Mental health problems

3

Outline

- Why do people develop mental health problems?
- Mental health disorders
- Personality disorders

WHY DO PEOPLE DEVELOP MENTAL HEALTH PROBLEMS?

We don't know exactly what causes mental health problems, nor can we predict who will have a few episodes and who will develop chronic problems. However, it's becoming more apparent that a mix of biological, psychological and social factors influence the development of mental health problems. That is why the biopsychosocial approach can be helpful in understanding key factors in what can be a very complex explanation. One way of explaining how biological, psychological and social factors influence one another is to look at stress and vulnerability.

The stress-vulnerability model

In general, the stress-vulnerability model holds that the greater the number of possible causes that are present, the greater the risk that a person may develop a mental health problem.

Treatment for mental health problems involves decreasing stress factors (e.g., working to develop a strong social network) and finding ways to decrease vulnerability (e.g., developing better coping skills or using medication to help balance chemical processes in the brain.

STRESS

Although stress does not cause mental health problems, it can trigger them, or make them worse.

Social factors

Events, either in childhood or adulthood, can contribute to the onset of a mental health problem. For example, some studies suggest that early childhood trauma and losses, such as the death or separation of parents, or adult events, such as the death of a partner or child or loss of a job, can be precursors to a mental health problem. Other environmental risk factors include:

- living in poverty
- lack of social support.

VULNERABILITY

Biological factors

Biological vulnerability is the tendency to develop problems in a specific area of the body—for example, respiratory system problems such as asthma. Similarly, people can

have a biological tendency to develop mental health problems such as depression, bipolar disorder or schizophrenia.

Vulnerability doesn't mean that problems *will* happen. It means that if certain factors come together, a person has a higher risk of developing a problem, and a higher risk of the problem being more severe.

Genetics
Some mental health problems seem to be genetic, or run in families. For example, the rate of schizophrenia in the general population is about one per cent. That rises to nine per cent for a child with one sibling with the diagnosis, 13 per cent for a child with one parent with the diagnosis and 46 per cent for a child with both parents with the diagnosis.[2]

Brain chemistry
Research indicates that chemical processes in the brain are involved in the development of mental health problems. Recent research has also pointed to abnormalities in brain structure as a possible factor in the development of mental health problems, particularly schizophrenia.[3]

Psychological factors
The temperament a person is born with (e.g., a tendency to internalize feelings) may play a part in increasing the risk of developing mental health problems. Psychological risk factors include:
- poor social skills
- poor coping skills
- problems with communication.

MENTAL HEALTH DISORDERS

As with substance use problems, there is no clear line that indicates when problems become severe enough to warrant treatment. As we explained in Chapter 1, many clinicians use the DSM-IV diagnostic criteria to help screen and assess people for mental health disorders. Most people with mental health problems will receive a specific diagnosis at some point during treatment. However, because the symptoms of many disorders are similar, the diagnosis may change several times during the course of treatment.

[2] You can find more information about research into the role of genetics on the Psychosis Sucks! website, created by the Fraser Health Authority in British Columbia, at www.psychosissucks.ca/epi.

[3] The National Institute of Mental Health in the United States (www.nimh.nih.gov/) is a good source of information about new developments in research into the biological basis of mental health problems.

You may hear mental health and substance use service providers use the terms Axis I disorder and Axis II disorder. The *DSM-IV* uses five axes to help organize information about mental disorders:

- Axis I: all mental health disorders (e.g. schizophrenia, bipolar disorder, substance dependence disorder) except personality disorders and mental retardation (also called intellectual disability)
- Axis II: personality disorders and mental retardation
- Axis III: medical conditions that may be contributing to psychological problems (e.g., infectious diseases)
- Axis IV: psychosocial and environmental problems (e.g., housing problems)
- Axis V: global assessment of functioning (how well a person is coping with daily life).

Axis II disorders are much less straightforward and even harder to diagnose than Axis I disorders.

Dimensional approaches

Another way to understand mental health problems is to divide mental health problems into broad groups based on the behaviours that we see. We did this in Chapter 2 with substance use problems by suggesting that drugs that have psychoactive effects could be divided into three groups: depressants, stimulants and hallucinogens.

We suggest that mental health problems can be divided into four groups:

- anxiety
- mood
- psychosis
- impulsivity (Skinner, 2005).

Mental health problems are described in terms of the severity of behaviours in each of these groups. This dimensional approach is a useful way to begin to organize the observations that indicate that a person has a mental health problem.

Table 3-1: The dimensional approach

DIMENSION	VERBAL BEHAVIOUR	MENTAL HEALTH PROBLEM		SUBSTANCE USE PROBLEM
		Axis I: Mental Health Disorders	**Axis II: Personality Disorders**	**Substance-Induced Disorders**
Anxiety	• "fear talk"	• anxiety disorders (e.g., phobias, obsessive-compulsive disorder)	• avoidant personality disorder • dependent personality disorder • obsessive-compulsive personality disorder	• substance-induced anxiety disorder (e.g., cannabis-induced anxiety disorder)
Mood	• "sad talk" • laconia • "manic or grandiose talk"	• depressive disorders • dysthymia • bipolar disorders	• affective features often present in personality disorders	• substance-induced mood disorder (e.g., heroin-induced depression)
Psychosis	• "weird talk"	• schizophrenia • other psychotic disorders • mania	• schizoid personality disorder • schizotypal personality disorder • paranoid personality disorder	• substance-induced psychotic disorder (e.g. cocaine-induced paranoia) • substance-induced delirium
Impulsivity	• "threat talk"	• impulse control disorders • gambling • bulimia • alcohol or other drug abuse/dependence	• antisocial personality disorder • borderline personality disorder • narcissistic personality disorder • histrionic personality disorder	• substance-induced impulse control disorder (e.g., amphetamine-induced sexual disorder)

ANXIETY

Anxiety disorders take on different forms. They are the most common type of mental health disorder. They have different causes and symptoms, but one thing people with anxiety disorders share is feelings of deep anxiety and fear that affect their mood, thinking and behaviour. When someone has an anxiety disorder, his or her thoughts and feelings may get in the way of taking the actions needed to be healthy and productive. These illnesses are chronic and can get worse over time if they are not treated. The following anxiety disorders:

- posttraumatic stress disorder
- generalized anxiety disorder
- panic disorder
- social phobia
- obsessive-compulsive disorder

are described below.

POSTTRAUMATIC STRESS DISORDER

As we discussed in Chapter 1, many people who develop substance use and/or mental health problems have experienced, or are experiencing, sexual, physical, psychological or emotional trauma.

Experiencing a traumatic event may trigger mental health problems such as anxiety, depression, psychotic symptoms or personality disorders (SAMHSA, 2003). The DSM-IV diagnostic category posttraumatic stress disorder (PTSD) describes a set of symptoms that people may experience following a traumatic event.

Simple posttraumatic stress disorder

PTDS may develop after a person experiences or sees an event where serious physical harm occurred or was threatened. Symptoms include:

- re-experiences of the event through flashbacks, nightmares or memories
- intense anxiety
- intense agitation
- increased heart rate
- tremors
- sweating
- increased awareness of the environment (hypervigilence)
- avoidance of anything associated with the traumatic event.

PTSD is diagnosed when symptoms last more than one month. Simple PTSD accurately describes the symptoms that can result when a person experiences a one-time event such as a car accident or a natural disaster.

Complex posttraumatic stress disorder

Clinicians and researchers have found that the current DSM-IV PTSD diagnosis often does not capture the severe psychological harm that occurs when the traumatic experience continues for a long time. For example, ordinary, healthy people who experience chronic trauma can experience changes in the way they see themselves and in the way they adapt to stressful events. Dr. Judith Herman suggests that a new diagnosis, called "complex PTSD" (sometimes called "disorder of extreme stress"), is needed to describe the symptoms of long-term trauma.

Experiences that can lead to complex PTSD include:
- long-term domestic violence
- long-term, severe physical abuse
- child sexual abuse
- internment in a concentration or prisoner of war camp.

The first requirement for the complex PTSD diagnosis is that the person experienced a prolonged period in a situation in which he or she felt helpless or trapped.

Symptoms include alterations in:
- emotional regulation (e.g., persistent sadness, suicidal thoughts, explosive anger or inhibited anger)
- consciousness (e.g., forgetting traumatic events, reliving traumatic events or having episodes in which one feels detached from one's mental processes or physical body)
- self-perception (e.g., a sense of helplessness, shame, guilt, stigma and a sense of being completely different than other human beings)
- the perception of the perpetrator (e.g., attributing total power to the perpetrator or becoming preoccupied with the relationship to the perpetrator, including a preoccupation with revenge)
- relations with others (e.g., isolation, distrust or a repeated search for a rescuer)
- one's system of meanings (e.g., a loss of sustaining faith or a sense of hopelessness and despair).

Survivors may avoid thinking and talking about trauma-related topics because the feelings associated with the trauma are often overwhelming. Survivors (anywhere from 50 to 90 per cent) may use alcohol and other substances as a way to avoid and numb feelings and thoughts related to the trauma. Survivors may also engage in self-mutilation and other forms of self-harm.

Crises that threaten the safety of the person with PTSD (e.g., talking about suicide) or the safety of others (e.g., reacting violently when they feel threatened), must be addressed first. However, the best treatment results are achieved when both PTSD and the other disorder(s) are treated together rather than one after the other. This is especially true for PTSD and alcohol and other substance use.

GENERALIZED ANXIETY DISORDER

People who have experienced at least six months of ongoing and excessive anxiety and tension may have generalized anxiety disorder. They usually expect the worst and worry about things, even when there is no sign of problems. They often experience the following symptoms:

- insomnia
- fatigue
- trembling
- muscle tension
- headaches
- irritability
- hot flashes.

PANIC DISORDER

Panic disorder occurs when people have repeated panic attacks, the sudden onset of intense fear or terror. During these attacks, people may experience physical symptoms such as:

- shortness of breath
- heart palpitations
- chest pain or discomfort
- choking or smothering sensations
- fear of losing control
- fear of going crazy.

Many people with panic disorder develop anxieties about places or situations in which they fear another attack, or where they might not be able to get help. Eventually this can develop into agoraphobia, a fear of going into open or public spaces. Women are twice as likely as men to develop panic disorder, which usually begins in young adulthood.

SOCIAL PHOBIA

People with social phobia experience a significant amount of anxiety and self-consciousness in everyday social situations. They worry about being judged by others and embarrassed by their own actions. This anxiety can lead them to avoid potentially humiliating situations. Other symptoms such as blushing, sweating, trembling, problems talking or nausea can also occur. Women are twice as likely as men to develop social phobia, which typically begins in childhood and early adolescence.

OBSESSIVE-COMPULSIVE DISORDER

People with this condition have obsessive, unwanted thoughts that cause marked anxiety or distress and/or compulsions to behave in certain ways to manage the anxiety. They

may perform rituals to prevent or make the obsessive thoughts go away (e.g., excessive hand washing or cleaning to prevent or diminish their fear of germs). These behaviours bring only temporary relief. If they are not treated, these obsessions and compulsions can take over a person's life.

Mood

Ordinarily, people experience a wide range of moods. They feel more or less in control of their moods. When the sense of control is lost, people experience distress. Those with an elevated mood (mania) can experience expansiveness, racing thoughts, decreased sleep, exaggerated self-esteem and grandiose ideas. People with depressed mood (depression) can have symptoms such as a loss of energy and interest, feelings of guilt and difficulty concentrating.

Major depressive disorder

Prevalence

Between 15 and 20 per cent of women and between 10 and 15 per cent of men will experience a major depressive episode in their lifetime.

Symptoms

A person who is experiencing at least five of the following symptoms meets the criteria for a diagnosis of a major depressive episode:

- Depressed mood: A depressed mood is much different from sadness. In fact, many people with depression say they cannot feel sadness, and many people cannot cry when depressed. Being able to cry again often means the depression is improving.
- Loss of interest or pleasure: At the start of depression or with mild depression, people can still enjoy and be distracted by pleasurable activities. When people are severely depressed, they lose these abilities.
- Weight loss or gain: Many people lose weight when depressed, partly because they lose their appetite. However, some people feel hungrier and may develop a craving for carbohydrate-rich foods. This causes them to gain weight. Depending on the type of depression, a person's metabolism may speed up or slow down. This can also cause weight loss or gain.
- Sleep problems: Sleep problems are common in depression. Many people have insomnia. They have trouble falling asleep, wake up often during the night, or wake up very early in the morning. They do not find sleep to be restful and may wake up feeling exhausted. Others may find that they sleep too much, especially during the day. This is called *hypersomnia*.

- Physical changes: For some people with depression, their movements, speech and/or thinking slows. In severe cases, they may be unable to move, speak or respond. With other people, the opposite happens. They become agitated and cannot sit still. They may pace, wring their hands or show their agitation in other ways.
- Loss of energy: People with depression find it difficult to complete everyday chores. It takes them much longer to perform tasks at work or home because they lack energy and drive.
- Feelings of worthlessness and guilt: When depressed, people may lack self-confidence. They may not assert themselves and may be overwhelmed by feelings of worthlessness. Many people cannot stop thinking about past events. They obsess about having let others down or having said the wrong things, and they feel guilty. In severe cases, the guilt may cause delusions. (See "Psychotic symptoms," three bullets below.)
- Inability to concentrate or make decisions: People may not be able to do simple tasks or make decisions on simple matters.
- Suicidal thoughts: People with depression often think that life is not worth living or that they would be better off dead. There is a high risk that they will act on these thoughts. Many people do try to kill themselves when depressed.
- Psychotic symptoms: These may include false beliefs, such as believing they are being punished for past sins. People with psychotic symptoms may believe that they have a terminal illness, such as cancer. They may also hear voices that are not there (auditory hallucinations).

Other symptoms may include:
- oversensitivity and preoccupation with oneself
- negative thinking
- little response to reassurance, support, feedback or sympathy
- less awareness of other's feelings because of one's own internal pain
- feeling a need to control relationships
- inability to function in a normal role.

Course

A first episode of depression can occur anytime in a person's life.

Most people struggle for long periods with the symptoms before seeking mental health intervention. They may have undergone several stressful events, and have tried to manage their mood fluctuations, only seeking help when they experience serious difficulties coping at home, at work or in important relationships.

A person may be diagnosed as having had a "single episode" (meaning that this is the first time he or she has experienced a major depression) or "recurrent episode"

(meaning that the person has experienced at least one previous episode of major depression). Different episodes may vary in severity: some episodes may be minor and have less impact on a person's ability to function, while others may be more severe and result in significant disruption to a person's life.

Bipolar disorder

Prevalence

About one to two per cent of the population will develop a bipolar disorder in their lifetime.

Symptoms

There are three major groups of symptoms related to bipolar disorder. These are mania, hypomania and depression.

Mania

If a person's mood is abnormally or persistently high for at least one week, he or she may be in a manic phase of the illness. However, not everyone who enters the manic phase feels euphoric. Some people may feel extremely irritable, behave rudely or become angry, disruptive and aggressive. They can be very impatient with others and make hurtful statements or behave impulsively or even dangerously.

In addition to mood symptoms, people must have at least three of the following symptoms to a significant degree to be diagnosed with bipolar disorder:
- exaggerated self-esteem or grandiosity
- reduced need for sleep
- increased talkativeness
- a flood of ideas or racing thoughts
- speeding up of activities such as talking and thinking, which may be disorganized
- poor judgment
- psychotic symptoms such as delusions (false beliefs) and in some cases hallucinations (mainly hearing voices).

Mania causes people to be emotional and react strongly to situations. For people with poor anger management skills or with low tolerance for frustration, this can lead to violent behaviour.

Hypomania

Hypomania is a milder form of mania with less severe symptoms. However, symptoms can interfere with the person's ability to function. We now recognize that

hypomania has more impact on a person's life and relationships than was previously recognized.

Depression

Depressive episode symptoms are described earlier in this chapter, in the "Major Depressive Disorders" section.

Bipolar I disorder

Some people experience mania or depression, or both, in addition to well phases during their illness.

Bipolar II disorder

Some people experience hypomania, depression and phases without symptoms—with no full manic phases.

Course

The manic/hypomanic, depressive and mixed (both manic/hypomanic and depressive) states usually do not occur in a particular order. How often they occur cannot be predicted. For many people, there are years between each episode, whereas others have episodes more often. Over a lifetime, the average person with bipolar illness experiences about 10 episodes of depression and mania/hypomania or mixed states. As the person ages, the episodes of illness come closer together. Untreated mania often lasts for two or three months. Untreated depression usually lasts longer, between four and six months.

One in five people with bipolar disorder have four or more—sometimes many more—episodes a year and have short phases without symptoms. This is called rapid cycling, and is a subtype of bipolar disorder for which people need specific treatment. The cause of rapid cycling isn't known. Sometimes, it may be triggered by antidepressants, but how this happens is not clear. In some cases, stopping the antidepressant may help the person return to a "normal" cycling pattern.

Psychosis

A psychotic disorder is a severe medical illness that disturbs the way a person acts, thinks, sees, hears or feels, and makes it difficult or impossible for him or her to distinguish between what is real and what is not.

Symptoms of psychosis may be either positive (something "added to" the person, something that is not always present) or negative (something "taken away" or "missing from" the person).

Schizophrenia

Prevalence

About one per cent of the population will develop schizophrenia at some point during their life.

Symptoms

Early warning signs of schizophrenia include:
- withdrawal from regular activities and from family and friends
- problems concentrating
- lack of energy
- confusion
- sleep problems
- unusual speech, thoughts or behaviour (e.g., a person may become intensely preoccupied with religion or philosophy).

This early phase can last weeks or months.

The seriousness of symptoms and chronic nature of schizophrenia can often cause a high degree of disability. Coping can also be difficult for family members who remember the person before the illness.

Positive symptoms (symptoms that appear in a person) include:
- Delusions: A delusion is a false or irrational personal belief. About one-third of people with schizophrenia experience delusions. These can include feelings of being persecuted, cheated or harassed, as well as delusions of grandeur (a false idea of oneself, e.g., as being famous).
- Hallucinations: A hallucination occurs when a person hears, sees, tastes or experiences something that is not really there. Hearing voices is the most common hallucination.
- Disordered thoughts: A person's thoughts may become unconnected, so that conversations no longer make sense. Their thoughts may come and go and they may not be able to focus for long on one thought. This is called thought disorder. It can contribute to a person's isolation.
- Cognitive difficulties: A person may have problems with memory, concentration and understanding concepts.

- Decline in social or occupational functioning: A person may have problems with work or school, or have trouble taking care of him- or herself.
- Disorganized behaviour: A person may seem agitated for no particular reason.

People with schizophrenia often have negative symptoms (elements that are taken away from a person) that include a "blunted affect" or "flat affect." This means they find it hard to show or express feelings. They may feel empty. A person with schizophrenia may appear extremely apathetic, have reduced motivation and withdraw socially.

Course

Men and women are equally likely to develop schizophrenia. However, men tend to have their first episode in their late teens or early twenties. With women, the onset is usually a few years later. In most cases, the illness can start so gradually that people will start to have symptoms, but they and their families may not be aware of the illness for a long time.

Symptoms of schizophrenia tend to vary in intensity over time. Some people have a mild form, and may only have symptoms for a few short periods during their lives. Others experience symptoms almost all the time, and may need to spend time in a hospital to protect themselves or others.

Impulsivity

Impulsivity disorders problems result from behaviour where the urge to do something is greater than the person's ability to understand that the behaviour has a high risk of being harmful to him- or herself or others.

Examples of impulsivity problems include substance use disorders and other behaviours such as problem gambling, antisocial behaviour, and problems related to anger and aggression.

A person with impulsivity problems needs to learn to think before acting. Too often the person reacts to a situation, and the action has consequences that could have been anticipated if her or she had sought more information and reflected more before acting.

Impulsive behaviour is often an attempt to control a situation that feels unsafe or threatening. In a smaller percentage of cases, the person doesn't care about the impact of his or her behaviour on others or even himself or herself. This type of behaviour is likely to be diagnosed as conduct disorder in young people or as antisocial behaviour in adults.

PERSONALITY DISORDERS

Personality is a way of describing how people think, feel and behave: the particular ways in which they understand and react to situations (e.g., their emotional response to an upsetting situation, their usual way of coping with stress, or how they understand and react to the external world).

Certain types of mental health problems are called personality disorders. As we saw when we looked at Table 3-1: The Dimensional Approach on p. 35, personality disorders are Axis II disorders. Axis II disorders are much less straightforward and are even harder to diagnose than Axis I disorders. Many of the features of these diagnoses (such as borderline personality disorder or antisocial personality disorder) overlap with many elements of *anybody's* personality. Personality disorders are often diagnosed when particular elements of a person's behaviours, reactions and perceptions of the world are extreme and lead to significant adverse problems in his or her life.

Personality disorders can have symptoms that are similar to mood, anxiety, psychotic and impulsivity disorders. Diagnosing personality disorders is open to error. The diagnosis is often used to describe a set of symptoms that don't fit into any other category.

Some practitioners do not even consider personality disorders to be mental health problems. Our view is that personality disorders are problems that a person experiences, and need to be seen as problems for which help should be provided.

Clusters of personality disorders

The *DSM-IV* divides personality disorders into three main groups, each of which fits into one of the dimensions we have previously outlined (psychosis, impulsivity and anxiety).

Cluster A (psychosis dimension) consists of schizoid personality disorder, schizotypal personality disorder and paranoid personality disorder. It is characterized by disturbances in cognition and perceptual organization in ways that resemble psychotic processes, although are usually less severe.

Cluster B (impulsivity dimension) includes antisocial personality disorder, borderline personality disorder, narcissistic personality disorder and histrionic personality disorder. This cluster is characterized by impulsive behaviours.

Cluster C (anxiety dimension) includes avoidant personality disorder, dependent personality disorder and compulsive personality disorder.

We are going to provide more information on borderline personality disorder (BPD) because this diagnosis is one of the most stigmatizing. People who are diagnosed with

BPD often have symptoms that make it difficult for them to avoid serious problems in the social world and to get effective help in mental health or social service settings.

Borderline personality disorder

The symptoms of BPD can occur in various combinations. People with the disorder have many, if not all, of the following traits:

- fears of abandonment
- extreme mood swings
- difficulty in relationships
- unstable self-image
- difficulty managing emotions
- impulsive behavior
- self-injuring acts
- suicidal ideation
- transient psychotic episodes.

Many of the characteristics of BPD reflect extreme ways that any person might react to a situation that upsets them. These reactions may be diagnosed as BPD when the person engages in severe self-destructive behaviour when he or she gets angry, or is disappointed, or experiences loss or grief and feels completely abandoned.

Activity 3-1: Identifying mental health problems

Read each of the following descriptions and write down whether mood, anxiety, psychosis or impulsivity describes the situation. More than one dimension may apply.

Tom, 50, and his wife, Laura, 47, have been married for 20 years. They both work full time—Tom as an executive at an architectural firm and Laura as the manager of a large fitness club. They do not have any children, but enjoy the company and companionship of several other couples who have been very good friends for many years. Tom and Laura work hard at their jobs, but also spend a great deal of time together in the evenings and on weekends. About one year ago, Tom began to have difficulty falling asleep at night and therefore waking up in time for work. He also described feeling nervous and jittery, and found it hard to complete work-related tasks that used to be very easy for him. Laura became concerned when Tom began to withdraw from her and to spend increasing amounts of time watching television or simply sitting outside staring into space. Ever since the changes in his behaviour began, Laura also worried about Tom's drinking, which had gradually increased from an occasional glass of wine to several shots of whiskey four to five evenings every week. He was also unable to express his feelings or to explain why his behaviour had changed so dramatically. One evening, when Laura and Tom were expected at a friend's home for a dinner party, Laura found Tom sitting on the floor in the bedroom crying and shaking. He told her that he felt too nervous to go out and that he "couldn't stand feeling like this anymore."

Ben is a 20-year-old, single, second-year university student majoring in biochemistry and living in a student residence on campus. In spite of Ben's characteristically shy and quiet personality, he has developed a close friendship with his roommate, an outgoing student from another province who goes by the nickname "Scat." Ben has even accompanied Scat to a few parties on campus and has been going to classes with Scat and several other students from their residence. Ben's parents live in a nearby city and are delighted that Ben, who was somewhat withdrawn and isolated as a child and teenager, has made new friends. Halfway through the school year, however, Ben suddenly began withdrawing from his new group of friends and refused to join them on outings. He started missing classes and instead stayed in his room in the student residence. Within a few months, Ben stopped eating meals in the cafeteria, complaining that there was "something in the food" and that somebody was trying to poison him. He became increasingly fearful that the other students were talking about him behind his back, and even accused Scat of plotting to harm him. Eventually, he stopped going to his classes altogether and spent his entire day in his room with the lights off, smoking cigarettes and marijuana, and listening to loud music. When Scat came home, Ben would angrily yell at him to get out. Scat reminded Ben that they lived in a non-smoking residence and Ben responded by

throwing a chair at Ben and storming out of the room. When Ben did not come home for three days, Scat contacted his parents. They were shocked with Ben's behaviour, especially his angry outbursts, smoking and use of drugs.

Cassie is a 32-year-old single woman working part-time in a department store. She has become used to living on her own and supporting herself, especially since she left home at age 17 due to her parents' constant fighting and daily drinking. Cassie has felt hopeless and despondent (dejected and sad) about her life for as long as she can remember, and has endured long periods of feeling worthless, useless and lonely. Since the age of 15, Cassie has also experienced bouts of intense anger and urges to harm herself. Her family has been unable to cope with their own emotions and have always turned to alcohol or gambling to deal with such unpleasant feelings as anger, boredom, sadness and anxiety. Cassie did not learn to deal effectively with her own feelings, and since the age of 17 has used various kinds of drugs to numb her psychological pain. She has also found that cutting her arms and legs with sharp objects often helps to get rid of painful emotions quite effectively—although the relief she gets from these self-harm behaviours never lasts very long. The intensity of Cassie's anger and loneliness has been increasing and she has begun to cope by overdosing on pills and then ends up in emergency departments. During one of her emergency admissions to a hospital she disclosed to a nurse that she is contemplating suicide.

Molly is a 35-year-old mother of four living in a subsidized housing complex in a Toronto suburb. Molly collects welfare in addition to financial aid for her children, aged seven years, five years, three years and nine months. Her ex-husband is in jail on a drug-related charge. Since her divorce one year ago, Molly has felt overwhelmed, particularly with finding a job that will pay her enough so that she can support her children. She is also worried about finding appropriate child care services should she find a good job. With four children to care for, Molly has not had time to make friends and she often feels an enormous sense of burden in addition to feeling "down in the dumps," isolated and alone with her responsibilities. She has developed daily episodes of severe nervousness and agitation during which she is completely unable to attend to her children's needs. She finds that as long as she paces around the same rooms in the same order and in the same direction and keeps repeating a particular phrase, her nervousness marginally subsides. Often Molly finds that during these episodes she also experiences shaking hands, shortness of breath, an extremely fast heart rate and profuse sweating. When these symptoms become really bad, Molly takes excessive doses of minor tranquillizers such as Valium, previously prescribed to her for insomnia by her family physician.

Comments

Tom is experiencing problems with *mood* and *anxiety*. Ben appears to be suffering from *psychosis*. Cassie appears to be struggling primarily with an *impulsivity* problem, accompanied by *mood* problems. Molly appears to be experiencing problems with *anxiety* and *mood* (depression).

REFERENCES

Skinner, W.J. (2005). *Treating Concurrent Disorders: A Guide for Counsellors.* Toronto: Centre for Addiction and Mental Health.