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## Overview of Treatment Modalities for Dual Diagnosis Patients

### Pharmacotherapy, Psychotherapy, and 12-Step Programs

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#### INTRODUCTION

In the past decade, interest has burgeoned in the treatment of patients dually diagnosed with substance-use disorders and coexisting psychiatric illness (1-3). One major reason for this attention has been the fact that this patient population has traditionally had poor outcomes; when compared with individuals with either disorder alone, dually diagnosed patients have higher rates of hospitalization, medication noncompliance, homelessness, criminality, and suicide (4). Research in the early 1980s by McLellan et al. (5,6), who demonstrated the ineffectiveness of certain forms of traditional substance-abuse treatment for psychiatrically ill substance abusers, served as an initial impetus for clinicians and researchers to develop treatment approaches that are specifically suited to dually diagnosed patients. In this chapter, we present an overview of these treatment methods. Since the treatment of many specific subpopulations of dually

diagnosed patients is discussed in detail later in this book, we do not present in depth the full scope of the work being done in this field. Rather, we focus on some of the major themes that have dominated this subject area, and will discuss issues that continue to present particular difficulty to clinicians and researchers in the field.

#### THE IMPORTANCE OF HETEROGENEITY AMONG DUALY DIAGNOSED PATIENTS

One unfortunate by-product of the interest in patients with coexisting psychiatric illness and substance-use disorders is the fact that the term "dually diagnosed patient" has often been used as if this is a discrete category of patients, requiring "dual diagnosis treatment." Our group (7) has previously discussed the problems inherent in this categorization; one would never find a ward in a general hospital strictly for patients with two *medical* disorders. It is similarly important to recognize the heterogeneity of patients dually diagnosed with both a substance-use disorder and a psychiatric illness. Thus, in devising a treatment plan for a dually diagnosed patient, one should consider not only the specific substance-use disorder(s), but other Axis I and/or Axis II disorder(s), and coexisting medical conditions. The clinician then needs to evaluate all the various medical conditions as well as their interactions. Consider, for example, the case of a diabetic patient with a narcissistic personality disorder who develops chronic pain as a result of a peripheral neuropathy. The patient is prescribed opioids for pain relief, and abuses them by taking more than the prescribed dose. He eventually feels discouraged by the pain and his illness, and becomes severely depressed. This "dually diagnosed" patient is then referred for evaluation and treatment. What are the "two" diagnoses? Clearly, this patient has six important diagnoses: diabetes, peripheral neuropathy, chronic pain, depression, narcissistic personality disorder, and opioid abuse. Only by performing a comprehensive evaluation and attending to the interaction of these disorders, as well as to other important phenomena such as presence or absence of family support, employment, and stable housing can one formulate an appropriate comprehensive treatment plan.

Different psychiatric disorders may have highly varied relationships with specific substance-use disorders. For example, Brown et al. (8,9) have found that symptoms of depression and anxiety abated quite dramatically over the course of 1 and 3 months, respectively, in male alcoholics treated in a VA setting. Conversely, there are some reports that women with coexisting posttraumatic stress disorder (PTSD) and substance-use disorder may experience an exacerbation of their PTSD symptoms upon

attaining early abstinence (10,11). Therefore, in devising a treatment strategy for a dually diagnosed patient, it is critical to understand the relationship between that individual's two disorders, including the impact on one disorder of improvement or worsening of the other.

Drug choice may also vary according to psychiatric diagnosis, although study findings conflict in this area. For example, in a study that our group conducted, 37% of 350 patients hospitalized for drug dependence had a concurrent Axis I psychiatric disorder other than substance dependence (12). Cyclothymic disorder was significantly more common among cocaine abusers, while generalized anxiety disorder and panic disorder were more prevalent among sedative-hypnotic abusers. Moreover, studies of PTSD have shown that the use of "harder" drugs (i.e., cocaine and opioids) produces a stronger association between trauma and a subsequent diagnosis of PTSD than does the use of marijuana (13,14). Other studies, however, have not demonstrated a clear link between specific drug preference and psychiatric diagnosis. Mueser et al. (15), for example, found little correlation between drug of choice and psychiatric diagnosis among 263 psychiatric inpatients. Rather, these investigators argued that sociodemographic characteristics (e.g., gender, age) and drug availability are more important than diagnosis as determinants of substance use among psychiatrically ill patients.

#### INTEGRATED VS. PARALLEL OR SEQUENTIAL TREATMENT

One of the fundamental clinical and research issues that arise in the treatment of dually diagnosed patients is the question of whether a patient with coexisting substance-use disorder and psychiatric illness can and should simultaneously receive treatment for both illnesses from the same staff in the same setting (i.e., integrated treatment) or whether the patient should initially be treated for the problem that is more acute and then begin treatment for the other problem (i.e., sequential treatment). A third option is "parallel" treatment, in which patients concurrently receive treatment in two settings, e.g., a mental health center and a drug-abuse clinic, each staffed by different clinicians. The difficulties inherent in the parallel treatment system have been well described (16,17). One of the major problems with parallel or sequential treatment is the fact that psychiatric and substance-abuse treatment programs frequently have different philosophical orientations. Psychiatric programs often downplay substance use, or see it as merely a secondary problem or as a form of "self-medication" that will resolve with treatment of the psychiatric disorder. In some psychiatric settings (particularly for patients with psychotic disorders), substance-use disorders frequently go undiagnosed (18).

Staff in substance-abuse programs, on the other hand, are generally much more strict and frequently confrontational about substance use and may, conversely, overattribute psychiatric symptoms to substance use. For example, depression or lack of motivation may be seen as a manifestation of self-pity or a lack of effort to resolve one's substance-abuse problem. Manic irritability may similarly be misinterpreted as willfulness and denial of substance use. Thus, confrontation may extend beyond substance use to psychiatric symptoms. In many substance-abuse settings, certain psychiatric symptoms (e.g., trauma) are not attended to, and clinical staff may be reluctant or ill-informed about the assessment of certain disorders such as PTSD (19).

By sheer chance, then, patients may receive very different treatment experiences in a parallel or sequential treatment model, based on initial routing to a substance abuse or a psychiatric treatment setting. Moreover, as described above, patients who receive parallel or sequential treatment in different settings are likely to receive different feedback from different staff members who treat them. This can be quite confusing, particularly if communication between the two programs is infrequent and not well organized. Unfortunately, this state of affairs is relatively common, and patients are likely to suffer as a result.

Several studies in the late 1980s and early 1990s suggested that integrated treatment of patients with dual disorders could improve outcome. Kofoed et al. (20) developed an outpatient program for severely mentally ill patients and found that patients who stayed in the treatment program experienced a reduction in hospital utilization. Hellerstein and Meehan (21) also reported a substantial decrease in hospital days among patients who entered a weekly outpatient therapy group for individuals with schizophrenia and substance abuse. Ries and Ellingson (22) found that integrating psychiatric and substance-abuse treatment on an inpatient psychiatric unit was also beneficial, as patients who attended substance-use discussion groups were more likely to be abstinent during the month following discharge from the hospital. Drake et al. (23) have shown the most dramatic long-term results from an integrated dual diagnosis treatment approach; over 60% of chronically mentally ill patients enrolled in their program had achieved stable abstinence at 4-year follow-up. One negative study of integrated treatment was reported by Lehman et al. (24), who found no reduction in substance abuse among dually diagnosed patients in an integrated program after a year.

Although the majority of studies have shown favorable outcomes of an integrated approach, most published studies of integrated programs have consisted of reports from pilot projects, with small sample sizes and/or no control groups. Hellerstein et al. (25), however, recently conducted

a prospective study comparing an integrated model of treatment for 23 patients with schizophrenia and substance-use disorder to a nonintegrated (parallel) treatment model ( $N = 24$ ). They found treatment engagement and retention to be significantly better in the group receiving integrated treatment. Moreover, descriptions of other integrated treatment approaches, e.g., for schizophrenia (26) and PTSD (27), have recently been published. Thus, integrated treatment of dually diagnosed patients is gradually becoming more commonplace. We await the results of ongoing empirical studies to see which specific integrative strategies are most successful for which populations.

The reluctance of the field to integrate substance-abuse and psychiatric treatment has been paralleled by a failure to integrate pharmacological and psychotherapeutic treatments, even in studies of dual diagnosis treatment (28). Rather, most research with dually diagnosed patients has focused on either a pharmacological or a psychosocial treatment approach, but not the combination of the two. Interestingly, studies of innovative treatments for patients with coexisting mood disorders and substance-use disorders have generally focused on medications, while studies of new treatments for patients with schizophrenia and substance-use disorders have generally emphasized psychosocial approaches. The combined use of an innovative pharmacotherapy and a new psychotherapeutic approach for dually diagnosed patients has been quite rare (29). In the remainder of this chapter, we review some of the major findings of pharmacological, psychotherapeutic, and self-help approaches that have been used in the treatment of dually diagnosed patients.

## PHARMACOTHERAPY

The use of pharmacotherapy for the dually diagnosed patient has generally been targeted to treat the patient's psychiatric illness rather than the substance-use disorder. Such an approach has several goals. First, it is hoped that the medication will be effective in treating the disorder (e.g., schizophrenia) for which it is designed. Moreover, with the relief of psychiatric symptoms, it is posited that the patient will experience a reduction in substance use as a result of having improved mood, less anxiety, better judgment due to fewer psychiatric symptoms, and increased ability to engage in and profit from psychosocial treatment. Many practicing clinicians, however, are reluctant to prescribe psychoactive medications for patients who are actively abusing substances. Reasons for this include 1) fear of a toxic interaction between a patient's drug(s) of abuse and prescribed medication; 2) fear that patients who are actively abusing drugs or alcohol are unlikely to experience improvement in their psychiatric

disorders because of the deleterious effects of substances of abuse on mood, anxiety, cognition, or psychotic symptoms; 3) a fear of "enabling" the patient, accompanied by the hope that issuing an ultimatum (e.g., "I won't prescribe you an antidepressant until after you have stopped drinking") will motivate the patient to abstain; 4) a fear of being manipulated by a substance-abusing patient, even if the clinician is unclear about the patient's potential ulterior motive; and 5) a fear that the patient's psychiatric symptoms are substance-induced, and that medication is unnecessary. Similar fears make clinicians wary about undertaking psychotherapy with substance-abuse patients.

Research findings from studies of the pharmacotherapy of dually diagnosed patients should alleviate some of the concerns described above. Specifically, Saxon and Calsyn (30) found that by conducting psychiatric evaluations on patients entering an outpatient VA substance-abuse program and then pharmacologically treating coexisting psychiatric disorders, outcome at the end of 1 year was as favorable for the dually diagnosed patients as for the patients with substance abuse alone. Moreover, a number of double-blind, placebo-controlled studies of patients with coexisting substance-use disorders and mood or anxiety disorders have shown a beneficial effect of the medication on the disorder for which the medication is targeted (e.g., improvement in depressive symptoms among patients receiving imipramine), and a less dramatic (but not countertherapeutic) effect on substance use (28).

The effect of pharmacotherapies on dually diagnosed patients has been studied most thoroughly for depression. This literature is well summarized by Nunes and Quitkin (31), whose group has studied the treatment of depression in patients dependent on alcohol (32) and opioids (33). They reported similar findings in both instances—specifically, a relatively good antidepressant effect and a more modest effect on substance use. Studies of the effectiveness and safety of antidepressants in the treatment of individuals with depression and coexisting substance abuse are important because they address some of the central concerns of practitioners who treat these dually diagnosed patients. Specifically, these studies help to allay concerns about the futility of treating depression in patients who are using drugs that may adversely affect mood. Moreover, they address the important question of whether prescribing psychotropic medications for patients who are abusing substances represents a form of "enabling." Although the use of antidepressants for depressed substance abusers does not generally lead to substantial improvement in their substance use, it does not worsen substance use, as would be the case if this were a form of "enabling" behavior. Indeed, one preliminary report (34) suggests that fluoxetine may reduce drinking in depressed alcoholics. Moreover, improvement

of depression (with its attendant morbidity and mortality) is itself an important goal, analogous to the appropriate treatment of a coexisting medical illness. It is unthinkable, for instance, that anyone would recommend withholding treatment for pneumonia from a drug-dependent patient on the grounds that the treatment would enable the patient's addiction. Properly diagnosed depression (and other psychiatric illness) should be treated similarly.

There has been very little research on the pharmacological treatment of patients with bipolar disorder and substance-use disorder; we are aware of only three very small open trials with this population: two with lithium (one positive, one negative) (35,36) and one with valproate (37). The latter report was relatively encouraging, in that the nine patients in the trial tolerated valproate well and showed improvement in both mood and substance use. However, the small sample sizes and open nature of these trials are significant limitations. Replication with a larger sample size is needed.

Research involving patients diagnosed with both substance-use disorders and anxiety disorders is also sparse. Although Quitkin et al. (38) long ago reported a successful trial of imipramine in a small group of patients with coexisting substance abuse and panic disorder (both drinking and panic attacks improved), little research has since been conducted with this subgroup of dually diagnosed patients. Two studies of patients with generalized anxiety disorder and substance-use disorder revealed a beneficial effect of buspirone on anxiety (39,40). However, drinking behavior did not improve in one of the studies, and substance use was not assessed as a treatment outcome measure in the other study. A recent double-blind, placebo-controlled study by Kranzler et al. (41) showed the potential benefits of buspirone in a group of 61 anxious alcoholics (i.e., they scored 15 or higher on the Hamilton Anxiety Rating Scale (42) after a week of abstinence from alcohol). Patients who receive buspirone were more likely to remain in the 12-week treatment trial, and had lower levels of anxiety, a slower return to heavy drinking, and fewer drinking days during the 6-month posttreatment follow-up.

Few issues generate as much controversy as the use of benzodiazepines for patients with an anxiety disorder and a coexisting substance-use disorder. Indeed, some authors (43) assert that this class of drugs is contraindicated in substance-dependent patients except during detoxification, since benzodiazepines can cause physical dependence, be abused, and serve as a trigger for other substance use. Other authors (44-46), however, have argued for the judicious use of these medications in patients who cannot take other pharmacological treatments or who fail to respond to them. More systematic studies of this topic are needed, since clinicians

often encounter patients who are currently being prescribed clonazepam or another benzodiazepine, most commonly for an anxiety disorder. The decision regarding whether to continue the benzodiazepine is a complicated one; factors to consider include whether an adequate trial of alternative pharmacological treatment has occurred, and whether psychological treatment approaches alone could allow the patient to cope with his or her anxiety.

Another highly controversial topic is the treatment of patients diagnosed with both attention deficit hyperactivity disorder (ADHD) and substance abuse. Several case reports (47,48) have supported the potential efficacy of stimulants in the treatment of patients with these coexisting disorders. However, one must be concerned about the potential abuse of stimulants in a drug-dependent population, particularly among patients who do not have ADHD (49) or who receive that diagnosis mistakenly. Roache et al. (50) recently conducted a double-blind, placebo-controlled study of methylphenidate in 27 cocaine-dependent patients, and found no differences between the groups in treatment retention or in subsequent cocaine use. Larger studies of the efficacy and abuse potential of stimulants in substance dependent patients with ADHD are currently underway.

As stated above, relatively little research has been done on pharmacological treatment of patients with coexisting schizophrenia and substance-use disorders. Most studies of these patients have focused on psychosocial treatment, with patients receiving standard pharmacotherapy, although occasional case reports have described reduced craving in patients treated with clozapine (51) or mazindol (52). One randomized pharmacotherapy study with this population was conducted by Ziedonis et al. (29), who compared the combination of desipramine plus antipsychotic agents to antipsychotic medications alone for patients with schizophrenia who were abusing cocaine. Patients who received desipramine had significantly fewer cocaine-positive urines during the third and final month of the trial.

In sum, then, pharmacological treatment of dually diagnosed patients is generally helpful for the targeted psychiatric disorder, and is sometimes (although generally less robustly) beneficial for the substance-use disorder. In general, the fears that many clinicians harbor regarding the prescription of psychotropic medications to this population have not been borne out by empirical studies. However, more well-designed clinical trials are needed in this area.

#### PSYCHOTHERAPY

Currently, there is substantial interest in the development of psychotherapies for dually diagnosed patients. Indeed, interest in psychotherapy for



substance abuse per se is itself a relatively recent phenomenon. For most of this century, therapists did not attend to substance abuse, and saw psychotherapy for this population as contraindicated. However, as drug abuse attracted increasing attention as a public health problem, and as attempts to develop effective pharmacotherapies (particularly for cocaine dependence) were disappointing, interest grew in the development of new psychotherapeutic treatments (53). Recent years have seen adaptation of psychodynamic approaches for substance-abuse patients (54), the seminal cognitive-behavioral work by Marlatt and Gordon (55) that launched the area of relapse prevention, the development of motivational enhancement therapy (56), and several creative behavioral treatments for substance abuse, such as contingency management (57,58) and cue exposure (59). A natural outgrowth of such developments has been their application to dually diagnosed patients, including patients with substance abuse and schizophrenia (26), PTSD (27), and borderline personality disorder (60). The recent initiative by the National Institute on Drug Abuse (61) to foster the development of psychotherapeutic and other behavioral treatments for drug abuse has also spurred this process.

The use of psychotherapy becomes particularly important when other treatments are either ineffective or contraindicated for particular dually diagnosed patients. Consider the case of a patient with severe borderline personality disorder who abuses cocaine. There is currently no standard psychopharmacological treatment for either borderline personality disorder or cocaine dependence. While 12-step self-help groups may be useful, they are also unlikely to resolve many of the patient's problems including (for instance) poor interpersonal relationships and self-destructiveness. Psychotherapy may thus be particularly helpful for such a patient. In contrast, some alcoholic patients with major depression might be successfully treated with a combination of disulfiram or naltrexone, an antidepressant, and Alcoholics Anonymous meetings. The extent to which a particular dually diagnosed patient needs psychotherapy must therefore be assessed on a case-by-case basis, particularly in the current climate of managed care, in which resources for treatment are often scarce. Psychotherapy should thus be neither automatically eschewed ("just send them to Alcoholics Anonymous") nor uniformly prescribed.

Psychotherapy may be particularly helpful for patients with longstanding psychiatric disorders for whom functional deficits (e.g., poor socialization, employment problems) are likely to remain even after resolution of acute psychiatric or drug-related symptoms. It may also be helpful for patients who are in danger of a worsening of their psychiatric symptoms during early abstinence (e.g., patients with PTSD), those with erratic treatment compliance (62), and those whose psychiatric illness makes it

difficult for them to appreciate the severity of their substance-use problems (63).

Although empirical research on the psychotherapy of dually diagnosed patients is still relatively sparse, certain common principles have emerged from descriptive reports of psychotherapeutic approaches with chronically mentally ill substance abusers (64,65). First, such treatment needs to proceed in stages, using a longitudinal, long-term perspective. Although substance-abuse treatment settings generally emphasize the importance of abstinence as an immediate (as well as long-term) goal, many patients with severe mental illness and substance abuse do not even perceive substance use to be problematic. Moreover, they often react adversely to the type of confrontation that is common in substance-abuse treatment settings. For these reasons, the psychotherapeutic approach to the dually diagnosed patient should be informed by knowledge of Prochaska and DiClemente's five stages of readiness to change substance-use behaviors: precontemplation, contemplation, preparation, action, and maintenance (66). Thus, for patients who are contemplating whether substance use is a problem, the goal of treatment is to discuss their ambivalence, rather than to practice drug-refusal skills. The latter is important in the action phase of treatment, when the patient's central question is *how*, not *whether* to get sober.

Osher and Kofoed (64) have divided the psychotherapy of dually diagnosed patients into four phases, which are consistent with a longitudinal approach. In *engagement*, the therapist tries to make a connection with the patient, and attempts to convince him or her that treatment may offer something beneficial. During *persuasion*, the goal is to convince the patient that substance use is a problem, and that he or she should therefore try to abstain. This stage of therapy consists primarily of motivational interventions based on the work of Miller and Rollnick (67), including a) expressing empathy, b) pointing out discrepancies between the patient's goals and his or her current behavior, c) avoiding argumentation, which generally only increases resistance to change, d) rolling with resistance, rather than challenging it, and e) supporting self-efficacy by expressing confidence in the patient's ability to make changes.

During the stage of persuasion, providing education about the negative consequences of substance use and the potential benefits of abstinence can be very important. Since chronically mentally ill patients are frequently demoralized, they may feel that they have nothing to lose by using substances, to gain a few hours of escape. A thorough discussion of potential adverse consequences of substance use (e.g., physical damage, medication nonadherence, worsening psychiatric status, estrangement from friends and family) may help to persuade a patient of the potential

benefits of abstinence. This stage of treatment may be quite lengthy, and needs constant reinforcement, since the desire to resume substance use can return at any time.

*Active treatment* is most familiar to clinicians in the substance-abuse field, since it focuses on techniques to achieve abstinence: learning drug- and alcohol-refusal skills, recognizing and avoiding high-risk situations, dealing with craving, and beginning to establish a drug-free lifestyle. Self-help-group attendance is generally most beneficial if begun during this phase.

Finally, *relapse prevention* attempts to solidify the gains made during the previous stages of treatment. During this stage, the patient identifies relapse triggers and ways of dealing with them, learns about the abstinence-violation effect, and develops positive coping behaviors to deal with risky situations, including "lapses" or "slips."

Throughout the process, the therapist needs to search for areas of common ground with the patient. For example, if the patient does not see substance use as a problem in its own right but is worried about depression, the therapist may stress the adverse effects of substance use on mood. Thus, one may help enhance motivation for substance-abuse treatment by linking the substance use to an issue that the patient *does* want to change (e.g., depression). Finally, dually diagnosed patients often need concrete training in social skills, both to help them attain abstinence (e.g., drug-refusal skills) and to aid them in other life areas, such as job interviews and social relationships.

Psychotherapy with dually diagnosed patients presents special challenges for the therapist. For example, as one disorder improves or worsens it is likely to affect the other, often in unpredictable ways. Abstinence may exacerbate PTSD symptoms (10,11) while making depressive symptoms better (8). Similarly, substance use may either increase, decrease, or not affect symptoms of the other disorder, depending on the substance, the diagnosis, and the specific patient. The etiological relationship between the two disorders may also vary widely (68). Some patients may be "self-medicating" their psychiatric symptoms, while others will have developed substance abuse first, predisposing them to other psychiatric illnesses. Still other patients will have two disorders that are not clearly related. Such variability may have implications for psychotherapeutic treatment by suggesting alternate interventions for the therapist to pursue (e.g., taking a harm-reduction approach rather than an abstinence-oriented stance with a patient whose other psychiatric disorder worsens with abstinence).

In conducting psychotherapy with dually diagnosed patients, therapists must also learn to compensate for whichever side of their training is weaker. Most clinicians are more experienced and adept in either sub-

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a broader array of domains and often slower progress. Some evidence suggests that treatment goals may mean giving up immediate expectations and thinking of treatment as a long-term endeavor.

An integrated treatment approach requires integration of the therapist, as well as in the structure of the treatment. A therapist who can fluidly move between the work of substance abuse and mental health is likely to be the most effective. Also willing to take on tasks not previously emphasized in psychotherapy: case management work such as case housing, calling to get up an HIV test for the patient to obtain public assistance, making oneself available outside of sessions, and carrying out an involuntary commitment. On an emotional level, the therapist must manage countertransference issues such as viewing substance abuse as "morally weak," or "manipulative" (67), or other psychiatric illness as "hopeless" or "making no sense." Developing an optimistic, compassionate attitude toward the dually diagnosed patient (63) may take considerable time.

### 12-STEP PROGRAMS

The use of 12-step, self-help programs such as Alcoholics Anonymous (AA) for dually diagnosed patients is a subject of great controversy. It is in this area that a parallel treatment approach is most problematic. Although many dually diagnosed patients find 12-step groups enormously helpful because of their structure, mutual advice, and optimism, some of these very characteristics are a number of patients, particularly those with more severe mental illness, feel more alienated (70).

A patient with a longstanding history of alcohol dependence was asked about his opinion of AA. He said, "It's too uptight. I hear about people's sobriety and hear how they're doing. I don't want to see pictures of people and hear how their lives have been turned around and I want company."

This quote concludes a common theme among dually diagnosed patients, who find it difficult to relate to the dogmatic AA members' experience as the result of some such individuals, who may remain quite sober, are sometimes accused of wallowing in self-pity.

Substance abuse or mental health, and few receive extensive training in dual diagnosis treatment. The therapist who is relatively less skilled in substance-abuse treatment must learn to obtain detailed information about substance use at each session (e.g., amount, type, frequency). Obtaining urine screens and/or breath-alcohol tests is often unfamiliar to psychiatrically oriented clinicians, and may be resisted on the grounds that it conveys distrust of the patient. However, such monitoring provides the most powerful method of accurately monitoring substance use and is quite common in substance-abuse treatment settings. Learning the psychobiology of substance abuse (such as withdrawal and habituation), the language ("craving," "enabling," slang terms for drugs), the lifestyle (e.g., sex-for-drug exchanges, needle-sharing), and the extraordinary ways in which substances come to dominate patients' lives beyond all other concerns may also be new to such a therapist. The therapist new to substance abuse must learn the need for stabilization before in-depth psychotherapeutic work can begin, the importance of delaying insightful interpretations and exploration of painful affects in favor of containment and support, and the need to continually reassess which symptoms are substance-induced and which genuinely reflect another disorder. The therapist also learns the limits of methods that work on single-diagnosis patients. For example, flooding, which is widely promoted for PTSD, may be dangerous for a patient with this disorder who is also prone to a substance-abuse relapse.

Clinicians who are more familiar with substance-abuse patients may similarly require new learning. The confrontational approach used in many substance-abuse treatment programs may be deleterious for dually diagnosed patients, for whom such interventions may increase resistance to substance-abuse treatment, as well as precipitate increased psychosis, depression, anxiety, or other symptoms. The emphasis on 12-step programs may also need to be modified, as described below. The therapist may need to become skilled in new treatment interventions, e.g., exposure therapy for obsessive-compulsive disorder, "grounding" for PTSD symptoms, and a motivational, long-term approach for psychotic patients. Knowledge of medications for psychiatric illnesses, their potential side effects, and their interactions with substances of abuse is also important. On a more subtle level, the therapist will need to acquire a sensitive understanding of how substance use may hold dynamic meanings within the context of another disorder. In a depressed patient, substance use may represent a "reward" for long-term suffering; in a patient with PTSD, it may represent retaliation against an abuser. Exploring the patient's past may also take up more of the session to understand how the substance use and psychiatric illness have intertwined to affect the patient's development. Outcome assessment is likely to become more complex, comprising

a broader array of domains and often slower progress. Setting realistic treatment goals may mean giving up immediate expectations of abstinence and thinking of treatment as a long-term endeavor.

An integrated treatment model requires integration within the person of the therapist, as well as in the structure of the treatment program. The therapist who can fluidly move between the worlds of substance abuse and mental health is likely to be the most effective. Such a therapist is also willing to take on tasks not previously emphasized within the domain of psychotherapy: case-management work such as helping the patient locate housing, calling to set up an HIV test for the patient, helping the patient to obtain public assistance, making oneself increasingly available outside of sessions, and carrying out an involuntary commitment to prevent violence. On an emotional level, the therapist may need to face strong countertransference issues such as viewing substance abusers as "low-lives," "morally weak," or "manipulative" (69), or viewing patients with other psychiatric illness as "hopeless" or "making an excuse for substance use." Developing an optimistic, compassionate stance in treating the dually diagnosed patient (65) may take considerable effort.

## 12-STEP PROGRAMS

The use of 12-step, self-help programs such as Alcoholics Anonymous (AA) for dually diagnosed patients is a subject of great interest and controversy. It is in this area that a parallel treatment approach can be most problematic. Although many dually diagnosed patients find self-help groups enormously helpful because of their structure, role modeling, practical advice, and optimism, some of these very characteristics may make a number of patients, particularly those with more severe mental illness, feel more alienated (70).

A patient with a longstanding history of depression and alcohol dependence was asked about his opinion of AA. He said, "I hate it." When asked why, he said, "It's too upbeat. I don't want to hear about people's job promotions and hear about the 'joys of recovery.' I don't want to see pictures of people's grandchildren and hear how their lives have been turned around. I'm miserable, and I want company."

This quotation echoes a common theme among patients with psychiatric illness, who find it difficult to relate to the degree of life improvement that so many AA members experience as the result of abstinence. Indeed, some such individuals, who may remain quite depressed despite their sobriety, are sometimes accused of wallowing in self-pity ("sitting on the

pity pot") by other AA members. Some psychiatrically ill patients will be criticized for taking medication, despite official AA publications to the contrary. When dually diagnosed patients heed the advice of well-meaning but misguided AA members who suggest that they stop their medication, disaster may ensue.

Another problem that frequently arises when dually diagnosed patients attend self-help meetings is the fact that the clinicians treating them often have unrealistically lofty expectations of self-help meetings. Psychotic patients who have long been socially withdrawn may be expected to relate to AA members in a way that they have been unable to achieve with anyone else in recent memory. Integrated dual diagnosis treatment programs may help to alleviate these difficulties, since the staff is familiar with both the psychiatric illness and the characteristics of self-help meetings. If they are helped to review and process what happens at 12-step meetings, patients can benefit much more from them.

Paying attention to a patient's motivation for treatment is also critical in helping to advise him or her regarding 12-step meetings. Ziedonis and Fisher (26), for example, have written about a longitudinal treatment program for schizophrenic substance abusers, based on the "readiness to change" model described above. Since self-help groups are part of the "action" stage, it is important to recommend them for patients who are most likely to be receptive, since the goal in having patients attend AA or other self-help meetings is for them to attend them *regularly*, not just once. The likelihood of regular attendance is enhanced if a patient's initial experience with AA is positive. Thus, it is less helpful to have patients attend such meetings if they are at only the precontemplation or even the contemplation stage. A recent study by Jerrell and Ridgely (71) compared a 12-step recovery approach with two other treatment models—behavioral skills training and intensive case management—for 132 patients with substance-use disorder and severe psychiatric illness. Patients in the 12-step treatment fared less well on measures of psychosocial functioning and symptom changes than did the other two groups. It is important to note, however, that 12-step meetings such as AA are "programs of attraction," and thus designed to help only a subgroup of patients. It is quite possible that blending aspects of a 12-step model into an overall integrated dual diagnosis program that includes pharmacotherapy, behavioral skills, and case management may yield better outcomes.

#### SUMMARY

Treatment for dual diagnosis patients is in an early but productive stage. In the past decade, both pharmacological and psychological treatment

approaches to specific subgroups of dually diagnosed patients have been formulated, empirical testing has been begun, and outcomes have been quite promising. The next decade is likely to see the continued refinement of these treatments; better integration of psychological, pharmacological, and self-help therapies; more controlled outcome studies; improved training of clinicians; and new standards of care.

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