

Case study: counseling a substance abuse treatment client who is suicidal

Beth M., an American-Indian woman, comes to the substance abuse treatment center complaining that drinking too much causes problems for her. She has tried to stop drinking before but always relapses. The counselor finds that she is not sleeping, has been eating poorly, and has been calling in sick to work. She spends much of the day crying and thinking

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of how alcohol, which has cost her her latest significant relationship, has ruined her life. She also has been taking painkillers for a recurring back problem, which has added to her problems. The counselor tells her about a group therapy opportunity at the center that seems right for her, tells her how to register, and makes arrangements for some individual counseling to set her on the right path. The counselor tells her she has done the

right thing by coming in for help and gives her encouragement about her ability to stop drinking.

Beth M. does not arrive for her next appointment, and when the counselor calls home, he learns from her roommate that Beth made an attempt on her life after leaving the substance abuse treatment center. She took an overdose of opioids (painkillers) and is recovering in the hospital. The emergency room staff found that Beth M. was under the influence of alcohol when she took the opioids.

Discussion: Although Beth M. provided information that showed she was depressed, the counselor did not explore the possibility of suicidal thinking. Counselors always should ask if the client has been thinking of suicide, whether or not the client mentions depression. An American-Indian client, in particular, may not answer a very direct question, or may hint at something darker without mentioning it directly. Interpreting the client's response requires sensitivity on the part of the counselor. It is important to realize that such questions do not increase the likelihood of suicide. Clients who, in fact, are contemplating suicide are more likely to feel relieved that the subject has now been brought into the light and can be addressed with help from someone who cares.

It is important to note that the client reports taking alcohol and pain medications. Alcohol impairs judgment and, like pain medications, depresses brain and body functions. The combination of substances increases the risk of suicide or accidental overdose. Readers are encouraged to think through this case and apply the assessment strategy included in the discussion of suicidality in appendix D, imagining what kind of answers the counselor might have received. Then, readers could consider interventions and referrals that would have been possible in their treatment settings.

Nicotine Dependence

In 2003 an estimated 29.8 percent of the general population aged 12 or older report current (past month) use of a tobacco product (National Survey on Drug Use and Health 2003c). The latest report of the Surgeon General on the Health Consequences of Smoking (U.S. Public Health Service Office of the Surgeon General 2004) provides a startling picture of the damage caused by tobacco. Tobacco smoking injures almost every organ in the body, causes many diseases, reduces health in general, and leads to reduced life span and death. Tobacco dependence also has serious consequences to non-

smokers through environmental tobacco smoke (secondhand smoke) and the negative effects on unborn children. Fortunately quitting smoking has immediate as well as long-term benefits (U.S. Public Health Service Office of the Surgeon General 2004).

Evidence suggests that people with mental disorders and/or dependency on other drugs are more likely to have a tobacco addiction. In fact, most people with a mental illness or another addiction are tobacco dependent—about 50 to 95 percent, depending on the subgroup (Anthony and Echeagaray-Wagner 2000; Centers for Disease Control and Prevention 2001; National Institute on Drug Abuse 1999a; Richter 2001; Stark and Campbell 1993b). Smokers with mental disorders consume nearly half of all the cigarettes sold in the United States (Lasser et al. 2000). A study of individuals doing well in recovery from alcohol dependence found that those who smoked lived 12 fewer years because of their tobacco dependence and the quality of their lives was affected by other tobacco-caused medical illnesses (Hurt et al. 1996).

There is increasing recognition of the importance of integrating tobacco dependence treatment and management into mental health services and addiction treatment settings. Although tobacco dependence treatment works for smokers with mental illness and other addictions, only recently have clinicians been given training to address this serious public health and addiction treatment concern. It is increasingly recognized that all clients deserve access to effective treatments for tobacco addiction, and that smokers and their families should be educated about the considerable risks of smoking as well as the benefits of tobacco dependence treatment. All current tobacco dependence clinical practice guidelines strongly recommend addressing tobacco during any clinical contact with smokers and suggest the use of one or more of the six Food and Drug Administration (FDA)-approved medications as first-line treatments (e.g., bupropion SR/zyban and the nicotine

patch, gum, nasal spray, inhaler, and lozenge).

Tobacco use and dependence should be assessed and documented in all clinical baseline assessments, treatment plans, and treatment efforts. A motivation-based treatment model allows for a wider range of treatment goals and interventions that match the patient's motivation to change. Like other addictions, tobacco dependence is a chronic disease that may require multiple treatment attempts for many individuals and there is a range of effective clinical interventions, including medications, patient/family education, and stage-based psychosocial treatments. Recent evidence-based treatment guidelines have been published for the management of tobacco dependence and this information can be a primary guide for addressing tobacco. Few recognize how ignoring tobacco perpetuates the stigma associated with mental illness and addiction when some ask, "Why should tobacco be addressed in mental health or addiction settings?" or "Other than increased morbidity and mortality, why should we encourage and help this group to quit?" or "What else are they going to do if they cannot smoke?"

What counselors should know about nicotine dependence

- Tobacco dependence is common in clients with other substance use disorders and mental illnesses.
- Like patients in primary care settings, clients in mental health services and addiction treatment settings should be screened for tobacco use and encouraged to quit.
- The U.S. Public Health Service Guidelines encourage the use of the "5 A's" (Ask, Advise, Assess, Assist, Arrange Followup) as an easy road map to guide clinicians to help their patients who smoke:
 - Ask about tobacco use and document in chart.

- Advise to quit in a clear, strong, and personal message.
- Assess willingness to make a quit attempt and consider motivational interventions for the lower motivated and assist those ready to quit.
- Assist in a quit attempt by providing practical counseling, setting a quit date, helping them to anticipate the challenges they will face, recommending the use of tobacco dependence treatment medications, and discussing options for psychosocial treatment, including individual, group, telephone, and Internet counseling options.
- Arrange followup to enhance motivation, support success, manage relapses, and assess medication use and the need for more intensive treatment if necessary.
- Assessment of tobacco use includes assessing the amount and type of tobacco products used (cigarettes, cigars, chew, snuff, etc.), current motivation to quit, prior quit attempts (what treatment, how long abstinent, and why relapsed), withdrawal symptoms, common triggers, social supports and barriers, and preference for treatment.
- Behavioral health professionals already have many of the skills necessary to provide tobacco dependence psychosocial interventions.
- Smokers with mental illness and/or another addiction can quit with basic tobacco dependence treatment, but may also require motivational interventions and treatment approaches that integrate medications and psychosocial treatments.
- Tobacco treatment is cost-effective, feasible, and draws on principles of addictions and co-occurring disorders treatment.
- The current U.S. Clinical Practice Guidelines indicate that all patients trying to quit smoking should use first-line pharmacotherapy, except in cases where there may be contraindications (Fiore 2000).
- Currently there are six FDA-approved treatments for tobacco dependence treatment: bupropion SR and five Nicotine Replacement Treatments (NRTs): nicotine polacrilex (gum), nicotine transdermal patch, nicotine inhaler, nicotine nasal spray, and nicotine lozenge.
- Tobacco treatment medications are effective even in the absence of psychosocial treatments, but adding psychosocial treatments to medications enhances outcomes by at least 50 percent.
- Specific coping skills should be addressed to help smokers with mental or substance use disorders to cope with cravings associated with smoking cues in treatment settings where smoking is likely to be ubiquitous.
- When clients with serious mental illnesses attempt to quit smoking, watch for changes in mental status, medication side effects, and the need to lower some psychiatric medication dosages due to tobacco smoke interaction.

Program-level changes

As with other COD, the most effective strategies to address tobacco include both enhancing clinician skills and making program and system changes. Effective steps for addressing tobacco at the treatment program level are listed in an outline in the text box on page 219. These steps have been developed at the University of Medicine and Dentistry of New Jersey Tobacco Program and used effectively to address tobacco in hundreds of mental health and addiction treatment settings (Ziedonis and Williams 2003a). The necessary steps include developing comprehensive tobacco dependence assessments; providing treatment, patient education, and continuing care planning; making self-help groups such as Nicotine Anonymous available to clients

Steps for Addressing Tobacco Within Treatment Programs

1. Acknowledge the challenge.
2. Establish a leadership group and commit to change.
3. Create a change plan and implementation timeline.
4. Start with easy system changes.
5. Assess and document in charts nicotine use, dependence, and prior treatments.
6. Incorporate tobacco issues into client education curriculum.
7. Provide medications for nicotine dependence treatment and required abstinence.
8. Conduct staff training.
9. Provide treatment and recovery assistance for interested nicotine-dependent staff.
10. Integrate motivation-based treatments throughout the system.
11. Develop addressing tobacco policies that are site specific.
12. Establish ongoing communication with 12-Step recovery groups, professional colleagues, and referral sources about system changes.

Source: Ziedonis et al. 2003.

and their families; providing nicotine dependence treatment to interested staff; and making policy changes related to tobacco. Such changes should include documentation forms in clinical charts that contain more tobacco related questions, labeling smoker's charts, not referring to breaks in the program's schedule as "smoking breaks," for bidding staff and patients to smoke together, providing patient education brochures, and providing NRT for all clients in smoke-free residential treatment settings (Ziedonis and Williams 2003a).

Case study: addressing tobacco in an individual with panic disorder and alcohol dependence

Tammy T. is a 47-year-old widow who has been treated in a substance abuse outpatient program for co-occurring alcohol dependence and panic disorder. She is about 9 months abstinent from alcohol and states that she is now ready to address her tobacco addiction. When she first entered treatment she was not ready to quit tobacco. Her substance abuse

counselor recognized her ambivalence and implemented some motivational interventions and followup on this topic over the course of the 9 months of her initial recovery. This persistence was perceived as expressing empathy and concern, and Tammy T. eventually recognized the need to quit smoking as part of a long-term recovery plan. She was now ready to set a quit date.

Tammy T. started smoking at age 17. Her only period of abstinence was during her pregnancy. She quickly resumed smoking after giving birth. She cut back from 30 cigarettes per day (1.5 packs) to 20 cigarettes per day (1 pack) in the last year but has been unable to quit completely. She lives with her brother, who also smokes. Her panic disorder is well controlled by sertraline (Zoloft), and she sees a counselor monthly and a psychiatrist four times a year for medication management. She works full time in a medical office as an office manager and must leave the building to smoke during work hours. Tammy T. drank alcohol heavily for many years, consuming up to 10 beers 3 to 5 times per week until about 1 year ago. At the advice of her physician, who initiated treatment for panic attacks, she was able to quit using alcohol

completely. She was encouraged by her success in stopping drinking, but has been discouraged about continuing to smoke.

In creating a quit plan for Tammy T., it was important for the counselor to determine what supports she has available to help her to quit. Encouraging her brother to quit at the same time was seen as a useful strategy, as it would help to remove smoking from the home environment. Tammy T. was willing to attend a 10-week group treatment intervention to get additional support, education, and assistance with quitting. Some clients may desire individual treatment that is integrated into their ongoing mental health or addiction treatment, or the use of a telephone counseling service might be explored since it is convenient and is becoming more widely available. In discussing medication options, Tammy T. indicated that she was willing to use the nicotine inhaler. Medication education enhanced compliance with the product and increased its effectiveness. She was encouraged to set a quit date and to use nicotine replacement starting at the quit date and in an adequate dose.

Tammy T. was taking sertraline for her panic disorder (a selective serotonin reuptake inhibitor [SSRI]) and therefore another medication option might be to add bupropion SR (not an SSRI) to her current medications for a period of 12 weeks, specifically to address smoking if another quit attempt is needed in the future. If she had not been successful in this attempt, it would have been important to motivate her for future quit attempts and consider increasing the dose and/or duration of the medication or psychosocial treatment. In this case the group treatment, 6 months of NRT inhaler, and eliciting her brother's agreement to refrain from smoking in the house resulted in a successful quit attempt, as well as continued success in her recovery from co-occurring panic disorder and alcohol dependence.

Personality Disorders

These are the disorders seen most commonly by addiction counselors and in quadrant II substance abuse treatment settings.

Personality disorders (PDs) are rigid, inflexible, and maladaptive behavior patterns of sufficient severity to cause internal distress or significant impairment in functioning. PDs are enduring and persistent styles of behavior and thought, rather than rare or unusual events in someone's life. Furthermore, rather than showing these thoughts and behaviors in response to a particular set of circumstances or particular stressors, people with PDs carry with them these destructive patterns of thinking, feeling, and behaving as their way of being and interacting with the world and others.

Those who have PDs tend to have difficulty forming a genuinely positive therapeutic alliance. They tend to frame reality in terms of their own needs and perceptions and not to understand the perspectives of others. Also, most clients with PDs tend to be limited in terms of their ability to receive, accept, or benefit from corrective feedback.

A further difficulty is the strong countertransference clinicians can have in working with these clients, who are adept at "pulling others' chains" in a variety of ways. Specific concerns will, however, vary according to the specific PD and other individual circumstances.

Borderline Personality Disorder

What counselors should know about substance abuse and borderline personality disorders

The essential feature of borderline personality disorder (BPD) is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, along with marked impulsivity,