Dual Diagnosis: Substance Dependence and Mental Illness

Definition & Prevalence

Over the past decade, there has been growing recognition that alcohol and other drug dependency and mental illness can coexist in a noncausal relationship. Various studies have found that between 20% and 80% of patients treated for psychiatric disorders have an active drug or alcohol problem (i.e., abuse or dependence), with higher rates generally found in patients receiving in-patient services (Barr, 1994; Robertson, 1992; Schottenfeld, 1993; Sheehan, 1993). Conversely, an estimated 14% to 60% of substance abusers have a mental health disorder (Robertson, 1992; Schottenfeld, 1993; Walker, 1992). A study conducted at an alcohol and drug abuse treatment center at a psychiatric hospital found that the most common comorbid conditions among abusers of all drugs were mood disorders—most prevalently, major depression (Weiss et al., 1992). Hesselbrock, Meyer, and Keener (1985) found that of women hospitalized for alcohol abuse or dependence, 52% had concomitant major depression, 44% had phobias and 20% had antisocial personality disorders (Riley, 1994).

More recently, AIA programs, and others serving chemically dependent women, are finding that a majority of their clients suffer from Post Traumatic Stress Disorder (PTSD). Since 1980, PTSD has been codified in the Diagnostic Statistical Manual (DSM), and more recently has been recognized as applying to women who experience such traumatic events as sexual and physical abuse. Although most of the research on PTSD has focused on male veterans, a recent study found that 104 out of 105 female drug users reported experiencing trauma, and 59% of them reported symptoms (e.g., sleep disturbances; anxiety; hypervigilance; numbing of responsiveness) consistent with a diagnosis of PTSD (Fullilove et al., 1993).

With a growing awareness of these conditions, the term “dual diagnosis” has evolved to refer to the coexistence of a substance use disorder and another mental health disorder. While some investigators restrict this definition to include only psychotic and major mood disorders, dual diagnosis also includes anxiety disorders, eating disorders, moderate depression and other disorders that interfere with full well-being and functioning. The coexisting illnesses may be independent, causally linked, or mutually reinforcing. A common hypothesis, for example, is that individuals with mental health disorders who abuse substances do so in an attempt to self-medicate their symptoms. On the other hand, prolonged abuse of some drugs may produce lasting psychological symptoms (Schottenfeld, 1993).

A recent National Comorbidity Survey of the general U.S. population found that 56% of respondents with at least one psychiatric disorder had two or more disorders, and that women have a higher prevalence than men of three or more disorders (Kessler et al., 1994). Consistent with this study, Marcus and Katz (1990) found that more than half of female patients in a substance abuse inpatient unit had an eating disorder with significant depression (Morris & Wise, 1992). Individuals who abuse substances are also at higher risk for HIV, which adds another clinical problem. HIV contributes to the already existing mental health problems through direct effects (e.g., secondary infections or neoplasms involving the central nervous system), and psychosocial factors associated with AIDS (e.g., isolation, ostracism, awareness of a terminal illness, and loss of health and sexuality) (Batki, 1990).

Experience indicates that individuals with comorbid illnesses tend to have: sporadic and bingeing substance abuse patterns, a history of job instability, impaired social interactions and love relationships, and low tolerance for frustration (Riley, 1994; Walker, 1992; Sheehan, 1993). There is also evidence that these...
patients have poor treatment compliance and poor outcomes in both traditional mental health and substance abuse treatment programs (Riley, 1994; Ries, 1992; Weiss et al., 1992; Morris & Wise, 1992; Sheehan, 1993). Despite these findings, however, there has been little discussion in the literature on successful treatment approaches for women with dual diagnosis, and there are few programs designed specifically to assist them.

**Philosophical and Administrative Challenges**

Traditional substance abuse treatment programs employ a recovery model which emphasizes abstinence from mood-altering substances (generally including psychotropic medications), confrontation, and heavy reliance on 12-step programs and spirituality. Staff in these programs are typically trained in substance abuse theory and counseling techniques, often with little or no content on psychopathology or psychotherapy (Riley, 1994). Consequently, traditional chemical dependency treatment programs are often ill-equipped to handle the complex psychological needs of women with comorbid substance abuse/dependency and mental illness (Riley, 1994). Thus psychopathology is often underdiagnosed, leading to unrealistic expectations, poor treatment planning, and generally poor outcomes for individuals with coexisting disorders (Zweben, 1992; California Advocates for Pregnant Women, 1990). McLellan (1986), for example, found that severely psychotic, chemically dependent patients, who received traditional chemical dependency treatments but no psychopharmacological or professional psychotherapy intervention, deteriorated in overall functioning and had low follow-up recovery rates (Morris & Wise, 1992).

Conversely, mental health treatment programs often involve use of medication and, particularly in private agencies, tend to be nurturing and non-confrontational. They typically emphasize empowerment and the importance of a long-term treatment relationship (Barr, 1994; Sheehan, 1993; Nigan et al., 1992). Mental health counselors often have little knowledge about chemical dependency, and very few psychiatrists are trained in the diagnosis and treatment of addictive disorders (Miller & Gold, 1992). As a result, treatment staff in psychiatric programs may evaluate clients without allowing adequate time for clearance of the cognitive impairments associated with withdrawal and early abstinence. They may, then, prescribe medication unnecessarily or inappropriately (Zweben, 1992). Additionally, most psychiatric departments do not endorse the primary standard of care in addiction treatment—abstinence-based 12-step programs.

**Treatment**

Designing treatment services tailored for women with dual diagnosis is a relatively recent and exploratory venture. Comprehensive treatment for this population should include medical and psychiatric assessment, a 12-step program designed for women, parenting groups, family therapy, multi-generational groups, relapse prevention, and a culturally appropriate women’s group (Jones-Barlock & Upsher, 1992).

**Assessment and Diagnosis**

Early assessment and identification of coexisting substance use disorder and mental illness is considered imperative to enhance successful intervention. Fullilove et al. (1993), for example, recommend that, because women in recovery are likely to have a history of violent trauma and are therefore at high risk for PTSD, psychiatric screening should become part of the diagnostic and treatment routine in all substance abuse treatment programs. A thorough psychiatric assessment, however, requires more than a single assessment tool (Weiss et al., 1992). To be effective, the assessment should be longitudinal, and include history from the client, the client’s family and significant others. Thorough assessment should also consider physical dependency, loss of control over the use of the substance, negative social sequelae (e.g., social dysfunction, unemployment, legal and family problems), intrapersonal processes (e.g., feelings, thought processes, behavior), and interpersonal processes (e.g., the quality and quantity of relationships with others, and the adequacy of role fulfillment) (Zweben, 1992; Riley, 1994).

A major challenge of the assessment process is distinguishing between the psychological effects of substance abuse and withdrawal and the influence of underlying psychiatric disorder. Further exacerbating the problem, these fundamentally opposing philosophical foundations are typically supported by separate, fragmented funding sources with different goals, guidelines, and reimbursement policies. Consequently, psychiatric facilities frequently make substance abuse an exclusion criterion (Zweben, 1992), and substance abuse treatment programs may refuse to treating clients with severe psychological illness. As a result of this philosophical and administrative separation between bureaucracies, funding sources, personnel and treatment locations, patients with two or more coexisting illnesses have typically received treatment from either chemical dependency or mental health programs, but not both (Ries, 1992). Some are denied service by both systems.

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Treatment Strategies

Treatment implications vary depending on the substance of abuse and the type of psychological illness. Experts, however, generally agree that the first task in treating dually diagnosed clients should be establishing a therapeutic relationship and a safe, trusting atmosphere (Levy, 1993; Kline, 1991). This generally includes provision of basic services, support, crisis intervention, acute stabilization (e.g., detoxification), and initial assessment. Once this is accomplished, Zweben (1992) describes a five-step treatment process: (1) obtaining an abstinence commitment through education about the realities and long-term effects of substance abuse; (2) breaking the addiction cycle by helping the client contain or express feelings and anxiety without returning to drug use; (3) establishing and consolidating abstinence and creating new life-styles (i.e., start to work toward resolution of some underlying issues, such as traumatic experiences); (4) renegotiating relationships; and (5) exploring long-term psychological issues (e.g., management of affect and impulse, development of self-care mechanisms, and improvement of self-esteem). Sheehan (1993) adds that any treatment program must be followed by comprehensive aftercare involving individual and group therapy; medication monitoring; self-help meetings; and access to occupational rehabilitation, family therapy, housing and other support services. Also, because many individuals with a coexisting psychiatric disorder experience a chronic pattern of relapse, this must be recognized as part of the recovery process, and handled in a non-judgmental, supportive manner which maximizes the gains achieved during abstinence, cushions the negative impact of regressive periods, and does not lead to automatic termination from the program (Zweben, 1992; Nigam et al., 1992).

Throughout the process, all treatment must be designed around the unique needs of persons with comorbid substance and psychological disorders. Men and women in this population are often extremely vulnerable to aggressive confrontation, and generally require reality-oriented treatment delivered in a supportive manner that avoids intensive “uncovering” therapy. While some education can be accomplished through group sessions, written material should be presented at a very basic level. Individual assistance also should be provided to help patients apply concepts to their own situation. Additionally, Nigam et al. (1992) suggest that successful therapeutic groups must include: active therapists, good communication with other care providers, abstinence as a goal rather than a requirement, a clear rule regarding use of substances when attending group, open group discussion of any relapses, an emphasis on education and skill building, and encouragement to use 12-step groups.

AA/NA meetings can provide invaluable support for these clients. However, therapists must fully prepare them for these meetings, in which members can be confrontational and may pressure their peers into discontinuing prescribed medication (despite AA’s official stance accepting psychotropic medication when appropriately prescribed). Experts also recommend offering separate recovery groups, often referred to as “double trouble” meetings, where denial can be addressed in a more nurturing way (Zweben, 1992; Sheehan, 1993).

Treatment issues for women

Along with these strategies, women-only support groups may best address trauma and abuse issues so prevalent in female substance abusers, and educate women about PTSD and its relationship to relapse. Sheehan (1993) notes that once
A Case Study

Theresa* is one of many SPARK (Supporting Parents at Raising Kids) clients who face multiple struggles. At 23, she is poor, HIV+ and symptomatic, a recovering drug user and the mother of 3 children under the age of 5. When Theresa was referred to the SPARK Program 2 years ago, she was in need of drug treatment and ongoing medical care for herself and her children. Theresa had few support systems and, though she loved her children, often took her frustrations out on them by being physically and verbally abusive. Already, there were signs that Tisha*, the 5 year old, was assuming a parental role in the care of her siblings and mother. To address her many needs, a SPARK case manager met with Theresa weekly to facilitate services for her and help her develop more appropriate coping skills. Additionally, a SPARK home visitor focused on helping Theresa attain permanent housing and, along with a child development specialist, assisted Theresa in developing new parenting skills.

Recently, Theresa became obsessed with her HIV status and fears of future debilitation. Primarily, she worried that her children would be taken from her should she become sick. When the intensity of her fears began to take precedent over everything in Theresa’s life, her case manager coordinated a referral to an affiliated outpatient psychiatric department. The case manager accompanied Theresa to her first appointment with the psychiatrist. Following this initial assessment, medication was prescribed and monthly follow-up appointments with the psychiatrist were scheduled. Additionally, Theresa continues to meet with her case manager on a weekly basis, and collaboration between the case manager and psychiatrist is an ongoing component of Theresa’s care.

The SPARK Program

Theresa’s situation illustrates SPARK’s mission to preserve families through a model of family centered care. Located in Philadelphia, PA, the SPARK program at Hahnemann University Department of Community and Preventive Medicine, provides comprehensive home visitation and support services to women who are pregnant and/or have a child under 3, and who have a history of substance abuse or are currently using drugs, and have or are at risk for HIV/AIDS. The core component of the SPARK program is intensive home visitation. “Wrap-around” services include: family and individual counseling, social services, developmental screening and referrals for children, transportation, emergency funds, parenting classes and support groups. Using a team approach, services are provided by 3 case managers, 3 community representatives (home visitors) and a child development specialist.

Collaboration with Other Programs

Increasingly, women referred to the SPARK program, like Theresa, present with a multitude of psychosocial problems, i.e., addiction relapse, homelessness, domestic violence, and mental health issues. To more fully address the complexity of these issues, SPARK collaborates with other programs which provide clients with additional services. These programs, most of which are gathered under the Hahnemann University Department of Community and Preventive Medicine umbrella, include:

- The Preventive Medicine Clinic, a health services clinic for HIV infected adults, which provides women’s health services, social work/case management and legal counsel for patients.
- CHANCES, a licensed outpatient and partial hospitalization drug treatment program for pregnant and postpartum women and their children, which provides “wrap-around” services including child care, prenatal and women’s health services, pediatric well baby care and chronic disease management, transportation, social work/case management, parenting classes, legal services, developmental assessments and referral.
- The Women’s Anonymous Test Site (WATS), which offers HIV testing at several sites in the Philadelphia area, also provides referrals for health care and social services, and educational outreach to the community.
- The AIDS Law Project of Pennsylvania, which provides on-site legal services to HIV involved families including custody planning, power of attorney, living wills and wills.
Hahnemann University's Out-patient Psychiatric Department and Emergency Room, which provide psychiatric evaluations and treatment.

**Interagency Coordination**

The SPARK program has implemented several mechanisms to ensure that collaborative efforts offer clients optimal care with minimal duplication or gaps. Staff from SPARK and the other collaborating programs have monthly joint case conferences, and team meetings with the primary counselors occur as needed. Staff from these programs also work together to develop joint policy and procedures, and the advisory committees for the SPARK and CHANCES programs recently merged, reflecting the strong connection between these two programs.

To support staff from SPARK and the collaborating programs, joint, educational in-services are provided monthly. Whenever possible, speakers are drawn from programs within the collaborating network. Examples include: a training on HIV and STDs by a physician from the Pennsylvania AIDS Education and Training Center; a training on loss and grief by an HIV counselor; and a training on the cycle of addiction by staff from the CHANCES Program. These trainings not only inform the staff, but offer much needed respite in this full and demanding job. Additionally, an HIV support group is offered on a monthly basis for SPARK staff and all members of the Department of Community and Preventive Medicine.

**Conclusion**

Theresa's problems have not been eliminated. Nonetheless, because of her involvement with SPARK and its collaborating programs, her needs are fewer, her resources richer, and her ability to care for herself and others is greatly increased. These accomplishments in the life of a client are vast improvements; even small successes in the face of devastating personal, family, and societal situations are reward enough for agencies like SPARK who serve these struggling individuals.

— Maria C. Frontera, LSW

Program Director, SPARK

*names have been changed*
Perinatal Issues for Women with a Dual Diagnosis: Substance Abuse and Mental Illness

The effects of perinatal substance abuse, while unclear, are preventable. The prevention solutions and strategies, however, are much more multifaceted and complex than simply providing information to women prior to and during their pregnancy. Segmenting the population and attempting to identify the specific groups of women at risk increases our likelihood of preventing the consequences of smoking, alcohol, or other drug use during the perinatal period. One part of the population is women who have a diagnosis of mental illness in addition to their addictive behavior. These women present many challenges for the development of prevention strategies, yet more and more providers find themselves frustrated and uncertain about how best to serve them.

There are obvious risks of complications in serving these women. There are effects of both the substance abuse and the medications prescribed for treating the mental illness; the lack of compliance with standards of care, including preconceptional check-ups before pregnancy; the use of contraceptives or compliance with their use; planned sexual intercourse or pregnancy; and late or no prenatal care. The complex nature of provider/patient interaction adds to the level of frustration including problems with expectations, explanations of information, soliciting information, compliance with instructions, and willingness to allow sharing of confidential information with other providers. Service providers are frustrated with their patients/clients and with providers from other systems who feel they should be more involved, effective and sharing. This is reflected in the providers’ resistance to recognize the presenting problems and in the providers’ hesitancy to deal with problems for which they feel unqualified or which will, perhaps, put them at risk for negligence if things do not go well.

In reality, women with a dual diagnosis of mental illness and substance abuse have a triple diagnosis when pregnant. If they are served at all, they will often be served by separate parts of the system: mental health service, substance abuse treatment, and perinatal care. In this fragmented situation probably lies the major barrier to effective treatment and the possibility of providing an effective outcome of the pregnancy.

Many anecdotal reports illustrate the complexities of providing adequate services to these women, but our literature review yielded no studies dealing with all three conditions simultaneously. Although there are many studies on women with a dual diagnosis of mental illness and substance abuse, none covers the issues related to pregnancy. Likewise there are numerous studies on women who are pregnant and mentally ill or using substances, but there are no published protocols, service models or data for women with a triple condition. This article is an attempt to summarize some concepts, ideas and strategies about pregnant women with a dual diagnosis. It is not based on empirical data; it is rather a hypothesis which requires testing by multiple providers. The ideas are the result of a work group convened as part of a five-year CSAP funded Pregnant and Postpartum Women and Infants Project. The work group, which consisted of perinatal, alcohol and drug, and mental health professionals, met monthly over a period of a few years to collect and evaluate data to clarify issues, develop strategies for intervention, and provide training to professionals from different backgrounds. Following is a summary of some of the issues and strategies we feel need attention if we are to help pregnant women with a dual diagnosis of mental illness and substance abuse.

Strategies

Interdisciplinary Dialogue

The first and probably most important strategy is to develop an approach for establishing an ongoing dialogue between providers from the three different systems: perinatal care providers (OB/GYN’s, nurses, midwives), mental health providers (psychiatrists, social workers, psychiatric nurses), and substance abuse treatment specialists. This dialogue will help develop trust, interdisciplinary understanding and working relationships for meeting the various needs of individual women. Providers should take the initiative to identify people from the other systems with whom they feel they might be able to work closely. They should meet regularly to share their own concerns, frustrations, and needs for assistance. There should be a sharing of assessment tools, strategies, protocols and literature. These meetings could be centered around individual clients/patients and over time a consensus of how to work together would evolve. Initially, this collaborative work will require face-to-face meetings; later it will require only periodic check-ins. All
of this seems so basic but it is often dismissed with as being too time consuming and unnecessary. In the long run, however, it will probably prove the most effective, most efficient investment of time and effort.

**Cross Disciplinary Training**

The effectiveness of working on a cross disciplinary team depends on an understanding of the different disciplines, strategies for effective communication between professionals from different disciplines, and methods of presenting a uniform message or approach to women with a triple diagnosis. This can be accomplished through cross disciplinary training which involves not only didactic information about the diagnosis, the assessment tools, and the treatment protocols, but also experiential observation and involvement in the other disciplines’ service delivery. Again, this strategy requires time and effort at the onset, with periodic updates and refresher courses/exposure over time. During the course of this cross disciplinary training, the dialogue will be enhanced, the attitudinal nuances of the jargon clarified, and subtleties of professional activities in the different settings clarified.

**Use of Case Studies**

The use of case studies to initiate interdisciplinary dialogue and cross disciplinary training can be a very effective tool. Case studies clarify where and when there are barriers to meeting individual women’s needs; where the lack of interdisciplinary knowledge and skills exist; what different approaches to working with these women might be helpful; and how philosophies guiding the work need to be enhanced. Initial case studies can be a compilation of several individual clients or anonymous real patients; their purpose is to get the different professionals working together. As trust and understanding between the providers grows and expands, the case studies will change from fictional compilations to real, shared patients/clients around whom the expertise will continue to develop.

**Minimum Data Base**

By establishing a minimum data base, information which is usually scattered throughout an individual woman’s chart and history is systematically collected and readily visible to all who refer to a specific chart. This chart consists of a set of basic mental health, alcohol, and drug abuse information, and a reproductive history which is used in the clinical setting. The items in the minimum data base are those which the interdisciplinary teams collectively select as relevant to presenting a snapshot of the individual woman. This should not be used as an intake form or for a one-time assessment since some of the information will surface over time. It is a method intended to systematically record data accumulated throughout the course of therapy and services. The systematic completion of this minimum data base tool will allow for collection of data, unavailable in most clinical settings, that will help clarify the problem, understand the behaviors, and generate potential intervention and treatment strategies. (A sample minimum data sheet is available from Raymond Kessel at 608-263-6557).

**Early Identification and Assured Assessment**

It is clear that each woman is different. Each woman’s reason for her addictive behavior is different, and each woman’s psychiatric disorder is different. Further, whether a pregnancy is planned, unplanned or unwanted varies from woman to woman, and each woman’s reproductive and prenatal care history is different. This requires that each woman be individually, comprehensively and carefully assessed as early as possible. Following is a list of basic strategies for integrating the work of the three types of providers in each of the three settings (all of which can be developed immediately). It must become standard procedure to do an initial screening of the other two areas. In the mental health setting, not only must the substance abuse issues be assessed (they frequently are), but an expanded effort must be made to ascertain whether the woman is or could become pregnant and other essential elements of her contraceptive and reproductive history. For mental health workers, pregnancy is often perceived as a complicating and, in some ways, frightening factor. Similarly, in the substance abuse intervention and treatment setting, the woman must be screened for psychiatric disorders. More significantly—because it is less frequently done—screening related to the woman’s reproductive history and present reproductive status must also be performed in the substance abuse treatment setting. This creates the greatest stress and anxiety among professionals in this field. In perinatal care settings, substance abuse and psychiatric screenings are essential for many reasons, including: assessing the possibility of teratogenic effects of medications and substances; encouraging compliance with perinatal care recommendations; and participating in decision-making regarding labor, delivery, and postnatal and infant care.

The initial screening is important, but more essential is the subsequent detailed assessments and the development of a care plan which coordinates the work of different service providers. Referrals to the other disciplines are not sufficient; they must be active, completed referrals which then lead to coordinated, collaborative care involving the family and other support systems.

**Assessment of Teratogenic Effects and Recognition of Alternatives**

Professionals need to have a clear understanding of teratogenesis, i.e., when, how, and if substances (legal and illegal) may increase risks to the embryo or fetus. This includes an understanding of human ter-
atogenic effects of the specific agents in humans and animals, and the potential risks to both the mother and the fetus. An awareness of the significance of timing, dosage and method of exposure may be critical in the risk assessment. There are sometimes alternatives which can be helpful, e.g., delaying medications before conception or during the first trimester, trying alternative medications, or intervening prior to pregnancy. The issues are complex and multifaceted, requiring close communication among the different professional disciplines in order to offer a uniform and well developed strategy to the woman seeking assistance. The most destructive effect is when women receive conflicting information and recommendations from different service providers. Who should they trust when the intervention and treatment recommendations they receive from different sources contradict one another? How can we turn these discussions into reassuring, supportive help for women rather than frustrating, anxiety-provoking and potentially negative triggers for their mental health condition or substance addictive behavior? The teratogenic issues provide a place around which professionals can rally to learn together, understand each other’s perspective, and come up with a unified approach that will prove supportive to the women they are helping. Some of these issues and concerns extend beyond the psychiatric medications into the medications provided for detoxification or for supporting a woman in substance abuse treatment. Issues related to the use of contraceptive medications, which taken during pregnancy may increase risks, must also be considered. Erratic use of contraception resulting in an unplanned pregnancy can lead to this particular complication; the woman may resume taking the contraceptive medication without being aware that she is pregnant.

Development of Understanding and Protocol for the Specific Psychiatric Disorder

The woman with a psychiatric disorder will respond differently not only to psychiatric care and management, but also to substance abuse interventions and treatment and to her reproductive care. A diagnosis of her condition must be established as soon as possible, and a thorough understanding of the condition and how its manifestations may impact her different levels of care is essential. In order to do this, the interdisciplinary team needs to discuss the woman’s anticipated reactions to potential recommendations; the way she deals with stress and the adverse and changing conditions in her body; and both her life and her interactions with multiple providers. These and other factors will influence the manner in which she complies with the care. It is through these discussions that many of the best strategies for caring for the individual woman will emerge. It may be difficult to predict a woman’s reactions, but if the options are discussed, providers will be more prepared to address her specific needs.

Assessment of Violence in the Woman’s Life

One of the phenomena providers and children’s advocates need to pay attention to is the linkage between all of these conditions and violence. The issue of violence both as it is directed at women and as it exists, in general, in our society surfaces as a major cause of perinatal substance abuse. It is disturbing to hear providers in women’s substance abuse treatment programs estimate that over ninety percent of their clients were abused (most often sexually) at a young age. The association of violence with psychiatric disorders is also striking. There is a tendency for some women to continue involving themselves in violent relationships, and the violence often escalates during pregnancy. Therefore, no strategy for providing coordinated care for a woman with a triple diagnosis can ignore the treatment of abuse in the woman’s past, and certainly in her present situation. The complexities of the situation should not deter efforts to focus on this issue because herein may lie the source of many of the problems. What should concern us is how best to assess and deal with these issues during the prenatal care period.

Specific Issues Which Require Additional Thought and Analysis

In the provision of services to pregnant women with a dual diagnosis, new concerns and issues will surface. Examples of these concerns and issues might include:

- benefits and negative consequences of encouraging breast-feeding, of single parenting, and of encouraging partners and support people to actively participate in the labor and delivery;
- methods of developing supplemental support systems to enhance intervention, treatment, and care of immediate and long-term conditions;
- problems this population experiences during pregnancy, e.g., how women cope with and manage miscarriages, stillbirths, children with birth defects or developmental problems;
- the relationship between treatment of the addictive behavior, treatment of the psychiatric disorder and the pregnancy, e.g., detox, treatment approach, patient resistance.

The prenatal period is only a very short period in both the woman’s life and the child’s. The interventions and treatments must continue beyond this period because, for many women, this may be the pre-conceptual period for the next pregnancy during which the work can begin to increase the chances of a healthy infant. The woman’s pregnancy can be a “window of opportunity” for identifying the multiple conditions and developing strategies for long term help and support. The pregnancy may also be the “turning point” in her life, the point at which what appear to be insurmountable problems begin to be resolved. It is this optimism that provides the impetus for all children’s advocates to help meet the challenges facing women with a triple diagnosis.

There are more similarities than differences in the three conditions; with the help of colleagues from different disciplines who we trust and with whom we can establish relationships of mutual understanding, we can clarify and sort out the issues and ultimately improve the care we provide to women with a triple diagnosis.

— by Raymond Kessel, PhD; Patricia Sizemore, MSN; Flo Hilliard, MSW
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Women who are mentally ill and alcohol and drug dependent face wrenching problems in their daily lives. In addition to the pain of addiction and negative consequences they will inevitably experience, the stigma and debilitation of mental illness requires aggressive advocacy from providers and those who determine public policy in this sphere. Since most women who have co-existing mental illness and an alcohol or other drug dependency are disempowered in their social relationships and usually oppressed by economic hardship, the responsibility of advocacy falls on those who would call themselves "helpers."

The needs of these women are multiple and varied. Yet they have in common the need for treatment of their mental illness and alcohol and drug dependencies and the presence of a healthy and functional support system. Effective advocates, whether service providers or administrators in a public or private agency, must be aware of particular public policy issues that can have an impact on women who are dually diagnosed and their children.

Legal issues regarding the supposed opposing interests of the mother and fetus have been the focus of lengthy discussions about drug-using mothers and substance-exposed infants (McNulty, 1987; English & Henry, 1990; Floyd & Sanford, 1992). Prosecution, imprisonment and severing of parental rights and other punitive "solutions," while carried out in health and human service providers, and the attendant "best practice" standards, whether service providers or administrators in a public or private agency, must be aware of particular public policy issues that can have an impact on women who are dually diagnosed and their children.

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The issue is not that standards of practice, patient management and bona fide answers to complex clinical puzzles do not exist. The "answers" and expertise abound! The issue is dissemination, support for and implementation of this knowledge. To insure benefit to women and their children, placement of quality assurance mechanisms and purging of ideological barriers (e.g., "You must stop taking your psychiatric medication..."

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Widespread and unbiased implementation of these protocols and public policies remains to be achieved. The extent to which any of these advisements, policies and procedures about perinatal addiction have been implemented in the service sector is difficult to measure and stands as the most challenging agenda for advocates in the 90's. Integration of what we know about mentally ill women who are alcohol and drug dependent is currently within our reach and can only further our efforts toward health and well-being for this population. An expansion of our consciousness is now required to be mindful of the mentally ill and their needs and to work for change in providing appropriate services.

— Marty Jessup, RN, MS

REFERENCES


Violence Against Women/Mental Illness and Addiction: An Integrated Model of Dual Diagnosis Treatment for Women

"We discovered that peace at any price is no peace at all . . . That life at any price has no value whatever; that life is nothing without the privileges, the prides, the rights, the joys which make it worth living and worth giving. We also discovered that there is something more hideous, more atrocious than war or death and that is to live in fear." —Eve Curie (Mills, 1994).

The term dual diagnosis is a medical definition used to describe both an addictive compulsion or dependency and a form of mental illness, which together cause severe impairment to the sufferer. For purposes of this article, dual diagnosis will include all forms of depression, bipolar disorders, personality disorders, and the most recent inclusion into the DSM IV known as “Problems related to abuse or neglect.” These include physical or sexual abuse or neglect of a child or adult (DSM IV, 1994; p. 294).

Milwaukee Women’s Center

The authors of this paper administer and provide clinical social work at the Milwaukee Women’s Center, Inc. (MWC). The mission of MWC is:
- to confront injustice and violence against women and children;
- to empower women to achieve their hopes and dreams; and
- to lead the community to solutions which enable all women and their families to lead full, productive lives.

Milwaukee Women’s Center is committed to sustaining a multi-cultural, feminist organization that reflects the diversity of the community it serves. As women who work in a feminist informed multi-service agency, we have incorporated the Trauma Model of psychopathology into a therapeutic approach with clients. According to the Trauma Model, developed by Colin Ross, M.D., mental health disorders can be arranged hierarchically with multiple personality disorder at the top, due to the highest rate of childhood trauma inflicted (Ross, 1991).

The most important prediction established by the Trauma Model, which affects our work with clients at MWC, is that the primary driver of pathology is not a genetic defect, as previously thought, but the trauma itself. Trauma, resulting from a history of physical, sexual or emotional abuse or neglect may cause a woman to develop depressive symptoms. In an attempt to alter or alleviate these depressive symptoms, a woman begins to self-medicate and may abuse or become dependent on drugs, alcohol, food, gambling, sex, and/or destructive relationships.

A clinical challenge at MWC is to assist women in identifying and understanding how trauma, sexism, racism, and homophobia manifest in a power imbalance in their lives. When we acknowledge that more than 400,000 cases of father-daughter incest occur in the U.S. annually, that 1 in 4 women is beaten every 13 seconds, and that 1 in 5 women will be sexually assaulted in her lifetime, a woman’s addictions, depression and mental illness can be recognized as desperate survival mechanisms.

Treatment Considerations

In order to create a context for change, most women need their trauma, mental illness, abuse and/or addictions addressed simultaneously. At MWC’s certified mental health/alcohol and drug abuse outpatient clinic, clinical social workers and substance abuse counselors (often one in the same), and a part time psychiatrist, provide short- and long-term therapy in mental health and alcohol and other drug abuse treatment. Other services at MWC...
include: emergency shelter and services for battered women and children; case management and treatment for pregnant and parenting women who abuse drugs or alcohol; and, in collaboration with another program, evaluation, assessment and treatment for 0-3 year olds with developmental delays.

By identifying a woman’s need for protection, and helping her establish a sense of power and control in her life, MWC creates a framework for developing solutions to mental health, abuse and addiction problems. Sobriety is not seen as a first condition of treatment. The therapist avoids a struggle, inherent in the demand for abstinence, and reinforces a woman’s ability to establish her own goals, which may indeed include sobriety. Involving the woman in creating solutions to her identified problems enhances the sense of equity within the therapeutic relationship. Focus is on the exploration of the self-abusive nature of using chemicals and how abuse or addictions maintain a woman’s oppression and keep her in a victim role.

To assist with recovery, 12 step programs are discussed and encouraged, with a significant twist on the powerlessness concept. Women are given copies of both the Feminist 12-Steps, written by Charlotte Kasl, and the traditional AA 12-Steps. The crucial shift from the male identified model of AA recovery has profound effects on women. Often, for the first time, women are encouraged to relax in and accept their personal power, identified in the Feminist 12-Steps, as a way to free themselves from dependencies. A shift in definition regarding a woman’s perception of her so called “co-dependent” behavior occurs in dual diagnosis treatment at MWC. Co-dependency, once a descriptor, has emerged as a diagnosis. Women who view themselves as sick or diseased effectively stop their awareness of the larger cultural, patriarchal structure which fosters and encourages women’s dependency on others and establishes women’s political, economic and emotional oppression. It is imperative to teach women how their learned behavior to take care of men, children and others first leads to under-responsibility for self, which almost always leads to the abuse of something: drugs, alcohol, food, self and relationships.

At the Milwaukee Women’s Center, Inc. we are committed to the creation, development and implementation of an integrated model of dual diagnosis treatment—a model that is gender sensitive, culturally competent and recognizes the link between violence and oppression against women and the potential development of mental health and/or addictive disorders.

— F. Maggie Williams, MSW, CADC III, Clinical Social Worker
Carey Tradewell, M.S., CADC III, Executive Director

REFERENCES

THE TWELVE-STEPs
Charlotte Davis Kasl

1. We acknowledge we were out of control with [type of addiction(s)] but have the power to take charge of our lives and stop being dependent on others for our self-esteem and security.
2. I came to believe that the Universe/God/dess/Great Spirit would awaken the healing wisdom within me if I opened myself to that power.
3. I declared myself willing to tune into my inner wisdom, to listen and act based upon these truths.
4. We examined our behavior and beliefs in the context of living in a hierarchical, male-dominated culture.
5. We shared with others the ways we have been harmed, harmed ourselves and others, striving to forgive ourselves and to change our behavior.
6. We admitted to our talents, strengths, and accomplishments, agreeing not to hide these qualities to protect others and to change our behavior.
7. We became willing to let go of our shame, guilt, and other behavior that prevents us from taking control of our lives and loving ourselves.
8. We took steps to clear out all negative feelings between us and other people by sharing grievances in a respectful way and making amends when appropriate.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to trust my reality, and when I was right promptly admitted it and refused to back down. We do not take responsibility for, analyze, or cover up the shortcomings of others.
11. Sought through meditation and inner awareness the ability to listen to our inward calling and gain the will and wisdom to follow it.
12. Having had a spiritual awakening as the result of these steps, we share this message with ourselves and others, and practice these principles in all our affairs.
stability is achieved, individuals with PTSD may also benefit from psychotherapy to work through abuse issues and other traumatic experiences. Other commonly recommended treatment methods for this population include anxiety reduction programs, assertiveness training, codependency counseling, stress management and relaxation training. Additionally, due to the high prevalence of depression among chemically-dependent pregnant and postpartum women, Burns et al. (1985) recommend providing group therapy designed specifically for the treatment of depression.

Programs serving women with dual diagnosis should also: (1) collaborate with pediatricians and other child care providers; (2) establish guidelines for assessing the mental and emotional needs of the children, and employ methods for addressing those needs; and (3) address parenting issues and present models of parent-infant relationships. One strategy is to videotape a client interacting with her children, then review it with her, inquiring about her behavior in a non-judgmental way and providing education about alternative parenting practices (Percansky, Wechsler & Bernstein, 1993).

**Psychotropic medication**

Use of psychotropic medication and medication compliance are other key issues in the treatment of dual diagnosis patients. Although a comprehensive discussion of this topic is beyond the scope of this article, it has become highly controversial and significantly affects the lives of individuals with comorbid disorders. For example, Benzodiazepines, which are commonly prescribed in mental health treatment, are usually contraindicated for people with a history of chemical dependency. Instead, experts recommend using cognitive behavioral and rational emotive therapy, and, if necessary and indicated, treating recovering patients who have anxiety disorders with tricyclic antidepressants (Zweben, 1992; Sheehan, 1993; Barr, 1994).

To make appropriate decisions about the use of medication, clinicians must understand the abuse potential of various drugs and distinguish between psychoactive and dependency-inducing drugs. These decisions become even more complicated in the treatment of pregnant women with dual diagnosis, which requires knowledge about pregnancy and fetal development in addition to mental illness and substance disorders. Experts generally recommend that psychotropic agents be avoided in the first trimester and used only when the risk to the mother and fetus from the mental disorder outweighs the risk of the medication (Cohen, Heller & Rosenbaum, 1989). Still, no medication should be prescribed without consultation of substance abuse and mental health clinicians and a physician, and close monitoring is needed.

**Treatment Models**

Ries (1992) describes three models—serial, parallel, and integrated—in which the mental health and substance abuse systems interact to treat clients with dual diagnosis.

In the **serial model**, patients are treated for one illness then transferred or referred to a separate agency for treatment of the other illness(es). This more traditional strategy often relies on establishing a primary and secondary diagnosis, based on chronology of symptoms or levels of severity; does not require personnel to learn new skills or change basic philosophies; and keeps the billing, administration, and treatment facilities separate. Possible negative consequences of this model are that patients may be given contrary information, explanations and therapies from the different programs; one of their illness may never be addressed; and/or they may simply fall between the cracks in the system (Riley, 1994; Ries, 1992). Additionally, because experience suggests that treatment for psychiatric illnesses is not effective if a comorbid substance abuse disorder is not treated, and, conversely, that traditional substance abuse treatment must be modified to recognize unique needs of individuals with comorbid, independent psychiatric illness, the serial approach may never effectively treat either illness. Ries suggests that the serial model can be somewhat improved through inservices provided by staff from the other program(s), which can also improve communication between them.

In the **parallel model**, patients receive concurrent but separate treatment for both illnesses. This model requires therapists in each program to become more aware of the philosophies and basic treatment approaches in the other field, resulting in less conceptual conflict in the patient. It also builds on existing systems in the community. The limitations of this model become apparent, however, if the programs are not geographically close, or if program rules dictate payment for only one type of treatment at a time. Additionally, Ries notes that this model requires each program to have enough flexibility to alter the intensity of service in response to activities in the other program or the patient’s reaction to the overall situation.

Also, when employing a parallel model, Mason and Siris (1992) emphasize the importance of case managers, who are highly trained in addictive and psychological disorders, to assist clients in the day-to-day management of their psychotropic medication, their recovery and other personal and social issues. The **SPARK Program**, an AIA project (described on p. 4), illustrates a strategy for treating dually diagnosed women through a parallel model, characterized by joint case conferences, staff trainings and policy development among various programs providing concurrent services.

The more efficient, **integrated model** of treating dual diagnosis has emerged over the past five years (Riley, 1994). This model “unites and applies core concepts and methods from both typical mental health treatment and chemical dependency treatment” (Ries, 1992: p. 176). Integrated services are provided concurrently by personnel in a single program and facility. Although few outcome studies have been conducted on this approach, the literature suggests that a unified team approach in a single location is the most effective treatment strategy for individuals with acute and subacute dual diagnoses. However, this strategy is also the most difficult to employ because it requires that: (1) treatment staff be co-trained in both mental health and chemical dependency; (2) funding be combined from two separate and typically territorial bureaucracies; and (3) existing programs be altered to incorporate the concepts of both mental health and chemical dependency.
An integrated approach also is not necessarily the best treatment option for all individuals with comorbid disorders. In Table 1, Ries identifies certain populations for whom each model (serial, parallel, and integrated) is most and least effective.

Nevertheless, experts agree that to improve the outcome of dually diagnosed individuals, coexisting problems must be addressed simultaneously, which may be accomplished in a primary substance abuse treatment setting with concurrent treatment by other providers (Nigam et al., 1992). Ideally, programs should have multi-disciplinary staffing, including peer counselors, substance abuse professionals and mental health professionals; formal screening procedures to identify dual diagnosis; access (internally, by formal written agreement or through staff privileges at connecting facilities) to an array of treatment modalities, including psychopharmacologic and psychotherapeutic treatment, detoxification, relapse prevention and 12-step techniques; a long-term aftercare program to address different stages of the recovery process; and financing mechanisms that minimize barriers to accessing treatment (Weiss et al., 1992; Morris & Wise, 1992).

Despite tight mental health budgets, and administrative and philosophical incompatibilities, several programs around the country are attempting to integrate services for persons with dual diagnosis. The Caulfield Center, a 21-bed hospital psychiatric unit in Boston, MA, developed an integrated program for treating individuals with drug addiction and serious psychiatric disorders (Robertson, 1992; Minkhoff, 1989). This program perceives both types of disorders as primary, chronic, biological illnesses charac-

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**TABLE 1**


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**TREATMENT OPTIONS FOR DUAL DIAGNOSIS**

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<th>SERIAL</th>
<th>PARALLEL</th>
<th>INTEGRATED</th>
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<td><strong>Works Best For</strong></td>
<td>Psychiatric disorders: Anxiety, depression, bipolar disorders in psychiatric patients who achieve a normal or nearly normal mental status for significant periods of time when treated with therapy or medications.</td>
<td>Longer-term, non-acute patients. Certain stabilized schizophrenics, most stabilized bipolar, and many other chronic psychiatric patients can attend mental health day treatment and concurrent AA meetings. Patients with major depression can see a psychiatrist and CD counselor concurrently once each disorder is partially stabilized.</td>
<td>Acute and subacute dual-diagnosis patients with all major psychiatric disorders.</td>
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<td><strong>Psychiatric disorders:</strong> Major psychotic disorders (schizophrenia, schiz-affective, paranoid disorders) which even when treated have significant psychosocial and functional effects, and rapid-cycling bipolar or unipolar depressives who only intermittently achieve normal function despite psychiatric treatment.</td>
<td>Psychiatry disorder: Severe substance use disorders with antisocial personalities and intravenous drug use. Most such patients do not seem very interested in psychiatric treatment anyway, unless they find some advantage in becoming a “psychiatric case.”</td>
<td>Psychiatry disorder: Acutely psychotic, suicidal, or toxic patients who need round-the-clock care oriented toward their primary disorder. Many patients may feel overloaded by therapy if they must attend two intensive programs concurrently, especially if they are in different locations. Borderline patients’ tendency to “split” is amplified in a system with separate therapists, groups, norms, etc.</td>
<td>Psychiatry disorder: Patients with stable psychiatric disorders, whose primary problems are reaching and maintaining sobriety, may not receive the degree of CD intervention that they need in an integrated program. They may be better managed in a parallel program with minimal psychiatric care but intensive CD treatment. Patients with severe chronic psychiatric symptoms who episodically use substances, but who may not have developed dependence or compulsive use, may be mystified by the lack of control demonstrated by addicted patients. They are better treated with relapse prevention education within standard psychiatric care.</td>
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terized by profound denial and loss of control. Treatment is based on an assessment which distinguishes between primary disease and secondary symptoms. In cases where two independent illnesses are diagnosed, both are seen as primary and these patients receive parallel treatment within the unit. This requires simultaneous medication compliance, abstinence and AA participation, but recognizes that progress occurs at a different pace for each illness.

In the State of New Hampshire, Continuous Treatment Teams (CTT) ensure continuity of mental health and substance abuse treatments across services and over time (Drake et al., 1991). Each CTT is comprised of four to six clinicians, including a half-time psychiatrist, a nurse, at least one addiction specialist, and at least one specialist in chronic mental illness, all of whom are cross-trained in both disciplines. Each team meets on a daily basis, and provides substance abuse counseling, leads dual diagnosis groups, educates families through extensive outreach, and links clients to the existing substance abuse treatment system and the self-help system by screening meetings, preparing them for the experience, attending meetings, and discussing the experience afterward. In recognition of the recovery process, groups are provided at two different levels: (1) persuasion groups—designed for clients in denial—are psychoducational, interactive and supportive; and (2) active treatment groups—for clients committed to working toward abstinence—use behavioral principles of substance abuse treatment.

Tehama Recovery Center’s Right Road in Corning, CA, is a social model residential alcohol and drug treatment program which recently received a CSAT grant to set aside 35 of its 100 beds for men and women with dual diagnosis (personal conversation, Jean Baker, 1994). Although the majority of counseling at Right Road has traditionally been peer oriented through 12-step programs, the CSAT grant enabled them to hire two licensed clinicians and a licensed clinical psychiatrist, along with additional case managers, to provide more intensive therapeutic counseling. Additionally, Right Road hired three outreach/aftercare workers to establish linkages with agencies (e.g., social services, mental health, alcohol/drug, homeless and vocational rehabilitation), in order to develop and maintain a comprehensive continuum of care for patients in the program.

Conclusion

In order to effectively serve women with coexisting illnesses, the philosophical differences between the substance abuse and mental health treatment systems must be addressed through community training and education, development of standards, procedures/protocols, and community organization and interagency collaboration (e.g., through memorandums of understanding and inclusion of staff from other agencies/disciplines on the service team). Although co-located services are ideal, completely integrated programs may not be feasible in all communities. Cross-disciplinary training and collaboration, however, is critical in order for practitioners in different systems to be familiar with each other’s basic assumptions and language. Such professional integration will increase service providers’ general understanding of mental illness, substance abuse, and the complicated interaction between them, leading to more effective treatment of clients with coexisting illnesses. A handful of programs in communities across the country show promise that this can be accomplished.

—Amy Price, MPA

REFERENCES


