Integrating MI with Dually Diagnosed Clients

Challenges & Strategies

Reference:

Challenge #1: Dually Diagnosed Need Integrated Services
- Multiple interacting behavioral targets

Strategy:
- Listen for client’s motivation to address both MH & AOD:
  - How motivations interact
- Use open ended/evocative questions:
  - Elicits discussion of interaction between disorders
  - Structured feedback, decision balance
- Elicit change re: other behavioral targets important to psychiatric recovery
  - Medication adherence, integrated DD services, housing, legal issues, benefits

Examples (pp. 281-283):
- “What effect does your drinking have on your voices?”
- “Tell me about what happens to your nerves when you smoke crack.”
- “What problems does marijuana cause you mentally?”
- “Instead of drinking and drugging, what have you done in the past that has helped you feel better?”
- “Your top priority right now is to find a place to stay. Yet you told me earlier, every time you’ve experienced trouble with housing you were using more drugs. What’s the connection there?”
  - “What could you do to make sure this doesn’t happen again?”
- Decisional Balance/Payoff Matrix of adhering to a dual diagnosis treatment program.

Other Ideas:
Challenge #2: Cognitive Impairments

- Attention, memory, language, executive reasoning
- Difficulty holding multiple aspects of problem or question in mind simultaneously

Strategy:

- Use simple, clear, and concise communication
  - Open ended questions, reflections, summaries
- Offer frequent, successive, clear reflections and summaries
  - Helps client with flow/organization of discussion
- Visual aids helpful

Examples (pp. 286-289):

- “Tell me about what you think are the main reasons for your being hospitalized.”
- Values/Affirmations Card Sort
  - “Personal Strivings” List – prompt how cutting down or quitting substance use would affect these goals.
- Decisional Balance/Payoff Matrix - simplify by:
  - Focusing only on the pros/cons of changing or reasons for changing and reasons for not changing.
  - Stack blocks in 2 piles (pros/cons). Put a block in the pro pile for each pro and one in the con pile for each con
  - Record reasons to stop using on color coded cards (red for stop).
- Record level of commitment/importance on thermometer scales.
- Use pie or bar charts to show pattern of use relative to population norms over time.
- Refer to “hot symptoms” (instead of “positive”) or “cold symptoms” (instead of “negative”)
  - Symptoms that make people feeling like they’re boiling or freezing inside

Other Ideas:
Challenge #3: Positive Symptoms

- Hallucinations, delusions, bizarre behaviors, disorganized speech

Strategy:

- Paraphrase often
  - Helps maintain reality-based, organized dialogue
- Use metaphor or simile;
  - Helps make sense of seemingly bizarre client statements
- Be cautious about exploring negative client thoughts/feelings/events
- Succinctly summarize ambivalence, then quickly begin strategies to elicit change talk
- Helps resolve ambivalence and promote change

Example (p. 292):

Clinician: What have been the negative effects of using these drugs?
Client: It’s been a mind-blowing experience of septic proportions.
Clinician: You feel that drugs have fouled up your mind.
Client: You know I can’t see college on my horizon right now.
Clinician: Your mind is not working the way it used to in part due to the drugs, and it’s hard to see going back to college right now.
Client: I can’t concentrate very well, and it’s hard to remember things. Will I be convicted when others have not?
Clinician: You wonder why this has happened to you. Others have used drugs, stopped, feel fine later, and continue to function. You aren’t sure how things will end up.
Client: (Gets up out of his chair, walks to the office door, opens and slams it, and then stands in the middle of the room looking confused.)
Clinician: You’re not sure if the door has been shut for you to return to college. You want to do what you can to open it, but you are not sure what you can do.
Client: (Looks at the clinician.) What can I do? (Sits down.)
Clinician then provides solicited feedback.

Other Ideas:
Challenge #4: Negative Symptoms

- Thought blocking, impoverished thinking, processing speed, speech, volition and drive

Strategy:

- Paraphrase frequently to stimulate discussion
- Allow adequate time for client to respond
- Affirm participation in session
- Offer personalized, structured feedback to promote discussion
  - Assessment instruments, decision balance, etc

Example (pp. 294-295):

Clinician: I appreciate you coming in to see me today. The fact that you’re here tells me you’re willing to talk about how things are going with Zyprexa.

Client: (Gazes at the floor.) Yeah.

Clinician: How are things going with Zyprexa?

Client: (Is silent for a few seconds and then speaks with little animation.) OK.

Clinician: (Pause – considers whether the patient’s flatness is purely symptomatic or implies ambivalence about taking Zyprexa.) In some ways, Zyprexa works OK, and in some ways it's not OK.

Client: It’s better. (silence)

Clinician: How is Zyprexa better for you than other medication?

Client: I think better. My body works better. (silence)

Clinician: Better.

Client: I can sit still and watch TV longer and talk in the group more.

Clinician: So taking Zyprexa has helped your mind and body work better. You’ve noticed your attention and concentration have improved, and you can talk to others more than you had been. Zyprexa also helps you feel physically more comfortable. For these reasons, and maybe others, you’ve continued to take Zyprexa longer than you’ve taken other medications. I give you lots of credit for your effort and your ability to know what medications work of you.

Other Ideas:

*When to use other interventions*

- Acute symptoms that might impair capacity to make informed decisions
- Clinicians legal/medical responsibilities take precedence; need for coercive interventions
- Rule of thumb
  - If client becomes more symptomatic as a result of MI interventions - use a different intervention
  - If client becomes more organized and reality-based - MI is appropriate
A. Client/speaker:

i. **Vignette A:** Susie is diagnosed with Schizophrenia, Alcohol Dependence and Marijuana Abuse. She is homeless and frequently stays at the local shelter. She is on probation for a disorderly conduct conviction stemming from a fight with a neighbor at her last apartment. She lost the apartment due to this incident. She hears voices frequently and drinks alcohol to reduce the severity of the voices.

ii. **Vignette B:** Allen is diagnosed with Schizoaffective Disorder, Bipolar Subtype, Cocaine Abuse, and Nicotine Dependence. He has been homeless for the past month due to losing his apartment for non-payment of rent. He is currently on probation for a possession conviction. Allen was recently referred by his psychiatrist to the IDDT team. He has been on disability for the last 10 years, but has expressed a desire to get a job.

iii. **Vignette C:** Bonnie is diagnosed with Major Depressive Disorder Severe with Psychosis, Post Traumatic Stress Disorder, Alcohol Dependence, Anxiolytic Dependence. Her three minor children are in the temporary custody of Child and Family Services due to alleged neglect. As part of her reunification plan with Child and Family Services she was referred to the IDDT team.

B. Professional (CPST, therapist, housing specialist, probation officer):

i. Your task is to maintain the role of your profession. You are meeting with this individual in the shelter (or, probation office). This is your first session with this individual. Attempt to engage the client in a discussion of their current concerns and life satisfactions.

C. Voice/Observer:

i. Your role is to talk to the client/speaker most of the time they are engaged in the role play with the professional. Stand or sit next to the client/speaker. This may be challenging, but persist for the duration of the role play. Also, be attentive to the communication between the client/speaker and professional.

ii. Suggested content may include:

- “Don’t listen to her/him. She/he doesn’t know what he is talking about”
- “You need to get out of here and get a drink, come on”
- “These people aren’t here to help you. What do they know?”