Substance Abuse and Mental Illness

DOUBLE TROUBLE

Because mental health and substance abuse treatment providers enjoy, at best, an uneasy truce, working as substance abuse specialists in a mental health setting has not always been comfortable. The authors of this article have spent 4 years developing substance abuse services in a state psychiatric hospital. While many hospital personnel welcomed our involvement, most discounted it. In fact, many of our original precepts were naive. Many of the accepted truths in each field have had to be unlearned, and much has been reframed and reconstructed. Through this process a challenging and complex area of clinical concern has emerged. As we learned more and more about the interface between substance abuse and mental illness, our work gained credibility with providers in both fields.

The “dual-diagnosis” patient has serious problems with both substance abuse and mental illness (Balcerzak, 1985; Gottheil, 1980; Pepper, 1984; Rutkowski, 1985). Historically, such people have been diagnostically funnelled into either the mental health or the substance abuse treatment system. Little, if any, allowance was made by either field for overlapping disorders. Yet many people are caught in a tangle of issues characterized both by psychiatric symptoms and the effects of substance abuse (Schwartz, 1981). We have begun to understand the basic dynamics of dual-diagnosis patients and what sort of treatment approaches benefit them. This article offers a description of that learning process.

The target population for our program was identified as “those patients admitted to the hospital who have substance abuse problems.” Thus, one of our first tasks was to clarify the term “substance abuse.” Because the program was funded by a premium on alcohol, some thought we would only look at alcohol problems. Others assumed the term referred specifically to drug problems. We found it impossible to separate the two because of the high number of patients who use both drugs and alcohol, and because treatment systems often do not distinguish between the two. Thus, for our purpose, the term “substance abuse” refers to a wide range of disorders characterized by problematic use of drugs, alcohol, or both, as described in DSM-III.

Prior to our arrival, it had been estimated that 10% to 15% of hospital admissions had problems with alcohol and/or other drugs. Interestingly, hospital admission criteria officially exclude alcohol abuse and drug dependence. However, because it is a state psychiatric hospital, anyone in imminent danger of hurting himself/herself or someone else must be admitted. Because there is a high correlation between substance abuse diagnoses and violent behaviors (Lion, 1969) it is not surprising that one admission in ten has a primary substance abuse diagnosis, but is threatening harm to him/herself or others. The general stance of both administration and staff has been that “these people don’t belong here.” Thus, responsibility for this 10% was relegated to the “new sub-
stance abuse project.”

Occasionally, we found an uncomplicated case of substance abuse appropriate for referral to an alcoholism treatment program. An “uncomplicated” case of substance abuse can be clearly described. In addition to a history of substance abuse, it demands the presence of:
- Motivation;
- Concerned and involved family;
- Insurance coverage;
- The ability to wait (sober) for a bed.

It demands the absence of:
- Current symptomatology or history of psychiatric illness;
- Suicidal risk;
- Psychotropic medication;
- Intellectual deficit.

Roughly one in every 100 cases referred to this project met these requirements. While we searched for these rare patients, we more typically found such patients as those described in the Case Reports (page 22).

When confronted with patients such as those in the Case Reports, we initially asked ourselves the standard question, “Which is the primary problem?” Was Tim depressed before he started abusing alcohol and marijuana, or has the drug use caused his depression? Was Lee in serious trouble before her alcohol use became a problem or has its use exacerbated her impulsive self-destructive behaviors? Did LSD trigger John’s psychosis, or would he have become schizophrenic anyway? Are they medicating an illness, or is the chemical use causing the symptoms?

We foundered in our treatment attempts until we stopped trying to divide complex clinical issues into service-related areas or simple cause-and-effect relationships. When we began to address the substance abuse and psychiatric issues concomitantly, our patients responded positively. Their presentations, histories, and symptoms made more sense, and the direction of our work became clearer.

We have also learned through the process of providing training and consultation to other professionals. In our presentations we use a variety of techniques, including videotaping and viewing group sessions through a one-way window. It always proves worthwhile to spend time processing the sessions with observers. In discussions with those who attend our workshops and/or observe our clinical work, we have found some of our own questions being echoed again and again. Some of the most commonly asked questions are discussed in Figure 1.

**Multiplied Risks**

We have treated over 1,000 dually-diagnosed patients. This number encompasses a wide spectrum of kinds and degrees of substance abuse within a mentally ill population. The...
CASE REPORTS

COMPLICATED CASES OF SUBSTANCE ABUSE

Tim was a 26-year-old father of two at the time of his admission. He had lost both his marriage and his job as a salesman as a result of heavy alcohol and marijuana use that had increased over a period of years. After 2 weeks in an inpatient alcohol treatment program, he attempted to hang himself. He was quickly transferred to a psychiatric unit and diagnosed as having a major affective illness, bipolar type. The severity of his depression eventually led to his involuntary commitment to the state hospital.

His escalated alcohol and drug use had accompanied an apparent onset of mania. Now detoxified but heavily sedated, Tim was totally debilitated by guilt and self-recrimination. Throughout his 2-year stay at the state hospital, he was considered a high suicide risk and, in fact, made a number of potentially lethal attempts.

Tim presented a difficult clinical dilemma. Whenever he improved enough to begin experiencing his feelings and examining his options, he felt such anguish that he again resorted to drinking, thus deepening his depression and suicidal ideation. He tried to deny both his psychiatric and drinking problems as he suffered through numerous cycles of depression/drinking/increased depression/suicidality/detoxification/depression...

Gradually, however, Tim was able to acknowledge this pattern and approach the huge challenge of dealing with his despair without alcohol. Once he began to look at his chemical dependency, he tentatively engaged in the program of Alcoholics Anonymous. The support and self-esteem he gained there then enabled him to counterbalance the agony of working through his numerous losses, and the cycle was broken.

Although still devastated by his loss of family, career, and “normality,” Tim came to believe that he needed lithium to avoid the mood swings of his affective illness and that he could not safely use alcohol or other drugs to cope with unpleasant feelings or situations. As he accepted this, he was able to begin the task of facing his grief and reclaiming control of his life.

Lee was 19 years old when she first came to the state hospital after a near-fatal overdose. The suicide attempt and several episodes of breaking window and cutting herself earned her a label of Borderline Personality Disorder. Lee’s childhood history of abuse and deprivation, including incest, is typical of this diagnosis.

At the time of admission to our program, she acknowledged that her mother and stepfather were both alcoholics. She had been drinking with them since age ten. Lee now had symptoms of late-stage alcoholism, including loss of tolerance and liver damage. Lee presented with a profound sense of hopelessness, which she reinforced by dwelling on the fact that despite participating in four inpatient alcoholism programs, she still had not maintained sobriety for any length of time.

Lee had an enormous amount of psychic pain and conflict to face and work through. Her chief defense involved rationalizing, minimizing, drinking, and angry “acting out” that kept others from getting close. She was mistrustful of support and appeared to undermine actively the caring offered her. The result of her attempts to avoid pain and conflict was, of course, more pain and more conflict.

Effective treatment for Lee had to integrate typically separate therapies for:

- Borderline personality issues;
- Alcoholism;
- Sexual abuse;
- The effects of a severely dysfunctional alcoholic family system.

A major objective was to support her efforts at sobriety. Our premise was that her chances for recovery hinged on removing alcohol abuse as a coping mechanism. Accomplishing this depended on both her ability to connect her urge to drink to particular internal and external cues and her ability to develop new responses. To provide an atmosphere in which Lee could begin to make these associations, we accepted her relapses non-judgmentally, which allowed both her and us to learn from them. As she realized that her drinking episodes couldn’t drive us away or elicit controlling responses, she began to drink less frequently. Only at this point could Lee begin the long process of unraveling her problems.

John had a history of eight admissions to the state hospital, beginning at age 23. When he was referred to us for a substance abuse assessment at age 36, he carried a primary diagnosis of Paranoid Schizophrenia, a secondary label of Mixed Personality Disorder, and plentiful documentation of his involvement with drugs as both user and dealer. Most of his admissions were precipitated by bizarre episodes of religiosity, suicidality, and/or violence. Some of these episodes resulted in prison terms, but he was usually transferred back to the forensic unit of the hospital because of suicidal or psychotic behavior.

When John was 2 years old, he was separated from his mother and twin brother and placed in the first of many foster homes following his mother’s psychiatric hospitalization. He has had no subsequent contact with any family. He reported poly-drug use from age 13, his chemicals of choice being alcohol, marijuana, Percodan®, and hallucinogens. As a teenager and young adult, he wandered all over the U.S., his travels punctuated by arrests and hospitalizations.

In our first interview, John explained that his “mental condition” was both relieved and worsened by drinking. Apparently the alcohol eased the terror and tension of his auditory hallucinations, but its disinhibitory effect also allowed him to stop fighting the voices and “obey” their commands. During this admission he became relatively well-compensated on antipsychotic medication. At that time he expressed a desire to get help for his alcohol problems. We arranged for transfer to a 28-day alcohol treatment program.

After only 3 days, John was sent back to the state hospital on emergency involuntary papers, having been observed “mumbling about Satan and suicide.” The staff told us that they were frightened and frankly outraged that we referred someone so “crazy.” John reported that he found the intensity of the group therapy too stressful and knew that showing symptoms of his mental illness would insure his removal.

John experienced this episode as a failure, both in his inability to handle the stress and in his using mental illness as a way out. Back in our substance abuse groups, he still expresses a strong desire to overcome his addiction, but simultaneously insists that “alcohol is the only thing that makes the voices go away.” To date he has continued his downward spiral of substance abuse, psychosis, and incarceration.
combined effect of two debilitating and chronic illnesses should warrant particular concern. Both mental illness and substance abuse diagnoses carry with them a powerful societal stigma, a potential suicide/violence risk, a high relapse rate, and severe impairment of family and social relationships. Overall quality of life is often extremely poor. It is our experience that having both problems in effect multiplies the risk and the impairment.

We have not seen recovery happen quickly or easily. It is usually a process wherein patients may report that they feel worse than before they began treatment. Many are strongly tempted to abandon the struggle, and some do. But we have acquired a strong belief in the value of maintaining close involvement and positive regard during the inevitable setbacks. When patients examine their feelings and actions, seek information, relate to and encourage each other, and value themselves more, significant and long-term change can occur. The more we practice the art and science of nonjudgmental intervention, the more the patients invest in the therapeutic process. Their investment is clearly crucial to their recovery. Whether the focus is on issues of substance abuse, issues of mental illness, or the vast gray area between them, we have found that content is mostly a vehicle for process.

Much work awaits both clinicians and patients engaged in this newly-identified gray area. Our experience has shown that the combined problems demand a combined response, ie, from both fields. The challenge lies in creatively integrating relevant theories and services from each discipline. The hope lies in the fact that many dual-diagnosis patients improve dramatically when they stop abusing alcohol and other drugs. Those who make this commitment will, at the very least, better manage their psychiatric vulnerability. At best, some go on to lead sober, productive lives in the community.

References
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FIGURE
COMMONLY ASKED QUESTIONS CONCERNING
SUBSTANCE ABUSE AND MENTAL ILLNESS

1. How widespread is the problem?
Our statistics show clearly that not 10% but, in fact, nearly 80% of admissions present drug and/or alcohol use as a complicating factor (see chart, below). About 20% of all admissions have a primary diagnosis in the substance abuse categories, but are not considered to have a major mental illness. The remainder, approximately 60%, show both mental illness and substance abuse problems. This growing “dual-diagnosis” population has recently been described in both the psychiatric and substance abuse literature (Abraham, 1980; Allgulander, 1978; Fischer, 1975; Freed, 1975; Powell, 1982). The term “dual-diagnosis” refers to two over-lapping but discernable subgroups. One subgroup has, by DSM-III criteria, both a major substance abuse disorder and a major psychiatric illness. The other subgroup uses drugs or alcohol in ways that affect both the course and the treatment of their mental illness.

2. What do you consider a substance abuse “problem”?
We have broadened our definition significantly. Originally we thought in terms of the disease of alcoholism as characterized by progression, loss of control, and denial. However, this formulation did not fit many of the patients we were seeing. There were many whose use of drugs or alcohol would not be regarded as excessive or problematic by most standards. However, this use appeared to exacerbate their psychiatric symptoms, decrease the effectiveness of chemotherapy, and thus directly or indirectly precipitate admissions to the hospital. Such patients may technically have only one DSM-III disorder, but it is clear that their drug use compromises their ability to manage that disorder (Hall, 1979). Thus, rather than focusing on amounts and frequencies of drug use in assessing a problem, we look for patterns of repeated use with detrimental consequences.

3. How do you determine a patient’s primary diagnosis?
We have found that unless a patient’s primary diagnosis is clear almost immediately, the question becomes irrelevant. These are people with both mental illness and substance abuse problems. In some cases the mental illness is clearly a predominant problem, and in others the substance abuse predominates. In either case the secondary problem tends to sabotage treatment of the so-called primary disorder. In most cases, the two diagnoses are so enmeshed and mutually reinforcing that specialized treatment planning is required. The pitfall of focusing on the “primary” question is the implicit assumption that treatment of the primary disorder will have an automatic ameliorating effect on the “secondary” disorder. In fact, both issues must be addressed. Even though there may be a relationship between symptoms, mental illness and chemical dependency are in one sense separate entities. Treating one does not automatically remove the other. For example, a person may have developed a “drinking problem” in attempting to medicate his/her depression. Even if this person remains abstinent and actively involved in treatment, he/she may still
experience significant depression. Conversely, a person may experience relief from the symptoms of depression but continue to drink problematically. Regardless of its etiology, the substance abuse tends to take on a life of its own and requires specific intervention (Brown, 1985). Similarly, some psychiatric problems may persist in the absence of substance abuse. However, we have found the former to be the more common occurrence. It is fairly typical, for example, for schizophrenics whose acute symptomatology is in remission to continue their use of alcohol or marijuana—even during hospitalization.

4. Is abstinence necessary for treatment?

Because many patients have found substantial relief in drugs and alcohol, their use of these substances does not necessarily stop in the hospital. Many are amazingly adept at securing street drugs while in institutions that forbid them. It is, however, ultimately pointless to try to exert authoritarian control over anyone's drug use. The chemically dependent person will invariably "win" that power struggle. Abstinence must be seen as desirable before patients will give up the perceived benefits of drug-taking.

From the onset of treatment, we encourage patients to do their own analysis of the costs and benefits of their chemical use. This self-examination process is the crux of dual-diagnosis therapy. Rather than "confront" in the stereotypical sense, or imply that we know more than they about the choices they make, we provide information and a climate in which patients can evaluate and make decisions about their use of drugs and alcohol.

In refusing to police patients' use of drugs, we have avoided the problems of an authoritarian structure and have noticed some definite benefits. First, patients have taken the risk and responsibility of self-disclosing their chemical use. Secondly, much useful information about their thoughts, feelings, and behaviors surrounding chemical use has become accessible. Finally, and surprisingly, strong abstinence norms have developed from within the group.

Realistically, for dual-diagnosis patients, abstinence must be a goal of rather than a pre-condition for treatment.

5. What is a "good" drug and what is a "bad" drug?

Patients are instructed to take medication as prescribed. On the other hand, they are told they must not take alcohol, marijuana and other non-prescribed drugs. Patients can state clearly the reasons they prefer not to take psychotropic medications. First, uncomfortable and stigmatizing side effects often accompany use of these drugs. Second, taking medication is a concrete reminder that the patient is mentally ill and therefore dramatically different from the population at large. Third, although these medications may relieve the symptoms of mental illness, they do not provide a sense of well-being.

By the same token, patients can identify a number of benefits in taking street drugs or alcohol. It is socially acceptable among the patients' peers, so it provides a sense of normalcy and belonging to a group. It promotes a sense of well-being; people who take drugs do feel better, at least briefly. Furthermore, patients have the satisfaction of deciding for themselves what chemicals to take, rather than simply complying with someone else's directions. These benefits may
even be accompanied by the symptom-relief that is the intended benefit of prescribed drugs. Among its other psychotropic effects, alcohol, for example, is a potent anti-anxiety agent. Patients are often genuinely perplexed about this paradox: "good" drugs don't make them feel good, and "bad" drugs do! In responding to this perplexity, it is important to acknowledge that there are benefits and drawbacks to any drug use, whether prescribed or not.

6. How do you treat unmotivated patients?

As with abstinence, "motivation" cannot be a pre-condition for treatment. It is unreasonable to expect fearful, developmentally damaged, chemically dependent people with very low self-esteem to want to relinquish their protection, to want to expose their pain and insecurity, or to want to go through any other uncomfortable therapeutic process.

Despite their defenses and resistance, these patients frequently express the desire to "get better." Unfortunately, they often have little idea how to accomplish such a goal and may attach responsibility for their difficulties to everything except their use of chemicals. Our task is to provide them with as much information, hope, and support as possible while encouraging them through the process of looking at their situation in some depth. When they are willing, self-help groups such as Alcoholics Anonymous and Narcotics Anonymous are introduced. We proceed slowly and exert little pressure because we know—and they will realize—that we are asking them ultimately to make major changes in their coping skills and their self-image. The motivation to do that must come from the expectation that the effort will be worthwhile.

Substance Abuse

KEY POINTS

Double Trouble: Substance Abuse and Mental Illness.

1. Data in at least one state psychiatric hospital suggest that over 75% of all admissions have a significant substance abuse history.

2. The "dual-diagnosis" patient presents complex clinical issues that do not divide easily into service-related areas or simple cause and effect relationships.

3. Mental health services often fail to meet the needs of patients with substance abuse problems; the alcohol/drug treatment system often fails to meet the needs of patients with psychiatric disorders.

4. In patients with psychiatric and substance abuse problems, both issues must be addressed concurrently; a model for dual-diagnosis assessment and treatment is now evolving.


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