SPEAKER NOTES

Dual Diagnosis: Practical Considerations for Dealing with Both Problems

Summarized by Thomas T. Thomas

Many people with a mental illness try to ease their suffering with a form of self-medication by taking alcohol and street drugs. Usually, as in other aspects of their lives, they don't know how to limit their consumption and end up with a dependency. This situation is called "dual diagnosis."

On November 19, **Nancy Piotrowski, PhD,** explained how dual diagnosis affects the patient's psychological assessment, treatment options, and long-term case management. Piotrowski is a clinical psychologist and research associate at the Alcohol Research Group in Berkeley. She also teaches in the Chemical Dependency Certificate program at U.C. Berkeley Extension.

"Dual Diagnosis is very prevalent," Piotrowski said. "About fifty percent of people getting treatment for alcohol and drug abuse have some kind of mental illness. Conversely, fifty percent of the people with mental illness have a substance abuse problem." The frequency of dual diagnosis varies, she said, from 45 percent of people with a diagnosed anxiety disorder to 65 percent of people with bipolar syndrome.

"I want to be clear that we're not talking about the so-called 'personality disorders' here, but the biologically originating mental illnesses. So, obviously, there is a linkage between chemical imbalance in the brain and chemical dependency."

In support of this, she noted that 85 percent of people with schizophrenia smoke cigarettes. Although nicotine is a usually classified as a stimulant, it seems to have a calming effect on the "brain noise" that is the hallmark of this illness. Similarly, people with sleep disorders have a tendency to overuse caffeine.

Although dual diagnosis is so common, Piotrowski said you will never see it on an insurance form. This is because diagnosis is a precise tool used by psychological professionals to communicate about the patient's condition and the management of his or her illness. And "dual diagnosis" is an extremely imprecise term.

For example, "substance abuse" has 90 different definitions in the *Diagnostic and Statistical Manual* (DSM), the psychological reference standard. "Schizophrenia" has 15 different subdivisions. "Bipolar syndrome" has nine distinct forms—and all of them react differently to the effects of drugs and alcohol. So a blanket reference to "dual diagnosis" is as clinically useless as saying that the patient has "gastrointestinal problems." It does not tell the physician what is really going on.

Another reason "dual diagnosis" is not officially used is that most insurance companies do not offer compensation for substance abuse treatments.

And Supplemental Security Income (SSI) may actually withhold benefits to substance abusers. So psychologists prefer a primary diagnosis of mental illness, which *is* compensated, and offer a subordinate diagnosis of substance abuse—if they mention it at all.

"Diagnosis is not a thing, not static," Piotrowski said. "It's an on-going process of evaluation. Over a person's lifetime, symptoms will shift and change in relation to life stresses. To manage the patient's care, the psychologist must keep diagnosing and evaluating the patient."

The key to treating dual diagnosis is to have a long-term perspective. The doctor and patient need to build a track record, starting with a good psychological assessment. Properly done, this involves several sessions over a period of a month or more, with at least one toxicology screening. The doctor should also check the patient's record for possible arrests involving substance abuse.

"Unfortunately," she said, "the economics of our health system leads to quick diagnosis based on the analysis of one or two symptoms. That is, the single diagnosis."

One of the indications of dual diagnosis, Piotrowski said, is that the patient does not respond to the prescribed medications or treatment for the indicated mental illness. That's a sign that the original diagnosis was not complete, and the doctor should look for signs of substance abuse.

Many substances can mimic psychological symptoms and so make diagnosis more difficult. For example, methamphetamines produce a state similar to psychosis and can be mistaken for the positive symptoms of schizophrenia. Heroin and the other opioids produce symptoms similar to depression. Other drugs can exacerbate or actually set off symptoms, as mind-altering drugs can produce schizophrenic hallucinations.

Conversely, patients who may have been using nicotine, alcohol, caffeine, and street drugs to self-medicate may show more pronounced symptoms of an underlying illness when they stop taking the substance. Thus, an alcohol abuser who quits drinking may be susceptible to panic attacks, which the alcohol was masking. Or an ex-heroin user begins to manifest the psychotic symptoms of schizophrenia that the drug had helped to suppress. And the ex-cocaine user may become clinically depressed.

"Substance abuse is a biological problem," she said. "Most often, people view it as a moral or personal failing, but substance abuse is really the body's response to a chemical stimulus. There's not a person in this room whom I can't make an addict by subjecting them to the right drug under the right circumstances. Some people just become addicted faster than others. Even animals can be come addicted to alcohol, nicotine, heroin, and cocaine."

The good news is that people with mental illness apparently can break their substance abuse just as easily as anyone else. A study in Vermont that used behavioral incentives to stop smoking—that is, rewards and goal setting—showed this technique is equally successful with schizophrenics and non-schizophrenics.

But the bad news is that, up until recently, many hospitals allowed schizophrenics to go outside the building only for cigarette breaks, as a way to calm them. This encouraged their habit. Now, most hospital staffs will permit and encourage recreation breaks.

The medical community is also studying use of the nicotine patch in an effort to save the patient's lungs. And, because nicotine is still a poison—damaging the cardiovascular system—researchers are at work on finding analogous molecules that will have the same soothing effect as nicotine without the poisonous side effects.

What can family members and friends do for a person with dual diagnosis?

"First, know your own limits and what you can deal with," said Piotrowski. "As they say on the airplane, put your own mask on first, then assist the person you're traveling with.

"Second, if you don't know about the drug that's being abused, try to find out about it." As information resources, she mentioned Alcoholics Anonymous and her own Alcohol Research Group in Berkeley. Fortunately, many of these Twelve Step groups have abandoned their previous bias against taking drugs in any form, including prescribed medications upon which patients with a mental illness rely.

Good local treatment centers include the Mt. Diablo Hospital; the University of California at San Francisco, which has established its own Dual Diagnosis Clinic; and the Alameda County medical system, which addresses problems of drug abuse in conjunction with its mental health programs.

"Third, begin to educate the person with the problem. Many patients simply don't realize that their intake of alcohol, which is a depressant, only makes their clinical depression worse. Or that drinking coffee aggravates their sleep disorder. You can't fix a problem if you don't know you have it," Piotrowski said.

She said that eighty percent of the substance abuse problem is lack of information; only twenty percent hinges on patient denial.

"Once you've helped the patient make a connection between substance abuse and mental illness, he or she can work out the pros and cons of the abusive behavior. Then he or she will be ready to accept treatment.

"As with parent training, it's not enough to say 'Stop doing that.' You have to offer a positive alternative and give the patient an idea of what kind of behavior you want."

Dual diagnosis touches on many areas of our society: medical and mental health treatments, police and the legal system, the insurance and welfare systems. With understanding and knowledge, we can begin to deal with the problems of dual diagnosis in a uniform and coherent way.