RELAPSE PREVENTION		
Current situation	**Family collaboration goal**	**What family members should expect**
Family members continue to offer their relative support and practical assistance in their efforts to avoid substances of abuse and follow their treatment plan	• To help family members maintain an awareness of their relative's vulnerability to relapses • To help family members build on their relative's successes by facilitating improvements in other areas	• Periodic review of progress made by the family and risk factors associated with relapse of substance use or mental health problems • Education about how to enhance other areas of their relative's functioning—for example, relationship skills, work, school, self-care, independent living skills and healthy leisure activities

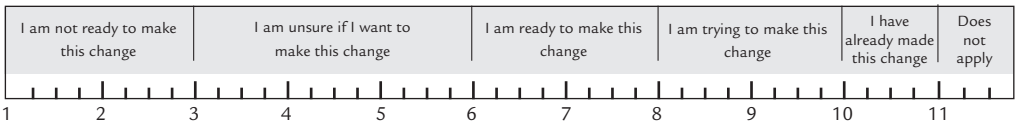
Activity 7-2: The family concurrent disorders

Readiness to change ruler

Completing this tool may help you to think about how ready you are to change certain beliefs and actions associated with having a loved one with concurrent disorders.

Using the ruler shown below, indicate how ready you are to make a change in each of the following areas. If you are not at all ready to make a change, you would circle the 1. If you are already trying hard to make a change, you would circle the 11. If you are unsure whether you want to make a change, your would circle 3, 4 or 5. If a particular item does not apply to you, circle "Does Not Apply" in the box to the right.

How **ready** am I to ... ?



. . . admit that my family member has both a mental health and a substance use problem?

1 2 3 4 5 6 7 8 9 10 11

. . . accept that my family member has both a mental health and a substance use problem?

1 2 3 4 5 6 7 8 9 10 11

. . . accept that I am not to blame for my family member's concurrent disorders?

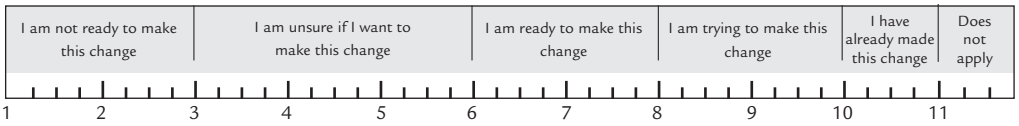
1 2 3 4 5 6 7 8 9 10 11

. . . think about ways I can best help my family member?

1 2 3 4 5 6 7 8 9 10 11

. . . seek help for my family member from mental health and/or addiction professionals?

1 2 3 4 5 6 7 8 9 10 11



. . . seek help for myself from mental health and/or addiction professionals?

1 2 3 4 5 6 7 8 9 10 11

. . . seek help for my family member from a self-help group (e.g., AA, Dual Recovery)?

1 2 3 4 5 6 7 8 9 10 11

. . . seek help for myself from a family peer support group (e.g. Al-Anon, Mood Disorders Association of Ontario)?

1 2 3 4 5 6 7 8 9 10 11

. . . seek help for my family member or for myself in spite of the stigma associated with concurrent disorders?

1 2 3 4 5 6 7 8 9 10 11

. . . work on overcoming any other barriers preventing me from attending a professional or self-help family intervention?

1 2 3 4 5 6 7 8 9 10 11

. . . commit to taking care of myself as a top priority?

1 2 3 4 5 6 7 8 9 10 11

. . . admit to and accept my own personal strengths and limitations?

1 2 3 4 5 6 7 8 9 10 11

. . . accept that relapses are common in recovery from concurrent disorders?

1 2 3 4 5 6 7 8 9 10 11

TREATMENT APPROACHES

Treatment for concurrent disorders includes psychosocial treatments (discussed in this chapter) and medication (discussed in Chapter 8). Clients may receive one or the other, or both.

Types of therapy

Individual therapy allows the therapist to focus his or her attention solely on the client, with no distraction from others. Individual therapy is especially helpful in developing a close working relationship, exploring personal motivation and goals, and identifying individualized targets for intervention.

Group therapy (groups led by professionals) approaches offer the advantage of promoting social support among clients and providing positive role models for clients at earlier stages of treatment. Groups usually consist of up to 10 people. Often two therapists run them. A group setting can be a comfortable place to discuss issues such as family relationships, medication side-effects and relapses.

PSYCHOEDUCATION

Psychoeducation is education about mental health and substance use issues. People who know about their problems are better prepared to make informed choices. Knowledge can help clients and their families deal with their problems, make plans to prevent future problems and build a plan to support recovery.

Everyone should receive psychoeducation when they begin treatment for concurrent disorders. Some people may have trouble processing or remembering information that they receive at this early stage. As they move through recovery, they may benefit more from psychoeducation. For people who have milder problems, psychoeducation alone may be the only treatment they need.

Psychoeducation sessions include discussions about:
- what causes substance use and mental health problems
- how the problems might be treated
- how to self-manage the problems (if possible)
- how to prevent future episodes.

PSYCHOTHERAPY

Psychotherapy is sometimes called "talk therapy." It helps people deal with their problems by looking at how they think, act and interact with others.

Certain types of psychotherapy are better for certain problems. Psychotherapy can be either short-term or long-term.

Short-term therapy has a specific focus and structure. The therapist is active and directs the process. This type of treatment usually lasts no longer than 10 to 20 sessions.

In long-term therapy, the therapist is generally less active, and the process is less structured. The treatment usually lasts at least one year. The aim is to help the client work through deep psychological issues.

Successful therapy depends on a supportive, comfortable relationship with a trusted therapist. The therapist can be a doctor, social worker, psychologist or other professional. Therapists may work in hospitals, clinics and/or private practice. There are many different types of psychotherapy.

Cognitive-Behavioural Therapy

Cognitive-behavioural therapy (CBT) is based on the theory that thoughts have an important influence on how people behave. Therapists help people to identify unhelpful thoughts and behaviours and learn healthier skills and habits. The client and therapist identify goals and strategies. There is an emphasis on practising the skills between sessions (homework).

Social Skills Training

Social skills training uses techniques such as role-playing, modelling, coaching, homework and feedback to help people learn (or relearn) interpersonal skills and competencies.

Dialectical Behaviour Therapy (DBT)

Dialectical behaviour therapy (DBT) is a type of cognitive-behavioural therapy. It is used to treat a range of behaviour problems. In DBT, people look at how their background and their life experience affect how they control their emotions. DBT draws on western cognitive-behavioural techniques and eastern Zen philosophies. It teaches clients how to:

- become more aware of their thoughts and actions ("mindfulness")
- tolerate distress
- manage their emotions
- get better at communicating with others
- improve their relationships with other people.

Structured Relapse Prevention

Structured Relapse Prevention (SRP) uses a cognitive-behavioural approach to help people with moderate to severe problems gain more control over their use of alcohol and other drugs.

Psychodynamic (or Insight-Oriented) Therapy

Psychodynamic psychotherapy, also referred to as insight-oriented therapy, is based on the theory that unconscious processes (issues that a person may not be aware of) influence behaviour. This approach helps people examine unresolved issues that have resulted from relationship problems in their past.

Interpersonal Therapy

Interpersonal therapies help clients get better at communicating and interacting with others. These therapies help people:
- look at how they interact with others
- identify issues and problems in relationships
- explore ways to make changes.

Interpersonal group therapy focuses on the interactions among group members.

Motivational Interviewing

Motivational Interviewing (MI) is a method of enhancing a client's own motivation to change. MI was originally developed as a way of working with people with alcohol and other substance use problems. The approach is now used with people who have problems such as bulimia, hypertension, diabetes and concurrent disorders.

Peer support groups

A peer support group is made up of people who all have similar problems. Group members can share their struggles in a safe, supportive environment. People who have recently been diagnosed with concurrent disorders can benefit from hearing about the experiences of others. Group members usually develop strong bonds.

There are peer support groups for clients and for families. Double Trouble groups and Dual Recovery Anonymous are examples of groups for clients. The Family Association for Mental Health Everywhere (FAME) has groups for families. Although these groups are often called *self-help*, peer support actually offers a type of help called *mutual aid*.

Tips for evaluating peer support groups

Most family self-help / mutual aid organizations are geared toward either mental health issues (e.g., Mood Disorders Association of Ontario or the Schizophrenia Society of Ontario) or substance use issues (e.g., Al-Anon). However, many family members of people with concurrent disorders have found either or both of these types of organizations and groups to be extremely helpful.

If you decide to attend one of these groups, it is a good idea to evaluate them to decide if the particular group suits you and your situation.

Questions to ask about a self-help group

- Does this group welcome new members?
- Do group members respect each other?
- Is the group relevant to my situation, concerns and needs?
- Are there any requirements for attending this group (e.g., a membership fee)?
- Is the group respectful and inclusive of family members from diverse backgrounds (e.g., from a range of cultural, racial, religious and economic backgrounds)?
- Does the group offer both support and education?
- Is the group ongoing or is it time-limited?
- Does the group have a positive attitude toward professional help for families?
- Who facilitates the group and how is the group process managed?

If this group is for family members of persons with mental health problems:
- Is it OK to discuss my relative's substance use problems?

Is the group willing to consider harm reduction as an option in substance use treatment? If this group is for family members of persons with substance use problems:
- Is it OK to discuss my relative's mental health problems?
- Does the group support using medication to treat mental health problems?

Therapy for family members

Family members can also enter care as clients themselves.

Family therapy can offer advice and support to family members and teach them:
- about concurrent disorders
- how to help the client and support treatment efforts
- how to care for themselves.

Usually, therapists work with one family at a time. However, sometimes, family therapy is offered in a group setting with other families in similar situations. Group members can share feelings and experiences with other families who understand and support them.

Family interventions take advantage of clients' natural support systems and can lead to the creation of a home/family environment that is supportive of decreased substance use and adherence to an overall treatment program for the mental health problem.

CO-ORDINATING TREATMENT

Assertive community treatment

The assertive community treatment (ACT) model was developed to meet the needs of clients with severe mental illness who often experienced relapse and rehospitalization, frequently due to their inability or unwillingness to go to local mental health centres. The ACT team provides around-the-clock support and services such as case management, assessment, psychiatric care, employment and housing assistance, family support and education, substance use treatment and other services that help a person to live in the community.

ACT teams may include a psychiatrist, psychologist, psychiatric nurse, social worker, peer support worker (someone with a similar problem or issue who offers support), caseworker, recreation therapist, addiction specialist, vocational (job) specialist and/or occupational therapist who help with tasks of day-to-day living. Some team members are linked to a hospital; others are based in the community.

ACT team members usually meet with the client every day in the community (e.g., in the person's home or in a coffee shop). They make sure that people receive consistent care and strong, ongoing support from the team members.

ACT team services are usually accessed through a mental health agency. Like many other services, you are more likely to find ACT teams in cities and larger communities.

In Ontario, the criteria used to decide which clients get priority for ACT services are:
- a diagnosis of schizophrenia, bipolar disorder or another psychotic disorder
- significant problems with basic activities of daily living
- long-term problems (such as a co-occurring substance use disorder) that require eight or more hours of service per month.

More details about the criteria are available in the *Ontario Program Standards for ACT Teams* (www.health.gov.on.ca/english/public/pub/ministry_reports/psychosis/psychosis.html).

Case management

Clinical case management has been the dominant model for co-ordinating and delivering mental health treatment. The overall goals of this model are:
- to assess clients' needs
- to identify and provide necessary services to meet those needs
- to monitor client outcomes to determine the success of treatment interventions or the need for other services.

In the ACT model, the responsibility for delivering services is shared by the team. In the case management model, services are provided by the case manager. However, case management is most effective when the case manager is part of a multidisciplinary treatment team that also includes a psychiatrist and various other mental health care professionals (e.g., nurses and vocational specialists).

CONTINUING CARE

People with concurrent disorders should be entitled to a team of resource workers that take an ongoing, respectful and proactive interest in supporting them and their families. **Continuing care does not necessarily mean that the client and counsellor must continue to meet regularly, but that, from the counsellor's perspective, the door is always open and the client is welcome, even if the last contact was some time ago.**

The long-term goal is a stable recovery and transition out of treatment. Because concurrent disorders are often complex, recovery may include several transitions between levels of care (e.g., between inpatient and outpatient care; between outpatient and community care). Treatment providers should take responsibility for managing the transition and for following up to ensure that the new arrangement works. However, we know that this co-ordination is sometimes left to the family and the client.

Transition or discharge planning should begin when the client enters care. You and your relative need to be involved. You should make sure that the treatment team

understands how much care you can provide for your relative, and that services are put in place to fill any gaps. A transition plan should include a full array of services:
- case management
- child care
- financial support
- housing
- physical health needs
- a support network.

When your relative leaves treatment, you need to be clear about how to reconnect with the service, if necessary.

Questions to ask about a transition or discharge plan
- Has a follow-up session been scheduled? (If so, make sure you know the date and time, location, contact name and telephone number.)
- What medications have been prescribed? What are they for? What is the dosage of each prescription? When should they be taken?
- Have relapse risk factors/triggers been identified?

If your relative isn't living with you:
- What arrangements have been made for housing?
- Have resources been identified to help the person reconnect to employment, school or vocational training?

It takes a lot of effort and commitment to make the mental health and substance use systems work for your relative. **You should be recognized as a partner in organizing and delivering the care your relative needs, so educate yourself about concurrent disorders and treatment options, be persistent, ask questions—and keep asking them until you get the information you need**

REFERENCES

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Medication

8

Outline

- Drug therapy for mental health problems
- Drug therapy for substance use problems
- Medication management
- Medication abuse or dependence
- Drug interactions
- Ongoing treatment
- Stopping medication

DRUG THERAPY FOR MENTAL HEALTH PROBLEMS

Medications are essential to many clients' treatment programs, but they are not the only treatment. In most cases, medications are more effective if they are combined with some of the interventions that were discussed in Chapter 7.

Often, psychiatric medication will help stabilize people and clarify their thinking so they can focus on treatments such as cognitive-behavioural therapy, group therapy or family-focused therapy.

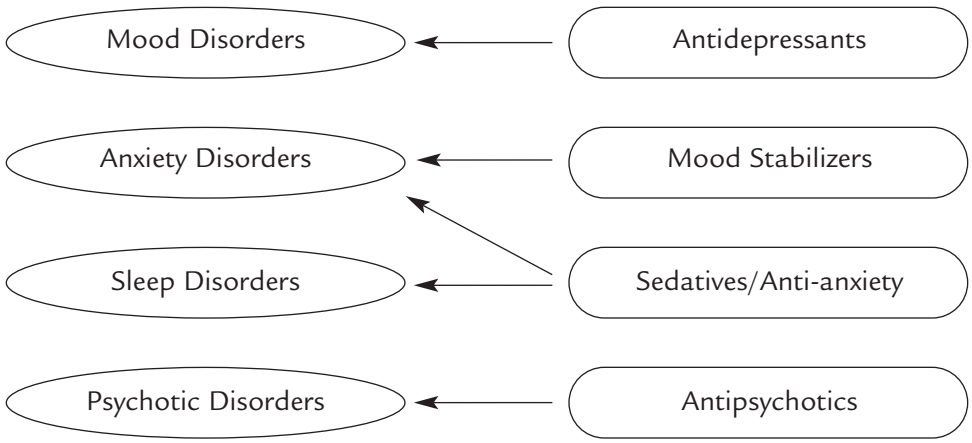
Types of psychiatric medication

Most mental health medications are used to help restore chemical balance in the brain. This can help to reduce the frequency and severity of symptoms. Medications are divided into four main groups based on the problems that they were developed to treat:

- antidepressants
- mood stabilizers
- anti-anxiety medications / sedatives
- antipsychotics.

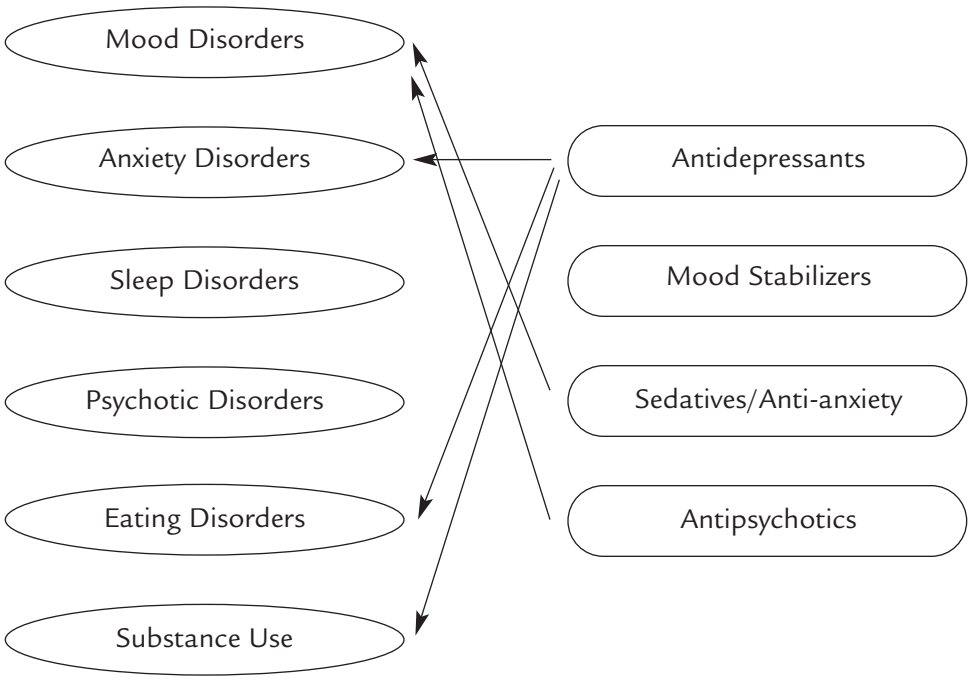
Medications have a generic (or chemical) name and a brand (or trade) name that is specific to the company that makes the medication. For example, the generic antipsychotic clozapine is sold under the brand name Clozaril. The brand name may change depending on the country in which the medication is marketed.

Figure 8-1: Traditional uses for classes of psychiatric medications



Despite the four distinct classes of psychiatric medications listed above, each type of medication can be used to treat various disorders. For example, a person who takes a mood stabilizer to treat bipolar disorder may also take an antidepressant, anti-anxiety or antipsychotic medication to treat symptoms such as depression, sleep problems, anxiety or psychosis.

Figure 8-2: Alternative uses for classes of psychiatric medications



ANTIDEPRESSANTS

Antidepressants work via a number of different mechanisms, but the end result is to increase the level of communication between nerve cells in the brain. While they were originally used to treat depression, antidepressants are also used to treat chronic pain, bulimia, premenstrual dysphoric disorder, chronic fatigue syndrome and anxiety disorders. In fact, antidepressants, especially the class known as selective serotonin reuptake inhibitors (SSRIs) such as Prozac, are used more often to treat anxiety disorders than are traditional anti-anxiety medications such as Valium.

MOOD STABILIZERS

Mood stabilizers are used to help control mood swings (extreme highs and lows) connected with bipolar disorder, and to prevent further episodes of this condition. Lithium was the first mood stabilizer on the market and is still a useful medication. Other medications used to stabilize mood include anticonvulsants, which were developed to treat epilepsy and other seizure disorders.

Treatment of bipolar disorder depends on the individual's symptoms. Bipolar disorder may also be treated with antidepressants in combination with mood stabilizers.

ANTI-ANXIETY MEDICATIONS / SEDATIVES

The main group of medications in this class consists of benzodiazepines, such as diazepam (Valium) and lorazepam (Ativan). While they are legitimate medications for treating anxiety and sleep disorders, they can become addictive if used for more than about four weeks; they also have the potential to be abused (see "Medication abuse or dependence," p. 148). An anti-anxiety medication that can be used for a longer period of time is buspirone (BuSpar).

ANTIPSYCHOTICS

Antipsychotics reduce the effect of dopamine in the brain. They are traditionally used to treat schizophrenia and other psychotic disorders. The newer, second-generation antipsychotics are now also being tested as mood stabilizers, anti-anxiety medication and even as a treatment for refractory depression (depression that is difficult to treat).

For more information about psychiatric medications, see:
- *Medications* (published by the National Institute of Mental Health in the U.S., and available online at www.nimh.nih.gov/publicat/NIMHmedicate.pdf).
- *Psychotherapeutic Medications 2006* (published by the Addiction Technology Transfer Center in the U.S. and available online at www.mattc.org/_media/publications/pdf/Medications2006_5.pdf).

DRUG THERAPY FOR SUBSTANCE USE PROBLEMS

Medication is not used as often to treat substance use problems as it is to treat mental health problems. However, sometimes medication is added to other behavioural and psychological treatments.

Treatment strategies include:
- withdrawal management
- substitution therapy
- antagonist therapy
- aversive therapy.

Withdrawal management

The main objective in the pharmacological treatment of drug withdrawal is to prevent severe complications, particularly seizures in the case of some drugs (e.g., alcohol, barbiturates, benzodiazepines) that can happen when people stop using substances. Medication is also sometimes used to help prevent relapse.

Substitution therapy

In substitution therapy, the substance of abuse is replaced with a medication that is less likely to be abused. Substituting methadone, a synthetic opioid, for heroin is one example of substitution therapy. Methadone suppresses the withdrawal symptoms of other opioids as well as the chronic craving, without causing a person to become euphoric or tolerant to the medication.

The side-effects of methadone include:
- drowsiness, insomnia, dysphoria (feeling uneasy), weakness, dizziness, light-headedness and nervousness
- nausea, vomiting, chronic constipation, decreased appetite and dry mouth
- sweating, flushing, impotence and ejaculatory problems.

Antagonist therapy

Antagonist therapy blocks the effects of opioids. For example, naltrexone (ReVia) is sometimes used to block the effects of alcohol. It is used to help maintain abstinence following withdrawal from opioids or alcohol. It is most useful in highly motivated clients.

The side-effects of naltrexone include:
- insomnia, anxiety, nervousness, dysphoria, depression, lethargy, fatigue, confusion and headache
- abdominal cramps, nausea, vomiting and weight loss
- joint and muscle pain.

Aversive therapy

In aversive therapy, a medication is prescribed that will cause unpleasant side-effects if substances are also used. Aversive therapy discourages use of the substance. Disulfiram (formerly marketed under the trade name Antabuse) is an example of aversive therapy to discourage alcohol use. Although Antabuse is no longer made commercially in Canada, pharmacies can make capsules using disulfiram powder.

The symptoms that result when disulfiram is combined with alcohol include:
- nausea and dry mouth
- flushing, sweating, throbbing head and palpitations.

MEDICATION MANAGEMENT

While full remission and recovery are possible, the amount of symptom relief varies from person to person. There is still a great deal of trial and error involved in finding the best medication for each person. You and your relative should be involved in the decision-making process, and be given information about the benefits and risks, including side-effects, of medications.

Identifying and minimizing side-effects

Side-effects may increase or decrease over time, and can range from mild discomfort to problems that are severe enough to make it impossible to cope with day-to-day life. Your relative should feel comfortable discussing side-effects with family members as well as with his or her treatment team. People often stop taking medication because of unpleasant side-effects, without reporting them to anyone. It is dangerous to stop or change medication without consulting the treatment team.

The treatment team can suggest ways to minimize side-effects. Strategies include:
- taking the medication in smaller doses spread out over the day
- taking medication with appropriate food
- taking an additional medication to treat specific side-effects
- changing the medication.

It is sometimes surprising how much of a difference even a very small dosage adjustment can make in how someone responds to treatment or is affected by side-effects. While a higher dose may be needed to control an acute episode, a person can generally be kept on a lower dose. The dose may need to be changed over time.

There are also practical, non-pharmacological strategies that your relative can use to deal with side-effects. Some of these are listed in Table 8-1.

Table 8-1: Managing common side-effects

ANTICHOLINERGIC EFFECTS	
Side-Effect	**Management Strategies**
Dry mouth	• chewing sugarless gum or sucking on sugarless or sour candy (both dry mouth and excess sugar can increase the risk of tooth decay) • ensuring good mouth hygiene, including frequent brushing, flossing and use of mouthwashes • having regular dental checkups • using oral lubricants (e.g., MoiStir)
Dry eyes and/or blurred vision	• reading under a bright light while holding the reading material at a distance • getting a prescription for eye drops
Constipation	• increasing fluid intake (e.g., water, juice and other non-caffeinated, non-alcoholic beverages) • increasing regular physical activity and exercise • increasing dietary fibre (e.g., bran, raw fruits and vegetables) • trying a bulk laxative (e.g., Metamucil, Prodiem) or stool softener (e.g., Surfak, Colace) • avoiding regular use of stronger or stimulant laxatives (e.g., sennosides [Senokot], bisacodyl [Dulcolax]).
Urinary retention	• using patience and running water while attempting to urinate if problem is mild • getting a prescription medication to help counteract this effect if problem is more severe

CENTRAL NERVOUS SYSTEM EFFECTS	
Side-Effect	**Management Strategies**
Drowsiness	• taking most of the dose, or the full dose if possible, at bedtime • using caution when driving or operating machinery
Lack of muscle co-ordination or muscle weakness (ataxia)	• checking with a doctor since it may be due to too high a dose
Headache	• trying over-the-counter headache remedies such as acetaminophen (Tylenol), aspirin or ibuprofen (Advil)—but first asking a doctor or pharmacist to check for possible drug interactions • getting a prescription for a different medication if, with time, headaches don't go away

INCREASED ENERGY (ACTIVATION EFFECT)	
Side-Effect	**Management Strategies**
Extrapyramidal effects (tremor, restlessness, muscle stiffness and spasms, difficulty walking)	• adjusting the dose • getting a prescription for antiparkinsonian drugs (e.g., benztropine [Cogentin]—but this medication must be monitored, as excessive doses may cause other side-effects such as disorientation, confusion and delirium) • taking propranolol, a prescription medication used to treat tremor or restlessness • taking a benzodiazepine (e.g., lorazepam [Ativan]) to treat restlessness

GASTROINTESTINAL EFFECTS	
Side-Effect	**Management Strategies**
Nausea	• taking medications with meals, having small snacks or drinking milk • not using antacids within two hours of taking the medication, as they may interfere with drug absorption
Diarrhea	• trying loperamide (Imodium) or attapulgite (Kaopectate) after checking with a doctor or pharmacist for any drug interactions • taking smaller doses throughout the day or—if the diarrhea is the result of taking lithium—using a slow-release preparation (sudden diarrhea may indicate lithium toxicity)

CARDIOVASCULAR EFFECTS	
Side-Effect	**Management Strategies**
Dizziness, fainting	• getting up slowly from a lying or sitting position and dangling feet • wearing support hose and doing calf exercises to reduce blood pooling in the calves • taking the drug in smaller, divided doses throughout the day
Rapid heartbeat	• reporting this side-effect to a doctor—however, this is usually not a serious problem
High blood pressure	• speaking to a doctor about reducing the dose, changing medications or adding a high blood pressure medication

OTHER	
Side-Effect	**Management Strategies**
Weight effects	• reducing carbohydrate and sugar intake and consulting a dietician, if possible • increasing physical activity and exercise
Sexual side-effects	• reporting these side-effects to a doctor, as all treatments for this side-effect involve prescription medications • trying a different drug, if these side-effects don't go away over time
Difficulty regulating extreme changes in temperature (altered thermo-regulation)	• spending only a short time in saunas or out in the sun on hot humid days due to increased risk of sunstroke • drinking plenty of fluids and staying in the shade as much as possible • wearing loose-fitting clothing and a wide-brimmed hat • avoiding overexposure on freezing days due to increased risk of hypothermia
Photosensitivity	• avoiding prolonged sun exposure • wearing loose-fitting clothing and a wide-brimmed hat • always using sunscreen with an SPF of 15 or higher
Excessive sweating	• using talcum powder and a stronger antiperspirant (e.g., Drysol) for greater comfort • reducing the dose • speaking to a doctor about adding another medication if a severe case

Questions for the doctor or pharmacist about medication:
- What is the name of the medication, and what is it supposed to do?
- How and when is it taken, and when should a person stop taking it?
- What food, drinks or other medications should be avoided while taking the prescribed medication?
- Should the medication be taken with food or on an empty stomach?
- Is it safe to drink alcohol while on this medication?
- What are the side-effects, and what should be done if they occur?
- Where is information about this medication available?

(National Institute of Mental Health, 2002)

Activity 8-1: Tracking side-effects

Try working with your relative to compile a record of medications and side-effects. This can be useful when you meet with the treatment team.

A: Side-effects		
Date	**Side-effect noted**	
B: Medications		
Date	**Medication**	**Dose**

Working with the treatment team

Make sure you and your relative know the name and dose of each drug taken, and the problem for which each has been prescribed.

You can help by:
- ranking symptoms of the illnesses on a scale of one to 10 and reporting any improvement
- noting side-effects and discussing them with the treatment team
- checking with a doctor and/or pharmacist for drug interactions before your relative takes any new medication (prescription or over-the-counter).

MEDICATION ABUSE OR DEPENDENCE

Health professionals have a very important consideration when prescribing pharmacological treatment for mental health problems in clients with a history of a substance use disorder. That's the possibility the client may abuse or become dependent on the medication being prescribed.

Abusing a medication means taking more of the medication than prescribed to try to get other effects (e.g., to get "high"). Dependence means that a person becomes tolerant to a medication's effects, and needs to use more and more of the medication to get the effect. This person will also experience withdrawal if he or she stops using the medication suddenly. Becoming dependent on a medication may not be due to abusing a medication. Anti-anxiety medications, stimulants and opioids are the prescription drugs that are most likely to be abused. The minimal reinforcing properties, along with troublesome side-effects, usually limit the abuse liability of antidepressants, antipsychotics and mood stabilizers. The following variables influence the likelihood of someone abusing or becoming dependent on medications:
- Substances vary in their ability to produce good feelings or pleasant effects (reinforcing effects). Someone is more likely to abuse a drug if its effects are felt quickly.
- A drug's potency or purity can influence its potential to be abused.
- A drug's cost and availability can also influence its potential to be abused.
- In general, drug effects vary greatly from one person to another. Because each person's genes are different, the drug is metabolized differently in different people. People may even respond differently to the same drug taken at the same dose.
- People may also self-medicate to cope with symptoms of a mental health problem, such as depression and anxiety.
- Starting and continuing to use and abuse substances (including abusing prescribed medications) is influenced by peer pressure and societal norms. Employment and education and the availability of other pleasurable activities (e.g., sports, socializing, club activities, recreation) have also been shown to be protective factors against drug-taking behaviour.

Benzodiazepines

There is still no agreement about the best approach to take with clients with anxiety and substance use problems. Some researchers strongly oppose prescribing benzodiazepines unless they are being given to people who are going through detoxification or who are in the acute stages of an anxiety syndrome. These researchers believe that people should stop taking benzodiazepines once another class of effective medication takes effect, as benzodiazepine use can lead to physical dependence, misuse and increased drug use. Other investigators believe that although such drugs should be avoided in many cases, the decision to prescribe benzodiazepines must be made based on each client's individual circumstances.

Anyone who takes benzodiazepines should have a complete medical and mental health assessment. The clinician should consider whether the client has tried alternative medication and whether a psychosocial approach to treatment might be enough to help the client recover, manage his or her anxiety, or prevent relapse. Clients should be told about risks such as seizures if alcohol or benzodiazepines are stopped abruptly.

DRUG INTERACTIONS

A drug interaction occurs when one drug alters the action or effects of another drug also present in the body. Some interactions are trivial, while others can be dangerous and possibly life-threatening.

Drugs taken together:

- can act independently of each other. For example, alcohol does not seem to interfere with the action of vitamins or oral contraceptives, or vice versa.
- can increase each other's effects. This could happen because they affect the brain in the same way or because one drug increases the concentration of the other in the body. For instance, alcohol and antihistamines are both central nervous system depressants. Therefore, the combination can increase both the desired effects of the drugs (e.g., disinhibition or decreasing of self-control) as well as the side-effects (e.g., drowsiness).
- can decrease each other's intended effects (an antagonistic effect). This could occur when one drug "blocks" or prevents another drug from producing its effect. It could also happen when two drugs have opposite effects on the brain (e.g., alcohol-induced drowsiness versus caffeine-induced alertness).

Consequences of drug interactions

An important factor in choosing a medication for someone with concurrent disorders is to pay attention to potential toxic interactions between the prescribed medication and the drugs of abuse. This is important in case the person relapses on the substance while taking prescribed psychiatric medication.

In some cases, drugs do interact but the result does not noticeably affect the person. However, combining substances of abuse, which can have toxic effects on their own, with prescription medications often has consequences that are much more serious. The most common toxic effects are:

- central nervous system depression, which, at its mildest, is drowsiness, but in its more severe form, can lead to a coma
- respiratory depression, which can lead to the person stopping breathing altogether
- cardiac effects, such as blood vessels constricting or dilating, or changes in heart rhythm that can lead to the heart stopping
- decreased seizure threshold, meaning that the brain can have a seizure more easily
- psychiatric effects, such as psychosis.

Some of the more common combinations and their effects are listed below.

STIMULANTS AND ANTIDEPRESSANTS

If a stimulant, such as cocaine or methylphenidate, is taken with a monoamine oxidase inhibitor (MAOI) antidepressant, a hypertensive reaction (high blood pressure) can occur. There have been many reports of rapid onset of headaches and severe hypertension when amphetamines are consumed by people who are taking MAOIs, some with fatal outcomes from cerebral hemorrhage (bleeding in the brain). The combination of a stimulant and a tricyclic antidepressant can cause an increased heart rate.

CANNABIS AND ANTIPSYCHOTICS

Marijuana can decrease the effectiveness of antipsychotic drugs and increase the risk of relapse. Taken with certain antipsychotic drugs, marijuana can also lead to marked hypotension (low blood pressure) and increased disorientation. There can also be additive effects with anticholinergics and other medications that have anticholinergic side-effects, leading to such symptoms as increased dry mouth, urinary retention and constipation.

TOBACCO AND ANTIPSYCHOTICS

Smoking decreases the blood concentration level of certain antipsychotics by 20 to 100 per cent, so smokers require higher doses. If a person reduces or quits smoking while taking an antipsychotic, the blood concentration levels of the drug will increase, leading to increased side-effects and possibly toxicity. Therefore, dose decreases are usually required, but must be monitored closely.

TOBACCO AND BENZODIAZEPINES

Some of the substances in tobacco can stimulate the liver enzymes that metabolize diazepam and chlordiazepoxide. This causes them to clear from the body more quickly, leading to a need for higher doses.

CAFFEINE AND LITHIUM

Caffeine acts as a diuretic, which can worsen incontinence. This affects water balance and can therefore affect lithium levels. Caffeine can also increase excretion of lithium from the kidneys and lead to lithium tremor. People who take lithium may still have some caffeine in their diet, but it is important that they do not drastically change their intake from day to day.

ONGOING TREATMENT

Clients and their families are often concerned about how long they will be taking medications. In some situations, the treatment will be short-term, as in the case of a sleeping pill for temporary insomnia. For a first episode of depression, medication is recommended for at least one year. For bipolar disorder and schizophrenia, the period of treatment is usually indefinite to prevent symptoms from returning. In the case of a first-episode psychosis, it can be difficult to distinguish between a drug-induced psychosis and schizophrenia. If a client does not have symptoms for several months, it may be possible to slowly taper and then stop the medication, with close monitoring.

Many mental health problems are lifelong conditions, so treatment with medications is often indefinite. Once an acute episode has been successfully treated, you, your relative and the treatment team need to watch for any signs of possible relapse.

STOPPING MEDICATION

People are often ambivalent about staying on their medications. Reasons for the ambivalence include:
- unpleasant side-effects
- feeling well and no longer seeing the need to take medications
- messages from peers (e.g., 12-step peers) that you should be able to cope without any substances, including prescribed ones
- concerns about interactions with alcohol or other substances.

Families should encourage their relatives to talk about problems with medications—with the hope that they will fully explore what could happen if they suddenly decide to stop taking a medication. For clients who choose not to take their medication:
- Acknowledge they have a right to choose not to use any medication.
- Stress that they owe it to themselves to make sure their decision is well thought out. (It is an important decision about their personal health and they need to discuss it with their doctor.)
- Ask their reason for choosing not to take the medication.

- Don't accept "I just don't like pills." Tell them you are sure they wouldn't make such an important decision without having a reason.
- Offer as examples reasons others might choose not to take medication. For instance, they:
  - don't believe they ever needed it (i.e., they were never mentally ill)
  - don't believe they need it anymore (i.e., they are cured)
  - don't like the side-effects
  - fear the medication will harm them
  - struggle with objections or ridicule of friends and family members
  - feel taking medication means they're not personally in control.

Medication is often an important part of a treatment plan for concurrent disorders, but finding the most effective medication, or combination of medications, can be a long, frustrating process. You can help by learning about the benefits and risks of the medications that your relative is taking, and by talking with your relative and the treatment team about how the medication is working, and the nature and severity of side-effects. Make sure the medication and dosage are reviewed regularly. If you are not satisfied, you and your relative can ask for a second opinion.

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Relapse prevention

9

Outline

- What is relapse?
- Relapse prevention for substance use problems
- Relapse prevention for mental health problems

WHAT IS RELAPSE?

A relapse occurs when a person in recovery re-experiences problems or symptoms associated with his or her disorders. With substance use disorders, a relapse means a return to problem substance use after a period of abstinence or controlled use. With mental health disorders, a relapse is a flare-up of symptoms that are associated with the disorder. A relapse of one disorder can sometimes trigger relapse of the other.

There are many contributing factors and warning signs that indicate that a person may be in danger of returning to substance use or redeveloping symptoms related to mental health problems.

RELAPSE PREVENTION FOR SUBSTANCE USE PROBLEMS

A relapse is an expected part of the recovery process in substance use treatment. Usually there are warning signs that start long before the relapse. It is possible to identify these warning signs and take action to prevent a relapse.

If a relapse does occur, it is not a sign that treatment has failed, or that a person has a weak character, or that the caregiver is at fault in any way. A person with a substance use problem needs to learn and practise a variety of skills to prevent relapses. A relapse should be seen as an opportunity for the person to think about how to manage similar situations in the future. However, if someone relapses over and over again, it may be a sign of a more serious, undiagnosed disorder, such as posttraumatic stress disorder.

It's common for people to have ongoing urges and cravings that they must deal with to prevent a relapse.

Risk factors

People may experience situations or feelings that put them at greater risk of relapsing. A person who has a stressful, demanding life may see substance use as the only way to get pleasure or escape stress. The following factors can increase the chances that a person will relapse:

- negative emotional states, such as anger, anxiety, depression, frustration or boredom
- conflict with others that leads to negative emotions
- social pressure from peers who use substances.

Positive occasions, such as birthdays, anniversaries or reunions may also increase the chances of a relapse if alcohol is part of the celebration. Any intense feelings, even

happy ones, can be uncomfortable for some people. As a result, they may use substances to try and reduce the emotional intensity. Other people may use substances to try and intensify positive emotions.

Preventing substance use relapse

A person who copes effectively with high-risk situations is less likely to relapse. Also, a person who recognizes that substance use can lead to negative consequences, despite the fact that it may bring temporary pleasure, is less likely to relapse than a person who only acknowledges the pleasure.

When people have one relapse, their reaction to this "slip" can affect whether they go back to a pattern of heavy use. People who feel that they have no control over their use are more likely to use substances again. Those who see the relapse as a single event in which they didn't cope effectively, and as an opportunity to develop more effective ways to deal with similar triggers, are more likely to avoid using substances again.

Relapse prevention strategies for substance use problems

The following strategies can help your family member prevent a relapse:

- Become familiar with a return, or worsening, of symptoms of the person's mental health problems (such as manic behaviour, worsening of depression, self-harm behaviour) that have, in the past, frequently been associated with a substance use relapse.
- Identify situations in which the person may have problems coping (e.g., for many people, it is risky to be in places where they used substances before—such as in a bar—and to be around people they used to drink or use with).
- Develop strategies to deal with these high-risk situations. For example, a person could be prepared to refuse drinks in social situations by going to an establishment that offers interesting non-alcoholic drinks or going with friends who will support their decision not to drink and who do not drink to excess themselves.
- Remove items that might trigger use (e.g., someone who has a problem with alcohol could remove all alcohol, favourite drinking glasses, corkscrews and bottle openers, at least temporarily, from the house).
- Practise techniques to deal with stressful situations (e.g., meditation, anger management, positive thinking and withdrawal from the situation)
- Pursue activities that increase a sense of balance in life, such as relaxation training, stress management, time management, pet ownership, exercise and yoga.
- Make a "relapse road map" that outlines and emphasizes choices available to cope with or avoid high-risk situations.

Be prepared for relapse. Try to understand what triggered it. Think of a relapse as an opportunity to plan for similar situations in the future, not as a mistake.

As people learn new skills and use them to avoid relapse and deal with stress, they develop a sense of mastery, which, in turn, decreases the risk of relapse.

RELAPSE PREVENTION FOR MENTAL HEALTH PROBLEMS

Some people only have one episode of mental illness, but many people have more than one episode. In some cases, the mental health problem is expected to recur.

Studies have shown that people can learn to recognize and manage their symptoms and reduce the chances that they will relapse. If they do relapse, the symptoms may be less severe.

There are some common factors that may contribute to relapse for many mental health disorders. However, sometimes there is no obvious reason.

Risk factors

People may experience situations or feelings that put them at greater risk of relapsing. A person who has a stressful, demanding life can be more vulnerable to relapse. Lack of regular routines and a poor diet and sleeping habits can also have a negative impact. A lack of social, family and community support may be a factor. Some common triggers are:

- substance use or abuse
- medication use problems—medication is stopped, taken irregularly or the dose is too low
- high levels of criticism, hostility or too much emotional involvement from family members (high emotional expression)
- conflicts with others
- severe mental stress, such as the death of a loved one
- condition-specific triggers—for example, the anniversary of a traumatic event could be a trigger for someone with posttraumatic stress disorder (PTSD)
- feelings, thoughts or situations that have come before a previous episode of illness
- other medical or physical problems.

Relapse prevention strategies for mental health problems

The following strategies can help your family member prevent a relapse:

- Identify signs of relapse and work with a professional to develop a relapse prevention plan.
- Take medication as prescribed, and speak to the doctor if it is not working or if side-effects are too unpleasant.
- Recognize situations that may trigger symptoms, and try to avoid them or reduce exposure to them.
- Learn about the disorders. Psychoeducation—formal learning about mental illness by the individual and family members—reduces the rate of relapse.
- Apply skills learned in treatment to deal with symptoms.
- Practise techniques to deal with stressful situations. Examples include meditation, anger management and positive thinking.
- Develop a structured routine. Pursue lifestyle choices and activities that increase a sense of balance in life, such as relaxation training, stress management, assertiveness training and conflict resolution.

Activity 9-1: Identifying risk factors

List specific factors that might lead your relative to relapse of his or her substance use and/or mental health problem.

Activity 9-2: Relapse prevention strategies

Not only is it crucial for families to become aware of potential warning signs of relapse, it is also important for families to develop an action plan to deal with relapses of their relative's substance use and/or mental health problem. What action would you take if you saw warning signs of relapse in your relative (e.g., sit down with your loved one in a quiet place and gently discuss your concerns, and suggest that he or she make an appointment to see the doctor, therapist and/or case manager)?

Activity 9-3: Caregiver relapse prevention plan

Think about your own needs as the relative of a person with concurrent substance use and mental health problems. As we discussed in Chapter 5, it is essential for you to take good care of yourself and to develop a self-care regime. Should you begin to notice signs of increased stress, anxiety, depression, fatigue or other symptoms in yourself that might indicate that you are becoming overwhelmed (*caregiver relapse*), what steps might you take to care for yourself? Write down a personal "caregiver relapse prevention action plan" for yourself.

If my family member suffers a relapse, I will take the following steps to care for my:

Physical health:

Emotional health:

Social health:

Spiritual health:

Sample caregiver relapse prevention plan

Physical health:

If my husband Frank starts drinking again, I will take care of myself physically by taking a "time out" to go for a long walk. This helps me to clear my head and calm down so I don't blow up at him and call him a failure. I will also try to stick with my plan to eat good food, but if I slip and go back to junk food a couple of times, I will be kind to myself—relapses are stressful for all of us in the family and if I eat a bag of chips when I'm upset, it doesn't mean I'm an awful person. I will just go back to eating a good diet afterward.

Emotional health:

I will take care of myself emotionally by reading the material that I got from my family support group and from Frank's therapist about why people who stop drinking suddenly start again. This always helps me to remember that addiction is an illness that gets better gradually. It will also remind me that recovery is often a long, slow process and that relapses are often part of the person's journey. Maybe this will help both me and my husband learn something positive from this experience.

I will also read the material I have about bipolar disorder to remind myself that sometimes, when people start getting too high or too depressed, they might turn to alcohol for comfort. All of these things help me cope when Frank picks up a drink again after being sober for a while. When I understand what's going on better, I don't blame him or myself. This helps me to stay calm and I don't end up freaking out.

Social health:

If Frank relapses, I will call my best friends: Lucy from my family mood disorders support group, and Beth from my Al-Anon group. I will ask them to go to a family group meeting with me and then out for a coffee after.

Spiritual health:

I will increase the length of my yoga exercises to more than 15 minutes, and I will go back to my daily meditation readings.

Crisis and emergency

10

Outline

- Understanding crises and emergencies
- Whose crisis is it?
- Limit-setting
- Dealing with inappropriate behaviour
- Example of an escalating crisis
- When a crisis becomes an emergency
- Creating an emergency plan
- Creating a crisis plan

UNDERSTANDING CRISES AND EMERGENCIES

Even the best planning can't always prevent a relapse. Sometimes a relapse develops into a crisis. A crisis may also occur with little or no warning.

A *crisis* is any serious deterioration of a person's ability to cope with everyday life. It can be a turning point—for better or worse. It does not necessarily involve a danger of serious physical harm. **A crisis develops when people feel they cannot control their feelings and behaviour and have trouble coping with the demands of day-to-day life.** People in crisis may experience extreme despair, sorrow or anger. They may not be able to sleep, they may hear voices or they may believe that they have superhuman powers. Although people in crisis are not necessarily a danger to themselves or anyone else, in many crisis situations, outside help (the person's doctor or therapist, a mobile crisis service or crisis line) is needed.

An *emergency* is a situation in which there is an immediate danger that the person will harm either him- or herself or someone else (Chan & Noone, 2000). Examples of emergencies:

- threats of suicide
- threats of physical violence
- extreme impaired judgment caused by problems such as psychosis or intoxication.

WHOSE CRISIS IS IT?

Sometimes issues related to concurrent disorders happen suddenly. The symptoms, problems and needs of the person affected create a crisis that galvanizes all members of the family into action. At other times, issues can unfold slowly, and may build until someone in the family decides that it's time to take action. For example, a behaviour that has become quite regular, such as an adolescent son coming home intoxicated, can suddenly become a heated issue because a parent decides that it is finally time to address this behaviour. Another example is a person who skips one session in his or her treatment program because of feeling down, but is confident that he or she will go back the next day. Family members may react strongly because they are worried that the person might be backsliding, missing needed care and risking relapse.

In both of these examples, how family members will perceive the situation will vary. One person might feel that things are at a point where immediate action is necessary—that things are in crisis; another might not see why today has to be treated differently than any other day. Sometimes the person with the co-occurring problems feels that something has suddenly gone seriously wrong and needs immediate attention, while family members aren't as concerned. In other situations, family members are convinced that action needs to be taken, but the person with the problems may not agree, or may be afraid of what taking action will mean for them.

So you need to ask yourself: Whose crisis is it? The answer will help you understand who is really asking for help—your relative, the family or both.

LIMIT-SETTING

Setting limits can help to prevent conflicts from turning into crises. Conflicts can result from interpersonal problems between the person who is ill and his or her family members, or between the ill individual and other people. The family member with concurrent disorders may also experience conflict for other reasons, such as changes in his or her daily routine, difficulties with finances or loss of housing.

Family members may feel guilty when they set limits on their ill loved one's behaviours or insist that he or she follow the rules and guidelines that everyone else in the family is expected to follow.

By refusing to set limits, families may believe that they are being helpful in preventing their relative from becoming unnecessarily upset or angry. Consistent rules and boundaries can help to create a sense of predictability and security.

It is usually best to avoid:
- making excuses (e.g., "He's just upset today." "She'll go to her day program tomorrow." "A few drinks won't hurt him and it may help him calm down." "It's okay if she comes home late. She has such a hard life.")
- paying their bills
- giving extra money, often over and over again, and being surprised when it's used to buy more alcohol or other drugs
- bailing the person out of jail
- making excuses for irresponsible behaviour
- ignoring problems (e.g., mental, emotional, financial, employment, legal) caused by the person's substance use
- accepting excuses or believing lies.

DEALING WITH INAPPROPRIATE BEHAVIOUR

Don't allow:
- yelling, swearing or other forms of emotional aggression
- physical aggression
- dangerous behaviour such as smoking in bed
- stealing from family members or friends
- misuse of money that is intended for rent or other basic needs.

Although it may be difficult when your loved one suffers from concurrent disorders, it can be helpful to set limits on his or her use of alcohol and/or other drugs in your home.

When objecting to unacceptable behaviour, be clear and request specific changes in the person's behaviour. For instance:

- Identify problems (e.g., spending weekly allowance on alcohol rather than on bus fare, or coming home late intoxicated and disturbing other family members).
- Work on one problem at a time.
- Avoid making demands or becoming confrontational.
- Clearly state your expectations for the future in a positive, non-judgmental, non-threatening manner. For example, try saying "I would like you to _____." or "We would really appreciate it if you would _____." or "It is important to me (and/or other members of the family) that you help us by_____."
- Help the person to understand the consequences of ignoring a boundary or limit on a particular behaviour (e.g., no additional money will be given that week; you will buy bus tickets and give them to your relative rather than giving him or her the money, which could be spent on alcohol).
- Be consistent in both limit-setting and following through with consequences.
- Review the limits set on particular behaviours and redesign the plan as necessary.

EXAMPLE OF AN ESCALATING CRISIS

Sometimes a sudden change in daily routine triggers a crisis that escalates into an emergency. Sometimes there is nothing that family members can do to prevent a crisis. Other times family members can prevent—or trigger—a crisis.

Read the following scenario and think about whether, had family members acted differently, the outcome could have been less severe.

> *Sam (who is away for the weekend) and Vera have three children, John (24 years old), Steven (20 years old) and Anna (16 years old). John and Anna live at home and Steven lives in a student residence nearby. Anna is in Grade 10. John has schizophrenia (diagnosed when he was 19) and a substance use problem (diagnosed recently). John takes medication for symptoms of psychosis and anxiety, but still finds it hard to deal with any changes in his life. When changes occur, he tends to become anxious and depressed and often uses alcohol to try to calm himself.*
>
> *When he drinks, he can easily become angry and often explodes with rage over the slightest provocation. He sometimes throws things and curses at family members. He then goes to his room to smoke cigarettes and listen to music until he falls asleep. His family carefully and discreetly monitors his smoking and takes turns watching him until he falls asleep. After sleeping for up to 15 hours, he usually wakes up calm, sober and with no memory of what had occurred the previous day.*
>
> *One weekend, John learns that his therapist for the past five years is moving to another city and that he will have to start seeing another doctor. John is visibly upset and begins pacing around the house. His mother and sister are at home. They are careful to stay out*

of his way except to gently ask him if they can help. John becomes so agitated that he ends up leaving and, rather than going to his day treatment program to speak to one of his workers, goes to a local bar. After drinking four or five beers, he starts to experience feelings of anger and paranoia. He wants a cigarette but realizes that he just spent the last of his allowance on beer.

When John finally returns home, Vera realizes that he is intoxicated. John approaches his mother in the kitchen and angrily tells her that he has no money and that he needs 10 dollars to buy cigarettes. Vera asks him what happened to the allowance that she gave him three days ago. John slams his fist on the table and screams at her that he used the money for food, and threatens to "kill somebody" if she refuses to give him what he wants. While this is happening, John's younger brother Steven comes into the kitchen. Anna comes into the kitchen from the living room and, hearing what is going on, fears for her mother's safety. She decides not to interfere, and stays quietly in the doorway.

Vera, seeing that her son John is becoming more and more agitated, angry, belligerent and demanding, quickly grabs her purse and is about to take out her wallet to give him the 10 dollars when Steven runs over and tells her to put her wallet back in her purse. Steven then angrily moves nearer to John and yells, "Look, you lazy jerk, I've just about had it with you. She is not going to give you any more of her hard-earned money just so that you can blow it on booze and cigarettes. And you're drunk again, aren't you?! Well, I'm sick of your crap. Nobody is going to give into you anymore. Mom, don't give him anymore money. He shouldn't be smoking anyway."

Steven keeps getting closer to John until they are staring right at each other, face to face. As Steven continues to yell at John, John begins to shake in anger and raises one fist while, with his other arm, he reaches into a kitchen cupboard and grabs a steak knife. In a split second, he stabs Steven in the stomach and Steven falls to the floor. Vera, watching in horror, turns to pick up the phone to call for help, when John rushes into the living room and begins pacing while still holding the knife. Anna runs into the kitchen to help her mother. Vera shouts for Anna to call 911 and get an ambulance. She also tells Anna to make sure they send the police.

Once the ambulance, police and fire department arrive and Steven has been taken to the emergency department, Vera tries to describe to the police the events that led up to the stabbing. She tries to explain that her son didn't mean to hurt anybody, that he suffers from a mental illness and that he has also been drinking. But Vera is so upset and devastated over what has happened that she can barely speak.

Activity 10-1: Reflecting on an escalating crisis

Do you think there is anything John's family members could have done differently to have prevented a crisis *in the first place*?

Do you think there is anything John's family members could have done differently to prevent what had become a crisis from escalating into an emergency?

Being prepared

Being prepared can help to prevent a situation from developing into a crisis and can also ease the person's pain and anxiety once a crisis does occur. John's family might think about the following:

- ensuring that John's doctor and day treatment program workers are aware of (a) his difficulties in coping with change, (b) how change affects him (he develops severe anxiety and depression), (c) how he copes with these feelings (he turns to alcohol to self-medicate) and (d) what happens when he drinks alcohol (he is unable to stop at one drink, and it only takes four or five drinks before he starts experiencing rage and paranoia; he often becomes violent and makes threats).
- determining that John's doctor and day treatment program workers are *willing and able* to work with both his mental health and substance use problems.
- ensuring that John's doctor and workers are helping him learn to cope with change in his life.
- finding a program that provides support and education for family members—this can help John's family learn how to cope with conflict and crises more effectively and can provide them with professional and peer support, experience and validation.
- starting to set limits to help John manage his feelings and behaviours. For example, to continue receiving an allowance from his parents, John must not avoid his responsibilities (such as attending his day program and keeping appointments with his doctor). John must smoke outside at all times to respect the health of his family members. John must use his allowance for necessary items such as clothes and bus fare, not for alcohol. John, like every member of the family, cannot be allowed to engage in threatening remarks or behaviours.

When John is ready (and is in a calm frame of mind), the family can talk with him about his smoking and give him some information about ideas for quitting smoking, including information about nicotine replacement therapy (such as the patch or nicotine gum).

During a crisis

When John does experience a crisis, the family should:

- try to be calm and supportive
- offer to call John's doctor or one of his day program workers and ask John if he wishes to talk with them on the phone
- if he is agreeable, offer to take John to his doctor's office or to his day program so that he can meet with one of his workers in person
- offer help and suggestions about what John can do to ease his anxiety and fear about whatever is concerning him.

Once John returned home obviously drunk, angry, paranoid and demanding money from his mother, several things might have helped prevent this crisis from becoming

an emergency:

- Vera was right in that it was too late to try to reason with John. Knowing his usual pattern of drinking alcohol to cope with conflict, and his routine of calming himself in his room until he fell asleep, it would be better to avoid questioning John about what he did with his allowance.
- Knowing that John always smoked cigarettes when he was intoxicated and feeling angry and paranoid, it might have helped for Vera to give him the ten dollars this time, since he was unlikely to respond very well to attempts at limit-setting when he was in crisis. When John is calmer, the family could talk to him about asking for money for cigarettes, and establish some ground rules.
- Vera could have accompanied him to the store to buy cigarettes (preferably with a third person, if John is agreeable), and then taken him home and given him time to calm down in his room alone until he fell asleep (his usual pattern), while family members monitored his smoking and ensured that he did not unintentionally harm himself or fall asleep with a lit cigarette.
- Vera might have considered asking a close family friend to come over and help monitor John. Either Vera or another family member might have then phoned his doctor, therapist or another health professional who knows John and asked for help or advice on how to proceed.
- When talking to John, Steven should have spoken more softly and avoided direct eye contact with him, since shouting, judging, accusing and blaming him increased his fear and paranoia.
- Anna was wise to stay quiet and in the doorway. She knew from past incidents that when John was intoxicated, he was easily provoked into threatening behaviour. Too many people "cornering" him could worsen an already precarious situation.

Steven could have helped by:

- not crowding John when he was upset and intoxicated
- speaking softly and gently
- not making accusations
- avoiding direct eye contact with John, especially staring at him
- keeping a safe distance from John (this would have helped to keep Steven safe and prevent John from feeling more paranoid and "imprisoned")
- letting one person (in this case, his mother) speak to John and handle the conflict.

Following through on these suggestions might have helped prevent a crisis from becoming an emergency. **However, families should be aware that sometimes an emergency cannot be avoided.** It is helpful to know what they can do in the event of an emergency.

WHEN A CRISIS BECOMES AN EMERGENCY

If your relative threatens to harm him- or herself or you, or to seriously damage property, you must do whatever is necessary to protect yourself and others (including your

relative) from harm. You may need to leave and call for help. This is advisable only under extreme circumstances, and only for very short periods of time. If possible, remove objects that your relative could use to harm him- or herself.

Don't:
- shout
- criticize
- stare
- argue with others about what to do.

Suicide

One of the most terrifying aspects of a serious mental health disorder is talk of suicide. Any talk—or even joking—about suicide must be taken seriously.

Most people do not want to end their lives. Suicidal thinking or attempts typically occur during a serious episode of mental illness when the person feels helpless, hopeless and in a state of despair. Although the feelings are often temporary, at the time, people do not believe that the feelings will pass. You can help by acknowledging your relative's feelings while offering to help him or her find other solutions. However, it is also important to recognize your own limitations. **Family members must realize that they do not have absolute control to change things and cannot be responsible for all of their relative's actions.**

WARNING SIGNS OF SUICIDE

There are several warning signs that a person is considering suicide. He or she may:
- discuss suicide and what it would be like to have things end
- be concerned with providing for children, other family members or pets
- give away possessions
- express feelings of worthlessness, such as, "I'm no good to anybody"
- feel hopeless about the future, reflected in comments such as, "What's the use?"
- talk about voices that tell him or her to do something dangerous.

What to do if you find someone after a suicide attempt:
- Phone 911 immediately.
- If you know first aid, administer it immediately.
- Phone someone to accompany you to the hospital or to stay with you at home.

Do not try to handle the crisis alone; contact a support group to help you with your immediate reactions and long-term feelings.

Getting treatment in an emergency

GOING TO THE HOSPITAL

It's best if you can get your relative to go to the hospital voluntarily. If he or she won't listen to you, ask someone your relative trusts to convince him or her to go to the hospital. This should be part of your prearranged action plan (see "Creating an Emergency Plan," p. 174. Try to offer your relative a choice. For example, John's mother might have asked him: "Will you go to the hospital with me, or would you prefer to go with your father or Anna?" This reduces a person's fear that he or she is being coerced.

CALLING THE POLICE

If your relative appears likely to endanger him- or herself or someone else, and refuses to see a doctor, you can get a judge or justice of the peace (depending on the province or territory in which you live) to issue a document that authorizes the police to take your relative to a hospital for an assessment. But if you're in a crisis or emergency situation (the danger is immediate), just call 911.

> *Sometimes you have to phone the police, and the first time is really tough. I remember the first time we had to phone 911, and the ambulance came, and the police—and then my neighbour who's a doctor came over and said, "Is there anything I can do?" And I had to say, and I remember I actually got it out, "My daughter is having a psychotic episode. And she's been using crack." And once I got that out, he was very supportive—and I was fine. I thought, OK, you know, that's behind me. So I told him, and he was very kind. So once you put it out there, and nothing terrible happens, you're OK.*

It's understandable that families are reluctant to call the police, but extreme circumstances may leave you no other choice. Often, merely telling the ill person that you are calling the police will calm him or her down.

When you call 911, tell the emergency operator that your relative needs emergency medical assistance and give the operator your relative's diagnosis. Say you need help getting him or her to the hospital.

In some communities, the police are given training in crisis intervention. It's helpful to find out what kind of training, if any, the police in your community have so you'll know in advance how much advocating you might have to do when and if you need to call on them. If you find yourself in a situation where you need to call the police, write down the officers' names, badge numbers and response time in case you later need to report any concerns about how the problem was handled. While the police are present, you may have time to call the doctor or any other emergency contact.

Even when your relative has been destructive or physically abusive, you may be reluctant to involve the police. Family members sometimes fear that their relative will be put in custody where they may be victimized and treated inappropriately.

But failing to take seriously the risk of violence and physical harm can have its own consequences. You should take care to recognize the signs of escalating threats and violence, and the presence of extra stress and triggers that could set your relative off, and know when things are beyond your control. Don't be afraid to call a crisis team in to your home or the police. In many cases that is the safest, kindest thing you can do for an ill family member.

Involvement with the forensic mental health system

Ironically, if a person with serious mental health conditions comes before a judge because he or she has been charged with doing something illegal, it may be more likely that person will be remanded for a full assessment and possibly treatment. *Forensic psychiatry* is a branch of mental health that works with people who have become involved with the law. For some individuals with mental health problems who have become involved with the law, being directed to a forensic facility allows them to receive the care that they have not been able to receive in the community system.

The forensic mental health system can be confusing for families. If you live in Ontario, *The Forensic Mental Health System in Ontario: An Information Guide* (available at www.camh.net/Publications/CAMH_Publications/forensic_menthealth_infoguide.html) will help you find your way through the system.

WORKING WITH EMERGENCY ROOM STAFF

If possible, go to the emergency department with your relative. The staff should interview you because you have information that they need to decide how to treat your relative. If the emergency room staff don't ask to talk to you, you should insist that you get a chance to talk to them.

Try to provide an organized account of the events leading up to the hospital visit. If you are worried about your safety should your relative be released, let the staff know.

INVOLUNTARY ADMISSIONS

In some cases, your relative may not want to get treatment after a crisis, or even after having serious symptoms. In Canada, people can't be forced to get treatment for a mental health disorder unless they are a threat to themselves or others. While this approach does acknowledge the rights of the individual, it has created complex problems for families. If a person who doesn't want to be admitted to hospital is admitted, he or she is considered an involuntary patient. The specific criteria used to decide whether a person

can be admitted to the hospital without his or her consent vary from province to province. The basic principles are:
- The person is believed to be a danger to him- or herself (e.g., is suicidal or self-harming).
- The person is believed to be a danger to others (e.g., is violent).
- The person is unable to care for him- or herself and is at immediate risk as a result (e.g., because he or she is not eating or drinking).

If the person meets the provincial criteria for involuntary admission, a physician can issue a document that authorizes a short stay in the hospital (in most provinces, one to three days) for emergency treatment. In some provinces, another document must be issued if longer-term treatment is needed.

Consenting to treatment

People who have been admitted to hospital involuntarily still have the right to make decisions about their treatment if they are mentally capable to do so. This includes refusing treatment.

To be considered capable, a person must:
- be competent to give consent
- have the intellectual capacity to make the decision
- give the consent voluntarily
- have enough information to make an informed decision, including information on potential risks or side-effects of treatment.

If the person is not able to give informed consent, then he or she must be declared incompetent. Someone is appointed to make decisions on the person's behalf. In some provinces, the decision-maker is a family member while others use people appointed by the state.

Information about the *Mental Health Act*

Each province has its own *Mental Health Act*, so the rules vary from province to province. Provincial offices of the Canadian Mental Health Association (CMHA) and websites of provincial ministries of health are sources of information. Here are some useful links:

Alberta
The Mental Health Act of Alberta: A Guide for Consumers and Caregivers
(available online through CMHA Alberta)

British Columbia
BC's Mental Health Act in Plain Language
(available online through CMHA BC)

Manitoba
www.gov.mb.ca/health/mh/act.html

New Brunswick
www.ahsc.health.nb.ca/Programs/MentalHealth/rights.shtml

Ontario
Rights and Responsibilities: Mental Health and the Law
www.health.gov.on.ca/english/public/pub/mental/rights.html

Prince Edward Island
Islanders Guide to the Mental Health Act
www.gov.pe.ca/publications/getpublication.php3?number=118

Quebec
Mental Illness: A Regional Handbook for Families
(available from CMHA Quebec)

Saskatchewan
www.health.gov.sk.ca/rr_your_prsnl_rights_mhsa.html

CREATING AN EMERGENCY PLAN

Before a situation turns into a crisis or an emergency, it may help to sit down with your family and discuss what you would do in an emergency. Don't try to deal with your family member when he or she appears to be under the influence of alcohol or other drugs, or when family members are extremely upset. You may say things under the stress of the situation that you don't mean, or take action that just makes things worse.

When everyone is calm, you can focus on planning what to do if:
- the family notices that some of the symptoms of the substance use or mental health problem are reoccurring
- the situation has already become a crisis.

Developing a plan together ensures that your relative is an active participant in his or her own care. Planning all of this before a crisis happens can sometimes help avoid a crisis altogether. However, there are times when a crisis may not be preventable.

CREATING A CRISIS PLAN

The following guidelines will help you create a crisis action plan that is tailored to the needs of your ill family member:
- Make sure that your relative is actively involved and participates in the discussion and in all decisions, and that his or her preferences are heard and respected.
- Involve as many members of your family as deemed appropriate and develop an approach that all can agree on.
- Generate a number of possible crisis plans and act on the ones that everyone, *especially your ill loved one*, agrees are the best ones.
- Develop specific steps for carrying out your plans. Decide what role each member will have in implementing the plan. For example, decide who is the best person to accompany your loved one to the hospital, should this become necessary, who should stay on at the hospital, and who should make phone calls from home.
- Decide who will speak to the treatment team or, in extreme situations, to the police, if your relative is unable to speak for him- or herself.
- Make sure to get your relative's permission to relate particular information to hospital staff or to the police.

Crisis cards

People with concurrent disorders and their family members have found it extremely helpful to write important information on a card or a piece of paper folded small enough so that it can be carried with them wherever they go. For example, the card or paper may be placed in a visible part of the person's wallet.

A crisis card usually contains information important for others (e.g., friends, health care workers, police, strangers) to have in the event that your relative experiences a mental health or substance use–related crisis while away from home. It contains information such as:

- important phone numbers—who to call in the event of a crisis or an emergency, including who to call first and who to call as a back-up
- the person's mental health or addiction professional (e.g., psychiatrist, therapist or worker)
- the person's family doctor
- the hospital or treatment centre at which the person has currently or previously been involved in inpatient or outpatient care
- a list of the person's current medications, the proper dosage for each, and the times of day or night that they are to be taken (you may also wish to include the name and number of the pharmacy at which the prescriptions are usually filled)
- a list of medications to which the person is allergic
- any medications used in the past for either the mental health or the substance use problem that did not work, or that the person would not take due to side-effects (you may list such medications in one column and list the side-effects in a second column)
- tips for effectively talking to and working with the person when he or she is in crisis
  - neutral topics of interest to them
  - comforting foods
  - self-calming measures, such as music or video games.

Activity 10-2: Creating a crisis card

Here are some suggestions for information that you might include on a crisis card. Choose the information that would be most useful in your situation.

Emergency personal contacts

Primary contact

Name_____ Home phone # _____

_____ Work phone # _____

_____ Cellphone # _____

_____ E-mail _____

Back-up contact

Name_____ Home phone # _____

_____ Work phone # _____

_____ Cellphone # _____

_____ E-mail _____

Treatment providers

Family doctor

Name_____ Phone # _____

Case manager / therapist / substance use or mental health worker

Name_____ Phone # _____

Name_____ Phone # _____

Hospital or treatment centre

Name_____ Phone # _____

Current medications

Medication _____ Dose _____ Time of day _____

Medication allergies

_____

_____

_____

The following medications were ineffective and/or caused serious side-effects:

Medication _____ Side-effects _____

_____ _____

_____ _____

_____ _____

Suggestions for helping in a crisis or an emergency:

_____

_____

_____

_____

_____

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Part IV: Recovery

Recovery 11

Outline

- What is recovery?
- Key factors in recovery

WHAT IS RECOVERY?

Recovery is a one-of-a-kind journey for each person with its own rewards and perils along the way. There is no one definition of recovery, and no single way to measure it. All definitions of recovery share a focus on developing new meaning and purpose in life as people grow beyond the impact of mental illness and substance use.

> *When I first started in the family support group, I found myself listening to other family members who were doing really well and had been in situations similar to my own. So it's the hope—it's the giving of hope, that it really is possible to get through it; that no matter how tough it's been and how often the treatment has failed, that it still may one day succeed, that recovery is possible. And no matter how many people turn away from you, or what they think of you, things will get better.*

Activity 11-1: What does recovery mean to me?

As a family member, loved one, friend or significant other of someone with concurrent substance use and mental health disorders, my definition of recovery is:

Recovery has been referred to as a process, an outlook, a vision and a guiding principle. Recovery has also been described as a process by which people recover their self-esteem, dreams, self-worth, empowerment, pride, dignity and meaning. For professionals and families, recovery is about treating the whole person: identifying their strengths, instilling hope, helping them to function by helping them take responsibility for their lives.

Recovery is also about refusing to settle for less. A positive way of looking at recovery is to embrace the humanity of people and their potential for change. People are *people* before they are diagnoses, or cases, clients or consumers. They are not defined or controlled by their symptoms.

People should be encouraged to:
- have hope for change
- form meaningful connections with others who understand their situation
- set their own goals
- nurture their interests and learn new skills
- develop self-awareness about aspects of their own illness and behaviour.

Recovery is defined by a belief in one's self. It is nurtured by the kindness, understanding, compassion and respect of friends, family and others who are significant in one's life. Ultimately, recovery involves sharing and gaining support from others.

Recovery:
- doesn't necessarily move in one direction; recovery implies learning from setbacks and having the courage to move forward in spite of them
- may occur even when symptoms are present; recovery does not necessarily mean that people will never again experience symptoms, go through hard times or relapse
- is facilitated by access to a support system, but it can occur without the intervention of mental health professionals
- must also involve attending to other areas of life, such as work, leisure time, life goals and dealing with stigma.

Relapse can be part of the overall recovery process. It is important to use setbacks or relapses as valuable learning opportunities.

KEY FACTORS IN RECOVERY

For people with concurrent disorders to achieve and maintain recovery, they need to:
- be treated as unique and important
- be treated as human being with goals and dreams
- have the freedom to make choices and decisions about their lives
- be treated with dignity and respect
- accept that their unique journey through life has taken a different path
- recognize that recovery is the potential to become free of symptoms by following an individualized treatment plan
- acknowledge that relapse is a common and expected part of recovery, but does not mean that they have "failed" or that previous gains are lost—rather, it is a chance to learn and to move forward again

- have hope about their future (see "The role of hope," p. 185)
- have meaningful relationships with others who care and do not stigmatize (see "The role of family," p. 190)
- have a routine and structure to their day marked by meaningful activities that may or may not include work (paid or volunteer)
- have a reliable and steady source of income
- live in stable, clean and comfortable housing, whether it is an independent living situation or supportive housing
- accept that recovery may require a structured community day treatment program or other links to professional mental health and addiction systems of care
- recognize that pets may be important
- recognize that spirituality or religious beliefs and practices may be important.

> *It seems to me that people reject the sick when there's little hope that they'll get better. Why invest time and energy if a person will very likely remain ill for the rest of their lives? But it's not true of most people with concurrent disorders, provided they are caught early enough and receive good care. My son is working now, he has a girlfriend . . . and it certainly didn't look like he would have any kind of a normal life five years ago when he was diagnosed with schizophrenia and drug abuse. So I tend to believe there's a lot of hope out there.*

Activity 11-2: What does recovery mean to my relative?

What elements might be particularly important for your loved one's recovery? Try to be as specific as possible. (For example, he or she might understand the purpose of medications and made the decision to take them; engage in meaningful activity each day, such as attending self-help groups, working, volunteering, seeing friends; have specific goals, plans and hope for the future.)

The role of hope

> *I think as family members we have an opportunity to offer a lot of hope to other families going through the same thing. The general public seems to think that once a doctor tells you your family member has a mental illness or a problem with drugs and alcohol, it's over—like, there's no hope; their lives are destroyed and yours too. But it's so different now, so many people recover from concurrent disorders. And look at the research, the new medications and treatments—there have been so many advances. I know so many parents whose kids have gone back to university or have jobs—I mean, they're doing well. Mental illness and substance abuse doesn't have to mean that the person's life is over. So I think we need to give some hope to people.*

There is great hope for people who have concurrent disorders. Over the past 10 years, many improvements have occurred, including:

- improved medications
- improved understanding of treatment needs
- increased opportunities for learning from others.

A diagnosis of both a mental health and substance use disorder does not mean that a person will inevitably decline and be unable to function. On the other hand, recovery does not necessarily mean that a person's previous abilities and situation will be completely restored or that they won't need medications or other treatment.

The overarching message of "recovery" is that hope and a meaningful life are possible. Hope is recognized as one of the most important determinants of recovery.

Patricia Deegan of the U.S. National Empowerment Council says:

> *For those of us who have been diagnosed with mental illness . . . hope is not just a nice sounding euphemism. It is a matter of life and death . . . We have known a very cold winter in which all hope seemed to be crushed out of us. It came like a thief in the night and robbed us of our youth, our dreams, our aspirations and our futures. It came upon us like a terrifying nightmare that we could not awaken from.*
>
> *—Deegan, 1993*

Inspirational quotes

If you have ever spoken with someone who has benefited from a 12-step program such as Alcoholics Anonymous or Al-Anon, you may have heard about the "recovery slogans" that thousands of people have said were important contributors to their recovery journeys.

Many family members affected by mental health and/or substance use problems have also found similar kinds of slogans (sayings and quotes) to be inspirational, motivating and enormously beneficial.

What is it about these little sayings or quotes that make them so powerfully memorable and effective that they can help people actually change how they think, feel and behave? They can be thought of as "bits of wisdom written in shorthand." Many of them, in a mere one or two lines, can shift a person's entire perspective on particular aspects of life.

For example, consider the following quote:

> *"I haven't failed. I've identified 10,000 ways this doesn't work."*
>
> *—Thomas Edison*

Thinking about a quote such as this (and even better, discussing it with people who care—what the quote means, how it gives you a new way to look at things in your life, how thinking this new way would be really useful and helpful for you) can help you focus on the positive aspects of a situation.

Quotes, slogans and sayings can help people change their attitudes and behaviours so they are less affected by the opinions and actions of others. In these ways and in so many others, these little pearls of wisdom are guides to peace that can have a powerfully beneficial effect on a person's emotional health. As such, they can help to build resilience (see Chapter 5) and reduce a person's vulnerability to developing compassion fatigue (see Chapter 4).

Activity 11-3: Wisdom written in shorthand

Think about each of the following quotes and sayings, and write down what they mean to you. There is no right or wrong way to interpret them. This exercise is designed to offer you different ways to cope, both as a family member affected by concurrent disorders and in your own personal life.

• If you share your pain, you cut it in half; if you don't, you double it.

• You can't direct the wind, but you can adjust the sails.

• This too shall pass.

• A journey of a thousand miles begins with the first step.

• If you find a path with no obstacles, it probably doesn't lead anywhere.

• Fall seven times, stand up eight (Japanese proverb).

• You are responsible for the effort, not the outcome.

• Act as if . . .

• Do not let what you cannot do interfere with what you can do.

Do you have any favourite quotes or sayings of your own? If so, jot some of these down in the space provided and think about why they are so important to you and how they help you to get through each day:

We have summarized some of our thoughts on a few of the quotes, just to get you started.

You can't direct the wind, but you can adjust the sails.

This quote is about learning to accept the things we can't control and to try to change those things we do have some control over, such as our own actions and behaviours, and sometimes even our thoughts, moods and perceptions. Learning this valuable lesson in life may very well be one of the keys to serenity and contentment.

We're responsible for the effort, not the outcome.

Do not let what you cannot do interfere with what you can do.

These two quotes centre on one important theme: It is much more helpful and realistic to concentrate your efforts on what you actually do have control over, rather than expend time and energy trying to make a change in something over which you have no control. For example, it is helpful to support family members in their struggle to stop or reduce the use of substances, as long as you understand and accept the fact that only they are ultimately responsible for their own recovery.

This too shall pass.

When you find yourself in the middle of a crisis or caught in the grip of distressing feelings or situations, it can feel like the experience will never end and that you won't be able to survive it. Sometimes the only way to get through extremely stressful and adverse situations in life is to keep in mind one simple truth: Nothing lasts forever.

Act as if . . .

For some people, trying to change their thoughts and feelings before they change their behaviours may not get them very far in their recovery. Waiting until you feel more motivated and less anxious before trying out new recovery behaviours can lead to a worsening of both the substance use and the mental health problems. More motivation and reduced anxiety won't happen if you stick to the same behaviours every day that allow the lack of motivation and anxiety to flourish. Sometimes, people have to take action in spite of feeling depression, anxiety, worry, shame, anger and exhaustion, *and in spite of* struggling with problematic thoughts and beliefs. So it might be helpful to live by one rule . . . act as if you are feeling great and thinking rationally. In other words, no matter what else is going on inside your own head or outside in the world, *follow through* on your commitments and your recovery plan (e.g., go to AA meetings, keep appointments with your therapist, eat three nutritious meals every day, get eight hours sleep every night). You will have to force yourself at first, but if you can **act as if** things are better, you'll actually help that come true.

The role of family

Not only should family members be included in discussions about recovery—they can actually share the road to recovery.

Many elements considered important for your loved one's recovery may overlap with your own journey of recovery. Some of these might include:

- having hope about your own and your relative's future
- being educated about your loved one's mental illness and substance use disorder and understanding how these problems interact
- having supportive relationships with others in the family and community who are caring and do not judge or stigmatize
- feeling a sense of connection to people who are important to you
- being considered a knowledgeable, engaged and respected part of your loved one's health care team, and being kept informed by health care professionals
- accepting that your loved one's journey through life has taken a new course
- understanding that if relapses occur it does not mean that your relative has "failed" or lost previous gains
- viewing relapses as a chance to help your family member get back on his or her path to recovery
- feeling a sense of control and personal mastery over your own life
- learning to let go of the all-encompassing preoccupation with your ill loved one and allowing yourself to have a life of your own, with meaningful and relaxing time to yourself to engage in activities that are pleasurable, stress-relieving and fulfilling, and learning to do so without anxiety or guilt
- recognizing that strong spiritual, philosophical or religious beliefs or practices may help you sustain yourself through difficult times.

> *When people meet my son now, everybody is just so flabbergasted. And I think he offers such hope to sufferers and families . . . and people tend to want to talk to you about it. And we try. We try to help families whenever we can. And I think we give them a lot of hope. We get a number of families calling us over the course of a year. And either a social worker or doctor or somebody from the family support group—they've used our family as an example and say, "their son is doing so well"—and then families say, "Can we come over and visit you?" and they come over and talk to my son. So we try to help. We try to give hope to other families.*

A family journey of recovery

My dad was treated for alcohol problems when he was 64 years old. By then I was seriously questioning the effects of my Dad's illness on me as wife and mother. I was concerned about the genetic, familial predisposition to addiction and mental illness and how it might impact on my children.

My mother and I sought out Al-Anon where we discovered that we were not alone in our search for direction regarding shame-based thinking and powerlessness over a loved one's addiction. We heard about the necessity of practising self-esteem and maintaining boundaries. However, many times while dealing with my adolescent and teenaged children, I found myself caught in a trap where my inability to say 'No!' made me question my parenting skills. As a child I avoided confrontation, hid anger and disappointment, and ran from conflict. This behaviour afforded me quietude but an inability to verbalize my emotions.

Our eldest son struggled with alcohol dependency between the ages of 19 and 23. We strongly encouraged and supported him through treatment at an inpatient facility (he stayed only three weeks). Although haunted by angry emotional outbursts in his early 20s, he succeeded in maintaining sobriety, facing his demons with honesty, courage and faith. My husband and I supported him financially, when necessary, and always communicated our love to him and our confidence in him as a special person. I was determined that I would shield my other children from exploring any form of addictive drug. I kept reading about substance abuse. I also took a course in assertiveness training that gave me confidence to believe in myself, stand firm in my beliefs and voice my feelings.

Our seventh child, a gregarious, bright, talented, honest, well-loved person, sank into depression at the age of 18. Over the next few years he struggled to avoid taking medication while seeking professional psychological help, attempting university studies as well as actively seeking out human relationships that most often failed him. He was plagued with suicidal thoughts, inability to cope with studies, and was unable to manage occupational work hours, all the while attempting to 'keep face.' He and I kept in close touch and we often had 'emergency meetings over coffee' when he felt that he couldn't carry on. But he would pluck up his courage and try again.

At age 21, after a suicidal episode, he was admitted to hospital with a diagnosis of *depression with suicidal tendencies.* He began antidepressant therapy that relieved his anxiety and increased his energy output so that he could continue university while living at home. Soon stress mounted; he found home too confining and he went to live downtown with friends in an environment where he felt comfortable. Once again he discontinued his studies. I was anxious when he left home but I

knew that he must walk his own journey. His brothers and sisters kept in touch with him and he faithfully called his dad and me. My husband, through all this, often remarked to me how he admired his son's courage in facing these hard moments in his life. And my son often said to me, in moments of desperation, 'Mom, no matter what happens to me, promise me that you will never blame yourself. You have been the best mother. I take responsibility for my life and how I am living it.' My prayer for him continued to be: *'Lord, you love this child of yours even better than I can. I know you will take care of him.'*

Two years later he succumbed to the temptation of street drugs in the hope of regaining lost energy and experiencing a more manageable life. Cocaine, crystal meth and marijuana, his drugs of choice, were at first exciting but within a few months, his life careened to a debilitating *crash.* His brothers, sisters and a cousin encouraged him to return home. They all knew he was desperate and could not manage on his own. Humiliation, guilt and his loss of independence were his major concerns. We are told to have self-reliance but that is tricky when one has no self to rely on.

My husband and I and our niece, a close friend of our son, attended an introduction to addiction and recovery program that helped us face the challenge before us. Our son always supported our need to learn coping skills and we shared insights with him and the other family members who were eager to share in the recovery process of their beloved brother. We learned that lapses can be oppor-tunities for growth. We must concentrate on love rather than fear and judgment.

At this time our son has been 'clean' for one year since the completion of a six-week inpatient treatment and follow-up program for concurrent disorders. He continues antidepressant medication under supportive medical care and has a full-time job. He also has a meaningful relationship and hopes to return to university this year. He is socially active and very grateful for each day.

Recovery (finding self and gaining control) is an ongoing life challenge. At some time on our journey, we all face grief, disappointment and loss. Each day brings its own challenges. Regaining control can only be accomplished when the pain from lost dreams is faced honestly in a safe, understanding setting. With concurrent mental health and addiction issues, the challenge is two-fold.

We were greatly helped by the open communication we shared with our son. He tried so hard to be affable and grateful even at the worst of times. He would stay talking and listening as long as he could and then retreat into the silences of his despair. At this time of his greatest need, we tried to be for him the beacon in the lighthouse.

One important factor in my recovery is self-care. Each day I ask myself, 'What do I need today and how can I accomplish this?' I have learned that, in recovery, I must not only be conscious of my own needs but I must verbalize them and take action to achieve them.

Activity 11-4: Your recovery journey

What elements might be particularly important for your own journey of recovery as the family member of a person with concurrent disorders? Try to be as specific as possible. (For example, maybe you would understand and accept your family member's illnesses, be able to let go of guilt and move forward with your own life goals and dreams, reconnect with friends and return to enjoyable leisurely activities.)

Activity 11-5: Recovery Attitudes Questionnaire

The Recovery Attitudes Questionnaire (RAQ-16) was developed by a team of consumers, service providers and researchers at the Hamilton County Recovery Initiative (Borkin et al, 2000).

The RAQ-16 consists of 16 questions designed to help you identity and think about your own beliefs and attitudes about recovery from concurrent disorders. There are no right or wrong answers. After you finish the questionnaire, read through the comments about each question that follow. They are meant to help you reflect on your responses. Try to complete the questionnaire before reading the comments.

Recovery is a process and experience that we all share. People face the challenge of recovery when they experience the crises of life, such as the death of a loved one, divorce, physical disabilities and serious mental illnesses. Successful recovery does not change the fact that the experience has occurred, that the effects are still present, and that one's life has changed forever. Rather, successful recovery means that the person has changed, and that the meaning of these events to the person has also changed. They are no longer the primary focus of the person's life (Anthony, 1993).

Please read each of the following statements and, using the scale below, circle the rating that most closely matches your opinion.

	Strongly Agree	Agree	Neutral	Disagree	Strongly disagree
1. People who are in recovery need the support of others.	SA	A	N	D	SD
2. Recovering from mental illness is possible no matter what you think may cause it.	SA	A	N	D	SD
3. A good understanding of one's mental illness helps in recovery.	SA	A	N	D	SD
4. To recover requires faith.	SA	A	N	D	SD
5. Recovery can occur even if symptoms of mental illness are present.	SA	A	N	D	SD

6. People in recovery sometimes have setbacks.	SA	A	N	D	SD
7. People differ in the way they recover from a mental illness.	SA	A	N	D	SD
8. Recovering from mental illness can occur without help from mental health professionals.	SA	A	N	D	SD
9. All people with serious mental illnesses can strive for recovery.	SA	A	N	D	SD
10. People who recover from mental illness were not really mentally ill in the first place.	SA	A	N	D	SD
11. The recovery process requires hope.	SA	A	N	D	SD
12. Recovery does not mean going back to the way things used to be.	SA	A	N	D	SD
13. Stigma associated with mental illness can slow the recovery process.	SA	A	N	D	SD
14. Recovering from the consequences of mental illness is sometimes more difficult than recovering from the illness itself.	SA	A	N	D	SD
15. The family may need to recover from the impact of a loved one's mental illness.	SA	A	N	D	SD
16. To recover requires courage.	SA	A	N	D	SD

Comments about each question are provided below. You may not agree with all of them. They are included simply as a way to help you think about the different ideas of recovery.

COMMENTS

1. People who are in recovery need the support of others.

   Feeling a sense of connection to people, such as other family members, friends and professionals, is very important to re-create a sense of belonging and closeness. We humans are social beings. We are most content and fulfilled when engaged in meaningful relationships with others. Support from people who are non-judgmental, compassionate and who accept concurrent disorders as legitimate illnesses from which a person can recover is crucial to the recovery of both consumers and their families.

2. Recovering from mental illness is possible no matter what you think may cause it.

   Concurrent disorders are generally a result of a complex mix of hereditary, genetic, biological, psychological and social factors. However, people can sometimes hold mistaken beliefs about the causes of these disorders. This journey of recovery may take different paths and look very different from person to person, but yes, it is a definite possibility regardless of one's beliefs about the causes.

3. A good understanding of one's mental illness helps in recovery.

   The experience of mental illness is often filled with fear and anxiety, grief and loss, altered expectations and dramatic changes in one's perception of oneself as a human being. These feelings increase when a substance use disorder is also involved. For many people with concurrent disorders and their families, becoming educated about concurrent disorders is essential for gaining a sense of control over these conditions and for recovery. It's important to learn about the signs, symptoms and effects of mental health and substance use disorders, possible causes, treatment methods, and the possibility for recovery.

4. To recover requires faith.

   "Faith" holds many meanings. Some people may think that believing in a higher being or following a particular religion is necessary for recovery. However, for many people, "faith" may simply mean believing in yourself, having hope for a better future and believing in the people around you who care about you and want to help you.

5. Recovery can occur even if symptoms are present.

   Recovery from concurrent disorders doesn't necessarily mean that people will never again experience symptoms, go through hard times or relapse. Recovery implies learning from these experiences and having the courage to move forward in spite of them. Many people reach their goals and realize their dreams even if they have setbacks along the way.

6. People in recovery sometimes have setbacks.

   As discussed above, people with concurrent disorders will likely have setbacks from time to time. This is not a sign of failure, but an opportunity to learn about potential triggers and sources of stress, and perhaps new and more effective ways to manage difficult aspects of life.

7. People differ in the way they recover from a mental illness.

   "Recovery" means different things to different people. Some may recognize the importance of psychiatric medication for their recovery, while others may need more intensive ongoing support from health care professionals. Some people want to return to work, while others find work too stressful and become involved in self-help groups or other community support activities. Some people hold on to strong spiritual beliefs, while others find that simply enjoying the company of a pet or close friend sustains them. No two people recover in the same way.

8. Recovering from mental illness can occur without help from mental health professionals.

   Many people in recovery from concurrent disorders will have contact with health care professionals at some point. Finding and working with compassionate and understanding health care professionals who respect clients' unique needs and goals is often very important to beginning the journey of recovery and to maintaining the gains that one makes. This contact with professionals may be intensive and continuous, as some clients may be part of supportive outpatient programs or have the ongoing help of a community case manager. Some clients may see a physician only once in a while, to obtain prescriptions for psychiatric medications. The type of contact may also change over time. As people become stronger and more comfortable in managing their illnesses and their daily lives, they may have less involvement with professionals and eventually may wish to stop seeing them, except in cases of relapse or more difficult times.

   Some people recover without the services of health care professionals. They may have milder forms of mental illness and may be able to reduce or control their problematic substance use so that these problems do not significantly disrupt their lives. Some in this group find that attending self-help groups and maintaining close and supportive relationships with family and friends is enough for them to enjoy a life of recovery.

9. All people with serious mental illnesses can strive for recovery.

   Yes. Any person with mental health (and substance use disorders) can work toward a life of recovery. Each person has the capacity for hope, for a sense of acceptance and belonging, and for goals and dreams.

10. People who recover from mental illness were not really mentally ill in the first place.

    The old belief in the chronic and hopeless nature of mental illness and substance use problems has been challenged. The fact is that people with concurrent disorders can enter a life of recovery that involves emotional stability, good physical health, meaningful social and work-related activities and close, supportive relationships. It is no longer true that people with serious mental illnesses and substance use problems are on a downward course to chronic disability. People with very serious forms of mental illness and substance use disorders can indeed recover.

11. The recovery process requires hope.

    Hope involves believing in your ability to overcome difficulties and looking to the future with optimism that recovery is possible. Having hope is considered fundamental to achieving and maintaining a life of recovery.

12. Recovery does not mean going back to the way things used to be.

    Some people who are in recovery may be able to return to their former activities, such as the same jobs, school, friends and social interests. On the other hand, recovery does not necessarily mean going back to exactly the same activities, beliefs and overall lives as in the past. For many people, being in recovery often involves establishing a new and different or altered set of goals and dreams—a different job, a different school, new friends and social interests. People may find that their priorities have changed dramatically from the way they used to think.

13. Stigma associated with mental illness can slow the recovery process.

    Stigma and discrimination can have devastating and destructive consequences for those with concurrent disorders and their families. Stigma and discrimination can definitely act as major obstacles to recovery. Stigma can make people lose confidence in themselves, undermine their attempts to reintegrate into the community and, in some cases, can even lead to such despair that a relapse occurs. It can also cause families to isolate themselves from others and feel shame and embarrassment.

14. Recovering from the consequences of mental illness is sometimes more difficult than recovering from the illness itself.

    The consequences of mental illness or substance use can vary dramatically. Some people may experience milder consequences, such as short leaves from school or work, taking medications or being hospitalized for a short time. Others may experience significant effects that might include jeopardized family relationships, loss of meaningful people in their lives, frequent and lengthy hospitalizations, inability to work or attend school, involvement in the legal system, medical problems, and so on. Once a person has become emotionally, mentally and physically stable, the person may have to deal with these consequences. This can cause more stress and anxiety, and possibly lead to despair, a sense of failure and relapse. This is why it is important to remember that recovery involves paying attention to the whole person—all of his or her needs, all areas of the person's life that have been affected. These can all be included in a comprehensive recovery plan.

15. The family may need to recover from the impact of a loved one's mental illness.

    Ideally, this chapter will have helped you realize the importance of recovery for yourself as well. We have discussed the effects of concurrent disorders on family members, ranging from physical to emotional, social, occupational, economic and spiritual. It is very important for family members to allow themselves to recover their sense of emotional stability, feelings of control, peace of mind and an overall sense of well-being as they experience the effects of concurrent disorders.

16. To recover requires courage.

    Having the courage to move forward in life despite experiencing the effects of both a substance use and a mental health problem is fundamental to the idea of recovery. Every seemingly small step forward, from getting out of bed in the morning, to getting through the day without using drugs, taking the bus to a community support program, calling up a friend, taking medications, going back to work, etc., requires more courage than most of us could ever imagine trying to muster.

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Resources 12

Outline

- Websites
- Online publications
- Books and booklets

WEBSITES

Questions to ask about information on the Internet

1. What is the purpose of the site? (check the "About" page for information).

2. Who created the material?
   - What credentials do the people have (academic, life experience)?
   - What are you told about the people who created the resource (e.g., do you know if they have anything to gain by publicizing a treatment)?
   - Who is sponsoring the website? Is there information about the role the sponsor played in developing the website content?
   - Is there information about how to contact the author or organization that developed the material?

3. Is the information credible?
   - What is the information on the website based on? Research? Expert opinion? Professional or personal experience? Personal stories are important, but they shouldn't be the only source.
   - Is information about the sources (e.g., author, publisher for books and journal articles; phone numbers and e-mail addresses for organizations) given? Sometimes information is taken out of context, so check the sources if possible.
   - Is there a list of other resources you can refer to? It's usually best to compare information from a number of different sources.
   - Does the site provide links to other websites? Although links don't guarantee credibility, a list of links to well-known, trusted websites is an indication that the website's creators are willing to have you check their information.
   - Are you encouraged to talk to other people, including doctors and other professionals?
   - Are other possible theories/explanations acknowledged?
   - If the information is describing a treatment, does it give some explanation of how and/or why it works? Does it mention risks or side-effects as well as benefits?

4. How recent is the information?
   - Each document should include the date that it was created and/or the date when it was last reviewed.

Evaluating Information: Resources

Intute: How to Evaluate an Internet-based Information Source
www.intute.ac.uk/healthandlifesciences/BIOME_Evaluation_Guidelines.doc

DISCERN on the Internet
http://www.discern.org.uk/index.php
http://www.discern.org.uk/index.php

General concurrent disorders

Centre for Addiction and Mental Health
www.camh.net

BC Partners for Mental Health and Addictions Information
www.heretohelp.bc.ca

Internet Mental Health
www.mentalhealth.com

Dual Recovery Anonymous
www.draonline.org

SAMHSA (Substance Abuse and Mental Health Services Administration)
www.samhsa.gov/index.aspx

General mental health

CANADA

Canadian Mental Health Association (CMHA)
www.cmha.ca

Consent and Capacity Board (Ontario)
www.ccboard.on.ca

PsychDirect
www.psychdirect.com

UNITED STATES

National Alliance on Mental Illness (NAMI)
www.nami.org

National Institute of Mental Health
www.nimh.nih.gov

National Mental Health Information Center (SAMHSA)
www.mentalhealth.org

INTERNATIONAL

Rethink (U.K.)
www.rethink.org

Anxiety

Anxiety Disorders Association of Canada
www.anxietycanada.ca

Anxiety Disorders Association of America
www.adaa.org

Obsessive Compulsive Foundation
www.ocfoundation.org

Attention-deficit / hyperactivity disorder

National Resource Center on ADHD
www.help4adhd.org

Bipolar disorder

Moodswing.org
www.moodswing.org/index.shtml

Depression

Mood Disorders Association of Ontario
www.mooddisorders.on.ca

Depression and Bipolar Support Alliance
www.dbsalliance.org

Eating disorders

National Eating Disorder Information Centre
www.nedic.ca

Schizophrenia and psychosis

Schizophrenia Society of Canada
www.schizophrenia.ca

Psychosis Sucks (Fraser Valley Health Authority: Early Psychosis Intervention Program)
www.psychosissucks.ca/epi/

EPPIC: Early Psychosis Prevention and Intervention Centre (Australia)
www.eppic.org.au

PEEP: The Prevention and Early Intervention Program for Psychosis (London, ON)
www.pepp.ca

PSPOPS: Peer Support for Parents of Psychosis Sufferers
www.psychosissupport.com

Open the Doors (World Psychiatric Association)
www.openthedoors.com

General substance use

Al-Anon/Alateen
www.al-anon.alateen.org

Alcoholics Anonymous
www.aa.org

Narcotics Anonymous
www.orscna.org

Double Trouble in Recovery
www.doubletroubleinrecovery.org/index.htm

CANADA

Alberta Alcohol and Drug Abuse Commission (AADAC)
www.aadac.com

UNITED STATES

National Institute on Drug Abuse (NIDA)
www.nida.nih.gov

Center for Substance Abuse Treatment (SAMHSA)
www.samhsa.gov/centers/csat2002/csat_frame.html

Center for Substance Abuse Prevention (SAMHSA)
www.samhsa.gov/centers/csap/csap.html

National Clearinghouse on Alcohol and Drug Information (PrevLine)
www.health.org

Resources for families and caregivers

CMHA Ontario Division: Family Members and Caregivers Resource Centre
www.ontario.cmha.ca

Family Association for Mental Health Everywhere (FAME)
www.fameforfamilies.com

Recovery

Rethink
www.rethink.org/recovery/

WRAP
www.mentalhealthrecovery.com/

Center for Psychiatric Rehabilitation (Boston University)
www.bu.edu/cpr/about/index.html

ONLINE PUBLICATIONS

Health Canada. *Best Practices: Concurrent Mental Health and Substance Use Disorders.*
Available: www.hc-sc.gc.ca/ahc-asc/pubs/drugs-drogues/bp_disorder-mp_concomitants/index_e.html

National Institute for Mental Health. *Medications for Mental Illness.*
Available: www.nimh.nih.gov/publicat/medicate.cfm

Expert Consensus Guidelines Series: Guides for Patients and Families. Available: www.psychguides.com/pfg.php.

Schizophrenia Society of Canada. *Learning about Schizophrenia: Rays of Hope.* Available: www.schizophrenia.ca/famref/szref1.pdf.

Substance Abuse and Mental Health Services Administration. *Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders.* Available: http://alt.samhsa.gov/reports/congress2002/index.html

BOOKS AND BOOKLETS

Anxiety

Burns, D.D. (1999). *Feeling Good: A New Mood Therapy.* New York: HarperCollins.

Copeland, M.E. (1998). *The Worry Control Workbook.* Oakland, CA: New Harbinger Publications.

Rector, N.A., Bartha, C., Kitchen, K., Katzman, M. & Richter, M. (2001). *Obsessive-Compulsive Disorder: An Information Guide.* Toronto: Centre for Addiction and Mental Health.

Rector, N.A., Bourdeau, D., Kitchen, K. & Joseph-Massiah, Li. (2005). *Anxiety Disorders: An Information Guide.* Toronto: Centre for Addiction and Mental Health.

Depression and bipolar disorder

Bartha, C., Parker, C., Thomson, C. & Kitchen, K. (1999). *Depressive Illness: An Information Guide.* Toronto: Centre for Addiction and Mental Health.

Bipolar Clinic Staff. (2000). *Bipolar Disorder: An Information Guide.* Toronto: Centre for Addiction and Mental Health.

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

Dowling, C. (1993). *You Mean I Don't Have to Feel this Way? New Help for Depression, Anxiety and Addiction.* New York: Bantam Books.

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Elder, N. (1989). *Holiday of Darkness.* Toronto: Wall & Emerson.

Fieve, R. (1997). *Moodswing.* New York: Bantam Books.

Gold, M. (1995). *The Good News about Depression.* New York: Bantam Books.

Greenberger, D. & Padesky, C. (1995). *Mind over Mood: Change How You Feel by Changing the Way You Think.* New York: Guilford.

Healy, D. (2005). *Psychiatric Drugs Explained* (4th ed.). St Louis, MO: Elsievier.

Manning, M. (1996). *Undercurrents.* New York: HarperCollins.

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

Norden, M. (1995). *Beyond Prozac.* New York: HarperCollins.

Papolos, D. & Papolos, J. (1997). *Overcoming Depression.* New York: HarperCollins.

Preston, J. (1996). *You Can Beat Depression: A Guide to Recovery.* Atascadero, CA: Impact Publishers.

Redfield Jamison, K. (1997). *An Unquiet Mind.* New York: Random House.

Turkington, C. (1997). *Making the Prozac Decision: A Guide to Antidepressants.* Lowell House.

FOR FAMILIES AND PARTNERS

Berger, D. & Berger, L. (1992). *We Heard the Angels of Madness: A Guide to Coping with Manic Depression.* New York: Quill.

Depaula, J.R. & Ablow, K. (1996). *How to Cope with Depression: A Guide for You and Your Family.* New York: Ballantine Books.

Gorman, J. (1998). *The Essential Guide to Psychiatric Drugs.* New York: St. Martin's Press.

Rosen, L.E. & Amador, X. (1996). *When Someone You Love Is Depressed.* New York: Fireside.

Schizophrenia

Blake, P., Collins, A.A. & Seeman, M. (2001). *Women and Psychosis: An Information Guide.* Toronto: Centre for Addiction and Mental Health.

Mueser, K.T. & Gingerich, S. (1994). *Coping with Schizophrenia: A Guide for Families.* Oakland, CA: New Harbinger Publications.

Torrey, E. (1995). *Surviving Schizophrenia: A Manual for Families, Consumers, and Providers.* New York: Harper Perennial.

Substance Use

Herie, M., Godden, T., Shenfeld, J. & Kelly, C. (2007). *Addiction: An Information Guide.* Toronto: Centre for Addiction and Mental Health.

Trauma / Posttraumatic stress disorder

Allen, J.G. (1995). *Coping with Trauma: A Guide to Self-Understanding.* Washington, D.C.: American Psychiatric Press.

Copeland, M.E. & Harris, M. (2000). *Healing the Trauma of Abuse: A Women's Workbook.* Oakland, CA.: New Harbinger Publications.

Haskell, L. (2004). *Women, Abuse and Trauma Therapy.* Toronto: Centre for Addiction and Mental Health.

Matsakis, A. (1998). *Trust after Trauma: A Guide to Relationships for Survivors and Those Who Love Them.* Oakland, CA.: New Harbinger Publications.

Vermilyea, Elizabeth. (2000). *Growing beyond Survival: A Self-Help Toolkit for Managing Traumatic Stress.* Baltimore, MD: The Sidran Press

Williams, M.B. & Poijula, S. (2002). *The PTSD Workbook: Simple, Effective Techniques for Overcoming Traumatic Stress Symptoms.* Oakland, CA: New Harbinger Publications.

Having concurrent substance use and mental health problems obviously affects the person experiencing the problems directly, but they also have powerful effects on family members and friends. Families need help to deal with the impact of concurrent disorders, but families are also a key to finding effective solutions.

A Family Guide to Concurrent Disorders is based on the collection of materials that was developed for a family support and education group at the Centre for Addiction and Mental Health.

Part I is an overview of concurrent disorders, an introduction to treatment options and information about substance use problems, mental health problems and how they interact.

Part II focuses on the impact of concurrent disorders on family life. It includes information on self-care strategies for family members and understanding and coping with the effects of stigma.

Part III explores treatment and support for people affected by concurrent disorders. It includes strategies for navigating the mental health and substance use treatment systems, information about psychosocial and medication treatment options, recognizing and planning for relapses, and anticipating and coping with crisis situations.

Part IV talks about the journey to recovery.

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Centre de toxicomanie et de santé mentale

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