ARTICLE

Dual Dilemma: When Addiction & Mental Illness Combine

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Can people with mental health disorders respond to addiction treatment? Available research suggests the answer is yes. In a study of treatment outcomes involving 6,335 addicted inpatients and outpatients at 41 different treatment sites, overall rates of abstinence were 56% for patients with a diagnosis of depressive disorder, versus 55% for patients without depression. Regular attendance at 12 Step groups and continuing care seemed a better predictor of success than the presence of a depressive disorder. In fact, patients with depression were more likely to attend AA than other patients.

Perhaps no psychiatric disorder is more challenging than schizophrenia Yet in a study of 18 schizophrenic alcoholics at four years post-treatment, more than 60% were in stable remission from alcoholism. The mean duration of remission was over two years.

The key seems to be the adoption of an integrated model of treatment. In the integrated approach, one treatment team treats both illnesses using an integrated treatment plan. Nobody assumes that depression is just an aftereffect of drug or alcohol use, or that addiction is simply the result of untreated emotional problems. Multiple disorders are treated concurrently because otherwise, the one that doesn't get addressed sabotages success with the others. or at.

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The therapist doesn't tell the patient that medication and therapy will take away the desire to drink or use drugs, because that isn't true. Nor is the patient advised to expect sobriety alone to end depression, because often it doesn't. Instead, Co-Occurring Disorders (COD) patients learn that recovery is an opportunity for a better life provided they are willing to make a few essential changes in the way they live.

How does addiction impact mental illness?

First, alcoholic drinking and drug use aggravate and prolong depression and anxiety. Many psychiatric emergencies are actuallyh the result of substance use. Nonetheless, users return again and again to alcohol, cocaine, marijuana, heroin, PCP, etc.

Why? Because of the addiction, which is characterized by continued use despite the adverse consequences.

At one time, many clinicians believed that people with psychiatric disorders were unable to get clean and sober. That's sad, because in reality, it's recovery from addictions that may make successful treatment of mental illness possible.

The Challenge of Differential Diagnosis

How do we know for certain whether anxiety or depression is caused by protracted withdrawal, a mood disorder, or some other cause? It's often difficult to tell.

Addicts and alcoholics may spend years misidentifying the symptoms of drug or alcohol abuse as some other illness. It's a dilemma similar to that faced by the person with chronic pain – once you're dependent on a painkiller, it's easy to confuse legitimate pain symptoms with the discomfort caused by withdrawal.

The addict with pain problems can fall into a vicious circle, treating his pain with drugs and experiencing still greater discomfort when the meds wear off – causing him to turn to still more medication.

In most areas of medicine, diagnosis is confirmed with a physical tests. Psychiatric illnesses, by contrast, are diagnosed largely by symptoms --- those subjective, possibly distorted reports from the patient. In the era of pop psychology, patients often arrive at the clinician's having already made their own diagnosis of what's wrong with them, based on something they heard on a talk show.

How do you make an authoritative initial diagnosis of depressive disorder in someone who's newly recovering from heavy, long-term stimulant use, when the normal course of recovery seems to include some episodes of depression and anxiety?

Just having symptoms isn't always proof that you have the disorder. Periodic re-evaluations are required to confirm a final diagnosis.

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Sometimes there are clues, such as:

- A family history of depression or psychiatric disorders
- Behavioral or emotional problems as a child or adolescent
- Prior psychiatric treatment that appears independent of alcohol or drug use
- Severity of depressive symptoms
- Symptoms that seem to persist during earlier periods of abstinence or diminished use.

Clinicians have learned to treat the symptoms in order to alleviate the patient's discomfort without being too firm about the diagnosis.

Depression

Most of us lay persons, regardless of education, still regard depression as a response to life problems rather than an illness. Nonetheless, major depressive disease is different than depressed mood in the way that alcoholic drinking is different from occasional alcohol abuse. The depressive's moods are the result of a disorder often complicated by a pattern of negative behaviors – including substance use.

For some, depression is chronic, progressive, and potentially fatal. Though often found in the same families as alcoholism, it should be seen as a separate disorder.

Self-diagnosis of depressive disorder is often complicated by the tendency to externalize onto a wide range of problems. Better to think of these as precipitants rather than causes – something that can help trigger depressed mood in persons who have the disorder.

Successful treatment usually involves medication as well as lifestyle and behavior change.

Normal Early Recovery in Stimulant Addiction

Stage	Timing	Signs & Symptoms
Panic	1-12 hrs after last use	Anxiety, agitation
Depressed mood	12-24 hrs after use	Dysthymia, fatigue, insomnia–possible suicidality
Honeymoon	1-5 days after use	Depression lifts
Relapse I	6-15 days after use	Depression returns
Emotional lability	16-28 days after use	Mood swing, peaks/valleys
Relapse II ("Wall")	28-42 days after use	Recurrence of depressed mood

The normal course of recovery from stimulant abuse includes some episodes of depression and anxiety.

Bipolar Disorder

Some epidemiological studies have suggested that perhaps 50% of persons with bipolar disorder also have a substance problem (comparable to the rate among depressed patients). Unlike depressed patients, bipolars may experience manic episodes and resist treatment. Medication regimens must be closely monitored to insure compliance.

Anxiety Disorders

Treatment of anxiety has improved with the use of alternatives to the benzodiazepine medications that addicts shouldn't use on an extended basis. Patients with chronic anxiety, phobia, or panic disorder may suffer as much from anticipatory anxiety (meaning fear of becoming afraid) as from the disorder itself. Many benefit from cognitive therapy designed to desensitize the patient to environmental triggers for anxiety episodes.

Post-Traumatic Stress Disorder (PTSD)

PTSD is strongly associated with increased substance use as well as with an array of complex behavior disorders (anorexia, bulimia, and compulsive overeating; compulsive gambling; dissociative disorders, among others). Core therapies may be cognitive-behavioral or employ alternative methods such as EMDR and somatic therapies.

Giving Medications to COD Patients

It's always a concern when psychoactive medications are prescribed to patients with a vulnerability to drug problems. A reawakened craving for alcohol, heroin, cocaine, sedatives, or methamphetamine may be tied to the use of a prescription medication.

Clinicians learn to avoid errors such as:

Prescribing the medication too quickly in treatment. If every alcoholic gets an antidepressant during detox, the doctor won't be able to tell if the

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patient's improvement results from the medication or from the beneficial effects of abstinence.

Circular reasoning: If the patient improves with an antidepressant, it's tempting to interpret that as proof positive that the patient has a depressive disorder. But many medications produce some benefit in a variety of conditions.

Expecting an addict to follow directions: You can't just hand medications to the patient with directions written on the label. A patient who hasn't followed a direction in years will not suddenly become compliant because the doctor orders it. Medication use must be monitored.

To minimize problems with medication, the clinician might use the following three step process:

1. Does the patient currently exhibit three or more DSM-IV criteria for the psychiatric disorder? This is especially important if the patient was medicated at another time by another clinician. Does he or she still meet the criteria for that disorder? Things change.
2. Have other possible factors received adequate investigation? One study found that nearly half the patients in a psychiatric hospital had an undiagnosed or misdiagnosed medical condition that caused or contributed to their symptoms. Are you satisfied that the principal cause has been identified?
3. Is the patient free of medical or psychiatric contraindications for the proposed medication? Is the drug compatible with all other medications the patient takes?

Then, once the new regimen has begun, confirm the response after an initial trial by asking:

- *Is the patient currently free of negative side effects?* Side effects can often be controlled by adjusting the dosage, or by switching to another drug.
- *Is the medication producing measurable improvement?* Are the symptoms abating?
- *Has the patient complied with previous drug regimens?* If not, that's a warning sign of future compliance problems.

Finally, it's best to monitor compliance through followup visits where the clinician can determine:

- *If the patient is currently following directions in other areas.* If not, then what makes us think the meds will be taken as prescribed?
- *If the patient understand the need for behavior change.* Most medications are more effective when integrated into a program of behavior and lifestyle modification.
- *If the patient is participating in continuing treatment.* We can't cure addiction. It requires ongoing treatment for better outcome.

Relapse Thinking Patterns

Example of "Relapse Thinking"	Flaw in Reasoning
"I was doing well, so I thought it was OK to stop taking the medication."	The meds were contibuting to success; stopping them contributed to failure.
" I didn't really see myself as that sick."	And so had no motivation for continued treatment
"The meds made me feel bad, and cocaine made me feel good."	Cocaine high was temporary, and led to worse problems.
"Nobody appreciated the effort I was putting out."	Can't make recovery contingent on others' appreciating your efforts.
"I thought it was OK to miss occasionally."	Broke the habit of recovery
"I don't like taking pills."	Yet willingly consumes drugs of abuse
"I took it for a few days, but it didn't help."	Probably never got to therapeutic levels.
"I feel like I've changed. I don't think I'll ever be depressed again."	Most psychiatric disorders are chronic & need preventive care.
"I need to do things my way for a while. You can't always do what other people want you to."	It isn't other people who set limits --- it's your illness.

Thinking patterns like these interfere with treatment for mental health disorders as well as addiction.

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Some Simple Guidelines for Treatment

COD treatment requires three things besides medication management. They are:

- A patient education program focused on co-occurring disorders
- A therapy group for COD patients only, and/or individual counseling.
- Case management, treatment plans and policies geared to COD patients.

Patient education for COD patients includes material about co-occurring disorders (COD), about recovery, and about the negative effects of drug or alcohol use on mental health. A group of fellow sufferers offers the COD patient a chance to discuss problems unique to his situation.

Treatment plans address the elements of COD recovery, which are, in brief:

1. Stabilizing symptoms.
2. Learning about the illnesses.
3. Self-diagnosis
4. Using a 24 hour plan that measures progress one day at a time.
5. Making recovery a priority in your life.
6. Putting treatment first.
7. Inform others of your treatment plan and telling them how they can help.
8. Examining the traps and triggers that could lead to relapse.
9. Making a plan to prevent relapse.

Positive Interactions

As a general rule, persons with COD do not respond well to direct confrontation. Some alternative forms of approach:

Provide new information or clarify facts.

Client: I don't need to be here. I don't have a problem.

Counselor: Really? Let's see how many symptoms you have. Remember, you don't need all the symptoms to qualify for the diagnosis.

Point out inconsistencies in behavior or approach.

Client: Look, I'm trying as hard as I can.

Counselor: Yet you won't go to an NA meeting. Isn't that a contradiction?

Reinforce strengths

Client: I can't talk in group.

Counselor: I think you have a lot to say if you'd give yourself a chance.

Refer to reality

Client: I don't need a halfway house.

Counselor: You're homeless, unemployed, and without family support. Does that sound like a good recipe for success on your own?

Summary

This is only a brief overview of co-occurring disorders treatment, but the message is hopeful:

Treatment works. But only if, as the saying goes, you're willing to 'work it.'

Some markers for success

How do you know when you're on the road to recovery? Here are a few suggestions for signs along the way.

1. Is your condition stable, as determined by a physician?
2. Can you explain key elements of both disorders?
3. Have you identified symptoms of both disorders in his/her experience?
4. Have you discussed these with at least 1 knowledgeable person & got feedback?
5. Have you learned to identify relapse thinking patterns?
6. Do you believe that you require continuing treatment?
7. Are you planning your days around a structured routine that promotes health?
8. Have you stopped dwelling on things you can't control?
9. Have you come up with ways to interrupt anxiety and restore focus to present?
10. Have you begun to implement daily recovery activities?
11. Do you have a plan for insuring that recovery remains a priority?
12. Have you identified situations where he is vulnerable to relapse?
13. Have you played each relapse scenarios and determined alternatives to relapse?
14. Can you explain how relapse would make each of the identified situations worse?
15. Have you made a genuine effort (where appropriate) to bring others into your recovery plan?
16. Do you have a plan for communicating your real needs to these individuals in the future?
17. Have you shared your relapse prevention plan with a counselor and small group?
18. Do you have a plan for dealing with your own relapse thinking patterns through getting feedback from others?
19. Are you working your relapse prevention plan one day at a time?
20. Can you demonstrate 3 changes you made because of others' suggestions?