



**OFFICE OF THE PURCHASING AGENT
COUNTY OF COOK**

118 NORTH CLARK ST. ROOM 1018
CHICAGO, ILLINOIS 60602-1375
(312) 603-5370

THIS PURCHASE ORDER NUMBER
MUST APPEAR ON ALL PACKAGES,
INVOICES, SHIPPING PAPERS AND
DROP SHIPMENTS.

PURCHASE ORDERED ISSUED TO
91243

Mark Sanders
3170 N Sheridan Rd Ste 807
Chicago IL 60657

DATE
2/6/2012
F.O.B. POINT

PURCHASE ORDER NO.
179953 - 000- OP
REQUISITION NO.
00101029 OR

**COOK COUNTY FEIN: 36-6006541
ILLINOIS SALES TAX EXEMPT: E-9998-2013-04
FEDERAL EXCISE TAX EXEMPT CERT: 36-75-D038K**

SHIP TO Adult Probation - Administration
Cook County Administration Offices
69 W Washington Ste 1940
Chicago IL 60602

DELIVERY INSTRUCTIONS
Maureen Noonan 312-603-0281

DEPT NO
2800847 Page 1 of 1

LINE	FURNISH THE FOLLOWING SUPPLIES AND/OR SERVICE	QUANTITY/ UOM	UNIT PRICE	EXTENDED PRICE	ACCOUNT NUMBER
1.00	TRAINING WORKING WITH PROBATIOENRS WITH CO-OCCURRING DISORDERS 6 SESSIONS @ \$600 PER SESSION JANUARY 2012 - MARCH 2012	1.00 LO	3,600.0000	3,600.00	2800847.501930
***** Total Order *****				3,600.00	

NOTE: VENDOR AGREES NOT TO EXCEED THE QUANTITY OR DOLLAR AMOUNT OF THIS ORDER WITHOUT WRITTEN AUTHORIZATION FROM THE PURCHASING AGENT

RECEIPT CERTIFICATION (FOR DEPARTMENT USE ONLY)

I hereby certify that I have received the goods/services reflected above and that the items referenced are in full conformity with the purchase order/contract.

Authorized Signature: _____

Date: _____

I hereby certify that this purchase is in agreement with the requisition on file authorizing the expenditure and is properly approved.

PURCHASING AGENT

Date:

Maureen Noonan
2/10/12 BN

Purchase Requisition

Office of the Purchasing Agent
Cook County of Illinois

Purchase Order Number

1229953

45 BK New

Requisition # OR 101029

Contract # 12-45-045

Open Date

Ship To: 8000005

Adult Probation - Administrati

Delivery/ Instructions:

Supplier: 91243

Sanders, Mark

3170 N Sheridan Rd Ste 618

Buyer Number 724150 Supervisor 40

Bid/Sole Src Code 2800847

Business Unit

69 W Washington

Site 1940

312-603-0281

Chicago IL 60602

Internal Regd Number 22804003

Board Apr Date & Item

Requisition Date 12/29/2011

Date Needed 12/29/2011

One Time Purchase Yes No Covers Need for months, Specific Period of time thru

Prior Contract No.

Expiration Date

Emergency No.

Line # Commodity Description

Bal. on Hand

Quantity UOM

Est. Unit Cost

Extended Cost

Business Unit and Object Account

1,000 961

TRAINING

<

>

6.00 DY

600.0000

3,600.00

2800847.501930

WORKING WITH PROBATIONERS WITH CO-OCCURRING DISORDERS

Total of Items Ordered

3,600.00

RECEIVED
OFFICE OF THE
PURCHASING AGENT
2011 DEC 31 AM 8:40
BOOKKEEPING

- need a
detailed
scope from
vendor

CERTIFICATION

I hereby certify that the items and/or services above are necessary to this department (or institution) and that the dept., no., account & activity numbers indicated above accurately reflect the specific line item budget appropriation approved by the Board of County Commissioners and there is a sufficient unencumbered balance in the account to grant same.

CCA

APPROVED BUDGETARY ACCOUNT

PURCHASING USE ONLY

ACCT #

DATE

BY

REQUISITIONER

BUREAU or DEPARTMENT AND
BUREAU Chief Probation Officer

Jesus Reyes, Acting Chief Probation Officer

Mark Sanders
ON THE MARK CONSULTING
3170 North Sheridan Road, Ste. 807
Chicago, IL 60657

TO: DELORES JOHNSON
DIRECTOR OF TRAINING
COOK COUNTY ADULT PROBATION DEPARTMENT
69 WEST WASHINGTON, SUITE 1940
CHICAGO, ILLINOIS 60602

PROPOSAL

TRAINING: Working With Probationers With Co-Occuring Disorders

6 SESSIONS \$600.00 per session \$3,600.00

TOTAL \$3,600.00



REMIT INVOICE TO: Mark Sanders
On the Mark Consulting
3170 North Sheridan Road, Suite 807
Chicago, IL 60657

Thank You!

COOK COUNTY ADULT PROBATION

PRESENTS

**SUPERVISING PROBATIONERS WITH CO-
OCCURRING DISORDERS**

PRESENTER

MARK SANDERS, LCSW, CADC

Six, 7-Hour Training Sessions

February – November 2012

THE PERSON CENTERED RECOVERY MOVEMENT

An approach to mental health treatment in which the client is the director of his or her plan.

EVENTS THAT LED TO THE PERSON-CENTERED MOVEMENT

- 1) In the 1980's there were many clients who did not respond well to traditional mental health treatment. These clients were chronically homeless and chemically dependent.
- 2) Audits by the federal government revealed that mental health treatment was ineffective.
- 3) Closing of state hospitals.
- 4) Former mental health consumers emerging as leaders in the field.

EVIDENCE BASED APPROACHES TO MENTAL HEALTH TREATMENT

- 1) Supportive employment.
- 2) Motivational incentives
 - *Fishbowl Technique
- 3) Prison based ACT Teams.
- 4) Motivational interviewing
- 5) Cognitive behavioral therapy
 - Chronic relapsers
 - Sex offenders
 - Depression
 - Personality disorders
- 6) Practice based evidence
 - A
 - B
 - C
- 7) Integrated dual disorders treatment
 - Psychoeducation
 - Intensive family case management
 - Effective doctor/patient relationship

BEST PRACTICES IN CO-OCCURRING DISORDERS TREATMENT

1) The 4 essentials

A

B

C

D

2) Address trauma-seeking safety

3) Family Therapy

4) Recovery coaching in the natural environment to support recovery and help build recovery capital

Levels of engagement

- Pre-treatment recovery support
- In-treatment recovery support
- Post-treatment recovery support

Recovery capital-Internal and external assets that support recovery

- Success prior to mental illness and addiction
- Education
- Employability
- Healthy family support
- Prosocial group affiliation

5) Treatment of other addictions

6) Drug courts

- Immediate rewards
- Immediate sanctions

**TREATMENT OF COMMON PSYCHIATRIC
DSORDERS WHICH OFTEN ACCOMPANY
ADDICTION**

DIAGNOSTIC CRITERIA FOR POSTTRAUMATIC STRESS DISORDER

1. The person has been exposed to a traumatic event in which both of the following were present:
 - A) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 - B) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.

2. The traumatic event is persistently re-experienced in one (or more) of the following ways:
 - A) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
 - B) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
 - C) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
 - D) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
 - E) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

3. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
 - A) efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - B) efforts to avoid activities, places, or people that arouse recollections of the trauma

- C) inability to recall an important aspect of the trauma
 - D) markedly diminished interest or participation in significant activities
 - E) feeling of detachment or estrangement from others
 - F) restricted range of affect (e.g., unable to have loving feelings)
 - G) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
4. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
- A) difficulty falling or staying asleep
 - B) irritability or outbursts of anger
 - C) difficulty concentrating
 - D) hypervigilance
 - E) exaggerated startle response
5. Duration of the disturbance (symptoms in Criteria 2, 3, and 4) is more than 1 month.
6. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

With delayed onset: if onset of symptoms is at least 6 months after the stressor

Source: *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, DSM-IV-TR*, American Psychiatric Association.

DIAGNOSTIC CRITERIA FOR ACUTE STRESS DISORDER

1. The person has been exposed to a traumatic event in which both of the following were present:
 - A) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 - B) the person's response involved intense fear, helplessness, or horror
2. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:
 - A) a subjective sense of numbing, detachment, or absence of emotional responsiveness
 - B) a reduction in awareness of his or her surroundings (e.g., "being in a daze")
 - C) derealization
 - D) depersonalization
 - E) dissociative amnesia (i.e., inability to recall an important aspect of the trauma)
3. The traumatic event is persistently re-experienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; distress on exposure to reminders of the traumatic event.
4. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).
5. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hyper-vigilance, exaggerated startle response, motor restlessness).
6. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

7. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

8. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

Source: *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, DSM-IV- TR*, American Psychiatric Association.

ACE STUDY

Directions - For each “yes” answer, give yourself one point. For each “no” answer, give yourself zero points.

When you were growing up in your household, before age 18, did you have any of the following experiences?

1. Often had a parent or someone else in the household who swore at you, yelled at you, and sometimes, or often, acted in a way that made you believe you might be physically hurt. ____
2. Sometimes, often, or very often, were you pushed, grabbed, slapped, or had something thrown at you, or hit so hard that you had marks or were injured?

3. An adult or person at least five years older ever touched you or fondled you in a sexual way, had you touch their body in a sexual way, attempted oral, anal, or vaginal intercourse with you or actually had oral, anal, or vaginal intercourse with you. ____
4. Were you ever made to feel unloved, unprotected, and not special in your home? ____
5. Were there times when you did not have food, clean clothes, and a place to live? If you were sick, were there times when an adult did not take care of you consistently? ____
6. Did you ever witness your mother or stepmother get pushed, grabbed, slapped, hit, or have something thrown at her? ____
7. Was there anyone in your household who was a problem drinker, alcoholic, or who used street drugs? ____
8. Did you live with a household member who was depressed, mentally ill, or attempted suicide? ____
9. Were your parents ever separated or divorced? ____
10. Did you ever have a household member who went to prison? ____

A BRIEF HISTORY OF TRAUMA TREATMENT

From Hysteria to PTSD

1. Sigmund Freud
2. WWI –
 - A) The term “shellshock” was born.
 - B) Men who succumbed to “shellshock” were considered weak-willed and inferior.
 - C) Moral weaklings should be courtmarshaled or back on the battlefield as soon as possible.
 - D) Group therapy in America was born.
 - E) Interest in treatment of shellshock ended soon after the war.
3. WWII
 - A) VA hospital formed.
 - B) Group treatment became popular again.
 - C) Harding - “200-240 days on the battlefield could cause any soldier to break down.”
 - D) Talking cure seen as helpful.
 - E) Interest faded in the understanding and treatment of shellshock following the war.
4. Vietnam War
 - A) Soldiers demanded care.
 - B) Veterans organized rap groups.
 - C) PTSD replaced shellshock.
 - D) Peers helping peers heal from PTSD.

5. Women's Movement
 - A) First rape crisis center formed 1971.
 - B) Many support groups to deal with incest were formed.
 - C) Women for Sobriety
- D) "You cannot keep trauma on the table without a political movement."
-- Judith Hermann

SOURCES OF TRAUMA

1. Family
 - A) Witnessing domestic violence
 - B) Physical abuse
 - C) Incest
 - D) Abandonment
2. School
3. Community
4. Natural disasters
5. Accidents
6. Television/videos and computer games
7. Incarceration
8. War
9. Exposure to an adult caretaker's PTSD
10. Multigenerational transmission of trauma
11. Counseling

RISK AND PROTECTIVE FACTORS FOR PTSD

Pre-event risk factors

- Previous exposure to severe adverse traumatic events in childhood (abandonment, neglect, abuse, witnessing abuse)
- Depression or anxiety
- Family instability
- Family history of anti-social behavior
- Early substance abuse
- Conduct disorder
- Absence of social support
- Multiple early losses

Event risk factors

- Geographic nearness
- Level of exposure to the event
- Age
- Duration of the trauma
- The existence of ongoing threats that the trauma will be repeated

Post-event risk factors

- The absence of social support
- Inability to do anything about what happened
- Inability to find meaning in the suffering
- Development of acute stress disorder

Protective Factors

- Early intervention
- One good relationship
- A good social support network
- Ability to turn pain into purpose
- A method of dealing with life's problems that involves talking
- Future orientation
- Involvement in activities that build heart, endurance, and confidence
- A sense of humor
- Therapy to help them heal from trauma

HEALING TRAUMA

The Therapeutic Relationship

1. Recovery is more likely to occur in a warm atmosphere.
2. The client is in charge of the pace.
3. Empowerment is the key.
4. You are a "moral witness."
5. The counselor's role is both empathic and intellectual.
6. You form a partnership.
7. You are aware of the unique feature of Traumatic Transference.
Traumatic Transference –
There are usually three people in the room.
A)
B)
C)
8. Counselor may get displaced rage.
9. Counselors need to possess the ability not to back away from the story.
10. Boundaries are important.
11. Be aware of traumatic countertransference.
12. Be aware of grief reactions.
13. Be aware of the possibility of counselor judgments.
14. Be aware of the possibility for "witness guilt."
15. The counselor needs a support system.

THREE PHASES OF TRAUMA TREATMENT

Safety

1. Name the problem.
2. Client should be informed of the diagnosis.
3. Establish safety.
 - A. Home
 - B. Community
 - C. Counseling

Making counseling safe

-
- Move at the client's pace
- Client is in charge of all disclosure
- A non-anxious presence helps.
- Optimism helps.
-

Safety Questions

- A.
- B.
- C.
- D. How safe do I feel around people I spend time with?
- E. When am I safest?
- F. Where am I safest?
- G. What do I do if I'm feeling unsafe?
- H. How can I tell if I need to protect myself around strangers?

- I. What I learned about my sense of safety by answering these questions.

My Safety Net

The phone numbers I need to know:

- A) My best friend _____.
- B) The nearest crisis hotline _____.
- C) My counselor _____.
- D) My doctor _____.
- E) My safest relatives _____.
- F) The local hospital _____.
- G) Group members _____.
- H) Others _____.

4. Move at the client's pace.

Remembrance and Mourning

- A. Helps to start with the life prior to the trauma.
- B. Help to monitor PTSD symptoms and other support.
- C. Listen to the story.
- D. Provide emotional support.
- E. Give each experience a name.
- F. Counselors need to be comfortable with uncertainty and missing details.
- G. Normalize feelings.

- H. The counselor is a witness, not a detective.
- I. One incident can stand for many.
- J. Testimony can be a healing ritual.
- K. Counselors can help with the grieving process.

Reconnection

Goals

1. Continuing to help the client develop tools to discover strategies to avoid being re-victimized and victimizing others.
2. Learning to stand up more successfully for one's self in the present.
3. Revisiting old hopes and dreams.
4. Establishing new hope and dreams.
5. Client marvels at his survival skills.
6. Finding a survival mission.
7. Reconnecting with others.
8. Striving to reach one's full potential.

Source: *Trauma and Recovery*, Judith Herman, M.D.

DONALD MICHENBAUM'S COGNITIVE BEHAVIORAL APPROACH TO TREATING TRAUMA

1. Listen to the metaphors.
2. Validate the client's feelings.
3. Commend the client for his symptoms.
4. Help the client reframe the symptoms as survival skills.
5. Help the client explore the usefulness of the survival skills today.
6. Symptom reduction.

THE COUNSELOR'S TOOLBOX: HELPING CLIENTS COPE WITH SYMPTOMS CAUSED BY EXPOSURE TO TRAUMATIC EVENTS

1. Relapse prevention plan for clients with substance use disorders and traumatic stress symptoms.

Triggers:

A.

B.

C.

D.

E.

2. Flashbacks

A. Plan for what you will do if you experience a flashback.

B.

C.

D.

E.

F. Name objects in your environment out loud.

G. Hold a safe object.

H. Clap your hands.

- I. Stomp your feet.

J.

- K. Affirmations.
 - L. Listen to soothing music.
 - M. Perform a monotonous task.

- 3. Dealing with nightmares
 - A. Dream preparation
 - B. Reach out for support.
 - C. Ground yourself.
 - D. Self talk
 - E. Hold a safe object.
 - F.

- 4. Difficulty sleeping
 - A. Exercise at least four hours before you go to sleep.
 - B. Do something boring before you go to sleep.
 - C.
 - D. Relaxation techniques.
 - E. Pray.
 - F. Write.
 - G. Avoid alcohol and caffeine.
 - H. Read a boring book.

- 5. Have strategies to deal with angry outbursts.

- 6. Use the SUDS Scale.

SUDS SCALE

- 0) I am completely relaxed with no distress.
- 1) I am very relaxed.
- 2) I am awake and I feel no tension.
- 3) I feel a little tension.
- 4) I feel mild distress, fear, anxiety, or tension in my body.
- 5) My distress is somewhat unpleasant, but I can still tolerate it.
- 6) I am feeling moderate distress and unpleasantness. I have some worry about the symptoms.
- 7) My body tension is substantial and unpleasant. I can still tolerate it.
- 8) I am feeling a great deal of distress, high levels of fear, anxiety, worry. I can't tolerate this for very long.
- 9) The distress is so great I can't think straight.
- 10) I am totally distressed; this is the worst possible fear I could ever imagine.

CRITERIA FOR ANTISOCIAL PERSONALITY DISORDER

- A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years indicated by three or more of the following:**
1. Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest;
 2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning of others for personal profit or pleasure;
 3. Impulsivity or failure to plan ahead;
 4. Irritability and aggressiveness, as indicated by repeated physical fights or assault;
 5. Reckless disregard for safety of others or self;
 6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations;
 7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.
- B. The individual is at least 18 years.**
- C. There is evidence of conduct disorder with onset before age 15 years.**
- D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode.**

Source: *Bad Boys, Bad Men: Confronting Antisocial Personality Disorder*, Black, D.W., Oxford University Press, 1999.

BREAKDOWN OF SYMPTOMS

1. Failure to conform

2. Deceit

3. Impulsiveness

4. Aggression

5. Recklessness

6. Irresponsibility

7. Lack of remorse

CONTRIBUTING FACTORS AND ALTERNATIVE EXPLANATIONS

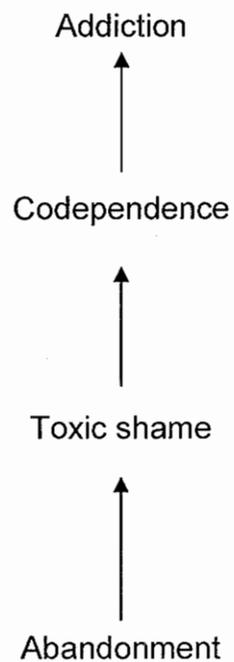
1. Male depression

- A.
- B.
- C.

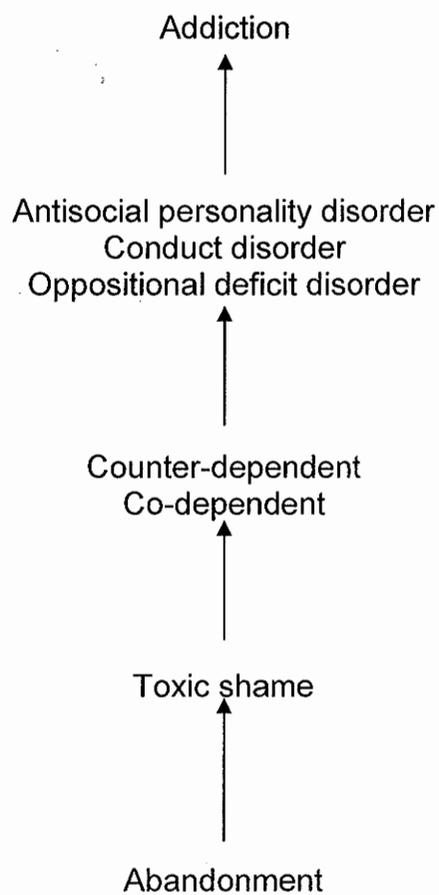
The Masks of Male Depression

- A.
- B.
- C.
- D.
- E.
- F.
- G.
- H.

2. Abandonment



THE ICEBERG MODEL APPLIED TO ANTISOCIAL PERSONALITY DISORDER



3. Killing of the spirit

- A.
- B.
- C.
- D.

4. Father/Son pain

- A.
- B.

5. Genetics

6. **Environment**
7. **Hormones and diet**
8. **Damaged brain**
9. **School bully behavior**
10. **Birds of a feather**
11. **Ignoring learning styles**

Work of Howard Gardner

Schools typically honor 3 types of intelligence

- A. Reading comprehension (with the clock on)
- B. Mathematical intelligence
- C. Memory

Other Types of Intelligence Commonly Ignored

- A. Bodily kinesthetic
 - B. Musical
 - C. Spatial
 - D. Linguistic
 - E. Interpersonal
 - F. Intrapersonal
 - G. Artistic
 - H. Emotional
12. **Abuse and trauma**
 13. **Family dynamics**

DIAGNOSING ANTISOCIAL PERSONALITY DISORDER

1. Interview the client.
 - A.
 - B.
2. Interview relatives and friends.
3. Be aware of common reasons individuals with antisocial personality disorder seek help.
 - A.
 - B.
 - C.
 - D.
 - E.
 - F.
 - G.
4. Look at former hospital records.
5. Legal and educational documents can be helpful.
6. Military records can be helpful.
7. Find out about a history of psychiatric treatment.
8. Frequency of moves and why
9. Work history
10. Administer the MMPI
11. Administer the Buss-Durkee Inventory
12. Ask about injuries from fights and other altercations.
13. Ask about gang, hate groups, or other destructive peer group affiliations.
14. Assess for process addictions.

HELPFUL QUESTIONS IN MAKING THE DIAGNOSIS

1. Do you have a short fuse and a hair-trigger temper?
2. When in trouble, do you blame others?
3. Have you had trouble keeping a job?
4. Have you ever quit a job out of anger without another one to go to?
5. Do you get into frequent fights?
6. Have you ever physically or verbally hurt your spouse?
7. Have you ever not paid child support required by law?
8. Have you ever not followed through on financial obligations?
9. Have you ever vandalized or destroyed property?
10. Have you ever pursued an illegal occupation such selling drugs or prostituting yourself?
11. Have you ever harassed or stalked others?
12. As a child, did you ever skip school?
13. Have you ever been cruel to small animals, such as cats and dogs?
14. Have you ever moved to a new location without having a job lined up?
15. Have you ever been homeless or lacked a fixed address?
16. Have you ever wandered around the country without any clear goal in mind about where you were going?
17. Have you ever stolen or burglarized?
18. If you were in the military, did you ever go AWOL?

19. Did you ever get a tattoo?
20. Have you ever used an alias or gone by another name?
21. Do you tend to be impulsive and make decisions without reflection?
22. Have you ever run a “scam” or tried to con others?
23. Have you ever lied in order to obtain sexual favors from another?
24. Were you ever suspended or expelled from school because of your behavior?
25. As a child, did you ever set fires?
26. Have you ever thought about harming or killing someone?
27. Do you tend to disregard laws that you don’t like, such as those against speeding?
28. Have you ever beaten or abused your children?
29. Are you sexually promiscuous?
30. Did you ever use a weapon in a fight as a child?
31. Did you engage in sexual activity before most of your peers?
32. Have you ever abused alcohol or other drugs?
33. Have you ever mugged anyone?
34. Have you been fired from jobs because of personality problems?
35. As a child, did you ever lie to authority figures, such as parents, teachers, or supervisors?
36. Have you ever been arrested or convicted of a felony?
37. Was your behavior incorrigible as a youngster?

38. Did you ever have to go to a reform school or detention center as a juvenile?
39. Have you ever been jailed or imprisoned?
40. Have you ever squandered money on personal items rather than buying necessities for your family?
41. Are you relatively unconcerned about having hurt or mistreated others?
42. Did you ever run away from home as a child?
43. Were you ever adopted or placed in foster care as a child?
44. Have you ever snatched a purse or picked someone's pocket?
45. Did you ever move in order to avoid the authorities?
46. Have you ever forged someone else's name on a document, such as a check?
47. Have you been married and divorced more than twice?
48. Do you feel that you are better than everyone else and therefore above the law?
49. Do you feel that the world owes you a living?
50. Have you ever forced someone to have sexual relations with you?

Source: *Bad Boys, Bad Men: Confronting Antisocial Personality Disorder*, Black, D.W., Oxford University Press, 1999.

TREATING ANTISOCIAL PERSONALTY DISORDER

1. Explain the diagnosis to the client.

A.

B.

C.

Example: “Now that we’ve learned more about your life, we have reached a few conclusions. Based on what you have told us, you have had a life-long challenge of getting along with others, dealing with authority, controlling your temper, and following the rules and regulations set by others. You told me that the result of this you’ve lost numerous jobs, relationships, and have gone to jail and prison on a number of occasions. Individuals with life-long patterns of stormy relationships, job instability, and criminal behavior have antisocial personality disorder. This does not mean you don’t like people. It means you’ve had years of finding yourself at odds with society and don’t like to follow its rules. This can put you at odds with people and lead to conflict, arrests, terminations, evictions, etc.”

2. Ask for feelings about your statement.

3. Show DSM criteria.

4. Discuss the DSM criteria.

5. Discuss treatment for antisocial personality disorder.

6. Treat co-occurring mental illnesses

7. Assess and treat addictions and sexual violence.

8. Provide recovery support in the natural environment.

9. Help develop recovery capital.

10. Use cognitive behavioral therapy.

COGNITIVE BEHAVIORAL THERAPIES

Rationale Emotive Therapy

Originator: Albert Ellis

Focus: the here and now

View of Human Nature

Rational emotive therapy is based on the belief that people are born with the potential for rational or irrational thoughts. People learn irrational beliefs as children from significant others. Since these thoughts are learned, people have the power to change them as well as their behavior, as irrational thoughts can lead to self-destructive behavior.

Core Beliefs that Cause Disturbances

- A. I am entitled to everything I want.
- B. The world owes me.
- C. My needs are more important than everyone else's.
- D. It is necessary to be loved by all.
- E. One should be thoroughly competent.
- F. Things are awful if they are not exactly the way I want them to be.
- G. I must have approval from all significant people in my life.
- H. It's easier to avoid dealing with life's difficulties than to strive for more rewarding endeavors.

Some of the Results of Irrational Beliefs

- Self criticism
- Isolation
- Self abuse
- Avoid relationships
- Never striving to reach potential
- Prison
- Substance use
- Drug use, etc.

Goal of Therapy

Using a variety of cognitive, emotive, and behavioral methods, particularly the A-B-C approach, to help clients challenge and minimize their irrational beliefs, so that they are able to change

The A-B-C Approach

- A. Activating event (something occurs)
- B. The individual's belief about the event (if the person is thinking irrationally, his/her view is often distorted).
- C. Emotional and behavioral consequence of the belief, often a painful consequence

Techniques

The therapist helps clients change irrational beliefs, using steps D and E.

- D. Disputing and challenging irrational beliefs. Five methods of challenging irrational beliefs:
 - Detecting irrational beliefs
 - Clients are helped to dispute irrational beliefs by paying attention to the exception to the rule.
 - To argue themselves out of the belief
 - To search for evidence that the belief is not true
 - Homework. Give clients assignment to check on assumptions.
- E. The client arrives at an effective philosophy, which is rational. The new philosophy replaces irrational thoughts with rational thoughts.

Other Therapist Techniques

- Help client stop thinking irrationally
- Help client eliminate self-defeating habits and behavior
- Help client accept self and others

COGNITIVE BEHAVIORAL THERAPY

Originator: Aaron Beck

This model is similar to Rational Emotive Therapy, as developed by Albert Ellis. A primary difference is that rational emotive therapy is more directive and the therapist is more in a teaching mode. Beck uses more Socratic questions to help clients reach their own conclusions.

Focus: The here and now

View of Human Nature

Individuals with emotional problems often have faulty thinking, as a result of having inadequate or incorrect information.

Goal of Therapy

To help clients change faulty thinking and thus modifying behavior by teaching clients how to identify and challenge these faulty beliefs cognitively (thinking). Beck calls these faulty beliefs cognitive distortions. They include:

- Entitlement
- Projections
- You're always the victim
- Grandiosity
- Never seeing your part in a dispute
- Over-generalization
- Minimization – making a situation smaller than it actually is
- Magnification – making a situation seem greater than it actually is
- Personalizing events
- Arbitrary inferences – reaching conclusions without evidence
- Labeling yourself (“I’m stupid”)
- Polarized thinking (black or white thinking) – thinking things are either all good or all bad (“I am either all good or all bad.”)

Therapeutic Procedure

- A. Explain cognitive behavioral therapy
- B. Ask client to monitor his/her thoughts and the feelings and behaviors that accompany those thoughts
- C. Challenge the client's thought process
- D. Help client challenge his/her beliefs and assumptions
- E. Help client develop coping skills

Techniques

- A. Challenge assumptions and faulty beliefs through Socratic questions, such as:
 -
 -
 -
- B. Giving homework - to test their beliefs in the real world
- C. Instilling hope – letting clients know that others have had similar problems and turned their lives around.

REALITY THERAPY

Developed by William Glasser – Trained as classic psychoanalyst, working as a consulting psychiatrist in the Vienna School for Girls, he was frustrated, because psychoanalysis was not working with this population. He developed a form of therapy known as reality therapy.

Focus: Helping clients to change in the here and now

View of Human Nature

Human beings have two basic needs:

- A. To love and be loved by others
- B. To feel worthwhile to self and others

Glasser believes that when these two basic needs are unmet, people will exhibit symptoms (i.e., delinquency, crime, violence, drug abuse, etc.).

Goal of Therapy

A major goal of reality therapy is to hold people accountable for their behavior and to teach them better and more effective ways of getting their needs met.

Reality Therapy Counseling Techniques

- A.
- B.
- C.
- D. The therapist believes in natural consequences for behavior rather than punishment.
- E. Emphasis on responsibility. "Regardless of your problem, it is not right to make other people suffer."
- F. Focusing on the client's strengths
- G. Actively discussing the client's current behavior
- H. Discouraging excuses for irresponsible and ineffective behavior

- I. Helping clients achieve goals
- J. Helping clients find constructive ways to meet their basic needs

11. The work of Saminow

12. Nation of Islam

- A. Change in appearance
- B. Change in diet
- C. Reframing the meaning of "Black man"
- D. Knowledge of culture
- E. Knowledge of self
- F. Challenged for inappropriate behavior
- G. Classes on how to live
- H. Hope
- I. Living examples of progress
- J. G.O.D.
- K. Help with employment

13. The newest approach to CBT

14. Provide additional suggestions

- A. Acceptance
- B. Your diagnosis is not an excuse to get into more trouble.
- C. Help secure the "right job"
- D. Provide supportive employment
- E. Educate yourself about antisocial personality disorder
- F. Consider ongoing help
- G. Acknowledge how antisocial personality disorder impacts your family
- H.
- I. Have strategies to control your temper

- J. Seek help for other problems
 - K.
 - L.
 - M.
 - N.
 - O.
 - P.
 - Q.
- 15. Provide help for the family**
- A.
 - B.
 - C.
 - D.
 - E.
 - F.
- 16. Avoid enabling**
- 17. Empower**
- 18. Have firm boundaries**
- A. Loose
 - B. Enmeshed
 - C. Healthy
- 19. Be aware of countertransference**
- 20. Avoid burnout and compassion fatigue**
- 21. Protect other clients**

OUTCOMES: WHAT THE RESEARCH SAYS

1. Even those who show the earliest and worse symptoms can improve.
2. The greatest prevention of antisocial personality disorder involves the effective treatment of conduct disorder.
3. Studies reveal that, in adulthood, 1/3 of antisocials remit, 1/3 have fewer symptoms, and 1/3 make no improvement.
4. Age 35 is the median age for improvement.
5. Many individuals with antisocial personality disorder mature and as older adults many “mellow with age.”
6. Many antisocials burn out
7. As they get older, the circle of whom they affect may shrink.
8. Some get murdered; others commit suicide.
9. Others continue to live their lives on the margins or as “outlaws.”
10. Mentors help.
11. Being over 40 helps.
12. Marriage and incarceration can help.
13. Sobriety helps.
14. Job stability helps.
15. The treatment of other addictions helps.

Source: Research by Lee Robbins

CASE VIGNETTES

Case #1

Melvin has been involved with the “revolving door syndrome” for 20 years. Each time he has entered chemical dependence treatment, he has been kicked out for demonstrating behavior that confirms his diagnosis of antisocial personality disorder—namely, arguing, breaking program rules, defiance, etc. After each discharge he goes back into the community and continues getting high, is rearrested, released, goes back to treatment...

He is about to enter your addictions program as a client. You have looked at his former charts and you are aware of his pattern. You have a meeting with the staff prior to his admittance to discuss how to successfully help Melvin complete treatment this time.

What are your recommendations?

Case #2

You work in a residential psychiatric facility. How do you help assure other patients are not injured by those with antisocial personality disorder?

APPENDIX I

Diagnostic Criteria for Conduct Disorder

A repetitive and persistent pattern of behavior in which the basic of rights of others or major age-appropriate societal norms or rules are violated, as manifested by presence of three (or more) of the following criteria in the past 12 months with at least one criterion present in the past six months:

1. Aggression to people and animals

- Often bullies, threatens, or intimidates others
- Often initiates physical fights
- Has used a weapon that can cause serious physical harm to others (e.g. a bat, brick, broken bottle, knife, gun)
- Has been physically cruel to people
- Has been physically cruel to animals
- Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
- Has forced someone into sexual activity

2. Destruction of property

- Has deliberately engaged in fire setting with the intention of causing serious damage
- Has deliberately destroyed others' property (other than by fire setting)

3. Deceitfulness or theft

- Has broken into someone else's house, building, or car
- Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
- Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

4. Serious violations of rules

- Often stays out at night despite parental prohibitions, beginning before age 13 years
- Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
- Often truant from school, beginning before age 13 years.

5. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.**6. If the individual is age 18 years or older, criteria are not met for antisocial personality disorder.**

DEPRESSION AND ADDICTION

Major Depression

A condition that involves persistent feelings of sadness, emptiness, or irritability everyday for at least two weeks or longer. (The average episode lasts approximately 8 months.)

Signs –

- Loss of interest in most or all activities
- Feelings of worthlessness, guilt, shame, or despair without hope
- Insomnia and difficulty concentrating
- Changes in weight and eating habits

Dysthymia – Chronic Depression

- Average period 4 years
- Symptoms are less pronounced
- Symptoms may not be experienced all day or everyday
- Suffer from similar, but less intense, feelings of worthlessness and despair

TREATMENT OF DEPRESSION AND ADDICTION

1. Cognitive behavioral therapy
2. Interpersonal therapy
3. Psycho-education
4. Biblio-therapy – feeling good book
5. Attachment based family therapy
6. Functional family therapy
7. Social skills training
8. Pharmacological treatment
9. Combine therapy and medication
10. Self-help group attendance

DIAGNOSTIC CRITERIA FOR SCHIZOPHRENIA

A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

- 1) delusions
- 2) hallucinations
- 3) disorganized speech (e.g., frequent derailment or incoherence)
- 4) grossly disorganized or catatonic behavior
- 5) negative symptoms, i.e., affective flattening, alogia, or avolition

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts or two or more voices conversing with each other.

B. Social/Occupational Dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

OBSERVATIONS AND ETIOLOGY

1. **Movement abnormalities in infancy and early childhood (early motor delays)**
2. **Family history**
3. **Interpersonal and emotional difficulties during childhood and adolescents**
4. **Social isolation**
5. **Likely to answer yes to 1 of 5 questions listed below:**
 - A. **Do you believe in mind reading or being psychic? Have other people ever read your mind?**
 - B. **Have you ever had messages sent just to you through the television or radio?**
 - C. **Have you ever thought that people are following you or spying on you?**
 - D. **Have you heard voices other people can't hear?**
 - E. **Has something ever gotten inside your body or has your body changed in some way?**

Source: Poulton, Caspi A. *Archives of General Psychiatry* (57) pp. 1053-1058 (2000) *Children's Self Reported Psychiatric Symptoms*

6. **Prodromal features prior to first psychotic episode**
 - A. **Reduced concentration and attention**
 - B. **Decreased motivation, drive, and energy**
 - C. **Mood changes, depression, anxiety**

- D. Sleep difficulties**
- E. Social withdrawal**
- F. Suspiciousness**
- G. Irritability**
- H. Decline in role functioning—academic, hygiene, appearance, interests**

TREATMENT OF SCHIZOPHRENIA

1. **Psychotherapy**
2. **Psycho-education**
3. **Cognitive behavioral therapy**
4. **Cognitive remediation therapy**
 - A. **Teach thinking skills**
 - B. **Teach memory**
5. **Interpersonal therapy**
6. **Social skills**
7. **Family therapy**
8. **Compliance therapy**
9. **Medication**
10. **Education about drugs of abuse**
11. **Treat co-occurring conditions**

DIAGNOSTIC CRITERIA FOR BIPOLAR DISORDER

- A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary)
- B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
- Inflated self-esteem or grandiosity
 - Decreased need for sleep
 - More talkative than usual or pressure to keep talking
 - Flight of ideas or subjective experience that thoughts are racing
 - Distractibility
 - Increase in goal-directed activity
 - Excessive involvement in pleasurable activities that have a high potential for painful consequences

Overlap

- A. ADD
- B. Normal adolescence
- C. Depression
- D. ADHP
- E. Conduct disorder
- F. Anxiety disorder

Risk Factors

1. Family history
2. Sexual abuse
3. Early losses
4. Gender

TREATMENT OF BIPOLAR DISORDER

1. Similar to the treatment of depression
2. Group therapy
3. Family-based therapy

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- Strategies for reducing recidivism for probationers with co-occurring disorders.
- How to integrate the mental health and addictions recovery movements in order to help probationers with co-occurring disorders recover.

ABOUT THE PRESENTER

Mark Sanders, LCSW, CADC, is a member of the faculty of the Addictions Studies Program at Governors State University. He is an international speaker in the addictions field whose presentations have reached thousands throughout the United States, Europe, Canada, and the Caribbean Islands. He is co-author of *Recovery Management* and author of *Relationship Detox: How To Have Healthy Relationships in Recovery*. He has had two stories published in the *New York Times* best selling book series, *Chicken Soup for the Soul*.