

A New Approach to the Dual Diagnosis Controversy: Counseling's Version of *The Emperor's New Clothes*

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In the child's tale *The Emperor's New Clothes*, unscrupulous tailors take advantage of the emperor's vanity and convince him that the new clothes that they have made for him are invisible to commoners when in fact they do not exist. During a parade, a young child is the only spectator brave enough to comment that the emperor is, in fact, naked. In terms of the dual diagnosis designation in counseling, there are no unscrupulous tailors. There are no bad guys per se, but, maybe, just maybe, like the emperor's new clothes, this dual diagnosis entity as it is presently understood in the counseling community doesn't really exist.

When President Reagan deinstitutionalized the mental health system, our corrections infrastructure, the nation's jails and prisons, became the primary provider of mental health services in the United States. Data provided by the American Correctional Association indicate that more than 11.4 million adults are booked into jail each year and up to 621,000 are in custody on any given day. Up to 700,000 adults in jail each year have active symptoms of mental illness, and 75% of those adults have cooccurring addictive disorders. In June 2000, 17,354 or 1.6% of state prison inmates were receiving 24-hour acute mental health care and up to 106,000 or 9.7% of prison inmates were taking psychiatric medication. It is likely that these numbers have increased since 2000.

"A generation or two of young men and women with serious problems have been caught in the intersection between deinstitutionalization on the one hand and the widespread availability and use of street drugs on the other" (Ryglewicz & Pepper, 1996, p. 73). Many of these young men and women have been convicted of crimes in some way related to drugs and are now incarcerated. Inmates with cooccurring disorders are often required to secure placement in dual diagnosis inpatient programs before they can be released on parole. Dual diagnosis programs are difficult to find and, when they exist, appear to have a great deal of competition for their bed space. This causes delays in treatment and, for many prison inmates, denial of parole opportunities.

The dual diagnosis designation appears to be a new or recent trend in diagnosis and treatment and has created a number of problems beyond just the availability of spaces in inpatient programs. "The psychiatric and substance abuse treatment systems have been, historically, very separate and very different in philosophy, methods, and staff backgrounds, and bringing them together is a complex and challenging task ..." (Ryglewicz & Pepper, 1996, p. 78). Many mental health programs are hesitant to accept individuals with cooccurring addictive disorders due to what is perceived as treatment resistance. Also, addiction treatment programs, many of which rely on the therapeutic community treatment model, are hesitant to accept individuals also diagnosed with non-drug-related problems, especially those that are often treated with psychiatric medications. Research has suggested that "severely mentally ill clients worsened over time when treated in the therapeutic community programs. This negative outcome is thought to be related to some of the characteristics of the therapeutic community model: sanctions against the use of psychotropic medications, the use of paraprofessionals and ex-addicts as counselors, and punitive or embarrassing confrontational group encounters" (Watkins, Lewellen, & Barrett, 2001, p. 20). Thus, this dual diagnosis assessment and treatment issue poses a number of questions.

Is This a Societal Problem?

People have been ingesting mind- or-mood altering substances and beverages containing alcohol for thousands of years. Beer-making recipes were discovered on clay tablets dating to almost 3000 BC in the Sumerian/Mesopotamian civilizations. Until the Whiskey Tax Act of 1791 was enacted, the private production of alcohol in the fledgling United States was legal and unregulated.

Coca plant chewing was a widespread practice in South America as long ago as 3000 BC, and it was thought that coca was a gift from the gods. Initially, access to coca was limited to royalty and the leaf was

used for religious as well as medicinal purposes. In 1539 the Bishop of Cuzco allowed for the tithing of 10% of the coca crop on plantations that Spanish landholders had taken over from the Incas. Cocaine was first extracted from coca leaves in 1855, and the pharmaceutical manufacturer Merck began cocaine production in 1862. Used in everything from a local anesthetic for eye surgery, detoxification from morphine, throat surgery, and as an ingredient in Vin Mariani, a wine, and the original Coca Cola, cocaine was finally banned in 1914 in the United States after an alarming rise in hospital admissions for individuals with nasal damage from snorting cocaine. The use of psychoactive substances appears to have evolved from an accepted and controlled part of culture to an out of control element in a negative counterculture. If psychoactive substances have been around for thousands of years but widespread problems of substance abuse and dependence are a historically recent phenomenon, perhaps we must look to society as a causative factor in the problem or its definition.

Emile Durkheim, a French sociologist, coined the term *anomie* in 1893 to describe a breakdown of social norms and the condition in which norms no longer control the behavior of members of society. Durkheim also noted that sudden social change and social disruption increase the rates of crime, suicide, and deviance.

Over the last century and, more specifically, since World War II, there have been a number of trends that may have contributed to an increase in anomie. The continuing urbanization of society has contributed to changing the organizational structure of the family from an extended family structure in which multiple generations shared residence and parenting chores to a single family structure in which two married adults live with their children. There has also been a trend toward both parents working full time, leaving supervision of their children to others for extended periods of time.

Increases in not necessarily quality but quantity of media exposure have provided both a babysitting service and a sound bite level of acculturation, influencing children's tastes, values, and attitudes. Peers have replaced the often absent parents as both role models and reinforcers of behaviors. Those behaviors are often seen through media exposure rather than modeled by parents and include references to gangs, drugs, and sex.

During the culturally turbulent 1960s, many teenagers and young adults experimented with psychoactive substances. A culture of music, drug paraphernalia, and shops that catered to a drug culture proliferated. For many, the novelty of drug experimentation wore off or the dangerous side effects

of drugs scared many casual users into more socially acceptable pursuits. Some people, however, continued to use drugs and later became parents. Children in those families were exposed to drug use by role models, and we now have a second generation of drug abusers.

Is the Dual Diagnosis Designation Due to Our Human Tendency to Categorize Things?

In the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; 2000)*, in an inpatient setting, the principal diagnosis is defined as the condition chiefly responsible for the admission and usually the main focus of treatment. In inpatient or outpatient settings where more than one diagnosis is considered at Axis I, it can be difficult to decide whether a mental disorder or substance-related disorder is the primary factor in production of the symptoms that bring the patient to the attention of therapy staff. The *DSM-IV-TR* even concedes that they may contribute equally to the need for treatment. How the assessment is performed and how a diagnosis is made can be influenced by the setting in which they are performed or by the training and treatment specialty of the therapist.

Are We Looking at the Problem Incorrectly?

According to the National Mental Health Association (NMHA) Web site (<http://www.nmha.org>), dual diagnosis is generally considered to define an individual with both a drug or alcohol problem and a cooccurring mood or thought disorder. There does appear to be some disagreement over what dual diagnosis actually entails, since other Web sites define dual diagnosis as substance abuse overlying Axis II personality disorders. Linehan (1996) proposed a specific treatment program for individuals, primarily females, with borderline personality disorder and noted that common symptoms of borderline personality disorder include impulsivity, gambling, substance abuse, and frequent parasuicidal behavior. Other studies identified a high correlation between substance abuse and antisocial personality disorder. Ryglewicz and Pepper (1996) proposed a four subgroup model of dual diagnosis in which two subgroups identify either substance abuse as a primary treatment concern in someone with a personality disorder or a personality disorder as a primary concern for treatment aggravated by substance abuse. Statistics on the NMHA Web site attributed to a study reported in the *Journal of the American Medical Association* indicated that "37% of alcohol abusers and 53% of drug abusers also have at least one serious mental illness," and further stated, "of

all people diagnosed as mentally ill, 29% abuse either alcohol or drugs” (NMHA, 2003). Common psychiatric or mental health disorders cooccurring with substance abuse include disorders related to depression and anxiety as well as schizophrenia and personality disorders. Only since 1984 in New York City have dual diagnosis specific programs been established, the definition of dual diagnosis once again being substance abuse disorders cooccurring with mental health disorders.

The problem with the present focus on dual diagnosis disorders and treatment is that it may be a somewhat artificial designation that, in the long run, does not contribute to the ability to provide appropriate services to individuals with both substance abuse and other mental health problems. Over the evolution of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, extensive research has been done and many disorders have been added, deleted, or changed. Substance abuse disorders coexist with other disorders in the *DSM-IV-TR*, the most recent edition of the *DSM* series.

It may be time for a treatment revolution in terms of how individuals with both mental health and substance abuse disorders are treated. At present there appears to be a rift in how these dual disordered individuals are provided therapy. The literature has suggested that the dually diagnosed present unique treatment problems. This rift may be an artifact of therapists mapping out their territory and lack of cross training in certain human services programs. Traditionally, mental health practitioners have been leery of substance abuse counselors who, for many years, were neither formally trained nor adequately certified. Also, substance abuse counselors often traditionally held the philosophy that substance abuse treatment could only be successful if done by one of their own, that is, by those who themselves have conquered the substance abuse nightmare. There is no more evidence that being an alcoholic is a prerequisite for being a substance abuse counselor than there is for the idea that schizophrenics are automatically good mental health counselors.

Although the majority of treatment models emphasize taking personal responsibility for poor choices and the need for learning and choosing more appropriate behaviors in order to facilitate positive change, the Alcoholic Anonymous model directly contradicts that philosophy. In the “big book” the foreword states, “...one alcoholic could affect another as no nonalcoholic could.” It also indicated that “strenuous work, one alcoholic with another, was vital to permanent recovery” (Alcoholics Anonymous, 1976, pp. xvi, xvii). There is, however, little research evidence

that “recovering chemical dependency counselors have an easier time, are better liked by recovering clients, or do a better job than counselors who have not used drugs” (Buelow & Buelow, 1998, p. 4). There is research evidence that “...empathy, authenticity, personality, and the courage to support and confront are qualities that contribute to treatment success with substance abusing clients” (Buelow & Buelow, 1998; Seligman, 1990; Watkins et al., 2001, p. 143). These are core counseling skills introduced in all human services professions. Again, in *Narcotics Anonymous: Twelve Steps and Twelve Traditions* (1988), the statements, “we are powerless over addiction and our lives are unmanageable,” and “although we are not responsible for our addiction....” (p. 19) suggest that the use of alcohol or drugs was not a choice and thus not the client’s responsibility. Correct me if I am wrong, but doesn’t this sound a lot like learned helplessness? “Furthermore, many professionals in the substance abuse field, in the light of research that does not support substance abuse as a disease (Kishline, 1998), object to the disease model that AA and its sister groups promote” (Watkinset et al., 2001, p. 152).

Finally, in summary, are the following points to ponder:

1. The Alcoholics Anonymous/Narcotics Anonymous philosophy is the foundation for a support system, not a template for treatment programs.
2. The predominant Axis I disorder as identified by the clinician is the focus of treatment regardless of other cooccurring disorders.
3. Training in common skills and exposure to a wide range of treatment techniques and theories are a commonality among human services specialties.
4. The idea that substance abusers are difficult to treat may be due to substance abuse actually being an Axis II personality disorder rather than a subset of either Antisocial or Borderline Personality Disorder.

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