Overview of Treatment Modalities for Dual-Diagnosis Patients

Pharmacotherapy, Psychotherapy, and 12-Step Programs

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INTRODUCTION

For the past 15 years, interest in developing and implementing new treatments for patients dually diagnosed with substance use disorders and coexisting psychiatric disorders has grown significantly (1–4). 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 an increased rate of hospitalization, medication non-compliance, homelessness, criminality, and suicide (5–8). Research in the early 1980s by McLellan et al. (9,10) demonstrated the ineffectiveness of certain forms of traditional substance abuse treatment for psychiatrically ill substance abusers; this served as an impetus for clinicians and researchers to develop treatment approaches that are specifically suited to dually diagnosed patients.

In this chapter, we will present an overview of these treatment methods. Since the treatment of many specific subpopulations of dually
diagnosed patients will be discussed in detail later in this book, we will not present in depth the full scope of the work being done in this field. Rather, we will 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 DUALLY DIAGNOSED PATIENTS

One unfortunate byproduct of the interest in patients with coexisting psychiatric illness and substance use disorders has been the fact that the term “dually diagnosed patient” has often been used as if this were a discrete category of patients, requiring “dual-diagnosis treatment.” Our group (11) 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 the specific substance use disorder(s), other Axis I and/or Axis II disorder(s), and coexisting medical conditions. The clinician then needs to evaluate all of the various disorders 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 opiates 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. Which are the “two” diagnoses? Clearly, this patient has six important diagnoses, namely diabetes, peripheral neuropathy, chronic pain, depression, narcissistic personality disorder, and opioid use disorder. Only by performing a careful 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. (12,13) found symptoms of depression and anxiety to abate quite dramatically over the course of one month and three 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 (14–16). 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 of improvement or worsening of one disorder on the other.

Drug choice may also vary according to psychiatric diagnosis, although there are conflicting findings 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 (17). Cyclothymic disorder was significantly more common among cocaine-dependent patients, while generalized anxiety disorder and panic disorder were more prevalent among those dependent upon sedative-hypnotic drugs. Moreover, "harder drugs" such as cocaine and opioids consistently show a higher association with trauma and the diagnosis of PTSD than do marijuana or alcohol (which are presumably "less severe" substances) (18). Other studies, however, have not demonstrated a clear link between specific drug preference and psychiatric symptoms or diagnosis. A recent study by Aharonovich et al. (19), for instance, showed that, while a sample of treatment-seeking individuals diagnosed with cocaine or opioid dependence had high levels of depression and anger, subjects diagnosed with heroin dependence were more likely to have depression and subjects diagnosed with cocaine dependence were more likely to have difficulties with anger. This finding could be seen as contradicting the hypothesis (20) that a sedating drug such as heroin would be preferred by patients with higher levels of anger and that a stimulating drug such as cocaine would be preferred by patients with higher levels of depression. Indeed, Mueser et al. (21) 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 were 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 arises 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
reatment in two settings, e.g., a mental health center and a drug
use clinic, each staffed by different clinicians. The difficulties inherent
in the parallel treatment system have been well described (22,23). 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
stance 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
(24–27).

Staff in substance abuse programs, on the other hand, are frequently
confrontational about substance use and might, conversely, attribute too
many psychiatric symptoms to substance use. For example, depression or
ack 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 some substance abuse treatment settings, certain psychiatric symptoms,
such as those that occur following trauma, are neglected. Clinical staff may
be reluctant to deal with psychiatric symptoms or may be ill informed about
the assessment of disorders such as PTSD (25,28).

Patients may therefore receive different treatment experiences in a
parallel or sequential treatment model, on the basis of initial routing to a
stance 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 the 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 quite common, and patients are
likely to suffer as a result.

Although many clinicians and researchers have long advocated an
“integrated” approach to the treatment of patients with substance use
orders and coexisting psychiatric illness, no single method is agreed upon
to accomplish this goal. Integrated models have been developed primarily
for patients with schizophrenia (29–38), but also for patients with bipolar
order (39,40), personality disorders (41,42), posttraumatic stress
disorder (43–45), and depression (46). These models provide integrated
treatment in a variety of ways. Strategies include discussing commonalities
between the disorders; alternating between sessions focusing on
psychiatric issues and sessions focusing on substance use issues; providing
intensive case management; and stressing the importance of compliance with medication.

Several studies in the 1980s and early 1990s suggested that certain forms of integrated treatment of patients with dual disorders could improve outcome. Kroen et al. (47) developed an outpatient program for severely mentally ill patients and found that patients who stayed in the treatment program experienced a reduction in hospital occupancy. Hetherstein and Methean (48) 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 Ellington (49) found that integrating psychiatric and substance abuse treatment on an inpatient psychiatric unit was also beneficial, as patients who attended substance abuse discussion groups were more likely to be abstinent during the month following discharge from the hospital. Drake et al. (50) showed 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 four-year follow-up. One negative study of integrated treatment from that era was reported by Lehman et al. (51), 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 from an integrated approach, many published studies of integrated programs have consisted of reports from pilot projects, with small sample sizes and/or no control groups. Hetherstein et al. (36), however, conducted a prospective study that compared an integrated model of treatment for 23 patients with schizophrenia and substance use disorder to a non-integrated (parallel) treatment model (N = 24). They found treatment engagement and retention to be significantly better in the group receiving integrated treatment. Similarly, Drake et al. (34) compared treatment outcomes for 159 homeless adults who received integrated treatment (IT) for severe mental illness and a co-existing substance use disorder to 59 homeless adults who received parallel treatment (called standard treatment or ST) for the same psychiatric conditions. When compared to the ST group, the IT group had greater numbers of days in stable housing, fewer days in an institutional setting, greater progress toward recovery from substance abuse (measured by the stage of substance abuse treatment), and greater improvement in their alcohol use disorders. Moreover, descriptions of other integrated treatment approaches for schizophrenia (29–33,37,38,52), posttraumatic stress disorder (43–45), personality disorders (41,42), bipolar disorder (39), and depression (46) have also been published. While the initial results of studies of integrated treatments for dual disorders with small sample sizes are encouraging (29–33,36,40,43,53,54),
further empirical research of integrated treatment of dually diagnosed patients, using control groups and larger samples, are needed to demonstrate which specific integrative strategies are most successful for which populations. In the remainder of this chapter, we will review some of the major findings of pharmacologic, 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 for which it was 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) an impression that the patient’s psychiatric symptoms are substance-induced, and that medication is thus unnecessary.

Research findings from studies of the pharmacotherapy of dually diagnosed patients should alleviate some of the concerns described above. Specifically, Saxon and Calsyn (55) found, by conducting psychiatric evaluations on patients entering an outpatient VA substance abuse program and then pharmacologically treating coexisting psychiatric disorders, that outcome at the end of one year was as favorable for the dually diagnosed patients as for the patients with substance use disorder alone. Moreover, a number of double-blind, placebo-controlled studies of patients with substance use disorders and coexisting 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 an antidepressant), and a less dramatic (but not countertherapeutic) effect on substance use (56,57). In one study, however, treatment with desipramine improved major depression secondary to alcohol dependence, and also prolonged abstinence from alcohol (58). In addition, untreated major depression has been shown to be associated with negative drinking outcomes. A study by Greenfield et al. (59) found that, while hospitalized patients dually diagnosed with alcohol dependence and major depression relapsed three times more quickly following discharge than did those without a depression diagnosis, those with major depression who were not prescribed an antidepressant at the time of discharge relapsed more quickly than those with depression who received antidepressants at the time of discharge. The treatment of co-occurring psychiatric disorders, therefore, is an important component of the overall treatment of patients diagnosed with substance use disorders; failure to treat the psychiatric disorders may result in poorer substance use outcomes for patients with dual disorders.

The effect of pharmacotherapies on dually diagnosed patients has been studied most thoroughly for depression. This literature is well summarized by Nunes and Quitkin (60), whose group has studied the treatment of depression in patients dependent on alcohol (61) and opioids (62). They reported similar findings in both instances—specifically, a relatively good antidepressant effect and a more modest effect on substance abuse. Studies of the safety and effectiveness of antidepressants in the treatment of individuals with depression and coexisting substance use disorder 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 patients 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. In fact, studies of fluoxetine in depressed alcoholics (63–65) and venlafaxine in depressed, cocaine-dependent individuals (66) have shown improvement in depressive symptoms as well as reductions in alcohol and cocaine use, respectively. One study by Pettinati et al. (67), however, found that a lifetime diagnosis of major depression in alcoholics was associated with a poorer response (as measured by drinking frequency during the 14-week study period) to sertraline than to placebo. The conflicting findings between the study of sertraline (67) and the studies of fluoxetine
(63–65) and venlafaxine (66) emphasize the importance of further study of antidepressants for the treatment of substance use disorders and coexisting major depression to determine which medications may be most efficacious for specific subgroups of dually diagnosed patients.

Even if antidepressant treatment of depressed alcohol-dependent patients does not result in a reduction in drinking behavior, improvement of depression (with its attendant morbidity and mortality) is itself an important goal, analogous to the appropriate treatment of 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 disorders; we are aware of only three small open trials with this population: two with lithium (one positive, one negative) (68,69), and one with valproate (70). The latter report was relatively encouraging in that nine patients in the trial tolerated valproate well and showed improvement in both mood and substance use. In one double-blind, placebo-controlled study of lithium in adolescents with bipolar disorder and substance dependence, Geller et al. (71) found that treatment with lithium was effective for both disorders. However, the open nature of three of these trials and the small sample sizes of all four studies are significant limitations.

Research involving patients diagnosed with both substance use disorders and anxiety disorders is also sparse. Although Quitkin et al. (72) 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 (73,74). 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 double-blind, placebo-controlled study by Kranzler et al. (75) 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 (76) after a week of abstinence from alcohol). Patients who received buspirone were more likely to remain in the 12-week treatment trial and had lower levels of anxiety (although only among a subgroup with the highest pretreatment anxiety levels), a slower return to heavy drinking, and fewer drinking days during the 6-month post-treatment follow-up. Finally, a recent 8-week, double-blind, placebo-controlled study of paroxetine for patients with social anxiety disorder
and coexisting alcohol dependence demonstrated significant reductions in symptoms of anxiety for patients treated with paroxetine (77). However, no significant differences in alcohol use outcomes between the paroxetine and placebo groups were found.

Few issues generate as much controversy as the use of benzodiazepines for patients with an anxiety disorder and a coexisting substance use disorder (78). Indeed, some authors (79) assert that this class of medications 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 (80–83), 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. Additionally, a study of the treatment of PTSD with benzodiazepines for VA patients with coexisting substance use disorders revealed both a decrease in PTSD symptoms and utilization of outpatient health services, without demonstrating an increase in substance abuse (84). These findings, however, apply to a specific patient population with PTSD and substance use disorders, and may not apply to other patients with the same disorders or to patients with other anxiety disorders. More systematic studies of this topic are needed, since clinicians often encounter substance-abusing 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 the level of certainty of the diagnosis, the adequacy of previous trials of alternative pharmacological treatments, 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 use disorders. Several case reports (85,86) have supported the potential efficacy of stimulants in the treatment of patients with these coexisting disorders. In their 12-week, open-label trial of sustained-release methylphenidate in 12 patients with ADHD and cocaine dependence, Levin et al. (87) demonstrated significant improvement in both symptoms of ADHD and cocaine use. One must be concerned, however, about the potential abuse of stimulants in a drug-dependent population, particularly among those patients who are not diagnosed with ADHD (88) or who receive that diagnosis mistakenly. Because of its low abuse potential, bupropion may prove to be a promising alternative to stimulants for patients with ADHD and substance use disorders. A recent single-blind study of bupropion for the treatment of cocaine dependence and adult ADHD reported decreases in both cocaine use and symptoms of ADHD (89).
Larger, controlled clinical trials will be necessary to assess its efficacy in this patient population. In addition, the recent approval by the US Food and Drug Administration of atomoxetine, a selective norepinephrine reuptake blocker, for treatment of ADHD, may offer another option in the treatment of the disorder among patients with substance use disorders.

Research investigating pharmacological treatment of patients with coexisting schizophrenia and substance use disorders has expanded with the introduction of atypical antipsychotic agents. Previously, most studies of these patients had focused on psychosocial treatment, with patients receiving standard neuroleptic pharmacotherapy. One randomized pharmacotherapy study with this population was conducted by Ziedonis et al. (90), who compared the combination of desipramine and antipsychotic agents to antipsychotic medications alone for patients with schizophrenia who were abusing cocaine. Patients who received desipramine had significant fewer cocaine-positive urine drug screens during the third and final month of the trial.

More recently, a number of studies have focused on the potential utility of atypical antipsychotic medications for treating patients diagnosed with schizophrenia and substance use disorders. Treatment with clozapine has been shown to decrease craving for cocaine (91) and reduce substance use (92–96). A retrospective chart review study by Zimmet et al. (96) showed that clozapine reduced both overall clinical symptoms and substance use in a sample of 43 patients diagnosed with coexisting schizophrenia or schizoaffective disorder and a substance use disorder. At the present time there are no published randomized, clinical trials examining the efficacy of clozapine for the treatment of patients with schizophrenia and coexisting substance use disorders.

In their 12-month, prospective, open label trial of olanzapine, Littrell et al. (97) reported significant reductions in psychopathology and substance use in 30 patients diagnosed with either schizophrenia or schizoaffective disorder and a coexisting substance use disorder. Similarly, a 6-week, open-label study comparing risperidone to standard neuroleptics in 18 patients diagnosed with schizophrenia and cocaine dependence found that treatment with risperidone resulted in significantly less cue-elicited craving and fewer relapses at the end of the study period (98). The results of studies of atypical antipsychotics for treatment of substance use disorders in schizophrenia must be viewed with caution because of small samples and a lack of control groups. More studies are necessary to determine whether atypical antipsychotic medications will be effective in treating coexisting substance use disorders in patients with schizophrenia.

While most medication studies involving patients with schizophrenia and substance use disorder primarily target schizophrenia, a small 8-week,
open-label, prospective trial of naltrexone administered three times per week to individuals diagnosed with schizophrenia and coexisting alcohol abuse or dependence demonstrated reductions in both psychotic symptoms and alcohol use (99). The greatest reductions in alcohol use were seen among those patients with higher levels of baseline drinking. Naltrexone may play a role in the treatment of schizophrenia and alcohol dependence, but randomized, clinical trials with larger samples are needed to determine its efficacy in this patient population. Furthermore, the degree to which improvement in schizophrenia symptoms is directly due to reduced drinking should also be examined.

In summary, 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 for 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 the 20th 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 (100). Recent years have seen the adaptation of psychodynamic approaches for substance abuse patients (101,102). These include the seminal cognitive-behavioral work by Marlatt and Gordon (103) that launched the area of relapse prevention, the development of motivational enhancement therapy (104), and several creative behavioral treatments for substance abuse, such as contingency management (105–107) and cue exposure (108,109). A natural outgrowth of such developments has been their application to dually diagnosed patients with schizophrenia (29–38,52,110), PTSD (43–45), personality disorders (41,42,53), depression (46), and bipolar disorder (39,40).

Preliminary studies of psychotherapies for dual disorders have shown some promising results. Brady et al. (43) found that a combination of exposure therapy to treat PTSD and cognitive-behavioral techniques to treat cocaine dependence resulted in significant decreases in PTSD symptoms and
cocaine use both during treatment and over a 6-month follow-up period. Similar decreases in psychiatric symptoms and substance use have also been reported in studies of a modified dialectical behavioral therapy (DBT) for borderline personality disorder (53), social skills training and motivational interviewing for schizophrenia (29, 31, 36, 37), and cognitive-behavioral therapy for PTSD (54) and bipolar disorder (40). However, it is important to note that, while these initial results are promising, much more remains to be achieved. Many of these studies represent early-stage work that needs refinement (e.g., elucidation of the impact of external treatments, application to larger samples, and comparison to randomized control conditions).

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 unlikely to resolve many of the patient's problems such as poor interpersonal relationships and self-destructiveness. Psychotherapy may 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 since resources for treatment are often scarce. In short, psychotherapy should be neither automatically eschewed (“just send them to Alcoholics Anonymous”) nor uniformly prescribed.

Psychotherapy may be helpful to a variety of dually diagnosed patients. Those patients with long-standing psychiatric disorders for whom functional deficits remain even after resolution of acute psychiatric or drug-related symptoms may benefit from having such problems as poor socialization or employment difficulties addressed in supportive psychotherapy. Psychotherapy may also be helpful for patients who are at risk for an exacerbation of psychiatric symptoms during early abstinence (e.g., patients with PTSD), those with erratic medication compliance (111), and those with psychiatric illnesses that make it difficult for them to appreciate the severity of their substance use problems (112).

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 (30, 113–115). 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 use disorder do not even perceive substance use to be problematic. Moreover, they often react negatively 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 (116). 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 Kofod (114) 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 (104), including a) expressing empathy, b) pointing out discrepancies between the patient’s goals and his or her current behavior, c) avoiding argumentation, which generally 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. A recent small study by Martino et al. (117) indicates some promise for the use of motivational interviewing techniques with dually diagnosed patients.

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 severely and persistently 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 non-adherence, worsening psychiatric status, estrangement from friends and family) may help 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" and "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 (15,16) while making depressive symptoms better (12). Similarly, substance use may have a variety of effects on symptoms of the other disorder, depending on the substance, the diagnosis, and the individual patient. The etiological relationship between the two disorders may also vary widely (118). 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 learn to compensate for whichever side of their training is weaker. Most clinicians are more experienced and adept in either substance abuse or mental health, and relatively 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, and frequency). Obtaining urine drug screens and/or breath alcohol tests is often unfamiliar to psychiatrically oriented clinicians, and may be resisted on the grounds that it conveys
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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 use (such as withdrawal and abstinence), 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, and the importance of delaying insightful interpretations and exploration of painful effects in favor of containment and support. There is a 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-dependent 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 precipitate increased psychosis, depression, anxiety, or other symptoms. Moreover, this approach may increase resistance to substance abuse treatment, leading to an early departure from treatment. The emphasis on 12-step programs may also need to be modified, as is described below in the next section. 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 illness, 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 bipolar disorder, it may represent a desire to precipitate euphoric mania; 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. Progress may be slower than in patients with a single disorder; setting realistic treatment goals may mean giving up immediate expectations of abstinence and thinking of treatment as a long-term endeavor. Outcome assessment
is thus likely to become more complex, comprising a broader array of domains.

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 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 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 a substance abuser as a “low-life,” a “morally weak” person, or “manipulative” (119). In turn, therapists sometimes view patients with other psychiatric illnesses as “hopeless” or “making an excuse for substance use.” Developing an optimistic, compassionate stance in treating the dually diagnosed patient (48) may take considerable effort.

In conclusion, the future development of psychotherapies for dually diagnosed patients should draw on the advances in both individual and group treatment models as well as the understanding of the skills that therapists should possess in order to enhance patient care.

12-STEP PROGRAMS

The use of 12-step, self-help or mutual-help programs such as Alcoholics Anonymous (AA) for dually diagnosed patients is a subject of great interest and some 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 (120).

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, some of whom find it difficult to relate to the degree of life improvement that so many AA members experience as the result of
abstinence. Indeed, some individuals who remain 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 are 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 relate 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. Patients who are helped to review and process what happens at 12-step meetings may 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 (52), 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 study by Jerrell and Ridgely (121) compared a 12-step recovery approach (i.e., patients were taken to or referred to AA meetings, received help with finding a sponsor, and received ongoing supportive counseling to help manage the 12-step recovery process) with two other treatment models—behavioral skills training and intensive case management—for 132 patients with substance use disorder and severe psychiatric illness. Patients receiving the 12-step approach fared considerably worse 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 are 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 results.
Recent evidence has suggested that 12-step groups that are specifically designed for psychiatrically ill individuals may be quite helpful. With the development of Double Trouble in Recovery (DTR), a 12-step self-help group for persons diagnosed with a substance use disorder and mental illness, dually diagnosed patients have a forum where they can discuss their psychiatric illness without fear of criticism from other group members. Recent research has demonstrated that participation in DTR may increase the likelihood of compliance with psychotropic medications. Magura et al. (122) found that patients who attended weekly DTR meetings had better self-reported compliance with their medications than did those patients who attended DTR less frequently. While these findings are promising, more research on DTR will be necessary to validate them with objective measures of compliance and to determine whether this 12-step self-help group will be beneficial for larger groups of dually diagnosed patients.

SUMMARY

The development of treatments for dually diagnosed patients is an exciting and productive area of psychiatric research. Both pharmacological and psychological treatment approaches to specific subgroups of dually diagnosed patients have been formulated, empirical testing is proceeding, and outcomes have been quite promising. The future of dual-diagnosis treatment is likely to include 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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REFERENCES


