

Introduction

An Examination of the Guiding Principles for Treating Co-Occurring Disorders

I would like to begin this book with a story. The story is about one of the more important events—and lessons—in my 45-year career as an addiction counselor. At the time, I had been in the profession for 10 years. Most of my efforts with clients resulted in extreme frustration. My practice was marked by noncompliance, relapse, recidivism, confrontation, and, basically, poor outcomes. My clients were getting nothing from me, and I was becoming a poster child for burnout. Perhaps some of you have been to this place. I remember dreaming about working in a flower shop or, my favorite escape fantasy, in a bookstore. During this time I placed the blame for my inadequate results on the clients. After all, I would proclaim to myself, I am appropriately applying the skills that I was taught in my graduate program that would enable these people to surrender the plague of drugs and alcohol from their lives. The problem, therefore, could not possibly be with me. The problem was with the clients and the fact that they were “just not ready.” I am sure that many of you have heard the old mantra in drug counseling that “addicts have to

INTRODUCTION: AN EXAMINATION OF GUIDING PRINCIPLES

hit rock bottom” before they see their behaviors as problematic. I would do my best to point out to them that their use of drugs and/or alcohol was destroying both themselves and those around them. They would not listen. I would educate them about the effects of drugs and alcohol on their brains and other body functions. They would not listen. I would resort, at times, to emotional blackmail. They would leave counseling. I was not a good counselor.

It was at this point that I was invited to participate in a two-week seminar sponsored by the Veteran’s Administration. The seminar was designed to acquaint us with a new treatment strategy for addiction disorders—Motivational Enhancement Therapy. This strategy, which is discussed at length in Chapter 5, had some glowing research outcomes. I was excited. I knew I could benefit from anything that would help change what I was doing. This training resulted in the watershed event of my career, but it began as a very humbling experience.

Three days into this training, I was gently confronted by one of the presenters regarding my attitude toward the skills being taught. These skills appeared, in my humble estimate, to be enabling. I was also presenting myself as being confused. This was a very appropriate observation because I was, indeed, confused. I was being presented with material that went against most of what I was taught regarding the treatment of addiction disorders. My “slap-face” methods were being attacked, and being put on the defensive did not sit well with me. At any rate, this wonderful gentleman comes to me and says: “Jack, your problem is that you are an addiction counselor.” I responded that this was a marvelous observation. He looked at me and respectfully replied: “Jack, hopefully, what you will learn from us is that we don’t treat addictions; we treat people with addictions.” He was telling me that I was locked into my professional definition. I am sure that those reading this book are very aware and sensitive to this frame of treating people and not behaviors. We don’t treat addicts. We don’t treat alcoholics. We treat people with addiction disorders. We do not define our clients by their DSM diagnosis! These are conditions our clients have, and these conditions do not define people. All of you are aware of this. Sadly, at this time in my career, I was not. I defined

Introduction: An Examination of Guiding Principles

myself as an addictions counselor so, therefore, I treated addictions. This was my problem.

I also discovered I had another problem. This person would not leave me alone. He made me his project. Why? To this day I have no answer for this. What I can tell you is he saved my career and, in doing so, helped me help others. He also helped me understand myself and why I became an addiction counselor. This lesson was perhaps the most profound, sobering, and centering message and will be discussed at a later time. He also informed me that people use, abuse, and depend on drugs for a reason. In their view there is a benefit to this behavior. It is essential, he says to me, that we are empathic to this situation. When we look at all dysfunctional, maladaptive, or pathologic behaviors, we will discover that folks engage in these behaviors for a reason. All behaviors are purposeful. One of the goals in counseling is helping the client discover what that benefit or goal is.

Edwin Shneidman and Marsha Linehan, in the realm of suicide, tell us that these behaviors are either *operant* or *respondent*. In the respondent frame, we would look at drug or alcohol use as a behavior designed to achieve some control in a threatening situation or stimulus event (Linehan, 1999). An example would be the case of an individual described by others as “shy to a fault.” In reality he or she is experiencing an undetected, untreated social phobia. As the person is presented with the challenging task of a coerced social interaction, he or she uses drugs or alcohol to diminish fear and have a relatively enjoyable social contact. Another case would be the person with psychotic episodes who discovers in cannabis use a calming of those intrusive episodes.

In the operant frame, Linehan tells us that drug use is elicited by a need for people to affect their environment (Linehan, 1999). Operant behaviors are those that are under the control of the consequences. An example is the often-used frame of “bonding with Budweiser.” This would be individuals who continue to use drugs to maintain friendships, and they fear that sobriety and abstinence would result in the loss of those friendships. As we get to know these people, we explore their history of drug and/or alcohol use. We discover with

them the operant and/or respondent benefits of their use. We may find they are the self-medicating mentally ill, or they are alone, or they need to escape a terrible reality, or they need to enhance a boring existence, or they need to avoid horrible withdrawal symptoms. Whatever the benefit may be, it is critical that we and the clients discover that benefit.

My presenter, and soon-to-be close friend, told me that in his entire career he never met a person who had the goal—as they began their history of drug or alcohol use—to become addicted. The physical, emotional, psychological addiction to their drug was the terrible consequence of a behavior that had, at the time, a very attractive motivation. The essential question during any evaluation is “What does the drug do for you?”

Regarding the self-medicating mentally ill—people with co-occurring drug/alcohol and mental disorders—Ken Minkoff tells us: “People with serious mental illnesses are vulnerable to substance use because the substance replaces prescribed psychotropic medication in order to bring relief from acute symptoms, remedy feelings of social isolation, and creates a temporary sense of well being” (Minkoff & Regner, 1999). I remember talking to a client who had a significant psychotic condition. We discovered that his cannabis use was designed to gain some relief from his symptoms. As we inched toward encouraging him to give a prescribed medication a chance to do the same thing and achieve the same goal, he says to me: “Well, tell me, can I party on these meds? And will my friends do the meds with me? And can it give me the same mellow feeling that weed does?” Substance use often begins as a “treatment” for an undiagnosed, untreated mental illness. This use evolves to become a persistent management strategy for stressors and the symptoms of the mental illness. Then, depending on multiple factors, the use becomes an addiction.

For a definition and conceptualization of co-occurring disorders, luminaries such as Ken Minkoff and Donald Meichenbaum offer us the following thoughts, which I will, respectfully, summarize. One disorder may, for instance, regularly precede the development of the other disorder. Therefore, the first disorder may be viewed as a significant risk factor or precipitant for the second (co-occurring)

Introduction: An Examination of Guiding Principles

disorder. A common example is seen in people with an undiagnosed, untreated Generalized Anxiety Disorder. This condition, which possibly emerged during late childhood or early adolescence, may render the individual vulnerable to the use of cannabis for the purpose of transient, temporary symptom relief. Research cited by Meichenbaum states that for individuals with co-occurring psychiatric and substance-related disorders, the mental health disorders usually precede the substance use disorder about 90% of the time. The median onset age of the psychiatric disorder is 11, with the substance-related disorder usually developing 5 to 10 years after the psychiatric disorder (median age of 21). Many cannabis users have told me: “When I’m stoned, I don’t have a worry in the world. My life is intolerable without weed.” It is not a stretch to conceptualize mental disorders as risk factors and precipitating conditions for the development of substance use disorders.

Another concept is that one disorder may act as a protective factor to another (co-occurring) disorder. When a client tells me that alcohol use allows her to “see another day,” I respect that alcohol use helps her manage the unbearable grief of losing a husband and, actually, protects her from dying by suicide. It is, therefore, not a stretch to view alcohol/drug use, in some circumstances, as keeping a person from acting on suicidal impulses. A young woman in her thirties with significant issues of posttraumatic stress disorder (PTSD) resulting from a history of ritual sexual assault as a child is now heavily addicted to prescription drugs to help her sleep and, according to her, “so I won’t jump off a bridge.”

A final view of co-occurring disorders is when one disorder modifies and/or complicates the presentation of another (co-occurring) disorder. Addiction is a brain disease, and it is chronic. We will discuss the importance of the chronic nature of addictions at a later point in this book. Many of the problematic behaviors we see in people who use drugs are a result of brain dysfunctions. We observe in the process of the DSM, when the issue of substance-induced disorder is examined, that we are urged to diagnose carefully, cautiously, methodically, slowly. We want to differentiate between an individual with schizophrenia and the person with a substance-induced psychotic disorder. We will approach, and treat, the

person with dysthymia in a different fashion than the individual with a substance-induced mood disorder. The concern for the co-occurring self-medicating mentally ill person is that the drug that provides them with transient relief from their symptoms could, in a matter of degrees, make their condition more complex. Neuroscience has uncovered how addiction to drugs hijacks different parts of the brain. The chemical dopamine conditions the brain to certain behaviors that are correlated to pleasure. Therefore, while the drug use is designed for symptom relief, the dopamine reaction creates a physiologic and emotional dependency. It is in the dependency and the continued use of the drug that will distort, modify, alter, and complicate symptomatic presentation.

PURPOSEFUL BEHAVIOR

All behaviors are purposeful. This cycle presents clinicians with, perhaps, their most significant challenge. I remember a client who once proclaimed to me during our first session together: “Telling me to quit my cocaine is like telling me to quit breathing.” For that client, drug use had become an essential part of his existence. The use of drugs had a varied purpose: To assist in the management of the intrusive symptoms of his mental illness, to present him with opportunities for social interaction, and to avoid the terrible reactions of withdrawal created by the dopamine-induced dependency. This person, and many like him, presented a unique challenge in therapy. Treatment effectiveness studies on this matter are quite clear and discouraging: “Non compliance with treatment, recidivism, and multiple relapses in the substance use disorder population have been directly linked to a co-occurring mental illness” (Minkoff, 1999). Donald Meichenbaum adds to this concern: “Relapse rates among chemical addictions (heroin, cocaine, nicotine, alcohol) and across various treatment models are fairly uniform and discouraging—around 75%. The likelihood of life-long abstinence is low” (Meichenbaum, 2010). In 2010 the National Institute on Drug Abuse estimated that in the United States there were approximately 25 million people with a definable

Purposeful Behavior

substance use disorder. Two million—less than 10%—sought help. But there is hope. I would not be engaged in this writing project if there was no hope. I am not, by nature, a pessimistic person.

Finally, this wise man at the conference tells me: “Nobody changes behaviors without motivation.” That was the purpose of the training—how to motivate our clients toward abstinence and sobriety. I thought I did that. I thought that when I outlined for them how drugs and/or alcohol were destroying their health and educated them about the effects of drugs on their brains that this cognitive input would surely motivate them to quit. I thought that when I confronted them for hurting their family with their drug use that this emotionally charged blackmail would motivate them to quit. I thought that was motivation enough. I was wrong, and to this day I feel a certain shame about this behavior.

What, then, *does* motivate people to change behaviors? The simple answer, as William Miller and Stephen Rollnick describe it: “Intrinsic motivation for change occurs in an accepting, empathic relationship in which the person discovers that current behaviors keep them from achieving what is wanted and valued in their lives” (Miller & Rollnick, 2002). This is what is called the *discrepancy* in a person’s life. The person becomes aware of the fact that “this is not the way I wanted my life to be.” As we will discuss in later chapters, this focus should become the primary task of therapy. In the discovery and acknowledgment of this discrepancy, we may find the source of our client’s motivation to change.

Most people who seek our help and guidance and are powerfully motivated have, on their own accord, discovered their discrepancy. They have acknowledged, in paying close attention to life’s messages, that this (drug and/or alcohol use and dependency) is not the way they want life to be. They are motivated to engage, perhaps, in a brutal period of medically supervised detoxification. They are motivated to attend, for the rest of their lives, support groups. They are motivated to engage in counseling to learn and acquire new ways of coping with life’s stressors and demands. They respond to counseling in a positive manner. They are motivated.

REASONS FOR SEEKING THERAPY

It has been my experience that there are basically three reasons why people seek out therapy. The first reason is that they are currently experiencing unbearable levels of emotional, psychological, and psychiatric pain. This sense of pain is a great motivator for change. This pain is individually defined by the person. Something is wrong in his or her life. Something is not the way it should be. This pain is often the discrepancy that Miller and Rollnick talk about. The most important feature here, however, is the individual nature of this pain or discrepancy. This pain has to be managed. I remember talking to a young woman who was in her second academic year at a local university. She had recently made a suicide attempt, and while she was in the emergency room, traces of alcohol and cocaine were found in her system. During our initial interview I asked her what the attempt to take her life was designed to accomplish. She looked at me and responded: "I just got my very first B." Now, that hardly seems to be a good reason to kill oneself. But for this young woman, at this period in her life, and with the individual stressors placed on her by her family for perfection, the decision to die appeared very logical to her. Her individualized definition of this failure was causing her unbearable emotional pain. She feared losing her parents' love and approval. She told me: "My parents don't accept failure." This pain defied her capacity to cope. She tried drugs, but this was not successful in curbing the pain. Finally, suicide was decided on as the ultimate problem solver.

Or consider the woman grieving the sudden loss of her husband of 38 years. To help her sleep and ease her anxiety-driven grieving, "a few" glasses of wine each night appears very appropriate—and helpful. Until, of course, this behavior for coping becomes a dependency—both physical and psychological. A wise man once told me in regards to this pain: "One person's unbearable pain is another person's irksome event." This pain is defined by the client.

Many of you have experienced this situation. When we experience intolerable levels of physical pain, we run to our primary care physician. We are diagnostically clear in indicating to that person the nature of the pain. We tell our healthcare provider everything he or

Reasons for Seeking Therapy

she needs to know about our pain. And, most important, we respond to our physician's direction to make this pain go away. In the arena of mental health, people in this level of pain usually make for very motivated clients. They are diagnostically clear, wanting us to know as much as possible about their pain. And they will normally respond in a positive fashion to insights and directions from us that they perceive as potentially helpful in the alleviation of their pain.

Edwin Shneidman, the icon of the study of suicide in our society, told us many years ago:

The first task of therapy is to discover the locus of the client's unbearable pain and to decrease the perturbation associated with that condition. In the context of a caring relationship we assist the person in discovering their pain and help them manage this condition. There are really only two questions we need to ask a person: "Where do you hurt?" and "how can I help you?" (Shneidman, 1973)

I am sure it comes as no surprise to many of you that a significant number of the people we have the privilege to meet are self-medicating an intolerable level of pain. That pain, again, is individually defined by the person and may vary from emotional to physical or mental. For these people, at this time in their lives, these drugs are very beneficial and attractive. Many of them, however, run a significant risk of becoming physically and/or emotionally dependent on this form of coping.

Our responsibility to these folks is to be empathic to the current purpose and benefit involved in their drug/alcohol use. Telling them to quit their drug or mandating abstinence as a contract of therapy can be damaging, harmful, and could motivate them to see therapy as "demanding too much." The practice of abstinence-mandated therapy could tragically strip them of a defense strategy that opens up significant vulnerability to suicide or other self-harm activities.

The second reason why people seek therapy is that they are being threatened with a loss of something important and meaningful to them if they do not seek counseling. Let us look at an example that many of you are familiar with: It is the person who has been told by

INTRODUCTION: AN EXAMINATION OF GUIDING PRINCIPLES

a spouse, partner, or mate that if they don't stop drinking, they will lose that relationship. They appear in counseling with the proclamation: "My wife doesn't like my drinking. She told me that if I don't do something about it she is going to leave." And then they may add: "I need to learn to control my drinking, handle it better, become a social drinker." These people are ambivalent about abstinence and sobriety. Part of them is motivated by the threat of the loss, and part of them is reluctant to quit entirely because alcohol presents some benefits to them. These benefits could include friendships they have gained over the years at the local pub, that alcohol use calms withdrawal symptoms, or that alcohol has an effect on an undiagnosed, untreated mental illness.

What we do know is that the *only* reason these people are seeking treatment is because of the threat. Without this threat, we would never have the chance to meet them. It is essential that we accept their current ambivalence. We accept where they are at this time and place in their lives. We also respect that once that threat is gone or minimized or reduced, therapy might well be over.

There is also the possibility, slight as it may be, that they may be able to achieve the goal of being "social drinkers." We may find that in using Harm Reduction strategies, we may allow them to continue drinking while not damaging their marital relationship. We discuss these strategies in Chapter 7. Although I am not a proponent of Harm Reduction, I will engage these strategies with the ambivalent client. There are times where harm reduction is the best we can hope for with ambivalent clients. In this same chapter, we discuss how we may use Motivational Enhancement strategies to move and resolve ambivalent clients into people who are motivated to change.

The third, and final, reason why people seek out therapy is coercion. They are told to go to counseling. More often than not, this order comes from the legal system. A drug court, parole agent, or probation officer has ordered them, with dire consequences if they do not comply, to seek counseling. These people are *not* motivated, and they are *not* ambivalent; they are resistant. They would rather be anywhere

Reasons for Seeking Therapy

other than your office. This resistance comes in many forms and presentations. Miller and Rollnick tell us that resistance is displayed by the client, basically, in four presentations. Let us briefly examine each resistance presentation.

We have, first of all, the Rationalizing client. These are people who love to argue and debate. They spend most of their time discussing with you the benefits of their behavior and the advantages of the status quo. They also love to trap the clinician in what I call the “great debate.” I have had numerous encounters with these people, and I have found, to my dismay, that once they trap you in the “great debate,” they will never let you go. With delight they discuss the benefits and harmless effects of cannabis. Once you step into this conversation, you will see a smile on their face. You are now theirs, and they control the counseling. You may try to extract yourself from this great debate format, but they are relentless.

Next we have the Reluctant client. These are people who fear change. They are quite accepting of the status quo, regardless of the dysfunction or pathology it may present. A request to change behaviors creates significant anxiety in them. They will often beg you to “not rock the boat” or state that “things are better off the way they are.” They do not see any advantages to change and, actually, see significant disadvantages.

The third presentation is the Rebellious client, and they can be a cause for concern. These are people who learned at a very early age that hostility is a useful tool for controlling their social environment. These people are quite confrontational, and they will challenge your authority and expertise. They also, on occasion, run a risk of being physically assaultive. Their goal is to control the relationship with you by using aggressive and confrontational tactics.

And, finally, we have the Resigned client. These people present the greatest concern because of their vulnerability to suicide. They have been through the system. They have experienced multiple relapses, and you happen to be the 15th counselor they have seen for their issues. They often tell you: “I could write the book on addiction counseling. There is nothing new you can give to me.

INTRODUCTION: AN EXAMINATION OF GUIDING PRINCIPLES

What are you going to do any different than the other counselors I've seen?" They are hopeless and often depressed. They need very special care. We later describe these four forms of resistance in greater detail and describe appropriate counseling approaches for them.

In 1954, Harry Stack Sullivan made a comment pertaining to the newly published DSM-I. He said: "The first goal in the therapy relationship is to discover who is this person and how does this person come to be here." He was advocating, obviously, that we treat people and not diagnostic categories. He feared, as many theorists did in reaction to the *Diagnostic and Statistical Manual*, that we could reduce our clients to nothing more than a neatly arranged set of symptoms. As a result, he was concerned that clinicians would place more emphasis on those behavioral issues than on the people sitting in their offices. As it turns out, he had every right to voice that concern, but he also urged us to determine what circumstances brought the person to our services. He was acutely aware that our clients come to us under a variety of different circumstances: They are strongly motivated because of an unbearable level of emotional, mental, or physical pain; they are ambivalent about being with us; or they are in a state of resistance. Therefore, he says to us, treat the person and discover the circumstances that bring this person to your office.

Treat the person and not the diagnosis. Respect that all behaviors are purposeful. Remain mindful that nobody changes behaviors without motivation. These essential guiding principles are the framework of this book. They will be repeated quite often as we examine the challenging population of people with co-occurring disorders.

Ken Minkoff, one of the icons in the study of co-occurring disorders, examines additional guiding principles in the treatment of this condition. He tells us that an awareness of individuals with co-occurring disorders has improved and increased considerably over the last few decades. With that increase in awareness and understanding, several best practice treatment models have been developed for this population. He talks about the basic principles that support those treatment approaches.

Reasons for Seeking Therapy

The first, and perhaps the most important, is a respect that co-occurring mental health issues and substance-related disorders are to be seen as the “expectation and not the exception” (Gange et al., 2002). Let us examine some epidemiological findings to support this claim and alert us to the prevalence of this condition. Some of these findings should alarm us to the fact that we rarely see a mental disorder that is not, in some way, correlated to a substance-related disorder. Also, we rarely see a substance-related disorder that is not correlated to a mental disorder.

The highest incidence of co-occurring substance-related disorders and mental illness is among young males, who are single, less educated, and who have a family history of substance-related disorders. Studies have shown that close to 50% of people with schizophrenia had a co-occurring substance-related disorder (either abuse or dependency). Regier discovered in 1992 that 55% of individuals in his study who were in treatment for schizophrenia had a substance-related disorder (Regier et al., 1992). In people with bipolar disorders (bipolar I, bipolar II, cyclothymia), the incidence of a co-occurring substance-related disorder was 61%. In people with a diagnosis of a depressive disorder (major depression or dysthymia), the co-occurring incidence of a substance-related disorder was 50% for women and 85% for men. The substance of choice with this population was alcohol, and this substance was powerfully correlated to poorer treatment outcomes. A note that is to be covered extensively in Chapter 6, the lifetime risk for suicide in the co-occurring population of depressive disorder and alcohol dependency is 60 to 120 times elevated over the general population. This risk is particularly increased when it is accompanied by a serious medical illness, living alone, being unemployed, significant interpersonal loss (aleness), and interpersonal conflict (Chapman, Specht, & Cellucci, 2005).

Alcohol dependency with co-occurring anxiety disorders complicates withdrawal and is powerfully correlated with vulnerability to relapse. People with co-occurring alcohol dependence and anxiety disorders will quite often manifest additional traits and symptoms of other anxiety issues. Finally, co-occurring alcohol and anxiety issues

INTRODUCTION: AN EXAMINATION OF GUIDING PRINCIPLES

severely interfere with treatment compliance, recidivism, and relapse (Meichenbaum, 2010).

In a study conducted by the Centers for Disease Control and Prevention in 2007, the incidence of suicide among people with a history of trauma was evaluated. This study used the “psychological autopsy” model, where the subjects were examined after a ruling of death by suicide had been determined by the medical examiner. The number of subjects examined was approximately 1,500, and they were identified by gender, age, race, vocational/occupational status, and religious affiliation. Seventy percent of the subjects had the co-occurring disorders of PTSD and substance-related disorder (primarily cannabis and/or alcohol) at the time of their death by suicide. The issue of co-occurring history of trauma (PTSD) and alcohol and/or cannabis use is *the* most powerful correlate to suicide. It is strongly recommended that when a client who is seeking services presents with a history of trauma and co-occurring substance use that is designed to provide temporary management of the issues related to the trauma that the clinician remain alert to suicide vulnerability. The issue of co-occurring disorders heightens our alarm not only because of the challenge they present in treatment, but also because of the significant risk for suicide.

Donald Meichenbaum speaks extensively about this population. What have we learned from Meichenbaum and others about these people?

- Substance-related disorders and PTSD are the most common of all the co-occurring disorders (Meichenbaum, 2010).
- A majority of patients (80% to 95%) seeking treatment for substance use disorders report having experienced intense trauma (Meichenbaum, 2010).
- Approximately 50% of women and 20% of men in addiction counseling programs report having been victims of childhood sexual abuse. Approximately 60% of women and 80% of men in such treatment programs report being victims of childhood physical abuse and neglect. Childhood sexual abuse doubles the

Reasons for Seeking Therapy

number of symptoms related to PTSD and addiction disorders (Ashley, Marsden, & Brady, 2003).

- PTSD is three times more common among alcohol- and drug-dependent individuals than it is in the general population. Men with PTSD are five times more likely than men without PTSD to have a substance use disorder (Ford, Gelernter, DeVoe, Zhang, & Weiss, 2009).
- In a study of patients with schizophrenia and bipolar disorders, 90% of them reported at least one traumatic event in their lives, and 43% met the diagnostic criteria for PTSD. However, only 2% had this traumatic event or this diagnostic criteria for PTSD noted in their medical charts (Mueser, Noordsy, Drake, & Fox, 2003).
- Concurrent PTSD and substance-related disorders are more common in women than in men (Hien, Litt, Cohen, Miele, & Campbell, 2009).
- People who have experienced multiple trauma exposures and victimization incidents (e.g., ritual sexual abuse, consistent physical abuse and/or emotional abuse, multiple combat exposures) report greater involvement for engaging in substance use (Bernstein et al., 2003).
- People with co-occurring PTSD and substance-related disorders tend to use, and become dependent on, cocaine, cannabis, alcohol, and prescription drugs (Klott & Jongsma, 2006).
- People with co-occurring substance-related disorders and PTSD show a more severe substance dependence profile and are, universally, self-medicating. They report using drugs to reduce the impact of depression and anxiety symptoms and hyperarousal symptoms (exaggerated startle responses and night traumas) (Ford et al., 2009).
- Symptoms of PTSD that significantly impair functioning and cause serious distress and/or disability are most predictive of relapse (Meichenbaum, 2010).
- People with the co-occurring disorders of PTSD and substance-related disorders are vulnerable to having other severe mental disorders and experiencing legal and medical problems, marital and

INTRODUCTION: AN EXAMINATION OF GUIDING PRINCIPLES

social conflicts, domestic violence episodes, assault charges, suicide ideation and completion, maltreatment of their children, homelessness, unemployment, social isolation, lack of social support, and report having a life “not worth living.” This population also reports having less effective coping strategies and a poorer response to treatment (Najavits, 2006).

- Large-scale trauma events, such as natural disasters, are associated with an increase in substance use (Coffey, Brady, & Bock, 2004).
- Certain subgroups are especially prone to have high rates of PTSD and co-occurring substance use disorders, including combat veterans, prisoners, rescue workers, prostitutes, and victims of domestic violence (Meichenbaum, 2010).
- Certain occupations are vulnerable to vicarious trauma reactions and are, therefore, vulnerable to co-occurring PTSD and substance-related disorders. Included in that group would be medical professionals, law enforcement, military, and mental health professionals (Klott & Jongsma, 2006).
- In a study on completed suicides in 2007, the Centers for Disease Control and Prevention revealed that 93% of the subjects studied had a diagnosed Axis I (DSM-IV-TR) disorder at the time of their death. Of that group, 70% had a depressive disorder and/or anxiety disorder (PTSD predominant). Of that 70% it was discovered that 90% were self-medicating with substances at the time of their death.

Ken Minkoff, who speaks extensively and eloquently on the need for integrated treatment strategies for co-occurring disorders, discusses the essentials of diagnosis-specific approaches for this population:

The quality of any integrated intervention depends upon the accuracy of diagnosis and quality of the intervention for each disorder being treated. In this context, integrated treatment interventions should apply evidence-based best practices for each separate primary disorder being addressed. In addition, a growing data set supports the high prevalence

Reasons for Seeking Therapy

of trauma histories and trauma-related disorders in this population. There is increasing evidence, therefore, of the value of trauma-specific interventions being combined with specific interventions for other psychiatric disorders as well as the substance related disorders. (Minkoff & Cline, 2004)

This strategy is implemented in the context of the empathic, hopeful, caring therapy relationship. When Dr. Minkoff speaks of “integrated treatment,” he is proposing to us the need for therapy flexibility. He urges us to look at treatment for this population not in terms of a single style of therapy, but “the capacity, in the primary treatment relationship, to integrate appropriate diagnosis-specific interventions for each disorder into a client-centered coherent whole, with the flexibility to modify each intervention” (Minkoff, 2004). The core task, however, in whatever integrated strategies the clinician develops will be the therapy relationship. I’m sure that most of you have learned the three essentials in therapy: the relationship, the relationship, the relationship.

Based on the aforementioned need for a flexible, person-centered treatment approach, we must conclude that there is no single correct co-occurring disorders treatment intervention, nor a single identified correct treatment program. Each individual therapy plan or program individualizes the person. The only commonality in all therapy approaches will be the enduring quality of the empathic, hope-providing therapy relationship and alliance. For each individual client, at any point in the therapy relationship, the correct intervention must be individualized based on criteria to be discussed in later chapters.

Perhaps the most important consideration in the concept of therapy flexibility is the essential respect for gender differences in co-occurring disorders and, therefore, the need to incorporate this respect in gender-specific treatment. I would like to conclude this introductory chapter by addressing some issues in the arena of gender differences. In later chapters these issues will be incorporated into a need for gender-specific treatment approaches.

Women with substance-related disorders differ significantly from their male counterparts in terms of risk factors, developmental

history of trauma experiences, the nature of their presenting problems, the pattern of co-occurring disorders, motivation for treatment, and reasons for relapse. Over their lifetime, women are less likely to seek treatment in an addiction counseling setting. Women with substance-related disorders are more likely than men to seek treatment in non-substance-related disorder settings, especially from mental health service agencies. This has a major implication in discovery and recognition of females with co-occurring disorders (Feeney et al., 2004).

What other gender-specific issues need to be addressed for appropriate integrated treatment for the female population?

- Women with substance-related disorders normally present with concerns about depression (Grella, 2009).
- Women with co-occurring depression and substance use usually seek treatment earlier than men once the substance use is seen as problematic (Grella, 2009).
- Alcohol use in women is more directly correlated to self-medicating symptoms of depression and/or PTSD than it is in men (Greenfield et al., 2009).
- Women with co-occurring disorders of substance-related issues and Axis II personality disorders usually present with a more severe clinical profile than do women with either disorder alone (McMain et al., 2007).
- There is a significant high rate of co-occurring substance-related disorders with women who have eating disorders. Forty percent of women with substance-related disorders report a history of eating disorders. This population also represents a group of women with an elevated risk of suicide. There is continuous investigation of this co-occurring population, with some possible relationships being explored: Substance use acts to service the eating disorder (amphetamines with anorexia and alcohol use with bulimia nervosa—purging type); do they occur concurrently or does one precede the other; or are they concurrent by nature? (Klott & Jongsma, 2006).

Reasons for Seeking Therapy

- For women, the most common trauma experience derives from a history of repetitive childhood sexual assaults, which was accompanied by multiple accumulative other stressors such as neglect, exposure to domestic violence, and an “emotionally invalidating” social environment (Linehan et al., 2002). In the male population, PTSD appears to stem from combat, crime trauma, and childhood history of physical abuse (nonsexual).
- Exposure to traumatic stressors and the accompanying psychological effects on the hypothalamic-pituitary-adrenal (HPA) axis increases cortisol and other stress-related hormones, which can increase drug cravings. Drug/alcohol use is seen as an act of self-medication lessening the effects of hyperarousal and numbing symptoms (Sinha & Rounsaville, 2002).
- Women who have been traumatized have a more rapid onset of substance dependency than do women who have not been traumatized. They also display more severe demonstrations of PTSD symptoms with initial abstinence from drugs/alcohol and are extremely vulnerable to relapse because of the self-medicating feature of the drugs/alcohol (Greenfield et al., 2009).
- Therefore, there is the need for early screening of childhood trauma, even in those patients who don’t demonstrate symptoms of PTSD (Early Trauma Inventory) and (Childhood Trauma Questionnaire; Bernstein et al., 2003).
- Helping women protect themselves from future trauma and/or revictimization (intimate partner violence, sexual assault, prostitution) is a critical feature of treatment for this population (Fallot & Harris, 2002).

We can now begin our discussion regarding integrated treatment strategies for co-occurring substance-related disorders and mental health disorders. Through the following chapters we will incorporate the guiding principles. We will keep the focus on the person and not the diagnosis; we will respect that all behaviors, even those that are seemingly dysfunctional and maladaptive, are purposeful; we will be reminded that people do not change their behaviors unless they

INTRODUCTION: AN EXAMINATION OF GUIDING PRINCIPLES

are motivated; and we will remember that people with co-occurring substance-related disorders and mental health disorders are the expectation and not the exception. When the discussion of treatment is addressed, we will focus on an integrated style and recall that there is no single correct intervention or program for this population. We will emphasize the importance of respecting that this population has a dangerously elevated vulnerability to suicide and other self-harm activities. Finally, we will respect the need for gender-specific interventions as people experience the challenge of co-occurring disorders in varied manners.