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ADDICTIVE DISORDERSDUAL DIAGNOSIS¹**SUMMARY**

An examination of “Dual Diagnosis” for substance abuse and co-existing mental health disorders, including screening and assessment, detoxification, treatment and discharge planning.

ARTICLE

All treatment professionals, physicians, mental health professionals, addiction/recovery professionals, and lay counselors are presented with problems outside of their scope of practice. Recognition of these problems, referral to appropriate treatment professionals and collaboration with these professionals is important in providing appropriate treatment to the individual patient/client.

The subject of Dual Diagnosis is of primary concern to counselors and treatment professionals in both mental health and substance abuse facilities. Many counselors and treatment professionals are specialists in either substance abuse or mental health and are ignorant or intimidated by co-existing mental health problems (Daley, Moss, and Campbell, 1987, Hatfield, 1993, and O’Connell, 1990). This ignorance has led to many persons receiving treatment only for the “primary diagnosis” and the co-existing problem has not been addressed, leading to a swift deterioration of the client/patient after discharge from treatment (O’Connell, 1990).

Alcoholism treatment centers historically chose to deal with the single-issue problem of alcoholism, then evolved to treat other substance abuse addictions, and over the past several years have been called upon to provide treatment of dually diagnosed patients/clients. Initially, the substance abuse treatment community balked at treating dually diagnosed persons, offering the reasonable argument that they could not be all things to all people, were not equipped to handle the medication management needed for these persons, and did not have staff trained to recognize and deal with the dually diagnosed individual (O’Connell, 1990).

With research statistics showing that over 70% of all substance abusing individuals suffer with some sort of mental illness, recovery professionals can no longer continue to remain ignorant of dually diagnosed participants (Daley, Moss, and Campbell, 1987 and O’Connell, 1990). As the evolution of substance abuse treatment continues, the problem of dealing with dual diagnosis must be addressed. Recovery treatment professionals will find it necessary to become open-minded and learn to collaborate their efforts with the mental health community to expand

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individualized treatment plans and improve treatment outcomes (O'Connell, 1990).

What is “Dual Diagnosis”?

Dual Diagnosis is a comprehensive term used to describe the presence of two co-occurring medical and/or mental health disorders and, for the purposes of this course, is simply the combination of a substance abuse diagnosis and a co-existing mental health diagnosis (U.S. Dept. Health and Human Services, 1994). Examples of Dual Diagnosis are a combination of stimulant abuse and depression, bipolar disorder and alcoholism, and schizophrenia and polydrug abuse (U.S. Dept. Health and Human Services, 1994). Many persons seek relief of their mental health symptoms by self-medicating with drugs and alcohol (Brown, S., 1999, and O'Connell, 1990).

Traditionally, severely mentally ill persons have been seen more often in mental health facilities than in substance abuse treatment centers, due to biased substance abuse treatment philosophies that preclude services that include medication management and alternative behavioral and counseling techniques (O'Connell, 1990). Mental health facilities, themselves, biased toward the treatment of mental illness, have provided inadequate treatment for the chemical abuse problem (Bailey, K. 2002).

Persons with a dual diagnosis more often experience greater social, emotional, and chronic health problems than those who suffer only chemical addiction or mental illness alone (U.S. Dept. Health and Human Services, 1994). Persons suffering with a dual diagnosis will need treatment for both problems to achieve a positive treatment outcome and treatment of only one problem may lead to a return to substance abuse and impaired functioning due to the mental health problem (U.S. Dept. Health and Human Services, 1994).

Some mental health problems are linked to the use of specific drugs, some substance abuse disorders have symptoms that mimic psychiatric diagnosis, and persons with mental health disorders will sometimes use specific drugs in an attempt to “self-medicate” the discomfort they suffer (O'Connell, 1990). There seems to be much controversy over what occurred first, the mental illness or the substance abuse problem, and the consensus seems to be that this is a moot point (National Mental Health Assn., 1997, Brown, S., 1999, and O'Connell, 1990). Whether one or the other occurred first, both illnesses need treatment and detoxification must take place prior to initiating effective mental health treatment (National Mental Health Assn., 1997).

Screening and Assessment

Both mental health and addiction/recovery professionals have long recognized the importance of screening and assessment as leading to the proper placement of clients in an appropriate level of care setting. Assessment questions should address the possible co-existence of substance abuse and mental health issues as over 70% of substance abusers have or have had a mental health diagnosis (Daley, Moss, and Campbell, 1987 and O'Connell, 1990). The most common psychiatric diagnoses among chemical abusers are anxiety disorder and mood disorder (U.S. Dept. Health and Human Services, 1994).

A client with a coexisting mental illness and alcohol or drug problem can be difficult to assess (Hatfield, 1993). Delirium, disorientation, tremors, variation in perception, and physical agitation may be observed and the cause could be chemical withdrawal, mental illness, or a combination of the two (O'Connell, 1990). Evaluation of the potential for violence and whether the person is of danger to himself or others is of utmost importance (Hatfield, 1993 and O'Connell, 1990).

Persons who talk about suicide and homicide **do** attempt to harm themselves and/or others and are more prone to do so when the person is under the influence of drugs or alcohol (O'Connell, 1990).

Comprehensive and diverse assessment tools should be utilized to insure that the individual's physical, substance abuse, and mental status are evaluated properly (U.S. Dept. Health and Human Services, 1994). The assessment should focus on identifying and stabilizing the crisis, insuring that the client has no life threatening disorders, evaluating the risk of danger to themselves or others, and placement in the proper treatment modality (U.S. Dept. Health and Human Services, 1994). The ability of the individual to tolerate, comprehend, and engage in a specific treatment atmosphere is more important in assessing placement than the specific diagnosis (U.S. Dept. Health and Human Services, 1994).

The observations of the person doing the assessment are an important component to the evaluation process and should be noted as part of the assessment (U.S. Dept. Health and Human Services, 1994). The appearance, speech, overall behavior, hygiene, gait and any seemingly erratic or illogical thinking or actions should be noted as part of the assessment (O'Connell, 1990). Ask probing questions when inquiring about alcohol and drug use to determine frequency and quantity of substance use can yield possible relationships between chemical use and psychotic symptoms (U.S. Dept. Health and Human Services, 1994).

It is important to note that if the person is intoxicated no accurate evaluation of mental status can be performed and if a dual disorder is suspect or known, re-assessment of the patient's condition should occur after detoxification (Brown, S., 1999, National Mental Health Assn., 1997, and O'Connell, 1990). If a dual disorder has been previously diagnosed, re-assessment should occur on a regular basis whether the person is currently in detoxification or not as changes in the patient's mental status can occur and interfere with treatment and safety (National Mental Health Assn., 1997 and O'Connell, 1990).

Dual Diagnosis and Common Drugs of Abuse

Anxiety Disorders

Anxiety is the most common symptom seen in substance abusers and will clear up within a few days to a few weeks if the cause is alcohol or drug abuse (U.S. Dept. Health and Human Services, 1994). A person who presents with an anxious mood that is present for at least a month combined with intense apprehension, hyper vigilance, uncontrolled hyperactivity, and motor tension combined with prolonged anxiety may be suffering from an anxiety disorder (O'Connell, 1990). Symptoms may vary in intensity and when severe the sufferer presents a dysfunctional, tormented, depressed, and demoralized attitude (O'Connell, 1990).

Persons with an anxiety disorder often abuse alcohol, sedatives, and barbiturates in an attempt to self-medicate their symptoms of irritability, insomnia, tension, and fear (O'Connell, 1990). They may become extremely fearful or feel embarrassment or humiliation when in public and avoid social situations to prevent symptoms from occurring (U.S. Dept. Health and Human Services, 1994).

Mood Disorders

Up to 40% of alcohol abusers and over half of drug abusers report symptoms of a mood disorder such as bipolar disorder, major depression, and mania (U.S. Dept. Health and Human Services, 1994). Persons in detoxification, having acute or chronic abuse of drugs, or while under the influence of alcohol and drugs may show symptoms of a mood disorder such as

depression, impaired attention and memory, confusion, elation, and loss of coordination (U.S. Dept. Health and Human Services, 1994).

Persons suffering from a mood disorder may use stimulants such as cocaine and amphetamines to increase both physical and mental energy and give them a feeling of well being (U.S. Dept. Health and Human Services, 1994). They may also use opioids, benzodiazepines or alcohol as these drugs cause an initial feeling of elation and euphoria followed by a period of relaxation (O'Connell, 1990 and U.S. Dept. Health and Human Services, 1994).

Psychological symptoms can prompt the urge to drink or use drugs in an attempt to self-medicate and reports of suicidal thought and behavior are prevalent in persons with a mood disorder (O'Connell, 1990 and U.S. Dept. Health and Human Services, 1994).

Personality Disorders

Among patients admitted for psychiatric services, the highest incidence of substance abuse is found in persons diagnosed with a personality disorder (O'Connell, 1990). Chemical abuse has been reported in over 40% of alcoholics and over 60% of drug users who suffer with personality disorders such as antisocial, passive-aggressive, avoidant, and borderline personality disorder (O'Connell, 1990). Symptoms include recklessness, poor impulse control, and an inability to anticipate consequences and regulate emotions (O'Connell, 1990).

Chronic substance abuse and poly-substance abuse are common among this population reportedly to increase the feelings of well-being and decrease impulsivity and guilt (O'Connell, 1990). Benzodiazepines, often prescribed to relieve symptoms, are regularly abused by this population, which often leads to a relapse to their drug of choice (O'Connell, 1990 and U.S. Dept. Health and Human Services, 1994).

Persons with antisocial personality disorder tend to engage in poly-substance abuse and combinations of alcohol, marijuana, cocaine, heroin, and methamphetamine are common for this population (U.S. Dept. Health and Human Services, 1994). Stimulants are a preference for the narcissistic personality disorder and may be combined with marijuana and/or alcohol to relieve feelings of anxiety and depression (U.S. Dept. Health and Human Services, 1994).

Passive aggressive and self-defeating personality disorders seem to vary in their substance abuse preference along the lines of gender (U.S. Dept. Health and Human Services, 1994). Women tend to use sedative-hypnotic medications and alcohol whereas men may mix these medications with stimulants such as cocaine and amphetamines to decrease their inhibitions and increase aggression (U.S. Dept. Health and Human Services, 1994).

Psychotic Disorders

Psychosis is an inability to differentiate fantasy from reality and the most common and best-understood psychotic illness is schizophrenia (U.S. Dept. Health and Human Services, 1994). Schizophrenia is a disease caused by a chemical imbalance in the brain and symptoms include inappropriate emotional response, paranoia, unusual movements, delusional ideas, and auditory and/or visual hallucinations (O'Connell, 1990).

Approximately 47% of persons diagnosed with schizophrenia are suffering from an untreated substance abuse problem and are seen for treatment most often in mental health facilities (O'Connell, 1990 and U.S. Dept. Health and Human Services, 1994). Most often their drugs of

abuse are alcohol and marijuana though they are also known for poly-substance abuse (O'Connell, 1990). Substance abuse in this population is often an attempt at self-medication of mental symptoms and/or to reduce the side effects of prescription medication (U.S. Dept. Health and Human Services, 1994).

Persons suffering alcohol withdrawal and who are under the influence or detoxifying from amphetamine, LSD, or PCP may have symptomology that mimics that of schizophrenia so it is important to note these symptoms and have them assessed by a mental health professional as soon as possible, especially if the symptoms escalate (O'Connell, 1990 and Pasquali, 1989).

Detoxification

Detoxification can present special problems in mentally ill patients and substance abuse can mimic psychiatric disorders (Hatfield, 1993). When dual-diagnosis is suspected, the patient should be observed and current mental and emotional symptoms noted and reported along with physical detoxification symptomology (O'Connell, 1990). If medications are prescribed for physical withdrawal or mental health conditions during detoxification, these medications should be monitored for safety, appropriateness, and effectiveness (U.S. Dept. Health and Human Services, 1994).

Symptoms and response to treatment should be periodically re-assessed and re-evaluated for effectiveness and to insure treatment is occurring in the proper treatment modality (O'Connell, 1990 and U.S. Dept. Health and Human Services, 1994). Any sudden escalation in symptoms is cause for concern and should be immediately reported to appropriate medical or mental health professionals (O'Connell, 1990 and U.S. Dept. Health and Human Services, 1994).

Treatment of Dually Diagnosed Clients

Having completed detoxification and upon appropriate treatment placement the addiction/recovery professional who has assessed the possibility of a co-existing mental health disorder will set up an appointment for a psychological assessment of the client (Daley, Moss, and Campbell, 1987). Prior to a formal diagnosis, the recovery professional may begin to alter their treatment techniques based on their knowledge of the suspected mental health disorder (Daley, Moss, and Campbell, 1987). This is not a license to diagnose, but a reasonable occasion to use alternative counseling approaches with participants in order to help them with their problem of substance abuse without exacerbating their mental state. Anxiety Disorders Persons with anxiety disorders may require short or long-term medication treatment with antidepressants and anti-anxiety medication in combination with addiction, cognitive, and behavioral treatment to realize the maximum benefit of long-term freedom from substance abuse (U.S. Dept. Health and Human Services, 1994). Participation in group activities is valuable for the recovering substance abuser who also suffers with an anxiety disorder though they may initially balk at participation (U.S. Dept. Health and Human Services, 1994).

Education on what to expect, followed by non-participatory observation of group or 12-step meetings and encouragement to begin group participation and interaction will aid in their assimilation into group treatment activities (U.S. Dept. Health and Human Services, 1994). To help them to break through their internal barriers and increase their comfort level, encourage them to begin assimilation by arriving early to meetings and introducing themselves, then encourage them to interact with others during set up and clean up (U.S. Dept. Health and Human Services, 1994).

Mood Disorders

Persons with mood disorders should have either a written or oral contract against self-harm and should be given immediate assessment and intervention if they threaten suicide (U.S. Dept. Health and Human Services, 1994).

Contracts outlining expected conduct and forbidding exclusive relationships are helpful in managing the behavior of these persons both in group and in social interactions with staff and peers (U.S. Dept. Health and Human Services, 1994). Any acting out behavior should be addressed immediately and since their need is for safety, they will benefit by interventions that include probing questions about places that feel safe and encouragement in learning to ask for what they need (U.S. Dept. Health and Human Services, 1994).

Persons with mood disorders can become overwhelmed and confused by different approaches to treatment so collaboration between substance abuse and mental health treatment practitioners is of vital importance for coordination and congruency of care (U.S. Dept. Health and Human Services, 1994). These persons will glean a greater benefit from same sex groups than mixed groups and, like persons with anxiety disorders, these persons will benefit from education on what to expect from group and 12-step meetings (U.S. Dept. Health and Human Services, 1994).

Personality Disorders

Persons with personality disorders lack the ability to regulate their emotions and may seek attention by exhibiting chaotic and unpredictable moods and behavior (O'Connell, 1990 and U.S. Dept. Health and Human Services, 1994). Their recovery may be a slow process as they are known for treatment resistance, and they may exhibit suicidal behavior (U.S. Dept. Health and Human Services, 1994).

Clear boundaries and behavior expectations, immediate intervention and attention to any acting out behavior, and contracts against self-harm are also indicated among this population (U.S. Dept. Health and Human Services, 1994). Clear, well-written, behavior contracts addressing expected conduct in group and in daily social situations are helpful for treatment compliance (U.S. Dept. Health and Human Services, 1994). Assessing feelings of safety, addressing manipulative behavior immediately, prohibiting exclusive relationships, and involvement in same-sex groups are keys to positive treatment outcomes (U.S. Dept. Health and Human Services, 1994).

Persons with personality disorders are known to engage others in playing the opposite role, for example: the person may appear to need nurturing in an attempt engage a nurturing response. Counselors and therapists are cautioned to avoid playing this opposite role, as this will hamper treatment (U.S. Dept. Health and Human Services, 1994).

Psychotic Disorders

Persons with psychotic disorders such as schizophrenia will need psychiatric medication to stabilize their condition (U.S. Dept. Health and Human Services, 1994). This population tends to lack medication compliance due to undesirable or intolerable side effects and reasoning that they "don't need it anymore" because the condition has improved (U.S. Dept. Health and Human Services, 1994). Medication management and fostering understanding among family members and 12-step sponsors of the need for medication may improve compliance (U.S. Dept. Health and Human Services, 1994).

Schizophrenic sufferers tend to have poor social skills and attention to education on the activities of daily living such as bathing, hair washing, tooth brushing, and clean clothing may be the most appropriate treatment at first (Daley, Moss, and Campbell, 1987).

When group activity begins, a non-confrontational, supportive approach is most appropriate for this population (Daley, Moss, and Campbell, 1987). Probing into the past is not indicated for these individuals; rather, focusing on specific, present day issues with attention to social and life skills is most beneficial (Daley, Moss, and Campbell, 1987). Encouragement to stay busy, behavioral and medication contracts, regular assessment of medication and treatment compliance will be necessary and enhance a favorable treatment outcome (Daley, Moss, and Campbell, 1987).

Discharge Planning

Discharge planning for all dual diagnosis participants will involve continued outpatient monitoring and collaboration by all treatment providers and should include both referrals and follow-up (U.S. Dept. Health and Human Services, 1994). Referrals may include all or some of the following: Primary care physician for regular health care, psychiatrist to manage mental health medications, a therapist to provide counseling, continued outpatient substance abuse and mental health treatment, 12-step or other support group attendance, sponsors and other support people (U.S. Dept. Health and Human Services, 1994). Clothes closets, homeless shelters, and food banks are also appropriate in many cases (O'Connell, 1995).

Case management should include follow-up, continued monitoring, and collaboration with the other treatment professionals to insure continued personal safety, mental health management, and cessation from substance abuse for the participant (U.S. Dept. Health and Human Services, 1994).

Conclusion

Persons suffering from a dual diagnosis are often juggled between mental health and substance abuse treatment professionals and do not get the treatment that they need for their co-occurring disorders. Since mental health disorders interfere with the ability to recover from substance abuse and substance abuse interferes with proper mental health assessment, diagnosis, and treatment, the individual with a dual diagnosis is caught in a catch-22 situation unless presented with a treatment option that addresses both problems.

Fostering understanding between mental health and substance abuse professionals is paramount. Expanded education on mental health problems and collaboration between mental health and recovery treatment professionals can occur to help both treatment communities recognize the importance of treating the whole person (O'Connell, 1990 and U.S. Dept. Health and Human Services, 1994). This education should include the signs and symptoms of mental disorders, common self-medication with alcohol and other drugs found among persons seeking relief from their particular mental distress, and the importance of medication management (U.S. Dept. Health and Human Services, 1994). Understanding that these persons may be more difficult to engage in treatment and require differing counseling and other treatment techniques is important to all treatment providers (Hatfield, A. 1993).

The issue is to provide appropriate treatment to the individual participant through expanded assessment, proper level of care placement, alternative counseling and intervention techniques, consultation, collaboration, and referral to treatment professionals and providers throughout the course of treatment and upon and after discharge.

SUGGESTED ADDITIONAL READING

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