

Psychotherapy of Dually Diagnosed Addicts: An Attempt to a Synthesis

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Abstract

Dual - Diagnosis conditions have important clinical implications for the newly established multidisciplinary approach in treating addiction. This paper is an outcome of the assimilation of a good number of publications on the subject with the aim of presenting a way to tackle the problem.

Introduction One of the greatest challenges facing the mental health community today is the accurate diagnosis and treatment of the client with dual disorders, those who have both chemical dependency and a separate but intermingled psychiatric disorder. It has been estimated that at least 30 percent of the clients presenting with chemical dependency have an underlying mood or anxiety disorder (*Meyer 1986; Gerstley et al 1990*). Many more individuals have personality disorders, eating disorders, schizophrenia or other psychiatric disorders.

In the past, dually diagnosed individuals were often treated by detoxification with little emphasis on underlying psychiatric pathology or individual treatment planning (*Osher & Kofoed 1989*). Many mental health

professionals incorrectly assumed that addiction was only a symptom of a psychiatric disorder and, once treated, the chemical dependency would disappear. The result of this narrow focus was a misdiagnosed and partially treated client.

Today, the diagnosis of individuals with dual psychiatric and chemical dependency issues remains difficult; yet missing the diagnosis altogether is truly tragic Ford et al (1989). If mental health professionals can learn to apply their knowledge within an interdisciplinary framework, they position themselves to make major advances in the current and future treatment of the chemically dependent (*Minkoff 1989; Schukit 1988*).

Psychiatric Disorders and Substance Abuse *	
A recent study by the National Institute of Mental Health found a significant relationship between psychiatric disorders and substance abuse. For example, the following table lists major psychiatric disorders with their increased risk for substance abuse:	
Psychiatric disorder:	Increased risk of substance abuse
Schizophrenia	10.1
Major Depressive Episode	4.1
Manic Episode	14.5
Obsessive - Compulsive Disorder	3.4
Phobias	2.4
Panic Disorder	4.3
Antisocial Personality Disorder	15.5

* *Overcoming addiction and psychiatric disorders* A. Scott Winters M.D. the PIA press Washington

Addiction and Mental Disorders

Mood disorders represent the most common psychiatric disorders that coexist with chemical dependency (Levin 1987; Sternberg 1989). They appear in two distinct forms: depressions and bipolar or manic-depressive disorders or variants of these two. During treatment of these disorders, the presence of co-existing chemical dependency, especially alcohol with its depressant effects, clouds the diagnostic presentation. Among clients presenting for chemical dependency treatment and depression, at least 50 percent will have marked improvement, if not complete resolution, of their depression following three weeks of sobriety.

Anxiety disorders represent a diverse spectrum of disorders, including generalized anxiety disorder, panic disorder, phobias, obsessive-compulsive disorder, and post-traumatic stress disorder. As a class, they represent either the direct expression of anxiety in the form of apprehension, fear or uncomfortable physiologic arousal, or they represent an exaggerated defense mechanism to combat the anxiety. Alcohol and antidepressant drugs are often used by these individuals as a form of self-medication although the anxiety is almost always worse after the chemical wears off, resulting in increased anxiety.

Individuals with antisocial personality disorders are prone to using mood-altering drugs and alcohol as they are frequently troubled, tense, and unable to tolerate boredom (Grande *et al* 1984). These drugs remove what few inhibitions the client may have, increasing the risk of unleashing anger and potential violence. The borderline personality is also prone to chaotic flare-ups of anger and violence triggered by chemical dependency. These individuals have a great deal of uncertainty about many important life issues such as self image, career, values, sexual orientation or friendships. With such conflicts in their lives, these individuals may use stimulants to induce feelings of pleasure or depressants to reduce internal distress (Nace & Isbell 1991).

People with dependent personality disorders are also uncertain about every day decisions and require a great deal of reassurance, prompting, and advice from others. They have a strong fear of being rejected and will go to

great lengths to please others (Mirin *et al* 1988). This disorder may lead to codependent relationships whereby the individual becomes emotionally dependent on the addicted person and enables their chemical or behavioral disorder. When treating addicted individuals, professionals must anticipate the unconscious resistance by any codependent family members. It is important to note that codependency is not limited to those with dependent personality traits. Anyone has the potential to become a codependent, regardless of personality style.

In contrast to the dependent personality, the schizophrenic individual has an impaired ability to express emotions with a significant degree of emotional distortion as well as disturbances in thoughts and behavior. Since the schizophrenics lack a solid grasp on reality, they are unable to envision the consequences of their actions before they take chemicals, and they are more susceptible to the use of mood-altering drugs, especially depressants. Schizophrenic clients can be helped by antipsychotic medications although they become easily frustrated about having to take the medications and frequently stop.

Nature of Addiction Before dual diagnosis patients can be treated effectively, the nature and dynamics of the addiction must be appreciated fully. Although psychiatrists have been well trained in their speciality, it is disturbing that many lack the most basic understanding and training in the specialized field of substance abuse treatment. It is very important to understand that addiction is a chronic and progressive disorder (Mivin & Weiss 1991).

Once entrenched, addiction can always be reactivated, even after long periods of abstinence. Medical, psychiatric, and psychosocial deterioration eventually compel the patient to seek treatment, although addicts seldom want to cease substance use altogether.

Euphoria and craving drive addiction, representing positive and negative reinforcers, respectively. The importance of euphoria explains why drugs that are the most capable of activating reward centers, such as central stimulants and opiates, are the most addictive agents. The biologic nature of drug reward (euphoria) is underscored by the amazing fact

that monkeys will self administer cocaine to the point of death and to the exclusion of eating, drinking fluids, or mating. By stimulating reward centers, drugs in effect "trick" the brain into thinking that a survival need is being met, when in fact the threat of mortality is close. Indeed, it is the high mortality rate that justifies aggressive treatments for substance abuse, and the lure of euphoria that sometimes precludes the efficacy of outpatient treatment approaches .

At variable times after intoxication wears off craving for further drug use develops. Modern research strongly suggests that neurochemical alterations caused by chronic exposure to addictive agents form the biologic basis of drug craving. For instance, functional depletion of dopamine in cocaine use and hyperactivity with opiate withdrawal appear to be related to craving and abstinence symptoms associated with these agents. Active neurochemical mechanisms that generate craving are needed and evolved for basic drive states. Thirst is required to ensure fluid intake, and hunger, to ensure nourishment. Interestingly, dopamine circuits that are profoundly involved in cocaine euphoria and craving are also intimately involved in these natural survival drives. Drug craving may even be conceptualized as an "acquired drive" that is similar to or even more intense than hunger, thirst, and sexual drive. This link to powerful mid-brain structures, both with regard to craving and euphoria, provides some insight into the high levels of recidivism encountered with addiction. Genetic loading appears to predispose certain individuals, based on extensive family studies and recent genetic mapping data. Genetic factors may even influence susceptibility to euphoria and craving, as evidenced by the recent implication of the dopamine D2 receptor gene in alcoholism. Although popular and appealing, the self-medication hypothesis of addiction rarely is operational with patients and seldom is helpful in their treatment (*Gold & Slaby 1991*).

A final inherent aspect of addiction that often serves to obscure the clinical picture is denial. Since addiction is pleasurable, and abstinence painful, the addict seldom wants to stop using until reality forcibly shatters his

denial system. Until then, denial gradually builds in response to (and one step ahead of) the insidious progression of addiction. The development of denial is largely unconscious in the addict and often is not noticed by family members who, immersed in their own denial, provide ever-expanding "safety nets" for the patient. Clinicians therefore must weigh each answer by patients and families against the likelihood that there is minimization, rationalization, and sometimes outright lying (*Ross et al 1988*).

Untreated addicts tend to develop progressive medical, psychiatric, and psychosocial problems. Tolerance and abstinence symptoms lead patients to realize that they are "physically" addicted, even though they have often been within the grips of biologically mediated craving and euphoria for years. Psychosocial deterioration typically involves family conflict, interpersonal isolation, impaired job performance, and inappropriate social functioning. Although denial enables the addict to tolerate increasingly severe impairment, external pressure due to legal, family, occupational, or medical problems will eventually shatter the illusion of well-being. It is at this point that the substance abuse reluctantly seeks external assistance (*McLellan et al 1979*).

The Psychotherapy of Dually Diagnosed Patients: Some Suggestions The dual diagnosis patient is most effectively treated in a specialized dual diagnosis unit (DDU). This unit should be staffed by nurses, social workers, psychologists, CACs, (recovered ex-patients) and mental health workers under the direction of a psychiatrist who sees each patient daily. It is the responsibility of the psychiatrist to possess the expertise required and use the authority needed to coordinate the medical, psychiatric, and rehabilitative treatments. Individual psychotherapy, family therapy, creative therapies, and other psychiatric modalities are conducted within the therapeutic community . Recovering unit staff members often are very effective and can provide role models through self disclosure. Obviously, the unit director physician must be familiar with all of the medical and psychiatric aspects of these patients. Rigid philosophic adherence to

either psychiatric or other approaches at the expense of the other is avoided. The psychiatrist and the treatment team reconcile these divergent and sometimes antagonistic approaches into an integrated treatment that addresses both illnesses. The dynamics of addiction and psychiatric illnesses, along with their respective treatments, are understood and discussed freely by the entire staff.

From my experience locked units are preferable for a number of reasons. Impulsive patients may run away in response to drug craving or, if withdrawal symptoms are present in addiction, drugs are prevented from finding their way onto the unit and suicidal patients are secured. Visitors should be screened by the staff, and visitation is better controlled with locked doors. Laboratory support is obviously critical, particularly when emergency medical tests are needed. Urine testing for substances of abuse should be conducted and a reliable laboratory and assay method should be available and used. Sufficient staffing should exist to provide special observation and treatment for suicidal or potentially assaultive patients. Unit rules should be enforced consistently, and drug use, and physical violence should be grounds for possible transfer or discharge. It is often useful to have a psychiatric unit in the same facility for patients unable to follow rules due to psychiatric impairment (*Case 1991*).

The psychotherapy of dually diagnosed patients can be divided into three phases: (1) achieving sobriety, (2) maintaining abstinence and early recovery, and (3) advanced recovery. To out line these: The phase of achieving sobriety includes: assessing psychopathology and the extent and consequences of substance abuse, developing methods to establish and maintain a drug - free state , diagnosing and beginning treatment of other disorders, enlisting participation of significant others, and finally, developing a therapeutic contract . The phase of early recovery involves a supportive, directive psycho-therapeutic approach that focuses on the disease of substance abuse and the goal of abstinence as well as on adequate treatment for concomitant psychiatric disorders. In this phase, defenses are redirected and psychodynamic psychotherapy is used mainly to reinforce methods of

maintaining abstinence. Therapy during the advanced recovery phase uses a more traditional reconstructive psychotherapeutic approach that explores underlying issues. Of course, when the psychiatric diagnosis a major psychotic illness such as schizophrenia or bipolar disease, therapy is directed more towards prevention of recurrence of psychosis through understanding of psychosocial stressors, facilitating medication compliance, and family education with personality disorders and anxiety disorders. The goal is insight and personality change using an integration of psycho-dynamic psychotherapy and cognitive behavioral methods. Defenses and underlying issues are explored while a firm identity and control of substance abuse is maintained.

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