Chapter 5—Strategies for Working With People Who Have Co-Occurring Disorders

KEY MESSAGES

- Building a positive therapeutic alliance is a cornerstone of effective, high-quality, person-centered care for all clients, especially those with co-occurring disorders (CODs). Clients with CODs often experience stigma, mistrust, and low treatment engagement.
- CODs are complex and are associated with certain clinical challenges that, if unaddressed, can compromise the counselor–client relationship and impinge on quality of care, potentially leading to suboptimal outcomes.
- Strategies and approaches like empathic support, motivational enhancement, relapse prevention techniques, and skill building help strengthen clients' ability to succeed and make long-term recovery more likely.
- Certain mental disorders are complex, chronic, and difficult to treat, including major depressive disorder (MDD), anxiety disorders, posttraumatic stress disorder (PTSD), and serious mental illness[2] (SMI). Clients with these disorders may have unique symptoms and limitations in function.
- Empirically based substance use disorder (SUD) treatment approaches can help counselors address these unique symptoms and functional limitations in ways that will minimize their potential to disrupt the therapeutic relationship and impede positive treatment outcomes.

Establishing and maintaining a successful therapeutic relationship with clients can enhance treatment engagement, participation, and outcomes. Building a good therapeutic relationship with clients who have CODs is especially important, yet doing so can be difficult. The first part of this chapter reviews guidelines and techniques for building rapport and optimizing outcomes when providing SUD treatment to clients who have CODs. The chapter also describes how to modify general treatment principles to suit the needs of clients with COD—particularly useful when working with clients in Quadrants II and III. (Chapter 3 addresses the Four Quadrants Model of service provision.) The second part describes evidence-based techniques for building therapeutic rapport and effectively counseling clients with CODs involving specific mental disorders—MDD, anxiety disorders, PTSD, and SMI.

The material in this chapter is consistent with national or state consensus practice guidelines for COD treatment and consonant with many recommendations therein:

- Counselors must be able to **address common clinical challenges,** like managing feelings and biases that could arise when working with clients who have CODs (sometimes called countertransference).
- Together, providers and clients should **monitor clients' disorders and symptoms** by examining the status of each disorder and alerting each other to signs of relapse.
- Counselors can help clients with functional deficits in areas such as understanding instructions by **using repetition, skill-building strategies, and other accommodations to aid progress.**

[2] SMI: A diagnosable mental, behavioral, or emotional disorder (other than developmental disorders or SUDs) that persists long enough to meet diagnostic criteria and that causes functional impairment sufficient to substantially disrupt major life activities (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017).

- The consensus panel recommends that counselors **primarily use a supportive, empathic, and culturally responsive approach** when working with clients who have CODs. Counselors need to distinguish behaviors and beliefs of cultural origin from those that may indicate a mental disorder.
- Counselors and other service providers should **use motivational enhancement and relapse prevention strategies consistent with each client's specific stage of recovery.** These strategies are helpful regardless of the severity of a client's mental disorder.

This chapter is intended for counselors and other behavioral health service providers, supervisors, and administrators. Throughout this chapter, "Advice to the Counselor" boxes highlight practical guidance for counselors.

Competencies for Working With Clients Who Have CODs

Before establishing therapeutic rapport with clients who have CODs, treatment providers first must ensure that they possess integrated competencies for working with the COD population. This means having the specific attitudes, values, knowledge, and skills needed to provide appropriate services to individuals with CODs in the context of the providers' job and program setting.

Just as other types of integration exist on a continuum, so too does integrated competency. Some interventions or programs require only basic competency in welcoming, screening, and assessing individuals with CODs to identify their treatment needs. Other interventions, programs, or job functions (e.g., those of supervisory staff) may require more advanced integrated competency. Clients with more complex or unstable disorders require providers with higher levels of integrated competency. They also require more formal mechanisms within programs to coordinate various staff members, providing effective integrated treatment.

The mental health service and SUD treatment systems are moving toward identification of a basic, required level of integrated competency for all providers. Many states are developing curriculums for initial and ongoing training and supervision to help providers achieve competency. Other states have created career ladders and certification pathways to encourage providers to achieve greater competency and to reward them for this achievement. (See Chapter 8 for further discussion of counselor competencies.)

Guidelines for a Successful Therapeutic Relationship

This section reviews 10 guidelines for forming a good therapeutic relationship with clients who have CODs, thereby increasing their chances of successful long-term recovery.

Develop and Use a Therapeutic Alliance To Engage Clients in Treatment

Research suggests that a therapeutic alliance is a strong, if not essential, factor in supporting recovery from mental disorders and SUDs (Kelly, Greene, & Bergman, 2016; Shattock, Berry, Degnan, & Edge, 2018; Zugai, Stein-Parbury, & Roche, 2015). The therapeutic alliance can foster desirable outcomes by improving symptoms, functioning, treatment engagement, treatment satisfaction, and quality of life (Dixon, Holoshitz, & Nossel, 2016; Kidd,

10 GUIDELINES FOR DEVELOPING SUCCESSFUL THERAPEUTIC RELATIONSHIPS WITH CLIENTS WHO HAVE CODS

1. Develop and use a therapeutic alliance to engage clients in treatment.
2. Maintain a recovery perspective.
3. Ensure continuity of care.
4. Address common clinical challenges (e.g., countertransference, confidentiality).
5. Monitor psychiatric symptoms (including symptoms of self-harm).
6. Use supportive and empathic counseling; adopt a multiproblem viewpoint.
7. Use culturally responsive methods.
8. Use motivational enhancement.
9. Teach relapse prevention techniques.
10. Use repetition and skill building to address deficits in functioning.

Given the proliferation of research over the past few decades on technology-based interventions in behavioral health services, some researchers have explored how technology can affect client–counselor relationships in COD treatment. A pilot study from Ben-Zeev, Kaiser, and Krzos (2014) examined the use of mobile phone technology to monitor clients with SMI and SUDs. Using daily text messages over 12 weeks, team members routinely texted clients (in what the study authors termed "hovering") reminders of upcoming appointments, inquiries about medication adherence, general suggestions about managing symptoms, and, as needed, crisis management. At the end of the trial, participant ratings of therapeutic alliance with providers who "hovered" were significantly higher than those for providers who did not use the intervention. Most clients were satisfied with the technology, and 87 percent said it helped them feel more in control of their lives.

Davidson, & McKenzie, 2017). For clients with SMI (e.g., bipolar disorder, schizophrenia), better therapeutic alliance has been linked to a reduction in symptoms, fewer hospitalizations, greater antipsychotic medication adherence, and improved client self-esteem (Garcia et al., 2016; Shattock et al., 2018). Studies of people with SUDs or CODs also suggest that a strong therapeutic alliance is a significant predictor of treatment retention, symptom reduction, enhanced abstinence-related self-efficacy, and more days of abstinence (Campbell, Guydish, Le, Wells, & McCarty, 2015; Connors et al., 2016; Maisto et al., 2015).

However, the personal beliefs of individuals with CODs, such as mistrust of treatment providers and fear of stigma, can be barriers to treatment seeking, access, and engagement (Priester et al., 2016) and can make establishing a close, trusting client–provider relationship challenging. Developing an effective relationship with clients who have SMI and SUDs can be especially difficult. Some individuals have little insight, lower motivation to change, and less ability to seek/access care than people without CODs (Pierre, 2018). Challenges may be more apparent in clients with SUDs and co-occurring psychosis, as they may have emotional/cognitive dysfunctions inhibiting their ability to participate in treatment (Priester et al., 2016). The presence and level of clinical and functional deficits varies widely from one person with CODs to the next, and among all people with CODs over the course of their illness and lifetime.

To foster treatment engagement for clients with CODs, therapeutic relationships must build on clients' existing capacities. The therapeutic alliance is the cornerstone of the COD recovery process. Once established, the alliance is rewarding for both client and provider and facilitates their joint participation in a full range of therapeutic activities. Counselors should document alliance-building activities to help manage risk.

Maintain a Recovery Perspective

Varied Meanings of "Recovery"

The word "recovery" has different meanings in different contexts. SUD treatment providers may think of clients who have changed their substance use behavior as being "in recovery" for the rest of their lives (but not necessarily in formal treatment forever). Mental health clinicians may think of

ADVICE TO THE COUNSELOR: FORMING A THERAPEUTIC ALLIANCE

The consensus panel recommends these approaches to form a therapeutic alliance with clients who have CODs:

- Demonstrate an understanding and acceptance of clients.
- Help clients clarify the nature of their difficulties.
- Indicate that you will work together with clients.
- Communicate to clients that you will help them help themselves.
- Express empathy and a willingness to listen to clients' understanding of their problems.
- Assist clients in solving external problems directly and immediately.

ADVICE TO THE COUNSELOR: MAINTAINING A RECOVERY PERSPECTIVE

The consensus panel recommends these approaches for maintaining a recovery perspective in treating CODs:

- Assess each client's stage of change (see the section "Using Motivational Enhancement Consistent With Clients' Specific Stage of Change").
- Ensure that treatment stage and expectations are consistent with each client's stage of change.
- Use client empowerment to motivate change.
- Foster continuous support.
- Provide continuity of treatment.
- Acknowledge that recovery is a long-term process; support and applaud even small gains by clients.

recovery as a process in which the client moves toward specific behavioral goals in stages; in this conceptualization, recovery is assessed by whether these goals are achieved. In mutual-support programs, recovery implies not only abstinence from substances but also a commitment to "working the program," which includes group members changing the way they act with others and taking responsibility for their actions. People with mental disorders may see recovery as the process of reclaiming a meaningful life beyond mental illness, with symptom control and positive life activity.

Generally, it is recognized that **recovery does not refer solely to a change in substance use but also to a change in an unhealthy way of living.** Markers such as improved health, better ability to care for oneself and others, increased independence, and enhanced self-worth indicate progress in recovery.

Implications of the Recovery Perspective

The recovery perspective as developed in the SUD treatment field has two main features:

1. It acknowledges that recovery is a long-term process of internal change.
2. It recognizes that these internal changes proceed through various stages (see De Leon [1996] and Prochaska et al. [1992] for a detailed description).

The recovery perspective generates two main principles for practice:

- **Develop a treatment plan that provides for continuity of care over time.** In preparing this plan, the provider should recognize that treatment may occur in different settings over time (e.g., residential, outpatient). The plan should reflect that much of the recovery process is client driven and typically occurs outside of, or following, professional treatment (e.g., through participation in mutual support). Providers should reinforce long-term participation in these settings.
- **Use interventions that match the tasks and challenges specific to each stage of the COD recovery process.** Doing so enables providers to use sensible stepwise approaches in developing and using treatment protocols. Markers that are unique to individuals—such as those related to their cultural, social, or spiritual context—should be considered. Providers should engage clients in defining markers of progress that are meaningful to them in each stage of recovery.

Stages of Change and Stages of Treatment

Working within the recovery perspective requires a thorough understanding of the interrelationship between stages of change (as originally defined by Prochaska et al., 1992, and built upon by De Leon, 1996) and stages of treatment (see the section "Using Motivational Enhancement Consistent With Clients' Specific Stage of Change"). De Leon developed a measure of motivation for change and readiness for treatment—Circumstances, Motivation, and Readiness Scales—and provided scores for samples of people with CODs (De Leon, Sacks, Staines, & McKendrick, 2000). The

scales have a demonstrated relationship with retention in general SUD treatment populations and programs (Ali, Green, Daughters, & Lejuez, 2017). A meta-analysis (Krebs, Norcross, Nicholson, & Prochaska, 2018) found that client stage or readiness level of change predicted psychotherapy outcomes among people with SUDs, eating disorders, anxiety disorders, depressive disorders, borderline personality disorder, and CODs (e.g., PTSD and alcohol dependence). The authors suggest tailoring goal setting, treatment processes, and resources to each client's stage of change to optimize outcomes. Expectations for clients' progress through treatment stages (e.g., outreach, stabilization, early-middle-late primary treatment, continuing care, long-term care) should be consistent with clients' stages of change.

Client Empowerment and Responsibility

The recovery perspective emphasizes clients' empowerment and responsibility and their network of family and significant others. Per Green, Yarborough, Polen, Janoff, and Yarborough (2015), achieving sobriety can be a major step in building clients' feelings of self-efficacy and confidence to further achieve recovery in SMI and can be a turning point in advancing their personal growth, improving functioning, and meeting recovery goals.

Continuous Support

The recovery perspective highlights the need for continuing recovery support. Providers encourage clients to build a support network that offers respect, acceptance, and appreciation. For example, an important element of long-term participation in Alcoholics Anonymous (AA) is the sense of belonging or a "home." AA offers this supportive environment without producing overdependence because members are expected to contribute, as well as receive, support.

Ensure Continuity of Care

Continuity of treatment flows from a recovery perspective and is a guiding principle in its own right. Continuity of treatment implies that COD services are constant. Treatment continuity for clients with CODs begins with proper, thorough identification, assessment, and diagnosis. Per a review by McCallum et al. (2015), continuity of care for people with CODs means providing:

- Care that is regular and consistent over time.
- Care that is continually adjusted to the client's needs.
- Continuity in the counselor–client relationship, such as through ongoing and reliable contact.
- Continuity across services via case management, coordination of care, and linkage to resources.
- Continuity in the transfer of care, including maintaining contact (as appropriate) even after handoff.

On a program level (Padwa, Larkins, Crevecoeur-MacPhail, & Grella, 2013), continuity of care for clients with CODs can include having structures, procedures, and training in place that enables providers to:

- Assess and monitor mental disorder and SUD symptoms.
- Develop discharge planning that continually supports clients through community resources (e.g., peer recovery support services, mutual support).
- Ensure medication needs are met (e.g., medication checks are scheduled, prescription refill procedures are in place) for people on pharmacotherapy.

More discussion of how counselors can ensure continuity of care for clients with CODs across different treatment settings can be found in Chapters 2 and 7.

Address Common Clinical Challenges

Ease Discomfort and Reluctance

Providers' ease in working toward a therapeutic alliance is affected by their comfort level in working with clients who have CODs. SUD counselors may find some clients with SMI or severe SUDs to be threatening or unsettling. This discomfort may result from lack of experience, training, or mentoring. Likewise, some mental health clinicians may feel uncomfortable or intimidated by clients with SUDs. Providers need to recognize certain

ADVICE TO THE COUNSELOR: MITIGATING RELAPSE BY MANAGING THE RECOVERY ENVIRONMENT

To guide clients through recovery and ensure delivery of comprehensive, recovery-oriented care, counselors must help clients establish and maintain a supportive recovery environment. This environment is more than where clients live; it compasses clients' entire physical, emotional, social, educational, and vocational world.

Understanding limitations in clients' recovery environments is critical to helping them prevent relapse and problem solve barriers. Environmental obstacles and lack of support can sabotage clients' recovery efforts and can be difficult to overcome without assistance from a mental health or addiction professional.

Counselors can help clients with CODs create a life conducive to recovery by assessing areas of functioning and symptoms and offering services relevant to the American Society of Addiction Medicine's Patient Placement Criteria, Third Revision, Domain 6 (Mee-Lee et al., 2013). This means working with clients to identify and explore:

- The client's current living situation, including the physical living space, the people who co-occupy their home, and the surrounding community (e.g., Is it safe? Is it disruptive to recovery? Does the client live in an area where illicit substances are easily accessible?).
- The client's available supports for all biopsychosocial needs, whether related to illness or broader areas of living, like social life, work, and relationships. For instance, does the client have reliable transportation? What about child care? Does the client have people in his or her life to rely on for tangible and emotional support? Is the client able to maintain primary care and behavioral health appointments?
- Threats to support in the client's life, such as friends or loved ones who actively misuse substances or family members who are unsupportive of SUD treatment?
- Whether the client engages in peer support, 12-Step support, or other mutual-support programs.
- Educational or occupational matters that facilitate or hinder recovery. For instance, is the client employed? Does his or her supervisor know that the client is in recovery (and supportive of this)? Is the client working to complete his or her degree, and does the client value degree completion as a recovery goal?
- Whether the client is engaged in meaningful activities with family, friends, partners, coworkers, classmates, or peers. Also, does the client have hobbies or otherwise regularly engage in pleasant activities?
- Whether the client is involved in the criminal justice system, child welfare system, or both.
- Whether the client needs financial assistance (e.g., applying for Social Security Disability Insurance).

patterns that invite these feelings and not let them interfere with clients' treatment. Providers who find it challenging to form a therapeutic alliance with clients who have CODs should consider whether their difficulty is related to:

- The client's difficulties.
- A limitation in their own experience and skills.
- Demographic differences between themselves and their clients in areas such as age, gender, education, socioeconomic status, race, or ethnicity.
- Countertransference (see the section "Manage Countertransference").

A consultation with a supervisor or peer to discuss this issue is important. Often these reactions can be overcome with further experience, training, supervision, and mentoring.

Individuals with CODs may also feel challenged

in forming a therapeutic relationship with their treatment providers. They often experience demoralization and despair, given the complexity of having multiple behavioral health concerns and the difficulty of achieving treatment success. Inspiring hope often is a necessary precursor that allows clients to give up short-term relief for long-term work, even when there is some uncertainty in timeframe and benefit.

Manage Countertransference

Providers should understand difficulties related to countertransference and be familiar with strategies to manage it. Although the concept of **countertransference** is somewhat dated and infrequently used in the COD literature, it can help providers understand how their past experiences can influence current attitudes toward certain clients. **Transference** describes the process whereby clients project attitudes, feelings, reactions, and images from the past onto their providers. For example, the client may regard the provider as an "authoritative father," "know-it-all older brother," or "interfering mother."

Countertransference is now understood to be a normal part of providers' treatment experience. Particularly when working with clients who have multiple, complicated problems, providers are as vulnerable as clients to feelings of pessimism, despair, and anger, as well as desires to abandon treatment. Less experienced providers may find it harder to identify countertransference, access feelings evoked by interactions with clients, name those feelings, and keep feelings from interfering with the counseling relationship.

SUDs and mental disorders are stigmatized by the general public. Stigma can also be present among providers. Mental health clinicians who usually do not treat people with SUDs may not have worked out their own responses to substance misuse, which can influence their interactions with these clients. Providers working with clients who have SMI may have more negative beliefs about and express more negative attitudes toward clients with SMI than those without such diagnoses (Smith, Mittal, Chekuri, Han, & Sullivan, 2017; Stone et al., 2019). Providers who treat clients with SMI can benefit from working with supervisors to uncover and correct underlying harmful thoughts and attitudes.

Similarly, SUD treatment providers may be unaware of their own reactions to people with specific mental disorders and may have difficulty preventing these reactions from influencing treatment. Their negative attitudes or beliefs may be communicated, directly or subtly, to the client—for example, through thoughts like, "I was depressed too, but I never took medications for it—I just worked the Steps and got over it. So why should this guy need medication?"

Negative feelings generated by countertransference can worsen over time. Some research indicates that providers treating clients with CODs may feel less satisfied with their jobs and increasingly frustrated with their clients the longer they stay in practice (Avery et al., 2016).

Providers' negative attitudes toward clients with CODs can have a significant impact on treatment services and outcomes. For example, countertransference may result in providers failing to offer timely, appropriate treatment and having poor communication with their clients (Avery et al., 2016). (For a full discussion of countertransference in SUD treatment, see Powell & Brodsky, 2004.) Countertransference

ADVICE TO THE COUNSELOR: MANAGING COUNTERTRANSFERENCE

The consensus panel recommends this approach to manage countertransference with clients who have CODs:

- Be aware of strong personal reactions and biases toward clients.
- Get further supervision when countertransference is suspected and may be interfering with counseling.
- Receive formal and periodic clinical supervision; counselors should have opportunities to discuss countertransference with their supervisors and with other staff at clinical team meetings.

Providers have a duty to be aware of federal rules under the Health Insurance Portability and Accountability Act and any additional regulations in their states dictating what information they can and cannot share with other providers (as well as caregivers and family members) and under which circumstances.

problems are particularly significant when working with people who have CODs, because people with **SUDs and mental disorders may evoke strong feelings in providers that could become barriers to treatment if providers allow such feelings to interfere.** Providers may feel angry, used, overwhelmed, confused, anxious, uncertain how to proceed with a case, or just worn out.

Cultural concerns may cause strong yet unspoken feelings, creating countertransference and transference. Counselors working with clients in their area of expertise may be familiar with countertransference, but working with an unfamiliar population will introduce different kinds and combinations of feelings.

Protect Confidentiality

Confidentiality and privacy are relevant to every clinical situation and are especially important for clients with SMI, SUDs, or both. These conditions can be complex and debilitating, and they are associated with an increased risk of harm to self and others. Furthermore, people receiving SUD treatment in federally funded programs are protected by additional regulations that affect information sharing, privacy, and consent. More information about these regulations is available online (www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs).

However, confidentiality is not absolute. **Contexts in which to be mindful of protections related to client privacy and confidentiality—and the limitations of those protections—include:**

- **When collaborating with other providers, especially those outside of the behavioral health field.** All clients have a right to privacy and confidentiality. There are federal as well as state regulations that dictate the type of information providers can share with other providers while upholding those rights for their clients. Remember that counselors who practice in more than one location must follow the regulations in each of the states in which they see clients. (See "Resource Alert: Federal and State Mental Health Privacy and Confidentiality Regulations.")

RESOURCE ALERT: FEDERAL AND STATE MENTAL HEALTH PRIVACY AND CONFIDENTIALITY REGULATIONS

Mental health regulations regarding privacy, confidentiality, and information sharing (including duty to warn laws) vary by state. Counselors can stay up-to-date on regulations in the state(s) in which they practice by accessing information and resources available online:

- SAMHSA's *Directory of Single State Agencies for Substance Abuse Services* (https://www.samhsa.gov/sites/default/files/single-state-agencies-directory-08232019.pdf)
- National Conference of State Legislatures' Mental Health Professionals Duty to Warn (www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx)

General resources about the protection of mental health clients' and SUD treatment clients' rights include:

- Department of Health and Human Services' Mental Health Information Privacy FAQs (www.hhs.gov/hipaa/for-professionals/faq/mental-health/index.html)
- SAMHSA's Laws and Regulations (www.samhsa.gov/about-us/who-we-are/laws-regulations)
- SAMHSA's Substance Abuse Confidentiality Regulations FAQs (www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs)

- **When working in a setting with electronic health records (EHRs).** The proliferation of EHRs has helped foster easier record sharing between mental health and general medical clinicians but also poses a risk to confidentiality that, if breached, could seriously damage client trust in the counselor and in the psychotherapy process in general (Shenoy & Appel, 2017).
- **When working with clients who verbalize specific threats of harm to a third party.** If the counselor has reason to believe a violent act is foreseeable and is directed at a specific person, breach of confidentiality may be appropriate or even required by the state's duty to warn mandate. Counselors should seek consultation, as needed and as appropriate given the volatility of the situation. If employed by an agency, follow required treatment facility policies/procedures as well.
- **When treating clients with trauma/PTSD.** Trauma survivors may be mistrustful and concerned about privacy, posing barriers to treatment (Kantor, Knefel, & Lueger-Schuster, 2017). Trauma in the context of ongoing intimate partner violence, child maltreatment, sexual assault, or elder abuse raises ethical and legal concerns about breaching confidentiality under duty to warn laws.
- **When working with clients ages 18 and under, including students.** Discussion of pediatric and adolescent mental disorders and substance misuse is beyond the scope of this TIP. Information on laws affecting mental health clinicians and addiction counselors is available via American Academy of Pediatrics' *Confidentiality Laws Tip Sheet* (www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Confidentiality_Laws.pdf) and in the resource alert about federal and state privacy and confidentiality regulations.

Providers must understand how to involve family members, when appropriate, without jeopardizing client privacy and confidentiality. Families often want to be involved in the care of a loved one with CODs—especially if the individual has a history of nonadherence to medication and other treatment and does not have other support systems in place. Sometimes, family members or caregivers must be involved because the client lacks capacity to make independent healthcare decisions.

Recommended practices for involving families (Rowe, 2012) in a client's COD treatment include:

- Involving family members in planning and implementing treatments to the extent possible (after discussing their involvement with the client and obtaining his or her written consent).
- Conveying the same respect and empathy toward family members as toward clients to build rapport.
- Developing a contract that spells out what type of information families will and will not receive and what role they can play in their loved one's treatment.

Monitor Psychiatric Symptoms

Joint Treatment Planning

When SUD counselors work with clients who have CODs, especially those who need medications or are receiving mental health services separately from SUD treatment, it is especially important that they participate in developing client treatment plans and monitoring clients' psychiatric symptoms. The SUD counselor should, at minimum, be knowledgeable of the overall treatment plan to permit reinforcement of the plan's mental health aspects as well as aspects specific to recovery from SUDs. It is equally important for clients to participate in developing their COD treatment plans.

For example, for a client with bipolar disorder and alcohol use disorder (AUD) who is receiving treatment at both an SUD treatment agency and a local mental health center, the treatment plan might include individual SUD treatment counseling, medication management, and group therapy. In another example, for a client taking lithium, the SUD treatment provider may assist in medication monitoring by asking such questions as, "How are your meds helping you? Are you remembering to take them? Are you having any problems with them? Do you need to check in with the prescribing doctor?"

Psychiatric Medications

Providers should ask clients with CODs to bring in all medications to counseling sessions. Providers can then ask clients in what manner, when, and how they are taking medications. They can also ask whether clients feel that the medication is helping them, and how. Doing so presents an opportunity for providers and their clients to review and discuss attitudes toward medication and clients' typical patterns in taking medication. Some clients may not disclose that they have discontinued their medications, but when asked to bring in their medications, they may bring medication bottles that are completely full. **Providers should help educate clients about the effects of medication, teach clients to monitor themselves (if possible), and consult with clients' physicians whenever appropriate.**

ADVICE TO THE COUNSELOR: MONITORING PSYCHIATRIC SYMPTOMS

The consensus panel recommends these approaches to monitoring psychiatric symptoms in clients with CODs:

- Obtain a mental status examination to evaluate clients' overall mental health and danger profile. Ask about clients' symptoms and use of medication and look for signs of mental disorders regularly.
- Keep track of changes in symptoms.
- Ask clients directly and regularly about the extent of their depression and associated suicidal thoughts.

Status of Psychiatric Symptoms

SUD counselors should monitor changes in severity and number of psychiatric symptoms over time. For example, most clients present for SUD treatment with anxiety or depressive symptoms. Such symptoms are substance induced (see Chapter 4) if they occur within 30 days of intoxication or withdrawal.

Substance-induced symptoms tend to follow the principle of "what goes up, must come down," and vice versa. Clients who have just ended a binge on stimulants will seem tired and depressed (clients using methamphetamines may present with psychotic symptoms that require medication). Conversely, those who recently stopped taking depressants (e.g., alcohol, opioids) will likely seem agitated and anxious. These substance-induced symptoms result from substance withdrawal and usually persist for days or weeks. Substance-related depression may follow (which can be seen as a neurotransmitter depletion state) and may begin to improve within a few weeks. If depressive or other symptoms persist, then a co-occurring (additional) mental disorder is likely, and a differential diagnostic process should ensue. Such symptoms may be appropriate targets for establishing a diagnosis or determining treatment choices.

SUD treatment providers can use various tools to help monitor psychiatric symptoms. Some tools consist only of questions and require no formal instrument. For example, to gauge the status of depression quickly, providers can ask a client: "On a scale of 0 to 10, with 0 being your best day and 10 your worst, how depressed are you?" This simple scale, used from session to session, can provide much useful information. SUD treatment providers should also monitor adherence to prescribed medication by asking clients regularly for information about their use of these medications and their effects.

To identify changes, providers should track psychiatric symptoms clients mention at the outset of treatment from week to week. For example, one may ask, "Last week you mentioned low appetite, sleeplessness, and feeling hopeless—are these symptoms better or worse now?" Providers should also ascertain whether clients follow their suggestions to alleviate symptoms, and if so, with what result.

Chapter 3 and Appendix C also address screening and assessment tools for mental disorders and SUDs.

Potential for Harm to Self or Others

According to the Centers for Disease Control and Prevention (2018), 46 percent of people who die by suicide have a known mental health issue; 28 percent have problematic substance

use. Individuals with CODs are at increased risk of self-harm (e.g., cutting, suicide attempt) or harm to others compared with people who do not have CODs (Carra et al., 2014; Haviland, Banta, Sonne, & Przekop, 2016; Tiet & Schutte, 2012).

Providers should always ask explicitly about suicide or the intention to harm someone else when client assessment indicates that either is an issue. For clients who mention or seem to be experiencing depression or sadness, explore the extent to which suicidal thinking is present. (To learn about duty to warn laws in each state, see "Resource Alert: Federal and State Mental Health Privacy and Confidentiality Regulations" in the previous section of this chapter.)

Follow-up services for clients who screen positive for suicide risk or have tried to commit suicide or other self-injurious behaviors may effectively prevent future harmful behaviors (including completed suicides), but more research in this area is needed (Brown & Green, 2014). Follow-up services can include:

- Conducting a full suicide risk assessment (see Chapter 3).
- Contacting the client (e.g., sending letters or postcards) to express care and concern.
- Scheduling follow-up appointments in person or by phone to discuss the treatment plan.
- Making home visits (as appropriate).
- Administering follow-up psychiatric and suicide risk assessments throughout the course of care.

Chapter 4 covers general approaches to preventing suicide and managing clients who have tried to commit suicide or are at risk for self-harm. Instructions on screening for risk of harm to self or others appear in Chapter 3 and Appendix C.

Use Supportive and Empathic Counseling

A supportive and empathic counseling style is one of the keys to establishing an effective therapeutic alliance with clients who have CODs. According to Lockwood, empathy is "the ability to vicariously experience and to understand the affect of other people"; it is the foundation adults use for relating to and interacting with other adults (Lockwood, 2016, p. 256).

ADVICE TO THE COUNSELOR: USING AN EMPATHIC STYLE

Empathy is a key skill for the SUD counselor, without which little could be accomplished. Bell (2018, p. 111) notes that "it is the job of counselor educators and supervisors to instill and nourish the trait of empathy, while building skills that relay empathy to the client." An empathic style is one that:

- Involves taking the client's perspective and trying to see life from his or her worldview.
- Tries to connect with clients who are difficult or are engaging in behaviors the counselor disagrees with or cannot otherwise relate to (e.g., misusing substances, breaking the law).
- Is mindful, compassionate, and warm rather than judgmental and accusatory.
- Is focused on listening to—rather than talking at—the client.
- Includes nonverbal communication (e.g., open body positioning, direct eye contact, nodding along).
- Conveys reflective listening via techniques like repetition and parroting, using verbal cues like "I see" or "Tell me more about that," and paraphrasing content and feelings ("So, you're saying that he left, and then you decided to go to the bar. Do I have that right?" or "I hear that you were extremely angry about that").
- Demonstrates comfort by expressing sympathy, consolation, and reflexive reassurance (i.e., phrasing designed to alleviate anxiety and worry without promising a certain outcome—such as saying, "Just give it your best shot, and let's see how things play out" instead of saying, "Everything will be just fine").

See also Treatment Improvement Protocol (TIP) 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment* (SAMHSA, 2019c).

Sources: Bell (2018); Kelley & Kelley (2013).

In empathic counseling, providers model behaviors that can help clients build more productive relationships. Providers' empathy helps clients begin to recognize and own their feelings, which is an essential step toward managing them. In learning to recognize and manage their own feelings, clients will also learn to empathize with the feelings of others.

Empathic counseling must be consistent over time to keep the alliance intact, especially for clients with CODs. Clients with CODs often have lower motivation to address mental illness or substance misuse, find it harder to understand and relate to others, and need strong support and understanding to make major lifestyle changes such as adopting abstinence. Support and empathy from providers can help maintain the therapeutic alliance, increase client motivation, and assist with medication adherence.

Confrontation and Empathy

Historically, addiction research defined confrontation as an aggressive, argumentative communication tactic to pressure people who misused substances into treatment. Confrontation has more recently come to be seen as a supportive, honest approach to warning or advising at-risk individuals about harmful behaviors (Polcin, Galloway, Bond, Korcha, & Greenfield, 2010; Polcin, Mulia, & Laura, 2012).

SUD treatment providers often feel tension between offering clients empathic support and addressing clients' potential minimization, evasion, dishonesty, and denial. However, providers can be empathic and firm at once. Straightforward, factual presentation of conflicting material or problematic behavior in an inquisitive, caring manner can be confrontational yet supportive. **Achieving a balance of empathy and firmness is critical for providers to maintain therapeutic alliances with clients who have CODs.**

Structure and Support

Clients with CODs benefit from a careful balance of structured versus free time. Free time is both a trigger for substance use cravings and a negative influence for many individuals with mental disorders. Thus, management of free time is of particular concern for clients with CODs. Clients with CODs need strategies to better manage their free time, such as by structuring one's day to include meaningful activities and to avoid activities that are risky. Providers can help clients plan their free time (especially weekends) to introduce new pleasurable activities that may alleviate symptoms and offer satisfaction through means other than substance use. Other activities that can help structure clients' time are working on vocational and relationship matters in treatment.

In addition to structure, clients' daily activities need to have opportunities for receiving support and encouragement. Counselors should work with clients to create a healthy support system of friends, family, and activities.

Mutual support is a key tool providers can introduce to clients with CODs. Dual recovery mutual supports are increasingly available in most large communities. Providers play an important role in helping clients with CODs access and benefit from such resources. (Chapter 7 has more information on mutual-support approaches for people with CODs.) If groups for clients who do not speak English are unavailable locally, providers can seek resources in nearby communities or, if the number of clients in need warrants, organize a group for those who speak the same non-English language.

A provider can assist a client with CODs in accessing mutual support by:

- **Helping the client locate an appropriate group.** The provider should be aware of available local mutual-support programs and dual recovery mutual-support groups, especially those that are friendly to clients with CODs, have other members with CODs, or are designed specifically for people with CODs. The provider can gain awareness by visiting groups to see how they are conducted, discussing groups with colleagues, updating personal lists of groups periodically, and gathering information from clients. The provider should ensure that the group selected is a good fit for the client in terms of its members' ages, genders, and cultural characteristics. Some communities offer alternatives to

CASE STUDY: HELPING A CLIENT FIND A SPONSOR

Linda, a 24-year-old woman, had attended her mutual-support group for about 3 months. Although she knew she should ask someone to sponsor her, she was shy and afraid of rejection. She had identified a few women who might be good sponsors, but each week in counseling, she stated that she was afraid to reach out. No one had approached her about sponsorship either, although the group members seemed "friendly enough." The counselor suggested that Linda share, in the next group meeting, that she'd like a sponsor but has been feeling shy and hadn't wanted to be rejected. The counselor and Linda role-played this act of sharing during a counseling session. The counselor reminded Linda that it was okay to feel afraid and reassured her that, if she couldn't share at the next meeting, they would talk about what had stopped her.

After the next meeting, Linda related that she almost shared but got scared at the last minute. She felt bad that she had missed an opportunity. She and the counselor talked about getting it over with, and Linda resolved to reach out, starting her sharing statement with, "It's hard for me to talk in public, but I want to work this program, so I'm telling you all that I know it's time to get a sponsor." This counseling work helped Linda convey her need to the group. The response from group members was helpful to Linda, as several women offered to meet with her and talk about sponsorship. This experience also helped Linda become more attached to the group and learn a new skill for seeking help. Although Linda was helped through counseling strategies alone, others who are anxious in social settings may need medications in addition to counseling.

mutual-support groups, such as Secular Organizations for Sobriety.

- **Helping the client prepare to participate appropriately in the group.** Some clients, particularly those with SMI or anxiety about group participation, benefit when providers offer an explanation of the group process in advance. The provider should inform the client of the structure of a meeting, expectations of sharing, and how to participate. The client may need to rehearse the kinds of things that are and are not appropriate to share at such meetings. The provider should also teach the client how to politely decline to participate and when this would be appropriate. The counselor should be familiar enough with group function and dynamics to walk the client through the meeting process before attending.
- **Helping overcome barriers to group participation.** The provider should be aware of the genuine difficulties the client may have in connecting with a group. Although clients with CODs, like any clients, may have some ambivalence about change, they also may have legitimate barriers they cannot remove on their own. For example, a client with cognitive difficulties may need help working out how he or she can physically get to the meeting. The provider may need to write down detailed instructions for this client that another would not need (e.g., "Catch the number 9 bus on the other side of the street from the treatment center, get off at Main Street, and walk 3 blocks to the left to the white church. Walk in at the basement entrance and go to Room 5.")
- **Debriefing the client after he or she has attended a mutual-support group to help process reactions and prepare for future attendance.** The provider's work does not end with referral to a mutual-support group. The provider must be prepared to help the client overcome any obstacles after attending the first group to ensure engagement. Often, this involves a discussion of the client's reaction to the group and a clarification of how he or she can participate in future groups.

Use Culturally Appropriate Methods

Research is lacking on the ethnic/racial diversity of populations with CODs. Limited published studies suggest that **although CODs are more frequently observed among Whites, non-White Americans also experience CODs.** A report (Mericle, Ta Park, Holck, & Arria, 2012) estimated lifetime prevalence of CODs at 5.8 percent among Latinos, 5.4 percent among African Americans, and 2.1 percent among Asians. Whites, by comparison, had a lifetime prevalence of 8.2 percent.

Notable gaps exist in the rates of behavioral health service access, utilization, and completion among diverse racial and ethnic groups compared with Whites (Cook, Trinh, Li, Hou, & Progovac, 2017; Holden et al., 2014; Maura & Weisman de Mamani, 2017; Nam, Matejkowski, & Lee, 2017; Saloner & Le Cook, 2013; Sanchez, Ybarra, Chapa, & Martinez, 2016). This is attributable to multiple factors such as underassessment, underdiagnosis, and underreferral (Priester et al., 2016) as well as cultural barriers like language differences, fear of stigma, and shame (Holden et al., 2014; Keen, Whitehead, Clifford, Rose, & Latimer, 2014; Masson et al., 2013; Maura & Weisman de Mamani, 2017; Pinedo, Zemore, & Rogers, 2018). Culturally responsive care and cultural competence training among behavioral health staff are needed to help break down barriers to service access and improve treatment outcomes for diverse populations with CODs.

Understanding Clients' Cultural Backgrounds

Population shifts are resulting in increasing numbers of diverse racial and ethnic groups in the United States (Colby & Ortman, 2014). Each geographic area has its own cultural mix. **To provide effective COD treatment to people of various cultural groups, providers should learn as much as possible about characteristics of their clients' cultural groups.**

Of particular importance are culturally based conventions of social interaction, styles of interpersonal communication, concepts of healing, views of mental illness, and perceptions of substance use. For example, some cultures may tend to somaticize symptoms of mental disorders, and clients from such groups may expect treatment providers to offer relief for physical complaints. These clients may be offended by too many probing, personal questions early in treatment and never return.

Similarly, COD treatment providers need to understand culturally based concepts of and expectations surrounding families. Providers should learn each client's role in the family and its cultural significance (e.g., expectations of the oldest son, a daughter's responsibilities to her parents, the role of a grandmother as matriarch).

Providers should not make assumptions about clients based on their perception of the clients' culture. An individual client's level of acculturation and specific experiences may result in that person identifying with the dominant culture or other cultures. For example, a person from India adopted by African American parents at an early age may know little about the cultural practices in his birth country. A provider working with this client would need to acknowledge the birth country and explore the client's associations with it as well as what those associations might mean. The client's country of origin may have little influence on his cultural beliefs or practices.

Chapter 6 of this TIP further discusses culture-related topics in COD treatment, including how counselors can reduce racial/ethnic disparities and use culturally adapted services. For more information about cultural competence in general behavioral health services, see TIP 59, *Improving Cultural Competence* (SAMHSA, 2014a), which is available free of charge online (https://store.samhsa.gov/system/files/sma14-4849.pdf).

Using Motivational Enhancement Consistent With Clients' Specific Stage of Change

Motivational interviewing (MI) is a client-centered approach that enhances clients' internal motivation to change by exploring and resolving ambivalence (Miller & Rollnick, 2013). MI involves accepting a client's level of motivation, whatever it is, as the only possible starting point for change. For example, if a client says she has no interest in changing the amount or frequency of her drinking, but is interested in complying with an SUD assessment to be eligible for something else (such as the right to return to work or a housing voucher), the SUD treatment provider would avoid arguing with or confronting her. Instead, the provider would focus on establishing a positive rapport with the client—even remarking on the positive aspects of the client's desire to return to work or take care of herself by obtaining housing. The provider would work with available openings to probe the areas in which the client does have motivation to change in hopes of eventually affecting the client's drinking or drug use.

For an indepth discussion of MI and how to apply its principles to stages of change in clients with SUD, see TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment* (SAMHSA, 2019c).

Guiding Processes of MI

Four overlapping processes guide the practice of MI (Miller & Rollnick, 2013).

1. **Engaging:** The counselor uses strategies to establish rapport and help build a trustful relationship with the client. Techniques include asking open- rather than close-ended questions, using reflective listening, summarizing statements from the client, and determining his or her readiness to change.
2. **Focusing:** The counselor helps direct the conversation and process as a whole through agenda setting and identifying a target behavior of change.
3. **Evoking:** The counselor helps clients express their motivations or reasons for change. Use of change talk (expressing a desire to change) is core to this process and helps clients recognize how their substance use is affecting their lives. It helps clients recognize and respond to sustain talk (expressing a desire not to change), which creates ambivalence and should be minimized. Use of open-ended questions and reflective listening by the counselor will facilitate this process.
4. **Planning:** The counselor collaborates with the client to develop a plan for change. The plan is critical for putting ideas about and reasons for change into action. The counselor works with clients to identify a specific change goal (like reducing the number of drinks per day), explore possible strategies that will lead to the change, create steps to make the change, and problem-solve possible obstacles to achieving lasting behavior change.

The details of these strategies and techniques are presented in TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment* (SAMHSA, 2019c) and in Miller and Rollnick's manual, *Motivational Interviewing: Helping People Change* (2013).

Matching Motivational Strategies to Clients' Stage of Change

The motivational strategies providers use should be consistent with their clients' stage of change (i.e., precontemplation, contemplation, preparation, action, maintenance, termination). A client with CODs could be at one stage of recovery or change for his or her mental disorder and another for his or her SUD, which can complicate selection of strategies. Furthermore, a client may be at one stage of change for one substance and another stage of change for another substance. For example, a client who has combined alcohol and cocaine use disorders with co-occurring panic disorder may be in the contemplation stage (i.e., aware that a problem exists and considering overcoming it, but not committed to taking action) in regard to alcohol use, precontemplation (i.e., unaware that a problem exists, with no intention of changing behavior) in regard to cocaine use, and action (i.e., actively modifying behavior, experiences, or environment to overcome the problem) for the panic disorder.

Evaluating clients' motivational state is an ongoing process. Court mandates, rules for clients engaged in group therapy, the treatment agency's operating restrictions, and other factors may act as barriers to implementing specific MI strategies in particular situations.

MI and CODs

MI has been shown to be effective or efficacious in improving behavior change—such as treatment engagement, attendance, and resistance—as well as enhancing motivation and confidence in people with mental or substance misuse problems, including comorbid conditions (Baker, Thornton, Hiles, Hides, & Lubman, 2012; Keeley et al., 2016; Laakso, 2012; Romano & Peters, 2015). MI also appears to be effective in helping clients with SUD reduce substance misuse and associated behaviors and consequences (DiClemente, Corno, Graydon, Wiprovnick, & Knoblach, 2017). For instance, a review of studies on COD interventions for people involved in the criminal justice system found MI helpful in reducing self-reported substance misuse (Perry et al., 2015). In a sample of people with PTSD seeking SUD treatment (Coffey et al., 2016), trauma-focused motivational enhancement therapy was associated

with significantly greater reductions in PTSD symptoms versus a control condition (12 sessions of healthy lifestyle education). At 6 months after treatment, just 6 percent of participants in the motivational enhancement therapy group had a positive urine drug screen for at least one illicit substance, compared with almost 13 percent in the healthy lifestyle control group.

Motivational strategies may be helpful with people who have SMI, but more research is needed. A 3-week MI intervention yielded improvements in medication adherence, self-efficacy, and motivation to change among clients receiving outpatient treatment for bipolar disorder (McKenzie & Chang, 2015). Results concerning MI and improved adherence to pharmacotherapy for clients with schizophrenia are generally negative, but some research suggests that MI reduces psychotic symptoms and hospitalization rates (Vanderwaal, 2015). A meta-analysis of MI plus cognitive–behavioral therapy (CBT) as an adjunct to or replacement for treatment as usual for co-occurring AUD and depression (Riper et al., 2014) found small but positive effects in decreasing alcohol consumption and improving depressive symptoms.

Although more research is warranted, it appears that MI strategies may be applied successfully to the treatment of clients with CODs, especially in:

- Assessing clients' perceptions of their problems.
- Exploring clients' understanding of their disorders.
- Examining clients' desire for continued treatment.
- Ensuring client attendance at initial sessions.
- Expanding clients' willingness to take responsibility for change.

Teaching Relapse Prevention Techniques

SAMHSA (2011) considers relapse prevention a critical component of integrated programming for effective COD treatment. The long-term course of comorbid mental illness and addiction is often marked by (sometimes multiple) instances of relapse and remission (Luciano, Bryan, et al., 2014; Xie, Drake, McHugo, Xie, & Mohandas, 2010). Per the National Institute on Drug Abuse (NIDA), relapse is "a return to drug use after an attempt to stop" (NIDA, 2018c). Others define relapse as "a setback that occurs during the behavior change process, such that progress toward the initiation or maintenance of a behavior change goal (e.g., abstinence from drug use) is interrupted by a reversion to the target behavior" (Hendershot, Witkiewitz, George, & Marlatt, 2011, p. 2).

> In relapse prevention, providers recognize that lapses (single episodes or brief returns to substance use) are an expected part of overcoming SUDs. Lapses do not signal failure or loss of all treatment progress.

A variety of SUD relapse prevention models are described in the literature (Hendershot et al., 2011; Melemis, 2015). However, **all relapse prevention approaches include anticipating problems likely to arise in maintaining change, acknowledging them as high-risk situations for resumed substance use, and helping clients develop strategies to cope with those situations without having a lapse.**

To prevent relapse, providers and clients must understand the types of triggers and cues that precede it. These warning signs precede exposure to events, environments, or internal processes (high-risk situations) where or when resumed substance use is likely. A lapse may occur in response to these high-risk situations unless the client is able to implement effective coping strategies quickly and adequately.

For clients with CODs who require medication to manage disruptive or disorganizing mental disorder symptoms, providers must address lapses in medication regimen adherence. In these cases, a "lapse" is defined as not taking prescribed medication. This type of lapse is different from lapses that involve returns to substance misuse for self-medication or pleasure seeking.

Counseling for relapse prevention can occur individually or in small groups, and may include practice or role-play to help clients learn how to cope effectively with high-risk situations. Relapse prevention approaches have many common elements (Daley & Marlatt, 1992) that highlight the need for clients to:

1. Have a range of cognitive and behavioral coping strategies to handle high-risk situations and relapse warning signs.

2. Make lifestyle changes that decrease the need for alcohol, drugs, or tobacco.
3. Increase healthy activities.
4. Be prepared to interrupt lapses so that they do not end in full-blown relapse.
5. Resume or continue to practice relapse prevention skills even when a full-blown relapse does occur by renewing their commitment to abstinence rather than giving up the goal of living a drug-free life.

NIDA (2018) includes relapse prevention therapy (RPT) in its list of effective SUD treatment approaches. RPT helps people maintain health behavior changes by teaching them to anticipate and cope with relapse. RPT strategies fall into five categories (Marlatt, 1985):

- **Assessment procedures** help clients appreciate the nature of their problems in objective terms, to measure motivation for change, and to identify risk factors that increase the probability of relapse.
- **Insight/awareness-raising techniques** help clients adjust their beliefs about the behavior change process (e.g., viewing it as a learning process). Via self-monitoring, RPT also helps clients identify patterns of emotion, thought, and behavior related to SUDs and co-occurring mental disorders.
- **Coping-skills training** strategies teach clients behavioral and cognitive strategies to avoid relapse.
- **Cognitive strategies** help clients manage urges and craving, identify early warning signals of relapse, and reframe reactions to an initial lapse.
- **Lifestyle modifications** (e.g., meditation, exercise) strengthen clients' overall coping capacity.

The goal of RPT is to teach clients to recognize increasing relapse risk and to intervene at earlier points in the relapse process. Thus, RPT fosters client progress toward maintaining abstinence and living a life in which lapses occur less often and are less severe. RPT frames a lapse as a "fork in the road," or a crisis. Each lapse has elements of danger (progression to full-blown relapse) and opportunity (reduced relapse risk in the future because of the lessons learned from debriefing the lapse).

RPT encourages clients to create a balanced lifestyle that will help them manage their CODs more effectively and fulfill their needs without using substances to cope with life's demands and opportunities. In delivering RPT, providers can:

- Explore with clients the positive and negative consequences of continued substance use ("decisional balance," as discussed in the motivational interviewing section of this chapter).
- Help clients recognize high-risk situations for returning to substance use.
- Teach clients skills to avoid high-risk situations or cope effectively with them.
- Develop a relapse emergency plan for damage control to limit lapse duration/severity.
- Support clients in learning how to identify and cope with substance-related urges and cravings.

Empirical Evidence Supporting Use of RPT in COD Treatment

Much of the empirical literature on RPT addresses its application in SUD treatment. In this context, RPT has demonstrated strong and consistent efficacy versus no treatment and similar efficacy to other active treatments on outcomes like reduced relapse risk and severity, increased treatment gains, and greater use of treatment matching (Bowen et al., 2014; Hendershot et al., 2011). **Research also supports RPT for enhancing substance use outcomes among people with CODs.**

In treating people with bipolar disorder and AUD (Farren, Hill, & Weiss, 2012), integrated group therapy focused on relapse prevention strategies was associated with greater abstinence, fewer days of substance misuse, and fewer days of alcohol use to intoxication than controls/treatment as usual. RPT with prolonged exposure therapy is linked to marked improvement in client- and provider-reported SUD and PTSD symptom severity and past-week substance use (Ruglass et al., 2017).

RPT Adaptations for Clients With CODs

RPT adaptations for clients with CODs should address their full range of symptoms and circumstances. Adapted RPT should support adherence to treatment (including medication

adherence—particularly critical for people with psychotic or bipolar disorders), improve social functioning, and help clients meet basic living needs (e.g., finding housing, gaining stable employment). The aspects of RPT most useful for improving recovery from CODs (Subodh, Sharma, & Shah, 2018; Weiss & Connery, 2011) include:

- Encouraging abstinence.
- Promoting adherence to mood-stabilizing medication.
- Supporting habits associated with stable mood, like good sleep hygiene.
- Promoting recovery by teaching clients strategies for:
  - Avoiding, recognizing, and responding to high-risk situations that are likely to exacerbate substance- or mood-related symptoms and problems.
  - Using substance-refusal skills.
- Addressing multiple areas of functioning, including interpersonal functioning.
- Using family-focused interventions, especially for clients who have demonstrated difficulty with adhering to treatment/medication or who have problems with cognition or insight.
- Facilitating engagement in mutual-support groups.

In a small qualitative analysis of men with CODs (Luciano, Bryan, et al., 2014), client-reported relapse prevention strategies deemed helpful for maintaining at least 1 year of sobriety included:

- Building a supportive community, including peers in treatment.
- Establishing a meaningful daily routine (e.g., going to work, attending school, exercising).
- Adopting a healthy mindset that helped individuals stay mindful of cravings and other symptoms, develop insight about the relationship between substance use and mental illness, and maintain a sense of responsibility (to themselves and to others) to live a life of recovery.

RPT-based SUD interventions with integrated components to address PTSD are supported by a growing number of studies, reflecting the field's recognition that trauma commonly co-occurs with addiction (Swopes, Davis, & Scholl, 2017; Vrana, Killeen, Brant, Mastrogiovanni, & Baker, 2017; Vujanovic, Smith, Green, Lane, & Schmitz, 2018). In just one example of trauma-informed RPT adaptations to address CODs, Vallejo and Amaro (2009) adapted a mindfulness-based stress reduction program for relapse prevention among women with SUDs and trauma/PTSD to better address trauma sensitivity and risk of relapse. Modifications included:

- Centrally focusing on stress management as a key skill in preventing relapse.
- Using shorter and more structured sessions.
- Altering body scan activities during mindfulness exercises to reduce anxiety and promote feelings of safety (e.g., having participants perform body scans with eyes open rather than

ADVICE TO THE COUNSELOR: USING RELAPSE PREVENTION METHODS IN COD TREATMENT

The consensus panel recommends using the following relapse prevention methods with clients who have CODs:

- Provide relapse prevention education on both mental disorders and SUDs and their interrelations.
- Teach clients skills to resist pressure to stop psychotropic medication and to increase medication adherence.
- Encourage attendance at dual recovery groups and teach social skills necessary for participation.
- Use daily inventory to monitor psychiatric symptoms and symptom changes.

If relapse occurs, use it as a learning experience to investigate triggers with the client. Reframe the relapse as an opportunity for self-knowledge and a step toward ultimate success.

closed; avoiding a detailed focus on scanning parts of the body that could be triggering or retraumatizing, like the pelvic area).
- Using a more flexible curriculum that emphasized early identification of warning signs of relapse.
- Having counselors available to work with clients on uncomfortable feelings that arose in sessions.
- PTSD-related adaptations may be particularly important when providing RPT for women, in whom trauma-related symptoms have been shown to predict returns to substance use (Heffner, Blom, & Anthenelli, 2011).

Integrated Treatment

RPT and other CBT approaches to mental health counseling and SUD treatment allow providers to treat CODs in an integrated way by:

1. Conducting a detailed functional analysis of the relationships between substance use, mental disorder symptoms, and any reported criminal conduct.
2. Evaluating unique and common high-risk factors for each problem and gauging how they interrelate.
3. Assessing cognitive and behavioral coping skills deficits.
4. Implementing cognitive and behavioral coping skills training tailored to the specific needs of each client with respect to substance use, symptoms of mental disorder, and criminal conduct.

Chapter 7 further discusses integrated treatments and their outcomes for clients with CODs.

Use Repetition and Skill Building To Address Deficits in Functioning

In applying the approaches described previously, **providers should keep in mind that clients with CODs often have cognitive limitations, including difficulty concentrating.** Sometimes, these limitations are transient and improve during the first several weeks of treatment. Other times, symptoms persist for long periods. In some cases, individuals with specific disorders (e.g., schizophrenia, attention deficit hyperactivity disorder) may manifest these symptoms as part of their disorder.

General treatment strategies to address cognitive limitations in clients with CODs include:

- Being more concrete and less abstract in communicating ideas.
- Using simpler concepts.
- Having briefer discussions.
- Repeating core concepts many times.
- Presenting information in multiple formats (verbally; visually; affectively through stories, music, and experiential activities).
- Using role-playing to practice real-life situations with clients who have cognitive limitations (e.g., having a client practice "asking for help" by phone using a prepared script individually with the counselor, or in a group to obtain feedback from the members).

Compared with individuals who have no additional disorders or disabilities, people with CODs and additional deficits require more SUD treatment to attain and maintain abstinence. Abstinence requires clients to develop and use a set of SUD recovery skills. Clients with co-occurring mental disorders face additional challenges that require learning yet more diverse skills. They also may require more support that provides treatment in smaller steps with more practice, rehearsal, and repetition. **The challenge is not to provide more intensive or complicated treatment for clients**

CASE STUDY: USING REPETITION AND SKILL BUILDING WITH A CLIENT WHO HAS CODs

In individual counseling sessions with Susan, a 34-year-old White woman with bipolar disorder and AUD, the counselor observes that she frequently forgets details of her recent past, including discussions and decisions made in recent counseling sessions. Conclusions the counselor thought were clear in one session seem fuzzy by the next. The counselor adjusts course, starting sessions with a brief review of the last session. The counselor allows time at the end of each session for a review. Susan has difficulty remembering appointment times and other responsibilities, so the counselor also helps her devise a system of reminders.

with CODs, but rather to tailor the skill acquisition process to the needs and abilities of each client.

Guidance for Working With Clients Who Have Specific Co-Occurring Mental Disorders

Clients with certain mental disorders may have specific treatment needs and do best with particular counseling approaches tailored to their diagnosis and levels of functioning. This is especially true for mental disorders known to be highly disabling, distressing, longstanding, or difficult to treat—such as depression, anxiety, PTSD, and SMI. These mental disorders are also the most likely to co-occur with substance misuse. This section of Chapter 5 offers guidance for SUD treatment, mental health service, and other providers on how best to deliver SUD treatment and build rapport with clients who have these disorders. Chapter 4 covers diagnosis and management of the specific mental disorders discussed.

MDD

Depression commonly co-occurs with SUDs (Lai et al., 2015), and each can exacerbate the other. To optimize treatment outcomes, counselors working with clients who have an SUD and MDD should:

- **Use integrated CBT treatment approaches.** Review studies and meta-analyses confirm CBT's effectiveness in improving symptoms and decreasing substance misuse among people with depression and SUDs, particularly when integrated with additional treatment strategies such as RPT or MI (Baker et al., 2012; Riper et al., 2014; Vujanovic et al., 2017). CBT treatment elements most helpful for clients with depression and SUDs include (Vujanovic et al., 2017):
  - Functional analysis of situations in which substance use is likely to occur and of situations associated with depressive symptoms.
  - Cognitive training to identify and reframe maladaptive thoughts associated with increased substance use as well as with negative mood.
  - Behavioral skills to address craving, coping with stressful situations, and improving mood.
- **Incorporate behavioral activation (BA) techniques into CBT treatment.** BA techniques are often used in CBT to help clients improve their mood by reengaging in pleasant and rewarding behaviors. BA supports clients in identifying rewarding activities and goals, barriers to engaging in those activities (e.g., avoidance triggers), and solutions for reducing avoidance. Research on BA for depression and SUDs is still growing, but early evidence suggests that CBT with BA is feasible and efficacious in reducing negative mood, increasing activation of pleasant behaviors, and improving treatment retention (Daughters, Magidson, Lejuez, & Chen, 2016; Martínez-Vispo, Martínez, López-Durán, Fernández del Río, & Becoña, 2018; Vujanovic et al., 2017).
- **Remain vigilant for double depression.** Not all clients with depression and SUDs will meet criteria for MDD, but they may still have distressing, impairing depressive symptoms that would benefit from treatment. Counselors need to look for clients with "double depression," or the occurrence of persistent depressive disorder and intermittent major depressive episodes. In a sample of clients seeking SUD treatment, 14 percent had double depression (Diaz, Horton, & Weiner, 2012) and reported higher levels of alcohol dependence and lower quality of life than participants with dysthymia only or MDD only.
- **Perform (or give referrals for) medication evaluations.** Antidepressants can be highly effective in treating MDD, but not all clients will need medication. Evaluation by a psychiatrist can help determine whether pharmacotherapy is warranted.
- **Be mindful of the unclear temporal relationship between depression and substance misuse, as this can affect treatment planning.** Providers may be tempted to assume that a client is misusing substances to self-medicate for depression or that a client's depression is substance induced. But the relationship between substance misuse and depression is multifactorial, with more research needed to clarify those factors. Although the

self-medication hypothesis has some support, several factors affect the temporal-causal relationship between depression and substance misuse, like sociocultural factors (e.g., income-to-poverty ratio) and demographics (Lo, Cheng, & de la Rosa, 2015). Counselors should not make treatment decisions based on assumptions that alleviating depressive symptoms will reduce substance misuse or vice versa. CODs tend to be intertwined in complex ways and often require multiple trials of various approaches to treatment.

Anxiety Disorders

Despite high rates of elevated anxiety among SUD populations, research on the complex relationship between substance misuse and anxiety is still developing. The emerging picture suggests that anxiety can be a risk for substance misuse (such as through avoidance coping or self-medication) and that substance use, craving, and withdrawal can lead to increases in anxiety.

Counselors treating clients for anxiety disorders and SUDs should be mindful that:

- **Anxiety needs to be assessed early in treatment.** Anxiety is related to more severe substance dependence and is associated with higher rates of treatment dropout and posttreatment relapse (McHugh, 2015; Smith & Randall, 2012; Vorspan, Mehtelli, Dupuy, Bloch, & Lépine, 2015). Identifying clients with elevated anxiety early in SUD treatment could help providers better address risks for premature treatment termination or posttreatment relapse. Screening for elevated anxiety early in treatment can also identify clients who may require additional skills to help them manage elevated distress related to stopping or decreasing their substance use (e.g., distress associated with withdrawal, worsening of anxiety symptoms previously self-managed with drugs or alcohol).
- **The type of anxiety disorder can affect treatment engagement, participation, and retention.** For instance, individuals with elevated social anxiety may be reluctant to speak during group treatment or to share their social worries with their counselors for fear of being judged or ridiculed. This can impede their ability to participate in and benefit from group or even individual SUD treatments. Counselors should discuss with anxious clients their reasons for treatment noncompliance when relevant. Sometimes, anxious clients have difficulty adhering to treatment because of their symptoms or anxiety-related avoidance, not because of low motivation.
- **Anxiety symptoms can mimic or occur as a part of withdrawal from substances:**
  - Anxiety is a commonly reported withdrawal symptom (Craske & Stein, 2016). When clients reduce or stop using substances, their anxiety may increase as a result of withdrawal.
  - Anxiety sensitivity (fear of anxiety-related sensations) is related to premature treatment termination (Belleau et al., 2017), in part because clients with this sensitivity face additional difficulty tolerating physical symptoms of withdrawal. People may misinterpret physical symptoms of withdrawal (e.g., increased heart rate, sweating, sleep problems, irritability) as signs of a medical problem. Anxiety symptoms and anxiety sensitivity can also evolve into full-blown anxiety disorders if left untreated, making clients vulnerable for returns to substance use.
- **Integrated treatments are highly recommended:**
  - Given the worse outcomes associated with treating anxiety and SUDs in isolation, clients may benefit from an integrated approach. Given the bidirectional relationship between the two conditions, addressing both simultaneously in integrated counseling can mitigate relapse and provide a holistic approach to treatment.
  - Effective techniques include psychoeducation about the nature of anxiety (e.g., the relationship between thoughts, feelings, and behaviors; normalizing anxiety), CBT (including anxiety monitoring, thought restructuring, clarifying cognitive distortions, exposure therapy, and relaxation training), medication, motivational enhancement, mindfulness, and encouraging a healthy lifestyle (e.g., good sleep hygiene, engaging in physical activity).

PTSD

People with PTSD or histories of trauma are susceptible to substance misuse, often as a coping mechanism. People with both PTSD and SUDs tend to have worse clinical symptoms than people with either disorder alone, including a higher risk of suicide (SAMHSA, 2014b). Providers whose clients have PTSD and SUDs can improve treatment success if they:

- **Treat disorders concurrently.** Integrated, concurrent treatments are effective; clients may prefer them over sequential treatment (Banerjee & Spry, 2017; Flanagan et al., 2016; SAMHSA, 2014b). Additionally, some symptoms of PTSD may worsen during abstinence. Do not make the mistake of thinking that treating the SUD will necessarily alleviate the PTSD. Both must be treated jointly. In some instances, medication for PTSD may also be needed.
- **Help clients increase their feelings of safety at the outset of treatment** through techniques such as grounding exercises, establishing routines in treatment, discussing safety-promoting behaviors, and developing a safety plan to help the client feel confident, prepared, and in control (SAMHSA, 2014b).
- **Take steps to help prevent retraumatization of clients.** This includes being sensitive to clients' triggers (e.g., allowing a client to sit facing the door instead of with his or her back to it), sensitively addressing clients acting out in response to triggering events, listening for cues that cause reactions and behaviors, and teaching clients to identify and manage trauma-related triggers (SAMHSA, 2014b).
- **Adjust the pace, timing, and length of sessions to the needs of clients.** Do not rush clients into talking about their trauma, and stay alert for signs of clients feeling overwhelmed by the intensity or speed of the intervention (SAMHSA, 2014b). Creating safety and enhancing coping skills to manage traumatic stress reactions are key aspects of helping clients heal from trauma.
- **Recognize the cyclical relationship between trauma and substance use.** Using substances places people at greater risk for additional traumatic events. These traumas increase risks of substance misuse. Counselors need to educate clients about this to help safeguard them from harm.

Chapter 4 provides more information about trauma-informed care for people with CODs.

SMI

People with SMI and SUDs often have complex recovery trajectories with drastic shifts in symptoms and functioning, employment, housing, family life, social relationships, and physical health. Counselors working with clients who have SMI and SUDs should be aware that:

- **Although integrated treatments work for many clients with SMI and SUDs, this approach has different levels of success.** Integrated treatment for SMI and SUDs has demonstrated mixed results in the empirical literature (Chow et al., 2013; Hunt, Siegfried, Morley, Sitharthan, & Cleary, 2013). It may help improve psychiatric symptoms better than nonintegrated treatment in outpatient and residential settings and may be better at reducing alcohol consumption, but not drug use, in residential settings compared with outpatient settings. However, some studies have found no significant effects of integrated versus nonintegrated treatments. For some clients with SMI and SUDs, parallel treatment may be preferable and should not be ruled out as an option after first trying to treat concurrently.
- **Many SMI symptoms, like psychosis, apathy, and cognitive dysfunction, can undermine treatment participation and adherence.** Treatment should address (Horsfall, Cleary, Hunt, & Walter, 2009):
  - Managing positive and negative symptoms of psychosis.
  - Increasing coping skills.
  - Improving social skills, including communication with others.
  - Enhancing problem-solving abilities.
  - Building distress tolerance.
  - Increasing motivation.
  - Learning how to set and achieve goals.
  - Expanding social support networks (including peer supports).

Given these potential cognitive, social, and functional challenges, counselors may need to use sessions that are shorter, more flexible, adapted to client impairments, and lower in intensity.

- **SMI often requires medication for symptom stabilization.** Counselors should consider referring clients not currently on medication or not being followed by a psychiatrist for a medication evaluation, especially for clients who are unstable or experiencing positive psychiatric symptoms (e.g., hallucinations, delusions).
- **Clients may need assistance with basic living needs.** Securing reliable housing and gainful employment are often among the greatest stressors people with SMI experience (Horsfall et al., 2009). Vocational rehabilitation and housing assistance should be provided as a part of comprehensive COD care to help increase the chances of long-term recovery. Certain clients may also need help from counselors in connecting with the criminal justice system.
- **Encouraging abstinence may indirectly help improve psychiatric symptoms.** Stopping substance use can give clients a sense of accomplishment and self-efficacy that can fuel their confidence in being able to recover from their mental illness as well (Green, Yarborough, et al., 2015).

Conclusion

Therapeutic alliance is a critical component of counseling essential to clients' success and long-term recovery. People with CODs often face numerous difficulties in managing complex and fluctuating symptoms as well as the effects of symptoms on everyday living, including their ability to function as a productive and healthy member of society, hold down a job, maintain housing, and have fulfilling relationships. Experiences of stigma and feelings of hopelessness can contribute to clients' mistrust or low motivation to initiate, engage in, and complete treatment.

Providers working with people who have CODs should be aware of basic approaches that can support the therapeutic relationship and make interventions more effective. Although there is no one-size-fits-all approach for treating CODs, the techniques, skills, and interventions described in this chapter should help counselors contribute to the recovery process in a way that is evidence based, person centered, and maximally beneficial to clients.

Substance Use Disorder Treatment for People With Co-Occurring Disorders

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TREATMENT IMPROVEMENT PROTOCOL

TIP 42

SAMHSA
Substance Abuse and Mental Health Services Administration