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Feature Articles

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This peer reviewed Journal is dedicated to the continuing development and ongoing evaluation of psychosocial rehabilitation, ACT programs and therapeutic techniques. As such, all articles remotely pertaining to such treatment will be considered for publication. However, the International Journal of Psychosocial Rehabilitation reserves the right to reject any and all articles, but will only do so in cases in which article content does not apply to the goals of the Journal.

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Behavioral Couples Therapy For Alcoholism and Drug Abuse

Timothy J. O'Farrell, Ph.D.
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Nearly 25 years ago, the National Institute on Alcohol Abuse and Alcoholism hailed couple and family therapy as "one of the most outstanding current advances in the area of psychotherapy of alcoholism" and called for controlled studies to test these promising methods (Keller, 1974). Currently behavioral couples therapy (BCT) is the family therapy method with the strongest research support for its effectiveness in substance abuse.

Purpose of BCT
BCT works directly to increase relationship factors conducive to abstinence. A behavioral approach assumes that family members can reward abstinence, and that alcohol- and drug-abusing patients in happier, more cohesive relationships with better communication have a lower risk of relapse. Typically, the substance-abusing patient and the spouse are seen together in BCT for 15 to 20 outpatient couple sessions over five to six months. Generally, couples are married or cohabiting for at least one year, without current psychosis, and one member of the couple has a current problem with alcoholism and/or drug abuse. The couple starts BCT soon after the substance user seeks help.

BCT Treatment Methods
BCT sees the substance-abusing patient with the spouse to build support for sobriety. The therapist arranges a daily "sobriety contract" in which the patient states his or her intent not to drink or use drugs that day (in the tradition of one day at a time), and the spouse expresses support for the patient's efforts to stay abstinent. For those alcoholic patients who are medically cleared and willing, daily Antabuse ingestion-witnessed and verbally reinforced by the spouse-also is part of the sobriety contract. The spouse records the performance of the daily contract on a calendar provided by the therapist. Both partners agree not to discuss past drinking or fears about future drinking at home to prevent substance-related conflicts that can trigger relapse. Instead, they reserve these discussions for the therapy sessions. At the start of each BCT couple session, the therapist reviews the sobriety contract calendar to see how well each spouse has done their part. If the sobriety contract includes 12-step meetings or urine drug screens, these are also marked on the calendar and reviewed. The calendar provides an ongoing record of progress that is rewarded verbally at each session. The couple performs the behaviors of their sobriety contract in each session to highlight its importance and to let the therapist observe how the couple does the contract.

Using a series of behavioral assignments, BCT increases positive feelings, shared activities and constructive communication because these relationship factors are conducive to sobriety. For instance, "Catch Your Partner Doing Something Nice" asks spouses to notice and acknowledge one pleasing behavior performed by their partner every day. In the caring day assignment, each person plans ahead to surprise their spouse with a day when they do some special things to show they care.

Planning and doing shared rewarding activities is important, because many substance abusers' families have stopped shared activities that are associated with positive recovery outcomes (Moos et al., 1990). Each activity must involve both spouses, as well as their children or other adults. In addition, the activities can take place at or away from home. Teaching communication skills can help the alcoholic and spouse deal with stressors in their relationship and in their lives, and this may reduce the risk of relapse.

Relapse prevention is the final activity of BCT. At the end of weekly BCT sessions, each couple completes a continuing recovery plan that is reviewed at quarterly follow-up visits for an additional two years.

This BCT overview describes methods used at the Counseling for Alcoholics' Marriages (CALM) Project in the Harvard Medical School department of psychiatry at the Veterans Affairs Medical Center in Brockton, Mass. More details can be found elsewhere (O'Farrell, 1993; Rotunda and O'Farrell, 1997).

Research on BCT With Alcoholism

Several studies have compared drinking and relationship outcomes for alcoholic patients treated with BCT or individual alcoholism counseling. Outcomes have been measured at six-month follow-ups in earlier studies and at 18 to 24 months after treatment in more recent studies. The studies show a fairly consistent pattern of more abstinence and fewer alcohol-related problems, happier relationships, and lower risk of marital separation for alcoholic patients who receive BCT than for patients who receive only individual treatment (Azrin et al., 1982; Bowers and al-Redha, 1990; McCrady et al., 1991; O'Farrell et al., 1992).

Domestic violence is the focus of recent BCT studies. Table 1 shows the percentage of male alcoholic patients who were violent toward their female partner at least once in the year before BCT and in the first and second year after BCT. Information from a control group, which consisted of demographically matched couples without alcohol problems drawn from a national survey of family violence in the United States population, was also reported (O'Farrell and Murphy, 1995; O'Farrell et al., in press; O'Farrell et al., 1998). Nearly two-thirds of the alcoholics had been violent toward their female partner in the year before BCT. This is significantly and substantially higher than in couples without alcoholism. Violence was significantly lower in the first and second year after BCT than it was before BCT, but it remained somewhat higher than among couples without alcohol problems.

These results are more dramatic when violence is examined in relation to drinking outcome status after BCT. Table 2 shows that domestic violence was nearly eliminated among patients who were remitted (i.e., about half of the sample who remained abstinent) after BCT (O'Farrell and Murphy, 1995; O'Farrell et al., in press). Thus, these studies showed that husband-to-wife violence was significantly reduced in the first and second year after BCT alcoholism treatment and was nearly eliminated with abstinence.

From studies of cost outcomes after BCT, Table 3 shows the average costs per case for alcohol-related hospital treatments and jail stays for male alcoholics in two of our Project CALM studies (O'Farrell et al., 1996a and 1996b). Costs for the year before BCT were about $7,800 in the first study and $6,100 in the second study. Costs were significantly lower after BCT, averaging about $1,100 for the two years after BCT in the first study and for the 18 months after BCT in the second study. Therefore, cost savings averaged

between $5,000 and $6,700 per case. The benefit-to-cost ratios show $8.64 in the first study and $5.97 in the second study in cost savings for every dollar spent to deliver BCT. Taken together, the data from these two studies show that reduced hospital and jail days after BCT save more than five times the cost of delivering BCT for alcoholism.

Research on BCT With Drug Abuse

The first randomized study of BCT with drug-abusing patients compared BCT plus individual treatment to individual treatment alone. Eighty married or cohabiting male patients with a primary drug abuse diagnosis (most frequently cocaine or heroin) in a substance abuse outpatient clinic were randomly assigned to one of the two treatments. The individual treatment was a behavioral coping skills program to help the patients resist using drugs. BCT used treatment methods described above. Both treatments had 56 therapy sessions over a six-month period. Individual treatment had all sessions with the patient alone; BCT had 12 of the sessions with the patient and female partner together.

Clinical outcomes in the year after treatment favored the group that received BCT for both drug use and relationship outcomes (Fals-Stewart et al., 1996a). Compared to individual treatment, BCT had significantly fewer cases that relapsed, fewer days of drug use, fewer drug-related arrests and hospitalizations, and longer time to relapse. Couples in BCT also had more positive relationship adjustment on multiple measures and fewer days separated due to relationship discord.

Cost-benefit outcomes in this same study favored BCT over individual treatment (Fals-Stewart et al., 1997). Table 4 shows social costs for the male drug abusers during the year before and the year after treatment. These social costs included costs for drug abuse-related health care, criminal justice system use for drug-related crimes, and income from illegal sources and public assistance. Social costs in the year before treatment averaged about $11,000 per case for both treatment groups. In the year after treatment, for the BCT group, social costs decreased significantly to about $4,900 per case with an average cost savings of about $6,600 per patient. In contrast, for the individual treatment only group, the average cost savings was $1,900 per patient. The benefit-to-cost ratio was significantly more favorable for BCT than for individual treatment, even though the cost to deliver the two treatments was nearly identical. There was $5.01 in social cost savings for every dollar spent to deliver BCT, and $1.37 in social cost savings for every dollar spent to deliver individual treatment.

Results of cost-effectiveness analyses also favored the BCT group. BCT produced greater clinical improvements (e.g., fewer days of substance use) per dollar spent to deliver BCT than did individual treatment. Therefore, this study showed that, in treating drug abuse, BCT as part of individual-based treatment is significantly more cost-effective and cost-beneficial than individual treatment alone.

In a second randomized study of BCT with drug-abusing patients (Fals-Stewart et al., 1996b), 30 married or cohabiting male patients in a methadone (Dolophine) maintenance program were randomly assigned to individual treatment only or to BCT plus individual treatment. The individual treatment was standard outpatient drug abuse counseling. Both treatments had 56 therapy sessions over a six-month period. Individual treatment had all sessions with the patient alone; BCT had 24 of the sessions with the patient and female partner together. Results during the six months of treatment favored the group that received BCT on both drug use and relationship outcomes. In comparison with individual treatment, BCT had significantly fewer drug urine screens that were positive for opiates, fewer drug urine screens that were positive for any of the nine drugs tested, and more positive relationship adjustment measured with a standard questionnaire.

Conclusions and Directions

The findings presented here support three main conclusions. First, BCT for both alcoholism and drug abuse produces more abstinence, happier relationships, fewer couple separations and lower risk of divorce than does individual-based treatment. Second, domestic violence is substantially reduced after BCT for alcoholism. Third, cost outcomes after BCT are very favorable for both alcoholism and drug abuse and superior to individual-based treatment for drug abuse.

Additional research on BCT is warranted, especially for drug abuse where there are fewer studies. But even more important is technology transfer, enabling patients and their families to benefit from what has already been learned about BCT for alcoholism and drug abuse. The Institute of Medicine (1998) has documented a large gap between research and practice in substance abuse treatment. BCT is one example of this gap.

BCT has relatively strong research support, but it has not yet become widely used. Hopefully the next few years will see progress in closing this gap.

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New Initiatives in the Treatment of the Chronic Patient with Alcohol/Substance Use Problems

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Development of Program

It is clearly evident that the lack of comprehensive treatment programs for persons with mental illness and alcohol/drug use problems has created a treatment dilemma in our mental health programs across the nation. It is also clear that there is movement to address this dilemma, and that a change in attitude among mental health professionals is taking place. For example, in my own travels in the mental health system I have heard the argument change from "We are not supposed to treat alcohol and/or drug problems in the mental health setting", to "Large numbers of our mentally ill patients also have problems with alcohol and drugs, how can we treat them, what can be done?"

Two and one-half years ago when I began work at one of Harlem Valley's Day Treatment programs I set out to answer the latter question. Through working with the patients themselves and by implementing a program within an existing psychiatric setting I began to find answers to that question. The answers that were discovered proved worthy of comprising a comprehensive treatment and proved to be applicable across separate treatment sites and multiple program formats. The first group, which began in December 1984, grew to eleven groups across six treatment sites, and includes clinics, day treatment, continuing treatment and residential program settings. Programs had to take place in our own treatment sites and utilize existing staff, without additional funds or special staffing. This led to the development of a treatment and group leadership approach that did not require extensive training in the area of substance abuse and alcoholism.

Treatment Approach and Philosophies

The issue that became most apparent when discussing substance abuse cases and issues with staff was the lack of knowledge or understanding of alcoholism and drug dependency as a disease--in effect, as an illness with symptoms that need to be brought into remission. Information about the disease concept of the use and abuse of various substances was disseminated to both staff and patients throughout our facilities, as an initial (and now an ongoing) approach to focusing attention on the problems. With the advent of a treatment group and a rise in information about the topics, some staff began to take interest in beginning a group in their service area.

In the summer of 1985 the administration formally identified staff members at each of the six sites who expressed an interest in providing group programming in their service area. The identified staff began meeting monthly for education, training, and the development and

implementation of program initiatives. i.e. assessment tools, etc. The same staff members took on the responsibility of presenting educational materials to co-workers at their program sites. Staff reported feeling comfortable in providing treatment for patients with substance use problems through the use of an exploratory approach to understanding and treating these patients. Staff are not expected to present themselves as substance abuse experts when conducting treatment groups. Instead they can be comfortable in learning from and with the patients about many issues relevant to mental illness and concomitant substance use problems. However, staff do have a working understanding of the scope of the problem of substance use, its genetic predisposing factors, issues of tolerance levels, psychological dependencies, and the issues specific to combining these problems with the symptoms of a chronic mental illness. Staff and patients together begin to identify the interaction effects of these dual disorders, and it becomes clear to the patients that they are not being judged as ill behaved, or being sent away to another treatment program, or having to relate to a staff member who feels hopeless about their prognosis because they have a substance use problem. This clarity enables patients to trust the staff and their peers in the treatment setting, and to speak openly about their problems in a supportive environment.

Treatment Methods and Content

Few mental health professionals would argue with the fact that heavy confrontation, intense emotional jolting, and discouragement of the use of medication are detrimental approaches to the treatment of a chronically mentally ill person. Yet efforts to treat these patients have consisted mainly, of referring them to agencies that treat primary substance abusers who do not have a chronic disorder, where in many cases the above treatment methods and strategies are employed. It is no wonder that there is a great deal of resistance from these patients to following through with these referrals, as well as refusal by these agencies to take responsibility for an ongoing psychiatric disorder.

The treatment method we have found effective features non-confrontational approach. The group process focuses upon educational materials and permits each patient to discuss substance use issues in an impersonal way when this is more comfortable. Treatment staff do not seek to catch patients in lies; rather the objective is to engage patients in a process that offers a variety of information and points of view on the use of drugs and alcohol.

Peer support evolves out of each patient's eventual openness in discussing issues that are important in their lives as well as the relationship between substance use and other variables. Group leaders and members assist individuals to gain insight into the dynamics and patterns of the use of the substances when this is applicable. One of the essential learning experiences is the relationship of the use of drugs or alcohol to each patient's psychiatric symptoms. Group members begin to identify these interaction effects in others and in themselves.

Since group members are often resistant about attending self-help groups such as AA and NA, the model includes inviting AA and NA speakers to the group sessions to conduct open meetings and to tell their story to the group. These sessions are always highly effective, and they enable patients to benefit from identifying with recovering substance users even though they may not be comfortable or able to follow a full program of AA or NA. As a result of these sessions some patients do begin to attend these support groups in addition to our program.

Content areas of the educational process include areas that are unique to patients with a chronic mental illness, such as mixing medication with other substances, as well as areas that are similar between primary substance abusers and our patients-- for example, the fact that in many cases the use of the substances begins to control the patient's motivation and behavior versus the patient being in control of the use of the substance. Recurring themes such as the need to find new social networks are addressed through general discussion as well as through each individual's discussion of his or her own problems.

Overview of Program

Substance abuse groups are integrated into regular programming. For example, a patient in the day treatment program will attend all other programming as usual, except that he or she will attend a substance abuse group once or twice a week in lieu of another scheduled activity. In a clinic program patients will visit a medicating physician (where applicable), have regular sessions with a primary therapist, and attend the substance abuse group once a week. Patients are not segregated or removed from regular program activities. Communication between group leaders and primary therapists ensues regarding the patient's progress in the group. However, criteria for improvement include many areas and are not confined only to achievement of abstinence. A patient's ability to discuss his or her problems or usage openly may be a very important criterion for a patient who has kept his/her substance use a secret. Various insights that a patient may gain are considered progress. Collaborating with other treatment staff must not have the tone of reporting on a patient's substance use; therefore criteria need to be carefully thought out and conveyed to others.

Treatment groups last from forty-five minutes to one hour. Numbers of patients in groups vary from program to program; eight seems to be an optimal number of members. Groups should be kept to manageable size so that patients may explore their issues in depth when necessary and so that each patient has an opportunity to participate verbally in each session.

A brief alcohol and drug screening tool is presently in use for all intakes at Harlem Valley. The questions include clinical intuition as well as historical information, so that the patient in the denial phase of his or her problem does not have the problem go unnoted. Where positive signs of substance use problems are identified, liaisons at the facility are notified of this, so that they may follow the case until a decision is made about referring the patient to the substance use treatment group. If a patient is referred he or she is interviewed by the group leader(s). This interview is really the beginning of the treatment process and is a method of establishing a purpose for the patient's participation in the group, be it to view educational materials or to work on an acknowledged problem. The interview focuses on the patient's potential contribution to the group as well as what is expected of a participant.

The assessment questionnaire is an in-depth interview of many aspects of a patient's substance use history and present usage. Treatment guidelines are included so that therapists who are unfamiliar with substance abuse treatment can integrate its goals and objectives into the treatment plan. The assessment takes place during the process of treatment and is not used for screening.

We recognize the need for specific substance abuse treatment programs such as inpatient detoxes, rehab programs that last at least several weeks, adjunct support groups, etc. To generate successful referrals we have developed an interview for adjunctive treatment services. These agencies are visited by liaisons and assessment of the agencies'

compatibility to our patients is obtained. We would like this effort to result in less rejection for our patients and more success outcomes where and when patients do engage in these programs.

Administrative Support

A program of this scope and pioneering experimentation cannot be implemented or sustained without the support of administrators in a given agency. The Harlem Valley administration including our Executive Director, Clinical Director, Director for Community services and Associate Director for Community services, to name but a few, are innovators within our field. Without their foresight and support in allowing a program such as this to progress, I could not report to you that these patients can improve along numerous criteria, and these programs can take place within our existing mental health programs.

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Buprenorphine Update: Questions and Answers

Reprint from: NIDA - June '99

Is buprenorphine (alone and in combination) a safe and effective treatment for drug addiction?

While the ultimate decision concerning safety and efficacy rests with the Food and Drug Administration (FDA), NIDA has funded many studies that support the safety and efficacy of buprenorphine and the buprenorphine/naloxone combination for the treatment of opiate dependence. During the time NIDA has studied this medication, we have been impressed with its safety and efficacy as a treatment for opiate dependence. Over the last five years NIDA has worked with Reckitt & Colman Pharmaceuticals, Inc., under a Cooperative Research and Development Agreement in an attempt to bring buprenorphine (which the FDA has designated as an orphan product), to a marketable status in the United States. These studies have been submitted by Reckitt & Colman to the FDA in support of a New Drug Application for buprenorphine products in the treatment of opiate dependence. The major studies of relevance have shown that buprenorphine is more effective than a low dose of methadone (Johnson et al, J.A.M.A., 1992), and that an orderly dose effect of buprenorphine on reduction of opiate use occurred (Ling et al, Addiction, 1998).

Most recently, buprenorphine tablets (either buprenorphine alone or the combination with naxolone) were shown in a large clinical trial to be superior to placebo treatment in reducing opiate use (Fudala et al, CPDD, 1998). Additional clinical studies have shown that the addition of naxolone to the buprenorphine tablet decreased the response to buprenorphine when the combination is injected under controlled conditions. This means that when persons attempt to dissolve the tablets and inject them, they will either experience withdrawal or a diminished buprenorphine effect. These properties will make buprenorphine combined with naxolone undesirable for diversion to illicit use, especially when compared with other existing illegal and legal opiate products.

Pharmacologically, buprenorphine is related to morphine but is a partial agonist (possesses both agonist and antagonist properties). Partial agonists exhibit ceiling effects (i.e., increasing the dose only has effects to a certain level). Therefore, partial agonists usually have greater safety profiles than full agonists (such as heroin or morphine and certain analgesic products chemically related to morphine). This means that buprenorphine is less likely to cause respiratory depression, the major toxic effect of opiate drugs, in comparison to full agonists such as morphine or heroin. We believe this will translate into a greatly reduced chance of accidental or intentional overdose. Another benefit of buprenorphine is that the withdrawal syndrome seen upon discontinuation with buprenorphine is, at worst, mild to moderate and can often be managed without administration of narcotics.

Do current regulations properly set forth the rules for administration, delivery, and use of these drugs?

There are no current regulations which address the use of buprenorphine or buprenorphine/naloxone for the treatment of opiate dependence because these products are not yet approved for this purpose by the FDA. The current regulations (21 CFR 291) for administration and delivery of narcotic medications in the treatment of narcotic dependent persons were written for the use of full agonist medications such as methadone with demonstrated abuse potential and do not take into account the unique pharmacological properties of these drugs. Therefore, these regulations would need to be re-examined and substantially rewritten in order to recognize the unique possibilities posed by buprenorphine/naloxone. Among these are the potential to administer buprenorphine and buprenorphine/naloxone in settings and situations other than the formal Narcotic Treatment Programs (NTPs) which have existed to date under existing regulations. NTPs are the most highly regulated form of medicine practiced in the U.S., as they are subject to Federal, State, and local regulation. Under this regulatory burden, expansion of this system has been static for many years. This has resulted in a "treatment gap", which is defined as the difference between the number of opiate dependent persons and those in treatment. The gap currently is over 600,000 persons and represents 75-80% of all addicts.

It may be useful to note the status of the last new product introduced to the opiate dependence treatment market (levoacetyl methadol, tradename ORLAAM). ORLAAM was an orphan product developed by NIDA and a U.S. small business in the early 1990s for narcotic dependence. ORLAAM was approved by the FDA as a treatment medication for opiate dependence in July 1993. In the five years since its approval and dispensing under the more restrictive rules relating to the use of full agonist medications (21 CFR 291), ORLAAM has been poorly utilized to increase treatment for narcotic dependence. It is estimated that 2,000 of the estimated 120,000 patients in narcotic treatment programs are receiving ORLAAM. The failure of ORLAAM to make an appreciable impact under the more restrictive rules suggests that if buprenorphine is to make an appreciable impact on the "treatment gap" it must be delivered under different rules and regulations.

The issue then becomes why should buprenorphine products be delivered differently from ORLAAM and methadone. First, buprenorphine's different pharmacology should be kept in mind when rules and regulations are promulgated. The regulatory burden should be determined based on a review of the risks to individuals and society of this medication being dispensed by prescription and commensurate with its safety profile, as is the case with evaluation of all controlled substances. It is our understanding that the Drug Enforcement Administration has recognized the difference between buprenorphine treatment products and those currently subject to 21 CFR 291. Second, there are many narcotic addicts who refuse treatment under the current system. In a recent NIDA funded study (NIDA/VA1008), approximately 50% of the subjects had never been in treatment before. Of that group, fully half maintained that they did not want treatment in the current narcotic treatment program system. The opportunity to participate in a new treatment regimen (buprenorphine) was a motivating factor. Fear of stigmatization is a very real factor holding back narcotic dependent individuals from entering treatment. Third, narcotic addiction is spreading from urban to suburban areas. The current system, which tends to be concentrated in urban areas, is a poor fit for the suburban spread of narcotic addiction. There are many communities whose zoning will not permit the establishment of narcotic treatment facilities, which has in part been responsible for the treatment gap described above. While narcotic treatment capacity has been static, there has been an increase in the amount of heroin of high purity. The high purity of this heroin has made it possible to nasally ingest (snort) or smoke heroin. This change in

the route of heroin administration removes a major taboo, injection and its attendant use of needles, from initiation and experimentation with heroin use. The result of these new routes of administration is an increase in the number of younger Americans experimenting with, and becoming addicted to, heroin. The incidence of first-time use of heroin in the 12 to 17 year old group has increased fourfold from the 1980s to 1995. Treatment for adolescents should be accessible, and graduated to the level of dependence exhibited in the patient. Buprenorphine products will likely be the initial medication(s) for most of the heroin-dependent adolescents.

Should more physicians be permitted to dispense these drugs under controlled circumstances?

More treatment should be made more widely available for the reasons stated above. The safety and effectiveness profiles for buprenorphine and buprenorphine/naloxone suggest they could be dispensed under controlled circumstances that would be delineated in the product labeling and associated rules and regulations. As currently envisioned, buprenorphine and buprenorphine/naloxone would be prescription, Schedule V controlled substances. The treatment of patients by physicians or group practice would allow office-based treatment to augment the current system, while placing an adequate level of control on the dispensing of these medications. Given the increased need for treatment, the relative safety and efficacy of the treatment product, and the development of a regulatory scheme satisfactory to the Department of Health and Human Services, these goals could be accomplished in a timely and effective manner.

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The New and Proposed Diagnosis Of "Substance Dependency-Induced Psychosis"

Norman Jay Gersabeck, M.D.

"Substance dependency-induced psychosis" (SDIP) is a very common type of functional psychosis that is caused by a substance dependency. All the cases of SDIP I have treated already had other psychotic diagnoses made (mainly schizophrenia) by other psychiatrists. SDIP is quite similar to schizophrenia in its symptoms, signs and psychodynamics. I could categorize it as a subtype of schizophrenia, but doing so would have had the disadvantage of minimizing the important differences between the two diagnoses. One difference is that most persons with a SDIP would never have developed any type of psychosis without the "help" of a preexisting substance dependency. This agrees with the fact that the average SDIP person is less ill than the average schizophrenic person. The most significant difference lies in the better treatment opportunities for the SDIP person.

An article in "Lancet" (12/26/87) reported on a Swedish study which revealed that, among army conscripts, heavy cannabis users later developed what was diagnosed as schizophrenia at a rate almost six times that for non-users. It was also determined that the premorbid personalities of the users were significantly better than the non-users, who were also so diagnosed. These findings correlate well with my finding that the SDIP-afflicted persons are usually less ill than thosetruly suffering from schizophrenia. It also implies that genetic factors in SDIP are
very minimal.

Gary Forrest, in his book "Alcoholism, Narcissism and Psychopathology" wrote that "alcoholic persons very seldom evidence a schizophrenic adjustment prior to the onset of their alcoholism." He also noted that approximately 8-12% of alcoholic persons show psychotic symptoms during the initial two or three months of recovery.

To speak of the potentially great power of an addiction is not to be unscientific. This power is very real, and is capable of wreaking great and usually negative changes in a person's thoughts, feelings and behavior. For example, a sane and intelligent alcoholic man may knowingly and literally be drinking himself to death. Despite not wanting to die, he may still go on to actually kill himself this way. It is both logical and scientific to reason that this same compulsive power
could be employed somewhat differently within the mind to, instead, produce a psychosis. Of course, as an addiction, substance dependency has strong and intimate connections with non-substance addictions, like compulsive gambling. However, the latter are very much less likely to be a critical factor in causing a functional psychosis. Only part of the reason for this are the pharmacological effects of the various substances. The complex psychodynamic factors attached to the actual intake of the substance into the body are also important.

Actual or potential psychological regression is an important aspect of any substance dependency, and the behavior of many substance addicts gives clear evidence of this. Regression is a necessary correlate to the development of a irrational and largely unconscious symbolization and powerful overvaluation of the substance- and it is this that

constitutes the learning process of becoming addicted. Enough regression can produce a psychotic degree of regression- or, in short, a psychosis. The usual result of a substance dependent person stopping the use of the addictive substance is a lessened degree of regression and, therefore, better functioning. But for some substance dependent persons the result can, instead, be the reverse. For example, in the case of an alcoholic person who reluctantly feels he must quit drinking after a second or third DWI offense, his powerful and regressive narcissistic aspect of the "self" may, in effect, refuse to give up its power level within the "self" that alcohol had previously facilitated. The development of a psychosis leads to the preferred alternative.

The powerful cause-and-effect relationship between a dependency and a resulting functional psychosis makes available an additional type of treatment for the SDIP person. An individualized type of substance dependency therapy, used in the context of its causal role in the psychosis, can be very effective for many patients. To be eligible for the treatment, patients must be motivated for improvement. They must also have an open mind for both having a substance dependency, and its possible role in having caused their psychosis. Substance dependency therapy here has the real advantage of being of a specific nature. This means that it is
capable of treating the core or basic cause of the disorder. Weekly outpatient psychotherapy sessions lasting from 3-12 months have been the rule. The therapist needs to be knowledgeable about substance dependency, psychotic illnesses, and dynamic psychotherapy. Sadly, very few mental health professionals have an adequate understanding of substance dependency.

In contrast, the only-symptomatic treatment of antipsychotic medication is essentially the only treatment that is available for the "true schizophrenic" person. This medication treatment is often quite effective, but it is associated with frequent and sometimes very serious side effects. The Harvard psychiatrist, Joseph Glenmullen remarked in a general fashion on this matter when he wrote (somewhat hopefully): "The psychiatric profession is now recognizing the limitations of the symptomatic use of antipsychotic medications and the value of psychotherapy in helping schizophrenic and other psychotic-prone individuals regain human connection in their lives."

Almost all of the patients who qualified for outpatient treatment of their SDIP illnesses experienced better functioning and a lesser need for medication than had been the case with their earlier diagnoses. Much more impressive is the fact that, in my experience, fully one-third of these patients eventually enjoyed a full remission of all psychotic symptoms. This means they no longer needed any antipsychotic medication and returned to normal functioning. The chances were then good that their remission would be a permanent one, provided they continue to abstain from all addictive substance use (except, often for cigarettes). AA or NA membership is also usually advisable to maintain remission.

The more chronic the substance dependency is, and the more substances are involved, the greater the likelihood is that there will eventually be a SDIP complication. The chance that any particular substance dependent person will eventually develop a SDIP complication is relatively small- but having the dependency at least doubles this likelihood. The nature and severity of the resultant psychosis doesn't seem to depend much on the particular addictive substance involved. Alcohol, marijuana and cocaine appear to be equally likely to cause a SDIP. Not surprisingly, alcoholism is the most common cause.

The onset of the psychosis most often occurs while the person is still using the substance, or is in the process of discontinuing or reducing it. The intervening period between stopping the use of the substance and the onset of a SDIP psychosis is not limited- but a case of SDIP rarely occurs beyond six months from the last use of the substance. A relatively common type of onset of a SDIP provides a very good clue to the diagnosis. These are cases where a person suffers his or her first psychotic symptoms and signs very shortly after a return to use of the substance. This usually involves moderate levels of intake, and occurs after a significant period of abstinence. The period of abstinence is often motivated for purposes of denial of the dependency.

To make the diagnosis of a SDIP, one must prove the existence of a substance dependency prior to the first (ever) signs or symptoms of a psychotic illness. This itself, doesn't make the diagnosis- but it does mean that a SDIP is rather likely. Of course, there can't be signs of an organic psychosis, such as delirium. The dependency diagnosis in most SDIP cases has not yet been made. Even in state hospitals that have a M.I./S.D. (mental illness/substance dependency) ward, many SDIP patients will be found on other wards. In making the diagnosis, it is important to find indications of temporal and symptomatic linkage between the practice of the addiction and the onset of the psychosis.

In outpatient populations of schizophrenic persons, one frequently finds occasional and usually very moderate use of addictive substances. Combined with the almost-always present history of a preexisting substance dependency, such behavior is an important clue to the presence of a SDIP. This use is always against medical advice. The finding of a person stopping the use of medication and resuming daily use of addictive substances virtually makes the diagnosis of a
SDIP. Another important clue to the presence of SDIP is the finding that the person's desire for the substance has greatly diminished or even disappeared with the initial onset of the psychosis. As the psychosis lessens, the desire partially returns. These findings correlate with similar findings sometimes noted in the acute onset of depression in some substance dependents.

A few years ago, psychiatrist Norman Miller of the University of Illinois cited in a journal article of an incidence of 80% of state hospital patients with a schizophrenic diagnosis having an associated diagnosis of a substance dependency. A majority of these dual diagnosis cases actually have a SDIP, rather than a schizophrenic illness. Ordinarily, most of these dependency diagnoses wouldn't have been even made. One of the reasons for this is that the onset of the
psychosis always helps to hide the dependency because of the resulting decreased desire and intake of the substance.

I fully agree with the psychiatrist's statistic, but not with his not-stated, but still obvious assumption concerning the sequence of the two disorders. He even posed the question as to "why so many mentally ill persons would be so prone to abuse alcohol and drugs." He uncritically went along with the "conventional psychiatric wisdom" on the subject. This "wisdom" erroneously holds that, in such dual diagnosis cases, the mental illness comes first. But this sequence can be easily disproved by simply taking a good history. Accepting this sequence conveniently avoids any consideration of the "much less biological," but otherwise obvious possibility that the dependency could be causing the psychoses. I was disappointed, but not surprised, when he failed to answer either of two letters I sent him. In

them, I attempted to answer "his question" by disputing his assumption about the dual diagnosis sequence- and its implications.

The origin of the current and predominant "biological psychiatric philosophy" has reflected the better understanding of neurophysiology, and the development of many worthwhile psychoactive medications. (I always use quotation marks for "biological" in this context because its true meaning is being abused.) Ironically, the desire to be more scientific has resulted in the introduction of a very subtle, but still troublesome ideological element into "biological psychiatry."

The influence of "biological psychiatry" has had the very regrettable effect of eliminating any training in psychotherapy at many psychiatric training programs. This anti-psychological action obviously implies the belief that the complex and basic functioning of our minds is, somehow, "not really biological." In other words, "biological psychiatry" regards our hopes, fears, beliefs, and experiences as not being particularly important in the development of mental disorders .
Instead, it greatly exaggerates the importance of genetic factors, which are expressed in "biochemical imbalances." This emphasis has been at the cost of largely ignoring the important emerging science of information processing- which, of course, intimately relates to psychology. Psychiatrist David Kaiser M.D. wrote an excellent essay for the "Psychiatric Times" (Dec 96) which was very critical of "biological psychiatry." It was entitled: "Not By Chemicals Alone: A
Hard Look At Psychiatric Medicine."

In his book, "Psychology of Science," the renowned psychologist Abraham Maslow strongly doubted that physical science could be an adequate model for behavioral science. The physicist Fritjof Capra, in his excellent book "The Turning Point," agreed with Maslow and cited the need for a paradigm shift away from the biomedical model- and especially so for psychiatry. He wrote: "The overwhelming majority of illnesses cannot be understood in terms of the reductionist concepts of well-defined disease entities and single causes. The main error of the biomedical approach is the confusion between disease processes and disease origins- with neglect of the latter."

I am quite aware that I can be criticized for "unnecessarily being polemical for introducing the issue of 'biological psychiatry'" into a paper on the SDIP diagnosis. But it has been a hard reality that this psychiatric philosophy has been responsible for effectively, though largely passively, opposing the establishment of the SDIP diagnosis. Though there are other opposing factors, it has been by far the most important one. My now being in the position of conceiving of and championing the diagnosis is not the result of any brilliance on my part. Rather it is the strength of these opposing factors which has resulted in this diagnosis not having been established many years ago by others.

A few years ago, I received a very interesting report from a substance dependency therapist at a state hospital M.I/S.D. ward. She reported that, in somewhat over half of such dual diagnosis cases, the addiction clearly came first. However, for "biological psychiatrists" the significance of this finding is largely negated by the convenient "biological understanding" regarding this sequence. It is that most cases of schizophrenia and substance abuse start incubating about the
same time in the late teens. Therefore, the substance abuse/dependency is considered to be merely secondary to the underlying subclinical schizophrenic processes at work.

There was a journal article ("Journal of Hospital and Community Psychiatry") which reported on the fact that 70% of persons with the diagnosis of schizophrenia at an inner city emergency room tested positive for cocaine use by urine tests. I felt that the conclusion of the authors of the article that the mental illness preceded the cocaine use was an exercise in "tortured ideological and automatic conformist thinking." It certainly didn't reflect any effort at history-taking of these persons.

A very probable correlate of this incidence is the recently reported increased rate of schizophrenia diagnoses among inner city black males- but not females. This increase was reported in the context of a nationwide decrease in this rate. Inner city black males have been increasingly using a lot of addictive drugs-significantly more than the females. This gender discrepancy indicates two things about the males' increase in these diagnoses. One is the that increased stress of inner city life is not the reason. Since the females share the same basic gene pool with the males, this rules out genetic factors as explaining the gender discrepancy. In short, this finding goes against the "biological theorizing" that similar genetic factors that cause schizophrenia also cause the associated substance abuse/dependencies. Therefore, the latter can't be dismissed as very likely causal factors for the substance abuse-related functional psychoses, that are currently diagnosed as schizophrenic. The SDIP diagnosis is the best answer to this puzzle.

Another indirect support for the SDIP diagnosis is the recent establishment of the DSM-IV "substance-induced psychosis" (SIP) diagnosis. It is a highly flawed diagnosis, as it should have been limited to non-addictive substances (for example, prednisone). Yet, in practice, nearly all of such diagnoses made are associated with both an addictive substance and a dependency. Just as the two diagnostic names differ only in one word, their theory and practice accurately
reflect this difference. The SIP diagnosis is a "biologically/politically correct" one which holds that its psychoses are completely a result of "direct physical effects of the substance." The SIP diagnosis also has the "biological advantage" of not encroaching at all on the diagnosis of schizophrenia- as the SDIP diagnosis definitely does. Significantly, the criteria of the SIP diagnosis completely ignore the issue of substance dependency. There are only the usual connotations of the term "substance" to tie it in to the subject of substance dependency.

The real etiology of addictive substance-related psychoses (SIP and SDIP), necessarily, is much more complex than the simplistic or reductionist reasoning behind the SIP diagnosis could possibly ever explain. Some idea of the problems with this type of thinking in relation to substance dependency is shown by an example. The same alcoholic man can react very differently to the same amount of alcohol, depending on the "set and the setting." He may respond with: somnolence in a library; tears at a sentimental movie; belligerence at a bar; being
the "life of a party;" being sexually passionate in the back seat of a car. Because of the SIP's theoretical "biological premise," the SIP diagnosis, necessarily, has the criteria of two very arbitrary 30-day time limits. It can't persist or have its onset from the last use of the substance occur any longer than that period of time. In contrast, the SDIP diagnosis can be quite brief, or last a lifetime. The latter can even happen when the person never uses the substance again.

The SIP diagnosis itself doesn't necessarily lead to the diagnosis of the usually-associated dependency, or not surprisingly, to its rational treatment. In short, in the case of addictive substance-related psychoses, the SDIP diagnosis would nearly always be much more

appropriate to use than a SIP diagnosis. It would also apply to many more cases. An alcoholic man whose illness qualifies for the SIP diagnosis is likely to be simply advised by his psychiatrist to either avoid alcohol- or to just significantly limit his intake (because of his supposed increased "biochemical sensitivity" to it). It is the existence of the dependency itself, whether active or not, which is the basic cause of a SDIP.

I first used the SDIP diagnosis 25 years ago for a 47 year-old alcoholic auto executive who had an uneventful stay at the substance dependency hospital where I was the psychiatric consultant. He had no other history for any psychiatric disorders. He was doing well in his recovery with AA as his only therapy. But three months into his recovery, an older brother unexpectedly died.
The morning after hearing this, he awoke in a confused state and told his wife: "I'm afraid my car will tell my employer that I want to drink." (He drove a company car and his employer didn't want him to drink alcohol.) If his brother had died a few months further into his recovery, he likely would have been able to avoid a psychosis.

I took over his case a week after he was hospitalized, when his wife learned that I was on the staff of the same psychiatric hospital where he was admitted. She wisely realized that it would likely be advantageous for him to be treated by a psychiatrist who was knowledgeable about alcoholism. He had already been diagnosed as schizophrenic by the psychiatrist on call. With the help of medication, he was fully lucid by this time. He was an intelligent man and accepted my very serendipitous diagnosis. This was despite my telling him it was far from being an official diagnosis. My making the diagnosis was prompted by his delusion, and the fact that he was still early in his recovery.

He was able to safely get off all medication after about six months of weekly outpatient psychotherapy. He had to be persuaded to stop his low dosage of medication. Within a few days, he was finally feeling like his old self. This result was clearly a lot more than just the straightforward physiological effects of the medication being discontinued. Substance dependent persons are always strong placebo reactors. Besides no longer being needed, the medication had assumed a negative placebo role for him. He also experienced a strong desire to drink for the first time in a year.. Fortunately, it didn't last long, and he coped well with it. His medication had been vitally important to him- but it finally become a detriment to him.

He continued to function well, and for the remaining 15 years of his life, never took another drink, or had any return of psychotic symptoms. This outcome was facilitated by his regular AA attendance and his knowledge that any alcohol or other substance use would very likely cause a return of mental illness. This knowledge was a much more powerful motivation for abstinence than the standard psychiatric advice given to substance-abusing "schizophrenic" patients. It is simply that of avoiding addictive substances because they interfere with the treatment of the illness- which as far as it goes, is true.

A 35 year-old man suffered a relapse in his 14 year history of psychosis which resulted in a four-month and fourth hospitalization. I first saw him shortly after his discharge. He claimed his "going berserk," which required hospitalization, was caused by his exposure to "wood alcohol fumes," of unknown origin. He denied any history for substance abuse. It wasn't until months and considerable improvement later that he admitted he had used both alcohol and marijuana heavily from ages 16-19. During his first year of college, he abstained from both substances for six months. This followed a religious experience at church. He then suffered

his first signs and symptoms of psychosis very shortly after his cautious return to substance use. He finally got honest with me after I suggested that the meaning of his "wood alcohol fumes" delusion was likely related to the fact that this type of alcohol was poisonous. Therefore, it could well symbolize "bad alcohol." This was in contrast to his predominant and earlier unconscious labeling of "good alcohol" that had characterized his early alcoholism. He also
told me that he had drank two cans of beer before he "went berserk." This was the first alcohol he had drank in months.

A 30 year-old woman had experienced a SDIP (by history) of three months duration, where alcohol was the main problem. Twelve years later (with occasional moderate drinking) she experienced two episodes of having "crazy thoughts" which lasted only a few hours. On each occasion, the symptoms started within several hours of the "last cigarette," during an attempt to stop smoking. Each time the symptoms abated almost immediately, following her resumption of
smoking several hours later. Clearly, these psychotic symptoms were not a result of a straightforward (biochemical) nicotine withdrawal. Instead it was her serious intention to quit smoking itself which was the critical precipitating factor. This mechanism correlates well with a SDIP, but not a SIP diagnosis.

A 25 year-old man with multiple alcoholism-induced brief psychotic episodes stated that either drinking alcohol or being psychotic had the (seductive) effect of making him "feel powerful and important." Nearly all of his psychotic episodes were caused by drinking alcohol and/or conflict about alcohol. One episode occurred as he was clearly getting ever closer to the "first drink," after three months of sobriety. These episodes finally stopped when he really got serious
about recovery from his alcoholism.

The National Alliance for the Mentally Ill (NAMI) is an advocacy organization for persons who largely have schizophrenic diagnoses. Many NAMI members and recovering alcoholic persons share an antipathy towards the SDIP diagnosis. The great irony here is that neither group likes the idea of any intimate relationship as possibly existing between the disorders of substance dependency and schizophrenia-like psychoses. The NAMI members equate such a relationship as implying an unwanted and pejorative "self-inflicted" element to a psychotic illness or disease. A reverse prejudice is held by the alcohol group. They dislike the mere idea of any close association of alcoholism with any serious psychiatric illness being possible. Unfortunately, these "not nice" perceptions of the SDIP diagnosis work against the "really nice" advantages of being able to correctly make the diagnosis.

There is a former alcoholic patient of mine who has 24 years of good recovery. She has had to be strong to deal with her 32 year-old son's disabling mental illness. Aided and abetted by a very dysfunctional family background, he had started to regularly use alcohol and marijuana in his mid-teens. He was diagnosed as being schizophrenic in his early twenties, and has been on SSI ever since. She first contacted me a couple of years ago about her son. I told her then there was a good chance that he had a SDIP, rather than a schizophrenic illness. She was open to this possibility. She later understood and fully accepted my reasoning in telling her that, even without examining him, I was now virtually certain of his having a SDIP illness. This greater certainty was due to my learning that he had recently stopped his medication and started drinking alcohol daily for two months. Then he was involved in a drunken auto accident, in which he left the scene. Interestingly, his functioning didn't suffer

during this time. But it certainly would have done so, if he hadn't then stopped drinking and resumed his medication.

It is a sure thing that the SDIP diagnosis will eventually become established. I am laboring to see that this occurs sooner, rather than later. If the diagnosis had been available when the woman's son first became psychotic, the chances are fairly good that he would now be living a relatively happy and productive life. Sadly, the son refused his mother's advice that he consult with me. His is a good example of the great amount of needless human suffering that is still occurring for lack of the diagnosis having yet become established.

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On Co-occurring Addictive and Mental Disorders: A Brief History of the Origins of Dual Diagnosis Treatment and Program Development

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Invited response to section on co-occurring addictive and mental disorders. Published letter to the editor. American Journal of Orthopsychiatry (66) 3, July,1996.

To The Editor,
The opening article of the Journal's special section (Osher & Drake,1996) which traces the history of separating mental health and addictive services, is an important contribution to the literature on dual disorders. Since we are now in the early stages of the evolution of dual diagnosis services, however, I believe it is important to provide a more complete and detailed account of the previous initiatives in this field.

In response to the article by Drake, Mueser, Clark and Wallach (1996) which states "Ten years ago the only treatment options available for people with co-occurring substance abuse and severe mental illness were parallel treatments in separate programs" (p.49), the record requires correction. Dual diagnosis treatment interventions and "integrated" programs that truly adapted to the needs of severely mentally ill chemical abusers (MICA) began in 1984 (Gigliotti,1986, Sciacca 1987a,1987b) in a New York State outpatient psychiatric facility. In 1985 these integrated treatment programs were implemented across multiple program sites (Sciacca,1987b). Concurrently, treatment and program elements were taught through training seminars in New York as well as nationally. Early articles by Gigliotti, 1986 and Sciacca, 1987a, 1987b, outlined these processes and documented their starting dates. In September, 1986, the New York State (NYS) Commission on Quality of Care (CQC) released the findings of eighteen months of research. Its report (Sundram, Platt, Cashen, 1986) described the detachment and downward spiral of dually diagnosed consumers who were bounced among different systems with " no definitive locus of responsibility." As a result, Governor Cuomo designated the NYS Office of Mental Health as the lead agency responsible for coordinating collective efforts for this population. CQC proceeded to visit the dual diagnosis programs developed in 1984, and declared the treatment interventions, the training, and integrated programs to be positive solutions to the dilemmas (Gigliotti, 1986). TIME magazine learned of the CQC report, and CQC suggested that TIME magazine investigate these programs. A reporter sat in on treatment groups, interviewed consumers and the director, and attended related training seminars. The story (Gorman, 1987) was held due to an international crisis, and later published with a survey of national dual diagnosis statistics (Ridgely, Osher, & Talbott, 1987). Hence, the "doubly troubled" were brought to the attention of the general public.

The Governor's task force put forward a vision for statewide program development. The "MICA Training Site for Program and Staff Development, New York Statewide" was created to attain that vision (Sciacca 1987b, 1991). Short term and on-going training and program

development were offered to hundreds of treatment providers at both state and local mental health and substance abuse agencies. Consumer led and family support programs were also developed. The state produced a training video that demonstrated the integrated treatment model. The CQC report called for "invested," "sustained," leadership. However, the training site closed in 1990 due to budgetary considerations. MICA programs and groups that grew out of this model continue to be an important nucleus of our present services in New York State and nationally.

The original treatment interventions evolved in "adaptation" to the needs of MICA clients. Methods and philosophies clearly differed from traditional substance abuse treatment. Consumers who were actively abusing substances, physically addicted, unstable, and unmotivated (Sciacca 1987a, 1991) were engaged into treatment. A "non-confrontational" approach to denial and resistance, involving acceptance of all symptoms was employed. Consumers participated in treatment groups without pressure to self disclose, and explored topics from their own perspectives. Subsequent providers either learned from this model, or came upon similar processes through their own experimentation. Presently, we find consistent similarities across the interventions that have evolved for the dually diagnosed, thereby validating the need for new treatment models.

The process of "interagency" program development implemented in 1985 (Sciacca, 1987b) has escalated in the state of Michigan. A project that included formal cross-training and cross-systems program development was jointly initiated by the split bureaus (Sciacca & Thompson, 1996) in 1993. It demonstrated that continuity of care across systems, including trained professionals from a variety of disciplines, is attainable and results in improved, less costly services for the dually diagnosed. Every program in both service delivery systems (across two counties) was included. This project is yet to be replicated.

In the Journal special section, Green (1996) diagrams for us the serious inadequacies of our divided systems, and the resulting deterioration and anguish for the consumer. In contrast, her participation in an integrated dual diagnosis program that was accepting of all of her symptoms led to her attainment of sobriety and stability.

Our history thus far demonstrates a lack of invested, sustained leadership that is capable of developing a cohesive national agenda for dual disorders. It is our respsonsibility to change the course of this history to meet the needs of dually diagnosed consumers and their families (Sciacca & Hatfield, 1995).

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Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol or Other Drug Abuse

Treatment Improvement Series – 9

SAMHSA

Table of Contents

Chapter 1 –Introduction

Overview

The treatment needs of patients who have a psychiatric disorder in combination with an alcohol and other drug (AOD) use disorder differ significantly from the treatment needs of patients with either an AOD use disorder or a psychiatric disorder by itself. This Treatment Improvement Protocol (TIP) consists of recommendations for the treatment of patients with dual disorders.

This TIP was developed by a multidisciplinary consensus panel that included addiction counselors, social workers, psychologists, psychiatrists, other physicians, nurses, and program administrators with active clinical involvement in the treatment of patients with dual disorders. Consumers also participated on the panel.

This TIP was written principally for addiction treatment staff. However, it contains information and treatment recommendations that can be used by healthcare providers in a variety of treatment settings. For example, it will be useful to people who work in primary care clinics, hospitals, and various mental health settings. In addition, there are recommendations that are targeted to administrators and planners of healthcare services.

A thoughtful attempt has been made to include information that the consensus panel felt was clinically relevant. While many clinical topics are explored in depth, some are only briefly mentioned, and a few are avoided altogether.

It is not the goal of this TIP to provide an exhaustive description of all of the possible issues that relate to the treatment of patients with dual disorders. Rather, the primary goal is to provide treatment recommendations that are practical and useful.

Indeed, the usefulness of this TIP can be enhanced by blending these recommendations with those of another TIP such as *Intensive Outpatient Treatment for Alcohol and Other Drug (AOD) Abuse.* By doing so, treatment protocols can be developed which will meet very specific treatment needs.

Contents

Definitions and Models

Chapter 2 -- *Dual Disorders: Concepts and Definitions* -- provides descriptions and diagnostic criteria for AOD abuse and dependence. There is also a description of the possible interactions between AOD use and psychiatric symptoms and disorders.

Chapter 3 -- *Mental Health and Addiction Treatment Systems: Philosophical and Treatment Approach Issue* -- describes the similarities, differences, strengths, and weaknesses of the treatment systems used by patients with dual disorders: the mental health system, the addiction treatment system, and the medical system. Similarly, there is a description of treatment models most frequently used: sequential treatment of each disorder, parallel treatment of each disorder, and integrated treatment of both disorders. The chapter includes a discussion of critical treatment issues and general assessment issues in providing care to patients with dual disorders.

Linkages

Chapter 4 -- *Linkages for Mental Health and AOD Treatment* -- describes several areas of critical concern for programs that provide services to patients with dual disorders. There are discussions regarding policy and planning; funding and reimbursement; data collection and needs assessment; program development; screening, assessment, and referral; case management; staffing and training; and linkages with social service, health care, and the criminal justice systems.

This chapter should be particularly useful for administrators and political planners who address the potential administrative overlaps and gaps that exist between the mental health and addiction treatment systems. The semi-outline format of the chapter will allow planners of services a rapid checkup of specific areas such as funding and reimbursement, program development, and case management.

Specific Psychiatric Disorders

While entire books can be written regarding specific psychiatric disorders, this TIP describes the disorders that account for the majority of psychiatric problems seen in patients with dual disorders. TIP chapters that address specific psychiatric problems include Chapter 5, *Mood Disorders;* Chapter 6, *Anxiety Disorders;* Chapter 7, *Personality Disorders;* and Chapter 8, *Psychotic Disorders.*

By combining chapters, strategies for treating patients with complex disorders may be developed. For example, by combining techniques recommended for the treatment of personality and mood disorders, borderline syndrome treatment strategies can be developed.

Both content and stylistic approaches vary markedly among these chapters, reflecting the differences of consensus panel members who composed them. Since these differences in stylistic approaches may be

useful to the reader, they have been retained.

Psychopharmacology

Chapter 9 -- *Pharmacologic Management* -- is a brief overview of the types of medications used in psychiatry and addiction medicine and for patients with dual disorders. A stepwise treatment model that can minimize medication abuse risks is discussed, and cautions about drug interactions are reviewed.

Addiction treatment program staff are increasingly encountering patients who require prescribed medications in order to participate in recovery. For this reason, it is important for clinical staff to have an understanding of the principle medications used in psychiatry and how they are used. In addition, agencies that hire a consulting psychiatrist may want to review with the psychiatrist the prescribing issues raised in this chapter.

A bibliography is provided for further study in Appendix A. A brief overview of sample cost data for the treatment of dual disorders is in Appendix B. It compares three treatment programs on features such as salary ranges and administrative costs.

Chapter 2 – Dual Disorders: Concepts and Definitions

The Relationships Between AOD Use and Psychiatric Symptoms and Disorders

Establishing an accurate diagnosis for patients in addiction and mental health settings is an important and multifaceted aspect of the treatment process. Clinicians must discriminate between acute primary psychiatric disorders and psychiatric symptoms caused by alcohol and other drugs (AODs). To do so, clinicians must obtain a thorough history of AOD use and psychiatric symptoms and disorders.

There are several possible relationships between AOD use and psychiatric symptoms and disorders. AODs may induce, worsen, or diminish psychiatric symptoms, complicating the diagnostic process.

The primary relationships between AOD use and psychiatric symptoms or disorders are described in the following classification model (Landry et al., 1991a; Lehman et al., 1989; Meyer, 1986). All of these possible relationships must be considered during the screening and assessment process.

- AOD use can cause psychiatric symptoms and mimic psychiatric disorders. Acute and chronic AOD use can cause symptoms associated with almost any psychiatric disorder. The type, duration, and severity of these symptoms are usually related to the type, dose, and chronicity of the AOD use.
- Acute and chronic AOD use can prompt the development, provoke the reemergence, or worsen the severity of psychiatric disorders.
- AOD use can mask psychiatric symptoms and disorders. Individuals may use AODs to purposely dampen unwanted psychiatric symptoms and to ameliorate the unwanted side effects of medications. AOD use may inadvertently hide or change the character of psychiatric symptoms and disorders.
- AOD withdrawal can cause psychiatric symptoms and mimic psychiatric syndromes. Cessation of AOD use following the development of tolerance and physical dependence causes an abstinence phenomenon with clusters of psychiatric symptoms that can also resemble psychiatric disorders.
- Psychiatric and AOD disorders can coexist. One disorder may prompt the emergence of the other, or the two disorders may exist independently. Determining whether the disorders are related may be difficult, and may not be of great significance, when a patient has long-standing, combined disorders. Consider a 32-year-old patient with bipolar disorder whose first symptoms of alcohol abuse and mania started at age 18, who continues to experience alcoholism in addition to manic and depressive episodes. At this point, the patient has two well-developed independent disorders that both require treatment.

- Psychiatric behaviors can mimic behaviors associated with AOD problems. Dysfunctional and maladaptive behaviors that are consistent with AOD abuse and addiction may have other causes, such as psychiatric, emotional, or social problems. Multidisciplinary assessment tools, drug testing, and information from family members are critical to confirm AOD disorders.

The symptoms of a coexisting psychiatric disorder may be misinterpreted as poor or incomplete "recovery" from AOD addiction. Psychiatric disorders may interfere with patients' ability and motivation to participate in addiction treatment, as well as their compliance with treatment guidelines.

For example, patients with anxiety and phobias may fear and resist attending Alcoholics Anonymous or group meetings. Depressed people may be too unmotivated and lethargic to participate in treatment. Patients with psychotic or manic symptoms may exhibit bizarre behavior and poor interpersonal relations during treatment, especially during group-oriented activities. Such behaviors may be misinterpreted as signs of treatment resistance or symptoms of addiction relapse.

AOD Use and Psychiatric Symptoms

- AOD use can cause psychiatric symptoms and mimic psychiatric syndromes.
- AOD use can initiate or exacerbate a psychiatric disorder.
- AOD use can mask psychiatric symptoms and syndromes.
- AOD withdrawal can cause psychiatric symptoms and mimic psychiatric syndromes.
- Psychiatric and AOD use disorders can independently coexist.
- Psychiatric behaviors can mimic AOD use problems.

The Terminology of Dual Disorders

The term *dual diagnosis is* a common, broad term that indicates the simultaneous presence of two independent medical disorders. Recently, within the fields of mental health, psychiatry, and addiction medicine, the term has been popularly used to describe the coexistence of a mental health disorder and AOD problems. The equivalent phrase *dual disorders* also denotes the coexistence of two independent (but invariably interactive) disorders, and is the preferred term used in this Treatment Improvement Protocol (TIP).

The acronym *MICA,* which represents the phrase *mentally ill chemical abusers,* is occasionally used to designate people who have an AOD disorder and a markedly severe and persistent mental disorder such as schizophrenia or bipolar disorder. A preferred definition is *mentally ill chemically affected* people, since the word *affected* better describes their condition and is not pejorative. Other acronyms are also used: *MISA* (mentally ill substance abusers), *CAMI* (chemical abuse and mental illness), and *SAMI* (substance abuse and mental illness).

Common examples of dual disorders include the combinations of major depression with cocaine addiction, alcohol addiction with panic disorder, alcoholism and polydrug addiction with schizophrenia, and borderline personality disorder with episodic polydrug abuse. Although the focus of this volume is on dual disorders, some patients have more than two disorders, such as cocaine addiction, personality disorder, and AIDS. The principles that apply to dual disorders generally apply also to multiple disorders.

The combinations of AOD problems and psychiatric disorders vary along important dimensions, such as severity, chronicity, disability, and degree of impairment in functioning. For example, the two disorders may each be severe or mild, or one may be more severe than the other. Indeed, the severity of both disorders may change over time. Levels of disability and impairment in functioning may also vary.

Thus, there is no single combination of dual disorders; in fact, there is great variability among them. However, patients with similar combinations of dual disorders are often encountered in certain treatment settings. For instance, some methadone treatment programs treat a high percentage of opiate-addicted patients with personality disorders. Patients with schizophrenia and alcohol addiction are frequently encountered in psychiatric units, mental health centers, and programs that provide treatment to homeless patients.

Patients with mental disorders have an increased risk for AOD disorders, and patients with AOD disorders have an increased risk for mental disorders. For example, about one-third of patients who have a psychiatric disorder also experience AOD abuse at some point (Regier et al., 1990), which is about twice the rate among people without psychiatric disorders. Also, more than half of the people who use or abuse AODs have experienced psychiatric symptoms significant enough to fulfill diagnostic criteria for a psychiatric disorder (Regier et al., 1990; Ross et al., 1988), although many of these symptoms may be AOD related and might not represent an independent condition.

Compared with patients who have a mental health disorder or an AOD use problem alone, patients with dual disorders often experience more severe and chronic medical, social, and emotional problems. Because they have two disorders, they are vulnerable to both AOD relapse and a worsening of the psychiatric disorder. Further, addiction relapse often leads to psychiatric decompensation, and worsening of psychiatric problems often leads to addiction relapse. Thus, relapse prevention must be specially designed for patients with dual disorders. Compared with patients who have a single disorder, patients with dual disorders often require longer treatment, have more crises, and progress more gradually in treatment.

Psychiatric disorders most prevalent among dually diagnosed patients include mood disorders, anxiety disorders, personality disorders, and psychotic disorders. Each of these clusters of disorders and symptoms is dealt with in more detail in separate chapters.

AOD Abuse, Addiction, Dependence, Misuse

The characteristic feature of *AOD abuse* is the presence of dysfunction related to the person's AOD use. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R), produced by the American Psychiatric Association and updated periodically, is used throughout the medical and mental health fields for diagnosing psychiatric and AOD use disorders. It provides clinicians with a common language for communicating about these disorders and for making clinical decisions based on current knowledge. For each diagnosis, the manual lists symptom criteria, a minimum number of which must be met before a definitive diagnosis can be given to a patient.

Criteria for AOD abuse hinge on the individual's continued use of a drug despite his or her knowledge of "persistent or recurrent social, occupational, psychologic, or physical problems caused or exacerbated by the use of the [drug]" (American Psychiatric Association, 1987). Alternately, there can be "recurrent use in situations in which use is physically hazardous." The DSM-IV draft continues this emphasis (American Psychiatric Association, 1993).

Thus, AOD abuse is defined as the use of a psychoactive drug to such an extent that its effects seriously interfere with health or occupational and social functioning. AOD abuse may or may not involve physiologic dependence or tolerance. Importantly, evidence of physiologic dependence and tolerance is not sufficient for diagnosis of AOD abuse. For example, use of AODs in weekend binge patterns may not involve physiologic dependence, although it has adverse effects on a person's life.

AOD Abuse

- Significant impairment or distress resulting from use
- Failure to fulfill roles at work, home, or school
- Persistent use in physically hazardous situations
- Recurrent legal problems related to use
- Continued use despite interpersonal problems

Therefore, screening questions should relate to life problems that result from AOD use, taking into consideration that patients may not have the insight to perceive that their life problems are caused by AOD abuse.

The phrase AOD addiction (called "psychoactive substance dependence" in the DSM-III-R and "substance dependence" in the DSM-IV draft) is an often progressive process that typically includes the following aspects: 1) compulsion to acquire and use AODs and preoccupation with their acquisition and use, 2) loss of control over AOD use or AOD-induced behavior, 3) continued AOD use despite adverse consequences, 4) a tendency toward relapse following periods of abstinence, and 5) tolerance and/or withdrawal symptoms.

AOD Addiction or Dependence

- Pathologic, often progressive and chronic process
- Compulsion and preoccupation with obtaining a drug or drugs
- Loss of control over use or AOD-induced behavior
- Continued use despite adverse consequences
- Tendency for relapse after period of abstinence
- Increased tolerance and characteristic withdrawal (but not necessary or sufficient for diagnosis).

The DSM-III-R describes nine diagnostic criteria (shown in Exhibit 2-1), of which three or more must be present for a month or more to establish a diagnosis of dependence. Screening questions can be based on these criteria. The DSM-IV draft committee deleted DSM-III-R criterion 4 and the requirement of symptoms being present for at least 1 month. The DSM-IV draft emphasizes the symptoms of tolerance and withdrawal, which the draft committee placed at the top of the list of criteria.

In the DSM-III-R, criteria 1 and 2 deal with loss of control; criterion 3 addresses time involvement; criteria 4 and 5 relate to social dysfunction; criterion 6 relates to continued use despite adverse consequences;and criteria 7, 8, and 9 relate to the development of tolerance and withdrawal. It is important to note that tolerance, physiologic dependence, and withdrawal are neither necessary nor sufficient for the establishment of a diagnosis of AOD addiction.

The term *AOD dependence* can be confusing because it has multiple meanings. The DSM-III-R uses the phrase "psychoactive substance dependence" to describe the process of addiction, while many pharmacologists use the term "dependence" exclusively for describing the biologic aspects of physical tolerance and/or withdrawal. The American Society of Addiction Medicine describes drug dependence as having two possible components: 1) psychologic dependence and 2) physical dependence.

Psychologic dependence centers on the user's need of a drug to reach a level of functioning or feeling of well-being. Because this term is particularly subjective and almost impossible to quantify, it is of limited usefulness in making a diagnosis.

Physical dependence refers to the issues of physiologic dependence, establishment of tolerance, and evidence of an abstinence syndrome or withdrawal upon cessation of AOD use. In this case, AOD type, volume, and chronicity are the important variables: Given a certain substance, the higher the dose and longer the period of consumption, the more likely is the development of tolerance, dependence, and subsequent withdrawal symptoms. Physical dependence and tolerance are best understood as two of many possible consequences (which may or may not include addiction and abuse) of chronic exposure to psychoactive substances.

Among patients with a psychiatric problem, any AOD use -- whether abuse or not -- can have adverse consequences. This is especially true for patients with severe psychiatric disorders and patients who are taking prescribed medications for psychiatric disorders. For patients with psychiatric disorders, the infrequent consumption of alcohol can lead to serious problems such as adverse medication interactions, decreased medication compliance, and AOD abuse. Screening questions can relate to evidence of any use of alcohol and other drugs, as well as frequency, dose, and duration.

Medication misuse describes the use of prescription medications outside of medical supervision or in a manner inconsistent with medical advice. While medication misuse is not an abuse problem per se, it is a high-risk behavior that: 1) may or may not involve AOD abuse, 2) may or may not lead to AOD abuse, 3) may represent medication noncompliance and promote the reemergence of psychiatric symptoms, and 4) may cause toxic effects and psychiatric symptoms if it involves overdose.

Thus, some patients may consume medications at higher or lower doses than recommended or in combination with AODs. Also, certain patients may respond to prescribed psychoactive medications by developing compulsive use and loss of control over their use.

Chapter 3 – Mental Health And Addiction Treatment Systems: Philosophical and Treatment Approach Issues

Introduction

For people with dual disorders, the attempt to obtain professional help can be bewildering and confusing. They may have problems arising within themselves as a result of their psychiatric and AOD use disorders as well as problems of external origin that derive from the conflicts, limitations, and clashing philosophies of the mental health and addiction treatment systems. For example, internal problems such as frustration, denial, or depression may hinder their ability to recognize the need for help and diminish their ability to ask for help. A typical external problem might be the confusion experienced when individuals need services but lack knowledge about the different goals and processes of various types of available services. Other problems of external origin may be very fundamental, such as the inability to pay for child care services or the lack of transportation to the only available outpatient program.

Historically, when patients in AOD treatment exhibited vivid and acute psychiatric symptoms, the symptoms were either: 1) unrecognized, 2) observed but misdescribed as toxicity or "acting-out behavior," or 3) accurately identified, prompting the patients to be discharged or referred to a mental health program. Virtually the same process occurred for patients in mental health treatment who exhibited vivid and acute symptoms of AOD use disorders.

Mislabeling, rejecting, failing to recognize, or automatically transferring patients with dual disorders can result in inadequate treatment, with patients falling between the cracks of treatment systems. The symptoms of psychiatric and AOD use disorders often fluctuate in intensity and frequency. Current symptom presentation may reflect a short-term change in the course of long-term dual disorders. Thus, even when patients receive traditional professional help, treatment may address only selected aspects of

their overall problem unless treatment is coordinated among services including AOD, mental health, social, and medical programs.

As a result, the treatment system itself may be a stumbling block for some people attempting to receive ongoing, appropriate, and comprehensive treatment for combined psychiatric and AOD use disorders. Thus, treatment services for patients with dual disorders must be sensitive to both the individual's and the treatment system's impediments to the initiation and continuation of treatment.

Treatment Systems: Mental Health, Addiction, And Medical

People with dual disorders who want to engage in the treatment process (or who need to do so) frequently encounter not one but several treatment systems, each having its own strengths and weaknesses. These treatment systems have different clinical approaches.

The Mental Health System

Actually, there is no single mental health system, although most States have a set of public mental health centers. Rather, mental health services are provided by a variety of mental health professionals including psychiatrists; psychologists; clinical social workers; clinical nurse specialists; other therapists and counselors including marriage, family, and child counselors (MFCCs); and paraprofessionals.

These mental health personnel work in a variety of settings, using a variety of theories about the treatment of specific psychiatric disorders. Different types of mental health professionals (for example, social workers and MFCCs) have differing perspectives; moreover, practitioners within a given group often use different approaches.

A major strength of the mental health system is the comprehensive array of services offered, including counseling, case management, partial hospitalization, inpatient treatment, vocational rehabilitation, and a variety of residential programs. The mental health system has a relatively large variety of treatment settings. These settings are designed to provide treatment services for patients with acute, subacute, and long-term symptoms. Acute services are provided by personnel in emergency rooms and hospital units of several types and by crisis-line personnel, outreach teams, and mental health law commitment specialists. Subacute services are provided by hospitals, day treatment programs, mental health center programs, and several types of individual practitioners. Long-term settings include mental health centers, residential units, and practitioners' offices. Clinicians vary with regard to academic degrees, styles, expertise, and training. Another strength of the mental health system is the growing recognition at all system levels of the role of case management as a means to individualize and coordinate services and secure entitlements.

Medication is more often used in psychiatric treatment than in addiction treatment, especially for severe disorders. Medications used to treat psychiatric symptoms include psychoactive and nonpsychoactive medications. Psychoactive medications cause an acute change in mood, thinking, or behavior, such as sedation, stimulation, or euphoria.

Psychoactive medications (such as benzodiazepines) prescribed to the average patient with psychiatric problems are generally taken in an appropriate fashion and pose little or no risk of abuse or addiction. In contrast, the use of psychoactive medications by patients with a personal or family history of an AOD use disorder is associated with a high risk of abuse or addiction.

Some medications used in psychiatry that have mild psychoactive effects (such as some tricyclic antidepressants with mild sedative effects) appear to be misused more by patients with an AOD disorder than by others. Thus, a potential pitfall is prescribing psychoactive medications to a patient

with psychiatric problems without first determining whether the individual also has an AOD use disorder.

While most clinicians in the mental health system generally have expertise in a biopsychosocial approach to the identification, diagnosis, and treatment of psychiatric disorders, some lack similar skills and knowledge about the specific drugs of abuse, the biopsychosocial processes of abuse and addiction, and AOD treatment, recovery, and relapse. Similarly, AOD treatment professionals may have a thorough understanding of AOD abuse treatment but not psychiatric treatment.

The Addiction Treatment System

As with mental health treatment, no single addiction treatment system exists. Rather, there is a collection of different types of services such as social and medical model detoxification programs, short- and long-term treatment programs, methadone detoxification and maintenance programs, long-term therapeutic communities, and self-help adjuncts such as the 12-step programs. These programs can vary greatly with respect to treatment goals and philosophies. For example, abstinence is a prerequisite for entry into some programs, while it is a long-term goal in other programs. Some AOD treatment programs are not abstinence oriented. For example, some methadone maintenance programs have the overt goal of eventual abstinence for all patients, while others promote continued methadone use to encourage psychosocial stabilization.

As with mental health treatment, addiction treatment is provided by a diverse group of practitioners, including physicians, psychiatrists, psychologists, certified addiction counselors, MFCCs, and other therapists, counselors, and recovering paraprofessionals. There can be a wide difference in experience, expertise, and knowledge among these diverse providers. As with mental health treatment, most States have public and private AOD treatment systems.

The strengths of addiction treatment services include the multidisciplinary team approach with a biopsychosocial emphasis, and an understanding of the addictive process combined with knowledge of the drugs of abuse and the 12-step programs. In typical addiction treatment, medications are used to treat the complications of addiction, such as overdose and withdrawal. However, few medications that directly treat or interrupt the addictive process, such as disulfiram and naltrexone, have been identified or regularly used. Maintenance medications such as methadone are crucial for certain patients. However, most addiction treatment professionals attempt to eliminate patients' use of all drugs.

Similarities of Mental Health and Addiction Treatment Systems

- Variety of treatment settings and program types
- Public and private settings
- Multiple levels of care
- Biopsychosocial models
- Increasing use of case and care management
- Value of self-help adjuncts.

Many who work in the addiction treatment field have only a limited understanding of medications used for psychiatric disorders. Historically, some people have mistakenly assumed that all or most psychiatric medications are psychoactive or potentially addictive. Many addiction treatment staff tend to avoid the use of any medication with their patients, probably in reaction to those whose addiction included prescription medications such as diazepam (Valium). Many staff have a lack of training and experience in the use of such medications. In the treatment of dual disorders, a balance must be made between behavioral interventions and the appropriate use of nonaddicting psychiatric medications for

those who need them to participate in the recovery process. Withholding medications from such individuals increases their chances of AOD relapse.

An important adjunct to addiction treatment services is the massive system of consumer-developed groups, such as the 12-step program of Alcoholics Anonymous (AA). Participants in AA and other self-help groups (Narcotics Anonymous [NA], Cocaine Anonymous [CA], etc.) can provide needed support and encouragement for patients in treatment. Importantly, these services are widespread nationally and internationally. While self-help programs are not considered treatment per se, they are integral adjuncts to professional treatment services.

However, patients in self-help groups may give others inappropriate advice regarding medication compliance, based on personal experience, fears of medication, or incomplete knowledge about the role of medication in dual disorders. In many urban areas, there are specialized 12-step groups for people with dual disorders. In these so-called "Double Trouble" meetings, medication compliance is a part of "working the program."

The Medical System

Primary health care providers (physicians and nurses) have historically been the largest single point of contact for patients seeking help with psychiatric and AOD use disorders. Physicians and nurses are uniquely qualified to manage life-threatening crises and to treat medical problems related and unrelated to psychiatric and substance use disorders. And because they are in contact with such large numbers of patients, they have an exceptional opportunity to screen and identify patients with psychiatric and AOD disorders.

However, physicians -- especially primary care physicians -- are able to devote very little time to each patient. Pressured for time, these physicians may prescribe such psychiatric medications as antidepressants or anxiolytics or medication such as disulfiram or naltrexone as a primary approach, rather than as an adjunctive approach. Indeed, primary care physicians are the largest single prescriber of antianxiety medications. Some of these medications, such as the benzodiazepines, are psychoactive and can be abused.

Also, physicians and nurses have historically been trained to focus on the medical consequences of addiction, such as withdrawal, overdose, or hepatitis, without assessing, treating, or actively referring the individual for treatment of the addiction itself. The role of physicians with regard to addiction is changing through the leadership of national organizations such as the American Society of Addiction Medicine, the American Academy of Psychiatrists on Alcohol and Addiction, and the Association of Medical Education and Research on Substance Abuse. Similar groups exist for nurses and allied health care professionals. Such groups can provide medical professionals with important information and education about the biopsychosocial nature of addiction and treatment, especially regarding patients with dual disorders.

Differing Approaches: Individual Responsibility and Treatment Focus

Traditionally, patients in mental health settings have had the responsibility of getting themselves to treatment services and appointments as a sign of treatment motivation. More recently, and in recognition that many severely mentally ill patients are unwilling or unable to use traditional community-based services, the mental health field has emphasized the role of case management. Case management (also called care management) can help to engage, link, and support patients in needed community services. Case management can help to reduce the negative consequences to the individual from lack of followup and participation in treatment. Without case management, many severely ill patients would decompensate, need to be hospitalized, or become homeless.

The case management model identifies individual limitations, deficits, and strengths and aggressively attempts to provide patients with what they need. When a patient rejects professional assistance, the case manager assumes the responsibility for finding a different way to get the individual to accept assistance. The case manager may minimize the negative consequences to the individual in order to engage or maintain the patient in treatment. This activity might be seen as "enabling" by traditional addiction treatment personnel.

In contrast, the addiction treatment system focuses on individual responsibility, including the responsibility of accepting help. Motivation for recovery is enhanced through confrontation of the adverse consequences of addiction. Further, addiction intervention and treatment involve diminishing the individual's denial about the presence and severity of the addiction through direct but therapeutic confrontation of examples of addiction-related behaviors. Thus, traditionally, patients in the addiction treatment system who did not want help or could not tolerate confrontation might not get help. Mental health personnel might regard this situation as an abandonment of the most needy. More recently, the addiction treatment system has been developing case management models to better address treatment-resistant patients.

Treatment of patients with dual disorders must blend both mental health and AOD treatment models, with each applied at appropriate times and in appropriate situations according to patients' needs. There should be a balance between clinician and patient acceptance of responsibility for treatment and recovery from dual disorders.

For example, in AOD treatment, clinical staff and fellow patients often aggressively confront patients who deny that they have an AOD problem or who minimize the severity of their problem. However, treatment of individuals with dual disorders first requires innovative approaches to engage them in treatment as a prerequisite to confrontation. The role of confrontation may need to be substantially modified, particularly in the treatment of disorganized or psychotic patients, who may tolerate confrontation only in later stages of treatment (when their symptoms are stable and they are engaged in the treatment process).

In addiction treatment, the focus is often on the "here and now," while in mental health treatment, the focus is often on past developmental issues. Mental health practitioners may identify AOD abuse as a symptom of a prior trauma rather than an illness in its own right. The focus of treatment may be on the developmental issues, with the assumption that the AOD use disorder will improve automatically once these issues are treated. Inadvertently, the mental health therapist can enable AOD use to continue.

The Role of Abstinence

Within parts of the addiction treatment system, abstinence from psychoactive drugs is a precondition to participate in treatment. For the more severely ill patients with dual disorders (such as patients with schizophrenia), abstinence from AODs is often considered a goal, possibly a long-term goal, similar to the approach at some methadone maintenance programs. On the other hand, treatment of less severe dual psychiatric conditions, such as depression or panic disorder, should require AOD abstinence, since AOD use compromises both diagnosis and treatment (see individual chapters).

For some patients with dual disorders, requiring abstinence as a condition of entering treatment may hinder or discourage engagement in the treatment process. For these patients, abstinence may be redefined as a goal, with encouragement provided for incremental steps in the reduction of amount and frequency of drug use. For example, patients who experience homelessness and housing instability likely do not live in drug-free environments. For such patients, it may be unrealistic to mandate

abstinence as a requirement for treatment. Exhibit 3-1 describes some of the treatment strategy differences for managing patients in mental health, addiction, and dual disorder treatment approaches.

Treatment Models: Sequential, Parallel, Or Integrated

As the mental health and AOD abuse treatment fields have become increasingly aware of the existence of patients with dual disorders, various attempts have been made to adapt treatment to the special needs of these patients (Baker, 1991; Lehman et al., 1989; Minkoff, 1989; Minkoff and Drake, 1991; Ries, 1993a). These attempts have reflected philosophical differences about the nature of dual disorders, as well as differing opinions regarding the best way to treat them. These attempts also reflect the limitations of available resources, as well as differences in treatment responses for different types and severities of dual disorders. Three approaches have been taken to treatment.

Sequential Treatment

The first and historically most common model of dual disorder treatment is sequential treatment. In this model of treatment, the patient is treated by one system (addiction or mental health) and then by the other. Indeed, some clinicians believe that addiction treatment must always be initiated first, and that the individual must be in a stage of abstinent recovery from addiction before treatment for the psychiatric disorder can begin. On the other hand, other clinicians believe that treatment for the psychiatric disorder should begin prior to the initiation of abstinence and addiction treatment. Still other clinicians believe that symptom severity at the time of entry to treatment should dictate whether the individual is treated in a mental health setting or an addiction treatment setting or that the disorder that emerged first should be treated first.

The term *sequential treatment* describes the serial or nonsimultaneous participation in both mental health and addiction treatment settings. For example, a person with dual disorders may receive treatment at a community mental health center program during occasional periods of depression and attend a local AOD treatment program following infrequent alcoholic binges. Systems that have developed serial treatment approaches generally incorporate one of the above orientations toward the treatment of patients with dual disorders.

Parallel Treatment

A related approach involves *parallel treatment:* the simultaneous involvement of the patient in both mental health and addiction treatment settings. For example, an individual may participate in AOD education and drug refusal classes at an addiction treatment program, participate in a 12-step group such as AA, and attend group therapy and medication education classes at a mental health center. Both parallel and sequential treatment involve the utilization of existing treatment programs and settings. Thus, mental health treatment is provided by mental health clinicians, and addiction treatment is provided by addiction treatment clinicians. Coordination between settings is quite variable.

Integrated Treatment

A third model, called *integrated treatment,* is an approach that combines elements of both mental health and addiction treatment into a unified and comprehensive treatment program for patients with dual disorders. Ideally, integrated treatment involves clinicians cross-trained in both mental health and addiction, as well as a unified case management approach, making it possible to monitor and treat patients through various psychiatric and AOD crises.

There are advantages and disadvantages in sequential, parallel, and integrated treatment approaches. Differences in dual disorder combinations, symptom severity, and degree of impairment greatly affect the appropriateness of a treatment model for a specific individual. For example, sequential and parallel treatment may be most appropriate for patients who have a very severe problem with one disorder, but a mild problem with the other. However, patients with dual disorders who obtain treatment from two separate systems frequently receive conflicting therapeutic messages; in addition, financial coverage and even confidentiality laws vary between the two systems.

- Sequential: The patient participates in one system, then the other.
- Parallel: The patient participates in two systems simultaneously.
- Integrated: The patient participates in a single unified and comprehensive treatment program for dual disorders.

In contrast, integrated treatment places the burden of treatment continuity on a case manager who is expert in both psychiatric and AOD use disorders. Further, integrated treatment involves simultaneous treatment of both disorders in a setting designed to accommodate both problems.

Critical Treatment Issues For Dual Disorders

Mental health and addiction treatment programs that are being designed to accommodate patients with dual disorders should be modified to address the specific needs of these patients. Although there are different dual disorder treatment models, all such programs must address several key issues that are critical for successful treatment. These issues include: 1) treatment engagement, 2) treatment continuity and comprehensiveness, 3) treatment phases, and 4) continual reassessment and rediagnosis.

Treatment Engagement

In general, treatment engagement refers to the process of initiating and sustaining the patient's participation in the ongoing treatment process. Engagement can involve such enticements as providing help with the procurement of social services, such as food, shelter, and medical services. Engagement can also involve removing barriers to treatment and making treatment more accessible and acceptable, for example, by providing day and evening treatment services. Engagement can be enhanced by providing adjunctive services that may appear to be indirectly related to the disorders, such as child care services, job skills counseling, and recreational activities. It may also be coercive, such as through involuntary commitment or a designated payee.

Engagement begins with efforts that are designed to enlist people into treatment, but it is a long-term process with the goals of keeping patients in treatment and helping them manage ongoing problems and crises. Essential to the engagement process is: 1) a personalized relationship with the individual, 2) over an extended period of time, with 3) a focus on the stated needs of the individual.

For patients with dual disorders, engagement in the treatment process is essential, although the techniques used will depend upon the nature, severity, and disability caused by an individual's dual disorders. An employed person with panic disorder and episodic alcohol abuse will require a different type of engagement than a homeless person with schizophrenia and polysubstance dependence. With respect to severe conditions such as psychosis and violent behaviors, therapeutic coercive engagement techniques may include involuntary detoxification, involuntary psychiatric treatment, or court-mandated acute treatment.

Treatment Continuity

To treat patients with dual disorders, it is critical to develop continuity between treatment programs and treatment components, as well as treatment continuity over time. In practice, many patients participate in treatment at different sites. Even in integrated treatment programs, many patients require different treatment services during different phases of treatment. For this reason, treatment should include an integrated dual disorder case management program, which can be located within a mental health setting, an addiction treatment setting, or a collaborative program.

Treatment Comprehensiveness

An overall system for treating dual disorders includes mental health and addiction treatment programs, as well as collaborative integrated programs. Programs should be designed to: 1) engage clients, 2) accommodate various levels of severity and disability, 3) accommodate various levels of motivation and compliance, and 4) accommodate patients in different phases of treatment. There should be access to abstinence-mandated programs and abstinence-oriented programs, as well as to drug maintenance programs. Different levels of care, ranging from more to less intense

treatment, should be available.

Phases of Treatment

In general, the medical term *acute* describes phenomena that begin quickly and require rapid response. Acute problems are contrasted with chronic problems. Most commonly, acute stabilization of patients with dual disorders refers to the management of physical, psychiatric, or drug toxicity crises. These include injury, illness, AOD-induced toxic or withdrawal states, and behavior that is suicidal, violent, impulsive, or psychotic.

The acute stabilization of AOD use disorders typically begins with detoxification, such as inpatient detoxification for patients with significant withdrawal or outpatient detoxification for mild to moderate withdrawal, as well as nonmedical withdrawal, such as occurs in social-model detoxification programs. Also, initiation of methadone maintenance can provide outpatient acute stabilization for patients addicted to opioids.

Acute stabilization of psychiatric symptoms more frequently occurs within a mental health or emergency medical setting, but involves a range of treatment intensity. Patients with severe symptoms, especially psychotic, violent, or impulsive behaviors, usually require acute psychiatric inpatient treatment and psychiatric medications, while patients with less severe symptoms can be treated in outpatient or day treatment settings.

Dual disorder programs that provide stabilization to patients with acute needs should have the capability to:

- Identify medical, psychiatric, and AOD use disorders
- Treat a range of illness severity
- Provide drug detoxification, psychiatric medications, and other biopsychosocial levels of treatment
- Provide a range of intensities of service.

These programs should be capable of promoting the patient's engagement with the treatment system. They should be able to aggressively provide linkages to other programs that will provide ongoing treatment and engagement.

Subacute Stabilization

The medical term *subacute* describes the status of a medical disorder at points between the acute condition and either resolution or chronic state. The subacute phase of a medical problem occurs as the acute course of the problem begins to diminish, or when symptoms emerge or reemerge but are not yet severe enough to be described as acute.

For example, patients recently detoxified from AODs frequently experience subacute symptoms such as insomnia and anxiety that may linger for a few days or weeks. On the other hand, recently detoxified patients with dual disorders may experience subacute symptoms of insomnia and anxiety either as subacute withdrawal symptoms or as a prelude to relapse with depression. Although the subacute phase is not generally regarded as a period of crisis, ignoring these symptoms and failing to assess and treat them may lead to symptom escalation, decompensation, and relapse.

As AOD-induced toxic or withdrawal symptoms resolve, constant reassessment and rediagnosis is required. During this phase, a psychoeducational and behavioral approach should be used to educate patients about their disorders and symptomatology. During this phase, treatment providers should provide assessment and planning for dealing with long-term issues such as housing, long-term treatment, and financial stability.

	AOD	Psychiatric
Biological:	Alcohol on breath Positive drug tests Abnormal laboratory tests Injuries and trauma Toxicity and withdrawal Impaired cognition	Abnormal laboratory tests Neurological exams Using psychiatric medications Other medications, conditions
Psychological:	Intoxicated behavior Withdrawal symptoms Denial and manipulation Responses to AOD assessments AOD use history	Mental status exam: Affect mood, psychosis, etc. Stress, situational factors Self-image, defenses, etc.
Social:	Collateral information from others Social interactions and lifestyle Involvement with other AOD groups Family history of AOD use disorders Family history Housing and employment histories	Support systems: Family, friends, others Current psychiatric therapy Hospitalization

ABC Model for Psychiatric Screening

- Appearance, alertness, affect, and anxiety:

  Appearance:
  General appearance, hygiene, and dress.
  Alertness:
  What is the level of consciousness?
  Affect:
  Elation or depression: gestures, facial expression, and speech.
  Anxiety:
  Is the individual nervous, phobic, or panicky?

- Behavior:

  Movements:
  Rate (Hyperactive, hypoactive, abrupt, or constant?).
  Organization:
  Coherent and goal-oriented?
  Purpose:
  Bizarre, stereotypical, dangerous, or impulsive?
  Speech:
  Rate, organization, coherence, and content.

- Cognition:

  Orientation:
  Person, place, time, and condition.
  Calculation:
  Memory and simple tasks.
  Reasoning:
  Insight, judgment, problem solving.
  Coherence:
  Incoherent ideas, delusions, and hallucinations?

Long-Term Stabilization

The treatment settings for long-term treatment, rehabilitation, and recovery from dual disorders include outpatient, day treatment, and residential settings. Ideally, treatment intensity is dictated by disorder severity and motivation for treatment, as well as by personal and local treatment resources. In more severe conditions, ongoing dual disorder case management is essential. The management of long-term severe conditions is described in more detail in the chapter on psychotic disorders (Chapter 8).

With regard to the initiation and maintenance of sobriety in patients with dual disorders, another way of looking at acute, subacute, and long-term phases involves a four-step approach that leads to abstinence. This approach is particularly important for patients with severe psychiatric problems and an AOD use disorder (Minkoff and Drake, 1991; Ries, 1993a).

Individual case management.
Individual case management provides an initial introduction to treatment goals and concepts and may provide assistance with regard to crises, housing, and entitlements. An individual treatment plan is developed.

Persuasion groups.
Patients who display strong denial about their AOD use disorder and lack motivation can attend persuasion groups, which provide basic AOD education and treatment engagement. Premature, potent, and direct confrontation and an insistence on abstinence should be avoided since these approaches may prompt more fragile patients to leave treatment.

Active treatment groups.
Active treatment groups consist of patients who have accepted the goal of abstinence and are relatively mentally stable. These groups use supervised peer confrontation and a psychoeducational-behavioral approach to AOD abuse.

Abstinence support groups.
Finally, abstinence support groups consist of patients who are essentially committed to abstinence and are relatively stable mentally, who require ongoing education and support for sobriety and the development of relapse prevention skills.

Psychiatric and AOD abuse treatment issues are woven into the groups in such a way that concrete issues (such as medication compliance) are addressed in persuasion groups, while abstract concepts (such as self-image) are addressed in active treatment or abstinence support groups. Some patients -- such as severely psychotic patients -- may not be able to advance beyond persuasion groups or active treatment groups.

General Assessment Issues
Each of the following chapters will address assessment and evaluation issues relative to specific psychiatric disorders. Specific assessment tools may be recommended for certain interventions and certain settings. Irrespective of the treatment or intervention setting, and notwithstanding the crisis that may have initiated the treatment contact, all treatment contacts with patients who may have dual disorders should include a basic screening for psychiatric and AOD use disorders. These issues are addressed in detail in the chapters on mood, personality, and psychotic disorders. With respect to both psychiatric and AOD use disorders, the assessment process should be sensitive to biological, psychological, and social issues.

Full assessments of patients with dual disorders should be performed by clinicians who have certified training in the areas that they assess. However, clinicians who are not certified can learn to perform screening tests. Assessments of patients who may have dual disorders should include at least a brief mental status exam to assess for the presence and severity of psychiatric problems, as well as a screening for AOD use disorders.

The "ABC" model described on the previous page is a simple screening technique for the presence of psychiatric disorders. The CAGE questionnaire and the CAGE questionnaire modified for other drugs (CAGEAID) are rapid and accurate screening tools for AOD use disorders (Exhibit 3-2). The substances used most often by patients with dual disorders are the same as those used by society in general: alcohol, marijuana, cocaine, and more rarely, opioids. It is recommended that all front-line AOD and mental health staff receive detailed training in the use of a mental status exam and AOD

screening tests.

Chapter 4 – Linkages For Mental Health and AOD Treatment

Overview

Conventional boundaries between single-focus agencies have impeded the clinical progress of patients who have psychiatric disorders and alcohol and other drug (AOD) use disorders (Baker, 1991; Schorske and Bedard, 1988).

The treatment of patients with dual disorders is a clinical challenge, as well as a systems challenge, requiring innovation and coordination. The goal of this chapter is to help State and local administrators consider strategies for linkages across systems in order to improve service delivery and treatment outcomes.

Profiles of patients with dual disorders demonstrate that they are more or differently disabled and require more services than patients with a single disorder. They have higher rates of homelessness and legal and medical problems. They have more frequent and longer hospitalizations and higher acute care utilization rates. For example, among patients with schizophrenia, episodes of violence and suicide are twice as likely to occur among those who abuse street drugs as among those who do not.

Treatment and social needs of patients with dual disorders differ depending on the type and severity of the disorders. Patients with dual disorders are generally less able to navigate between, engage in, and remain engaged in treatment services. Focusing on linkages highlights the fact that treatment providers, rather than patients and their families, have the responsibility for coordinating diverse and often conflicting treatment services.

Treatment must be suited to patients' personal needs and characteristics, linking services across several different systems of care. Instead of blaming patients for poor treatment outcomes as they fall through the cracks of separate service systems, patients can be empowered and better treated when given effective options.

Collaboration across multiple systems and philosophies of care is needed to treat patients with dual disorders effectively. The systems often affected include:

- Alcohol prevention and treatment services
- Drug prevention and treatment services
- Mental health treatment services
- Criminal justice systems
- Legal services
- Social and welfare services
- General health care services
- Child and adult protective services
- Vocational rehabilitation programs
- Housing agencies
- Agencies for homeless people

- Educational systems
- HIV/AIDS prevention and treatment services.

For the treatment of patients with dual disorders, the primary systems involved are AOD and mental health treatment. Programs that focus on dual disorders operate in both the mental health and AOD systems. Staff and administrative initiative is required to collaborate across systems. At a minimum, both systems should be involved when developing initiatives to improve linkages. This TIP is focused on the linkages between these systems.

In order to work effectively together, AOD treatment providers and mental health professionals need to understand and respect the different historical and philosophical underpinnings of both systems. As explained in the third chapter, the systems developed separately. There are inherent stresses and strengths among medical, psychoanalytic, psychosocial, and self-help care orientations, as well as between AOD treatment and mental health treatment.

These differences have frequently been a source of conflict and have caused problems for some patients. For example, if a patient with a dual disorder is told by his psychiatrist that he needs psychotropic medication to treat his psychiatric disorder, but members of his self-help AA group tell him to give up all mood-altering drugs to recover from his AOD abuse, to whom does he listen?

Patients with dual disorders challenge the treatment systems. Their involvement in treatment can become an opportunity for providers to examine the philosophical and practical aspects of treatment.

- Providers should acknowledge that no single field has all the answers and that a need exists to integrate treatment by building upon and adapting from experience. Clinicians who work with dual disorder patients must add to their existing clinical skills. The development of a dual disorders program is an evolutionary process that requires agreed-upon outcome measures and program evaluation.
- Providers should review admission criteria. These criteria should be inclusive, not exclusionary. Admission and placement criteria should be based on behaviors and skills required to participate in and benefit from a program rather than based solely on diagnosis.
- Providers should find creative ways to bridge the differing funding streams, target populations, legal and regulatory mandates, and professional backgrounds and expertise.
- Providers should accept the responsibility to provide integrated treatment -- not parallel or concurrent treatment efforts that require the patient to integrate and adapt to different and sometimes conflicting treatment models.

In spite of the historical and philosophical differences that have separated the fields, the consensus panel identified several shared treatment concepts that administrators can use to help move toward integration.

- Treatment should be provided in the least restrictive and most clinically appropriate setting within a continuum of care.
- Treatment should be individualized for each patient.
- The patient should be seen from a holistic, biopsychosocial perspective.
- Self-help and peer support are valuable in the recovery process.
- Families need education and support.
- Case management plays a key role in effective treatment.
- Multidisciplinary teams and approaches are necessary.
- Group education and group process are valuable elements of the treatment process.
- Ongoing support, relapse management, and prevention are necessary strategies.

- Understanding that relapse and recovery are processes, not single events, and that relapse is not synonymous with failure is essential.
- Cultural competence in programs and staff is required.
- Gender-specific approaches to treatment are necessary.

Areas of Primary Concern

To establish and maintain linkages among the various systems working with patients who have dual disorders, several primary administrative areas need to be examined.

It is beyond the scope of this document to provide detailed discussion of each area, but the following discussion of problems and solutions will help readers in their problem solving. The areas to be discussed in this chapter include:

- Policy and planning structures
- Funding and reimbursement
- Data collection and needs assessment
- Program development
- Screening, assessment, and referral
- Case management
- Staffing issues
- Training and staffing
- Linkages with social services agencies
- Linkages with the medical health care system
- Linkages with the criminal justice system.

Policy and Planning Structures

Problems

Often there is little or no communication or collaboration among various departments and levels of government that have separate administrative structures, constituencies, mandates, and target groups. There are also different Federal, State, and local planning cycles within the AOD use and mental health treatment systems.

The Federal Government requires two separate planning processes for programs receiving Federal funds: A State mental health plan and a State substance abuse plan. The federally mandated State planning processes required under the Public Health Service Act for mental health treatment and AOD abuse treatment are separate and have no requirements for coordination.

Solutions

Amendments are needed to the Public Health Service Act to encourage coordinated long-term planning between the State mental health and AOD abuse treatment systems for patients with dual disorders.

The development and use of long-term structural mechanisms (such as coordinating bodies, task forces, memoranda of understanding, and letters of agreement) can help improve planning for and integration of services for patients who have dual disorders.

To accomplish this goal, States might create a joint planning mechanism -- an officially organized planning group -- that would: 1) have diverse composition, 2) carry out specific types of tasks, and 3) maintain specific foci.

1. The planning organization should have diverse composition.

- There should be dedicated policy-level staff from different agencies to work on the joint planning body.
- The planning group should be culturally competent and include a culturally diverse cross-section of the population.
- The planning group should include a significant percentage of direct recipients of the services.
- The planning group should include family members of patients.
- The planning group should include providers.
- The planning group should include academic representation from schools of medicine, nursing, psychology, social work, and public health.

2. The planning group should accomplish the following tasks:

- The group should set yearly objectives that are practical and outcome oriented, and that can be tied to observable results on the service level.
- The group should examine existing licensing requirements and regulations that affect programs that treat patients who have dual disorders. The goal should be to make the programs compatible and to reduce duplication of licensing reviews where possible.
- The group should alert AOD and mental health programs that provide treatment for patients with dual disorders to existing Federal and State patient protection and confidentiality laws that may be applicable for both fields.
- The results, findings, and recommendations of the joint planning body should be formally structured to feed back into the system and ensure that the initiatives are implemented and maintained.
- The group should recommend model policies regarding dual disorders, and stimulate initiatives in program development and training.
- There should be collaboration with universities and colleges to develop and integrate coursework, field placements, and treatment research specific to patients with dual disorders.
- There should be a linkage with vocational rehabilitation and employment services.

3. The planning group should maintain the following foci:

- Define a needed array of services to address the needs of the full spectrum of patients with dual disorders.
- Encourage county and other joint or collaborative planning with similar objectives for treating patients with dual disorders.
- Encourage the use of funding and contracting mechanisms as incentives to ensure that services for patients with dual disorders are included.
- Ensure that competitive contract bids to operate treatment services specify services for patients with dual disorders.
- Award additional points to proposals for programs that address the needs of patients with dual disorders.
- Require that local and county program plans submitted for State funds address services for dually diagnosed patients as a special population.

- Promote training and staff development strategies to encourage acquisition of and recognition for skills in treating patients with dual disorders. The planning group should identify and disseminate information regarding the availability of Federal grants.

Funding and Reimbursement

Problems

Because of diminishing fiscal resources and competition among many interest groups for particular types of treatment, those who seek funds for the treatment of patients with dual disorders have an increasingly difficult task. In many areas, patients with dual disorders may not be recognized as a priority group for funding. No specific monies are set aside for patients with dual disorders under the block grants. The amount of funds that the Federal Government allocates to States for the AOD and mental health block grant programs changes from year to year and often includes mandated set-aside for specific groups (for example, needle users, women, etc.). Set-asides tend to be different for mental health and AOD abuse treatment and limit the amount available for special groups not specifically targeted.

States often do not take advantage of Federal monies that can be used for patients with dual disorders. It is difficult to identify Federal grants that can be used for dual disorders, since grants and announcements are scattered across many agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA), CSAT, the Center for Substance Abuse Prevention (CSAP), the National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute of Mental Health (NIMH), and the Center for Mental Health Services (CMHS), to name a few.

Current reimbursement practices inhibit integration of services and effective treatment, and there are several problems related to reimbursement from both public and private third-party payers. These problems include the following:

- There are separate monies for AOD abuse and mental health treatment.
- The span of coverage limits the types of services that can be provided in each setting.
- Few standards exist that define minimum benefits for either AOD abuse or mental health services.
- Depending on the type of treatment program in which patients participate, the separation of AOD abuse services and mental health services often drives the: 1) primary diagnosis, 2) type of treatment, 3) level of treatment, and 4) level of reimbursement. This causes competition for benefits rather than cooperation.
- Benefit funding levels vary dramatically.

Solutions

1. Facilitate the aggressive pursuit of Federal funds by the following actions:

- Assign an individual to search for Federal grant programs serving patients with dual disorders. This can be done at the State, local, and agency levels.
- A lead Federal agency should be identified to screen grants applicable to patients with dual disorders, and to encourage States to take advantage of potential Federal funding. (CSAT might be the lead agency.)
- At the State level, technical assistance should be provided to screen for and assist local agencies to pursue Federal mental health and AOD funding.

2. Facilitate the use of block grant funds for treating patients with dual disorders.

- Work to create joint funding of programs. For example, New Jersey's Division on Alcoholism and Drug Abuse and Mental Health cofunded a number of model programs for patients with dual disorders.

- Strive to share staff resources in programs, thus spreading out monies. For example, mental health staff can cofacilitate a dual disorders group in an AOD treatment program, and vice versa. Similarly, a mental health program can provide staff to monitor medications to avoid duplication of effort by the AOD treatment program.
- Coordinate the provision of services and the expenditure of funds within each block grant area.
- Encourage the allocation of more Federal dollars for block grants and set-asides that include treatment for dual disorders.
- There may be some innovative mechanisms other than set-asides to encourage use of block grant funds for patients with dual disorders.

3. Promote Requests for Proposals (RFPs) for treating patients with dual disorders.

- States should promote the development of RFPs specifying programs and services for patients with dual disorders.
- State grants might give extra points for demonstrating linkages among the systems.

4. Encourage initiatives within third-party reimbursement mechanisms to cover treatment for patients with dual disorders.

- Play an active role in keeping dual disorders a priority in health care reform efforts.
- Encourage providers and payers to more effectively communicate with each other.
- Encourage State-mandated benefit minimums that recognize that a more intense level of case management than usual is needed for treating patients with dual disorders.
- Educate third-party providers that treatment for patients with dual disorders may be not only more intense but also more lengthy.
- Consolidate and coordinate reimbursement rules for AOD abuse and mental health treatment.
- Negotiate with local health maintenance organizations and other providers of health and mental health services to contract services for patients with dual disorders.
- Encourage managed care companies to cover and facilitate treatment for dual disorders.
- Encourage States to establish standards for different levels of care and requirements for staffing. Encourage the development or adoption of criteria such as those developed by the American Society of Addiction Medicine with regard to dual disorder typologies, levels of care, and reimbursement. Reimbursement should be linked to the use of criteria.

Data Collection and Needs Assessment

Problems

Only limited treatment and research data are available, and those that are available are not in a standardized format. Existing data also tend to be general and not useful to local planners for developing a continuum of care. Data collection systems are mandated to be separate from each other. It is difficult to gather prevalence data on patients with dual disorders because many of them interact with several treatment agencies or systems, while others do not interact with any.

There are systemic disincentives to gathering data on patients with dual disorders. For example, Medicaid may cover a patient who makes a suicide attempt as a result of major depression, but may not cover a patient who makes a drug-induced suicide attempt.

Solutions

At least on the State level, common identifiers in data collection should exist for both AOD abuse and mental health treatment systems. Research should be in a form that allows for evaluation of cost-effectiveness and outcome.

Outcomes should be measured across several categories encompassing biopsychosocial issues. Examples might be 1) severity of AOD and psychiatric symptomatology, 2) housing, 3) service involvement and utilization, and 4) vocational involvement. Collaboration with local colleges and universities to conduct such research should be encouraged.

State planning bodies should encourage or require local needs and resource assessment and data collection. Local planners should collect data from various systems, examining and comparing data from different groups, programs, and locations. The State could gather all the data and compile them for use in improved planning and in evaluating outcomes.

Confidentiality laws must protect the patient, but also must allow for inclusion of anonymous case number data in pools to promote better assessment and treatment outcome studies.

There should be aggressive efforts to examine cost-effectiveness and outcomes of specific models of treatment services for patients with dual disorders. These research efforts can be incorporated into State and local initiatives, perhaps involving local colleges and universities.

Program Development

Problems

Linkages in the development of programs for treating patients with dual disorders are impeded by several factors:

- Rigid models, resistance to changing programs, and turf battles
- Regulations and reimbursement rules
- Clinical assumptions about dual disorders
- Program development driven by reimbursement rules rather than by patients' needs
- Limited knowledge about what is effective; absence of outcome research for program models
- Absence of good processes for disseminating information about existing programs throughout the country
- Lack of standards for comprehensive dual disorders programs
- Lack of incentives for good program development on the State and local levels
- Absence of State licensing criteria specific to dual disorders
- Lack of appropriately trained staff and other resources
- Lack of ownership. Dual disorder treatment systems are not "owned" by the AOD abuse or mental health treatment systems. Therefore, development of dual disorder treatment programs is not a priority in either system.

Solutions

- Provide financial incentives for integrated dual disorder treatment programs.
- Provide grants for model program development.
- Identify State and county dual disorder experts.
- Publish a State bulletin to facilitate information exchange.
- Encourage research on existing programs from both AOD abuse and mental health fields by collaborative grants between States and universities.

- Determine how existing services can be adapted (such as with special tracks or staff training to serve the dually diagnosed population) and help define which services need to be developed and which are special and unique to groups (for example, detoxification, longer-term residential programs, halfway houses). For example, the State of New Jersey issued guidelines for a continuum of care that describe how to adapt existing AOD abuse and mental health services and what services need to be specialized to care for dual disorder patients. The guidelines serve as a blueprint for systems integration.

- Publish a State glossary of terms to encourage communication across systems.

- Make sure programs have integrated expertise from both AOD abuse and mental health treatment fields through a joint review process for RFPs as well as joint ongoing monitoring processes.

- Review programs for gender and cultural competency.

- Establish a consumer feedback process to modify programs.

- Encourage the involvement of providers, patients, and their families in educating the public on the needs of dual disorder patients and advocating for resources.

Screening, Assessment, And Referral

Problems

The screening process amplifies the tendency to look for a single diagnosis. Staff in single-focus screening services are not trained to assess patients for dual disorders.

There is no "gold standard" instrument to diagnose dual disorders. Some of the instruments that are used often yield false positive results.

Screeners are not adequately trained to make effective referrals across systems, which can result in denial of treatment services.

Screening for dual disorders may take longer than screening for a single disorder. For example, psychiatric symptoms can appear or disappear as the AOD-induced symptoms clear.

Solutions

- State policies should lengthen the time frames in which screening and assessments are done for patients thought to have dual disorders. State policies should recognize that screening and assessment are ongoing processes.

- The Federal Government should encourage research to develop standardized screening and assessment tools for dual disorders. These tools should be appropriate for people with severe and moderate AOD and psychiatric problems.

- There should be systems-wide training of gatekeepers on the proper way to screen for dual disorders and on effective ways to make referrals.

- There should be widespread encouragement of the multidisciplinary approach through joint staffing of screening centers or on-call backup support.

Case Management

Problems

There frequently is no single person or agency responsible for following up on referrals and ensuring that patients are linked to treatment and that services are coordinated. People with dual disorders need others to help them obtain the services that they require, which are often fragmented.

The Public Health Service Act requires that State mental health agencies that receive Federal funds provide case management services to patients with severe mental illness. However, a comparable requirement is not built into the Federal mandate for AOD abuse treatment services. AOD abuse treatment agencies usually do not have enough social service staff to handle the case management functions of linkage or followup for many dual disorder patients.

Solutions

- States and agencies need to define criteria for patients who need and do not need case management. Case management should be targeted to those who need it, while less severely ill persons should receive other services.
- Develop multidisciplinary teams with expertise in dual disorders within AOD and mental health treatment settings. Also, encourage the use of peer counselors to help engage patients with dual disorders into appropriate treatment.
- Encourage a continuum of case management, defining who should get what level of case management. Levels may range from treatment plan coordination while the patient is in treatment to coordinating services within the community (such as Social Security Income [SSI] and housing). Assertive mobile outreach teams can encourage out-of-treatment individuals to become engaged in treatment. These efforts can help potential patients who are reluctant to participate in treatment or who are unable to get to treatment.
- States should help increase the case management function within the AOD abuse treatment field. Ways to develop collaboration by including AOD treatment experts in a mental health facility and in outreach operations should be found.

Staffing

Problems

All too often, treatment staff are knowledgeable about either mental health or AOD treatment. They lack thorough training and education about dual disorder patients.

There is often insufficient staff time available for the level of case management required for dual disorder patients.

Staff selection is often driven more by clinicians' academic degree and their ability to provide reimbursable services than by clinicians' expertise in dual disorders.

Solutions

- Standards for staffing dual disorders programs should be developed. These standards should include expertise in meeting the emotional, social, psychological, biological, vocational, and recreational needs of the patient.
- A certification process should be established for certifying clinicians who have expertise in treating dual disorders. Third-party payers should be encouraged to reimburse based on clinicians' knowledge, competence, and expertise rather than on academic degree.

Training and Staffing

Problems

Clinicians in AOD abuse treatment and mental health treatment usually are not trained in the other discipline. The availability of staff trained in both fields is limited. Agencies frequently lack the resources to recruit and retain staff who have sufficient education and experience. There is both a shortage of qualified staff and an inability to financially compensate qualified staff for their specialized abilities.

The diagnosis and treatment of dual disorders are not generally understood by staff, administrators, and legislators, let alone the general public. Agency directors and supervisors often assign whom they believe to be the most appropriate staff member to work with dual disorder patients without a clear idea of the knowledge and skills required.

Professionals in AOD abuse and mental health treatment have accumulated biases against the other discipline, as well as negative stereotypes of both patients and staff.

There are no structured incentives for individuals or programs to develop or take part in training, such as pay differentials and career opportunities specific to dual disorders. Opportunities and incentives for cross-training are lacking.

Consumers are not adequately involved in the training process.

Relatively few academic programs involve training or research in this field.

Solutions

Cross-training is one of the most effective tools administrators have for bridging gaps between clinicians and services from different fields. Training programs that provide knowledge about local networking can greatly improve linkages for patients with dual disorders.

Solutions for administrators:

- Hire administrators with clinical backgrounds in dual disorders.
- Expose administrators to what is currently being done in the field of dual disorders through conferences, literature, visits to facilities, and visits to other States.
- Develop clear education and experience guidelines for different levels of staff members who treat dual disorder patients. These guidelines should be used to establish training goals with staff and to establish opportunities for advancement.
- Develop standards for State, local, and facility training for various levels of staff.
- Ensure that continuing education credits are available for both AOD abuse and mental health staff.
- Provide certification or credentialing for training in the other discipline to promote sensitivity in AOD and mental health treatment.
- Discuss with State certification board members their willingness to develop associate credentialing on AOD treatment targeted to social welfare, mental health, and criminal justice personnel.
- Increase awareness of dual disorders for State legislative and networking systems through appropriately detailed curricula on patients with dual disorders.
- Prepare a training plan for new staff and plan ongoing training for existing staff.
- Provide ample time to have staff fully trained (2 to 3 years).
- Coordinate with local universities and colleges to create a dual disorders training track.

Solutions for staff:

- Create an individualized plan for each staff person, defining strengths as well as deficits and areas of needed growth; identify areas of greatest needs; define a training plan with a timetable and components.

- Receive training at an established dual disorders treatment program.
- Attend workshops on treating patients with dual disorders.
- Include on-the-job training:
    - AOD abuse and mental health jointly facilitated groups
    - Mental health workers on an AOD abuse service
    - AOD abuse workers on a mental health service
    - Staff sharing.
- Provide didactic inservice training:
    - Train mental health workers in AOD abuse treatment
    - Train AOD treatment staff about mental health treatment
    - Train staff in dual disorders.
- Provide staff with important articles from the field by providing subscriptions to appropriate peer-reviewed journals. Purchase textbooks on dual disorders.
- Work with local universities, colleges, and community college programs to create a dual disorders training track.

Solutions for the community:

- Disseminate information to the general population through newspapers, television, and radio shows. Recovering people with dual disorders are good models.
- Make presentations to community interest groups through speakers and speakers' bureaus.

Solutions for consumers and their families:

- Consumers of treatment services should be offered a role in the training process for staff in the AOD abuse and mental health fields.
- Consumers should be included on advisory boards for nonprofit and government treatment programs.
- Consumers should be offered the opportunity to receive training in both fields to enhance their skills as peer counselors and group cofacilitators, and to help start AA and NA meetings that are sensitive to people with dual disorders, sometimes called "Double Trouble" meetings. Organizations that can help provide education to the public and patients include the National Alliance for the Mentally Ill, the National Association of Psychiatric Survivors, the National Association of Right Protection and Advocacy, and groups such as the Manic Depressive Association.
- Families of patients should participate in Al-Anon and other support groups.

Linkages With Social Service Systems

Problems

A large proportion of patients with dual disorders require social services. The scope of social services is extremely broad, encompassing public and private multisystems.

Federally mandated income support programs are notoriously complex, each with its own set of regulations. Some, such as the Social Security Income (SSI) maintenance program, are administered by the Federal Government, while others are administered by the State and vary from State to State.

Income support programs include SSI, Medicaid, Medicare, welfare, Aid to Families With Dependent Children (AFDC), and food stamps.

Regulations for each program are often not understood by professionals and others who provide services to potential recipients. This makes it even more difficult for the potential recipient to get and retain benefits.

Some programs, such as SSI, require proof of a permanent and total disability. Mental health problems often do not neatly fit into categories, making it difficult to obtain this support.

Income support programs for single individuals have been cut drastically in recent years.

Applications for these income support programs are often taken at a site other than where either mental health or AOD services are provided for the patient.

The complexity of the application and appeal process adds to the stress of a person with a dual disorder.

Overburdened staff who are processing income support applications often do not understand dual disorders.

Federally mandated services for children, youth, and families include services that fall under the child welfare system (for example, child protective services and foster care placement).

Child welfare system staff are overburdened and understaffed. A large percentage of caseloads involve family AOD use problems.

Most child welfare staff are not trained in recognizing or treating dual disorder problems. Mental health and AOD abuse staff are not trained in child welfare. There is a lack of knowledge of each other's systems and resources.

Other social service programs serve a wide range of special needs populations, including the homeless and victims of domestic violence or sexual abuse, who require a broad array of support services. Although many users of these services have mental health and AOD abuse problems, these services are often not available on site. Social service staff often lack knowledge of how to refer people with such problems into these systems.

Solutions

- Train SSI maintenance staff about patients with dual disorders.
- Train AOD abuse and mental health staff in a range of social service areas, including income support, child welfare, and special populations.
- Encourage an on-site application process for income support programs at AOD abuse and mental health treatment facilities. Mental health and AOD abuse treatment programs can request training and support from Federal, State, or local administrators of various income support programs.
- Develop mobile outreach approaches to assist patients with dual disorders in gaining access to income support programs and other needed social service programs.
- Encourage an ongoing exchange among policy-level staff of AOD abuse, mental health, and Social Security agencies on Federal, State, and local levels.

- Encourage a designated policy-level social services staff to create and maintain links with AOD abuse and mental health treatment systems.
- Allocate sufficient social service staff time to assist patients who need a range of supports and services.

Linkages With the Health Care System

Problems

The medical system is vast, covering a wide range of public and private programs including primary, secondary, and tertiary care.

Public primary care clinics are often overburdened, understaffed, and underfinanced. They are often oriented to treating presenting physical problems, and staff may not be trained in screening for either AOD abuse or mental health problems. The same problems often exist in nonprofit primary care facilities. Staff are often not knowledgeable about how and where to refer patients.

Historically, physicians have not received any education about AOD treatment and little education about mental health problems in medical school. Primary care physicians are often unaware of the signs and symptoms of AOD use disorders, and may have only a basic understanding of a few psychiatric problems such as depression and anxiety. For example, persons who experience physical trauma, such as burn injuries or falls, often have AOD use disorders. Yet, when presented with injured patients, primary care physicians may not screen for AOD use disorders.

At hospital discharge, personnel often have difficulty dealing with AOD abuse and mental health concerns. Patients are sometimes discharged inappropriately with inadequate discharge planning and linkage with aftercare services.

Staff in mental health and AOD abuse treatment systems often do not know how to gain access to medical systems and therefore are ineffective in providing information and ongoing education.

Solutions

- AOD abuse and mental health staff should take the initiative to conduct training sessions through established medical organizations such as medical societies, hospital associations, nurses' associations, and other professional organizations.
- AOD and mental health planning groups should publish materials that provide tips on linkage techniques for patients with dual disorders, and target such materials to the medical community.
- Many public health clinics operated by the local health department are under the same administrative umbrella as the AOD programs. The local public health director can encourage the development of interagency training sessions, protocols, and policies and procedures to facilitate linkages between the clinics and AOD abuse treatment services and network with the mental health treatment services. Also, the local health director can help to establish stronger linkages between AOD and mental health providers with HIV/AIDS prevention and treatment systems.

Linkages With the Criminal Justice System

Problems

The criminal justice is a top-down system. There is often no mandated joint planning.

The mental health system has no formal responsibility for inmates with dual disorders.

Incarceration is often a substitute for AOD abuse and mental health treatment. Treatment may not begin until shortly prior to release.

Medical services for the incarcerated are not reimbursable under Medicaid or any third-party payer. There is often an interagency debate regarding who should pay for care.

Offenders who should be committed are often released. Prerelease assessments are often inadequate. There usually is no coordinated plan for release. No systemic funding incentives to provide care exist. There is a range of custody status.

Criminal justice staff often have AOD abuse or mental health problems. There are many inadequate employee assistance programs within the criminal justice system.

The criminal justice system and community AOD abuse and mental health treatment agencies may compete for the same AOD abuse and mental health treatment dollars.

Solutions

1. State

- Establish joint top-level planning by the AOD abuse, mental health, and criminal justice fields.
- Encourage funding that supports linkage at the service delivery level.
- Work with AOD abuse and mental health treatment monitoring and licensing regulations to require and encourage cooperation with the criminal justice system.
- Encourage funding for research and gathering data on persons with dual disorders in the criminal justice system.
- Formally identify the responsibility of each system for providing specific services within the criminal justice system.

2. County and locality

- Include representatives from the criminal justice system in local AOD abuse and mental health treatment planning groups.
- Identify patients in each system who have an interest in cooperation.

3. Consumers

- Educate consumer groups and the general public about the need for treatment of persons with dual disorders in the criminal justice system.
- Encourage consumer groups to influence policy makers regarding linkages.

4. Pretrial process

- Monitor and assess cases that involve AOD treatment and mental health treatment issues.
- Advise and train judges regarding AOD treatment and mental health treatment options.

5. During incarceration

- Conduct assessment for dual disorders at admission.
- Provide treatment early in the incarceration.
- Consider AOD abuse and mental health treatment issues during the parole hearing.

6. During the probation-parole period

- Conduct joint assessment by AOD, mental health, and criminal justice staff prior to release.

- Develop a release plan that addresses AOD and mental health issues.
- Develop a clear contingency plan to address noncompliance.
- Establish prompt and consistent graduated sanctions of custody status.
- Establish joint supervision of problem cases.

7. Criminal justice staff

- Provide EAP services that assess, identify, and treat AOD and mental health problems of staff.
- Cooperate with unions.
- Provide training on screening and assessment.
- Provide training to address negative attitudes of criminal justice personnel regarding AOD abuse and mental health treatment and patients with dual disorders.

Chapter 5 – Mood Disorders

Definitions and Diagnoses

The term *mood* describes a pervasive and sustained emotional state that may affect all aspects of an individual's life and perceptions. *Mood disorders* are pathologically elevated or depressed disturbances of mood, and include full or partial episodes of depression or mania. A *mood episode* (for example, major depression) is a cluster of symptoms that occur together for a discrete period of time.

A *major depressive episode* involves a depression in mood with an accompanying loss of pleasure or indifference to most activities, most of the time for at least 2 weeks. These deviations from normal mood may include significant changes in energy, sleep patterns, concentration, and weight. Symptoms may include psychomotor agitation or retardation, persistent feelings of worthlessness or inappropriate guilt, or recurrent thoughts of death or suicide. The diagnosis of *major depression* requires evidence of one or more major depressive episodes occurring without clearly being related to another psychiatric, AOD use, or medical disorder. Major depression is subclassified as major depressive disorder, *single episode* and *recurrent.* There are nine symptoms of a major depressive episode listed in the DSM-IV draft, and diagnosis of this disorder requires at least five of them to be present for 2 weeks.

Dysthymia is a chronic mood disturbance characterized by a loss of interest or pleasure in most activities of daily life but not meeting the full criteria for a major depressive episode. The diagnosis of dysthymia requires mild to moderate mood depression most of the time for a duration of at least 2 years.

A *manic episode* is a discrete period (at least 1 week) of persistently elevated, euphoric, irritable, or expansive mood. Symptoms may include hyperactivity, grandiosity, flight of ideas, talkativeness, a decreased need for sleep, and distractibility. Manic episodes, often having a rapid onset and symptom progression over a few days, generally impair occupational or social functioning, and may require hospitalization to prevent harm to self or others. In an extreme form, people with mania frequently have psychotic hallucinations or delusions. This form of mania may be difficult to differentiate from schizophrenia or stimulant intoxication.

A *hypomanic episode* is a period (weeks or months) of pathologically elevated mood that resembles but is less severe than a manic episode. Hypomanic episodes are not severe enough to cause marked impairment in social or occupational functioning or to require hospitalization.

A *bipolar disorder* is diagnosed upon evidence of one or more manic episodes, often in an individual with a history of one or more major depressive episodes. Bipolar disorder is subclassified as manic, depressed, or mixed, depending upon the clinical features of the current or most recent episodes. Major depressive or manic episodes may be followed by a brief episode of the other.

Cyclothymia can be described as a mild form of bipolar disorder, but with more frequent and chronic mood variability. Cyclothymia includes multiple hypomanic episodes and periods of depressed mood insufficient to meet the criteria for either a manic or a major depressive episode. The revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R) states that for a diagnosis of cyclothymia to be made, there must be a 2-year period during which the patient is never without hypomanic or dysthymic symptoms for more than 2 months.

Substance-induced mood disorder is described in the DSM-IV draft according to the following criteria:

A. A prominent and persistent disturbance in mood characterized by either (or both) of the following:
1) depressed mood or markedly diminished interest or pleasure in all, or almost all, activities,
2) elevated, expansive, or irritable mood.

B. There is evidence from the history, physical examination, or laboratory findings of substance intoxication or withdrawal, and the symptoms in criterion A developed during, or within a month of, significant substance intoxication or withdrawal.

C. The disturbance is not better accounted for by a mood disorder that is not substance induced. Evidence that the symptoms are better accounted for by a mood disorder that is not substance induced might include: the symptoms precede the onset of the substance abuse or dependence; they persist for a substantial period of time (e.g., about a month) after the cessation of acute withdrawal or severe intoxication; they are substantially in excess of what would be expected given the character, duration, or amount of the substance used; or there is other evidence suggesting the existence of an independent non-substance-induced mood disorder (e.g., a history of recurrent non-substance-related major depressive episodes) .

D. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance does not occur exclusively during the course of delirium.

Substance-induced mood disorder can be specified as having 1) manic features, 2) depressive features, or 3) mixed features. Also, it can be described as having an onset during intoxication or withdrawal. For most of the major mental illnesses, the DSM-IV draft includes the alternative of a substance-induced disorder within that diagnosis.

Prevalence

Using structured interviews, the Epidemiologic Catchment Area (ECA) studies found that nearly 40 percent of people with an alcohol disorder also fulfilled criteria for a psychiatric disorder. Among people with other drug disorders, more than half reported symptoms of a psychiatric disorder (Regier et al., 1990).

The most common psychiatric diagnoses among patients with an AOD disorder are anxiety and mood disorders. Among those with a mood disorder, a significant proportion has major depression. Mood disorders may be more prevalent among patients using methadone and heroin than among other drug users. In an addiction treatment setting, the proportion of patients diagnosed with major depression is lower than in a mental health setting.

The prevalence rates of mood disorders in the general population can be estimated from the results of the ECA studies (Regier et al., 1988; Robins et al., 1988). These studies indicate that:

- The lifetime prevalence rates for any mood disorder ranged from 6.1 to 9.5 percent in the ECA study of New Haven, Baltimore, and St. Louis.
- The lifetime prevalence rates for major depressive episode ranged from 3.7 to 6.7 percent.
- The lifetime prevalence rates for dysthymia ranged from 2.1 to 3.8 percent.
- The lifetime prevalence rates for manic episode ranged from 0.6 to 1.1 percent.

Some studies demonstrate that the prevalence of mood and anxiety disorders is no greater among AOD abusers than in the general population. Other studies show elevated rates of these disorders among people with AOD disorders. Many patients receiving treatment for addiction appear depressed, but only a small percent receive a formal diagnosis of major depression as a concurrent illness.

During the first months of sobriety, many AOD abusers may exhibit symptoms of depression that fade over time and that are related to acute withdrawal. Thus, depressive symptoms during withdrawal and early recovery may result from AOD disorders, not an underlying depression. A period of time should elapse before depression is diagnosed.

Among women with an AOD disorder, the prevalence of mood disorders may be high. The prevalence rate for depression among alcoholic women is greater than the rate among men. Counselors should be reminded that women in both addiction and nonaddiction treatment settings are more likely than men to be clinically depressed.

In addition to women, other populations require special consideration. Native Americans, patients with HIV, patients maintained on methadone, and elderly people may all have a higher risk for depression. The elderly may be the group at highest risk for combined mood disorder and AOD problems. Episodes of mood disturbance generally increase in frequency with age. Elderly people with concurrent mood and AOD disorders tend to have more mood episodes as they get older even when their AOD use is controlled.

Differential Diagnosis

Diagnostic Process

Diagnoses of psychiatric disorders should be provisional and constantly reevaluated. In addiction treatment populations, many psychiatric disorders are substance-induced disorders that are caused by AOD use. Treatment of the AOD disorder and an abstinent period of weeks or months may be required for a definitive diagnosis of an independent psychiatric disorder. Unfortunately, the severely depressed person may drop out of treatment or even commit suicide while the clinician is trying to sort things out (see section on "Assessing Danger to Self or Others.")

Acute manic symptoms may be induced or mimicked by intoxication with stimulants, steroids, hallucinogens, or polydrug combinations. They may also be caused by withdrawal from depressants such as alcohol and by medical disorders such as AIDS and thyroid problems. Acute mania with its hyperactivity, psychosis, and often aggressive and impulsive behavior is an emergency and should be referred to emergency mental health professionals. This is true whatever the causes may appear to be.

Other psychiatric conditions can mimic mood disorders. The predominant condition that mimics a mood disorder is addiction, which is frequently undiagnosed or misdiagnosed. Disorders that can complicate diagnosis include schizophrenia, brief reactive psychosis, and anxiety disorders.

Patients with personality disorders, especially of the borderline, narcissistic, and antisocial types, frequently manifest symptoms of mood disorders. These symptoms are often fluid and may not meet the diagnostic criterion of persistence over time. In addition, all of the psychiatric disorders noted here can coexist with AOD and mood disorders.

Case Examples: George and Mary

George is a 37-year-old divorced male who was brought into the emergency room intoxicated. His blood alcohol level was 152, and the toxicology screen was positive for cocaine. He was also suicidal ("I'm going to do it right this time! I've got a gun."). He has a history of three psychiatric hospitalizations and two inpatient AOD treatments. Each psychiatric admission was preceded by AOD use. George has never followed through with psychiatric treatment. He has intermittently attended AA, but not recently.

Mary is a 37-year-old divorced female who was brought into a detoxification unit with a blood alcohol level of 150 and was noted to be depressed and withdrawn. She has never used drugs (other than alcohol), and began drinking alcohol only 3 years ago. However, she has had several alcohol-related problems since then. She has a history of three psychiatric hospitalizations for depression, at ages 19, 23, and 32. She reports a positive response to antidepressants. She is currently not receiving AOD or psychiatric treatment.

Differential diagnostic issues for case examples.

Many factors must be examined when making initial diagnostic and treatment decisions. For example, what if George's psychiatric admissions were 2 or 3 days long -- usually with discharges related to leaving against medical advice? Decisions about diagnosis and treatment would be quite different if two of his psychiatric admissions were 4 to 6 weeks long with clearly defined manic and psychotic symptoms continuing throughout the course, despite aggressive use of psychiatric treatment and medication.

Similarly, what if Mary had abstained from alcohol for 6 months "on her own," but over the past 3 months, she had become increasingly depressed, tired, and withdrawn, with disordered sleep and poor concentration, as well as suicidal thoughts? In addition, last night, while planning to kill herself, she relapsed. A different diagnostic picture would emerge in this case if Mary had been using antidepressants for the past year and, during the past month, she had experienced an increase in heavy drinking, losing her job yesterday because of alcohol use.

AOD-Induced Mood Disorders

It is important to distinguish between mood disorders and AOD intoxication, withdrawal, and/or chronic effects. These distinctions are especially important following the chronic use of drugs that cause physiologic dependence.

All psychoactive drugs cause alterations in normal mood. The severity and manner of these alterations are regulated by preexisting mood states, type and amount of drug used, chronicity of drug use, route of drug administration, current psychiatric status, and history of mood disorders.

AOD-induced mood alterations can result from acute and chronic drug use as well as from drug withdrawal. AOD-induced mood disorders, most notably acute depression lasting from hours to days, can result from sedative-hypnotic intoxication. Similarly, prolonged or subacute withdrawal, lasting from weeks to months, can cause episodes of depression, sometimes accompanied by suicidal ideation or attempts.

Also, stimulant withdrawal may provoke episodes of depression lasting from hours to days, especially following high-dose, chronic use. Stimulant-induced episodes of mania may include symptoms of paranoia lasting from hours to days. Overall, the process of addiction per se can result in biopsychosocial disintegration, leading to chronic dysthymia or depression often lasting from months to years.

Since symptoms of mood disorders that accompany acute withdrawal syndromes are often the result of the withdrawal, adequate time should elapse before a definitive diagnosis of an independent mood disorder is made.

Conditions that most frequently cause and mimic mood disorders and symptoms must be differentiated from AOD-induced conditions. When symptoms persist or intensify, they may represent AOD-induced mental disorders. Transient dysphoria following the cessation of stimulants can mimic a depressive episode. According to the DSM-IV draft, if symptoms are intense and persist for more than a month

after acute withdrawal, a depressive episode can be diagnosed. Symptoms of shorter duration can be diagnosed as a substance-induced mood disorder.

It is difficult to generalize about specific drugs causing specific behavioral syndromes. There is tremendous variability, as demonstrated in Exhibit 5-1. Multiple drug use further complicates the differential diagnosis. Diagnostic procedures such as urinalysis and toxicology screens should be used if possible. It should also be emphasized that addicted patients may experience withdrawal from one drug despite using another drug.

Stimulants

Stimulants such as cocaine and the amphetamines cause potent psychomotor stimulation. *Stimulant intoxication* generally includes increased mental and physical energy, feelings of well-being and grandiosity, and rapid pressured speech. Chronic, high-dose stimulant intoxication, especially when combined with sleep deprivation, may prompt an episode of mania. Symptoms may include euphoric, expansive, or irritable mood, often with flight of ideas, severe impairment of social functioning, and insomnia.

Acute stimulant withdrawal generally lasts from several hours to 1 week and is characterized by depressed mood, agitation, fatigue, voracious appetite, and insomnia or hypersomnia. Depression resulting from stimulant withdrawal may be severe and can be worsened by the individual's awareness of addiction-related adverse consequences. Symptoms of craving for stimulants are likely and suicide is possible.

Protracted stimulant withdrawal often includes sustained episodes of anhedonia and lethargy with frequent ruminations and dreams about stimulant use. There may be bursts of dysphoria, intense depression, insomnia, and agitation for several months following stimulant cessation. These symptoms may be either worsened or lessened by the quality of the patient's recovery program.

Depressants

The general effect of the central nervous system depressants such as alcohol, the benzodiazepines, and the opioids is a slowing down of an individual's psychomotor processes. However, acute *alcohol intoxication* and *opioid intoxication* often include two phases: an initial period of euphoria followed by a longer period of relaxation, sedation, lethargy, apathy, and drowsiness.

Alcohol, barbiturates, and the benzodiazepines can cause *sedative-hypnotic intoxication,* especially when taken in high doses. Psychomotor symptoms include mood lability, mental impairment, impaired memory and attention, loss of coordination, unsteady gait, slurred speech, and confusion.

Hallucinogens, Marijuana, and PCP

The hallucinogens can cause a state of intoxication called hallucinosis, which has several features in common with psychotic disorders and a few in common with mood disorders. Hallucinogens such as LSD and drugs such as MDMA (methylenedioxy-methamphetamine, or Ecstasy) and MDA (methylenedioxyamphetamine) may precipitate intense emotional experiences that may be perceived as positive or negative mood states by the drug user.

These experiences are affected greatly by personality, preexisting mood state, personal expectations, drug dosage, and environmental surroundings. While many users will experience sensory and perceptual distortions, some will experience euphoric religious or spiritual experiences that may resemble aspects of a manic or psychotic episode. Others may have a deeply troubling introspective experience, causing symptoms of depression.

Marijuana, which has sedative and psychedelic properties, can cause a variety of mood-related effects. In the individual who has not developed tolerance for the drug's effects, high doses of marijuana can cause *acute marijuana intoxication* with euphoria or agitation, grandiosity, and "profound thoughts."

Together, these symptoms can mimic mania. Because marijuana is only slowly eliminated from the body, chronic use results in relatively constant marijuana levels. Thus, daily marijuana use can be, in effect, a *chronic marijuana intoxication.* This state may include symptoms of chronic, low-grade lethargy and depression, perhaps accompanied by anxiety and memory loss. *Phencyclidine (PCP) intoxication* can include symptoms of euphoria, mania, or depression, in addition to sensory dissociation, hallucinations, delusions, psychotic thinking, altered body image, and disorientation.

Mood Disorders Due to A Medical Condition

The DSM-IV draft describes diagnostic criteria for *mood disorder due to a general medical condition.* The five criteria are:

A. A prominent and persistent mood disturbance is characterized by either (or both) of the following:
   1) depressed mood or markedly diminished interest or pleasure in all, or almost all, activities,
   2) elevated, expansive, or irritable mood.

B. There is evidence from the history, physical examination, or laboratory findings of a general medical condition judged to be etiologically related to the disturbance.

C. The disturbance is not better accounted for by another mental disorder (e.g., adjustment disorder with depressed mood, in response to the stress of having a general medical condition).

D. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance does not occur exclusively during the course of delirium or dementia.

Mood disorder due to a general medical condition can be described as having 1) manic features, 2) depressive features, or 3) mixed features in which symptoms of both mania and depression are present and neither predominates.

Medical conditions that can either precipitate or mimic mood disorders include the following:

- Malnutrition
- Anemia
- Hyper- and hypothyroidism
- Dementia
- Brain disease
- Lupus
- HIV/AIDS
- Postcardiac condition
- Stroke, especially among elderly people.

Medications, including reserpine and other medications that treat hypertension and hypotension, can cause conditions that may be confused with psychiatric or AOD disorders. Both prescribed and over-the-counter (OTC) medications can precipitate depression. Diet pills and other OTC medications can lead to mania. Patients treated with neuroleptic (antipsychotic) drugs may have a marked constriction of affect that can be misinterpreted as a symptom of depression.

Stages of Assessment

The patient with coexisting AOD and mood disorders requires a thorough assessment and treatment for both disorders. The assessment process can be divided into three clinical phases: acute, subacute, and long term.

Acute and subacute assessment may not be applicable to certain patients seen in some clinical settings. For instance, AOD treatment program staff in outpatient settings may see fewer patients with acute psychiatric symptoms than are seen in detoxification settings.

Acute Evaluation

Assessing Danger to Self or Others

It is critical to assess whether patients are threats to themselves or others. This evaluation helps to determine if there is a duty to protect patients from self-harm, interrupt intentions of violence toward others, and/or warn intended victims of patients' announced violent intent.

The responsibility to protect some patients from suicide or violence due to mental illness is not mitigated by confidentiality laws with respect to AOD addiction. Imminent risk, according to the laws of most States, justifies and requires commitment of patients or the warning of potential victims.

Generally, AOD confidentiality laws are very stringent. While some States protect against involuntary commitment for AOD abuse, they do not protect against commitment for AOD-induced psychiatric states which involve danger to oneself or others.

Screening personnel should assess whether suicidal feelings are transitory or reflect a chronic condition. Consider: Do patients have a suicide plan or serious intentions? Have they made past attempts? Whether the patients have had prior psychiatric hospitalization or are in current treatment should be determined. If patients are acutely dangerous to themselves or others, either voluntary or involuntary methods such as commitment should be pursued through local resources. AOD staff should have a thorough knowledge of local resources prior to and in anticipation of crises.

Placement in a safe holding environment can have a positive effect on patients with AOD problems and apparent suicidal intentions. If an intake facility cannot hold such patients, referral to an appropriate facility is recommended. For example, if someone walks into a program at 8:00 a.m. on Monday saying he wants to hurt himself, there should be time to talk the person down, assess treatment needs, and begin treatment or make assessment referrals. When necessary, an assessment should include a rapid triage. See the sections on the assessment of high-risk conditions in Chapter 7 *(Personality Disorders)* and Chapter 8 *(Psychotic Disorders).*

In virtually every recent study of successful or attempted suicide, AOD use and major depression are among the top associated conditions. Having both conditions simultaneously leads to even greater risk of suicide.

Patients with manic symptoms that approach psychotic proportions require thorough evaluation and require urgent care. Evaluation of mania should be done on a priority basis and should be monitored during subacute assessments.

Patients who have manic and hypomanic symptoms often minimize AOD and psychiatric disorders. Because of the symptom of grandiosity, manic patients may have poor insight into their AOD disorder, their mania, and their social situation. Manic patients may not see themselves as ill. They are usually hyperactive and irritable, and often become a danger to themselves or others through impulsivity, irritability, and poor judgment. When such people are also intoxicated, most will require involuntary commitment. See Chapter 8 for a discussion of assessment of patients with psychosis.

Medical Assessment

Patients, particularly the elderly, with mood disorders may have life-threatening medical conditions, including hypoglycemia (insulin overdose), stroke, or infections. These conditions, as well as withdrawal and toxic drug reactions, must always be considered and require a thorough physical examination and laboratory assessment. Assessment personnel should make appropriate referrals for medical assessment and treatment. Facilities that have no medical component should train assessment staff in triage and referral.

A plan should be developed to assess and treat medical conditions that precipitate or complicate mood disturbances. Endocrine disorders (such as thyroid problems), neurological disorders (such as multiple sclerosis), and HIV infection should be considered. In addition to obvious medical problems, it can be assumed that basic medical needs of patients with dual disorders are not being met, and a plan should be developed to address these deficits.

Initial Addiction Assessment Using the CAGE Questions

Clinicians can easily use the CAGE questions for screening (see Chapter 3) as well as adapt them for use with patients who may have mood disorders. For example, consider the following questions adapted from the CAGE questionnaire. "Have you ever *cut down* or increased your AOD use related to being severely depressed (or manic, etc.)?" "Do you ever get more irritable, angry, depressed, or *annoyed* when using AODs?" "Do you drink or use other drugs to deal with *guilt* feelings?" "Do you feel more moody in the morning or evening?" "Have you ever been suicidal when intoxicated?"

Initial AOD assessment should focus on recent use of alcohol and other drugs and a behavioral history. The assessor needs to know what drug has been used, in what quantity, with what frequency, and how recently. Past treatments, past episodes of delirium tremens, hallucinosis, blackouts, and destructive behavior should be recorded.

Social Assessment

The social assessment should evaluate the patient's social environment, especially in relation to AOD and psychiatric disorders. It is important to assess whether the patient experiences housing instability or homelessness. Where does the patient live? Does the patient live in a home? With whom does the patient live? With whom does the patient have regular social contact? Are the social and home environments stable?

In the patient's social life, is there a precipitating crisis occurring? What is the patient's existing support structure in the home and community? What role do others have? Is the home free of AODs? Are the home and social environments safe and free from violence? Do the home and social environments support an abstinent lifestyle? If not, it should be assessed whether the patient has the support necessary to overcome the adverse effect of home and social environments that do not support abstinence and recovery.

Violence by Others

During the screening interview, it is important to determine whether the patient's family members are physically abusive. It should be determined whether the patient is in danger. Physical and behavioral observation can be an important aspect of evaluation. The best predictor of future violence is previous violence.

Assessing Mood Symptomatology

During AOD use history taking and psychiatric screening and assessment sessions, patients with AOD disorders may overemphasize or underemphasize their psychiatric symptoms. For instance, patients who feel depressed during the assessment may distort their past psychiatric experiences and unwittingly exaggerate the intensity or frequency of past depressive episodes.

In contrast, patients who are profoundly depressed during the assessment may minimize their depressive illness because they think it represents a normal state. Indeed, some patients may believe that they "deserve" to be depressed, rather than recognizing that depression is a deviation from normal mood states.

Some patients experience feelings of guilt that are excessive and inappropriate. Other patients do not accurately label their depression and fail to remember that they have experienced depression before. Since patients frequently confuse depression with sadness and other emotions, it is important during the assessment to ask such questions as: "Have you ever seen a psychiatrist or therapist?" (If yes: "Why?")

"Are you able to get out of bed in the morning or do you feel chronically tired?" "Have there been any recent changes in your sleeping patterns or in your appetite?"

Patients may select details from their psychiatric history consistent with their current mood. Those who are depressed may give a generally negative self-report. Addicted patients tend to emphasize psychiatric symptoms; psychiatric patients often underemphasize them. Unhappy addicted patients in a transient disturbance of mood will often rationalize their histories as lifelong depression. Thus, it is important to obtain collateral information from other people and from documents such as medical and psychiatric records. It is critical to continue the process of evaluation past the period of drug withdrawal.

Tips for Assessment

The following are sample questions to ask during the assessment process.

For depression:

- "During the past month, has there been a period of time during which you felt depressed most of the day nearly every day?"
- "During this period of time, did you gain or lose any weight?"
- "Did you have trouble concentrating?"
- "Did you have problems sleeping or did you sleep too much?"
- "Did you try to hurt yourself?"

For mania:

- "During the past month, have you experienced times during which you felt so hyperactive that you got into trouble or were told by others that your behavior was not normal for you?"
- "Have you recently experienced bouts of irritability during which you would yell or fight with others?"
- "During this period, did you feel more self-confident than usual?"
- "Did you feel pressured to talk a great deal or feel that your thoughts were racing?"
- "Did you feel restless and irritable?"
- "How much sleep do you need?"

Patients' responses to questions are often influenced by the way questions are asked. Most patients being interviewed tend to say what they believe the interviewer wants to hear. Therefore, the manner in which the interview is conducted is important. The interviewer should not lead the patient or make suggestions regarding the "correct" answer.

Because of the subjective nature of mood disturbances, the way in which questions are asked is important. Subjective and quantifiable questions should be asked in an objective way. Neutral, open-ended questions can be effective. Questions should be asked about impairment and disturbance of sleep, appetite, and sexual function, as well as other disturbances in functional impairment. Interviewers must be alert to contradictory responses and recognize that AOD-dependent patients have a tendency to distort information.

Subacute and Longer-Term Assessment

Settings for subacute assessment include the following:

- Medical clinics
- Mental health clinics
- Sexually transmitted disease (STD) clinics
- Hospitals
- Emergency rooms
- Welfare and social services offices
- Other nontreatment settings
- Doctors' offices
- Psychotherapists' offices.

This section will focus on patients who likely have coexisting AOD use and mood disorders, are not imminently dangerous, and are candidates for treatment. Their functional levels, liabilities, and strengths should be assessed. The goal of subacute assessment is to develop treatment plans with less need for the focus on acute protection (as in the case of acute assessment). Treatment planning is based on a full assessment of treatment needs.

Assessments can be considered part of the treatment process since the assessment process often facilitates breaking through the addicted person's denial mechanisms. By asking specific questions (about work, relationships, health, or legal problems), the clinician calls attention to the consequences of AOD use. Toxicology screens and/or abnormal liver function tests such as the GGT should be obtained when symptoms and AOD use reports don't match. Such results can be identified as "consequences" of AOD use. Diagnostic and assessment sessions can be the first intervention. The boundary between assessment and treatment is fluid.

Medical Assessment

A plan should be developed to assess and treat medical conditions that can precipitate or complicate mood disturbances. Such conditions include endocrine disorders (such as thyroid problems), neurological disorders (such as multiple sclerosis), and HIV infection.

Some medical problems may have a heightened visibility because of their more obvious need for ongoing treatment. However, frequently the primary health care needs of patients with combined AOD and mood disorders are not pursued. For this reason, a plan to assess and meet these treatment needs should be developed.

Psychiatric and Addiction Screening

A subacute nonemergency setting is appropriate for screening and in depth diagnostic interviews for AOD and psychiatric disorders. The following sources can provide valuable information for screening and assessment: psychiatric history, previous medical and psychiatric records, and information from collateral sources such as employers, family members, and laboratory data.

A diagnostic interview, unlike a screening interview, can be done over the course of several sessions. Collateral sources, especially family members, can help clarify diagnostic issues and to help patients recognize the denial that may accompany their disorders.

A thorough history of AOD use, problems, patterns, and treatments should be obtained at this stage. Such information should be collected in a supportive nonjudgmental manner and over multiple interviews when possible. As with the psychiatric assessment, interviews with family and collateral

sources are important.

Assessment Instruments

The diagnostic evaluation can include the clinical application of the DSM-III-R (or DSM-IV), perhaps in the form of the Structured Clinical Interview from DSM-III-R (SCID). The Brief Psychiatric Rating Scale, the Hamilton Scale, the Addiction Severity Index (ASI), and the Beck Scale can also be used to assess patients with dual disorders.

The SCID and the ASI are research instruments, but their demonstrated reliability and the advantages of consistent, standardized tools make it reasonable to administer them. Facilities that use these instruments should provide training in their use.

Psychosocial Assessment

A comprehensive psychosocial and vocational assessment can be an important aspect of the overall assessment. Evaluation of the patient's ongoing support system is important: What is the patient's support network, including friends and family? What patterns of interpersonal and family relationships exist within the nuclear family, the extended family, and the family of choice? What means of financial support does the patient have? What job skills does the patient have? Also, both ethnic and cultural backgrounds may alter a person's experience of both AOD and psychiatric conditions.

Treatment Strategies, Issues, and Goals

Acute Treatment Strategies

Management of Intoxication And Withdrawal

Management of withdrawal is often crucial to patients' safety and comfort. Withdrawal management can foster patient engagement in an ongoing treatment and recovery process. Although withdrawal management does not in itself produce enduring abstinence, it can help to increase retention in the treatment process, which improves long-term outcome.

Treatment strategies for intoxication range from letting patients "sleep it off" to confinement in a medical or psychiatric unit. Treatment for acute sedative-hypnotic withdrawal should include medically managed detoxification. Hospital settings are preferable, especially for depressed patients. Opiate withdrawal, while not life threatening, should also be treated medically and on an inpatient basis when possible. When such hospital-based settings are unavailable, residential or outpatient support with or without medication should be attempted.

Since unassisted withdrawal can cause seizure, psychosis, depression, and suicidal thoughts, it can be dangerous. Thus, successful detoxification is often a lifesaving process. Also, the medical management of withdrawal alleviates patients' suffering. It can provide a safe, supportive, and nonthreatening environment for depressed patients.

Medical Treatment

Acute treatment may be required for medical conditions identified in the medical assessment. For example, thyrotoxicosis (thyroid storm) is a life-threatening imitator of mania. Also, low blood sugar resulting from insulin overdose can resemble intoxication and depression.

Psychiatric Treatment

Patients who are imminently dangerous to themselves or others due to a psychiatric disturbance require emergency psychiatric treatment. Such treatment may involve voluntary or involuntary confinement.

The presence of a coexisting AOD use disorder or the suspicion that the psychiatric disturbance is AOD induced does not mitigate requirements for confinement. Rather, it may necessitate addiction-specific emergency treatment such as detoxification.

Patients not requiring confinement after evaluation may benefit from the support of existing family networks, existing programs, or when available, a rapid referral to a dual disorders treatment program.

Medical management of acute psychiatric symptoms is a treatment strategy during the acute phase regardless of long-term diagnostic results. Patients who experience hallucinations, delusions, mania, or significant disorganization of thought can benefit from medical treatment with antipsychotic medication (such as haloperidol or thioridazine) whether or not their symptoms are AOD induced. If potentially abusable medications are required (such as benzodiazepines for acute mania), a period of tapering or reduction of the medication within 1 or 2 weeks should be built into the original treatment plan.

Subacute Treatment Issues

Matching Patients and Treatment

During subacute treatment, the first decision to be made is whether patients should receive treatment in a psychiatric or addiction setting. In some locations, a third alternative is available: the dual disorders treatment setting. When realistic, both types of treatment should be provided simultaneously; integrated treatment generally is preferable.

Criteria for determining placement include the patient's treatment needs and potential for loss of control, as well as program features such as intensity, structure, and limitations. There are also considerations specific to mood disorders.

For example, if patients are experiencing mania or psychotic depression with disordered thinking, it must be determined whether the program is capable of handling and treating patients with these problems. While psychotic depression or mania is being managed, patients may then be shifted to an addiction or dual disorder setting. Appropriate matching of patients to facilities is important.

Some patients with dual disorders require rare or minimal psychiatric intervention, such as AOD patients whose bipolar disorder is successfully managed with lithium and regular blood level monitoring. Patients who require a strong recovery-oriented AOD abuse treatment program should also receive treatment for their psychiatric disorder (parallel treatment), with an emphasis on AOD treatment.

In contrast, patients who experience chronic and severe psychiatric disturbances and who episodically use AODs in a markedly destructive fashion will be better treated in a psychiatric program that has staff with expertise in addiction treatment. The optimal match for the patient with two active disorders that require treatment is the integrated facility. The intensity of each disorder dictates the relative intensity of each treatment component required.

Referral to an appropriate facility should be based on practical clinical criteria rather than on diagnosis alone. For example, patients' ability to understand, interpret, and tolerate the level of care being provided is most important. Some patients can participate in standard 12-step groups. Others will require 12-step groups that are intended for people with dual disorders (Double Trouble groups). Still others will require professionally run therapy groups that include patients with similar problems.

Effective treatment is based on what patients can understand and tolerate, which is not always predicted by diagnosis. Some psychotic patients function well in traditional programs, while others require special settings. An individual plan and a flexible ongoing reassessment of effectiveness are the best ways to ensure fit.

Psychiatric Medications

The judicious use of antidepressant and mood-regulating medication is appropriate for AOD patients with mood disorders. For example, patients who experience debilitating, misery-provoking, and incapacitating depressive symptoms may require antidepressant medication to participate in addiction recovery. (See Chapter 9 for further discussions of psychiatric medications.)

When depressive symptoms interfere with functioning, antidepressant medication can provide symptom relief and allow participation in recovery activities and activities of daily living. Relief from depression and anxiety can be significant motivating factors in recovery. Left untreated, symptoms can keep patients from taking part in recovery activities.

Patients who have difficulty engaging in Alcoholics Anonymous and other support groups and who do not exhibit evidence of a personality disorder may be depressed. Depression may manifest as social withdrawal, reclusiveness, or inability to complete activities of daily living such as going to work. Regularly spending many hours a day in bed or having serious insomnia may be cardinal signs of depression but are often seen among patients with AOD disorders during the first weeks and months of abstinence.

When prescribing antidepressants for people participating in addiction treatment, the acronym MASST is a reminder for clinicians of the areas of AOD recovery that need to be continually assessed. MASST is an acronym that reminds clinicians to assess patients' treatment needs regarding: 1) Meetings, 2) Abstinence from all psychoactive drugs, 3) Sponsor (or other helping people), 4) Social support systems, and 5) overall Treatment efforts. (See the discussion on the use of 12-step programs in Chapter 6.)

MASST Areas of Recovery

M:
Meetings (12-step or other recovery-oriented self-help)

A:
Abstinence from all psychoactive drugs

S:
Sponsor and other helping people

S:
Social support systems

T:
Treatment efforts.

Case Management

Case management is crucial when patients are receiving simultaneous AOD and psychiatric care at separate settings (parallel treatment). There must be good linkages between the two treatment programs or providers. For example, patients might see their mental health counselor three times a week, go to both AOD self-help group meetings and mental health support group meetings, and receive AOD counseling. This level and mix of treatment can be overwhelming and confusing for the patient. An effective case manager can help with planning sensible treatment. Case managers can also facilitate the use of self-help groups. (See the discussion on the use of 12-step programs and other self-help groups in Chapter 6).

The separate disorders, their distinct treatment needs, and the divergent treatment approaches can cause staff splitting and turf problems that exacerbate the patient's denial and can cause other treatment problems. These problems can be avoided in almost all cases by effective communication and coordinated treatment planning. Good psychiatric and addiction treatment efforts are rarely truly conflicting.

Counseling and Psychotherapy For Depression

It is beyond the scope of this TIP to provide comprehensive details on the use of psychotherapeutic treatment. However, there are numerous resources regarding counseling and psychotherapy and depression. Recent publications written for both counselors and patients include *The Good News About Depression* by M.S. Gold and *When Self-Help*

Levels of Care

Once psychiatric and addiction severity has been determined, the treatment intensity, structure, and level of care required must be decided. From the least to the greatest intensity, the levels of care are:

1. Individual treatment with a psychotherapist or counselor. This is the least intensive level of care and includes few, if any, additional treatment services such as education.

2. Outpatient treatment. Within this level of care are services that vary greatly in structure and intensity. They include weekly to daily individual or group counseling, often in combination with additional treatment services such as detoxification, education, medical services, and specially focused groups. A multidisciplinary treatment team that includes assertive and intensive case management services may be needed for patients with severe and persistent mood disorders coexisting with AOD disorders.

3. Intensive outpatient treatment. This level of care includes treatment models such as partial hospitalization (which includes day treatment, evening, and weekend programs). For example, patients in day treatment generally participate in a full day of treatment for 5 or more days per week. Intensive outpatient treatment represents a range of treatment intensities. The level of intensity of a given program is based primarily on the number of treatment services offered. Generally, intensive outpatient treatment programs offer several treatment components such as group therapy, educational sessions, and social support services.

4. Halfway houses. These are settings that serve as safe AOD-free homes for people who can manage independent daily activities and can benefit from a structured and recovery-oriented group living arrangement. They vary widely in style and purpose.

5. Residential rehabilitation setting. Participation can vary from 30 days to 3 months or more, with patients removed from familiar surroundings and separated from AODs. In residential settings, patients receive education about dual disorders and learn important recovery skills such as utilizing groups, building trust, and talking about feelings. Therapy and support groups provide socialization and support and are the core of treatment. They prepare the patient for increased reliance on group support systems after discharge.

6. Therapeutic communities. Long-term therapeutic communities often require patient participation lasting from 6 months to 2 years. They are generally considered to be appropriate for patients with severe AOD disorders who have significant social and vocational deficits and who require long-term and intensive support, skill building, interpersonal abilities refinement, and trauma resolution.

7. Hospitals. Psychiatric or AOD hospitalization may be required for acute and subacute stabilization. In this age of managed care, hospitalization episodes have become much shorter and more acute than a few years ago. This puts more responsibility and risk on outpatient treatment providers.

Patients with severe and persistent mood and AOD disorders frequently require intensive and assertive treatment approaches as outlined in Chapter 8 on psychotic disorders. These patients will benefit from programs that can provide concurrent, integrated dually focused treatment. Also, these patients may require assertive case management to encourage medication compliance and to help them secure all psychiatric, addiction, and social services that they may need.

While some programs for dual disorders exist at all levels of care and in several program models, few AOD or mental health residential programs are dually focused, and many AOD programs refuse to accept patients who have histories of psychiatric disorders or who currently are prescribed medication for psychiatric disorders.

Traditional biases in the addiction field against psychiatric medication should be shed in light of the evidence that medicating existing disorders is humane, can be provided safely, and is necessary for some patients to engage in treatment. It is helpful to use psychiatrists who are skilled and are perhaps specialists in the treatment of coexisting psychiatric and AOD disorders.

Similarly, traditional psychiatric biases regarding rapid medication intervention and some clinicians' emphases on "getting in touch with feelings" can impede or reverse the AOD recovery process.

Encouraging emotional expression without regard for the patient's stage of AOD recovery and stability can aggravate AOD disorders. Many residential facilities in the mental health system are inadequately controlled for the presence of AODs, are not abstinence based, and are not safe environments for AOD users.

Family Involvement In Treatment Settings

In all of the above settings, patients should receive family therapy and education, addiction and recovery counseling, and psychiatric counseling. Special attention must be focused on the chronic and cyclical nature of addiction and mood disorders and the likelihood of relapse.

Manic patients' uncontrolled grandiose behaviors have frequently caused their families great stress. Thus, family members need education about the nature of addiction, mania, and recovery. It is necessary for staff to ally with family members to ensure cooperation with treatment and reduce collusion between family members and the patient.

Similarly, the depressed patient is frequently seen as a family burden. Families need assistance to engage the depressed patient. The combination of depression and addiction can be very difficult for family members, and the challenges for the family must be considered.

Family and friends are often mistakenly afraid that they might exacerbate or aggravate depression or mania if they confront the dangerous and maladaptive behaviors and denial that result from addiction and mood disorders. Such fears are ungrounded. In fact, supportive intervention by the patient's social network is helpful with respect to both disorders.

The patient's family should be encouraged to confront the patient rather than remain reticent, and they should be coached to confront the patient in a supportive way. Support for and education of family members are necessary to encourage their constructive involvement and to help them avoid collusion in the patient's drug-using behavior or denial of psychiatric disturbance.

Professional and Vocational Planning

While some patients with dual disorders have severe and poorly remitting mood and AOD disorders, most patients improve, especially with careful psychiatric treatment. Since these disorders are generally well controlled, patients can experience very high levels of vocational, social, and creative functioning. As a result, vocational planning should be long term and accentuate patient strengths.

AIDS and HIV Risk Reduction

Studies demonstrate that HIV/AIDS risk reduction measures can make a difference in the rate of HIV infection. Potential and actual risk behaviors that are identified in evaluation should be addressed by referral to specific educational, training, and intervention programs.

Staff at these programs should be sensitive to patients' cultural and ethnic backgrounds, and understand how these can influence AOD use, sexual behaviors, and patients' receptivity to risk reduction measures. Programs should be proficient in communicating with patients using culturally sensitive language. However, the most culturally insensitive position is to avoid raising these issues out of fear or hesitancy.

With respect to risk reduction, special attention should be paid to the fact that, while depressed, many patients may be sexually abstinent, but this behavior may not reflect their typical behavior patterns. If patients are assessed while they are depressed, they should be asked to describe their sexual behavior during times when not depressed, or perhaps they should be assessed when they are not depressed.

Mania and active AOD use markedly elevate the potential for high-risk behaviors and should be seen as extremely dangerous situations for the transmission of HIV and other sexually transmitted diseases.

HIV counseling and testing is appropriate and advisable for patients with coexisting AOD and mood disorders. There is no evidence that people with mood disorders become suicidal or experience thought disorganization in response to HIV testing.

Long-Term Treatment Goals

Treatment goals should include consolidating the AOD-free lifestyle, establishing psychiatric stability, achieving social independence and stability, and enhancing vocational choices and goals. Long-term treatment can be viewed as a maintenance period -- a time for personal growth and development and consolidation of long-term, satisfying patterns of social adaptation.

Addiction Treatment

The long-term management of addiction includes participation in 12-step programs and other support groups, individual and group counseling, and in some cases, continued participation in a treatment program. The severity of a patient's illness should be matched with the appropriate treatment intensity and level of care.

Patients with dual disorders who experience low levels of psychiatric impairment require a level of care that can be provided in traditional low-structure abstinence-oriented addiction treatment programs. Dual disorder patients who experience severe psychiatric symptoms or cognitive impairment require a more intense level of care such as that provided by a highly structured dual disorders treatment program. Matching patients to the appropriate treatment and level of care can help achieve desired outcomes.

Psychiatric Treatment

The majority of patients receiving treatment for combined mood disorders and addiction improve in response to treatment. When they don't improve, there should be a reevaluation of the treatment plan. For example, a patient receiving antidepressant medication who is abstinent from AODs but anhedonic (unable to feel pleasure or happiness) requires a careful evaluation and assessment to identify resistant psychiatric conditions that require treatment. In this example, based on assessment, an additional treatment service such as psychotherapy may be added. Indeed, psychotherapy has been shown to improve the efficacy of addiction treatment and of psychiatric treatment that involves antidepressant medication.

When patients do not improve as expected, it is not necessarily because of treatment failure or patient noncompliance. Patients may be compliant and plans may be adequate, but disease processes remain resistant. Persistent attention to the addictive process and its complications as well as meticulous attention to psychiatric therapy usually leads to improvement. However, patients with severe and persistent AOD and mood disorders should not be seen as resistant, manipulative, or unmotivated but as extremely ill and requiring intensive treatment.

Long-Term Treatment Needs

Patients who have experienced sexual, physical, or psychological abuse may have problems that surface during acute treatment or that are identified during long-term treatment evaluations. Treatment needs resulting from these types of abuse should be addressed in the long-term treatment plan.

The resolution of problems related to sexual, physical, and psychological abuse usually requires specialized, long-term treatment. However, these problems should be addressed whenever they surface in any phase of treatment for AOD and mood disorders.

For example, addressing these problems during early recovery should be viewed from the perspective of anxiety reduction and consolidation of abstinence. At that phase of recovery, the treatment goal is to

have patients contain or express their potent and surfacing feelings without using alcohol and other drugs. Later in recovery, these problems can be dealt with in terms of long-term stabilization and psychological resolution.

Continuing addiction counseling and participation in group support activities are useful to help consolidate abstinence. These recovery maintenance activities include participation in social clubs, 12-step programs, religious organizations, and other cultural institutions. Community-based activities can provide long-term stability to these patients.

At this stage of treatment, special treatment needs can be identified through targeted testing in such areas as neurologic, cognitive, and personality disorders. Special treatment needs should be specifically addressed by the appropriate treatment strategy. STD and HIV risk reduction, evaluated throughout the progression of illness, should now address the importance of long-term stable changes in behavior.

Family Issues

Family members should be evaluated for AOD problems in acute and subacute stages when the family members begin to become involved in the patient's treatment. There is usually adequate time to deal with family issues in the subacute phase, when personnel and family members become acquainted. Family members include household members as well as members of the patient's support system.

The family often needs and should receive treatment. After careful evaluation of family dynamics, the presence of addictive disorders or codependent behavior in the family should be evaluated. The presence of AOD and mood disorders in the patient is the best predictor of AOD and mood disorders in the family. A family history of one disease increases the risk for the other; a family history of both disorders multiplies the risk factor.

Family therapy can be provided on site. Individual family members should be referred for the treatment of specific problems when required. It is often necessary to help families "mop up the rage" that has accumulated. It is important to determine when to deal with the family as a group to resolve conflicts and when members need to work with a therapist alone to develop independence from dysfunctional reliance. Participation in Al-Anon and related self-help groups for family members should be encouraged and incorporated in the treatment schedule for family members.

Eating Disorders and Gambling

Other conditions that coexist with dual disorders include eating disorders and pathologic gambling. It may be helpful to refer patients to support groups that deal with these conditions. Eating disorders are more commonly diagnosed in women, and pathologic gambling is more commonly diagnosed in men.

Reassessment and Reassessment...

The purposes of ongoing reassessments are: 1) to continue to refine prior diagnostic assessments, 2) to evaluate life adjustment in general, 3) to evaluate the effectiveness of treatment efforts for the dual disorders, and 4) to evaluate the discontinuation or continued use of medication and other treatments.

Persistently emerging and remitting problems should be addressed. For example, patients who chronically exhibit a negative disposition should be assessed for a personality disorder. Such patients may have a personality disorder with depressive features rather than a mood disorder.

Testing

Specific neuropsychological, psychological, educational, and vocational testing assessments should be performed when necessary and appropriate. These include testing for learning disorders, cognitive or literacy impairments, and

personality disorders. These tests are more reliable and accurate when performed following several months of sobriety.

Chapter 6 – Anxiety Disorders

Definitions and Diagnoses

The anxiety disorders are the most common group of psychiatric disorders. The term *anxiety* refers to the sensations of nervousness, tension, apprehension, and fear that emanate from the anticipation of danger, which may be internal or external. *Anxiety disorders* describe different clusters of signs and symptoms of anxiety, panic, and phobias.

A *panic attack* is a distinct period of intense fear or discomfort that develops abruptly, usually reaching a crescendo within a few minutes or less. Physical symptoms may include hyperventilation, palpitations, trembling, sweating, dizziness, hot flashes or chills, numbness or tingling, and the sensation or fear of nausea or choking. Psychologic symptoms may include depersonalization and derealization and fear of fainting, dying, doing something uncontrolled, or losing one's mind. A *panic disorder* consists of episodes of panic attacks followed by a period of persistent fear of the recurrence of more panic attacks.

When the focus of anxiety is an activity, person, or situation that is dreaded, feared, and probably avoided, the anxiety disorder is called a *phobia.* Phobia-inspired avoidance behavior as well as travel and activity restrictions may become intense and incapacitating. The phobias include agoraphobia, social phobia, and simple or specific phobia; panic attacks and panic disorders are often but not necessarily involved.

Specific phobia, also called single or simple phobia, describes the onset of intense, excessive, or unreasonable fear, stimulated by the presence or anticipation of a specific object or situation. The causes may be naturally occurring (for example, animals, insects, thunder, water), situational (such as heights or riding in elevators), or related to receiving injections or giving blood. *Social phobia* describes the persistent and recognizably irrational fear of embarrassment and humiliation in social situations. The social phobia may be quite specific (for example, public speaking) or may become generalized to all social situations. *Agoraphobia* is the fear of being caught in a situation from which a graceful and speedy escape would be impossible, difficult, or embarrassing. Examples of feared situations include attendance in an auditorium, being stuck in traffic, and being outside the house.

In *generalized anxiety disorder,* there is no specific focus to the anxiety; symptoms are free-floating. Generalized anxiety disorder involves excessive anxiety, worry, and apprehensive expectations focused on many life circumstances, more days than not, for a period of at least 6 months. The intensity, duration, and frequency of symptoms are out of proportion to the probability or consequences of the feared event. Somatic symptom clusters often involve: 1) motor tension (such as trembling, restlessness, and fatigue), 2) autonomic hyperactivity (for example, shortness of breath, palpitations, sweating, dry mouth, dizziness, and abdominal distress), and 3) hyperarousal (such as exaggerated startle response, irritability, insomnia, and poor concentration).

Obsessive-compulsive disorder (OCD) is an anxiety disorder involving obsessions or compulsive rituals or both. *Obsessions* are repetitive and intrusive thoughts, impulses, or images that cause marked anxiety. They often involve transgressing social norms, harming others, and becoming contaminated, but they are more intense than excessive worries about real problems. *Compulsions* are repetitive rituals and acts that people are driven to perform and which they perform reluctantly to prevent or reduce distress. The frequency and duration of their repetition make them inconvenient and often incapacitating. Examples include ritualistic behaviors (such as hand-washing and rechecking) and

mental acts (for example, counting and repeating words silently); they are time-consuming and interfere significantly with daily functioning.

Post-traumatic stress disorder (PTSD) involves an individual's experiencing a psychologically traumatic stressor such as witnessing death, being threatened with death or injury, or being sexually abused. At the time of the stressor event, the individual experiences intense fear, helplessness, or horror. PTSD entails a persistent reexperiencing of the trauma in the form of recurrent and intrusive images and thoughts, or recurrent dreams, or experiencing episodes during which the trauma is relived (perhaps with hallucinations). People with PTSD experience persistent symptoms of increased arousal such as insomnia, irritability, hypervigilance, and exaggerated startle response. They persistently avoid stimuli related to the trauma such as activities, feelings, and thoughts associated with the traumatic event.

Interest in the role of sexual abuse and incest in PTSD and other psychiatric and AOD disorders has increased. Clinicians note that long-term responses to childhood and adult sexual abuse often include symptoms associated with PTSD and other psychiatric problems, including an increased risk for AOD disorders. Many such problems are addressed in treatment efforts popular in adult children of alcoholic (ACOA) programs, some of which are controversial and unsubstantiated by research or long-term observation. Such treatment approaches may exacerbate AOD use and psychiatric disorders and should be cautiously undertaken. Amnesic periods have to be carefully evaluated both as blackout phenomena and as possible dissociated states. Such differentiation can be extremely complicated. While a clinician's immediate response may be to identify these patients as being intoxicated, they may be experiencing independent psychiatric phenomena.

Prevalence

Prevalence rates for anxiety disorders in the general population can be estimated from the Epidemiologic Catchment Area (ECA) studies. According to the ECA studies, anxiety disorders affect more than 7 percent of adults (Regier et al., 1988). (In the general population, the lifetime prevalence rate of anxiety disorders is 14.6 percent.) Women, individuals under age 45, those who are separated or divorced, and those in low socioeconomic groups all have a higher rate of anxiety disorders than individuals in other groups.

The ECA studies indicate that in the general population:

- The 1-month prevalence rate for any anxiety disorder is 7.3 percent (4.7 percent for males and 9.7 percent for females), and the 6-month rate is 8.9 percent.
- The 1-month prevalence rate for phobia is about 6.2 percent (3.8 percent for males and 8.4 percent for females).
- The 1-month prevalence rate for panic disorder is about 0.5 percent (0.3 percent for males and 0.7 percent for females).
- The 1-month prevalence rate for obsessive-compulsive disorder is 1.3 percent (1.1 percent for males and 1.5 percent for females).
- Lifetime prevalence of post-traumatic stress syndrome in the general population is estimated to be less than 1 percent. The prevalence among individuals who have experienced a psychologically traumatic stressor and then developed psychiatric symptoms is poorly understood.

Among patients with AOD problems, there is a significant likelihood for having a coexisting anxiety disorder. One study noted that more than 60 percent of patients being treated for AOD disorders had a lifetime diagnosis of an anxiety disorder, and about 45 percent experienced an anxiety disorder within the past month (Ross et al., 1988). Other studies have demonstrated that most anxiety disorders among patients in addiction treatment are AOD induced (Anthenelli and

Schuckit, 1993).

Differential Diagnosis

Anxiety sometimes has value as a signal of danger. In the same way that being sad is an appropriate response to some situations, experiencing anxiety can be an appropriate response. When manifestations of anxiety occur without apparent triggers or are out of proportion to the situation, they can be considered anxiety *symptoms.* If the symptoms are persisting, maladaptive, and meet certain diagnostic criteria, then the symptoms can be described as a *syndrome.* Further, if specific criteria are met in terms of consistency, repetitiveness, and duration, then the symptoms can be considered an *anxiety disorder.*

Anxiety symptoms are the most common psychiatric symptoms seen in AOD abusers. AOD-induced or withdrawal-related anxiety symptoms usually resolve within a few days or weeks. Most anxiety symptoms seen in AOD abusers resolve with AOD treatment; such conditions would be diagnosed according to the DSM-IV draft as substance-induced anxiety disorders. However, some people with AOD disorders have coexisting anxiety disorders that can be mildly to seriously debilitating.

Medical problems that may produce symptoms of anxiety include those affecting the cardiovascular and respiratory symptoms; neurological, hematological, and immunological disorders; and endocrine dysfunction. Several disease states can resemble generalized anxiety or panic, including acute cardiac disorders, cardiac arrhythmia, hyperthyroid conditions, brain disease, and HIV infection and AIDS. However, the most frequent imitator is addiction.

Medications that can cause anxiety symptoms include antispasmodics, cold medicines, thyroid supplements, digitalis, prescribed or over-the-counter diet medications, antidepressant medications, and, paradoxically, some antianxiety drugs such as benzodiazepines. Methylphenidate (Ritalin) and neuroleptic drugs can also cause anxiety. Withdrawal from depressants, opioids, and stimulants invariably includes potent anxiety symptoms. Steroids can make people hyperactive and anxious. Idiosyncratic reactions to medications, caffeine use, and nicotine withdrawal all can cause states similar to panic. Similarly, some medications cause *acathisia,* which is a feeling of restlessness and the urgent need to move about. Acathisia can be confused with anxiety.

The differential diagnosis of agoraphobia and social phobia includes avoidance behaviors that occur as a part of depression, schizophrenia, paranoia, other anxiety disorders, and some organic mental disorders. Many features of OCD can emerge as secondary complications of major depression, and obsessions may appear in the context of either depression or schizophrenia; distinctions between delusions and obsessions can be difficult to make. Like PTSD, adjustment disorder is a maladaptive reaction to a psychosocial stressor but involves a broader range of less extreme experiences. Adjustment disorder may result in a few of the symptoms seen in PTSD, but intense reexperiencing is less common.

PTSD and dissociative disorders such as multiple personality disorder (MPD) are often diagnosed among individuals with AOD disorders. Although the relationship has not been systematically examined, it is one to consider in differential diagnosis. MPD is receiving renewed attention and may occur frequently with AOD use disorders. Addiction treatment personnel should be trained that patients in a blackout or altered state may appear to be sober, and may in fact be sober. Recent studies indicate evidence of overdiagnosis of MPD. It is not necessary to assess all AOD patients for this disorder. Rather, training clinical staff to be alert for the signs and symptoms of MPD is a worthwhile goal. Mental health staff who treat patients with MPD should be alert for the signs and symptoms of AOD use disorders.

Many of these individuals need treatment provided by professionals who have specialized training in trauma resolution. Such patients need stability in their primary therapeutic relationship; hence, this work should not be undertaken in settings with high staff turnover. In most settings, the AOD abuse counselor should not try to treat patients who have experienced trauma.

Traditional long-term psychotherapy can cause patients anxiety, especially patients who were traumatized during some part of their lives. During acute treatment it may be best to teach patients the skills to express conflicts in socially appropriate ways, such as in self-help and therapeutic groups. Later, psychotherapy can help patients to resolve the underlying conflicts.

AODs and Anxiety Disorders

Psychoactive drugs can markedly arouse intense psychomotor stimulation and numerous manifestations of anxiety, including generalized anxiety and panic attacks. Stimulant and marijuana use and depressant withdrawal can prompt the emergence of anxiety symptoms. Hallucinogenic drugs can cause intense emotional excitement and subsequent anxiety.

Stimulants

Stimulants, such as cocaine and the amphetamines, cause potent psychomotor stimulation. Stimulant intoxication, including caffeine intoxication, can cause motor tension, autonomic hyperactivity, hyperarousal, and panic attacks. Chronic and high-dose stimulant use can provoke the onset of obsessions and compulsive behaviors. Acute stimulant withdrawal typically involves an agitated depression, often with anxiety and sometimes with panic attacks. Subacute stimulant withdrawal, although characterized by sustained episodes of anhedonia and lethargy, frequently involves intense ruminations and dreams about stimulant use. These may prompt symptoms of anxiety and panic.

Depressants

Cessation of chronic use of sedative-hypnotics, such as alcohol and the benzodiazepines, can cause an *acute sedative-hypnotic withdrawal.* Cessation of chronic use of opioids, such as heroin and methadone, can cause an *acute opioid withdrawal.* Acute withdrawal from depressants can include intense anxiety symptoms, including motor tension, autonomic hyperactivity, and hyperarousal, depending on the degree of tolerance. Panic attacks are common. Anxiety symptoms are often self-medicated with depressants.

Following acute withdrawal, some patients experience a *subacute withdrawal* syndrome, also called "prolonged" or "protracted" withdrawal. Subacute withdrawal may begin shortly after acute withdrawal or may emerge weeks or months later, often in discrete episodes that last one or more days. Subacute withdrawal syndromes have been identified for alcohol, benzodiazepines, opioids, and stimulants. For example, sedative-hypnotic subacute withdrawal often includes such symptoms as bursts of anxiety, insomnia, and irritability. Benzodiazepine-related subacute withdrawal may also cause muscle spasm, tinnitus (ringing in the ear), and parasthesias (unusual physical sensations often described as burning, pricking, tickling, or tingling).

Hallucinogens

Most hallucinogenic drugs exert stimulant effects in addition to causing perceptual and sensory alterations. Some drugs, such as MDMA (Ecstasy), MDA, and mescaline are related to the amphetamines. At low doses, perceptual and sensory distortions predominate; at high doses, stimulant effects prevail. Thus, high doses of hallucinogens can prompt symptoms of anxiety and panic much like other stimulants.

While the effects of hallucinogens are pleasant at times to many users, some individuals may respond with intense anxiety and panic. Some may fear the sensory distortions and others may fear that the experiences will be permanent. In such cases, a soothing interaction in a quiet, comfortable room with minimal distractions can often allay distress. In these circumstances, individuals are often suggestible

and respond well to a calm discussion that includes reassurance that the experience is drug induced, time limited, and not likely to result in permanent damage.

Marijuana, which has sedative and hallucinogenic properties, can cause a variety of mood-related effects. *Acute marijuana intoxication* can include periods of anxiety and panic, usually seen in persons who have not acquired a tolerance to the effects of the drug.

Case Example

While Molly and a group of her friends were preparing to attend a rock concert, they each consumed a tablet that was described as Ecstasy (methylenedioxymethamphetamine or MDMA). About an hour later, Molly began to experience potent emotional sensations, and felt an internal pressure to talk about her feelings. Once inside the coliseum, Molly gravitated toward the stage. At some point, she became increasingly aware of the loudness of the music, the brightness of the stage lights, and the intense crowding of concert attendees. Molly began to sweat heavily, tremble, and feel dizzy. She turned to escape the overstimulation, but the crowd of people made her passage difficult. She became fearful and nauseous, and her hands and feet tingled and became somewhat numb. By the time she reached the first-aid tent, she felt that she was losing her mind.

By taking a history from Molly and speaking with her friends, the emergency medical technician determined that she had taken MDMA, which along with the explosion of sight, sound, and crowding, prompted a severe panic attack. Molly was treated by moving her to a quiet room without bright lights, letting her walk off some of the nervousness, and using "talkdown" techniques. The acute panic symptoms resolved within minutes, although she was anxious for the next hour. About 3 hours after taking the MDMA, the stimulant effects diminished, and Molly felt only a sense of mild anxiety and frustration for having missed much of the concert.

AOD-Induced Conditions

The addiction counselor should not assume that anxiety symptoms, especially those emerging or persisting after 30 days in treatment, or depersonalization are related to AOD abuse. Staff in mental health programs, on the other hand, may fail to recognize that the symptoms of anxiety, caused by AOD use, may resemble a psychiatric disorder. Addiction counselors have historically been encouraged more than psychiatric personnel to seek referrals for the patient who requires treatment beyond their clinical skills. Both groups should view increased cross-referral and consultation as beneficial.

Panic.

Panic attacks can occur in individuals who are chronic users of alcohol, cannabis, inhalants, hallucinogens, organic solvents, and especially stimulants such as cocaine and the amphetamines. Use or withdrawal from these drugs can produce panic effects. For example, panic attacks can occur during acute and subacute withdrawal from sedative-hypnotics and opioids.

Phobias.

What appears to be a phobia may be the result of the chronic use of alcohol, benzodiazepines, or hallucinogens. For example, patients may avoid leaving the house not because of agoraphobia but because of the desire to have ready access to an AOD supply. Apparent phobias are not likely to occur following the acute use of these drugs.

Post-traumatic stress disorder.

Some effects of hallucinogens, marijuana, PCP, alcohol, and benzodiazepines may be dissociative. However, PTSD, MPD, and dissociative disorders seem to cluster with chemical dependency. PTSD is difficult to accurately diagnose and is often misdiagnosed. It is necessary to differentiate between PTSD and acute dissociative states due to drug use.

Dissociative disorders.

Some drugs, including hallucinogens, phencyclidine (PCP), and marijuana, can cause dissociation while they are being used. People who are experiencing withdrawal from alcohol, benzodiazepines, barbiturates, and opiates can manifest symptoms of dissociation. The differentiation between blackouts and dissociation can be extremely complicated. The

initial response may be to describe dissociated people as inebriated, often because they are glassy eyed and poorly responsive. In response to questions about situations or events that are not recalled because of memory impairment, some people will fabricate facts or events. This process is called *confabulation.* It differs from lying in that the person is not consciously attempting to deceive.

Acute withdrawal and dissociative disorder often appear similar. Dissociated people require an immediate toxicological screen and should be admitted for continued observation. Attempts to establish reality-based grounding are necessary with these patients before medications are given or other interventions are attempted. The clinician should establish a soothing atmosphere, establish eye contact with the patient, and keep the patient grounded. It is often helpful to encourage agitated patients to focus externally on things they can see and describe, instead of focusing on their internal states. This shift in attention is often effective in allaying distress.

People in outpatient treatment may be verifiably abstinent and participating in recovery but may be experiencing dissociative symptoms. Patients with these disorders may have great difficulty in establishing and maintaining abstinence. Thus, integrated (rather than parallel) treatment is especially important for this group.

The evaluation of anxiety disorders and dissociative disorders, including PTSD and MPD, should include a careful history of recent and remote traumas. An assessment of trauma should include physical, sexual, and psychological abuse, and catastrophic stresses such as combat or hostage situations. For example, a rape experience within the last year and early childhood incest both could lead to the development of anxiety disorders. People living in violent situations, such as prostitutes who have been raped, can manifest anxiety symptoms. It is a mistake to ignore violence such as rape and look solely at early traumas. Recent traumas can be the trigger for PTSD or an MPD event. Early childhood abuse of males as well as females must be considered.

Obsessive-compulsive disorder.

With chronic use, several types of drugs (alcohol, benzodiazepines, and stimulants) can produce signs and symptoms similar to those of obsessive-compulsive disorder.

Assessment of the Anxious Person

Anxiety is one of the most common symptoms of people with AOD disorders. During acute assessments, many patients who are anxious and/or depressed are experiencing the effects of AOD use. As is the case with depression, time must pass before it is possible to make a definitive differential diagnosis of either AOD abuse, anxiety, depression, or a combination thereof. Most symptoms related to AOD use usually clear within 2-4 weeks, although the generally less severe subacute withdrawal symptoms may emerge after this time.

Patients with panic disorder are more likely to give a better history and description of panic attacks than the depressed patient can give regarding episodes of depression. Many people with a history of panic or anxiety disorders will be able to describe them with impressive accuracy. Also, patients with anxiety disorders are more likely to perceive them as abnormal conditions or "illnesses" that they don't deserve, compared with depressed patients who often feel that they deserve to be depressed or may feel that being depressed is a normal condition. Both depressed and anxious patients tend to ignore the connection with AOD use.

Various states may be mistakenly called anxiety, and people often use terms such as "panic attack" to describe nonpsychiatric states. Thus, clinicians should clarify the nature of the experience described by the patient. For example, many people consider any fear as anxiety or panic: "You really scared me. I

almost had a panic attack." Careful inquiry along the lines of DSM-III-R criteria will distinguish definitive characteristics of anxiety disorders from commonplace distress described with popular terms.

Anxiety can be dangerous. In combination with depression (which is frequent), the risk for suicide is markedly increased. In the emergency room or clinic, people may exhibit panic, dissociation, or PTSD; they can be very difficult to handle. Anxiety can mimic signs of heart disease such as angina, arrhythmias, heart attacks, cardiac ischemia, and congestive heart failure; it can also accompany these conditions.

In the medical examination of the anxious person, there should be a high index of suspicion of AOD use, especially withdrawal from depressants and intoxication with stimulants and hallucinogens. The seemingly dissociated individual should receive immediate toxicologic screens. AOD-induced anxiety symptoms can signal serious medical crises; for example, benzodiazepine withdrawal can cause seizures.

In cases where medications cause depression, caretakers have time to deal with them. In contrast, anxiety caused by drug use may signal a medical emergency. Nonmedical people should be familiar with warning signs and have rapid access to medical screening.

Acute Assessment Issues

The medical management of withdrawal is driven by the drug(s) to which a patient has developed tolerance; it does not vary significantly if the patient is anxious or depressed. Whatever the drug involved, the management of withdrawal-related anxiety involves issues similar to those associated with depression. Psychiatric support, confinement, and medication may all be needed.

People with simple anxiety are less likely to need to be hospitalized involuntarily. Since coexisting anxiety and depression constitute a greater risk factor for suicidal behaviors than depression alone, individuals with combined anxiety, depression, acute AOD use, and suicidal thoughts should be assessed for possible hospitalization, including involuntary commitment. Similarly, people who have uncontrollable agitation or who experience depersonalization may need to be confined. However, if tension is the main manifestation, there is less need for protection.

If the patient describes acute anxiety secondary to hallucinogen or marijuana use, the first line of treatment is "talking the patient down." If this does not calm down the patient, pharmacologic treatments can be used in some situations where the anxiety symptoms remain overwhelming and dangerous. Benzodiazepines may be indicated over the short term. Sedating antidepressants may be used during the subacute phase.

Phencyclidine-induced states can be extremely variable; they can be brief and mild or long-lasting and associated with significant danger and seizures. PCP can induce vertical nystagmus (involuntary motion of the eyeball), which is otherwise rare. Glutethimide causes agitated intoxication alternating with severe sleepiness and depression.

Agitated patients who do not have parasites (scabies, lice, and crabs) but complain of the sensation of insects crawling on or under their skin have probably used stimulants. *Tactile hallucinations* are hallucinations that involve the sense of touch. *Formications* are a type of tactile hallucination that involves the sensation of something creeping or crawling on or under the skin. Formication is seen in patients with alcohol withdrawal delirium and during the withdrawal phase of stimulant intoxication. Bilateral (affecting both sides of the body) and symmetrical symptoms (itching, scratching, and redness) are indicative of formications rather than of parasites. Manifestations of parasite infestations

are not symmetrical but have asymmetrical patterns on each side of the body.

Subacute Assessment Issues

While danger to self and others is not a hallmark of anxiety disorders, people in dissociated states may put themselves in great danger and require involuntary commitment. The relationship between anxiety, depression, and suicide has been noted. Thus the potential for harm to self and others should be considered. The possibility of medical disturbance and psychological and AOD issues must be considered. Consider the example of a patient who is treated in the emergency room for a panic attack. Once the patient is transferred to treatment in an outpatient mental health clinic, a plan should be developed that includes assessing AOD use, functional level (liabilities and strengths), and physical status, including cardiac and endocrine tests as indicated. Specifically, patients should be assessed for hyperthyroidism; this is especially true for women, who are four times as likely as men to have this disorder. Anxious people should also be evaluated for early stages of HIV infection and transient ischemic attacks. Neurological status should be carefully evaluated.

A psychosocial assessment is needed. If AOD use has been ruled out, it should be determined if an overwhelming stressor has provoked the anxiety response, such as grief or psychosocial stressors. For example, confusion about sexual orientation can be a potent source of stress that can lead to anxiety symptoms. Anxiety can also have cultural influences. For example, there is a subgroup of addicted people who have lost the majority of their friends to AIDS. When an individual has a pervasive anxiety disorder, develops AOD problems, and lives in a dismal social situation, a thorough biopsychosocial assessment is needed.

Grounding people in the here and now is most important. This should be accompanied by providing education about addiction to the patient and family. There are several self-help and support groups for people with anxiety and phobias. People with phobias are often treated in specialized treatment programs that utilize desensitization techniques, biofeedback, and behavioral and cognitive therapies. These specialized treatment strategies have been shown to be effective by empirical research.

Long-Term Assessment Issues

In long-term treatment, dissociative states may occasionally emerge in patients, and counselors should have the skills for handling these patients. In people who appear to be in a glassy-eyed dissociative state, the interviewer should evaluate AOD use, and if this is ruled out, consider dissociation. If the patient appears to be in a dissociative state, the clinician should ground the patient in time and place, and focus on here-and-now issues. Focusing on external events and processes rather than the patient's internal processes or history is helpful. These methods will be effective whether the patient proves to be in a drug-induced state or is manifesting a frank dissociative disorder. Both AOD and mental health counselors need to evaluate these patients.

Some people who experience anxiety are in fact experiencing an anxious depression, but the diagnosis must be reevaluated over a 30-day period. This is sufficient time for observation except in the case of subacute withdrawal from benzodiazepines. After 30 days, all traces of AODs will be gone, most neurochemical disturbances will disappear, and acute withdrawal symptoms should be over. By this time, a depression can be seen with some clarity.

Once patients have established and somewhat consolidated abstinence in their lives, they should be provided with educational and vocational testing and given support to help plan short-term and long-term goals. Patients with dual disorders may experience setbacks during overall periods of improvement. Thus, concrete planning efforts for future goals often occur over a long period of time. Although generalized anxiety disorder may severely restrict day-to-day functioning of some patients, most respond well to treatment.

Acute Treatment Strategies

Some very anxious patients misinterpret their symptoms of chronic anxiety as symptoms of an acute anxiety episode. Their misinterpretation may prompt the therapist to make the same misinterpretation. Two of the acute anxiety conditions most commonly encountered in emergency room settings are panic attacks and dissociative states -- which may resemble psychosis.

Acute interventions include calming reassurance, reality orientations, breathing management, and when needed, sedative medications such as benzodiazepines. These interventions are nearly identical to those used for the two most common AOD-related anxiety emergencies: withdrawal from sedative-hypnotics (including alcohol) and intoxication from stimulants (including cocaine). While the use of benzodiazepines is generally not problematic during acute withdrawal, their use may be problematic for abstinent recovering people who experience panic attacks. Indeed, such people may have abused benzodiazepines before they became abstinent. Acute interventions should include behavioral, cognitive, and relaxation therapies, often in combination with long-term serotonergic and depressant medications. Cognitive therapy can be used; patient manuals and workbooks exist for such treatment.

During an acute panic attack, people often believe that they are having a heart attack, feel dizzy, and are unable to catch their breath. Enforced regular breathing through the use of a paper bag helps to regulate breathing and diminish excess release of carbon dioxide. Such breathing exercises, education about symptoms, and reassurance will diminish panic symptoms for many patients.

Subacute Treatment Strategies

For many patients in early recovery from AOD abuse, treatment of anxiety disorders can be postponed unless there is a certain or verifiable history that the anxiety preceded the addiction or is incapacitating. If symptoms are mild and not interfering with function, including participation in treatment, it is judicious to wait and see if the symptoms resolve as the addiction treatment progresses. Subacute withdrawal may be difficult to differentiate from anxiety disorders.

Antecedent traumas, as well as dysfunctional family situations that have been identified during the assessments, should be addressed in a supportive and calming manner. However, affect-liberating therapies should probably be deferred until stability with respect to AOD abuse and acute anxiety has been established. Issues of importance to the patient and raised by the patient should not be ignored, but exploration of underlying trauma should not be encouraged until the patient is stabilized.

Supportive, cognitive, behavioral, and dynamic therapies can all be used, but in early recovery, patients need significant support and will have very limited tolerance for anxiety and depression. The emphasis should be on supporting recovery, attending 12-step meetings, and participating in other self-help and group therapies. Insight-oriented treatments must be carefully measured and limited by their potential to increase anxiety and trigger relapse. When psychotherapy is required, patients should be referred to recovery-oriented psychotherapists who will integrate psychotherapy with 12-step program approaches.

Patients may overuse medications or relapse on illicit drugs. Certain medications that do not produce physical dependence or withdrawal and have much lower potential for abuse have been found to be effective for treating anxiety disorders. Many are as effective as the benzodiazepines but without the abuse liability. The antidepressants fluoxetine (Prozac) and sertraline (Zoloft) and the antianxiety medication buspirone (BuSpar) are relatively new medications that can be used to treat symptoms of anxiety disorders, have good safety profiles, are not euphorigenic, and have few drug interaction cautions. They can be used in the management of subacute withdrawal states. When these drugs do not produce the desired results, the tricyclic and monoamine oxidase inhibitors (MAOIs) antidepressants may be used. (See Chapter 9 for a discussion of psychiatric medication.)

Medications should be used in combination with nondrug treatment approaches. Although studies are still under way, acupuncture, aerobic exercise, stress reduction techniques, and visualization techniques appear to be useful components of treatment and recovery. These tools can be valuable adjuncts for the reduction of stress. It appears that acupuncture is more effective if used regularly for 2 weeks or more. Patients should be taught that efforts to improve their general health, such as eating more healthful foods and exercising regularly, can lead to better mental health.

Long-Term Treatment Issues

While medications are useful for anxiety disorders, they are not a substitute for addiction treatment or other activities related to recovery from other illnesses. Cognitive and behavioral techniques used in addiction are often as effective as medications in treatment of anxiety disorders but generally take longer to achieve an equivalent response. For patients with dual disorders, psychotherapy has significant advantages over AOD counseling alone. Many techniques of cognitive and behavioral therapy can be incorporated into AOD abuse treatment.

The consumption of foods containing stimulants should not be overlooked. People who consume significant amounts of caffeine and sugar may have a higher risk for episodes of anxiety and depressive symptoms. Chocolate should be avoided. Diets that cause significant variations in blood sugar levels should be avoided. It is important to be sure that eating habits don't imitate the rushes and crashes of AOD abuse. Diets that cause variations in blood sugar levels may tend to aggravate or induce both mood and anxiety states. Patients should avoid large quantities of refined carbohydrates.

Over the long term, special attention should be given to the resolution of preexisting and long-term trauma issues. Patients with dissociation and PTSDmay manifest poor social judgment, and special attention should be given to risky practices. People who continue to experience episodes of depersonalization or MPD will require special support and counseling, especially concerning sexually transmitted diseases and risk-reduction issues. Those who continue to experience these episodes may need special counseling about risk factors. During these episodes, people may be more likely to have sex, and may forget about the risk of HIV infection.

Experts in the treatment of these disorders have developed techniques of working with patients, including the management of behavior during trance and dissociated states, as well as *fugue states* in which people suddenly travel away from home or work, assume a new identity, and are unable to recall their previous identity. Many of the psychotherapeutic management issues that relate to patients with dissociative disorders run parallel to those outlined in the section of Chapter 7 on borderline personality disorder.

Use of 12-Step and Other Self-Help Programs

Participation in the 12-step programs provides valuable therapeutic experiences for many recovering people who have anxiety disorders. People who have a social phobia and the fear of public speaking are often extremely resistant to attending self-help meetings. Yet, such people can make tremendous recovery gains in terms of anxiety desensitization and AOD recovery.

There are few situations that are as safe, supportive, and predictable and less demanding than the average 12-step group meeting. For this reason, groups such as Alcoholics Anonymous provide ideal situations to help patients desensitize social fears. However, anxious patients must not simply be thrust unprepared into 12-step group meetings. Rather, AOD staff should educate and prepare such patients regarding the process and approach of 12-step group meetings or other self-help groups.

A Stepwise Approach to Using Self-Help

It is important for AOD abuse treatment staff to appreciate the difficulty and distress that are experienced by people who have social phobias and fears of speaking in public. Staff who assist such patients with 12-step group participation should become knowledgeable about the signs and symptoms, course, and treatment of generalized anxiety disorder, panic disorder, the phobias -- especially social phobia -- and other anxieties related to public speaking and social situations.

Staff can help socially anxious patients participate in 12-step group meetings by using a stepwise approach of progressively active exposure and participation -- based somewhat on the principles of systematic desensitization. Patients can be encouraged and counseled to participate in progressively intense levels of group preparation and participation.

One of the least intense levels of preparation involves the use of mock Alcoholics Anonymous meetings consisting of staff and patients. This process makes it possible to frequently stop the meeting, discuss various meeting components, examine group methods, and allow potential participants to observe and practice. This type of approach can be helpful with most other patients with dual disorders.

The next level of intensity involves the attendance at a 12-step group meeting as a nonspeaking observer. However, staff should encourage patients to understand that being a nonspeaking observer is a transitional phase, and is not a substitute for active participation. For this reason, it may be helpful to limit nonspeaking observation by the patient to a specific number of meetings.

The next level of intensity involves patients attending a limited number of 12-step meetings during which they identify themselves beyond just giving their name but do not talk about themselves. The therapist can give assistance by providing easily rehearsable suggestions for self-introductions such as, "Hi, my name is Mary. I'm an alcoholic and I am glad to be here, although I am a little nervous."

Since much of the networking and mutual support associated with the 12-step group meetings occur outside of the meeting, anxious patients should be encouraged to do more than merely attend and participate in the meetings. Rather, they should be encouraged to arrive before the meeting begins and to linger and mingle with others following the meeting. Patients can be encouraged to volunteer to help set up the room, make the coffee, or clean up afterwards. In particular, socially phobic patients can be encouraged to join others for coffee and conversation after the meetings on a more one-to-one basis, a traditional aspect of 12-step group involvement.

By participating in step-by-step, rehearsed activities, many anxious and depressed patients seem to break through an internal barrier. As they do, participation in self-help group meetings becomes an integral aspect of recovery from AOD and psychiatric problems.

The stepwise approach described for patients with anxiety disorders can be adapted for patients who are depressed. Anxious patients often avoid group participation and public speaking, saying to themselves, "If I talk or if I am noticed, I will freak out." Similarly, depressed patients often avoid group participation and other recovery activities, perhaps thinking, "I just don't have the energy to go. No one will care anyway. Why bother?"

The therapist must elicit comments, understand them, and help patients to reverse these internal barriers to recovery and participation in group and other social activities. For practical guidance on these issues, the reader is encouraged to read the information on step work and "thinking-error work" in the chapter on personality disorders, adapted from *Step Study Counseling With the Dual Disordered Client* by K. Evans and J. M. Sullivan.

Treating Anxiety During AOD Abuse Treatment

- It can be postponed unless anxiety interferes with AOD abuse treatment.
- Anxiety symptoms may resolve with abstinence and AOD abuse treatment.
- Affect-liberating therapies should be postponed until the patient is stable.
- Psychotherapy, when required, should be recovery oriented.
- Nonpsychoactive medications should be used when medications are needed.
- Antianxiety treatments such as relaxation techniques can be used with and without medications.
- A healthy diet, aerobic exercise, and avoiding caffeine can reduce anxiety.

Chapter 7 – Personality Disorders

Overview

Definitions and Diagnoses

The word *personality* describes deeply ingrained patterns of behavior and the manner in which individuals perceive, relate to, and think about themselves and their world. *Personality traits* are conspicuous features of personality and are not necessarily pathological, although certain styles of personality traits may cause interpersonal problems. *Personality disorders* are rigid, inflexible, and maladaptive behavior patterns of sufficient severity to cause significant impairment in functioning or internal distress. Personality disorders are enduring and persistent styles of behavior and thought, not atypical episodes.

Several alcohol and other drug (AOD)-induced states can mimic personality disorders. If a personality disorder coexists with AOD use, only the personality disorder will remain during abstinence. AOD use may trigger or worsen personality disorders. The course and severity of personality disorders can be worsened by the presence of other psychiatric problems such as mood, anxiety, and psychotic disorders.

The personality disorders include paranoid, schizoid, schizotypal, histrionic, narcissistic, antisocial, borderline, avoidant, dependent, obsessive-compulsive, passive-aggressive, and self-defeating personality disorder. Many features of the personality disorders may occur during an episode of another mental disorder. Individuals may meet criteria for more than one personality disorder.

Four personality disorders have been selected for detailed discussion: borderline, antisocial, narcissistic, and passive-aggressive. These are among the greatest challenges to treatment providers. This TIP provides information about engagement, assessment, crisis stabilization, and longer-term care, and describes a continuum of care for patients with personality disorders.

Antisocial personality disorder involves a history of chronic antisocial behavior that begins before the age of 15 and continues into adulthood. The disorder is manifested by a pattern of irresponsible and antisocial behavior as indicated by academic failure, poor job performance, illegal activities, recklessness, and impulsive behavior. Symptoms may include dysphoria, an inability to tolerate boredom, feeling victimized, and a diminished capacity for intimacy. *Borderline personality disorder* is characterized by unstable mood and self-image, and unstable, intense, interpersonal relationships. These people often display extremes of overidealization and devaluation, marked shifts from baseline to an extreme mood or anxiety state, and impulsiveness.

Narcissistic personality disorder describes a pervasive pattern of grandiosity, lack of empathy, and hypersensitivity to evaluation by others. *Passive-aggressive personality disorder* involves covertly

hostile but dependent relationships. People with this disorder commonly lack adaptive or assertive social skills, especially with regard to authority figures. They often display a passive resistance to demands for adequate social and occupational performance. They generally fail to connect their passive-resistant behavior with their feelings of resentfulness and hostility toward others. Exhibit 7-1 describes the characteristics of passive-aggressive, antisocial, and borderline personality disorders.

Avoidant personality disorder includes social discomfort, hypersensitivity to both criticism and rejection, and timidity, with accompanying depression, anxiety, and anger for failing to develop social relations. *Obsessive-compulsive personality disorder* describes a disorder of perfectionism and inflexibility. Symptoms may include distress associated with indecisiveness and difficulty in expressing tender feelings, feelings of depression, and anger about being controlled by others. Hypersensitive to criticism, these people may be excessively conscientious, moralistic, scrupulous, and judgmental.

Histrionic personality disorder is characterized by a pervasive pattern of excessive emotionality and attention seeking. Behavior may include constant seeking of approval or attention, striking self-centeredness, or sexual seductiveness in inappropriate situations. *Paranoid personality disorder* is characterized by a pervasive and unjustified proclivity to interpret the actions of others as intentionally threatening, demeaning, and untrustworthy. *Dependent personality disorder* is characterized by a pervasive pattern of dependent and submissive behavior and an intense preoccupation with possible abandonment. Persons with this disorder often feel anxious and depressed, and may experience intense discomfort when alone for more than a brief time.

Schizoid personality disorder involves a pervasive pattern of indifference to social relationships and a restricted range of emotional experience and expression. *Schizotypal personality disorder* entails deficits in interpersonal relatedness and peculiarities of ideation, appearance, and behavior and dysphoric states such as anxiety and depression. *Self-defeating personality disorder* is characterized by a pattern of self-defeating behavior in work and personal relationships, often with complaints of exploitation by others; these persons are often unaware of their contributions to the outcomes of their behavior.

Personality disorders not otherwise specified (NOS) include disorders of personality functioning that are not classifiable as specific personality disorders. Instead, individuals do not meet the full criteria for any one personality disorder; yet their symptoms cause significant impairment in social or occupational functioning, or cause subjective distress. Personality disorders NOS include impulsive, immature, and sadistic personality disorders.

Diagnoses should be clinically based, and not influenced by professional, personal, cultural, or ethnic biases. For example, in the past some African Americans were stereotyped as having paranoid personality disorders; women have been diagnosed too frequently as being histrionic, but they are seldom diagnosed as antisocial or psychopathic; Native Americans with spiritual visions have been misdiagnosed as delusional or having borderline or schizotypal personality disorders.

AOD Use Among People With Personality Disorders

People with a personality disorder often use AODs for purposes that relate to the personality disorder: to diminish symptoms of the disorder, to enhance low self-esteem, to decrease feelings of guilt, and to amplify feelings of diminished individuality.

People with borderline personality disorder often use AODs in chaotic and unpredictable patterns and in polydrug patterns involving alcohol and other sedative-hypnotics taken for self-medication. People

with personality disorders often develop problems with benzodiazepines that have been prescribed for complaints such as anxiety, which may lead to relapse to the primary drug of choice.

Many people with antisocial personality disorder use AODs in a polydrug pattern involving alcohol, marijuana, heroin, cocaine, and methamphetamine. The illegal drug culture corresponds with their view of the world as fast-paced and dramatic, which supports their need for a heightened self-image. Consequently, they may be involved in crime and other sensation-seeking, high-risk behavior. Some may have extreme antisocial symptoms. They tend to prefer stimulants such as cocaine and the amphetamines. Rapists with severe antisocial personality disorder may use alcohol to justify conquests. People with less severe antisocial personality disorder may use heroin and alcohol to diminish feelings of depression and rage.

People with narcissistic personality disorder are often polydrug users with a preference for stimulants. Alcohol has disinhibiting effects, and may help to diminish symptoms of anxiety and depression. Socially awkward or withdrawn people with narcissistic personality disorder may be heavy marijuana users. One group of people with narcissistic personality disorder uses steroids to build up a sense of physical perfection. When not using AODs, people with narcissistic personality disorder may feel that others are hypercritical of them or do not sufficiently appreciate their work, talents, and generosity. During a crisis, these people may be severely depressed and upset.

Drug preference among people with passive-aggressive and self-defeating personality disorders often varies according to gender. Women may prefer alcohol and other sedative-hypnotics to sedate negative feelings such as anxiety and depression. Although men may use these AODs, they may also use stimulants to disinhibit aggressive or risk-taking behaviors. People with passive-aggressive personality disorder often complain of somatic problems, such as migraines, muscle aches, and ulcers. They may seek over-the-counter medications as well as cocaine and amphetamines to relieve somatic symptoms.

Key Issues and Concerns

Progress with patients who have personality disorders can be slow. Therapists should be realistic in their expectations and should know that patients will try to test them. To respond to such tests, therapists should maintain a matter-of-fact, businesslike attitude, and remember that people with personality disorders often display maladaptive behaviors that have helped them to survive in difficult situations. These behaviors may be called "survivor behaviors."

It is important to educate patients about their AOD use and psychiatric disorders. Patients should learn that recovery from AOD use is not synonymous with treatment for personality disorders. Written and oral contracts can be a useful part of the treatment plan. They should be simple, clear, direct, and time-limited. Contracts can help patients create safe environments for themselves, prevent relapse, or promote appropriate behavior in therapy sessions and in self-help meetings.

Treatment of people with personality disorders requires attention to several particular issues, such as violence to self or others, transference and countertransference, boundaries, treatment resistance, symptom substitution, and somatic complaints.

Suicidal Behavior

All suicidal behavior, from threats to attempts, must be taken seriously and assessed immediately to determine the type of immediate intervention needed. Special attention must be given to previous attempts and their seriousness, previous intervention strategies, whether the failure of the attempt was intended or accidental, the relation of previous suicidal behavior to psychiatric symptoms, and current psychiatric symptoms. All suicidal behavior should provoke the following questions:

- How specific is the plan?
- What method will be used?
- When will it happen?
- How available are materials (drugs, weapons)?

Patient Contracting

Management of self-harm can be accomplished by creating written or oral contracts with patients. In these contracts, a patient may promise to avoid certain self-harm or high-risk behavior (such as suicide or relapse), or may promise to engage in a specific healthy behavior (such as calling his or her 12-step sponsor or a suicide prevention hotline) when self-harm or a high-risk behavior appears imminent.

Therapists should attend to the patient's need for safety. Safety may range from the need for safe shelter to escape domestic violence to the need to reside in a controlled environment in order to remain abstinent.

Transference and Countertransference

Transference and countertransference can present problems in group and individual therapy. Therapists should be prepared to manage these issues. Transference refers to positive and negative feelings and perceptions that the patient projects onto the therapist. Countertransference refers to distortions in the therapeutic process due to the therapist's unresolved conflicts. Both transference and countertransference rely on the mechanism of projection.

Projection is a combination of personal past experiences along with feelings experienced during the course of therapy. Being aware of transference issues and commenting on them when appropriate is extremely important when working with these patients.

Clear Boundaries

Boundaries are clear expectations regarding limitations or requirements in roles or behavior. Boundaries are ethical and practical ground rules that help therapists to be therapeutically helpful to patients. The clinician and patient must establish and maintain clear boundaries. Boundaries must also be set in group therapy sessions. For example, therapists should not lend money to patients or involve them in financial deals. Patients should not establish intimate relationships with others in group therapy.

Changing Roles

People with personality disorders often assume certain roles or ways of social interaction. They may shift from one role to the next, depending upon the situation. Some of these roles include: the victim, the persecutor, and the rescuer.

As these patients assume a specific role (such as the victim), other people may be prompted to assume a complementary role (such as the rescuer). Therapists should be aware of the roles that people with personality disorders may assume. They should resist assuming dysfunctional complementary roles themselves and become aware when they do assume such roles.

Resistance

Patients with personality disorders often exhibit acting-out behaviors that were developed as psychological defenses and survival techniques. The patient may be reenacting a response learned during experiences of abuse or trauma. Resistances are defenses and coping mechanisms that help patients survive in situations confronted in therapy which are perceived as threatening.

Confronting a patient's resistance without helping the patient develop other strategies for safety will probably escalate the patient's tension. Therapists should view and use resistance as a therapeutic issue, not as a challenge to treatment.

Subacute Withdrawal

It is becoming increasingly clear that alcohol and most other drugs of abuse produce acute and subacute withdrawal syndromes. Depending on the specific drug, subacute withdrawal may include mood swings, irritability, impairment in cognitive functioning, short-and long-term memory problems, and intense craving for AODs. Subacute withdrawal syndromes often trigger relapse and exacerbate existing psychiatric symptoms

Symptom Substitution

During periods of abstinence from AODs, some people will engage in other types of compulsive behaviors. Some of these behaviors include eating disorders, and compulsive spending, gambling, and sex. Relationship problems may also increase.

Somatic Complaints

Patients with addictions to prescription drugs often seek treatment because of somatic complaints. Therapists should watch for use of prescription and over-the-counter drugs and for drug-seeking behaviors.

Therapist Well-Being

Therapists should be mindful of their own well-being, which can be compromised when working with patients with personality disorders. Clinicians can be drawn into playing certain roles in the lives of patients with personality disorders. To prevent this, therapists should care for themselves by seeking outside supervision. Therapists should join or develop support systems with others in the field through 12-step program participation, regular meetings with other therapists, grand rounds, and the like.

The following sections describe specific strategies and techniques that therapists can use when working with patients who have an AOD use disorder and a borderline, antisocial, narcissistic, or passive-aggressive personality disorder.

Each section describes techniques for assessing patients and engaging them in treatment, stabilizing crises, providing long-term care, and creating a continuum of care. Each section concludes with a case example in which the reader is asked to make a treatment decision. Where appropriate, clinical tools are provided.

Key Issues and Concerns in The Treatment of Personality Disorders

- Slow progress in therapy
- Suicidal behavior
- Patient contracting
- Transference and countertransference
- Clear boundaries
- Changing roles
- Resistance
- Subacute withdrawal

- Symptom substitution
- Somatic complaints
- Therapist well-being

Borderline Personality Disorder

Engagement

Safety is an anchor for patients with borderline personality disorder, for whom abandonment and fear of rejection are often core issues. To engage and assess these patients, the therapist should acknowledge and join with the patient's need for safety. The therapist's absence, even for brief periods, can prompt acting-out behavior.

Acting-out behavior is a maladaptive survivor response that expresses a need for safety. Therapists should identify each patient's motivation for recovery, which may be rooted in safety. Further, therapists should discover what safety means to the patient.

Therapists can learn how patients create their own feelings of safety by asking them about safe spots, magic getaway places, closet-sitting, rocking or other repetitive movements, or other techniques the patient may use to generate a sense of security. To help patients with borderline personality disorder establish and maintain a sense of safety, therapists can continually ask patients: "What do you need right now?" "What do you want right now?"

Therapists may work with patients to develop a patient-generated list of the conditions that they need in order to feel safe. Therapists may ask patients: "What would have been helpful (in a specific situation) to make you feel safe?" Through teaching cognitive skills to promote patients' sense of safety, therapists can help patients with borderline personality disorder to assume personal responsibility for their own safety.

Written and verbal contracts can identify specific ways to help patients stay physically and emotionally safe and to prevent relapse. Written and verbal contracts for safety should be developed during the assessment process with simple and clear behavioral responses regarding the management of unsafe feelings and behaviors. These contracts can be very simple and direct:

- "If I feel like I want to get drunk, I will call my sponsor."
- "If I feel like getting loaded, I will go to the next NA meeting."
- "If I feel like hurting myself, I will call a crisis hotline and go to my sister's house."
- "I will report self-harm thoughts and behaviors to the therapist at the next session."

Assessment

When assessing a patient, the therapist is attempting to understand and view the patient within a holistic framework. Areas of assessment may include a history of AOD and mental health treatment, suicidal planning, dissociative experiences, psychosocial history, history of sexual abuse, and a history of psychotic thinking. Some patients may also require a neurological examination.

The assessment of patients with borderline personality disorder should look for a history of self-harm. Behaviors such as AOD use should be described as unsafe behaviors. However, clinicians should help people with borderline personality disorder to avoid black-and-white thinking, such as right/wrong and good/bad, and all-or-nothing styles of thinking. Specifically, the assessment should include the following:

- A history of previous treatment, including psychiatric medications administered, and a description of what worked and what did not work in treatment, as well as information on why the patient left earlier treatment. Patients are not always a reliable source of information about themselves, and therapists should evaluate this information accordingly. The treatment history can help the therapist avoid unnecessary repetition of treatment strategies, such as skill-building activities in which the patient is already competent (for example, relaxation strategies). The history taking is an opportunity to examine patients' strengths and weaknesses.

- A list of potential means available to patients to injure themselves in their own homes, such as a large supply of medication.

- History and evidence of dissociative experiences, such as trance states, rocking, flashbacks, nightmares, and repressed memories. Any and all parts of a memory can be repressed. One model for assessing dissociation and identifying repressed memories is the BASK model. The BASK model is a quick way to check what part of the memory is missing, and whether or not it is Behavior, Affect, Sensation, or Knowledge. Survivors of abuse may detach themselves from their feelings so that they recall memories of abuse in a robot-like fashion.

- Attachment to a special object. Anniversary reactions are also common to survivors of abuse, whose memories or feelings may be triggered by certain dates, events, or objects. For no apparent reason, the survivor may become sick or suicidal when faced with a situation similar to a past reminder of abuse.

- History of fugue states and losing time. For example, patients with borderline personality disorder might start watching a movie and suddenly reorient later in the middle of another movie, with no clear memory of the elapsed time.

- Psychosocial history and history of sexual abuse. It is common for people to feel as if they were sexually abused without having any actual memories of the abuse or trauma. Questions should be framed in a manner that facilitates the acquisition of all relevant information. By asking open-ended questions while paying attention to the patient's body language, the therapist may be able to draw useful conclusions.

- Neurological workup of individuals who have a history of self-mutilating behaviors that could have resulted in cognitive impairment such as head-slamming. Some psychologists will conduct neurological screening; in other cases, a neurologist should be consulted.

- Psychotic-like thinking and history of suicidal behavior, especially under intense stress. Psychotic-like thinking may be evident during episodes of trauma and stress. For example, a patient may state, "The walls are bleeding."

Crisis Stabilization

Safety issues are at the core of crisis stabilization. To ensure the patient's safety or to detox a patient, a brief psychiatric hospitalization may be necessary. Issues to be addressed during crisis stabilization might include an unwillingness or inability to contract for safety. A written release of medical information is important to coordinate care with physicians and addiction counselors.

At this stage, therapists should avoid psychodynamic confrontations with patients and should not engage patients in further therapy for abuse or trauma. The treatment focus should be on addressing the patient's need for safety, especially important with patients who have borderline personality disorder. More complicated and emotionally charged material should be deferred until the patient has better skills to manage emotional pain.

It may be helpful to describe out-of-control crisis behavior as a survivor response. Therapists and patients should avoid rigid black-and-white thinking. Describing events or issues as being more helpful or less helpful may circumvent the inflexibility of seeing life's challenges and problems only as black and white, while ignoring the numerous grey areas of experience.

During crisis stabilization, the continued use of written and verbal contracts is critical. These contracts should be rooted in the here-and-now, and should offer patients practical ways to manage crisis behavior. The contracts must focus on safety. Contracts written on 3-by-5-inch cards that they can carry

and read when necessary are very helpful for patients with borderline personality disorder. Contracts should be simple and concrete and should emphasize problem-solving skills.

Therapists should work on relapse management strategies that are clear and concrete, such as: "Before I use cocaine, I will call my sponsor." At the same time, therapists should encourage patients to be honest about relapse. Therapists should assume a posture of concerned support about relapse and view it as an opportunity to learn from past mistakes and strengthen relapse prevention skills and the therapeutic relationship.

The family -- as defined by each patient -- should take part in this process. It may be useful to encourage contracts with family members. These contracts can dissuade family members from assuming dysfunctional roles such as the victim, the persecutor, and the rescuer. The family should learn how to set boundaries with the patient, and should learn not to play certain roles, especially the role of rescuer.

Longer-Term Care

Individual Counseling

In individual therapy, issues stemming both from borderline personality disorder and from AOD use may emerge. Issues related to unsafe behavior or AOD use will continue to be important. Longer-term care is a stage in which teaching the patient skills, such as assertiveness and boundary setting, can be useful.

Patients may need to be educated about survivor issues without exploring more psychodynamically based issues. Patients should be oriented to a survivor framework, but therapists must build slowly before engaging patients in retrieving painful memories.

The abuse survivor should demonstrate the necessary skills to benefit from psychotherapy. Patients should tell the therapist when they are not ready to discuss certain issues. Once patients are ready to do so, the integration of psychodynamic material and trauma therapy may begin. There is no pressing need for the retrieval of early memories of trauma. Rather, the focus of therapy may be on behavior rather than memory.

Therapists might try to frame acting-out behaviors as survivor behaviors. Complications at this stage can include a variety of compulsive and impulsive behaviors, such as eating disorders (obesity, anorexia, bulimia), compulsive spending and money mismanagement, relationship problems, inappropriate sexual behaviors, and unprotected sex (in regard to STDs and pregnancy). Other maladaptive behaviors include sexual impulsiveness, which can cause confusion about sexual identity dramatized in experimental sexual relationships, adding to the crisis and drama on which people with borderline personality disorder often thrive.

Therapists may want to consider limiting access to educational material about adult children of alcoholics (ACOAs) for patients with borderline personality disorder. Reading some ACOA material and self-help books and participating in self-help support groups may be detrimental to some patients' recovery. For some patients, self-labeling can become counter-productive -- and in worst-case scenarios, it can lead to self-fulfilling prophesies.

For example, books suggesting that some people self-mutilate in order to relieve pain may teach patients with borderline personality disorder to self-mutilate. Some books offering "inner-child work" lead the patient through age-regressive exercises that can cause an overwhelming flood of feelings the abused patient may not yet be ready to manage.

Therapists should remember that progress in treating patients with borderline personality disorder and AOD problems can be slow. There may be many setbacks. Rather than looking for enormous changes in personality or behavior, therapists should look for small, measurable signs of improvement.

In addition, therapists may want to consider the following in treating patients with borderline personality disorder:

- Using mini-contracts for each session to encourage the patient to stay focused.
- Immediately asking patients about any crises that have occurred, reviewing the entire week, not just a particular day.
- Stating the purpose of each session.
- Running through a checklist can be helpful. A list might include: homework, failing tests, arguments with others, interactions with the criminal justice system, problems in school or work life, family relationships and friends, relapses, thoughts of self-harm, nightmares, flashbacks, painful situations, and bad memories. Questions should be specific.
- Encouraging patients to keep mood and dream journals (especially during survivor work) between sessions for brief comments on mood.
- Conducting survivor work only after daily living skills are successfully demonstrated.
- Keeping and dating all correspondence and notes from telephone conversations. Having previous conversations documented can help to remind the patient of earlier agreements and conversations.

Group Therapy

There are special issues concerning work with people with borderline personality disorder in group therapy. Therapists should consider the following:

- Making contracts for all members to stay in the room.
- Making contracts for group rules that promote safe behavior and not hurting oneself or others.
- Working with transference and countertransference issues.
- Discussing thoughts and feelings about other group members as they arise.
- Setting time limits at the start of each session.
- Making mini-contracts for those who have issues to work on in each session.
- Having group members sign contracts for abstinence and reporting self-harm and AOD use to the group.
- Making contracts for confidentiality.
- Disallowing participants to form intimate or exclusive relationships. Supportive activities, such as calling one another during crises or attending 12-step meetings together, are acceptable and should be encouraged.
- Evaluating safety issues in screening people with borderline personality disorder for group therapy. Patients should be safe from predatory, manipulative behavior of others, and should not engage in such behaviors themselves.
- Promoting same-sex groups.

Twelve-Step Participation

Although 12-step involvement is important for patients with borderline personality disorder, some may not be immediately able to attend 12-step meetings. Some patients may find it more helpful to participate in pre-12-step practice sessions. These patients should be helped to organize their thoughts, to practice saying "pass," and to create

safety in a 12-step meeting. Counselors may want to use the step work handout as a treatment tool for working with people with borderline personality disorder (see Exhibit 7-2 and Chapter 6 on use of 12-step meetings).

Patients should be encouraged to join same-sex 12-step groups when possible. People with borderline personality disorder may find it helpful to use same-sex sponsors as guides to recovery. When possible, therapists should educate the sponsor about survivor behaviors. The sponsor may even attend a therapy session to learn why the patient is taking medications. Antidepressants or lithium may be an important part of the patient's recovery. Explaining how medications are helpful may enable sponsors to help improve medication compliance.

Some sponsors may have problems setting boundaries. Such sponsors should not be paired with borderline patients. If they must be paired, however, they need to understand how important boundaries are in helping borderline patients feel safe. Understanding this may keep them from taking on borderline patients, who may be more than they can handle. Material in the step program should be limited to the here-and-now. Patients should not engage in dealing with sexual abuse issues until they are ready.

Longer-term care should include specialized 12-step work. In using step one ("We admitted we were powerless over alcohol -- that our lives had become unmanageable.") with patients who have borderline personality disorder, therapists should encourage patients to recognize that powerlessness does not mean helplessness. Instead, patients should focus on gaining personal control over AOD use. Faith and hope concepts used in 12-step work may also be difficult for this group to comprehend or integrate.

Continuum of Care

An aftercare plan for patients with dual disorders is essential. This plan should integrate rather than fragment strategies for treating the patient. It should include methods to coordinate care with other treatment providers. Relapse prevention is critical and should be managed through careful planning throughout treatment. Relapse should be defined as engagement in any unsafe behavior such as AOD use, self-harm, and noncompliance with medications. Relapse prevention should focus on preventing AOD use and recurrence of psychiatric symptoms.

Patients should be encouraged to participate in 12-step groups and other self-help and support groups such as Adults Molested As Children (AMAC), Incest Survivors Anonymous (ISA), and Survivors of Incest Anonymous (SIA).

Acute hospitalization may be necessary during suicidal crises. Again, the emphasis of treatment should remain on safety. Outpatient therapy should continue. AOD treatment should be obtained when appropriate. Therapists should be wary of triangulation in coordinating with other professionals.

Case Example

Rachel was 32 years old when she was taken by ambulance to the local hospital's emergency room. Rachel had taken 80 Tylenol capsules and an unknown amount of Ativan in a suicide attempt. Once stable medically, Rachel was evaluated by the hospital's social worker to determine her clinical needs.

The social worker asked Rachel about her family of origin. Rachel gave a cold stare and said, "I don't talk about that." Asked if she had ever been sexually abused, Rachel replied, "I don't remember." Rachel acknowledged previous suicide attempts as well as a history of cutting her arm with a razor blade during stressful episodes. Rachel reported that the cutting "helps the pain."

Rachel denied having "a problem" with AODs but admitted taking "medication" and "drinking socially." A review of Rachel's medications revealed the use of Ativan "when I need it." Rachel used Ativan three or four times a week. She reported using alcohol "on weekends with friends" but was

vague about the amount. Rachel did acknowledge that before her suicide attempts, she drank alone in her apartment. This last suicide attempt was a response to her breakup with her boyfriend. Rachel's insurance company is pushing for immediate discharge.

Question -- Should Rachel be discharged? Where should she be sent? Exhibit 7-3 shows a recovery model for treatment of borderline personality disorder.

Antisocial Personality Disorder

Clinicians should be careful to avoid mislabeling patients. Although some women may have antisocial personality disorder, they receive this diagnosis less often than men. Instead, they may be misdiagnosed as having borderline personality disorder. Among the male prison population, 20 percent may have antisocial personality disorder. However, once they are abstinent, many AOD-using offenders may not meet the criteria for antisocial personality disorder.

Engagement

In engaging the patient with antisocial personality disorder, it is useful to join with the patient's world view, which may include a need for control and a sense of entitlement. In this context, entitlement refers to people who believe their needs are more important than the needs of others. Entitlement may include rationalization of negative behavior (such as robbery or lying). People with antisocial personality disorder may evidence little empathy for their victims. If incarcerated, they may believe they should be released immediately. In an AOD treatment program, they may describe themselves as being unique and requiring special treatment.

The primary motivation of the patient with antisocial personality disorder is to be right and to be successful. It is useful to work with this motivation, not against it. Although this motivation may not reflect socially acceptable reasons for changing behavior, it does offer a point from which to begin treatment. Wanting to be clean and sober, to keep a job, to avoid jail, and to become the chair of an AA meeting are reasonable goals, despite a self-serving appearance. Therapists may help patients by working with patients' world view, rather than by trying to change their value system to match those of the therapist or of society.

Patients should understand their role in the process. In engaging patients, therapists may want to use contracts to establish rules for conduct during treatment. The contract should explicitly state all expectations and rules of conduct and should be honored by all parties. Such an approach can be useful with people with antisocial personality disorder, who often view relationships as unfair contracts in which one person attempts to take advantage of the other. Therapists may find that once a level of interpersonal respect has been established, working with antisocial patients can lead to important gains for the patient.

Assessment

In addition to an objective psychosocial and criminal history, the following steps may be useful in assessing the antisocial patient:

- Taking a thorough family history.
- Finding out whether or not the patient set fires as a child, abused animals, or was a bed-wetter.
- Taking a thorough sexual history that includes questions about animals and objects.
- Taking a history of the patient's ability to bond with others. Therapists can ask: "Who was your first best friend?" "When was the last time you saw him or her?" "Do you know how he or she is?" "Is there any authority figure who has ever been helpful to you?"

- Asking questions to find out about possible parasitic relationships and taking a history of exploitation of self and others. In this context, parasitic refers to a relationship in which one person uses and manipulates another until the first has gotten everything he or she wants, then abandons the relationship.
- Taking a history of head injuries, fighting, and being hit. It may be useful to perform neuropsychological testing.
- Testing urine for recent AOD use.
- HIV testing.

The assessment should consider criminal thinking patterns, such as rationalization and justification for maladaptive behaviors. There is a special need to establish collateral contacts and to assess for criminal history and the relationship of AOD use to behavior.

Useful assessment instruments include the Minnesota Multiphasic Personality Inventory (MMPI), the Millon Clinical Multiaxial Inventory (MCMI), the PCL-R (Hare Psychopathy Checklist-Revised), and the CAGE questionnaire.

Crisis Stabilization

People with antisocial personality disorder may enter treatment profoundly depressed, feeling that all systems have failed them. Often, their scams and lofty ideas have failed and they feel exposed, feel like losers, and have no ego strength. They are at risk for suicide, especially during intoxication or acute withdrawal. They may require psychiatric hospitalization and detoxification.

They may become acutely paranoid. Containment in the form of a brief hospitalization may be indicated for patients experiencing acute paranoid reactions to avoid acting out against others. For less acute paranoid reactions, therapists should try to avoid cornering patients, disengage from any power struggle, offer lower stimulus levels, and create options, especially if those are supplied by the antisocial patient. During this phase, clarification without harsh confrontation is recommended.

When patients with antisocial personality disorder have crises, therapists should become cautious and careful. During crises, these patients may engage in dangerous physical behavior in order to avoid unpleasant situations or activities, and therapists should avoid angry confrontations.

Longer-Term Care

Individual Counseling

It is helpful to view the process of working with antisocial patients as a process of adaptation of thinking rather than the restructuring of a patient into a person whose morals and values match those of the therapist or society. Therapists may benefit from modifying their own expectations of treatment outcomes, and realize that they may not help some patients to develop empathic and loving personalities. It is enough to guide patients to lead lives that follow society's rules.

Individual therapy offers the therapist an opportunity to point out patients' errors in thinking without causing them to feel humiliated in the presence of the therapy group. Other issues for individual therapy may include continued relapse management and identity of empathy. Three key words summarize a strategy for working with people with antisocial personality disorder: corral, confront, and consequences.

Corral.

Corralling with regard to patients with antisocial personality disorder means coordinating treatment with other professionals, establishing a system of communications with other professionals and with the patient, contracting patients to be responsible for their AOD use in the recovery program, monitoring information about the patient, and working toward specific treatment goals. Patients may benefit by signing agreements to comply with the treatment plan and by receiving written clarification of what is being done and why. Interventions and interactions should be linked to

original treatment goals.

One approach to treatment that adds to the notion of "corralling" is to "expand the system." Spouses, family members, friends, and treatment professionals may be invited to participate in counseling sessions as a way to provide collateral data. This is sometimes called "network therapy."

Confront.

In confronting antisocial patients, therapists can be direct without being abusive. They can be clear in pointing out antisocial thinking patterns. They can remark on contradictions between what patients say and what patients do. Random AOD testing is essential for monitoring patients. Honest reporting of AOD use should be an active part of treatment.

Consequences.

Patients should bear the consequences of their behavior. For instance, violation of probation or rules should be recorded. Patients who are offenders should be encouraged to report behavior that violates probations, thus taking responsibility for their own actions. Positive consequences that demonstrate to patients the benefits of appropriate behavior should also be designed and incorporated into the treatment plan. Financial incentives and opportunities for power or recognition can be a key element of treatment.

Case management may involve coordinating care with a variety of other professionals and individuals, including those in the criminal justice system, AOD counselors, and family members. Therapists need to make it clear to patients that the therapist must talk to other providers and to family members. Thus, it is helpful for patients to sign releases of information for all people involved in their treatment.

The question of terminating therapy can be a puzzling one for therapists treating antisocial patients. The patient may frequently express a desire to end treatment. This desire should be closely examined to determine whether it is a manifestation of patient resistance or whether it is a valid request. There is some question about whether it is appropriate to terminate therapy with patients who have antisocial personality disorder who may need ongoing treatment. Reasons for termination may include noncompliance with treatment, continued drug use without improvement, any aggressive behavior, parasitic relationship with other patients, or any unsafe behavior.

Patients with antisocial personality disorder compulsively try to break rules. If a treatment plan is not devised to work with a person who wants to redefine rules, termination should be considered and transfer to more appropriate care should be arranged.

Continued thinking-error work, as described in Exhibit 7-4, may help patients to identify various types of rationalizations that they may use regarding their behaviors.

Group Therapy

Group therapy is a useful setting in which people with antisocial personality disorder can learn to identify errors not only in their own thinking, but in the thinking of others. The group can help identify relapse thinking. For example, when an individual begins to glamorize stories of AOD use or criminal and acting-out behaviors, the group can help to limit that grandiosity. Therapists may also ask people with antisocial personality disorder to discuss feelings associated with the behavior being glamorized.

Role play exercises can be useful tools in group therapy. However, therapists should be careful to prevent patients with antisocial personality disorder from using newly learned skills to exploit or control other group members. In group therapy, patients with antisocial personality disorder can be encouraged tomodel prosocial behaviors and learn by practicing them. Role play exercises can help these patients to focus on their shortcomings rather than on the faults of others.

AOD therapists should avoid creating groups that consist entirely of patients with antisocial personality disorder. Such groups are best conducted in very controlled settings in which therapists have control over the environment.

Patients with antisocial personality disorder may be asked to sign contracts that establish healthy and nonparasitic relationships with other group members. This means not becoming romantically involved with other members, not borrowing money from them, and not developing exploitive relationships.

Therapists themselves should try not to become obsessed with being manipulated or tricked by group members. Such power struggles are not helpful.

Counseling Tips for Patients With Antisocial Personality Disorder

Corral:	• Coordinate treatment. • Communicate with other providers. • Make contracts with patients.
Confront:	• Be direct, not abusive. • Identify antisocial thinking. • Conduct random AOD testing.
Consequences:	• Make patients responsible for their behavior. • Record violations of rules. • Allow patients to experience consequences of their behavior. • Designate positive consequences of good behavior.

Continuum of Care

A key to treating people with antisocial personality disorder is to be flexible within an array of containment interventions. Therapists should have the ability to quickly move a patient from a less controlled environment to a more controlled environment. Patients benefit from sanctions that match the degree of severity of behavior. Sanctions should not be "punishments" but responses to the need for containment and more intensive treatment. Antisocial patients need a range of treatment and other services: from residential to outpatient treatment, from vocational education to participation in long-term relapse prevention support groups, and from 12-step programs to jail.

When patients with antisocial personality disorder shed aspects of the disorder, they may become more dependent. Therapists often try to limit such dependence. However, with regard to antisocial patients, such a transition should be allowed rather than confronted. It often represents a healthy change. Feelings of dependency are easily frustrated at this stage, and disappointment may result in relapse.

Case Example

Mark was 27 years old when he was arrested for driving while intoxicated. Mark presented himself to the court counselor for evaluation of possible need for AOD treatment. Mark was on time for the appointment and was slightly irritated at having to wait 20 minutes due to the counselor's schedule. Mark was wearing a suit (which had seen better days) and was trying to present himself in a positive light.

Mark denied any "problems with alcohol" and reported having "smoked some pot as a kid." He denied any history of suicidal thinking or behavior except for a short period following his arrest. He

acknowledged that he did have a "bit of a temper" and that he took pride in the ability to "kick ass and take names" when the situation required. Mark denied any childhood trauma and described his mother as a "saint." He described his father as "a real jerk" and refused to give any other information.

In describing the situation that preceded his arrest, Mark tended to see himself as the victim, using statements such as "The bartender should not have let me drink so much," "I wasn't driving that bad," and "The cop had it out for me." Mark tended to minimize his own responsibility throughout the interview. Mark had been married once but only briefly. His only comment about the marriage was, "She talked me into it but I got even with her." Mark has no children and currently lives alone in a studio apartment. Mark has attended two meetings of Alcoholics Anonymous "a couple of years ago before I learned how to control my drinking."

Question -- What might the court counselor recommend to the judge as an appropriate treatment plan for Mark?

Exhibit 7-5 shows a treatment tool for use with patients who have antisocial personality disorder.

Narcissistic Personality Disorder

Engagement

In trying to engage and assess patients, therapists should remember that patients with narcissistic personality disorder will have certain traits that should be addressed therapeutically. Therapists should try to join with patients' hypersensitivity and need for control by saying such things as "I'm impressed with what a bright and sensitive person you are. If we work as a team, I think we can help you get out of this spot."

Patients with narcissistic personality disorder often have a need to be the center of attention and to control events. They crave affection and admiration from others. They are perfectionists (about themselves). They may try to create dramatic crises to obtain attention to return the focus to themselves. As with patients with antisocial personality disorder, entitlement issues are very important. Patients with narcissistic personality disorder feel as if everyone and everything owes them -- without any contribution on their part.

It is helpful for therapists to work with these personality traits in therapy. Working with narcissistic motivations for recovery, such as an improved appearance or a desire to continue in a job or to make romantic and sexual conquests, may help the patient to change inappropriate behaviors. Therapists may benefit from working with, rather than against, ego inflation. Therapists who try to squelch the narcissistic ego may be met with rage. Therapists should position themselves as trying to help the narcissistic patient reach his or her goals.

Therapists may work with patients to identify thinking errors that interfere with the patient's ability to work. These errors may include beliefs such as "Everybody loves me." Therapists may need to work with patient's victim-stance thinking. An example of such thinking is "Everybody is out to get me." The antisocial thinking-error work described in the previous section (see Exhibit 7-4) can be a very effective tool for working with the narcissist.

To manage narcissistic rage and depression, therapists may contract for patient safety as well as for the safety of others. The therapist may offer the patient a combination of empathy and reality testing. For example, when patients say, "Everything is messed up," or "Everybody is causing me trouble," therapists may empathize with patients, while also indicating the reality of the situation and the need for

behavior change.

Assessment

Some examples of items to cover during the assessment include:

- A psychosocial history, including early childhood beliefs with regard to looks, behaviors, and thoughts
- A history of AOD use
- A sexual history to identify the ability to be empathic with partners
- Early Memory Procedures test (EMP)
- CAGE questionnaire
- Millon Clinical Multiaxial Inventory (MCMI-II)
- California Personality Inventory (CPI).

Crisis Stabilization

Therapists may need to assess patients' defenses, and to put those defenses to therapeutic use. For example, when a patient blames the police for "setting me up," the therapist can mention that the best way to avoid being set up again is to not drink and drive.

Patients with narcissistic personality disorder have a central concern with being perfect. For these individuals, the disease concept approach can assist in recovery by removing blame from the patient and conceptualizing the illness as a biochemical disorder. This can help to lessen the feelings of failure which can be a barrier to treatment.

People with narcissistic personality disorder may become depressed when they feel deeply wounded, when their systems have failed them, and when they sense that their world is falling apart. When wounded, they are at the highest risk for acting out against themselves and others. When in a narcissistic rage, patients may become homicidal, feeling a need to seek revenge. This rage comes from the intensity of the narcissist's wound. The counselor needs to work carefully with this rage and to avoid getting into power struggles.

When these patients are in suicidal crises, patients should sign contracts for safety. Safety may include brief psychiatric hospitalizations that are goal oriented and designed for stabilization.

When working with HIV-positive patients with narcissistic personality disorder, therapists may establish contracts with them to engage in safer-sex practices. Often sexual prowess is part of the narcissistic ego-inflation. Their need to see themselves as great lovers, coupled with self-centeredness, puts them at high risk for sexually transmitted diseases.

Longer-Term Care

Individual Counseling

There will be an ongoing need to manage the rage and depression of patients with narcissistic personality disorder and their need for attention, control, and admiration. Continued attention to self-centeredness and the need to work the 12 steps is essential. Step work designed for people with antisocial personality disorder (as previously described in Exhibit 7-5) can be helpful for patients with narcissistic personality disorder. Similarly, the individual and group approaches to the treatment of patients with antisocial personality disorder can be used for patients who have narcissistic personality disorder. Indeed, it may be helpful to view the patient with narcissistic personality disorder as a hypersensitive patient

with an antisocial personality disorder.

Group Therapy

People with narcissistic personality disorder may benefit from group therapy. In group therapy, therapists may need to set time limits in a firm but pleasant manner, pointing out the need for all patients to have group time. At the start of each session, therapists should make a contract with patients with narcissistic personality disorder to encourage prosocial behaviors and to avoid attempts to dominate, control, or compete for attention with other group members. Some behaviors to contract for might include:

- To limit the time that they can speak during group sessions
- To not interrupt others while they speak
- To respect other group members' time and feelings
- To give responses to other group members
- To receive responses and feedback from others.

It is important not to smash the narcissistic ego or to attack the narcissistic patient within the group. It is more useful to comfort and confront the narcissist simultaneously: "I understand that the part of you that is sensitive is wounded to hear that the group does not believe everything you are saying." Continue to work with the narcissist's defenses, not against them.

Continuum of Care

For patients with narcissistic personality disorder, the least restrictive treatment environment is preferable. It permits patients to feel that they are in control. These patients should be moved quickly from inpatient to outpatient levels of care. If they do not like the treatment, they will stop participating. Thus, it is critical not to overpathologize the patient's disorder with constant criticism. However, acute hospitalization for psychiatric emergencies (such as homicidal or suicidal plans) may be necessary.

Narcissistic patients generally enjoy the attention they receive through involvement in outpatient treatment; retention in the program is easily accomplished. Long-term outpatient involvement is critical to maintain narcissistic patients' prosocial behavior and sobriety. Therapists who strive to build narcissistic patients' strengths and who pay close attention to them in therapy will find them active participants in the recovery process. In addition to their personality disorder and AOD use disorder, some patients may engage in compulsive sexual or spending behaviors that should be addressed therapeutically.

Tip for Narcissistic Patients

A helpful exercise for patients with narcissistic personality disorder is to ask them not to say anything during a specific number of 12-step or self-help groups, but to simply listen. Once this has been done, narcissistic patients should discuss their feelings with the therapist in response to the exercise.

Case Example

Bill is a 45-year-old male who was referred by his employer to the company's employee assistance program (EAP). The employer was concerned about Bill's temper, his difficulty accepting criticism, and his difficulty in getting along with other staff. At the EAP appointment, Bill's appearance was that of an extremely well-groomed man who paid exceptional attention to his dress and attire. His manners were impeccable, although he was critical of the receptionist at the EAP's office for not offering him coffee when he came in. Bill was friendly but cool toward the EAP counselor, tending to gloss over the importance of his boss's concerns.

When the EAP counselor asked him for more specifics about his problems with his coworkers, Bill became extremely defensive and hammered away in a raging attack on his coworkers and their jealousy of his success. Bill felt that his boss was a well-intentioned but incompetent person who frequently

made mistakes. Bill also felt that his boss didn't appreciate the caliber of his work or the time he put into his work. Bill took pride in his perfectionism, attention to detail, and firm and inflexible beliefs.

Bill was not married, although he reported that he had come close a few times only to discover that these women had "fooled him" in one way or another. Bill reported to have only one male friend and indicated that he much preferred the company of women to men. Bill denied having any "problem with drugs" but did indicate that he uses marijuana and cocaine recreationally. Bill reported using alcohol most weekends and occasionally drinking to the point where he "forgot" what happened.

Question -- What should the EAP counselor suggest as a treatment plan to address employer concerns over Bill's behavior?

Passive-Aggressive Personality Disorder

Engagement

As in working with all patients with personality disorders, therapists should attempt to join with the world-view of patients with passive-aggressive personality disorder, rather than work against it. Therapists may try to work with patients' need for safety and with their ambivalence toward recovery. Therapists should work with patients' indirect displays of anger and assertiveness.

Passive-aggressive patients try to avoid commitment and responsibility. All interventions should be focused on the patient's needs, wants, and desires, a strategy that promotes treatment compliance.

Assessment

Areas to address in the assessment include the following:

- Survival skills and self-care assessment
- Monitoring of use of over-the-counter drugs, such as NyQuil, Dexatrim, Benadryl, niacin, laxatives, and tryptophan (somatic illnesses are often medicated with these chemicals)
- Information on all other professionals and medical providers being seen for treatment
- Psychosocial and AOD history, and mental status
- Coexisting anxiety disorders
- Medication evaluations for antidepressants or other nonaddictive substances
- Identification of the patient's typical passive-aggressive maneuvers or "scripts."

Useful assessment instruments include the MMPI, CAGE, or MAST, to assist clinical review and/or to evaluate substance abuse.

Crisis Stabilization

Often, several issues must be managed during crises experienced by patients with passive-aggressive personality disorder, such as responses to abusive relationships, obtaining safe housing, and receiving emergency psychiatric admissions for suicidal crises. These patients may need to be detoxified from benzodiazepines and other sedative-hypnotics. To manage various crises, therapists may need to insist that patients provide release of information authorizations for all providers of care. This can help the therapist to coordinate services. Verifying all prescribed medications can prevent medical emergencies and improve patient responsibilities.

Longer-Term Care

Patients who have AOD use disorders that involve prescription drugs will find it helpful to inform their prescribing physicians of their involvement in treatment and recovery efforts. This helps to stop the supply of psychoactive medications, to learn assertive behavior, and to teach personal responsibility for recovery.

Patients with passive-aggressive personality disorder require skill building in several areas including: assertiveness, boundary setting, anger management, and identifying and expressing their feelings directly. They will also need to work through sexual intimacy problems. This might be done in a same-sex group, individual therapy, or marital or couple therapy. Treatment planning should include goals and objectives that are reasonable and measurable. For example, a goal may be set to increase the length of time during which a patient is abstinent between relapse episodes. An excellent focus for the skill-building part of therapy is developing the ability to express anger through assertiveness rather than through indirect acting out.

Passive-aggressive patients may engage in compulsive behaviors including eating disorders and compulsive shopping and spending; money management problems, as well as AOD relapse, may also occur. Throughout treatment, therapists should continue to monitor the patient's use of alcohol, prescribed and over-the-counter medications, and other drugs.

Individual Counseling

In individual therapy, therapists may help patients to express their emotions directly. Therapists can encourage patients to process comments made when the patient appears to be passive or disinterested in the process. Therapists can prompt patients to express their needs, wants, and desires directly without waiting until a later session. Therapists can use written and verbal contracting as an ongoing therapeutic method. Therapists should not apologize for setting and enforcing limits and reinforcing boundaries between the passive-aggressive patient and the program staff.

Group Therapy

Patients with passive-aggressive personality disorder should be encouraged to join same-sex support groups. This helps them identify strongly with same-sex peers and prevents relationships built on a mutual need to avoid recovery. Group therapy sessions provide patients an opportunity to develop ways to manage hostility.

When hostility manifests itself during group sessions, therapists may manage it by commenting on the hostile behavior, asking other group members to comment, and asking the patient to respond. The therapist may then quickly assess the patient by asking: What do you need? Who can you ask for it? When can you ask for it? The patient can then rehearse appropriate behavior in group.

Parents can be taught not to assume these dysfunctional roles. Patients who are also parents may need to be taught parenting skills to help them avoid creating destructive relationships with their children. Passive-aggressive parents need direct methods for dealing with their children's behavior so that children do not develop personality and emotional problems themselves. Children raised by parents who are overcontrolling, unpredictable, and hostile can develop antisocial or dissociative defenses and styles.

Once patients with passive-aggressive personality disorder have managed to work through primary issues, therapists may want to use opposite-sex models who can demonstrate appropriate types of behavior. Learning how to set limits on opposite-sex facilitators helps with generalization of newly learned skills.

Twelve-Step Work

Control is an essential feature of the passive-aggressive personality. Therapeutic work that centers on step one of the 12 steps can be helpful. Therapists should remember to emphasize that patients can gain certain types of control by

giving up other kinds of control. Step work discussed in the section on borderline personality disorder (Exhibit 7-2) can be helpful.

Patients may benefit from participation in 12-step programs for their AOD problems and for relationship dependencies and conflicts. Patients should be educated about avoiding romantic involvement with other group participants, and especially escaping a bad relationship by becoming involved in a new relationship.

Continuum of Care

Inpatient hospitalization may be necessary for detoxification of patients who have AOD use disorders that involve sedative-hypnotics such as the benzodiazepines. Ongoing therapy for substance use and psychiatric issues can be done on an outpatient basis with a combination of individual same-sex group therapies and integration into 12-step or self-help recovery groups.

Brief inpatient psychiatric stays may also be necessary to deal with psychiatric emergencies such as overwhelming depression, anxiety, or suicidal ideation or behavior.

Patients may need assistance to locate shelters and safe housing when domestic violence is a problem or threat. A primary care physician is essential so that medical management can be provided and coordinated with psychosocial treatment. A complication to recovery for many passive-aggressive patients may be compulsive eating or spending problems. Ongoing assessment and treatment of these issues as part of the overall treatment plan are encouraged.

Case Example

Jane was 37 when she sought marriage counseling with Dr. Myers. She attended the initial appointment with her husband. Both Jane and her husband were vague and nonspecific about what they needed from couple counseling. Jane was quiet until the last 10 minutes of the appointment when she started crying, stating that "nothing was going to help." Jane's husband, confused but accommodating, tried unsuccessfully to comfort Jane who withdrew to a chair in the corner of the office, refusing to talk. Dr. Myers contracted with Jane to meet with her individually for three sessions to assist in developing a better understanding of her unhappiness and frustration in the marriage. Both Jane and her husband agreed.

Jane attended the first session on time and was "ready to get to the bottom of this problem." Jane openly discussed her own "dysfunctional family," discussing parents who were both alcoholic and physically abusive. Jane discussed her difficulties dealing with feelings of depression and fear. Jane further reported how frustrated and upset she got whenever her husband criticized her or when he was angry at her.

Jane reported having thoughts of suicide, although there was no plan or history of any attempts. Jane found it helpful to have a "glass of wine" when anxious and reported to have a prescription medication that she can take for "her nerves" when she gets overwhelmed.

Further discussion revealed Jane to be getting a prescription for alprazolam (Xanax) from her family doctor. She was vague about how much alprazolam she used but said she took it "several times a week." Jane complained about recent weight gain. She felt if she could get her weight under control, "everything else would be fine." Jane reported to be drinking only juices and coffee and using over-the-counter diet pills when she got too hungry. She was somewhat defensive about her drinking and use of medications and preferred to discuss issues related to her husband. At the end of the session, she commented, "I hope this helps my marriage and my husband's drinking" and she left. Jane missed the second appointment, calling 3 days later stating she had "forgotten about the appointment." Jane attended the third appointment but was 25 minutes late.

Question -- What should Dr. Myers' treatment plan consist of and what should she do next?

Tips for Use With Passive-Aggressive Patients

To show patients the effect of letting hostilities and needs build up internally, the therapist can blow up a balloon until it nearly bursts, letting it fly around the room. This demonstrates visually what it is like to let overwhelming feelings build up. The therapist should be willing to sit in silence, forcing the patients to respond. Watch for patients enabling other group members' codependency. Relationship issues are a cornerstone of the passive-aggressive patient's problems.

Coordination of Care

Work With Other Parties

It is easy for therapists to assume dysfunctional roles with patients who have personality disorders. Also, because of the chaos that may accompany treatment, important patient information may be missed. Maintaining ongoing and up-to-date contacts is essential for all patients with personality disorders. The following are tips to remember in coordination of care of patients with personality disorders.

Primary case manager.
Frequently, patients with personality disorders have many different people and systems in their lives. The identification of one key person as a gatekeeper for information can greatly improve coordination of care and reduce interagency conflicts.

Legal issues.
Providers should obtain releases of information to monitor any new involvement in the criminal justice system or to be aware of the disposition of old charges. Issues of divorce and child custody may need to be monitored in the sessions, with the goal of having the patient spend an appropriate amount of session time on these topics.

Managed care.
Typically, managed care does not provide benefits for patients with personality disorders. Many patients with personality disorders also meet criteria for psychiatric disorders such as depression or anxiety. Brief stays in hospitals and limited insurance coverage need to be realistically evaluated so treatment goals match benefits and assets available for care.

Funding issues.
Reimbursement for the treatment of patients with dual disorders may not include patients who have personality disorders. Often, a coexisting diagnosis of depression or anxiety is appropriate. For billing or funding purposes, listing the AOD problem as the primary illness may be an option.

Staffing and cross-training.
All staff benefit from training in AOD treatment in general, and in working with AOD-using patients with personality disorders in particular. Integrated treatment for coexisting disorders is most effective.

Medical issues.
Patients participating in inpatient AOD treatment should have a complete physical examination. Outpatients should have a current (within past 30 days) physical examination on file. Physical examinations are particularly important for patients who have coexisting medical problems or who are HIV positive. HIV testing should be encouraged.

Integration into 12-step self-help groups.
It is important to encourage 12-step participation as a means of ensuring long-term recovery. Therapists and patients should discuss patients' objections to participation in these self-help group meetings. Patients should be encouraged to find 12-step groups with which they are comfortable.

Chapter 8 – Psychotic Disorders

Dual-Focus Perspective

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This chapter is an overview of current assessment and treatment principles for patients with alcohol and other drug (AOD) use disorders and psychosis. Along with an increased awareness of the treatment needs of patients with these dual disorders, an increased emphasis on service systems has evolved. These and other forces have prompted the need to reassess traditional models and service approaches to develop assessment and treatment strategies that meet the specific needs of patients with AOD use disorders and psychosis.

All too often, AOD use disorders are undetected in patients with psychotic disorders, and traditional treatment approaches are often inadequate. For example, attempts have been made to treat psychotic and AOD use disorders in a sequential manner, treating one disorder first and then the other. While a single-focus approach is helpful for differential diagnosis, and is effective in treating some patients, it is frequently unsuccessful for patients with AOD problems who have severe and recurrent psychotic episodes. This chapter provides an overview of a dual-focus approach to the assessment and treatment of patients with these dual disorders. A single-focus approach emphasizes the importance of developing a diagnosis and subsequent treatment plan -- such as is done when treating patients who have a single disorder. In a dual-focus approach, the emphasis is not on making a diagnosis, but rather on 1) the severity of presenting symptoms, 2) crisis intervention and crisis management, 3) stabilization, and 4) diagnostic efforts within the context of multiple-contact, longitudinal treatment. By concentrating on symptoms, crisis management, and stabilization, clinicians can simultaneously focus on patients' treatment needs that are caused by both the psychotic and AOD use disorders, rather than focusing on one disorder or the other.

Dual-Focus Approach for Assessing and Treating Patients with Dual Disorders

- Initial focus on severity of presenting symptoms, not on diagnosis of one disorder or another
- Acute crisis intervention and crisis management
- Acute, subacute, and long-term stabilization of patient
- Ongoing diagnostic efforts
- Multiple-contact longitudinal treatment.

Definitions and Diagnoses

The term *psychosis* describes a disintegration of the thinking process, involving the inability to distinguish external reality from internal fantasy. The characteristic deficit in psychosis is the inability to differentiate between information that originates from the external world and information that originates from the inner world of the mind (such as distortions of normal thinking processes) or the brain (such as abnormal sensations and hallucinations).

Psychosis is a common feature of schizophrenia. Psychotic symptoms are often a feature of organic mental disorders, mood disorders, schizophreniform disorder, schizoaffective disorder, delusional (paranoid) disorder, brief reactive psychosis, induced psychotic disorder, and atypical psychosis.

Schizophrenia is best understood as a group of disorders with similar clinical profiles, invariably including thought disturbances in a clear sensorium and often with characteristic symptoms such as hallucinations, delusions, bizarre behavior, and deterioration in the general level of functioning.

Severe disturbances occur with relation to language and communication, content of thought, perceptions, affect, sense of self, volition, relationship to the external world, and motor behavior. Symptoms may include bizarre delusions, prominent hallucinations, incoherence, flat affect, avolition, and anhedonia. Functioning is impaired in interpersonal, academic, or occupational relations and self-care.

Schizophrenia can be divided into subtypes: 1) in the paranoid type, delusions or hallucinations predominate; 2) in the disorganized type, speech and behavior problems predominate; 3) in the catatonic type, catalepsy or stupor, extreme agitation, extreme negativism or mutism, peculiarities of voluntary movement or stereotyped movements predominate; 4) in the undifferentiated type, no single clinical presentation predominates; and 5) in the residual type, prominent psychotic symptoms no longer predominate. The diagnosis of schizophrenia requires a minimum of 6 months' duration of symptoms, with active psychotic symptoms for 1 week (unless successfully treated).

Clinicians generally divide the symptoms of schizophrenia into two types: positive and negative symptoms. Acute course schizophrenia is characterized by positive symptoms, such as hallucinations, delusions, excitement, and disorganized speech; motor manifestations such as agitated behavior or catatonia; relatively minor thought disturbances; and a positive response to neuroleptic medication.

Chronic course schizophrenia is characterized by negative symptoms, such as anhedonia, apathy, flat affect, social isolation, and socially deviant behavior; conspicuous thought disturbances; evidence of cerebral atrophy; and generally poor response to neuroleptics. In general, acute substance-induced psychotic symptoms tend to be positive symptoms. .

Schizophreniform disorder is a condition exhibiting the same symptoms of schizophrenia but marked by a sudden onset with resolution in 2 weeks to 6 months. Some patients exhibit a single psychotic episode only; others may have repeated episodes separated by varying durations of time.

Schizoaffective disorder is a condition that includes persistent delusions, auditory hallucinations, or formal thought disorder consistent with the acute phase of schizophrenia, but the condition is also frequently accompanied by prominent manic or depressive symptoms. Schizoaffective disorder is further divided into bipolar (history of mania) and unipolar (depression only) types. .

Delusional disorders are characterized by prominent well-organized delusions and by the relative absence of hallucinations; disorganized thought and behavior; and abnormal affect. The delusional disorders are divided into six types: persecutory, grandiose, erotomanic, jealous, somatic, and unspecified.

Brief reactive psychosis describes a condition in which an individual develops psychotic symptoms after being confronted by overwhelming stress. The onset of symptoms is abrupt, without the gradual symptom development often seen in schizophrenia or schizophreniform disorder, and the duration is brief (no longer than 1 month). .

Induced psychotic disorder describes a disorder characterized by the uncritical acceptance by one person of the delusional beliefs of another. In other words, a dominant partner has a delusional psychosis that is believed and accepted by a passive partner.

Substance-Induced Disorders

AOD-induced psychotic disorders are conditions characterized by prominent delusions or hallucinations that develop during or following psychoactive drug use and cause significant distress or impairment in social or occupational functioning. This disorder does not include hallucinations caused by hallucinogens in the context of intact reality testing.

Although there can be great variability in individual susceptibility to AOD-induced psychotic symptoms, it is important for the clinician to determine if the presenting symptoms could plausibly be induced by the type and amount of drug apparently consumed. For example, vivid auditory, visual, and

tactile hallucinations are plausible side effects of a 5-day, high-dose cocaine binge. However, should these symptoms emerge during a brief episode of mild alcohol intoxication, it is likely that the symptoms represent an underlying psychotic process that has been exacerbated by the use of alcohol.

Stimulant-Induced Symptoms

Psychotic symptoms induced by *stimulant intoxication* are unusual when stimulants are used in low doses and for brief periods. Acute stimulant intoxication in the context of a chronic, high-dose pattern can cause symptoms of psychosis, especially if coupled with a lack of sleep and food and environmental stressors. Stimulant-induced psychotic symptoms can mimic a variety of psychotic symptoms and disorders including delirium, delusions (often persecutory and paranoid), prominent hallucinations, incoherence, and loosening of associations. Stimulant delirium often includes formication, a tactile hallucination of bugs crawling on or under the skin.

Depressant-Induced Symptoms

Particularly when unmedicated, *sedative-hypnotic withdrawal* can include symptoms of psychosis. Acute withdrawal from alcohol, barbiturates, and the benzodiazepines can produce a withdrawal delirium, especially if use was heavy and tolerance was high or if the patient has a concomitant physical illness. Hallucinations and delusions are common features of sedative-hypnotic withdrawal delirium.

Psychedelic- and Hallucinogen-Induced Symptoms

Many psychedelic drugs, such as the amphetamine-related psychedelics (for example, MDMA and MDA), are not hallucinogenic at the lower doses associated with situational psychedelic drug use. However, in a chronic, high-dose pattern of use (which is rare), psychotic symptoms are possible, by virtue of the drugs' stimulant properties. Other psychedelic drugs, such as LSD, have strong hallucinogenic properties.

Hallucinogen intoxication can cause hallucinogenic hallucinosis, characterized by perceptual distortions, maladaptive behavioral changes, and impaired judgment. Hallucinogen intoxication may also prompt hallucinogenic delusional disorder and a hallucinogenic mood disorder. However, hallucinogen-induced perceptual distortions such as hallucinations or visions are not considered evidence of psychosis when the drug user retains reality testing and is aware that the distortions are drug induced. *Acute marijuana intoxication* can produce a delusional disorder that may include persecutory delusions, depersonalization, and emotional lability. Similarly, *acute PCP intoxication* can lead to delirium, delusions, or a PCP-induced mood disorder.

Prevalence

Various studies have noted that the lifetime prevalence rate for schizophrenia is roughly 1 percent among the general population (Africa and Schwartz, 1992). In the Epidemiologic Catchment Area (ECA) studies, the prevalence rate for schizophrenia and schizophreniform disorders combined were as follows: 1) 1-month prevalence rate: 0.7 percent; 2) 6-month prevalence rate: 0.9 percent; and 3) lifetime prevalence rate: 1.5 percent (Regier et al., 1988).

The ECA studies reported that the lifetime prevalence rate of schizophrenia was 1.5 percent, and the 6-month prevalence rate was 0. 8 percent. The lifetime and 6-month prevalence rates of schizophreniform disorder were both 0.1 percent (Regier et al., 1990).

Clinical observation of high rates of AOD use disorders among patients with schizophrenia were supported by the ECA studies. Among individuals identified as having a lifetime diagnosis of schizophrenia or schizophreniform disorder, 47 percent have met criteria for some form of an AOD use disorder. Indeed, the odds of having an AOD use disorder are 4.6 times greater for people with schizophrenia than the odds are for the rest of the population: the odds for alcohol use disorders are over three times higher, and the odds for other drug use disorders are six times higher (Regier et al., 1990).

One study noted that among patients with AOD use disorders, 7.4 percent had a lifetime diagnosis of schizophrenia; the 1-month prevalence rate was 4.0 percent (Ross et al., 1988), although other studies

of persons in AOD abuse treatment found the prevalence of schizophrenia to be about the same as in the general population -- about 1 percent (Rounsaville et al., 1991). While patients with AOD use disorders may experience acute episodic psychotic symptoms, few meet the diagnostic criteria for schizophrenia if AOD-induced symptoms are excluded.

Among severely mentally ill outpatient treatment populations, AOD use disorders are common; often more than 50 percent have AOD use disorders, depending upon the treatment setting. Among patients being treated for psychiatric problems in acute settings such as inpatient hospitals, combined psychiatric and AOD use disorders are also common.

Among patients with combined psychotic and AOD use disorders, bizarre behavior and communication generally prompt a mental health referral. Thus, people with psychotic disorders usually receive services through the mental health system and are rarely treated in the typical addiction treatment program.

Lifetime Prevalence Rates

- Among the general population, 1 percent have a schizophrenic disorder.
- Among schizophrenic patients, 47 percent have an AOD use disorder.

Case Examples

The following three case examples can help to demonstrate the need for a dual-focus approach to treating patients with combined psychotic and AOD use disorders, or patients with psychotic symptoms and AOD use disorders.

Martha

Married for over 15 years, Martha was responsible for most of the duties related to raising four children and maintaining the home. In the past, she had been treated for an episode of postpartum psychosis. Until recently, she had not required any psychiatric medications or mental health services.

Her husband, a successful businessman, was the family's only source of financial support and was emotionally distant. While Martha believed that her husband was frequently out of town on business trips, he was actually nearby having an affair with a woman whom Martha had known for many years. One day, he abruptly informed Martha of the affair and moved out of the house.

During the next 3 days, Martha was intensely depressed and agitated. Her normally infrequent and low-dose alcohol use escalated as she attempted to diminish her agitation and insomnia. During this time, she ate and slept very little. She began to feel extremely guilty for even the smallest problem experienced by her four children. She felt burdened by what she called her "transgressions, faults, and sins." She expressed fears about being doomed to "eternal damnation." Loudly and inconsolably, she declared that she "had lost her soul" and would have to repent for the rest of her life. While being taken to a nearby clinic for evaluation, she passionately described a conspiracy by members of the Catholic Church to steal her soul.

Thomas

In his inner-city neighborhood, Thomas is well known by the local medical clinic, AOD treatment program, and community mental health program. During the day, he spends much of his time walking around the neighborhood, frequently talking to himself or arguing with an unseen individual. He spends most of his evenings in the park in a wooded area away from other people, except in the winter when he sleeps in community-run shelters.

Thomas has a prominent scar in the center of his forehead. When asked about it, he describes in great detail his "third eye," and the fact that he can see into the future through the eye. When asked about his

stated reluctance to live in an apartment, he describes an aversion to "electromagnetic fields" that drain his "life force" and make it difficult for him to "think about good things." For extended periods lasting several months, Thomas appears disheveled and agitated, and can be seen drinking heavily or using whatever drugs are available.

However, he also experiences prolonged periods during which he does not drink or use other drugs, appears well groomed, and exhibits less severe psychotic behavior. In general, Thomas is pleasant and well liked, although he is known to become hostile and potentially violent during periods when he uses AODs.

Laura

During a rock concert, Laura was brought by her boyfriend Morris to the paramedics at a first aid station in a large auditorium. Morris described Laura's gradual deterioration over a 1-hour period. At first, Laura displayed abrupt shifts in affect, giddy and laughing one moment and agitated and impulsive the next. Morris said that she began "talking crazy" and not making much sense. He also mentioned that Laura had brief bursts of absolute terror lasting a few seconds or minutes, during which he had to stop her from running away. Morris believed that she was responding to hallucinations. He said that Laura stopped speaking and appeared to have lost the ability to do so. Later, she had a hard time walking and tried to crawl away from Morris. By the time that the paramedics were able to examine her, Laura was rigid, immobile, mute, and unable to communicate with others. Later, Morris admitted that they had used some PCP.

Case Example Discussion

As can be seen, Martha, Thomas, and Laura have very different long-term needs. Martha's brief reactive psychosis and depression may never recur, and the relationship between her alcohol use and psychiatric symptoms should be explored. Thomas's chronic psychosis and frequent AOD abuse episodes are intricately woven together and require combined treatment. Until Laura's boyfriend provided information about Laura's acute drug use, the reason for her psychotic episode was unclear.

These case examples are valuable to demonstrate how the absence of a dual-focus approach can lead to treatment failure. While Martha's psychotic episode was related to overwhelming stress, her alcohol use might be underemphasized in a traditional mental health setting. Doing so may obscure the possibility that her drinking severely deepened her depression, increased daytime agitation, and exacerbated the psychotic episode.

While Thomas has an ongoing psychosis and AOD abuse problems, focusing on only one set of these problems means that he bounces back and forth between the mental health and addiction treatment programs, depending upon his current symptoms. His involvement with the local medical clinic for treatment of physical injuries that are sustained during episodes of impaired thinking often complicates his already uncoordinated treatment.

While Laura's drug-induced psychosis may fade as the drug is eliminated from her body, the episode can be used as a point of entry into AOD abuse treatment. Also, her immediate needs will be the same irrespective of the cause of her psychotic episode.

As these case examples illustrate, patients who experience psychosis and AOD use problems are often highly symptomatic and may have multiple psychosocial and behavioral problems. It is common for patients with dual disorders to have undergone different approaches to treatment by different providers without long-term success. Furthermore, clarifying the diagnosis and "underlying disorder" is extremely complicated in the early phases of assessment. The first step in treatment of a person with a dual disorder is an assessment that addresses biological, psychological, and social issues.

Acute Assessment

A common difficulty that clinicians experience is determining whether psychotic symptoms represent a primary psychiatric disorder or are secondary to AOD use. However, in the early phase of assessment, the goal is to stabilize the crisis rather than to establish a final diagnosis. The final diagnosis is often best determined during a multiple-contact, longitudinal assessment process. All assessments include direct client interviews, collateral data, client observations, and a review of available documented history.

Assessment of High-Risk Conditions

The initial step of every assessment is to determine whether the individual has an imminent life-threatening condition. There are three domains of high risk that require assessment: biological (or medical), psychological, and social. At any given time, one aspect of this biopsychosocial approach may be more urgent than the others.

Medical Risks

With regard to medical or biological issues, the goal of assessment is to ensure that patients do not have life-threatening disorders such as AOD-induced toxic states or withdrawal, delirium tremens, or delirium. Also, patients may be exhibiting symptoms that represent an exacerbation of their underlying chronic mental illness. The symptoms may be due to an aggravation of medical problems such as neurological disorders (for example, brain hemorrhage, seizure disorder), infections (central nervous system infection, pneumonia, AIDS-related complications), and endocrine disorders (diabetes, hyperthyroidism). The presence of cognitive impairment (such as acute confusion, disorientation, or memory impairment), unusual hallucinations (such as visual, olfactory, or tactile), or signs of physical illness (such as fever, marked weight loss, or slurred speech) show a high risk for an acute medical illness. Patients who exhibit this degree of risk need to be immediately referred for a comprehensive medical assessment.

Psychological Risks

With regard to psychological issues, the primary goal must be an assessment of danger to self or others and other manifestations of violent or impulsive behavior. Patients with a dual disorder involving psychosis have a higher risk for self-destructive and violent behaviors. Patients should be assessed for plans, intents, and means of carrying out dangerous behaviors. Patients who are imminently suicidal, homicidal, or dangerous need to be in a secure setting for further assessment and treatment. In addition, some patients may have cognitive impairment related to their dual disorder and be unable to adequately care for basic needs.

Social Risks

With regard to social issues, the primary goal is to ensure that patients have access to minimal life supports and have their basic needs met. Patients with a dual disorder involving psychosis are particularly vulnerable to homelessness, housing instability, victimization, poor nutrition, and inadequate financial resources. Patients who lack basic supports may require aggressive crisis intervention, such as the provision of food and assistance with locating a safe shelter. Lack of these social supports can be life threatening and can worsen medical and psychiatric emergencies.

Biopsychosocial Assessment of High-Risk Conditions

- Biological risks: Assess for life-threatening medical problems
- Psychological risks: Assess for violent and impulsive behaviors
- Social risks: Assess basic needs and life supports.

High-Risk Probing Questions

To provide a thorough assessment of patients who are experiencing psychotic symptoms, it is important to directly question patients about the three domains of medical, psychological, and social safety.

Medical Safety

In the absence of overwhelming medical and psychiatric crises, the clinician should ask patients a series of questions that relate to medical assessment. One example is: "Have you been diagnosed or hospitalized for any major medical disorders?" Similar questions should address the recent onset of significant medical symptoms, episodes of head trauma or loss of consciousness, prescribed and over-the-counter medications, recent changes in medications, the use of AODs, and nutritional and sleep needs.

In addition, the assessment of medical symptoms should include a thorough cognitive examination of patients' orientation, memory, concentration, language, and comprehension.

Psychological Safety

Psychological safety issues relate to self-destructive and violent behaviors or an inability to care for oneself. The clinician should ask direct questions about plans, means, and intent for violence. Plans include specificity of lethal methods, such as time and place. Means include implements such as medications, ropes, and guns. Intent refers to the desire or explicit goal to end either one's own or another's life.

In particular, patients should be asked about command hallucinations and delusions that direct the person to hurt him- or herself or another. Impaired judgment or cognition that may result in an increased likelihood of impulsive, destructive behaviors.

It is also important to ask patients about their past, and particularly recent, history of violent behaviors, since a history of suicidal and homicidal behaviors is the best predictor of current risk for such behaviors.

Assessing Psychological Safety

- Suicide plans, means, and intent
- Delusions and command hallucinations
- Impulsivity or impaired judgment or cognition
- History of suicidal or homicidal behaviors.

Social Safety

Patients should be asked direct questions about past and current access to basic needs such as food, shelter, money, medication, or clothing. Patients should be assessed for past and recent episodes of victimization and of exchanging sex for money, drugs, and shelter.

Comprehensive Assessment

It is essential to rule out imminently life-threatening medical or AOD-induced emergencies which may be causing or contributing to the psychotic symptoms.

Probing Questions for Psychiatric And AOD Abuse Assessment

Once medical and AOD-induced emergencies have been addressed or ruled out, the focus of probing assessment questions should relate to the severity of presenting behaviors and symptoms rather than to whether symptoms are primary or secondary to AOD use. The focus should be on assessing the severity of the immediate symptoms. With the exception of life-threatening emergencies, the clarification of "primary versus secondary" is an important issue in working with patients who have a dual disorder involving psychosis, but such clarification requires multiple-contact, longitudinal diagnostic differentiation.

Examples of key probing questions for delusions include the following:

- "Do you sometimes feel as if people are talking about you?"
- "Do you sometimes feel as if people are purposefully trying to injure or offend you?"
- "Have you ever felt as if you were receiving special messages through the television, radio, or some other source?"
- "Do you sometimes feel that you have special powers that other people do not have?"

- "Have you ever felt that something or someone outside of yourself was controlling your behavior, thoughts, or feelings against your will?"Examples of key probing questions for auditory hallucinations include:
- "Do you sometimes hear things that other people cannot hear?"
- "During these episodes, what exactly do you hear?"
- "If you heard voices, what were the voices saying?"
- "If you heard voices, did the voices tell you what to do, or criticize your thoughts or behaviors?"
- "How often do you have these experiences?"

Examples of key probing questions for AOD use disorders include:

- "Do you often drink or use other drugs more than you plan to?"
- "Have you made attempts to cut down or stop using alcohol and other drugs?"
- "How much time during the week do you spend obtaining, using, or recovering from the effects of alcohol and other drugs?"
- "Since you began using, have you stopped spending time with family and friends and begun spending more time using alcohol and other drugs or spending more time with people who do?"

It is important to recognize that direct interview questions will be of limited value for some patients in detecting substance use. Patients may underestimate, overestimate, or not recognize the severity or existence of their AOD use disorder.

Standardized Screening and Assessment Measures

There are several standardized instruments for AOD abuse screening and assessment. While valuable for assessing patients with AOD use disorders, these instruments have not been extensively tested among patients with concomitant psychotic and AOD use disorders. However, even brief instruments such as the CAGE questionnaire, the Michigan Alcohol Screening Test (MAST), and case manager rating scales will detect most AOD use disorders in this group.

Such instruments may be unreliable when used with patients who are acutely psychotic or whose residual impairments interfere with their capacity to respond to the interview questions. Since these tools involve self-report interviews, denial mechanisms may also reduce accuracy. Also, instruments that rely heavily on detecting signs of dependency syndromes (such as the Alcohol Dependency Scale) may fail to detect significant numbers of people with dual disorders. This is because even limited AOD use may be extremely problematic for patients with a psychotic disorder.

Especially for patients with psychotic symptoms, clinicians should inquire about the use, frequency, and quantity of all drugs of abuse, not merely alcohol. Also, clinicians can adapt the CAGE questionnaire (see Chapter 3) in such a way that the possible relation-ships between AOD use and psychotic symptoms can be elicited. For example, patients can be asked if they have *cut down* (or increased) their AOD use in relation to hearing "voices" or because of paranoia. They can be asked if they become more or less *annoyed,* angry, or irritable when using AODs. Clinicians can ask patients if they feel *guilty* about using AODs when taking medication, or if their guilt causes them to occasionally stop taking their medication.

Patients can be asked if AODs have been used to diminish the side effects of medications prescribed for psychiatric problems. Also, they should be asked if AOD use or withdrawal has ever been associated with a hospitalization or a suicide attempt. Patients should be asked if the frequency, quantity, and

episode duration of their AOD use has changed and what consequences are associated with these changes.

Standardized assessment measures include the MAST, which has been demonstrated to have value for assessing this group. The Addiction Severity Index (ASI) is an instrument that guides the interviewer through a series of questions about drug use and consequences, as does the American Psychiatric Association's Structured Clinical Interview for DSM-III-R (SCID).

Alternatives to direct interview scales with demonstrated efficacy include case manager rating scales that are based on longitudinal observations of the patient, and aggregate multiple sources of information, including medical records, families, the criminal justice system, employers, landlords, and related sources. The patient's informed consent must be obtained before these contacts are made.

Clinician's Observations

An important aspect of the assessment is the clinician's observations. The clinician should make careful note of the patient's overall behavior, appearance, hygiene, speech, and gait. Of particular interest are any acute changes in these behaviors, as well as the emergence of disorganized or bizarre thinking and behavior. A long-term therapeutic relationship with the patient increases the opportunity to make clinical observations that assist in making the differential diagnosis. Within this context, clinicians can better understand the relationships between the AOD use and the psychiatric symptoms.

Collateral Resources

As previously mentioned, data obtained from direct interviews and self-reports, as well as observational data, are limited. One important way of augmenting these approaches is to obtain information from collateral sources by directly interviewing family members and significant others about the psychiatric and AOD-related behavior of patients. The family interview can also be a useful means to obtain further information regarding family history of psychiatric and AOD use disorders.

Other collateral information can include available documentation such as medical and criminal justice records, as well as information gathered from other sources such as landlords, housing settings, social services, and employers. Case managers may be in a unique position to compile aggregate reports from these various sources, since they are able to follow these patients over an extended period of time in a variety of settings.

Laboratory Tests

Laboratory tests for drug detection can be valuable both in documenting AOD use and in assessing AOD use in relation to psychotic symptoms. Objective urine and blood toxicology screens and alcohol Breathalyzer tests can be useful. Data from urine screens may be particularly useful for patients who deny regular use of AODs and who may benefit from objective feedback about the presence or absence of AOD use. Toxicology screens that document an absence of drug use can provide positive feedback for abstinent patients who are actively working to maintain sobriety.

Liver function tests have limited assessment value, particularly for patients ingesting large amounts of alcohol. However, the absence of abnormal liver findings should not be used as an indication of nonproblematic alcohol use.

Social Issues

While psychiatric, medical, or AOD-induced disorders may be more visible to the clinician than social problems, the latter can contribute significantly to the emergence and maintenance of these disorders. Indeed, the psychotic patient

with dual disorders is more likely than not to have significant impairment in the social area. Thus, identifying the problem areas of a specific patient's social life becomes a core component of the service or treatment plan.

Actively helping patients to secure basic needs is a powerful way to engage them in the treatment process. Patients with dual disorders frequently face problems with living conditions, employment, homelessness, housing instability, loss of social support systems, and nutrition. The frustration and emotional turmoil that accompany problems in these areas can be intense. Indeed, many cases of treatment failure that are perceived as resistance to treatment and denial actually represent the failure of the treatment provider to recognize the impact of a patient's deteriorated social situation and to help the patient gain access to services.

In addition to social needs, clinicians should be aware of and sensitive to the impact of race, culture, ethnicity, nationality, gender issues, sexual orientation, and sexual history upon the lives of their patients.

Primary Health Care

A current or recent comprehensive medical evaluation is an essential aspect of the overall assessment. Nonmedical clinical personnel should become familiar with patients' medical histories and specifically inquire about the possible relationship between existing medical conditions and presenting symptoms.

Meeting the medical needs of patients with psychiatric and AOD use disorders is a critical aspect of treatment. For patients with psychotic disorders, attention to medical needs is even more important, since they generally have a high prevalence of medical problems, including chronic medical problems that are frequently untreated or undertreated.

During long-term treatment, it is important to evaluate the relationships between patients' medical problems and their psychotic and AOD use disorders. For example, medical problems may: 1) coexist with psychotic and AOD use disorders, 2) prompt or exacerbate psychotic and AOD use disorders, or 3) be the direct or indirect result of psychotic and AOD use disorders.

It is especially important for these patients to have easy access to treatment for medical conditions that are strongly associated with AOD use, such as tuberculosis, hepatitis, and HIV/AIDS. In addition, they should have easy access to treatment for basic medical needs, such as diabetes and hypertension, as well as cardiovascular, respiratory, and neurological disorders. Attention should be provided for the pregnant woman with regard to prenatal care and ongoing monitoring of pregnancy. The pregnant woman may be especially at risk for relapse when her regular antipsychotic medication regimen is contraindicated.

In addition to medical treatment, patients with dual disorders that involve psychosis need basic education about fundamental health care, hygiene, and AIDS prevention. A program that serves patients with dual disorders should include basic medical education components on site as a routine part of treatment, rather than referrals to another agency.

For patients who are prescribed medications, it is important to assess the types of medications, whether or not the medications are being taken, and the types of side effects they may cause. Patients should be asked specifically about the frequency, dosage, and duration of any prescription medication.

Medication noncompliance is the rule, not the exception, for people with dual disorders. Psychiatric medication noncompliance is particularly associated with dual disorders that involve psychosis, causing significant impact on presenting symptoms and level of function. Because of this common association

between AOD use and noncompliance and the limitation of self-reports, it is useful to complement this assessment with an assessment of serum drug levels of psychiatric medications.

In addition to considering AOD use as a primary factor that affects the use of psychiatric medications, it is also important to consider the potential role of psychiatric medications in subsequent AOD use. For example, side effects such as akathisia (severe restlessness) or sedation may be caused by antipsychotic medications, and patients may take AODs in an attempt to medicate these unwanted side effects.

Frequently, psychoactive substances become replacements for adequate and nutritious food. Nutritional impairment is associated with impaired cognition. A lack of regular meals and poor nutrition are common occurrences among patients with dual disorders; thus, access to regular meals should be assessed.

Also, acute dental problems as well as ongoing dental care should be assessed. Because this group frequently experiences financial difficulties, access to dental care is often limited or nonexistent. Attention should be given to the social and emotional consequences of poor dental health, such as poor self-esteem and diminished social interaction.

Treatment Issues

The most important initial step in treatment is to identify high-risk conditions that require immediate treatment, while recognizing that there will likely be important issues that require long-term management.

Acute Management

Within the area of acute management, it is useful to differentiate between acute management of crises and the resolution of subacute problems that may be severe but not life threatening.

High-Risk Conditions

The initial critical consideration for high-risk conditions is to determine if patients require emergency medical treatment, psychiatric treatment, or both. The critical decision is whether patients require hospitalization, and if so, what type of treatment is required (for example, primary health care, detoxifi-cation, or psychiatric care). This aspect of treatment necessarily involves medical assessment and intervention.

With regard to biological or medical issues, the priority is addressing and stabilizing the acute crisis in a hospital-based setting. Once the acute crisis has been stabilized, mental health and AOD use consultation may be necessary to address the concomitant psychiatric and AOD disorders.

With regard to high-risk psychological conditions (that is, danger to self or others and other violent and impulsive behavior), the initial focus is on stabilizing the acute psychological crisisÒproviding that acute medical causes have been ruled out. Stabilization may require acute involuntary psychiatric hospitalization. Thus, coordination with emergency mental health services and the local police department is necessary to ensure the immediate safety of the patient and others.

With regard to high-risk social conditions (homelessness, housing instability, victimization, and unmet basic needs), the priority is on implementing aggressive social crisis intervention. Meeting patients' basic needs is critical in the management of the treatment of dual disorders that include psychosis. The high-risk social conditions may be related to the medical or psychiatric crisis, and therefore will require followup upon hospital discharge.

Regardless of the priority of crisis intervention, the overall biopsychosocial needs of patients must be addressed in a holistic manner, considering both the psychosis and the AOD use disorder. The approach

must be integrated and comprehensive despite the higher visibility of one of the disorders.

Subacute Conditions

Following the resolution of the acute crisis, subacute conditions must be addressed before long-term management can occur. (Subacute conditions can also occur as a precursor to acute relapse of psychiatric symptomatology or AOD use.) Examples of specific subacute management issues include resuming or adjusting psychotropic medication, patients' comfort with the medication, medication compliance, addressing acute psychiatric symptoms, establishing early AOD use treatment intervention, and establishing or sustaining patients' connection with support systems and services for obtaining housing and meeting basic needs.

The subacute phase allows for an opportunity to reassess the diagnosis and overall treatment needs. The ultimate goal should be to establish a long-term treatment plan, to avert imminent decompensation or relapse, and to address long-term needs.

Long-Term Management

The overall goal of long-term management should involve: 1) providing coordinated and integrated services for both the psychiatric and AOD use disorders, and 2) doing so with a long-term focus that addresses biopsychosocial issues.

Patients with severe or persistent psychiatric and AOD use disorders, such as Thomas, require dually focused, integrated treatment. Patients like Martha, who have mild or brief symptoms of mental illness, may benefit from parallel treatment or self-help. Patients with AOD-induced psychiatric symptoms similar to Laura's should receive long-term management and treatment by AOD abuse treatment providers. Irrespective of the treatment setting, the goal is to help patients with dual disorders gain control over their psychiatric and AOD use disorders.

Gaining such control is a long-term process. For this group, the initial expectation during the engagement period should not be immediate compliance with psychiatric treatment or immediate abstinence. Indeed, mandating these treatment prerequisites may interfere with access to services or lead to the patient's rejection of the treatment services. Abstinence from AOD use is the long-term goal for patients with dual disorders that involve psychosis, but should not be a prerequisite for offering or continuing treatment services.

Therapeutic Engagement

The first step in the long-term treatment of patients with dual disorders that involve psychosis is to engage them in the treatment process. The basis of therapeutic engagement is building a relationship with patients. Engagement is a long-term process, not a single event that occurs only during the initial stages of treatment. The engagement process may need to be revisited throughout the course of treating these two unremitting disorders.

Frequently, patients with dual disorders do not acknowledge or appreciate that AOD use or a psychiatric disorder is a problem in their lives. Hence, establishing a relationship with these patients may first require knowing what they want and need. They may not want AOD treatment or psychiatric services. Rather, they may best be engaged by offering them assistance to meet their basic needs such as housing or entitlements or by providing basic medical and legal services.

A variety of approaches can be used to facilitate the engagement process. These include assertive outreach by case managers and clinicians, offering to facilitate the acquisition of basic services and entitlements and help with legal services. Similarly, engagement may be facilitated through involvement with alternative social and recreational activities, programs, clubs, and drop-in centers.

Engagement techniques can include the therapist's involvement with the family and other significant parties. Indeed, at times, clinicians may be able to maintain contact with patients only through the family.

Patients often want help finding and keeping a job. Thus, engagement includes vocational rehabilitation.

For patients who have particularly severe psychiatric or AOD use disorders and do not respond to these initial attempts at engagement in the treatment process, the use of therapeutic coercive approaches may be necessary. Patients with severe dual disorders may have gross cognitive impairment due to AOD use and may be severely disorganized due to psychiatric illness. They may be impulsive, exhibit extremely poor judgment, or be chronically dangerous to themselves or others.

Without therapeutic coercive interventions, some of these patients may be at substantial risk of catastrophic outcomes, including death, injury, violent behavior, or long-term incarceration. Examples of therapeutic coercive approaches include the appointment of a representative payee, guardian, or conservator and the use of parole or probation. Legal advocacy by a case manager for court-mandated treatment services may be essential for engaging and maintaining treatment services. Other mechanisms include commitment to outpatient treatment services, conditional discharge, and commitment to appropriate inpatient dual disorder treatment.

Therapeutic coercive efforts should be temporary and reserved for patients who have failed with other interventions. The long-term goal for these patients is to regain control over their lives. As mentioned above, service providers have traditionally expected patients to be motivated before initiating treatment. They have often misinterpreted the lack of engagement as denial or resistance to treatment.

It is essential for treatment professionals to understand that the provider is responsible for motivating or providing incentives for the patient to engage and remain in treatment.

Concurrent and Integrated Dually Focused Treatment

Service providers in traditional treatment programs have often maintained that patients with dual disorders should be treated sequentially, that is, by treating the AOD use disorder before treating the psychiatric disorder, or vice versa. Rather, there should be an ongoing dual focus on both disorders, especially for patients with psychosis or AOD use disorders.

Particularly for the severely disorganized patient or for the patient with persistently disabling conditions, integrated treatment is essential. Ideally, the services should be integrated within the same agency and program.

When mental health and addiction treatment services are not integrated, fragmentation of services and discontinuous service are significant risks. In situations where services cannot be integrated, it is crucial for one provider to accept full responsibility for the patient and to aggressively coordinate service with other programs and services. For treatment to be effective, and to ensure continuity of care, a long-term relationship and treatment approach should be developed.

For patients with milder psychiatric symptoms, parallel treatment approaches such as concurrent psychiatric and AOD treatment may be helpful, although such approaches have the disadvantage of placing the burden of integrating different treatment options on patients. This burden should be minimized by a case manager or clinician who can provide appropriate clinical liaison between different agencies.

Engaging the Chronically Psychotic Patient

Noncoercive Engagement Techniques	Coercive Engagement Techniques
• Assistance obtaining food, shelter, and clothing • Assistance obtaining entitlements and social services • Drop-in centers as entry to treatment • Recreational activities • Low-stress, nonconfrontational approaches • Outreach to patient's community.	• Involuntary commitment • Mandated medications • Representative payee strategie

Long-Term Perspective

For patients with dual disorders involving psychosis, a long-term approach is imperative. Research has shown that individuals become abstinent and gain control over psychiatric symptoms through a process that frequently takes years, not days or months. Front-loaded, intensive, expensive, and highly stimulating short-term treatment modalities are likely to fail with this group of patients.

Both psychotic and AOD use disorders tend to be chronic disorders with multiple relapses and remissions, supporting the need for long-term treatment. Also, an accurate diagnosis and an assessment of the role of AODs in the patient's psychosis necessitate a multiple-contact, longitudinal assessment and treatment perspective.

Treatment Teams

Especially for programs that treat patients with psychotic and AOD use disorders, it is essential that the program philosophy be based on a multidisciplinary team approach. Ideally, team members should be cross-trained, and there should be representatives from the medical, mental health, and addiction systems. Staff members should learn to use gentle or indirect confrontation techniques with these patients.

Assertive Case Management

Team members should endorse an assertive case management approach, wherein the case manager is not limited to the treatment site, but is expected to provide services to patients in their own environments. The case manager must not attempt to solely broker treatment services or exclusively provide office-based treatment. A supportive and psychotherapeutic approach to individual, group, and family work should be employed.

For these patients, flexible hours are necessary. Because crises frequently occur during evening and weekend hours, services should be provided during these hours. In addition, alternative social activities and peer group activities often take place in the evening and on weekends.

Also, individual and group programs for patients with dual disorders that involve psychosis should be based on a behavioral and psychoeducational perspective, not a psychodynamic approach. Educational information should be frequently repeated and presented in concrete terms using a multimedia format. Programs should be modified to include frequent breaks and shorter sessions than normal.

Special care should be taken with regard to patient education and group discussion about Higher Power issues. Staff members should be trained to teach patients and lead group discussions about spirituality and the concept of a Higher Power. Staff members should understand the difference between spirituality and religion, and especially the differences between spirituality, religion, and delusional systems that have a religious or spiritual content.

Personalized Service Planning

It is essential that the treatment plan for each patient be personalized, and based on the specific needs and stated goals of the patient, rather than on the clinician's goals. The patient should participate in the ongoing review and evaluation of the treatment plan.

Associated Psychosocial Needs

Even intensive, carefully designed AOD abuse treatment is likely to fail if the extensive psychosocial problems associated with dual disorders are not concurrently addressed. Common psychosocial concerns of this group include housing, finances and entitlements, legal services, job assistance, and access to adequate food, clothing, and medication.

Housing

A particularly common complication of dual disorder patients with psychosis is housing instability and homelessness. Among the possible housing services that may be particularly useful are shelters, supervised housing settings, congregated living settings, treatment milieu settings, and therapeutic communities. Ideally, residential options and placements should be long term, with the goal of promoting independent, stable, and safe housing.

Despite the long-term goal of sobriety, the housing needs of patients with chronic psychosis and AOD use disorders may be met temporarily by housing that is not explicitly drug free. Shelters or other forms of temporary housing that are not explicitly drug free but provide basic safety from weather and violence are better than no housing at all.

Various housing settings are necessary, including housing for current AOD-using individuals ("wet" or "damp" housing setting) and settings for individuals who are abstinent. Although there is a need for this broad range of housing, many communities do not currently have it. Within this range of agency-supported housing, there should be explicit policies regarding AOD use, understood by both the patient and the clinician.

It is also critical for treatment programs to have easy access to housing for patients with special needs, such as women and children, pregnant women, and battered women. Specific housing should be developed for patients with specialized, ongoing medical and psychological needs associated with complications of serious medical conditions such as AIDS.

Vocational Services

Vocational services are also essential for the long-term stabilization and recovery of the dual disorder patient. Both AOD and mental health services have traditionally referred clients to generic vocational rehabilitation services. These services must be integrated and modified for the specialized needs of the individual with psychosis and AOD use disorders. Temporary hire placements and job coaching options are important elements to incorporate into rehabilitation services for this group.

Sober Support Groups

An essential part of treatment for patients with dual disorders is the development of alternative peer group settings that do not include drug use. Developing these non-AOD-using social networks can be enhanced by programs that provide social club activities, recreational activities, and drop-in centers on site, as well as linkages to other community-based social programs. At the same time, patients should be encouraged to establish and maintain relationships, including family relationships, that are supportive of treatment goals.

Family

Treatment of the dual disorder patient can be substantially supported and enhanced by direct involvement of the patient's family. Services can include family psychoeducational groups that specifically focus on education about AOD use disorders and psychosis. This also includes multifamily treatment groups that may include the individual with the dual disorder.

Families may also be helpful in identifying early signs of psychiatric or AOD use relapse symptoms. They can work with the treatment team in initiating acute relapse prevention and intervention.

Confidentiality issues need to be addressed at the beginning of treatment, with the goal of identifying a significant support person who has the patient's permission to be involved in the long-term treatment process.

Relapse Prevention

An essential component of relapse prevention and relapse management is close monitoring of patients for signs of AOD relapse and a return of psychotic symptoms. Relapse prevention also includes closely monitoring the development of patients' AOD refusal skills and their recognition of early signs of psychiatric problems and AOD use. The goals of relapse prevention are: 1) identification of patients' relapse signs, 2) identification of the causes of relapse, and 3) development of specific intervention strategies to interrupt the relapse process.

Close monitoring involves the long-term observation of patients for early signs of impending psychiatric relapse. Such signs may include the emergence of paranoid symptoms and symptoms related to AOD use such as hostile or disorganized behavior. For example, a sign of paranoid symptoms may be the patient's sudden and constant use of sunglasses. Additional important clues may involve changes in daily routine, changes in social setting, loss of daily structure, irritation with friends, and rejection of help. Family members who reside with the dual disorder patient are often the first to detect early signs of psychotic or AOD use relapse.

Additional signs of possible psychotic or AOD relapse include eviction from housing, job loss, or involvement with the criminal justice system. It is important that the clinician understand that routine daily stressors may have an intense impact on the dually diagnosed patient and may prompt relapse.

Objective laboratory tests may also be particularly useful in detecting early risk of AOD relapse. This includes the use of random urine toxicology screens, the alcohol Breathalyzer test, and blood tests to detect street drugs. As medication noncompliance is strongly associated with both AOD use and psychotic relapse, blood medication levels (including antipsychotic and lithium levels) may be particularly useful. Finally, intramuscular forms of antipsychotic medications may be particularly useful for verifying and assuring long-term compliance with antipsychotic medications.

In addition to close monitoring by health care professionals, family members, and significant others, an important component of relapse prevention is assisting the dual disorder patient to develop skills to anticipate the early warning signs of psychiatric and AOD use disorders. These skills can be acquired through direct individual psychoeducation and participation in role play exercises and psychoeducation groups. These patients should be trained to use AOD refusal skills and to recognize situations that place them at risk for AOD use.

Similarly, these patients may benefit significantly from behavioral therapy; development of relaxation, meditation, and biofeedback skills; exercise; use of visualization techniques; and use of relapse prevention workbooks. Pharmacologic strategies may include the use of disulfiram or naltrexone for certain patients.

Group Treatment

Group process is a core element of AOD abuse and mental health treatment. However, for patients with psychosis, group treatment should be modified and provided in coordination with a comprehensive service plan. The different types of groups specifically designed for the dual disorder patient include persuasion groups, active treatment groups, dual disorder-oriented 12-step groups (Double Trouble groups), pre-12-step groups, and groups that focus on medication and anger management.

Groups that are specifically designed for dual disorder patients are essential during the early phases of treatment. Patients who have accepted the goal of abstinence, have maintained psychiatric stability, and have essential social skills may benefit from carefully selected traditional 12-step programs that are sensitive to the needs of the severely mentally ill. However, during the early phases of treatment, an unfacilitated referral to traditional 12-step programs will likely result in treatment failure. (See the discussion on the use of the 12-step programs in Chapter 6.) A wide variety of group settings may be useful for the person with a dual disorder. However, the core approach should include psychoeducational, supportive, behaviorally oriented, and skill-building activities.

Medication

With patients who have dual disorders that involve psychosis, a common provider mistake that often leads to psychiatric or AOD use relapse involves a lack of attention to medication issues. Most important, treatment programs must provide aggressive treatment of medication side effects. Ignoring the side effects of prescribed medication often results in patients using AODs to diminish the unwanted medication side effects.

Equally important, patients should be educated and thoroughly informed about: 1) the specific medication being prescribed, 2) the expected results, 3) the medication's time course, 4) possible medication side effects, and 5) the expected results of combined medication and AOD use. Whenever possible, family members and significant others should be educated about the medication.

Medication should not simply be prescribed or provided to the psychotic patient with dual disorders. Rather, it is critical to discuss with patients 1) their understanding of the purpose for the medication, 2) their beliefs about the meaning of medication, and 3) their understanding of the meaning of compliance. It is important to ask patients what they expect from the medication and what they have been told about the medication. Overall, it is important to understand the use of medication from the patient's perspective. Indeed, informed consent relative to a patient's use of medication requires that the patient have a thorough understanding of the medication as described above.

It is also important to help patients prepare for peer reaction to the use of medication when they participate in certain 12-step programs. Patients should be taught to educate other people who may have biases against prescription medications or who may be misinformed about antipsychotic medications.

Patients receiving medication should participate in professionally led medication education groups and medication-specific peer support groups. These groups will help patients deal with the emotional and social aspects of medication, promote medication compliance, and help clinicians and patients identify and address early noncompliance and side-effect problems.

Overall, there must be a specific and aggressive treatment strategy that helps make medication use simple and comfortable. The scheduling and administration of medication should be simple and convenient for patients. The ideal schedule for oral medications is once per day. The use of injectable medications may be the most comfortable and effective option for some patients with dual disorders.

Anything that helps patients feel more comfortable about taking medication should be considered. In addition, an important treatment goal is a medication regimen that is self-monitoring.

When patients experience difficulty acquiring medication, the treatment program should directly help patients acquire them, not make referrals and recommendations.

Staff and Administrative Training

Traditional training in mental health and AOD abuse treatment, and in medicine in general, has been inadequate relative to the unique needs of the dual disorder patient. Thus, program staff require ongoing education about current understanding and treatment of dual disorders. It is imperative that the service principles of each discipline be presented and modified for application to people with dual disorders. Training also must be integrated, not sequential or parallel.

Perhaps the most important goal of clinical staff development and training is the cross-training of addiction and mental health personnel. Addiction specialists need training in psychiatric and mental health issues, while mental health and psychiatric specialists need training in AOD and addiction issues. In addition to cross-training, both addiction and mental health clinical staff require clinical and theoretical training in dual disorders.

Clinical staff training content must include information about the assessment and treatment of high-risk and subacute problems and about long-term treatment issues. There must be a focus on the interaction between AOD use and psychiatric symptoms. In addition, attention must be given to high-risk behaviors such as violence to self or others, suicide, impulsive behavior, and high-risk sexual behavior.

Clinical staff training must also address less obvious clinical issues such as cultural competency and sensitivity to the roles of culture, ethnicity, nationality, religion, and spirituality.

While 1- or 2-day workshops may be useful for disseminating clinical information, ongoing and routine education is critical. To emphasize the multidisciplinary team approach, staff education should be done in a group setting with interaction among group participants and trainers.

The need for clinical supervision among clinical staff is crucial. Supervision must be an ongoing, routine process, not driven by clinical crises. Nonetheless, because treatment of dual disorders involves frequent crises, the clinical supervisor must be readily available to team members and able to provide rapid coaching and support.

An important aspect of clinical supervision and clinical staff development is education in the theoretical basis of treatment. Irrespective of disciplines, all clinical staff must thoroughly understand and support the philosophical basis, values, and goals of the treatment program in which they work. Further, an important task of the clinical supervisor is to integrate the formal theory and principles within the specific treatment setting.

Clinical staff education and development must include the formation of procedures and supports to prevent staff burnout and demoralization. Components of staff burnout prevention include mechanisms for multidisciplinary group support, a focus on long-term rather than short-term gains for patients, anticipation and expectation of relapse as part of psychotic and AOD use disorders, and an understanding of relapse as a treatment opportunity rather than a treatment failure.

Program administrators, whether they are in contact with patients or not, require clinical education in dual disorder issues to provide an appropriate environment for the treatment of patients with dual disorders and to better understand the needs of staff and patients. Thus, program administrators require education in the latest conceptual and technological developments in the fields of psychiatry and AOD treatment as well as in dual disorders.

It is important for program administrators to regularly review, articulate, and discuss the program's philosophy, goals, and objectives with all program staff. Enhanced and open communication between administration and staff in both individual and group settings is also critical. For example,

administrators should regularly communicate with staff regarding administrative constraints such as financial limitations, legal mandates, and political influences.

Administrators should thoroughly understand the appropriate role of clinical supervision: that this supervision is designed for skill enhancement and staff support. Clinical supervision skills are critical for providing effective services to high-risk populations such as patients with psychotic and AOD use disorders.

There should be open discussion of administrative styles, since these significantly affect staff morale and performance. Similarly, administrators should be aware of the influence of their personal characteristics upon staff and patients. For example, administrators should become aware of the influence that their culture, ethnicity, gender, sexual orientation, and background has on others.

Chapter 9 – Pharmacologic Management

Pharmacologic Risk Factors

Addiction is not a fixed and rigid event. Like psychiatric disorders, addiction is a dynamic process, with fluctuations in severity, rate of progression, and symptom manifestation and with differences in the speed of onset. Both disorders are greatly influenced by several factors, including genetic susceptibility, environment, and pharmacologic influences. Certain people have a high risk for these disorders (genetic risk); some situations can evoke or help to sustain these disorders (environmental risk); and some drugs are more likely than others to cause psychiatric or AOD use disorder problems (pharmacologic risk).

Pharmacologic effects can be therapeutic or detrimental. Medication often produces both effects. Therapeutic pharmacologic effects include the indicated purposes and desired outcomes of taking prescribed medications, such as a decrease in the frequency and severity of episodes of depression produced by antidepressants.

Detrimental pharmacologic effects include unwanted side effects, such as dry mouth or constipation resulting from antidepressant use. Side effects perceived as noxious by patients may decrease their compliance with taking the medications as directed.

Some detrimental pharmacologic effects relate to abuse and addiction potential. For example, some medications may be stimulating, sedating, or euphorigenic and may promote physical dependence and tolerance. These effects can promote the use of medication for longer periods and at higher doses than prescribed.

Thus, prescribing medication involves striking a balance between therapeutic and detrimental pharmacologic effects. For instance, therapeutic antianxiety effects of the benzodiazepines are balanced against detrimental pharmacologic effects of sedation and physical dependency. Similarly, the desired therapeutic effect of abstinence from alcohol is balanced by the possibility of damage to the liver from prescribed disulfiram (Antabuse).

Side effects of prescription medications vary greatly and include detrimental pharmacologic effects that may promote abuse or addiction. With regard to patients with dual disorders, special attention should be given to detrimental effects, in terms of 1) medication compliance, 2) abuse and addiction potential, 3) AOD use disorder relapse, and 4) psychiatric disorder relapse (Ries, 1993a).

Psychoactive Potential

Not all psychiatric medications are psychoactive. The term *psychoactive* describes the ability of certain medications, drugs, and other substances to cause acute psychomotor effects and a relatively rapid change in mood or thought. Changes in mood include stimulation, sedation, and euphoria. Thought changes can include a disordering of thought such as delusions, hallucinations, and illusions. Behavioral changes can include an acceleration or retardation of motor activity. All drugs of abuse are by definition psychoactive.

In contrast, certain nonpsychoactive medications such as lithium (Eskalith) can, over time, normalize the abnormal mood and behavior of patients with bipolar disorder. Because these effects take several days or weeks to occur, and do not involve acute mood alteration, it is not accurate to describe these drugs as psychoactive, euphorigenic, or mood altering. Rather, they might be described as *mood regulators*. Similarly, some drugs, such as antipsychotic medications, cause normalization of thinking processes but do not cause acute mood alteration or euphoria.

However, some antidepressant and antipsychotic medications have pharmacologic side effects such as mild sedation or mild stimulation. Indeed, the side effects of these medications can be used clinically. Physicians can use a mildly sedating antidepressant medication for patients with depression and insomnia, or a mildly stimulating antipsychotic medication for patients with psychosis and hypersomnia or lethargy (Davis and Goldman, 1992). While the side effects of these drugs include a mild effect on mood, they are not euphorigenic. Nevertheless, case reports of misuse of nonpsychoactive medications have been noted, and use should be monitored carefully in patients with dual disorders.

While psychoactive drugs are generally considered to have high risk for abuse and addiction, mood-regulating drugs are not. A few other medications exert a mild psychoactive effect without having addiction potential. For example, the older antihistamines such as doxylamine (Unisom) exert mild sedative effects, but not euphoric effects.

Reinforcement Potential

Some drugs promote *reinforcement,* or the increased likelihood of repeated use. Reinforcement can occur by either the removal of negative symptoms or conditions or the amplification of positive symptoms or states. For example, self-medication that delays or prevents an unpleasant event (such as withdrawal) from occurring becomes reinforcing. Thus, using a benzodiazepine to avoid alcohol withdrawal can increase the likelihood of continued use. *Positive reinforcement* involves strengthening the possibility that a certain behavior will be repeated through reward and satisfaction, as with drug-induced euphoria or drug-induced feelings of well-being. A classic example is the pleasure derived from moderate to high doses of opiates or stimulants. Drugs that are immediately reinforcing are more likely to lead to psychiatric or AOD use problems.

Tolerance and Withdrawal Potential

Long-term or chronic use of certain medications can cause tolerance to the subjective and therapeutic effects and prompt dosage increases to recreate the desired effects. In addition, many drugs cause a well-defined withdrawal phenomenon after the cessation of chronic use. Patients' attempts to avoid withdrawal syndromes often lead them to additional drug use. Thus, drugs that promote tolerance and withdrawal generally have higher risks for abuse and addiction.

A Stepwise Treatment Model

As can be seen, there are pharmacologic as well as hereditary and environmental factors that influence the development of AOD use problems. All of these factors should be considered prior to prescribing medication, especially when the patient is at high risk for developing an AOD use disorder. High-risk patients include people with both psychiatric and AOD use disorders, as well as patients with a psychiatric disorder and a family history of AOD use disorders.

One aspect of this issue relates to the pharmacologic profile of certain medications that are used in the treatment of specific psychiatric disorders. For instance, many medications used to treat symptoms of depression and psychosis are not psychoactive or euphorigenic. However, many of the medications used to treat symptoms of anxiety, such as the benzodiazepines, are psychoactive, reinforcing, have potential for tolerance and withdrawal, and have an abuse potential, especially among people who are at high risk for AOD use disorders. Other antianxiety medications, such as buspirone (BuSpar), are not psychoactive or reinforcing and have low abuse potential, even among people at high risk.

Thus, decisions about whether and when to prescribe medication to a high-risk patient should include a risk-benefit analysis that considers the risk of medication abuse, the risk of undertreating a psychiatric problem, the type and severity of the psychiatric problem, the relationship between the psychiatric disorder and the AOD use disorder for the individual patient, and the therapeutic benefits of resolving the psychiatric and AOD problems.

For example, the early and aggressive medication of high-risk patients who have severe presentations of psychotic depression, mania, and schizophrenia is often necessary to prevent further psychiatric deterioration and possible death. For these patients, rapid and aggressive medication can shorten the length of the psychiatric episodes. In contrast, prescribing benzodiazepines to high-risk patients with similarly severe anxiety involves a substantial risk of promoting or exacerbating an AOD use disorder. For these high-risk patients, the use of psychoactive medication should not be the first line of treatment.

Rather, for some high-risk patients, treatment efforts should involve a stepwise treatment model that begins with conservative approaches and progressively becomes more aggressive if the treatment goals are not met (Landry et al., 1991a). For example, the stepwise treatment model for treating high-risk patients with anxiety disorders may involve three progressive levels of treatment: 1) nonpharmacologic approaches when possible; 2) nonpsychoactive medication when nonpharmacologic approaches are insufficient; and 3) psychoactive medications when other treatment approaches provide limited or no relief (Landry et al., 1991).

Pharmacologic Risk Factors

A medication may have:

- Psychoactive potential (causes acute psychomotor effects)
- Reinforcement potential (decreases negative symptoms and increases positive symptoms)
- Tolerance and withdrawal potential (a higher does is needed to gain the effect or to avoid ill effects).

A Stepwise Management Approach For Mild and Moderate Mental Disorders *

Step One:
Try nonpharmacologic approaches
Step Two:
Add nonpsychoactive medications if Step One is unsuccessful
Step Three:
Add psychoactive medications if Steps One and Two are unsuccessful.

* For severe conditions, such as psychotic depression, mania, and schizophrenic disorders, rapid and aggressive use of medications is needed to prevent danger to self or others and further psychiatric deterioration.

Nonpharmacologic Approaches

Depending upon the psychiatric disorders and personal variables, numerous nonpharmacologic approaches can help patients manage all or some aspects of their psychiatric disorders (Weiss and Billings, 1988). Examples include psychotherapy, cognitive therapy, behavioral therapy, relaxation skills, meditation, biofeedback, acupuncture,

hypnotherapy, self-help groups, support groups, exercise, and education.

Nonpsychoactive Pharmacotherapy

Some medications are not psychoactive and do not cause acute psychomotor effects or euphoria. Some medications do not cause psychoactive or psychomotor effects at therapeutic doses but may exert limited psychoactive effects at high doses (often not euphoria, but sometimes dysphoria).

For practical purposes, all of these medications can be described as nonpsychoactive, since the psychoactive effect is not prominent. Medications used in psychiatry that are not euphorigenic or significantly psychoactive include but are not limited to the azapirones (for example, buspirone), the amino acids, beta-blockers, antidepressants, monoamine oxidase inhibitors, antipsychotics, lithium, antihistamines, anticonvulsants, and anticholinergic medications.

Psychoactive Pharmacotherapy

Some medications can cause significant and acute alterations in psychomotor, emotional, and mental activity at therapeutic doses. At higher doses, and for some patients, some of these medications can also cause euphoric reactions. Medications that are potentially psychoactive include opioids, stimulants, benzodiazepines, barbiturates, and other sedative-hypnotics.

Stepwise Treatment Principles

One of the emphases of stepwise treatment is to encourage nondrug treatment strategies for each emerging symptom before medications are prescribed. Nondrug treatment strategies alone are inappropriate for acute and severe symptoms of schizophrenia and mood disorders, but nondrug strategies do have their place in the treatment of virtually any psychiatric problem, and may provide partial or total relief of some symptoms related to severe psychiatric disorders. For example, relaxation therapy can minimize or eliminate somatic symptoms of anxiety that may accompany an agitated depression.

A second emphasis of stepwise treatment is to encourage the use of medications that have a low abuse potential. This conservative approach must be balanced against other therapeutic and safety considerations in acute and severe conditions, such as psychosis or mania. On the other hand, a conservative approach is not the same as undermedication of psychiatric problems. Undermedication often leads to psychiatric deterioration and may promote AOD relapse. There should be a balance between effective treatment and safety.

A third emphasis of stepwise treatment is to encourage the idea that different treatment approaches should be viewed as complementary, not competitive. For example, if psychotherapy or group therapy does not provide complete relief from a situational depression (such as prolonged grief), then antidepressants should be considered as an adjunct to the psychotherapy, but not as a substitute for psychotherapy.

In practice, treatment providers often use a combination of drug and nondrug strategies. This practice includes medication to treat the acute manifestations of the disorder while the individual learns long-term management strategies. For example, an individual may be prescribed nonpsychoactive buspirone to reduce anxiety symptoms while learning stress reduction techniques and attending group therapy.

These guidelines are broad, general, and more applicable to chronic than to acute psychiatric problems. Also, these guidelines have limited application to very severe psychiatric problems.

Specific Medications and Recovery

Antihistamines

Several antihistamines are approved for sale as over-the-counter hypnotics, including diphenhydramine (Nytol, Benadryl), doxylamine (Unisom), and pyrilamine (Quiet World). The efficacy of these drugs is not uniform, and tolerance to the anxiolytic and hypnotic effects is rapid, limiting their utility for episodic use. Antihistamines are frequently prescribed for mild anxiety and insomnia, particularly for patients in general hospitals, patients with physical illness (Salzman, 1989), and elderly patients.

Antihistamines and Recovery

In general, the early antihistamines exert very mild anxiolytic and hypnotic effects, but lack euphoric properties and do not promote physical dependence (Meltzer, 1990). While lacking significant abuse potential themselves, antihistamines may cause problems for some patients by reinforcing the idea of self-medication of insomnia and anxiety. Taken in high doses, antihistamines may cause acute delirium, alter mood (often causing dysphoria), or cause morning-after depression. Under close medical supervision, the conservative use of antihistamines can be valuable in treating brief episodes of insomnia during an otherwise drug-free recovery process. Patients in recovery should be discouraged from purchasing and using over-the-counter antihistamines.

Antidepressants

The antidepressants include several types of medication, such as tricyclics, monoamine oxidase inhibitors (MAOIs), and other, newer, antidepressants such as trazodone (Desyrel), bupropion (Wellbutrin), sertraline (Zoloft), and fluoxetine (Prozac). Antidepressants are effective for the treatment of depression, and several are valuable for the treatment of anxiety disorders, including generalized anxiety disorder, phobias, and panic disorder.

Antidepressants and Recovery

The antidepressants are not euphorigenic, and do not cause acute mood alterations. Rather, they are mood regulators and diminish the severity and frequency of depressive episodes; they also have anti-panic capabilities unrelated to sedation.

While the general effects of most of the older tricyclic antidepressants are similar, they differ considerably with regard to side effects. For example, some antidepressants such as doxepin (Sinequan) exert a mild sedating effect, while others such as protriptyline (Vivactil) exert a mild stimulating effect. These side effects can be clinically useful. For example, clinicians might give antidepressants with slight sedating effects to depressed patients with insomnia or give those with mild stimulating effects to depressed patients who experience low energy and hypersomnia (Davis and Goldman, 1992).

Other side effects of tricyclic antidepressants are common. Anticholinergic effects such as dry mouth, blurred vision, constipation, urinary hesitancy, and toxic-confusional states are common anticholinergic effects. Adrenergic activation symptoms may include tremor, excitement, palpitation, orthostatic hypotension, and weight gain. These noxious side effects are frequently the cause of requests to switch from one medication type to another. Also, side effects often prompt discontinuation of medication, which may provoke reemergence of the psychopathology. Tricyclics unfortunately are quite toxic when combined with AODs. Therefore use of tricyclic antidepressants in early recovery should be carefully monitored.

More expensive, but much less toxic when used with AODs, are the newer serotonin reuptake inhibitors including fluoxetine, paroxitine (Paxil), and sertraline. These agents also have anticompulsive effects, and their side effects tend to be slight to moderate stimulation rather than sedation. They are much safer to use in early recovery.

Overall, the use of antidepressants is consistent with a psychoactive-drug-free philosophy, does not compromise recovery from addiction, and enhances recovery from depressive and panic disorders. However, patient information must include clear explanations of the reasons for prescribing, the

expected results, and the risks of adverse effects, including overdose. The risk-benefit analysis must include the risk of lethal overdose with tricyclic antidepressants, especially for depressed patients (Reid, 1989).

Beta-Blockers

The beta-blockers such as propranolol (Inderal) are well-recognized medications for the treatment of hypertension, cardiac arrhythmias, and angina pectoris. They also have clinical efficacy as an adjunct in the treatment of anxiety (Lader, 1988). The b-blockers may reduce or eliminate the adrenergic discharge associated with panic attacks, thus blocking the somatic components of some anxiety states, especially when somatic symptoms predominate (Trevor and Way, 1989). b-blockers diminish the tremor and restlessness related to lithium or antipsychotics in some patients.

Beta-Blockers and Recovery

The Beta-blockers are not psychoactive, euphorigenic, or mood altering. Since tolerance to the anti-panic effects of b-blockers develops rapidly, they cannot be used for extended periods of time for this purpose. Rather, they are often used prophylactically for anticipated panic-producing situations, or for episodes of anxiety that may last a few days. The b-blockers are also used to decrease acute and subacute anxiety symptoms during detoxification from sedative-hypnotics such as the benzodiazepines. Overall, the use of b-blockers is consistent with a psychoactive-drug-free philosophy, does not compromise recovery from addiction, and can be an important adjunct to anxiety management.

Benzodiazepines

While all of the benzodiazepines have anxiolytic characteristics, they differ in their effectiveness in treating generalized anxiety disorder, mixed anxiety and depression, panic attacks, phobic-avoidance behaviors, and insomnia. In general, the benzodiazepines promote sedation, central nervous system depression, and muscle relaxation, and thus are effective for anxiety reduction and, at higher doses, for short-term management of insomnia.

The Benzodiazepines and Recovery

The benzodiazepines are psychoactive, mood altering, and reinforcing. Chronic use and subsequent cessation can cause withdrawal symptoms. Studies have shown that the benzodiazepines are not uniformly euphorigenic. Also, patients with a family and personal history of AOD abuse and addiction are more likely to experience euphoria with the benzodiazepines (Ciraulo et al., 1988, 1989).

Benzodiazepines are the most commonly used agents to moderate alcohol withdrawal and prevent dangerous withdrawal conditions such as delirium tremens and seizures. They are also widely used during detoxification from sedative-hypnotics. The benzodiazepines are frequently prescribed for use alone and in combination with antipsychotics during the treatment of acute psychotic symptoms caused by mania, schizophrenia, and drugs of abuse such as cocaine. Such treatment should be limited to the acute episode for most patients with dual disorders, so that one problem (psychosis) is not replaced by another problem (physical dependence or addiction). The benzodiazepines are not usually recommended for long-term use in patients with dual disorders unless all nonpsychoactive approaches have failed. That is, if all other less potentially adverse medications have proven inadequate and the benzodiazepines are indicated, then careful dispensing, regulation of dose, and scrupulous monitoring are required.

Overall, the use of benzodiazepines after the medical management of withdrawal is not consistent with a psychoactive-drug-free philosophy and may compromise recovery from addiction (Zweben and Smith, 1989). However, they can be used in the management of acute and severe withdrawal, panic, and psychosis with special guidelines in nonroutine situations.

Buspirone

Buspirone is the most well known of a new group of drugs (the azapirones) that selectively diminish multiple symptoms of anxiety without the acute mood alteration, sedation, or associated somatic side effects seen in the sedative-hypnotic anxiolytics. Buspirone is useful for generalized anxiety disorder, chronic anxiety symptoms, anxiety with depressive features, and anxiety among elderly patients. Buspirone is generally equivalent to the benzodiazepines with regard to anxiety management (Petracca et al., 1990; Strand et al., 1990). However, it takes several weeks for the maximal therapeutic effect of buspirone to occur.

Buspirone and Recovery

Buspirone is not psychoactive, mood altering, or euphorigenic (Balster, 1990). In particular, buspirone does not cause the mood alteration, central nervous system depression, sedation, and muscle relaxation associated with the benzodiazepines. However, many people with experience taking benzodiazepines may associate these mood alterations with relief of anxiety. As a result, patients who have experience with the benzodiazepines may misinterpret the absence of these side effects as evidence that the medication is ineffective. Educating patients about the distinction between anxiety reduction and sedation and about treatment expectations can avoid these misinterpretations.

Overall, the use of buspirone is consistent with a psychoactive-drug-free philosophy, does not compromise recovery from addiction, and enhances recovery from anxiety disorders.

Clonidine

Used in the form of a patch (Catapres Transdermal Therapeutic System patches) or tablets (Catapres), clonidine is well recognized as a treatment for symptoms of hypertension, including hypertensive symptoms that occur during withdrawal from depressant drugs, especially the opioids. In addition, clonidine appears to have anxiolytic and anti-panic properties comparable to the antidepressant imipramine. Patients may become less anxious but remain symptomatic. Some patients who have anxiety-depression or panic-anxiety experience significant antianxiety effects from clonidine. The anti-panic effect is the result of clonidine's ability to decrease locus ceruleus firing and thus decrease adrenergic discharge. Thus, clonidine may be useful for short-term use in the treatment of refractory anxiety with panic (Domisse and Hayes, 1987; Uhde et al., 1989).

Clonidine and Recovery

Clonidine is not psychoactive, euphorigenic, or mood altering. Clonidine may have significant antianxiety effects when administered to patients with anxiety-depression and panic-anxiety. However, tolerance to the anti-panic effects of clonidine can develop within several weeks. Thus, clonidine may be most useful for short-term use in the treatment of refractory panic disorder.

Overall, the use of clonidine is consistent with a psychoactive-drug-free philosophy, does not compromise recovery from addiction, and may be an adjunct in the treatment of anxiety symptoms.

Neuroleptic (Antipsychotic) Medications

The neuroleptic medications are most effective in suppressing the positive symptoms of psychosis such as hallucinations, delusions, and incoherence. In addition, they may help reduce disturbances of arousal, affect, psychomotor activity, thought content, and social adjustment (Africa and Schwartz, 1992). These psychotic symptoms may accompany schizophrenia, brief reactive psychosis, schizophreniform disorder, mania, depression, and organic mental disorders induced by AODs and medical conditions (Ries, 1993a).

Although neuroleptic medications are equally effective in suppressing psychotic symptoms, individuals may respond to one medication better than another. The chief differences among the neuroleptics relate to dosage, onset of effects, and (especially) side effects. Some side effects may be clinically useful, such as nighttime sedation with chlorpromazine or avoidance of appetite stimulation with molindone (Moban) (Africa and Schwartz, 1992).

In general, low-potency neuroleptics, for example, chlorpromazine, thioridazine (Mellaril), and clozapine (Clozaril), have significant sedative and hypotensive properties. Tolerance to these properties

may develop within a few weeks. Also, low-potency neuroleptics are inherently anticholinergic, so that the use of additional anticholinergic drugs to prevent extrapyramidal symptoms may be unnecessary. The high-potency neuroleptics such as fluphenazine (Prolixin) and haloperidol (Haldol) cause more extrapyramidal side effects than the low-potency medications.

Neuroleptic Drug-Induced Extrapyramidal Symptoms

The extrapyramidal system is a network of nerve pathways that links nerves in the surface of the cerebrum (the deep mass of the brain), the basal ganglia deep within the brain, and parts of the brain stem. The extrapyramidal system influences and modifies electrical impulses that are sent from the brain to the skeletal muscles.

When this system is damaged or disturbed, execution of voluntary movements and muscle tone can be disrupted, and involuntary movements, such as tremors, jerks, or writhing movements, can appear. These disturbances are called extrapyramidal syndromes, which can be caused by all of the neuroleptic medications except clozapine.

Medicating Extrapyramidal Symptoms

Extrapyramidal symptoms are unwanted, noxious, and uncomfortable. Compliance with neuroleptic medications is worsened because of the onset of these drug-induced symptoms. A class of medications called anticholinergic agents can eliminate the muscle spasms in the neck, oral, facial, cheek, and tongue regions. Several other types of medications may also be helpful, including amantadine and beta-blockers.

Anticholinergic agents can also reduce the extrapyramidal movement disorder called akathisia, which consists of purposeless movements, usually of the lower extremities, often accompanied by the experience of severe, uncomfortable restlessness. These medications include benztropine (Cogentin), biperiden (Akineton), diphenhydramine (Benadryl), trihexyphenidyl (Antitrem), and procyclidine (Kemadrin). Patient response should be monitored because some anticholinergic medications may be mildly psychoactive for some AOD patients.

Neuroleptic Medications and Recovery

Neuroleptic drugs are not euphorigenic and do not cause acute mood or psychomotor alterations. However, side effects are common. Most of the neuroleptics cause sedation as a side effect, although adaptation to the sedative (but not the antipsychotic) effects develops within days or weeks. The anticholinergic side effects of neuroleptic medications can include dry mouth, constipation, and blurred vision. The neuroleptics can also cause extrapyramidal symptoms. The adverse side effects of neuroleptic medications are a frequent cause of medication compliance problems. These adverse effects can also prompt patients to use AODs to self-medicate noxious symptoms.

Because patients with psychotic symptoms often experience significant biopsychosocial problems, the neuroleptics allow them to engage in problem-solving and recovery-oriented interpersonal activities. Overall, the use of neuroleptics is consistent with a psychoactive-drug-free philosophy, does not compromise recovery from addiction, and enhances recovery from psychotic disorders.

Lithium

Lithium is the standard and first-line treatment for manic episodes, even though 10-14 days may be required before full effect is achieved. The initial symptoms managed by lithium include increased psychomotor activity, pressured speech, and insomnia. Later, lithium diminishes the symptoms of expansive mood, grandiosity, and intrusiveness. Lithium also treats signs related to disorganization of the form of thought such as flight of ideas and loosening of association.

Lithium and Recovery

Lithium does not cause acute mood alteration, and is not psychoactive or mood altering. Rather, lithium is a mood regulator, and diminishes symptoms of acute mania. The common adverse effects of lithium include thirst, urinary frequency, tremor, and gastrointestinal distress. Lithium allows patients who may have seriously disabling symptoms to engage in problem-solving and recovery-oriented interpersonal activities. Overall, the use of lithium is consistent with a

psychoactive-drug-free philosophy, does not compromise recovery from addiction, and enhances recovery from bipolar disorders.

Anticonvulsants

Anticonvulsants have a role in the management of bipolar disorders, mania, schizoaffective disorder, and alcohol and benzodiazepine withdrawal. In addition, these medications may be prescribed for "flashbacks" related to drug use or post-traumatic stress disorder. These medications, such as carbamazepine (Tegretol) and valproic acid, are not psychoactive. The typically minor side effects of sedation and nausea may emerge as treatment is initiated. Rarely, carbamazepine causes a decrease in white blood cell count. Both medications are monitored according to blood levels. For the treatment of bipolar disorder, the anticonvulsants are most often used when lithium has failed. However, they are occasionally used by highly skilled physicians as first-line treatment. These medications are consistent with a psychoactive-drug-free philosophy, and may enhance the abilities of those who need them to participate in the recovery process.

Drug Interaction Cautions

There are certain risks associated with AOD use and withdrawal among patients who are also being administered medications to treat psychiatric disorders. Because of these risks, serious consideration should be given to inpatient treatment for withdrawal.

- Alcohol and barbiturates can cause increased tolerance by increasing the amount of liver enzymes responsible for their metabolism. These same liver enzymes are also responsible for metabolizing many antidepressant, anticonvulsant, and antipsychotic medications. Thus, serum levels of medications will be decreased, possibly to subtherapeutic levels. Without assessing for possible AOD use, some physicians may mistakenly increase medication doses.

- Alcohol interferes with the thermoregulatory center of the brain, as do antipsychotic drugs. Patients taking both medications may be unable to adjust their body temperature in response to extremes in the external environment.

- The interaction of stimulants in a person taking monoamine oxidase inhibitor antidepressants can lead to a life-threatening hypertensive crisis.

- Alcohol and cocaine enhance the respiratory depression effects of opioids and some neuroleptics such as the phenothiazines. This effect can increase vulnerability to overdose death.

- Marijuana has anticholinergic effects. In combination with the anticholinergic medications such as Cogentin, marijuana use can lead to an anticholinergic (atropine) psychosis.

- Patients who are vulnerable to hallucinations, such as schizophrenic patients, are at high risk for having hallucinations during the withdrawal from alcohol and other sedative-hypnotics.

- Antipsychotics and antidepressants lower the seizure threshold and enhance seizure potential during withdrawal from sedative-hypnotics and alcohol.

- Alcohol intoxication and withdrawal disturbs the fluid electrolyte balance in the body, which can lead to lithium toxicity.

Appendix A – Bibliography

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Appendix B – Treatment of Patients With Dual Disorders: Sample Cost Data

To provide readers with illustrative data on the costs of running programs for patients with dual disorders, the consensus panel Chair obtained data on actual costs during fiscal year 1991-1992 from three programs in urban areas. One program, on the West Coast, provided day and evening intensive outpatient services. The second, in the Northeast, provided intensive outpatient services during the day. In the third program, in the Northwest, daytime intensive outpatient services, partial hospitalization, and intensive case management were provided.

Included in the tables below are descriptive data for each program, including institutional status (for example, private for-profit or public), payer mix (for example, Medicaid or self-pay patients), number of clients served (at 100 percent capacity), salary ranges of various levels of staff, and other expenses (for example, facility costs). Total expenses and total revenues for each program are listed at the end.

TREATMENT OF PATIENTS WITH DUAL DISORDERS SAMPLE COST DATA

	Program 1	Program 2	Program 3
PROGRAM TYPE			
Evening Intensive Outpatient	X		
Day Intensive Outpatient	X	X	X
Partial Hospitalization			X
Other			Day treatment and intensive case management
REGION	West Coast	Northeast	Northwest
LOCALE	Urban	Urban	Urban
INSTITUTIONAL STATUS			
Private for-profit	X		
Private nonprofit			
Public		X	X
Other			
PAYER MIX (BY PERCENT)			
Insurance/Managed Care	X		
Medicaid		66%	30%
Medicare	X		25%
Self-pay	X	4%	
HMO contract	X		
State grant/purchase of care		30%	45%

	Program 1	Program 2	Program 3
NUMBER OF PATIENTS SERVED (AT 100 PERCENT CAPACITY)			
Daily	50+	45	100

Weekly	320	225	300
SALARY RANGES			
Administrators/managers	$60,000 to 70,000	$38,000 to 50,000	$35,000 to 60,000
Physicians	$70/Hour to 100/Hour	$85,00	$70,000 to 90,000
Social workers	$30,000 to 50,00	$30,000	$26,000 to 35,000
Psychologists	$50,000 to 60,000	n/a	$50,000 to 70,000
Support staff	$18,000 to 27,000	$20,000 to 29,000	$22,000 to 28,000
Other	Addiction counselors, $23,000 to 35,000	Nurses, counselors and recreational therapists, $25,000 to 38,000	Addiction mental health specialists, $23,000 to 33,000
			Nurses $32,000 to 48,000

	Program 1	**Program 2**	**Program 3**
OTHER EXPENSES (BY PERCENT)			
Administrative overhead	7.1%	24%	20%
Personnel (including fringe benefits)	80.5%	60%	70%
Facility costs	12.4%	16%	10%

	TOTAL EXPENSES FY 1991-1992	**TOTAL REVENUES FY 1991-1992**
Program 1	$482,000	$489,000
Program 2	$811,052	$561,052
Program 3	$2,200,000	$1,980,000

Appendix C – Federal Resource Panel

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Exhibits

Exhibit 2-1
DSM-III-R and DSM-IV Draft Criteria for AOD Dependence

DSM-III-R Criterion No.	DSM-IV Draft Criterion No.	Diagnostic Criterion (language from DSM-III-R)
No. 1	No. 3	AODs are often taken in larger amounts or over a longer period of time than the person intended.
No. 2	No. 4	The person has a persistent desire or has made one or more unsuccessful efforts to cut down or control AOD use.
No. 3	No. 5	The person spends a great deal of time in activities necessary to obtain, consume, or recover from AOD effect
No. 4	Deleted	The person experiences frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations at work, school, or home, or when AOD use is physically hazardous.
No. 5	6	Important social, occupational, or recreational activities are given up or reduced because of AOD use.
No. 6	7	AOD use continues despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by AOD use.
No. 7	1	There is evidence of marked tolerance: a need for markedly increased amounts of AODs to achieve intoxication or a desired effect, or markedly diminished effect with continued use of the same amount.
No. 8	2	Evidence of characteristic withdrawal symptoms.
No. 9	2	AODs are often taken to relieve or avoid withdrawal symptoms.

Exhibit 3-1
Treatment Approach Similarities and Differences

	Mental Health System	Dual Disorders Approach	Addiction System
Medications	Central to the management of severe disorders in acute, subacute, and long-term phases of treatment: antidepressants, antipsychotics, anxiolytics, mood stabilizers.	Central to the treatment of many patients with dual disorders. Caution is used when prescribing psychoactive, mood-altering medications.	Central for acute detoxification; less common for subacute phase. Few used during long-term treatment: disulfiram, naltrexone, methadone, and LAAM.
Therapeutic Confrontations	Minimal to moderate use, depending upon setting, patient, and problem. Not central to therapy.	Generally used, but use is modulated according to fragility of mental status.	Use by staffand peers is one of the central techniques in AOD treatment.
Group Therapy	Central to treatment.	Central to treatment.	Central to treatment.
12-Step Groups	Although historically underused, use is growing. Examples include: Emotions Anonymous, Obsessive-Compulsive Anonymous, and Phobics Anonymous.	Dual Disorders Anonymous groups not yet widespread. Use of 12-step groups for AOD problems is central, but actively psychotic or paranoid patients may not mix well in meetings. "Double Trouble" AA groups are becoming more numerous.	Use of 12-step groups is central to AOD treatment. Great availability. Examples include: Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous.

Other Self-Help Groups	Numerous national organizations. Growing numbers of local groups. Use depends upon availability and awareness. Examples include: Anxiety Disorders Association of America, National Depressive & Manic-Depressive Association, Recovery, Inc., and National Association of Psychiatric Survivors.	Use of self-help groups regarding AOD and mental health problems is increasing.	Numerous organizations and groups, often specialized. Examples include: Women for Sobriety, Rational Recovery, Secular Organizations for Sobriety, International Doctors in AA, Recovering Counselors Network, and Social Workers Helping Social Workers.

Exhibit 3-2

The CAGE and CAGEAID Questionnaires

The CAGE Questionnaire:

- Have you ever felt you should cut down on your drinking?
- Have people annoyed you by criticizing your drinking?
- Have you felt bad or guilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?

Source: Mayfield et al., 1974.

The CAGE Questions Adapted to Include Drugs (CAGEAID):

- Have you felt you ought to cut down on your drinking or drug use?
- Have people annoyed you by criticizing your drinking or drug use?
- Have you felt bad or guilty about your drinking or drug use?
- Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover or to get the day started?

Source: Brown, 1992.

Exhibit 5-1

Drugs That Precipitate or Mimic Mood Disorders

Mood Disorders	During Use [Intoxication]	After Use [Withdrawal]
Depression and dysthymia	Alcohol, benzodiazepines, opioids, barbiturates, cannabis, steroids (chronic), stimulants (chronic)	Alcohol, benzodiazepines, barbiturates, opiates, steroids (chronic), stimulants (chronic)
Mania and cyclothymia	Stimulants, alcohol, hallucinogens, inhalants (organic solvents), steroids (chronic, acute)	Alcohol, benzodiazepines, barbiturates, opiates, steroids (chronic)

Exhibit 7-1

Characteristics of People With Passive-Aggressive, Antisocial, and Borderline Personality Disorders

Characteristic	Passive-Aggressive	Antisocial	Borderline
Affect	Overcontrolled hostility	Angry intimidation	Angry self-harm
World-view	I do everything right and they still act this way. I don't deserve this. I'm fine; ignore the tears.	If you don't do what I want, you'll be sorry. I deserve it all. They're the ones with the problem.	I've got to get you, before you get me. I don't deserve to exist. Help me, help me, but you can't.
Presenting problem	Depression, somatization, sedative dependence, codependency relationships	Legal difficultie polysubstance abuse and dependence, parasitic cold relationships	Self-harm, impulsive behavior, episodic polysubstance abuse.
Social functioning	Consistent underachievement	Episodic achievement	Gross dysfunctioning
Motivation	Belonging	Self-esteem	Safety

Defenses	Repression	Rationalization, projection	Splitting, projection

Adapted with permission from Evans, K., and Sullivan, J.M. Step Study Counseling With the Dual Disordered Client. Center City, Minnesota: Hazelden Educational Materials, 1990.

Exhibit 7-2

Step Work Handout For Patients With Borderline Personality Disorder

Step One: *"We admitted we were powerless over alcohol-that our lives had become unmanageable."*

- Describe five situations where you suffered negative consequences as a result of drinking or using other drugs.
- List at least five "rules" that you have developed in order to try to control your use of alcohol or other drugs. (Example: "I never drink alone.")
- Give one example describing how and when you broke each rule.
- Check the following that apply to you:
    - I sometimes drink or use other drugs more than I plan.
    - I sometimes lie about my use of alcohol or other drugs.
    - I have hidden or stashed away alcohol or other drugs so I could use them alone or at a later time.
    - I have had memory losses when drinking or using other drugs.
    - I have tried to hurt myself when drinking or using other drugs.
    - I can drink or use more than I used to, without feeling drunk or high.
    - My personality changes when I drink or use other drugs.
    - I have school or work problems related to using alcohol or other drugs.
    - I have family problems related to my use of alcohol or other drugs.
    - I have legal problems related to my use of alcohol or other drugs.
- Give two examples for each item that you checked.

Step Two: *"We came to believe that a Power greater than ourselves could restore us to sanity."*

- Give three examples of how your drinking or use of other drugs was insane. (One definition of insanity is to keep repeating the same mistake and expecting a different outcome.)
- Check which of the following mistakes or thinking errors that you use:
    - Blaming
    - Lying
    - Manipulating
    - Excuse making
    - Beating up yourself with "I should have" statements
    - Self-mutilation (cutting on yourself when angry)
    - Negative self-talk
    - Using angry behavior to control others
    - Thinking "I'm unique."

- Explain how each thinking error you checked above is harmful to you and others.
- Give two examples of something that has happened since you stopped drinking or using other drugs that shows you how your situation is improving.
- Who or what is your Higher Power?
- Why do you think your Higher Power can be helpful to you?

Step Three: *"Made a decision to turn our will and our lives over to the care of God as we understood Him."*

- Explain how and why you decided to turn your will over to a Higher Power.
- Give two examples of things or situations you have "turned over" in the last week.
- List two current resentments you have, and explain why it is important for you to turn them over to your Higher Power.
- How do you go about "turning over" a resentment?
- What does it mean to turn your will and life over to your Higher Power?
- Explain how and why you have turned your will and life over to a Power greater than yourself.

Step Four: *"Made a searching and fearless moral inventory of ourselves."*

- List five things you like about yourself.
- Give five examples of situations where you have been helpful to others.
- Give three examples of sexual behaviors related to your drinking or use of other drugs, which have occurred in the last 5 years, about which you feel bad.
- Describe how beating yourself up for old drinking and other drug-using behavior is not helpful to you now.
- List five current resentments you have, and explain how holding on to these resentments hurts your recovery.
- List all laws you have broken related to your drinking and use of other drugs.
- List three new behaviors you have learned that are helpful to your recovery.
- List all current fears you are experiencing, and discuss how working the first three Steps can help dissolve them.
- Give an example of a current situation you are handling poorly.
- Discuss how you plan to handle this situation differently the next time the situation arises.

Adapted with permission from Evans, K., and Sullivan, J.M. Step Study Counseling With the Dual Disordered Client. Center City, Minnesota: Hazelden Educational Materials, 1990.

Exhibit 7-3
Recovery Model for the Treatment Of Borderline Personality Disorder

Stage	Indications	Goal	Interventions

I. Crisis	Behavior out of control; risk of harm to self or others; extreme withdrawal or intrusiveness	Safety and health through structure and support	• Inpatient stay • Contracts for safety • Case manager or support groups • Identify triggers for relapse or stress to plan for crisis • Make daily or weekly schedule to structure time
II. Building	Routine attendance at therapeutic sessions, meetings, appointments; some ability to stay focused on here and now	Increasing coping skills and self-esteem	• Develop an assets or accomplishments list • Positive self-talk and affirmations • Skills training in time management, assertiveness, and so on
III. Education	Expresses, exhibits increased self-efficacy	Reframe self-perceptions and history from victim to survivor	• Read or debrief clinician-prescreened ACOA or incest-survivor literature • Classes on dysfunctional families, survivor issues • Written assignments on strengths and limitations of "survivor behaviors"
IV. Integration	Able to express feelings	Integrate past, present, and regulate thinking and actions behaviors	• Art therapy, journal work, current feelings, thoughts, other expressive modalities • Psychodynamic therapy, here-and-now interpretations • Grief and child-within work, marital, sex, or family therapy

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Exhibit 7-4

Antisocial Thinking-Error Work

The group facilitator will present thinking errors and then ask each group member to identify two thinking-error examples that apply to him or her and to choose one to focus on with group help.

1. **Excuse making** -- Excuses can be made for anything and everything. Excuses are a way to justify behavior. For example: "I drink because my mother nags me," "My family was poor," "My family was rich."

2. **Blaming** -- Blaming is an excuse to avoid solving a problem and is used to excuse behavior and build up resentment toward someone else for "causing" whatever has happened. For example: "They forced me to drink it!"

3. **Justifying** -- To justify an antisocial behavior is to find a reason to support it. For example: "If you can, I can," "I deserve to get high," "I've got 30 days clean."

4. **Redefining** -- Redefining is shifting the focus on an issue to avoid solving a problem. Redefining is used as a power play to get the focus off the person in question. For example: "I didn't violate my probation. The language is confusing and the order is full of typos."

5. **Superoptimism** -- "I think; therefore it is." Example: "I don't have to go to AA. I can stay sober on my own."

6. **Lying** -- There are three basic kinds of lies: (1) lies of commission -- making things up that are simply not true; (2) lies of omission -- saying partly what is so, but leaving out major sections, and (3) lies of assent -- pretending to agree with other people or approving of their ideas despite disagreement or having no intention of supporting the idea.

7. **"I'm Unique"** -- Thinking one is special and that rules shouldn't apply to one.

8. **Ingratiating** -- Being nice to others, and going out of one's way to act interested in other people, can be used to try to control situations or get the focus off a problem. Apple polishing.

9. **Fragmented Personality** -- Some people may attend church on Sunday, get drunk or loaded on Tuesday, and then attend church again on Wednesday. They rarely consider the inconsistency between these behaviors. They may feel that they have the right to do whatever they want, and that their behaviors are justified.

10. **Minimizing** -- Minimizing behavior and action by talking about it in such a way that it seems insignificant. For example: "I only had one beer. Does that count as a relapse?"

11. **Vagueness** -- This strategy is to be unclear and nonspecific to avoid being pinned down on any particular issue. Vague words are phrases such as: "I more or less think so," "I guess," "probably," "maybe," "I might," "I'm not sure about this," "it possibly was," etc.

12. **Power Play** -- This strategy is to use power plays whenever one isn't getting one's way in a situation. Examples include walking out of a room during a disagreement, threatening to call an attorney or report the group facilitator to higher-ups.

13. **Victim Playing** -- The victim player transacts with others to invite either criticism or rescue from those around him.

14. **Grandiosity** -- Grandiosity is minimizing or maximizing the significance of an issue, and it justifies not solving the problem. For example: "I was too scared to do anything else but sit," "I'm the best there is, so no one else can get in my way."

15. **Intellectualizing** -- Using an emotionally detached, data-gathering approach to avoid responsibility. For example, when faced with a positive urine drug screen the patient states: "When was the last time the laboratory had their equipment calibrated?" or "What is the percentage of error in this testing procedure?"

Adapted with permission from Evans, K., and Sullivan, J.M. Step Study Counseling With the Dual Disordered Client. Center City, Minnesota: Hazelden Educational Materials, 1990.

Exhibit 7-5
Step Work Handout For Patients With Antisocial Personality Disorder

Step One: *"We admitted we were powerless over alcohol -- that our lives had become unmanageable."*

- Give five examples of ways you have tried to control your use of chemicals and failed.

- Give five examples of people you have tried and failed to control, and explain why your controlling behavior was unsuccessful (minimum of 150 words each).

- Give five examples of situations not associated directly with drinking or using other drugs where you have tried to control things and failed (minimum of 100 words each).

- Give two examples of people who currently have control over you, and explain how that is helpful to you (minimum of 100 words each).
- Give ten examples of how your drinking and using other drugs caused you problems (minimum of 25 words each).
- Give five examples of negative consequences that await you should you continue using or abusing alcohol or other drugs (minimum of 50 words each).

Step Two:*"Came to believe that a Power greater than ourselves could restore us to sanity."*

- Repeating the same mistake over and over when you continually receive negative consequences is one definition of insanity. From the list below, identify your "mistakes" (place a check mark on the line next to each "mistake" that applies). Then, below the list, explain how each of these mistakes in your thinking has caused you problems.
    - Excuse making
    - Minimizing
    - Blaming
    - Intentionally being vague
    - Using anger and threats
    - Superoptimism
    - Using power plays
    - Playing the victim
    - Making fools of others
    - Love for drama and excitement
    - Assuming what others think and feel
    - Not listening to others and being closed-minded
    - Thinking "I'm unique"
    - Maintaining an "image"
    - Being ingratiating (kissing up)
    - Being grandiose
    - Lying: commission, omission, assent
- List three people with whom you are angry and explain how they can be helpful.
- List five people more powerful than you who can help you stay clean and sober. Explain why and how each person can help.
- Who or what is your Higher Power?
- Describe how this Higher Power can help you with your mistakes in thinking.

Step Three: *"Made a decision to turn our will and our lives over to the care of God as we understood Him."*

- How did you decide that you needed to turn your will over to a Higher Power?

- Why is it important for you to turn your will and life over to a Higher Power?
- Explain how you go about "turning it over."
- Give three examples of things you have had to "turn over" in the last week.
- Give three examples of things you have yet to turn over and explain how and when you plan to do so.
- What does it mean to "turn your will and life over to your Higher Power"?
- Without displaying any thinking errors, explain how and why you have turned your will and life over to a Power greater than yourself.

Step Four: *"Made a searching and fearless moral inventory of ourselves."*

- List any and all law violations you have committed regardless of whether or not you were caught for these crimes.
- List every person you have a resentment against, and explain how this resentment is hurting you.
- Give ten examples of sexual behavior you engaged in that was harmful to your partner, and explain the negative consequences to you of this behavior.
- Give five examples of aggressive behavior (either verbal or physical) you have been involved in, and explain how it was hurtful to the other person and to you.
- List five major lies you have told, and explain how that lying was hurtful to you.
- List three lies you have told within the last 48 hours, and explain how this lying hurts your recovery program.

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