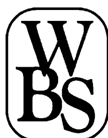

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Dual diagnosis: substance-related and psychiatric disorders

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One of the most challenging situations facing mental health professionals is intervening effectively with patients who present with a mental illness and a substance abuse problem. Central to this problem is that a universal definition of *dual diagnosis* or *dual disorder* does not currently exist. Diminished resources, in the form of financial reimbursement and clinical programs for this complex, diverse population, compound the issue. Finally, as long as clinicians who deal with this population continue to intervene from a dichotomous stance of psychiatry versus chemical dependence, things are not likely to change. This dichotomous clinical approach parallels the federal and state governments' systems that continue to have separate departments for mental health and for alcohol and drug issues. Even more detrimental is that funding sources continue to provide different benefit levels for the two sets of disorders [1].

Defining the problem

The term *dual diagnosis* initially was developed to refer to a coexisting major mental illness and substance disorder. The psychiatric disorder was perceived as severe and persistent, causing prolonged disability and requiring long-term care. For purposes of this article, the psychiatric diagnosis predominantly refers to an Axis I disorder. The substance disorder label encompasses a second Axis I disorder that includes alcohol and other drugs (including prescription drugs, such as tranquilizers and sleeping medicines) and abuse and dependence of these substances as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision* (DSM IV-TR) [2].

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Today, it is rare to find a patient who limits his or her chemical misuse to only one substance. Polysubstance abuse/dependence is more the norm than the exception. The acronym *MICA* may describe these individuals more accurately as "mentally ill, chemically addicted or abusing" [3].

Although the term *addiction* has not been the favored term in describing substance dependence, it may define the problem more accurately. The American Society of Addiction Medicine [4] defines addiction as: "a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use; compulsive use; continued use despite harm; and craving." When addressing dual diagnosis, addiction is defined as follows: "the whole problem is greater than the sum of the parts, since the two disorders inevitably exacerbate each other" [1]. Each patient is unique because co-occurring mental health and substance use disorders vary along the dimensions of severity, chronicity, and degree of functional impairment.

It now generally is agreed that 50% of patients diagnosed with a mental illness also have a coexisting substance abuse problem [5]. Minkoff's [6] first principle of treatment is that "comorbidity is an expectation, not an exception." This situation may be underestimated. The National Alliance for the Mentally Ill, in its "HelpLine Fact Sheet," reported that mental health professionals and the families of mentally ill patients underestimate the amount of drug dependency among people in their care [5].

Limited resources

When a dual diagnosis is made, in the acute phase of treatment, less emphasis needs to be placed on which disorder preceded the other. Psychiatric disorders may have developed before, concurrent with, or after the onset of chemical dependency. Just as is true in the general population, some of these patients may begin to use drugs or alcohol on a recreational basis. It is probable that many of these patients continue using in an attempt to subdue symptoms of their illness. This situation may be due to inadequate medication in the treatment of the psychiatric disorder or to an attempt to deal with the adverse side effects of the psychotropic medication. It may be an attempt to reduce anxiety or merely to substitute for the prescription that has run out. Often the patient does not have access to medication because of economic or basic transportation issues.

Additionally, patients with co-occurring disorders often are housed precariously and are especially vulnerable to becoming homeless. Homelessness significantly compromises the chances of recovery from either or both disorders, and it may contribute to the exacerbation of symptoms of both disorders [7].

The result of substance use is compounded by the fact that patients with mental disorders have such fragile brain chemistry that even "social" use of

alcohol or drugs can destabilize them and cause psychotic episodes [8,9]. These episodes can lead to the need for additional hospital admissions. Currently, there are not many supportive alternative environments in place for these patients to turn to outside of an inpatient stay. The scrutiny by third-party payers resulting in diminished reimbursement and length of stay for partial hospitalization programs often limits these settings as a treatment option.

If the patient is not decompensated enough to warrant hospitalization, he or she also may encounter difficulties in seeking help within the community. Organized groups, such as Dual Disorders Anonymous, Dual Recovery Anonymous, and Double Trouble in Recovery, are limited to larger metropolitan areas where, even there, they are in short supply. The dually disordered patient is required to explore the mainstay of 12-step support groups, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Although many of these groups are becoming more accepting of attendees on prescription medication, it still may take visiting several groups before finding one in which the patient feels comfortable; this is not something that a patient in need of immediate support could or would want to handle.

One program, called "Support Together for Emotional and Mental Serenity and Sobriety" (STEMSS), has been developed for individuals with schizophrenia and chemical abuse problems. Although predominantly concentrated in rural areas, it has established more than 80 sites since its inception in 1984. It evolved because fellow AA or NA members did not understand that persons with mental illness also needed to take prescription medications. STEMSS is not a therapy group but has been described as "closer to an AA meeting than group therapy and closer to group therapy than an AA meeting" [10]. It has six basic characteristics: (1) secure, safe environment; (2) structured format; (3) strong peer support; (4) social and recreational opportunities; (5) heavy emphasis on medication compliance and abstinence; and (6) psychoeducation. STEMSS fosters self-esteem by focusing on the growth, potential, and gifts each member brings to the group, rather than on members' singular or collective deficiencies.

Effective interventions

The approach most effective with a dual diagnosis population is use of an illness model and avoidance of a moralistic tone. Embracing certain basic tenets increases the likelihood of the group's and the group members' success. In contrast to traditional 12-step programs, the individual should not be required to acknowledge publicly that he or she has a problem. Relapse must be accepted as an inevitable occasional outcome of the illness, which includes open acceptance of an individual returning.

The most significant progress in the treatment of the dually diagnosed patient is in addressing the heterogeneity of the group, including the

different levels at which these patients present for and continue in treatment. Clinicians should expect varying levels of motivation and insight. "Starting to Stop" describes the approach taken in a treatment-based dual diagnosis patient group. The name of this group reflects the basic philosophy—an acceptance of the group in including members at various stages of recovery. Recognizing motivation as an emotional state rather than a fixed personal attribute provides the foundation for developing strategies to empower consumers and enhance their readiness to benefit from treatment [11]. This philosophical approach also empowers the health care professional and diminishes the incidents of burnout.

Prochaska and colleagues [12] developed a model for change that identified six patient stages with concomitant presenting behavior and effective intervention. This model was adapted by the Texas Department of Mental Health and Mental Retardation and the Texas Commission on Alcohol and Drug Abuse to address nuances within this patient population (Table 1) [13].

Although authorities in the field view abstinence as the safest option, some providers and immediate family members may find that tolerance of occasional use or agreement to cut back may get more cooperation than insisting on total abstinence. The latter approach tends to promote denial, however, and result in diminished communication on the subject. Achieving abstinence is a process. Accepting occasional relapses is different from allowing "controlled" alcohol or drug use.

The primary goal of treatment is improving patients' conditions and helping them function more adequately in their current lives. Because these

Table 1
Dual Diagnosis Project Summary: Principles of Treatment

Stage of treatment	Patient behavioral presentation
Preengagement	Service provider works toward establishing trust and rapport with potential patient/consumer
Engagement	Consumer/patient has irregular contact with service providers as trust and interest in services builds
Early persuasion	Regular contact with service providers and discussion of reduction of nonprescribed drug use
Late persuasion	Established relationship with service providers and actual reduction of nonprescribed drug use
Early active treatment	Continued reduction of nonprescribed drug use as patient/consumer works toward abstinence
Late active treatment	No use (or controlled use without associated problems) for 1–6 months
Relapse prevention	No use (or controlled use without associated problems) for at least 6 months
Recovery	No use for >1 year and formal substance abuse treatment ceases

Data from Texas Department of Mental Health and Mental Retardation's and Texas Commission on Alcohol and Drug Abuse's Dual Diagnosis Project Summary. Available at: www.mhmr.state.tx.vs/central office/behavior. Accessed 1999.

patients often present with multiple issues, responding to a hierarchy of needs within a "here-and-now" focus is most effective with this population. A nonconfrontational, empathetic, and optimistic style by the health care professional is desirable. A nonjudgmental and individualized approach that takes into account the patient's strengths, deficits, response to feedback, and individual stage of treatment is paramount.

Patients who perceive change as a threatening and negative experience may be reluctant and uncomfortable with practitioners who suggest strategies for change. If the desired outcomes of these changes seem unlikely or possible only in the distant future, commitment will not be sustained. Substance abusers by the nature of their disease respond to and expect instant gratification. Strategies for behavioral change need to include a supportive relationship and should begin by targeting achievable, short-term goals that build confidence. In addition, providers should ensure that the patient is involved with developing treatment plans and that the pace and intensity of interventions are sensitive to the patient's ability. It is helpful if providers are aware of the person's recent life experiences. Individuals who have been chronically deprived or abused need to experience a sense of security and stability that allows them to explore the potential for change and future improvement [7].

The best program with the highest trained providers cannot replace a good therapeutic alliance. Daley and Thase [14] described a therapeutic alliance as the ability to "connect with the patient, respect differences, show empathy, use humor, and understand the 'inner world' of the patient." A good therapeutic alliance facilitates recovery, whereas a poor therapeutic alliance results in missed appointments, reduced group attendance and participation, or noncompliance with the treatment plan.

Motivational interviewing has been shown to be effective in working with dually diagnosed patients [15]. Its emphasis on placing the responsibility for change directly on the patient works hand in hand with the individualized models for stages of change described earlier. Within this framework there is a reduced focus on confrontation that is more acceptable with this particular population. Resistance on the part of the patient is viewed as an interpersonal behavior pattern that is influenced directly by the therapist's behavior. The personal concerns of the patient are elicited, providing the therapist with leverage to challenge denial. Reflection is used to amplify the patient's discrepancies and to enhance motivation for change.

Problem-solving processes are elicited from the patient and significant people in his or her life. The perceptions of the patient seeking treatment are explored without any attempts made at correcting them. Placing attention and the onus for change on the patient is instrumental in achieving more permanent, significant change.

Helpful topics with these patients include defining specific chronic mental illnesses and addiction in patient-friendly terms, discussing triggers for relapse, identifying good and bad drugs, and discussing family issues [16].

Included is assisting the MICA patient in developing basic insight into the connection between substance abuse and mental health. Relapse in the former arena is most likely to exacerbate psychiatric symptoms.

It is commonly known that an increase in perceived stress is one of the most frequent causes of exacerbation of symptoms of psychiatric disorders. The importance of didactic training on ways to deal with stress cannot be overemphasized. It is hypothesized that persons with schizophrenia relapse when they have inadequate strategies for handling stress, and we know that in schizophrenia the tolerance for stress is limited [11]. Teaching social skills training and behavioral strategies for limiting stressful interactions and providing information regarding how to function effectively in activities of daily living are important modules of this education. Attendees are encouraged to ask questions, share personal experiences, and express their ideas on ways to cope with problems that may impede their path to recovery.

Research conducted at Cornell University, "Lifeskills Training," found that the most effective antidrug education for teenagers focuses on helping kids cope with the demands and stress of daily life. This approach could be adapted easily to an adult dually diagnosed population.

Teaching behavioral techniques as simple as deep breathing exercises to deal with an increase in anxiety is not only practical but also effective. A 30-minute meditation group allows ample time not only to teach the skill but to build trust and bonding within the group itself. Role playing or getting the audience involved in discussing how they would react if they saw others drinking or using is paramount to the development of sound coping skills. These individuals need to be able to apply what they learn to their own life situations. Similar to teenagers, they relate better to an interactive experience than to didactic lectures given about the harms of alcohol and drug usage.

Employing written material in groups and individual contacts has been found to be more effective than verbal instruction alone. It also provides the patient with something to refer to long after the session has ended. Repetition and review are integral approaches needed to aid patients in assimilating this material.

Staying abreast and focusing on a currently popular drug with harmful effects has been found to be effective in reducing usage of that particular drug. Although information this can be handled well through the media, health professionals working with MICA patients can make a difference by quickly spreading the word about the harmful effects of the latest street drug. Staff must continue to educate themselves, especially regarding the drugs that are most popular and accessible in their geographic area.

Summary

Although significant strides have been made in the treatment of dually diagnosed patients, integrated treatment still is not offered. Until behavioral health providers can broaden their perspectives and stop focusing on

which came first, the mental illness or substance abuse/dependence, they will continue to evade the approach that would serve this challenging patient population most effectively and efficiently. Integration needs to occur not only within the philosophical framework, but also within the clinical interventions used. Treatment modalities that have proved or could prove most effective have been presented. The challenge now is to apply the modalities in an individualized plan of care, meeting the patient at his or her own personal level.

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