Treating the Dually Diagnosed Woman

By Linda M. Poverny, Ph.D., LCSW

Who is this woman? How do we know when she comes to our office? She has many faces. She is often found outside our treatment systems, as she doesn't fit neatly into our substance abuse programs or our mental health clinics. She is often found in our criminal justice system, or if middle income, she comes to our private practice seeking mental health treatment, generally for depression or anxiety. She is the woman with co-occurring disorders of mental illness and substance abuse.

The most common psychiatric disorders accompanying substance abusing women are antisocial, borderline and narcissistic personality disorder. Co-occurring mood or affective disorders are PTSD, other anxiety disorders and depression. Depression is equally likely to precede as to follow alcohol misuse, and dually diagnosed women are more likely to have histories of trauma - physical and sexual abuse, as well as domestic violence. For women who are in treatment for their addictions, treating the mood disorder can have a positive effect on drug abuse, particularly among opiate dependent women. Symptoms of one disorder can contribute to relapse in the other disorder, so co-occurring treatment is recommended.

Offering simultaneous treatment can be problematic because of the continuing divide in the systems of care. Under most insurance plans and at most clinics each disorder is treated separately. There are segregated admission criteria, programs and reimbursement streams. The providers in each system are different and often collaboration is mistrusting or nonexistent. Our educational and training programs for addiction and mental health specialists are vastly different, although both sets of skills are imperative if one is going to effectively treat the dually diagnosed. Each provider tends to be suspicious of the other. Addiction specialists often feel that mental health providers are condescending; while mental health providers, not in recovery themselves, generally do not appreciate the skills and knowledge derived from personal experience. In many cases, both practitioners have knowledge of the other's field, but all too often this is not shared in a spirit of cooperation.

Treatment needs to include a bio-psycho-social assessment, consideration of individual and group addiction counseling, pharmacotherapy and behaviorally oriented therapeutic interventions. Initially the social worker will want to conduct a thorough drug, alcohol and tobacco-use screening. The Addiction Severity Index (ASI) is a useful tool for obtaining a clinical picture of drug use and drug seeking behavior. Creating a network of providers using self-help groups, a psychiatrist knowledgeable about addictions, and perhaps a couple's therapist provides support for both the clinician and the client. Many of these women are parents; therefore, parenting skills training and support is another essential service. Thus, practitioners find that they perform vital case management services in addition to therapy when working with this population.

Forming an alliance with the woman while stabilizing acute symptoms will be the first order of business after the assessment and treatment plan are established. Achieving and maintaining abstinence from alcohol and other drugs is the goal, however individuals do not always come to us ready to quit their drug(s) of choice. Reducing the amount and frequency of use can be a start, but is never the desired goal. Depending upon the severity of addiction and the drug of choice, detoxification, residential treatment or inpatient care may be necessary.

Interventions need to be more directive than in traditional mental health treatment when working with the dually diagnosed woman. The clinician monitors and collaborates in the recovery process, monitors psychiatric symptoms, encourages engagement and continuation with

self-help groups, sets limits, provides realistic feedback about problems and progress, and points out self-defeating behavior patterns. Working toward positive lifestyle changes is a must.

Monitoring the triggers for relapse is essential during the first phases of treatment. What are the warning signs for relapse with this client? What people, places and things trigger this woman? What relapse prevention strategies will work? Individualizing the approach will be essential for a successful outcome. If abstinence has not been achieved, what will it take for that goal to be realized? Contracting around this issue is often a good approach.

When women come into mental health treatment they are often not fully aware of their substance misuse or abuse. Their readiness to engage in help-seeking behaviors concerning their addiction is crucial for the clinician to evaluate. There are four identifiable stages of readiness to seek treatment. These include: 1. Pre-contemplation - the woman has not thought about changing her behavior, 2. Contemplation - seriously considering changing her behavior during the next six months, 3. Preparation - planning to take action within a month, and 4. Action - starting to change her behavior. (Prochaska et al., 1994) The woman may not progress through these stages in an organized and linear fashion. What is more common is a spiral pattern of cycling back through several of these stages, while moving ever closer to the goal of action.

For this population, the single most important variable after treatment readiness is the ability of the counselor/therapist to form a relationship with the woman. The longer the woman stays in treatment, the more likely she is to achieve and maintain abstinence. Also, longer treatment correlates with increased reduction in mental health problems, greater use of positive coping strategies for these problems, and more likelihood of making positive lifestyle changes. The middle phase of treatment should address intrapersonal and interpersonal issues. Women need to learn how to cope with negative affect, emptiness, depression and anxiety. They need to learn how to cope with or alter maladaptive beliefs and thinking along with improving communication.

Work on deeper clinical issues should be reserved for the maintenance phase of treatment when the pharmacotherapy is regulated and stable, the recovery program is solidly in place and maladaptive life style issues have been significantly improved.

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