National Comorbidity Guidelines

Face-to-Face Training Program

Module 7: Psychosis, Eating Disorders and Obsessive-Compulsive Disorder

Participant Workbook

Funded by

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Delivered by

THE UNIVERSITY OF SYDNEY
Matilda Centre

360edge.

The training development team

Paula Ross, 360Edge

Nicole Lee, 360Edge

Christina Marel, the University of Sydney's Matilda Centre for Research in Mental Health and Substance Use, University of Sydney

Erin Madden, the University of Sydney's Matilda Centre for Research in Mental Health and Substance Use, University of Sydney

Katherine Mills, the University of Sydney's Matilda Centre for Research in Mental Health and Substance Use, University of Sydney

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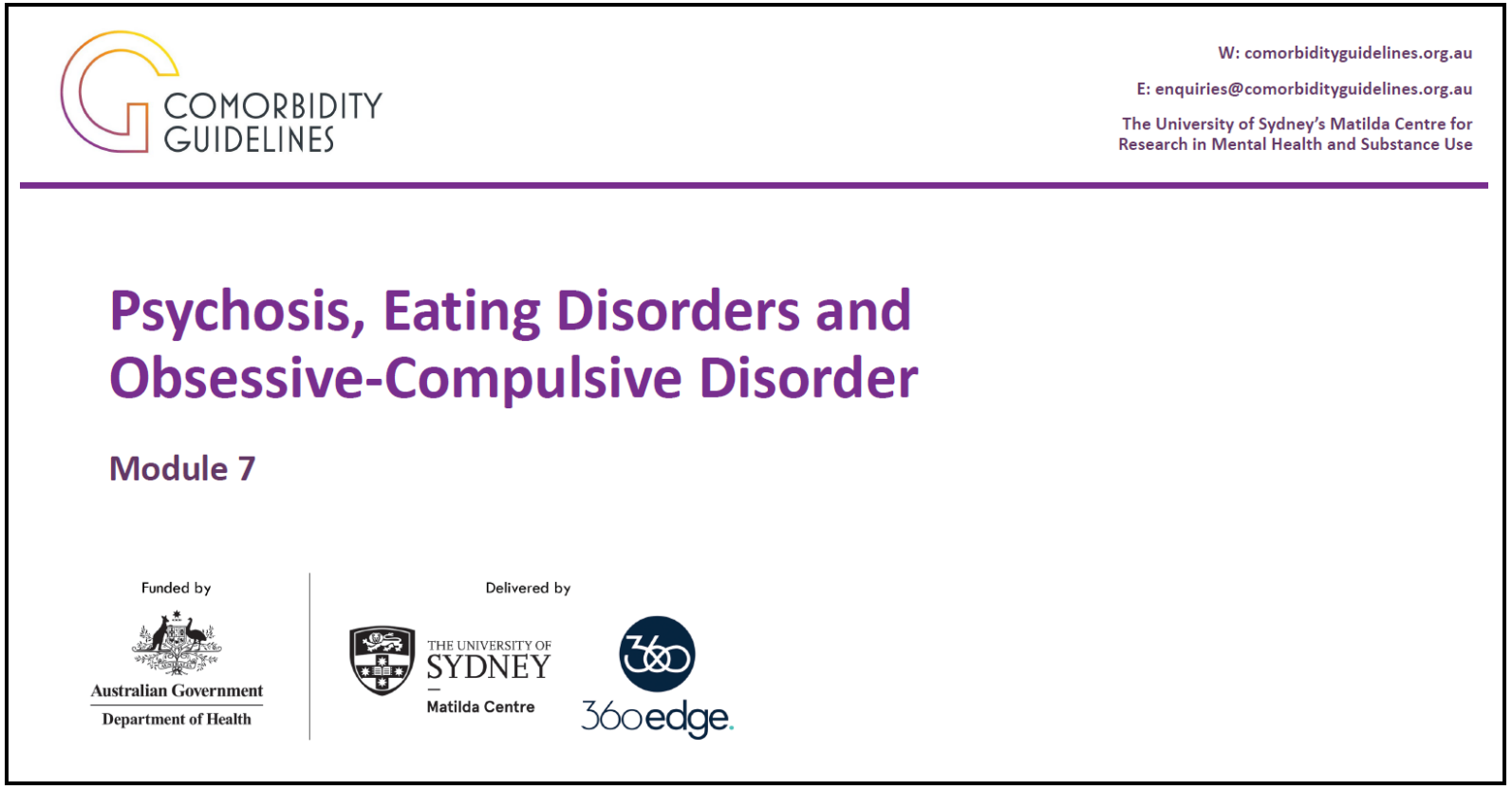
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W: comorbidityguidelines.org.au
E: enquiries@comorbidityguidelines.org.au
The University of Sydney's Matilda Centre for Research in Mental Health and Substance Use
Psychosis, Eating Disorders and Obsessive-Compulsive Disorder
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Psychosis, eating disorders and obsessive-compulsive disorder

Agenda

Understanding psychosis and psychotic disorders

Helping clients with AOD use and psychosis to manage symptoms

What treatments work for clients with AOD use and psychosis

Understanding obsessive-compulsive disorder

Helping clients with AOD use and obsessive-compulsive disorder to manage symptoms

What treatments work for clients with AOD use and obsessive-compulsive disorder

Understanding eating disorders

Helping clients with AOD use and eating disorders

What treatments work for clients with AOD use and eating disorders

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Guiding principles

Guiding principles

First, do no harm

Work within your capacity

Engage in ongoing professional development

Recognise that the management of comorbidity is part of AOD workers' core business

Provide equity of access to care

Adopt a 'no wrong door' policy

Guiding principles

Recognise that comorbidity is common and that all clients should be routinely screened for comorbid conditions

Conduct ongoing monitoring of symptoms and assessment of client outcomes

Adopt a holistic approach

Adopt a client-centred approach

Emphasise the collaborative nature of treatment

Have realistic expectations

Guiding principles

Express confidence in the effectiveness of the treatment program

Adopt a non-judgemental attitude

Adopt a non-confrontational approach to treatment

Involve families and carers in treatment

Consult and collaborate with other health care providers

Ensure continuity of care

Psychosis

NOTES

How do people with psychosis present?

Delusions	• False beliefs; persecutory, referential, grandiose, erotomanic, nihilistic, somatic, bizarre, thought withdrawal or insertion, delusions of control
Hallucinations	• False perceptions; vivid, clear, not under voluntary control, auditory most common but can be visual, taste, olfactory, sensing
Disorganised thinking/speech	• Switch between topics (derailment or loose associations), answers unrelated to questions (tangential), incoherent speech (word salad)
Disorganised or abnormal behaviour	• Unpredictable or erratic behaviour, peculiar movements or postures, agitation, problems with goal directed behaviour, catatonia
Negative symptoms	• Diminished emotional expression and avolition, mostly associated with schizophrenia

NOTES

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Sub-acute presentations

Low grade psychotic symptoms are a common presentation in AOD treatment

Associated with methamphetamine use

Agitation, sleep disturbance

Mood swings

Distorted sense of self, others, the world

Suspicious, guarded, paranoid

Odd or overvalued ideas

Low level hallucinations or illusions

Erratic behavior

NOTES

Module 7 Activity 1: Assessment of psychosis worksheet

Delusions	False beliefs; persecutory, referential, grandiose, erotomanic, nihilistic, somatic, bizarre, thought withdrawal or insertion, delusions of control
Hallucinations	False perceptions; vivid, clear, not under voluntary control, auditory most common but can be visual, taste, olfactory, sensing
Disorganised thinking/speech	Switch between topics (derailment or loose associations), answers unrelated to questions (tangential), incoherent speech (word salad)
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Module 7 Activity 1: Assessment of psychosis worksheet

1. Which of these symptoms do you routinely assess or enquire about with your clients? Make a note of the ones that you don't.

2. How might you ask about these symptoms?

_____

_____

3. What would be the benefit of this? (Case formulation? Treatment plan?)

_____

_____

A psychosis screener is available in Appendix O of the Comorbidity Guidelines.

Module 7 Activity 2: Case study Luka. Comorbid psychosis and substance use

- Luka, 25 year-old male.
- Has a five year history of methamphetamine use which he has recently cut down.
- Is very late for the appointment as couldn't 'get going' to leave the house until his mother persuaded and then drove him. Paces up and down in the waiting room. Presents with very flat affect.
- Believes neighbours are spying on him and listening through the walls at home (neighbour's house is some distance away; walls are brick).
- Reports hearing the neighbours talking about him in a derogatory manner.
- Believes his dealer is substituting other drugs for his meth as an experiment to test new drugs to develop new drug markets. Is certain about this as reports an ability to be aware of blood moving through his brain and body 'I can tell where the drugs are at any point in my body' and the current drugs 'don't move in the same way'. Describes the experience of drugs in his body and feeling them 'sticking and getting trapped' in places that he can identify.

DSM-5 psychotic disorders

Delusional disorder	• One or more delusions, symptoms longer than 1 month
Brief psychotic disorder	• Delusions, hallucinations, disorganised speech, disorgansied or catatonic behavior (1+), less than 1 month
Schizophreniform disorder	• Delusions, hallucinations, disorganised speech, disorganised or catatonic behavior, negative symptoms (2+), 1-6 months
Schizophrenia	• As above, functioning significantly reduced, more than 6 months
Schizoaffective disorder	• As above concurrent with a major mood episode (depression or manic)
Substance/medication-induced psychotic disorder	• Delusions or hallucinations, related to substance intoxication or withdrawal or medication use

There are ICD-10 codes to match these DSM-5 diagnoses found in Appendix D of the Comorbidity Guidelines

NOTES

Substance-induced psychosis

Can be difficult to distinguish from independent psychotic disorder

Likely to be substance induced if occurs in the context of intoxication or withdrawal

If persists during abstinence, started before onset of substance use or there is a family history, may be an independent mental heath condition

NOTES

Do's and don'ts of managing a client with symptoms of psychosis

- ✓ Ensure the environment is well lit to prevent perceptual ambiguities
- ✓ Ensure the discussions take place in settings where privacy, confidentiality, and dignity can be maintained
- ✓ Try to reduce noise, human traffic, or other stimulation within the person's immediate environment (e.g., reduce clutter)
- ✓ Ensure the safety of the client, yourself, and others
- ✓ Allow the person as much personal space as possible
- ✓ Be aware of your body language – keep your arms by your sides, visible to the client

Do's and don'ts of managing a client with symptoms of psychosis

- ✓ Ignore strange or embarrassing behaviour if you can, especially if it is not serious
- ✓ Listen attentively and respectfully
- ✓ Appear confident, even if you are anxious inside – this will increase the client's confidence in your ability to manage the situation
- ✓ Speak clearly and calmly, asking only one question or giving only one direction at a time
- ✓ Use a consistently even tone of voice, even if the person becomes aggressive

Do's and don'ts of managing a client with symptoms of psychosis

- ✓ Limit eye contact as this can imply a personal challenge and might prompt a hostile, protective response
- ✓ Point out the consequences of the client's behaviour. Be specific
- ✓ Ensure both you and the client can access exits – if there is only one exit, ensure that you are closest to the exit
- ✓ Have emergency alarms/mobile phones, and have crisis teams/police on speed dial
- ✓ If psychosis is severe, arrange transfer to an emergency department for assessment and treatment by calling an ambulance on 000

Do's and don'ts of managing a client with symptoms of psychosis

- ✕ Get visibly upset or angry with the client
- ✕ Confuse and increase the client's level of stress by having too many workers attempting to communicate with him/her
- ✕ Argue with the client's unusual beliefs or agree with or support unusual beliefs – it is better to simply say 'I can see you are afraid, how can I help you?'
- ✕ Use 'no' language, as it may provoke hostility and aggression. Statements like 'I'm sorry, we're not allowed to do ___ but I ***can*** offer you other help, assessment, referral…' may help to calm the client whilst retaining communication
- ✕ Use overly clinical language without clear explanations
- ✕ Crowd the client or make any sudden movements
- ✕ Leave dangerous items around that could be used as a weapon or thrown

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Asking about psychosis

Have you noticed a change in the way that you think – slower, faster, more confused?

Does anything unusual seem to be happening, or have you thought that strange things were happening around you, or to you?

Have you been worried that something bad might happen to you, or that people have turned against you in some way?

Have you noticed any new and unusual experiences – like hearing things or seeing things that others could not or when other people are not present?

headspace clinical toolkit psychosis assessment (2020)

NOTES

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Module 7 Activity 3: Asking about psychosis

- In this activity, the facilitator will roleplay Luka from Activity 2
- The facilitator will assign you to either the category of delusions or hallucinations by doing a 1,2 allocation, with 1s focusing on delusions and 2s on hallucinations
- The facilitator will ask you to reflect on how you would ask questions to identify possible symptoms of psychosis in Luka

My category is: ☐ Delusions ☐ Hallucinations

What questions would you ask Luka to identify symptoms?

_____

_____

_____

_____

Helping clients with AOD use and psychosis to manage their symptoms - psychosocial treatments

AOD treatment as usual if psychotic disorder is well maintained

No clear support for any one psychosocial treatment

Some support for:

- MI for improving AOD use
- MI/CBT for improvements in AOD and mental state (mixed results)
- Integrated MI/CBT with case management, family counselling, housing support, vocational rehabilitation and medication

Contingency management may be a useful adjunct to other treatment

Clients should have the opportunity to participate and make informed choices about their treatment

NOTES

Working with clients with comorbid psychosis

Adapting MI

Use simple open questions

Shorter and more frequent reflections

Provide frequent summaries of information and allow sufficient time for clients to respond

Avoid emotionally salient material that may increase disordered thoughts

NOTES

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Helping clients with AOD use and psychosis to manage their symptoms – psychoeducation

Educate the client about 'reverse tolerance'

Encourage the client to avoid high doses of drugs and riskier administration methods

Encourage the client to take regular breaks from using and to avoid using multiple drugs

Teach the client to recognise early warning signs that psychotic symptoms might be returning and encourage them to immediately stop drug use and seek help to reduce the risk of a full-blown episode

Inform the client that the use of AOD can make prescribed medications for psychosis ineffective

NOTES

Helping clients with AOD use and psychosis to manage their symptoms – what else works?

A coordinated care approach that draws on a range of services (accommodation, legal or employment services, social workers)

Longer term (at least one year) residential 'dual diagnosis' treatment programs are more likely to lead to positive outcomes for those with severe psychosis

Promising early findings for the use of e-health: web based psychoeducation, therapy, advice and forums

Some evidence for physical activity improving cognitive functioning, managing side effects of medication (schizophrenia)

NOTES

Helping clients with AOD use and psychosis manage their symptoms – pharmacotherapy

May be effective for this client group as negative symptoms (e.g. cognitive impairment) may restrict involvement and outcomes for psychosocial interventions

Limited research available for comorbid psychosis and substance use

Antipsychotics recommended, but no evidence for efficacy of any one type over the other

Theorised that substance use leads to dopamine dysfunction, newer (atypical) antipsychotics recommended (e.g. clozapine)

Being well maintained on medication enables AOD treatment to proceed as usual

Caution when selecting medications that they don't exacerbate psychosis symptoms (e.g. disulfiram)

Consider contraindications

Consult the Comorbidity Guidelines (Chapter B6) for full list of antipsychotic medications

NOTES

Module 7 Activity 4: Adding to current practice

- The facilitator will assign you to groups or pairs
- Discuss which interventions from pages 21-25 (summarised again below) you would consider adding to your practice or organisation, and how you will implement this

Psychosocial treatments (e.g., Cognitive Behavioural Therapy, Motivational Interviewing, Contingency Management)

_____

Psychoeducation

_____

Other treatment approaches (e.g., coordinated care approach, e-health, physical health)

_____

Pharmacotherapy

_____

Eating disorders (ED)

NOTES

How do people with eating disorders present?

Behaviours	• Food restriction, bingeing, vomiting and purging, over-exercise, deny behaviours
Beliefs	• Being out of control, unrealistic assessment of weight, size and shape, minimize symptoms
Self-evaluation	• Disproportionally influenced by body shape, size and weight

May show few outwards signs of ED, and any visible physical signs may be complicated by AOD use

NOTES

Eating disorders and AOD use

Severe consequences: medical complications, severe psychiatric comorbidities, suicidal ideation and attempts, mortality

AOD use complicates physical signs of ED

Both ED and AOD may involve craving and compulsive use

AOD use can exacerbate ED symptoms such as weight, appetite, food restriction

AOD use may be directly related to the ED, appetite suppression, weight control

AOD assessment and formulation needs to address above factors

NOTES

DSM-5 eating disorders

Anorexia nervosa	• Dramatic weight loss, denial, control of weight and food, beliefs that control will cause or prevent an outcome, potential significant medical complications
Bulimia nervosa	• Cycle of food restriction/binge/purge, guilt, attempt to hide behaviours, may have more self-awareness than with anorexia, may not have dramatic weight loss or significant medical symptoms
Binge eating disorder	• Episodes of binge eating without weight control, loss of control, isolation, guilt, self disgust, some medical complications

There are ICD-10 codes to match these DSM-5 diagnoses found in Appendix D of the Comorbidity Guidelines

NOTES

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Do's and don'ts of managing a client with symptoms of eating disorders

- ✓ Encourage and emphasise successes and positive steps (even just coming in for treatment)
- ✓ Take everything they say seriously
- ✓ Approach the client in a calm, confident and receptive way
- ✓ Be direct and clear in your approach
- ✓ Use open-ended questions such as 'So tell me about…?' which require more than a 'yes' or 'no' answer. This is often a good way to start a conversation
- ✓ Constantly monitor suicidal thoughts and talk about these thoughts openly and calmly
- ✓ Encourage the client to express his/her feelings
- ✓ Focus on feelings and relationships, not on weight and food

Do's and don'ts of managing a client with symptoms of eating disorders

- ✓ Be available, supportive and empathetic
- ✓ Encourage participation in healthy, pleasurable and achievement-based activities (e.g., exercise, hobbies, or work)
- ✓ Encourage, but do not force, healthy eating patterns
- ✓ Assist the client to set realistic goals
- ✓ Involve family or friends in management or treatment strategies
- ✓ Be patient in order to allow the client to feel comfortable to disclose information
- ✓ Explain the purpose of interventions

Do's and don'ts of managing a client with symptoms of eating disorders

- ✕ Act shocked by what the client may reveal
- ✕ Be harsh, angry, or judgemental. Remain calm and patient
- ✕ Use statements that label, blame or shame the client
- ✕ Invalidate the client's feelings
- ✕ Make comments (either positive or negative) about body weight, appearance or food – these will only reinforce their obsession
- ✕ Express any size prejudice, or reinforce the desire to be thin
- ✕ Engage in power struggles about eating
- ✕ Criticise his/her eating habits
- ✕ Trick or force the person to eat
- ✕ Get frustrated or impatient

Asking about eating disorders

It is important for clinicians to develop comfort and familiarity asking about symptoms. This is not to conduct a full mental health assessment or diagnose but to be able to:

- Understand a client's experience
- Understand the relationship between symptoms and AOD use
- Monitor symptoms throughout treatment
- Consider what impact eating disorder symptoms might have on treatment engagement and participation

NOTES

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Module 7 Activity 5: Understanding eating disorders and AOD use

The facilitator will divide you into groups or pairs and assign one of the three case studies of co-occurring AOD use and eating disorders on pages 36-38 of the workbook. For your case study, consider the following questions:

Why do you think a relationship has formed between the substance use and eating disorder for this person?	_____ _____
How might the substance use and eating disorder maintain each other?	_____ _____
How might a change in substance use affect thoughts or behaviours associated with the eating disorder?	_____ _____

Module 7 Activity 5: Understanding eating disorders and AOD use

Case study 1: Cannabis and binge eating disorder

- Jamal, 42 year-old male.
- Works fulltime in computing and lives with his partner.
- He reports that his parents have always been very critical of his appearance and achievements, and growing up he was often shamed for displaying negative emotions, which were seen as 'weak'.
- He reports being fearful of showing any negative emotions, as he is worried that this will result in his partner leaving him and he won't be able to cope.
- Jamal first smoked cannabis when he was 17 years old, and although he still uses, he describes his use as 'social'.
- He describes feeling agitated much of the time, especially when he hasn't used cannabis.
- He does not report any other AOD use.
- Reports being excessively worried about being seen as 'less than' by co-workers, friends or family, and that this often leads to low mood and low self-esteem. As a result he avoids social activities wherever possible. Reports smoking cannabis at least 3 to 4 times a week, as this is the only way he is able to relax.
- When cannabis is not available, Jamal will instead eat even though he is not hungry.
- He reports a long history of this type of eating, starting when he was in his mid-late teens.
- Jamal says he feels a loss of control when 'bingeing', and describes these 'episodes' as eating very rapidly until he feels uncomfortable. This type of eating is occurring more frequently, with and without cannabis use.
- After 'bingeing', Jamal feels guilty and ashamed. As a result of his frequent 'bingeing', he is becoming even more self-conscious about his weight and appearance.

Module 7 Activity 5: Understanding eating disorders and AOD use

Case study 2: Psychostimulants and anorexia nervosa

- Kelly, 26 year-old female.
- Studying at TAFE and working part time, lives alone.
- Says her mother was emotionally abusive and very critical of her weight growing up. Throughout primary and high school Kelly was bullied and taunted about her appearance.
- Upon presentation, Kelly was very cooperative and pleasant. She reported frequent headaches, feeling fatigued, and had missed her last period. Kelly appears to be quite thin, and upon further examination, is found to be 5ft (153cm) tall, with a weight of 40kg.
- Kelly reports a fear of abandonment and appears to have very low self-worth. She judges herself by her physical appearance, and describes herself as fat, despite her physical examination indicating that she is underweight.
- She is currently restricting her daily calorie intake, consuming around 600 calories per day, and exercises 2 to 3 hours each day.
- Kelly reports using phentermine to suppress her appetite, and dexamphetamine to help her maintain energy levels throughout the day. She initially had prescriptions for these substances from her prescribing doctor, but he is now refusing to reissue her with a new script due to her frequency of use. Kelly is finding it increasingly difficult to stick to her routine, and has become irritable and anxious.
- She reports feeling less concerned about her self-worth and more in control when she uses these substances, as they allow her to maintain her routine. Kelly has noticed her relationships with family and friends are suffering, which she believes support her notion that maintaining 'thinness' is key to being worthy of acceptance.

Module 7 Activity 5: Understanding eating disorders and AOD use

Case study 3: Alcohol and bulimia nervosa

- Yasmin, 20 year-old female.
- Studying and working in sales part time, lives with her mum and brother.
- Reports childhood loss – her father passed away when she was 8 years old and her mother struggled to provide financially.
- Yasmin frequently says she feels like a disappointment to her family, as she has mental health difficulties while she sees her mum and brother as 'managing fine'. She says her mum gave her everything so it must be her fault that she 'turned out a mess'.
- Reports her mum often comments on her weight and warns her to be mindful of not gaining weight. Yasmin equates thinness with social acceptability and has a fear of 'becoming obese', despite her physical examination indicating that she is within a healthy weight range.
- Yasmin says she is currently restricting her eating until 2-3pm each day and drinks only coffee to keep her going. She says she will often then become so hungry that she eats high calorie food until she feels uncomfortably full. She reports feeling out of control while 'bingeing' and feels shame afterwards which leads her to induce vomiting or go on the treadmill at home for 2 hours or more. Yasmin says that she only binges when her mum and brother are not home as she feels ashamed.
- Yasmin also reports that most weekends she drinks alcohol to the point of blacking out, despite telling herself each time she will only have one drink. She says this has caused arguments and problems in her friendships, and she often feels very depressed and anxious in the days after drinking.

Helping clients with AOD use and ED to manage their symptoms – what works?

Little evidence on the treatment of comorbid ED and AOD

Many treatments for single disorder ED but limited empirical evidence

Recommendations from single disorder ED

- Comprehensive assessment by a multi-disciplinary team
- Psychotherapy
- Pharmacotherapy not recommended without psychotherapy
- E-health as an adjunct to other treatments
- Caution with physical exercise

The Comorbidity Guidelines addresses recommended treatment methods for each individual eating disorder in greater detail. Please consult Chapter B6 for further information

NOTES

Obsessive-compulsive disorder (OCD)

NOTES

How do people with OCD present

Obsessions

- Persistent, intrusive, unwanted thoughts or impulses e.g. hoarding or collecting, fear of germs, harm from illness or injury, excessive concerns with order, intrusive thoughts about sex

Compulsions

- Repetitive ritualistic actions e.g. hand washing, checking locks or appliances, repeating activities or routines

NOTES

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Do's and don'ts of managing a client with obsessive-compulsive symptoms

- ✓ Ignore the strange or embarrassing behaviour if you can, especially if it not serious
- ✓ Approach the client in a calm, confident and receptive way
- ✓ Move and speak at an unhurried speed
- ✓ Be patient in order to allow the client to feel comfortable to disclose information
- ✓ Minimise the number of staff present and attending the client

Do's and don'ts of managing a client with obsessive-compulsive symptoms

- ✓ Minimise surrounding noise to reduce stimulation
- ✓ Reassure the client frequently (e.g., 'This won't take much longer')
- ✓ Explain the purpose of interventions
- ✓ Remain with the client to calm him/her down

Do's and don'ts of managing a client with obsessive-compulsive symptoms

- ✕ Crowd or pressure the client
- ✕ Become frustrated or impatient
- ✕ Laugh or let others (laugh) at the person
- ✕ Act horrified, worried or panic
- ✕ Confuse and increase the client's level of stress by having too many workers attempting to communicate with him/her

Do's and don'ts of managing a client with obsessive-compulsive symptoms

- ✕ Argue with the client's unusual beliefs or agree with or support unusual beliefs – it is better to simply say 'I can see you are anxious, how can I help you?'
- ✕ Use 'no' language, as it may provoke hostility and aggression. Statements like 'I'm sorry, we're not allowed to do ___ but I ***can*** offer you other help, assessment, referral…' may help to calm the client whilst retaining communication
- ✕ Use overly clinical language without clear explanations

Asking about OCD

It is important for clinicians to develop comfort and familiarity asking about symptoms. This is not to conduct a full mental health assessment or diagnose but to be able to:

- Understand a client's experience
- Understand the relationship between symptoms and AOD use
- Monitor symptoms throughout treatment
- Consider what impact obsessive-compulsive symptoms might have on treatment engagement and participation

NOTES

Helping clients with AOD use and OCD to manage their symptoms – what works?

Limited research available for comorbid psychosis and substance use

Evidence suggests treating both conditions together leads to better outcomes

High level of evidence for treating OCD as a single disorder with CBT, incorporating Exposure Response Therapy (ERP)

If not responsive and functioning is impaired by OCD, offer higher intensity CBT or SSRIs (or both together)

SSRIs associated with reductions in OCD symptom severity and recommended. Required dosage may be higher than depressive disorders - consider side effects and consult with client

CBT-based e-health interventions effective for OCD as a single disorder

Alternate therapies - some evidence for mindfulness, electroacupuncture, yoga. May be used as adjunct

Research for individual e-health programs or apps is limited, and clinicians are encouraged to explore options with client

NOTES

Module 7 Activity 6: Case study Shayna. Comorbid obsessive-compulsive disorder and substance use

- Shayna, 39 year-old female.
- Separated from partner recently. Shared custody of their two children (10 and 7 years). Describes difficult relationship with ex-partner and concern that he may try to increase his custody due to her alcohol use and 'behaviour'. Trained as a childcare worker, but has not worked since having children. Reporting a desire and a financial need to return to work.
- 20 year history of regular alcohol use and recreational drug use (ecstasy, cocaine). Used methamphetamine regularly from the age of 20-29. Ceased all substance use when pregnant with her first child but resumed daily alcohol use 7 years ago.
- Has always worried. Recalls worrying about family members becoming ill and dying from the time she was a child. Reported that this worry increased when she began working in childcare, that a child would be harmed in her care (become unwell, injured, choke or die). She reported that this resulted in her being unable to take breaks at work as she needed to keep supervising the children and worrying excessively at night causing insomnia, leading to regular exhaustion. Her worry about the children escalated to thoughts of children being left behind or locked in the centre. She was unable to leave the centre without multiple checks and often drove back at night and on weekends to do further checks. She reported that she couldn't leave the job as she believed the children would be more at risk. Her methamphetamine use commenced at this time to manage the exhaustion.
- She reports constant distressing thoughts about her own children being harmed and similar checking. She describes by the late afternoon she is exhausted and 'worked up' and usually commences drinking at that time. She reports that the drinking assists her to relax and to sleep but that she needs to do something about it so she can return to work.

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Module 7 Activity 6: Case formulation worksheet for Shayna

Presenting issues (What are the current problems?)	_____ _____
Pattern (of current problems)	_____ _____
Predisposing factors (What factors in the person's history are relevant to the current problems?)	_____ _____
Precipitating factors (How did these problems develop? How do you know this?)	_____ _____
Perpetuating factors (How are these problems maintained? What evidence do you have?)	_____ _____

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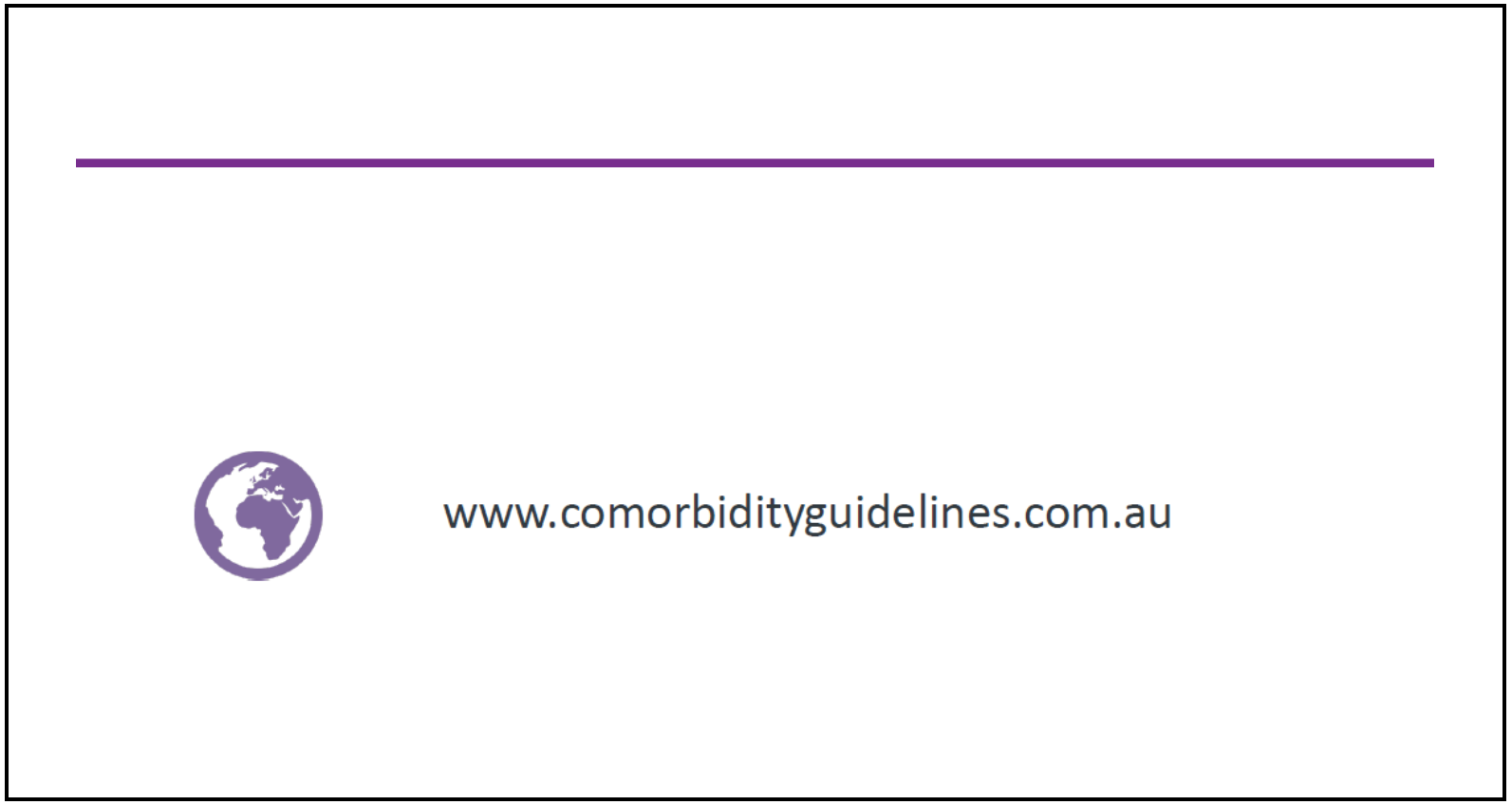
Module 7 Activity 6: Case formulation worksheet for Shayna (cntd)

Protective factors (What factors are relevant to the current problems?)	_____ _____
How do the above factors interact?	_____ _____
How do the AOD use and mental health symptoms relate and influence each other?	_____ _____
Prognosis (What is the likely outcome for this client?)	_____ _____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