

LEARNING FROM THE AMERICAN EXPERIENCE

**One River Both Separate: A Review of the Relationship Between Psychiatric
Illness and Addiction**

Declan Byrne

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Introduction

This submission is working on the premise that there is no need for us in Ireland to make the same mistakes as those that were made in America. I believe that even a limited literature review would help us to understand the core issues involved in dual diagnosis and the treatment implications. I believe that there is no need for us to re-invent the wheel and that it is possible for us to assimilate the lessons learnt elsewhere into an Irish context.

This paper sets out to look at the relationship between psychiatric illness and addiction by reviewing four chapters from *Essential Papers on Addiction* (Edited by Daniel L. Yalisove-1997). The aim of the paper is firstly, to gain an understanding of the subject matter and secondly, to contribute to the debate on dual diagnosis, which hopefully is beginning to take place in Ireland.

“Psychiatric Severity” as a Predictor of Outcome from Substance Abuse Treatments- A. Thomas McLellan.

McLellan starts by introducing the addiction Severity Index ASI. It could be described as a ‘problem severity profile’. “These include alcohol use, drug use, medical condition, employment, legal problems, family relations, and psychiatric status”. McLellan states, “My colleagues and my experience has suggested that these problems combine in a variety of complex ways to create particular treatment needs in each patient. Furthermore, we feel that if these problems are not addressed along with the chemical dependence in a substance abuse treatment. They can leave the patient susceptible to relapse, re-addiction, and return to treatment”. McLellan based his findings on a seven-year programme of research in Philadelphia. The core of this research consisted of a four-year outcome prediction project. The research focused on four inpatient therapeutic community programmes plus outpatient alcohol and drug abuse clinics. The initial assessment covered 1035 male army veterans, of these 879 engaged in treatment and McLellan was able to track 742 of these. Arising from this research he was able to establish a number of findings, which he believed had significant clinical implications.

His main finding was that “our results indicate that a global estimate of patient’s psychiatric symptomatology is the single best overall predictor of outcome across patient types, treatment methods, and outcome measures”. He concluded “that low-severity patients have the best treatment prognosis generally, and that they appear to improve significantly in any of the treatment programs to which they are assigned”. Turning to the ‘high-severity patients’ and by combining the research findings with his clinical experience he felt that “none of the programs currently available within our treatment network were effective with these individuals”. Despite the difficulties presented by the ‘high-severity patients’ McLellan et al., 1981 recommend that they be detoxified and stabilized, then referred to inpatient psychiatric treatment”. Attempting to design a programme that would help high-severity patients he looked at “the potential benefits of adding professional psychotherapy to existing drug counselling services”. The results of this study offered convincing evidence that traditional drug abuse counselling was able to provide significant benefit to the low-severity patients” and that the supplemental therapy (psychotherapy) did provide significant benefit to the high severity patients.

The core of the article states, “that admission psychiatric severity was a better predictor of post-treatment alcohol/drug use than was alcohol/drug use at the time of admission”. Summarising his findings this means that low-severity patients should be directed to programmes with drug counselling, while high-severity patients should be sent to programmes designed to include psychotherapy. This means that high-severity patients should not be sent to therapeutic community programmes (counterproductive) and they should not be sent to programmes where only drug counselling is provided. The research identified the need to design programmes for approximately 15-30% of the primary psychiatric and primary drug-dependent patient population (the patients with clear and concurrent problems of addiction and one or more other psychiatric disorders), which combines methadone with weekly psychotherapy sessions. “Drug-dependent patients with more severe psychological problems require more focused and independent interventions to address their psychopathology directly through appropriate medication and psychotherapy”.

The Self-Medication Hypothesis of Addictive Disorders: Focus on Heroin and Cocaine Dependence- Edward J. Khantzian.

Khantzian opens with a look at recent trends in psychoanalysis. These include: (1) “There has been a shift from a focus on drives and conflict to a greater emphasis on the importance of ego and self structures.” (2) “The development of standardized diagnostic approaches for classifying psychiatric disorders.”

He introduces the ‘modern psychodynamic perspective’ - “these analysts succeeded in better identifying the nature of the psychological vulnerabilities, disturbances, and pain that predispose certain individuals to drug dependence. This perspective emphasizes that heavy reliance on and continuous use of illicit drugs are associated with severe and significant psychopathology.” He continued by looking at diagnostic and treatment studies that dealt with the coexistence of psychopathology in drug-dependent individuals. He focused on these studies in order to examine the clinical and treatment implications.

Khantzian then deals with his clinical observations with narcotic and cocaine dependent individuals. He adopts a certain position- “ I have been impressed that the anti-aggression and anti-rage action of opiates is one of the most compelling reasons for its appeal.” While observing over 200 addicts who had lifelong problems with rage and violent behaviour he points out “these patients repeatedly described how opiates helped them to feel normal, calm, mellow, soothed, and relaxed.” Commenting specifically on cocaine addiction, “For, some the energizing properties of these drugs are compelling because they help to overcome fatigue and depletion states associated with depression.” By drawing the strands together, developments in psychoanalysis, other relevant studies, and his clinical observations he concludes “Rather than simply seeking escape, euphoria, or self-destruction, addicts are attempting to medicate themselves for a range of psychiatric problems and painful emotional states. Although most such efforts at self-treatment are eventually doomed... addicts discovered that the short-term effects of their drugs of choice help them to cope with distressful subjective states and an external reality otherwise experienced as unmanageable or overwhelming.”

Substance Abuse as an Attempt at Self-Medication- Roger D. Weiss and Steven M. Mirin.

This article again explores the relationship between substance abuse and psychopathology. Weiss and Mirin begin by reviewing the work of others in this area.

Weiss and Mirin then introduce the reader to 'deficiency theories', which provide the basis for more recent self-medication theories. The authors have some methodological concerns about the theories on self-medication. They point out—"One limitation of this theory is the fact that the mere presence of two disorders in the same individual does not imply causality." They then focus on the issue of depression and alcoholism—"it can be hypothesized that the depression seen in many alcoholics is often secondary to their drinking rather than vice versa." They then move to examine depression and drug abuse—"the depression seen at the beginning of treatment is related in part to the effects of chronic intoxication. Unfortunately depression levels are most often measured precisely at this time when psychosocial stresses are likely to be highest, and when drug effects are greatest. Results from a study by Rounsaville and associates showing that depressive symptoms in opiate addicts generally improve over time without specific anti-depressant treatment, lend even further weight to the conclusion that the mere presence of depressive symptoms in a newly admitted opiate addict is insufficient evidence to warrant a diagnosis of an affective disorder." On bipolar disorder they state—"In addition to hypothesizing that manics use drugs and alcohol as self-medication, we can attribute the increased use of drugs and alcohol during manic episodes in part to impulsiveness, recklessness, and poor judgement." By conducting the McLean Hospital Study they were able to examine the self-medication theory in relation to those who suffer from panic and anxiety disorders.

Their overall conclusions particularly in how they relate to the clinical implications were

1. The high prevalence rate of other psychiatric disorders in substance abusers makes a careful search for coexisting psychopathology an integral part of the evaluation of these patients.
2. The need to separate those patients with pre-morbid psychopathology from individuals with drug-related symptoms.
3. It is clear that substance abusers are a heterogeneous group; treating them otherwise does these patients a great disservice. Careful evaluation, followed by individualized flexible treatment planning is necessary in order to successfully treat this very difficult patient population.

Parallels and Paradigms- H. J. Richards.

In the opening section of this chapter – Confronting The Problem – Richards introduces us to Suzanne "she had already become a treatment failure in three systems, the mental health system, the formal substance abuse treatment system, and the self-help alcoholism recovery community. " The purpose is to provide the reader with an experiential grasp of the effects of mental illnesses, and addictions as processes acting upon the total life of the individual, but especially upon the individual's experience of self. Richards states that Suzanne suffers from an 'emergent psychiatric syndrome', by an emergent syndrome he means that

“ They are becoming more frequently encountered in clinical settings due to improved clinical sensitivity and because larger numbers of patients are developing the syndromes.” He discusses the ‘dismantling’ of the mental health system and the ‘relegation’ of substance abuse to ‘low status professionals, paraprofessionals, or self-help groups’. This has resulted in a system with ‘more cracks to fall through’ and the individual involved being ‘referred out’ of these ‘speciality delivery systems’. He then goes on to define dual diagnosis populations and to introduce the reader to the ‘key dimensions of dual diagnosis work’. “Often, the dual diagnosis patient reaches the health care system in acute distress from both a severe psychiatric problem as well as severe substance abuse problems”. He then introduces a number of analytical tools:- Acuity, Chronicity, Cyclicity and Severity.

He then discusses the lowering of the level of needs that typically occur as a result of addiction or mental illness. He talks about the ‘stuckness’, which “connotes the sense of being caught mired down-as if in mud or quicksand” and he points out that “The goal of both substance abuse treatment and treatment for psychopathology is to help individuals to move toward high levels of the experience of freedom”. He then turns his attention to ‘the psychiatric severity dimension’ – “The different levels reflect differences in ego strength, adequacy of coping skills and mechanisms, structural level, range of behavioural freedom, and other ways of viewing optimal versus dysfunctional states of behaviours”. Next up is the ‘addiction severity dimension’ where he deals with ‘insidious dependence’ - “A dependence that is systematic of an individual’s emotional problems, persistent conflicts, or pervasive pattern of self-defeating behaviours and thoughts.”

In the section ‘parallels in experience and needs motivation’ we enter a discussion on the schematic concepts of the “depleted self, the inflated self, and the detached self. In the depleted self “the drug use results in a chemical bolstering of the self.” In the inflated self “the self has become inflated and overextended, and balance is totally lost.” In the detached self “the ground or basis for the self to grow and manage the life space has been undermined to the point of collapse.” He then relates this to a ‘developmental view’ and asserts, “The roots of these experiences... are in infancy before the development of speech.” He then suggests ‘dialectical thinking’ as a means to understanding the challenge presented by dual diagnosis. “In early dual diagnosis programs patients in this population were treated in logical sequences... Patients first were detoxed chemically in a controlled environment, with the expectation that they would turn into normal mental patients. Then they were treated chemically for psychopathology or given psychotherapy. This consecutive or sequential strategy did not work after the acute phase of treatment, because of the interactive-emergent nature of the dual diagnosis problem.” He then makes the point that ‘reciprocity’ is a key dimension in dual diagnosis work and he sets out the aim of treatment strategies ”to create a synergistic relationship between the pathological processes.” -“both disorders are in constant flux, both make up one river, yet both are separate.”

Conclusion

I hope that this paper has underlined the need to address dual diagnosis in the treatment of drug addiction. Otherwise I believe that we are not dealing with the whole person.