

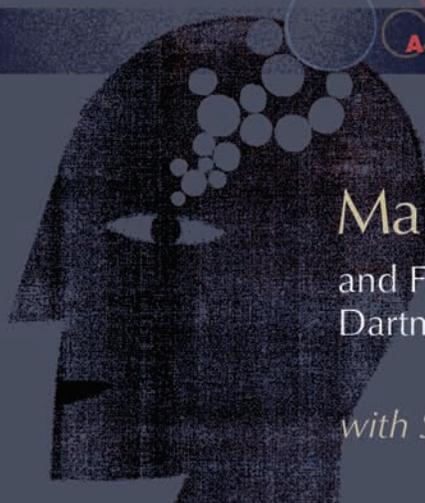
LIVING WITH

Co-occurring Addiction AND

Mental Health Disorders



A HANDBOOK FOR RECOVERY



Mark McGovern, Ph.D.
and Faculty from the
Dartmouth Medical School

with Scott Edelstein



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Editor's note

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*This book is dedicated to the men and women who suffer
from co-occurring addiction and mental health problems.
We hope our work can take each of them and their loved ones
a step closer to fulfilling the promises of recovery.*

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Introduction

How This Book Can Help

Let's listen in as several people talk about their lives:

Rashid: It seems like I'm always arguing with people. I'm not a mean person, but many things people say just piss me off. Just yesterday a total stranger walked up to me and dissed my girlfriend, for no damn reason. What could I do but get in his face? Most of the time it's just words, but once in a while, especially after a few beers at Barney's, my neighborhood bar, it boils over into a fight.

Natasha: My emotions rule me. I don't want them to, but they do. Sometimes I feel like I'm queen of the universe, filled with love and great ideas, and I want to hug everyone I meet and tell them about the incredible plans I have. Then, sometimes the very next morning, I can hardly get out of bed. Just making coffee seems like way too much work. Some days if it weren't for the meth, I'd stay in bed and not move all day.

Seth: I'm the first to admit that I'm wound pretty tight. The endless details of life nag at me. Just leaving the house in the morning can set off a string of worries. Did I lock the back door? Did I turn off the stove after boiling my tea water? Did I remember to leave the bedroom door open for the cat? Sometimes I start out for work and then, a few blocks from home, I have to turn around and go back to

make sure everything's okay. I take lots of deep breaths—ten at a time—to help me relax. They do help a little. But what really helps calm me, especially at the end of the day, is a couple of bowls of weed. The only problem is that, lately, I've been having trouble sleeping without it.

Kim: The big problem with coke dealers is that they don't trust anybody. After you've been around one for a while, neither do you. It's not like I hang out with Brad, but when I go to his apartment every Monday to make a buy, often there's a game on his giant plasma TV, and he usually invites me to watch it with him. The problem is that lately I've got the feeling that someone's watching me. At first I thought it was the woman I see each morning walking her dog by the river. Now I wonder if it's my dry cleaner. Last summer she bought a house just around the corner, and now I run into her at least once a day—at Starbucks, at the drugstore, in the park across the street. It's possible that she's a narc staking me out, planning on arresting me. I know that sounds crazy, but just three weeks ago there was a big drug bust only four blocks away. I can't help but wonder if I'm next.

Alison: I don't know how my roommate does it. She always seems to know just what to say to people, how much to smile, what tone to use—all that stuff. I'm the opposite. If I meet somebody, once we've exchanged names and talked about what we do for a living, my brain locks up. I have no idea what to say. I get more and more anxious and embarrassed. Finally I make an excuse and get out of there. Sometimes I force myself to go to a party or art opening, but after ten or fifteen minutes, I just can't handle it. I get a drink, park myself in a corner, slurp the drink down, and repeat the process five or six times. Eventually I'm not anxious or embarrassed anymore, but I'm too wasted to do anything but call a cab, go home, and crawl into bed.

Each of these five people has what's called *co-occurring disorders* (or, sometimes, a dual disorders, a dual diagnosis, a co-morbid condition, or—as some recovering people refer to it—double trouble). Since *co-occurring disorders* is the most common variation, it's the term used most often in this book.

“Co-occurring” just means that someone has two or more disorders at the same time, like diabetes and high blood pressure. Each of the people quoted above has both a mental health disorder and a substance use problem (either substance abuse or substance dependence).

A reasonable amount of stress and a healthy physiology keep us sane and content. When things get out of balance, however, we can become absolutely miserable, and sometimes dangerous to ourselves or others. Medical professionals call this lack of balance a *mental health disorder*. Like many other disorders, it may require treatment. Also like many other disorders, it can be effectively treated in the vast majority of cases.

Although many people don't realize it, *substance dependence*—or, as it's more commonly known, *addiction*—is a type of mental health disorder. When someone can no longer control how much of a drug they use, or how much alcohol they drink, and they continue to use it even though it causes problems for themselves or others, they've got an addiction. This means they crave the addictive substance. Even though it causes them harm, this craving, in turn, leads to their uncontrolled drinking or drug use.

Co-occurring disorders occur when addiction gets mixed together with a second mental health disorder. This can be a powerful recipe for trouble—mostly to the person who has the disorders.

A second common type of co-occurring disorder affects people who *aren't* addicted, but who regularly abuse alcohol and/or other drugs. These individuals can also have depression, obsessive-compulsive disorder, or some other mental health disorder. Unfortunately, even when no addiction is involved, substance abuse typically plays havoc with people's lives and their ability to function. This can be doubly true for someone who already has a mental health disorder.

But there's a bright spot: many effective treatments are available for a wide range of mental health problems, for substance dependence or abuse, *and* for these disorders when they occur together.

Researchers now know that *most* people who have a mental health disorder have a substance use disorder—either substance abuse or addiction—as well. The inverse is true, too: 50 to 65 percent of people who receive services in addiction treatment centers also have a mental health disorder. And in any given year, eleven million North Americans suffer from co-occurring mental health and substance use disorders.

Let's not pull punches here: having co-occurring disorders is at least twice as difficult as having only one. But no one has only one big problem in life. Ask around; try to find someone with only one big life issue that regularly causes them problems.

Yet there is also some very good news for everyone with co-occurring disorders: there is lots of hope—and lots of help. More than two decades of intensive research has enabled professionals to create integrated treatment programs that address both sides of co-occurring disorders, at the same time, in the same place, and with the same group of

professionals. These integrated programs have proven very effective, helping countless people to recover their health, their happiness, and their lives. This is true for every type of co-occurring mental health and substance use disorder.

This isn't cheerleading or wishful thinking. Scientists know success is possible because it has been evident in a wide range of clinical studies. Since this is a practical self-help book rather than a book for professionals, my colleagues and I won't trot out all the research—but everything in this book is based on studies of real people in real situations. It's all been tested and proven to be the world's "evidence-based practices": the things that work the best, and the most often, for the largest number of people.

The result of these evidence-based practices is that large numbers of people are now able to deal with every major type of co-occurring disorder. A great many are in successful recovery from their substance abuse and addictions. Many are in recovery from their mental health disorders. Others are able to control or manage their mental health disorders through proper treatment. And people from all of these groups have built or rebuilt meaningful lives.

This book contains the essence of what a small group of Dartmouth Medical School faculty have learned during more than twenty years of research involving people with co-occurring disorders and the professionals who treat them.

The single most important thing we've learned is that people who have a co-occurring diagnosis are more likely to get better, to get better faster, and to stay better, when both disorders are treated together, using a unified, integrated approach.

But "unified" doesn't mean a lockstep program. Over the years, we've also learned that one-size-fits-all approaches haven't yielded the best results. In fact, part of what does work best is letting each person make certain key decisions about his or her own treatment and recovery.

This book informs, empowers, explains what works and what doesn't, and offers a variety of positive choices and options. Its goal is to help people with co-occurring disorders to feel better, recover from their substance abuse or addiction, manage or recover from their mental health problems, build lives worth living, and be empowered advocates for their own health and sanity.

Accepting the Help That You Need

No one volunteers for a substance use disorder. No one signs up to have a mental health disorder. These are not life goals, not lifelong personal aspirations. Although we

may choose to take our first drink, or our first hit on a joint, or our first line of cocaine, over time the element of choice or willpower seems long gone.

Admitting we have lost control of our substance use and meet diagnostic criteria for a bona fide disorder is difficult. It is difficult for a number of reasons. First, it seems like such a simple act: If we really put our mind to it, we could change. We could stop if we really wanted to. Unfortunately, even after repeated attempts, people who are addicted can't stop successfully (or can't stay "stopped"). Second, we may have shame and guilt about this loss of control. We think we must be weak, lazy, unmotivated, sleazy, a floozy, or a loser. But it simply means we have the disease of addiction, which is an equal opportunity destroyer. And third, substances like drugs and alcohol affect the brain. This is why we like them so much, but also why, over time, they have a deleterious effect on our memory, our judgment, our will, and our reasoning. Making the connection between the multiple life problems (failed marriages, lost jobs, relationship conflict, DWIs) and substance use should be obvious. But due to the brain changes associated with chronic substance use—the repeated ingestion of toxic substances—we don't see the cause-and-effect relationship. This needs to be pointed out to us.

Likewise, if we have the symptoms of depression or anxiety, avoid various situations and people, have nightmares and flashbacks of traumatic experiences, or rapidly cycle between intense euphoria and profound sadness, we want to believe these are simply extreme versions of normal human emotional experience. In some respects they are. However, these symptoms don't go away, or if they do, they come back with a vengeance. In addition, these symptoms interfere with our capacity to function normally. We have a hard time showing up for work, raising our hand in class, ordering in a restaurant, dating someone we find attractive, staying out of the hospital, or keeping a dollar in our bank account. We don't choose this kind of problem any more than an alcoholic or addict chooses theirs.

Remember, if you have a substance use problem, you are more likely to have a mental health problem and vice versa. So what if you have both? This is at least doubly hard to accept.

Once you do accept that you have a problem, you are only halfway there. You may be motivated for relief, to get better, to feel normal, but you'll need to take concrete steps.

No one gets better from a substance use disorder or mental health problem alone. Although there are some rare cases of individuals who overcome cancer or other serious medical problems without treatment, most of us would agree that trying to treat cancer

alone would be preposterous. These percentages of “spontaneous remission” are also small for persons with co-occurring disorders, perhaps less than 5 percent. Don’t we all want to be part of that 5 percent?

Professional help is available for people with mental health, substance use, and co-occurring mental health and substance use disorders. Sadly, the majority of people with these problems never seek this help. The barriers range from not believing they have a treatable condition, to cost concerns, to transportation problems, to not knowing effective help exists, to continuing to believe things will get better on their own. But they don’t.

Treatment for substance use and mental health conditions is comparable in effectiveness to chronic medical diseases such as hypertension, diabetes, and asthma. People get help during acute or severe situations, get stabilized, and then get less intensive help in an ongoing low-maintenance way over time. They get checkups and have routine visits, monitor their functioning, take medication, and try to lead a healthy lifestyle. It’s a big commitment, but one does what one must do. Most of us would consider these steps reasonable and normal if confronted with diabetes, hypertension, or asthma.

When it comes to mental health and substance use disorders, however, there is still a tendency to believe things like the following:

- “It’s not that bad.”
- “I am afraid of what it says about me and my image to others.”
- “It won’t work. My case is the worst ever.”
- “It will be a hassle.”
- “What will my family and friends think?”
- “What if the ‘cure’ is worse than the ‘disease?’”

These common apprehensions are obstacles for everyone who eventually gets help. Some of us work through these hurdles faster than others. For some it takes days, for others, years.

If you are reading this book, you are at least open-minded enough to be considering your options. That’s great. If you are concerned about a loved one and are reading this book on his or her behalf, that’s equally great. Knowing the facts will empower you and enable you to help your loved one get help. We know that being in a relationship with a person with untreated co-occurring disorders is at least as unbearable as having the disorders themselves.

Thus, there are two steps to acceptance. The first is admitting you have a problem. The second is admitting you need help.

Getting the Most from This Book

This book contains information, guidance, and practical tools. Everyone can benefit from these tools, but readers who have already sought help, been assessed, and know about their diagnosis will already have much of the information in chapters 1 and 2. If so, feel free to go straight to chapter 3. (But you may still want to read or skim chapters 1 and 2, since these chapters probably contain some information that's new and useful.)

The same principle applies to anyone familiar with the basic information in any section or chapter: you can skip that material without worry or guilt. However, even when certain basic information may be familiar, the worksheets and other tools will likely be fresh and helpful. For many readers, the worksheets in this book may feel too small or uncomfortable to write on. Full-page worksheets are available for downloading at www.cooccurring.org.

No book can be everything to every reader, and each person's own recovery and ideal treatment plan will always be unique. What works—or even what might be ideal—for one person may not work at all for another. For this reason, you are encouraged to bring your own personal experience and judgment to each topic. You are also encouraged to discuss your concerns with a mental health professional, medical professional, or drug and alcohol counselor.

Lastly, although everything in this book is meant to be accurate and authoritative, this book does not—and cannot—offer medical or psychological advice, and it is not meant to be used in place of the guidance of a qualified substance use, mental health, or medical professional. *No one can effectively deal with any of these disorders alone.*



CHAPTER 1

Understanding the Situation

What Is a Disorder?

In the human body, a *disorder* is any ongoing condition that's less than healthy. If Sheila's arm often gets itchy and scaly, she's got a localized skin disorder. If Maurice is nearsighted, he's got an eye disorder. If Irina needs a couple of drinks before she can get out of bed and go to work each morning, she's got a substance use disorder. And if Yolanda often feels too anxiety-stricken to go to school, she may have a mental health disorder.

Let's look more closely at these last two types of disorders.

Substance Use Disorders

Just as there are big differences between an ordinary sore throat, a serious strep infection, and throat cancer, there are big differences between substance use, substance abuse, and substance dependence.

Substance use just means drinking alcohol or using another mood-altering drug. Although the drug may be illegal, one use alone doesn't constitute dependence. *Use* is different from *abuse*. For example, many people use alcohol, but don't abuse it. Someone *abuses* alcohol or another drug when their use of it persistently interferes with their ability to function, or with their social relationships, or with their own (or someone else's) health or safety. If Brad drinks three beers at a party, he isn't abusing alcohol. But if he

drives home drunk, or if he picks a drunken fight with a stranger—or his partner—he’s probably gone from use to abuse.

Alcohol or drug *dependence* (or *addiction*) is much more serious than abuse. It includes all the features of abuse—but, in addition, the person can’t stop or control their substance use, even when he or she tries. The person will likely develop tolerance, using more and more to get high, and may experience withdrawal when he or she stops using or drinking.

If Perry often gets stoned and rowdy, he’s got a substance abuse problem. If even when he tries, he can’t stop himself from regularly getting stoned, rowdy, and in trouble, he’s probably got a dependence problem.

Mental Health Disorders

Someone has a *mental health disorder* (sometimes called a *psychiatric disorder* or simply *mental illness*) if they have persistent or recurring problems with how they think, feel, or function.

If Katrina has trouble getting out of bed because she’s taking antihistamines for her hay fever, or because her cousin died two days ago and she’s grieving, she probably doesn’t have a mental health disorder. But if Katrina can’t get out of bed most mornings because it feels like way too much effort and she misses work because of it, she probably *does* have a mental health disorder.

The interaction of stress, environment, and physiological vulnerability is the central cause of mental health disorders. Decades of medical research have demonstrated that mental health disorders are comparable to other diseases, such as asthma, hypertension, and diabetes. They’re not the result of moral failures, character flaws, a weak will, a lack of discipline, or parents who didn’t read the right parenting manual. They’re not punishment for sins, either. While genetics and brain chemistry factors influence all of us, mental health disorders are mainly the result of environmental factors and stress, just as diabetes may result if a vulnerable pancreas is exposed to unhealthy diet, lifestyle, or severe infection.

For a condition to be considered a disorder, it needs to last a certain length of time and not be a normal reaction to specific life events. If Mitch is having a tough month, it’s normal for him to feel stressed out. But if his sense of impending doom never changes, even when things start going well for him, a mental health disorder could be at work.

What can cause a mental health disorder? All kinds of things: genetics; environmental factors, such as exposure to toxic chemicals or drugs or extreme and/or prolonged stress caused by trauma (often, but not necessarily, while growing up); physical disorders and

conditions; serious injury, particularly to the brain; or, as is often the case, some combination of these factors.

How Are Disorders Treated?

Each disorder, and each combination of co-occurring disorders, is unique. So is each human body and psyche. This is why any disorder needs to be assessed by a professional (or a team of professionals), and why a unique treatment plan needs to be created for each person. Even if two people are prescribed the same medication, a 90-pound, 16-year-old girl may need a smaller dosage than a 240-pound, 40-year-old man. Similarly, two people might receive the same form of psychotherapy, but one may benefit from only nine sessions, while the other might need twenty or more.

Substance use disorders—particularly addiction—are often treated with one or more of the following:

- an addiction treatment and recovery program. Some of these are *inpatient* programs, which require people to live temporarily at a treatment facility; others are *outpatient* programs that allow people to commute.
- individual psychological, psychiatric, and/or drug and alcohol counseling.
- group therapy or counseling, usually with other people who have a substance use disorder.
- support groups. Many of these are freestanding Twelve Step groups such as Alcoholics Anonymous and Narcotics Anonymous; others are sponsored by hospitals, clinics, recovery centers, churches, or other organizations.
- medications. A variety of medications can reduce cravings and help people who abstain from drugs or alcohol to avoid a relapse. Some of these are tailored for alcohol dependency, others for drug dependency.

Mental health disorders are typically treated using one or more of the following (similar to the above treatment for chemical dependency):

- medications. These normally need to be prescribed by a psychiatrist or other medical doctor. (In some states, they can be prescribed under certain circumstances by other qualified professionals, such as nurse practitioners, physician assistants, or psychologists.) Contrary to what many people believe, most of the current medications for mental health disorders are entirely nonaddictive.

- individual psychological and/or psychiatric therapy.
- group therapy or counseling, often with other people who have the same disorder, for example, post-traumatic stress disorder.
- support groups sponsored by hospitals, clinics, churches, associations (Anxiety Disorders Association of America, National Alliance on Mental Illness, etc.), and other service organizations.

Until relatively recently, people with co-occurring mental health and substance use disorders were rarely treated for both disorders together, in an integrated fashion. Much more often, professionals would first try to help clients recover from one disorder, then move on to the other. Or they'd only treat one disorder on the incorrect assumption that it was the "root" or "core" or "primary" disorder. In many cases, professionals wouldn't even know about the existence of one or more of the co-occurring disorders. It shouldn't be surprising that the rate of successful treatment for these co-occurring disorders wasn't very high.

When only one part of co-occurring disorders is treated, the problems caused by the untreated disorder often get in the way of working successfully on the other disorder. For example, if someone with both alcoholism and depression is treated just for his or her depression, the person may continue drinking alcohol, which is a depressant and which interferes with the effectiveness of antidepressant medications. On the other hand, if the person is treated just for alcoholism, he or she may readily relapse and use alcohol to medicate the depression. Or the person may simply be too depressed to get off the couch and go to Alcoholics Anonymous meetings.

It is now known that if professionals just treat the psychiatric part of co-occurring disorders, the whole person will usually get worse; if they just treat the substance use, the whole person will also usually get worse. People do best when both disorders are treated together—ideally by the same group of professionals, in the same setting, following a single integrated recovery plan.

Effective treatment for disorders of all types also includes education and skill building. Whatever disorder someone may have, they can benefit greatly from learning how to best manage it, cope with it, and control or deal with its symptoms.

Understanding Mental Health Disorders

When people first learn—or suspect—that they have a mental health disorder, they can have a wide range of reactions.

Some feel a great sense of relief. *Oh, so that's what's been going on! Man, it was hard not*

knowing why I felt so strange or acted the way I did. But now that I know what the problem is, I can get it treated and start feeling better.

Others feel scared, just as they would in facing any other disorder. *Is it serious? Will I get better? Will I get worse? What are my chances of being cured?*

Both of these are normal and appropriate reactions—and it's not unusual to feel both ways at once.

There's a third group of people, though, who at first feel ashamed or blame themselves for their disorders. *It's my own damn fault. If I were stronger and more disciplined, like my sister, I wouldn't have let this happen.* But this self-blame is entirely unjustified. Decades of medical research have shown without a doubt that *anyone* can contract a mental health disorder, just as anyone can get cancer or fall down and break their wrist.

Many people are also afraid of what others—friends, family, neighbors, co-workers, and employers—will think about their disorders. They worry that others will look down on them as weak or crazy or screwed up.

These fears are partly—but only partly—justified. On the one hand, it is now known unequivocally that having a mental health disorder doesn't make someone less of a human being. It doesn't mean that they're bad, evil, wimpy, sinful, or shameful. It means something's not working as it should and they need treatment. On the other hand, it's also true that some people don't yet understand this—and their own ignorance can cause them to ridicule, pity, or stigmatize others. But they're just plain wrong. They don't have their facts straight.

You can't stop these people from judging you and telling you what to do, but you don't have to take them seriously. Here are the sorts of things you might hear from them, and some possible ways to respond.

- *“So, are you like those who get locked up, put in straitjackets and stuff?”* “Not really. I've got a disorder, like asthma or fibromyalgia or arthritis, and I'm getting treated for it. With the right treatment, my brain chemistry will stabilize, and I can live a normal life, like anyone else.”
- *“It's really a spiritual problem. You don't need doctors or medications. Just give it all over to God.”* “I'd need a doctor if I broke my leg, wouldn't I? Well, right now some part of me is broken. Professionals can help me fix it, just like a doctor would set a broken bone. But I'm not denying the power of prayer. In fact, I'd be grateful if you'd pray for my healing and quick recovery.”
- *“You've always been too sensitive, scared of a lot of things. Forget the doctors and*

appointments. Just straighten up and grow a backbone!” “I’m not scared of the truth, and the truth is I’ve got real stress and things happening in my body that need correcting. Professionals can help me with that, just like my dentist can help by filling cavities. Cavities don’t just straighten up and grow fillings. It’s the same for this—it won’t correct itself without some help.”

The point here is that no one with any kind of disorder—whether it’s kidney stones, diabetes, panic disorder, or bipolar disorder—should avoid getting the professional help they need because of what others say, think, or believe.

Common Mental Health Disorders

Medical and mental health professionals divide mental health disorders into five basic types:

1. Anxiety disorders, including panic disorder, social anxiety disorder, generalized anxiety disorder, post-traumatic stress disorder, and obsessive-compulsive disorder
2. Mood disorders, including depression, bipolar disorder, seasonal affective disorder, dysthymia, and cyclothymia
3. Personality disorders, such as borderline personality disorder, narcissistic personality disorder, histrionic personality disorder, and paranoid personality disorder
4. Organic disorders or disorders caused by physical illnesses, such as Huntington’s disease, Parkinson’s disease, systemic lupus erythematosus, and a variety of neurological disorders
5. Thought disorders, such as schizophrenia, schizoaffective disorder, and delusional disorder

The *Diagnostic and Statistical Manual of Mental Disorders*, a well-known reference book for mental health and addiction professionals, includes and classifies substance use disorders with the above disorders.

The great majority of people with co-occurring disorders have one (or more) of the anxiety or mood disorders and a substance use disorder. Smaller numbers of people with co-occurring disorders have manic disorder (also called *mania*) or schizophrenia or

schizoaffective disorder and a substance use disorder. These are the types of co-occurring disorders discussed in this book.

Interestingly, many people who have one mental health disorder also have one or two others—which means that they literally have not only double trouble but also triple trouble, or even quadruple trouble. Modern therapies and medications, however, can often treat multiple conditions effectively.

Let's take a quick look at the most common co-occurring mental health disorders—as well as a few that are somewhat less common.

Bipolar Disorder

Sometimes known as *manic depression*, this disorder causes extreme mood swings between mania and depression, usually with symptom-free periods in between. In the manic phase, people with bipolar disorder typically experience euphoria, grandiosity, excitement, overconfidence, and a decreased need for sleep. They may speak or move rapidly and may easily become irritable, angry, aggressive, and/or easily distracted. In the depressed phase, they usually feel hopeless, sad, discouraged, fatigued, and/or empty; they have trouble sleeping or else oversleep; they quickly lose or gain a great deal of weight; they have trouble focusing or concentrating; they become easily frustrated; they lose interest in things and activities they used to care about; and they may have persistent thoughts of death or suicide. Each phase typically lasts for weeks or months. Hallucinations or delusions may accompany either or both stages. In any given year, about 2 percent of all people experience bipolar disorder (estimates range from fewer than 1 percent to 2.5 percent).

Cyclothymia

This is sometimes described as a milder version of bipolar disorder. As with bipolar disorder, it involves cycling through two phases. In the first, people experience euphoric highs and boosts of energy, and require less sleep than usual; in the second, they experience an ongoing mood of negativity and sadness. Neither phase is as severe as in bipolar disorder. However, untreated cyclothymia tends to be chronic and long lasting; in fact, to be diagnosed with the disorder, a person must have experienced it for at least two years, with periods of relief lasting no more than two months. In any given year, less than 1 percent of all people experience cyclothymia (estimates range from 0.4 percent to 1 percent).

Depression

Unlike ordinary sadness (feeling depressed temporarily about some situation or event), major depression (sometimes called *clinical depression*) involves intense and prolonged feelings of worthlessness, hopelessness, emptiness, helplessness, regret, and/or guilt. Often these are accompanied by thoughts of death or suicide. Depression can also create a variety of physical symptoms, including pronounced changes in sleep, energy, and/or appetite; difficulty thinking, concentrating, or remembering; a lack of interest in previously pleasurable activities; and persistent headaches, digestive disorders, and/or pains that do not respond to treatment. In any given year, about 7 percent of all people experience major depression. People with depression are not just “bummed out” or “feeling the blues.” Depression as an illness is serious and requires treatment.

Dysthymia

Sometimes referred to as low-grade depression, dysthymia is a persistent, chronic form of mild to moderate depression. Because it is less severe than clinical depression, people who have dysthymia often experience it not as a disorder, but as their normal state of being. Symptoms include long-term feelings of hopelessness, sadness, and/or pessimism; trouble sleeping and/or oversleeping; extreme fatigue; difficulty concentrating or focusing; irritability; indecisiveness; constant self-criticism; and feelings of guilt or worthlessness. In any given year, about 2 to 3 percent of all people experience dysthymia.

Generalized Anxiety Disorder (GAD)

People with GAD worry excessively and chronically over everyday concerns such as health, money, family, and work. Often their thoughts get stuck on the potential for disaster in normal situations. People with GAD cannot shake these worries even though they know they are largely unwarranted. Physical symptoms of GAD include restlessness, edginess, fatigue, difficulty concentrating, irritability, muscle tension, and trouble falling or staying asleep. In any given year, about 1 percent of all people experience GAD.

Obsessive-Compulsive Disorder (OCD)

People with OCD often say that their minds are stuck in a loop: a single thought, urge, or image repeats over and over, and they cannot let go of it. Often this is combined with obsessive feelings that things must be done in a certain exact way. These compulsive

thoughts typically lead to compulsive actions, such as excessive hand washing; repeatedly checking, ordering, cleaning, or arranging things; doing the same task or activity over and over, often in a ritualistic way; and repeating the same phrase again and again. In any given year, about 2 percent of all people experience OCD.

Mania (or Manic Disorder)

Although this disorder can appear on its own, it is more likely to occur as part of bipolar disorder (see page 15). Symptoms include grandiosity, high energy, restlessness and/or a reduced need for sleep, rapid speech, racing thoughts, impulsivity, creative and/or disjointed thinking, excitability, and irritability. *Hypomania* is a mild form of this disorder.

Panic Disorder

People with this disorder experience sudden panic attacks: episodes of extreme fear and terror lasting from a few minutes to an hour. They may also feel as if they are dying, going crazy, or having a heart attack. People with panic disorder can be so shaken by these episodes that they withdraw and shut themselves off from the outside world. In any given year, 1 to 2 percent of all people experience panic disorder.

Social Anxiety Disorder

People with this disorder experience intense anxiety in ordinary social situations and interactions. Making a phone call, attending a meeting or a party, making a purchase at a store, or asking a stranger for directions can feel intensely stressful and difficult. People with this disorder also worry that others are constantly watching them and judging them negatively. In the presence of others, they may experience physical symptoms such as a pounding heart, sweating, shaking, blushing, muscle tension, an upset stomach, or diarrhea. Not surprisingly, people with social anxiety disorder tend to stay home and avoid social situations; they also tend to feel lonely, because they avoid contact with others. In any given year, about 6 percent of all people experience social anxiety disorder—a surprisingly high percentage.

Post-traumatic Stress Disorder (PTSD)

PTSD is the result of one or more traumatic events. These events can range from being sexually abused as a child, to being in an automobile accident or natural disaster,

to being in a combat or war zone. People with this disorder often feel vulnerable and out of control, or as if their lives are in danger. They also typically reexperience the traumatic event over and over in memories, dreams, and flashbacks. Not surprisingly, they may try to avoid people, places, and situations that remind them of this traumatic event. People with PTSD often feel constantly vigilant or on guard and may be easily startled or upset. Other common symptoms of PTSD include constant fear or tension, restlessness, insomnia, irritability, and/or poor concentration. In any given year, about 2 percent of all people experience PTSD.

Schizophrenia

This serious disorder profoundly affects people's behavior, thinking, emotions, and functioning. It includes misperceptions, distorted reality, delusions, hallucinations, mood changes, bizarre behavior, and a general loss of contact with reality. Schizophrenia can be managed and successfully treated, but it is not usually cured.

Schizoaffective disorder is itself a co-occurring disorder. It comes in two forms: a combination of schizophrenia and major depression, and a combination of schizophrenia and bipolar disorder.

In any given year, about 0.2 to 0.4 percent of all people (between one-fifth of 1 percent and four-tenths of 1 percent) experience schizophrenia. About half that percentage—one-tenth to one-fifth of 1 percent—experience schizoaffective disorder.

Understanding Co-occurring Disorders

It's not always easy to tell if you have co-occurring disorders. Of course, in some cases it may be obvious to you (*Jeez, when did I start worrying myself sick? And when was the last time I made it through a whole day without doing coke?*) or to the people around you (*"Sandra, you're starting to smell like a walking bong. And your plans don't sound ambitious; they sound completely off the wall. When did you last feel good about yourself?"*).

More likely, though, you'll have a vague sense that something is wrong, but won't know what. Or you'll feel anxious, or afraid, or sad, or depressed, or guilty, or angry, and not know why. An important relationship may suddenly fall apart, seemingly without warning. Or maybe you're already aware of one of your problems, but one day you realize that something else must be going on as well.

People with co-occurring disorders typically develop them in one of three ways:

1. They first develop a mental health problem and then turn to drinking or drugs in an attempt to reduce their symptoms and feel better. For example, many people with an anxiety disorder will drink alcohol to help themselves relax and calm down. Over time, this attempt at self-medication can turn into an addiction.
2. They first develop an addiction, which in turn induces a mental health problem. For example, the regular use of certain mind-altering drugs can sometimes be a partial cause of major depression, anxiety, or panic disorder. In other cases, the mental health disorder is latent or relatively minor, and the addiction becomes the catalyst that brings it out or makes it worse.
3. Some people are genetically more vulnerable to addiction, or to a mental health disorder, or to both—just as some people are more likely than others to lose their hearing as they age.

Other people may be more vulnerable to co-occurring disorders because of their environment or life experience. For example, Kim's parents were both cocaine addicts; she naturally became curious about the drug at an early age and soon developed her own addiction to it. Chauncey served in the military and was captured and briefly tortured; he developed symptoms of PTSD when he returned home. In college, Adrienne fell in with a group of friends who regularly indulged in binge drinking; eventually her friends grew out of the alcohol abuse, but Adrienne found she couldn't stop. All of these people are more vulnerable than most to co-occurring disorders.

Although drug or alcohol use can sometimes temporarily reduce the symptoms of certain mental health problems, substance use actually has exactly the opposite effect. For example, if Suzette has depression, even two drinks might make her depression much worse or make her feel suicidal. Frederico has generalized anxiety disorder, and for him even a few puffs on a joint ratchet up his anxiety to an almost intolerable level.

Then there's the issue of prescription medications. A glass of wine will take the edge off Jacob's post-traumatic stress disorder, but now that Jacob has begun taking a medication to help his PTSD, he can't drink alcohol. That same glass of wine, mixed with the medication, could make his PTSD worse, or at least render the medicine ineffective. (This is yet another reason why it's essential to treat both parts of co-occurring disorders together, in an integrated way.)

Most doctors now know that a person with a mental health disorder is more likely than other people to also have a substance use disorder. And if the person has a substance use problem, he or she is more likely than the average person to also have a mental health disorder. Statistically, someone with schizophrenia or bipolar disorder has a one in two chance of acquiring a substance use disorder; someone with depression or an anxiety disorder has a one in three chance.

There's a positive side to this, though. If Mariana has both alcoholism and depression, there's a three in five chance that when she stops drinking, the depression will go away.

How Do You Know If You Have a Mental Health or Substance Use Disorder?

Sometimes professionals can determine a great deal from an initial assessment. That's why, if you suspect you might have co-occurring disorders—or even just a substance use problem or just a mental health disorder—your best first step is to get a thorough assessment.

There are online tests or screenings you can take with complete anonymity. Some of them are quite good and have proven validity and reliability. That means you can count on them to assess accurately what they are intended to assess. You might also visit the National Institute on Drug Abuse (NIDA) at www.nida.nih.gov or the National Institute on Alcohol Abuse and Alcoholism (NIAAA) at www.niaaa.nih.gov. You'll find excellent information to help you better understand alcohol and drug abuse and dependence. If you're wondering about your mental health, visit the National Alliance on Mental Illness (NAMI) at www.nami.org. To learn more about both mental health and substance use disorders or co-occurring disorders, visit the Substance Abuse and Mental Health Services Administration (SAMHSA) at www.samhsa.gov. All of these Web sites are good starting points for any individual to begin looking at his or her own mental health and substance use.

If you suspect you have one or both disorders, it's recommended that you contact a qualified professional immediately for an assessment, which is explored in the next chapter.



CHAPTER 2

Getting an Assessment

What Is an Assessment?

An assessment is a professional evaluation of someone's mental health, general physical health, and alcohol and/or drug use. An assessment can determine whether someone has a mental health disorder, multiple mental health disorders, a drug use problem, an alcohol use problem, or some combination. It's also the necessary foundation for developing an effective recovery plan.

An assessment may take place in a clinic, treatment center, hospital, or mental health professional's office. The client and the professional meet for about one to two hours, during which the professional asks the client questions about his or her life. These typically include several dozen standardized questions, as well as a less structured interview about the client's health, lifestyle, thoughts, emotions, concerns, and willingness to recover. All answers are kept strictly confidential, except in cases where clients seem likely to harm themselves or others.

In some cases, this meeting with a professional may be preceded by a brief preliminary screening, either in person or by phone, conducted by a nurse or staff person. In other cases, the client may be asked to answer some initial questions in writing before the face-to-face interview begins.

Here are some typical assessment questions:

- In the past two weeks, have you been less able to enjoy the things you used to enjoy?
- In the last six months, have you worried excessively?
- In the past month, did you do something repeatedly without being able to resist doing it? What?
- Have you ever heard things other people couldn't hear, such as voices?
- Have you ever had a drink or used drugs first thing in the morning, to steady your nerves or get rid of a hangover?
- Have any of your family members ever had a drinking or drug problem?
- During the past week, how often did you feel lonely?

The professional does more than just listen to clients' answers. Professionals also pay attention to clients' speech, body language, demeanor, and facial expressions. Do they have trouble sitting still? Do they have difficulty concentrating? Do their hands tremble? Is their speech slurred?

Most high-quality assessments for co-occurring disorders also include a urine test (for opiates, cocaine, cannabis, barbiturates, amphetamines and methamphetamine, and other common mind-altering drugs) and/or a breath test (which measures blood-alcohol concentration). Sometimes there is a physical exam and/or blood is drawn. In rare cases, even a hair sample may be taken and analyzed.

In any assessment, honesty and forthrightness are crucial. If a client lies or withholds essential information, the assessment is not likely to be altogether accurate, and any proposed treatment may be inappropriate and unhelpful.

After the assessment interview, the client should find out when the results will be available and make an appointment to discuss those results with the professional face-to-face. Usually the results will be ready in a few days, and sometimes they'll be available immediately.

Who Should Conduct an Assessment?

Only someone who is trained in *both* the mental health and substance use disorder (also called *addiction*, *chemical dependency*, or *substance abuse*) fields can conduct a thorough and accurate assessment of any co-occurring disorders. For this reason, it's best to seek an assessment from a professional or program that specializes in integrated treatment for co-occurring disorders. Sometimes programs may note they have dual diagnosis "capable" or dual diagnosis "enhanced" services.

Approximately eleven million people in North America have a substance use disorder and at least one other mental health disorder. Those who are struggling with a combination of these disorders may be faced with a powerful recipe for destruction, especially self-destruction. The good news is that there is help.

Drawing from an evidence-based program by internationally recognized pioneers in the integrated treatment of co-occurring disorders from the Dartmouth Medical School, *Living with Co-occurring Addiction and Mental Health Disorders* is a handbook designed to inform and empower those with dual disorders. It allows each person to make the best choices about his or her own treatment and, in collaboration with a trained clinician, sculpt a program that works. Key topics include

- getting an assessment
- reviewing treatment options
- selecting the right treatment team
- setting achievable goals and making positive changes with cognitive-behavioral therapy
- building a support network of family and friends, and connecting with others recovering from co-occurring disorders

Informative, thorough, and easy to follow, this book is designed to help the millions of people with co-occurring disorders thrive and be their own best recovery advocates.



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