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ABSTRACT

Clients with concurrent substance abuse and other psychopathology constitute an often neglected patient population which presents significant assessment and treatment challenges. Proper treatment requires a careful assessment of issues not always addressed in standard substance abuse or mental health treatment settings. Psychologists with expertise in the psychology of addiction and psychopathology are needed to develop and implement effective approaches to working with such patients. Assessment issues which need to be addressed include the nature and severity of both types of problems, but also the presence and nature of interactions between concurrent problems. This document addresses some of the assessment and treatment questions posed by the client presenting with concurrent substance abuse and psychopathology. It sets forth a way of classifying concurrent problems, including a taxonomy of types of interactions between substance abuse and other psychological problems. To facilitate such an assessment, a set of assessment categories is proposed. Common treatment options for persons with concurrent problems are discussed. Optimal treatment strategies for persons falling into the various assessment categories are considered, with a particular emphasis on the treatment of problem interactions. (Author/NB)

The Assessment and Treatment of Persons with Concurrent Substance Abuse and Other Psychopathology: The Importance of Problem Interactions

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Abstract

Clients with concurrent substance abuse and other psychopathology constitute an often neglected patient population which presents significant assessment and treatment challenges. Proper treatment requires a careful assessment of issues not always addressed in standard substance abuse or mental health treatment settings. Psychologists with expertise in the psychology of addiction and psychopathology are needed to develop and implement effective approaches to working with such persons. Assessment issues which need to be addressed include the nature and severity of both types of problems, but also the presence and nature of interactions between concurrent problems. To facilitate such an assessment, a set of assessment categories is proposed. Common treatment options for persons with concurrent problems are discussed. Finally, optimal treatment strategies for persons falling into the various assessment categories are considered, with a particular emphasis on the treatment of problem interactions.

The distinctive treatment needs of persons who have substance abuse problems and other types of psychopathology have often been neglected by both mental health professionals and substance abuse counselors.

The reasons for such neglect are not hard to discover: questions about the incidence of concurrent disorders, a decided paucity of research, training, and treatment which cuts across the boundaries of the mental health and substance abuse fields, and questions about optimal treatment approaches for this population.

Consensus about the incidence of concomitant substance abuse and other psychopathology does not exist because a variety of definitions and measurement approaches have been used and different populations have been studied. Among alcoholics, the reported range of depression has varied from 3% to 98% (Weissman & Myers, 1980; Behar & Winokur, 1979). Findings from an epidemiological catchment study indicate that 71% of those diagnosed as alcoholic at some time in their lives have also been given another psychiatric diagnosis and that 15% of those currently alcoholic are also depressed (Weissman & Myers, 1980).

Another measurement approach has been to determine the percentage of those with psychiatric diagnoses who also have problems with substance abuse. Freed (1975) found that from 3% to 63% of schizophrenics were reported to have substance abuse problems as well. Alterman, Erdlen, & McLellan (1980) found that 10% of psychiatry inpatients were also alcoholic, and half of those used during treatment.

Despite the range in those estimates, it appears that a substantial number of persons do suffer from concurrent substance abuse and other psychopathology. And Gottheil & Weinstein (1980) suggest that clinicians tend to underestimate the actual incidence of concurrent disorders.

One of the challenges faced in working with such persons is that, although substance abuse is included in the DSM-III and frequently covered in Abnormal Psychology texts, there is a de facto separation between substance abuse and other types of psychopathology in research, training, and service delivery systems.

A burgeoning group of substance abuse counselors has arisen in recent years to join psychologists in dealing with human problems. But substance abuse

counselors work with substance abuse and may not have developed competence in working with other psychopathology. And mental health professionals generally work with other types of psychopathology and may not have the specialized skills required to provide treatment for those with substance abuse (Alterman, 1985b).

To compound this compartmentalization, the Alcohol, Drug Abuse, and Mental Health Administration [ADAMHA] of the U. S. Department of Health and Human Services divides its institutes into the National Institute of Mental Health, the National Institute of Alcohol Abuse, and the National Institute on Drug Abuse. This balkanization has a decidedly negative impact of persons with concurrent problems (Bachrach, 1986-1987).

The unfortunate result of this division of the substance abuse and mental health fields is that there are two sets of professionals treating two sets of psychological problems, frequently in different types of treatment settings, and often relying on different research traditions funded by different branches of ADAMHA.

The distinction between substance abuse and other

forms of psychopathology is not necessarily problematic, and may even be advantageous, in that specialized treatment can be provided. The distinction becomes problematic, however, when a given individual has concurrent problems which cut across the boundaries of the competencies of professionals or treatment settings. Neither the mental health professional nor the substance abuse counselor may have the specialized skills necessary to work with persons having concurrent problems.

Particular assessment questions and intervention strategies need to be employed in working with persons with concurrent problems (Alterman, Erdlen, LaPorte, & Erdlen, 1982; Alterman, Erdlen, & McLellan, 1980). Clarity regarding their particular treatment needs is essential. Clinicians and researchers cross-trained in substance abuse and psychopathology, for instance, members of the Society of Psychologists in Addictive Behaviors, are in a position to play a central role in developing such clarity.

In this paper, I will address some of the assessment and treatment questions posed by the client presenting with concurrent substance abuse and psychopathology. I will set forth a way of classifying

concurrent problems, including a taxonomy of types of interactions between substance abuse and other psychological problems. The proposed assessment categories will be followed by a discussion of the treatment approaches indicated for persons falling into the various categories. A particular focus of attention will be the complex ways in which the two sets of problems often interact with (and thereby exacerbate) each other.

ASSESSMENT

Assessment Issues

General Considerations

In determining the most effective treatment approach for persons exhibiting symptoms of both substance abuse and some other kind of psychopathology, it is necessary to (A.) determine the nature and severity of the substance abuse problem, (B.) determine the nature and severity of the other psychological problem or problems, and (C.) determine the nature of the interactions (if any) between the problems. Obviously, some sophistication in assessment is required. Psychologists have (too often correctly) been accused by substance abuse counselors of being

naive about substance abuse issues. On the other hand, substance abuse counselors are usually not trained to assess other psychopathology. It is necessary that a thorough assessment of both types of problems be made, however, to work effectively with persons having both types of problems.

A controversial issue in assessing both types of problems is whether assessment should be categorical or dimensional. Should formal diagnostic categories be employed in determining the appropriate treatment for a person's problems? Or should problem severity? Empirical support may be claimed for the efficacy of using both assessment approaches in the treatment of psychiatrically impaired substance abusers. Woody, McLellan, Luborsky, & O'Brien (1985) found that psychotherapy in conjunction with standard drug counseling improves treatment outcome for those falling into some diagnostic categories, but not for those falling into another diagnostic category. On the other hand, McLellan and his associates have found that level of psychological severity predicts the success of substance abuse treatment (McLellan, Luborsky, Woody, O'Brien, & Druley, 1983; McLellan, Erdlen, Erdlen, & O'Brien, 1981). Meyer and Hesselbrock (1984) concluded

that neither assessment approach has yet established itself as clearly superior.

The position adopted in this paper is that both approaches to assessment are important. Formal diagnosis is important in those instances, e.g., schizophrenia, in which treatment implications clearly follow from the diagnosis. And an assessment of problem severity is helpful for determining whether or not, and in what ways, a problem may need attention.

What results from the first two sets of assessment issues is a fivefold classification:

1. Substance abuse diagnosis or severe problem only
2. A non-substance abuse psychiatric diagnosis or severe problem only
3. Substance abuse diagnosis or severe problem, associated with another less severe (not diagnosable) psychological problem
4. A non-substance abuse psychiatric diagnosis or severe problem, associated with a less severe (not diagnosable) substance abuse problem
5. Concurrent substance abuse and other psychopathology (diagnosable or severe problems)

Interactions

An assessment which examines only the nature and severity of substance abuse and other psychopathology may fail to point to proper treatment. An additional step needs to be taken. The interactions between problems (meaning either problems warranting a diagnosis or non-diagnosable problems of clinical significance) must also be assessed: Do any interactions between the two sets of problems exist? For instance, deep sadness, which Schuckit (1986) properly distinguishes from a formal diagnosis of depression, may be a problem which interacts with and exacerbates substance abuse. That sadness therefore needs to be addressed in a comprehensive treatment approach for a person with concurrent problems. An assessment which stops at formal diagnosis would be an incomplete assessment, leading to less than optimal treatment.

An assessment of the interactions of problems is a difficult task, one about which there is controversy. It is, in the first instance, critical that the particular relationship of the problems for a particular client be understood (Fine, 1980). When faced with a phobic alcoholic, for instance, the generalization from empirical research that phobias

antedate alcoholism in males (Hesselbrock, Meyer, & Keener, 1985) may be substantially misleading. One cannot know whether a given client is one of the 64% of phobic male alcoholics for whom the phobia developed first, one of the 31% for whom the alcoholism came first, or one of the 4% for whom the two problems developed within the same year. To the extent the order in which problems developed is relevant, one must know the order of problem development for a given individual so treatment may be properly planned. The exact nature of the problem interactions (if any) present in this individual must be assessed in the clinical situation.

To assist in such an assessment, a taxonomy of types of interactions between substance abuse problems and other psychological problems follows. Simple and complex problem interactions are distinguished. Simple interactions are unidirectional and linear, with one problem contributing to the other or blocking its treatment; complex interactions are multi-directional and systemic, problems are mutually reinforcing. Four types of simple interactions will be discussed, followed by a consideration of complex problem interactions.

Simple Interactions

1. Psychopathology contributing to substance abuse. In response to the dysphoria of a variety of psychological problems, persons may use chemicals in an attempt to reduce the dysphoria, to avoid psychological issues or reduce symptoms temporarily, to "self-medicate" (Alterman, 1985a). Substance abuse may thus, at times and in part, be a maladaptive response to other psychopathology, which psychopathology contributes to substance abuse.

A variety of psychological problems have been linked to the dysfunctional use of psychoactive substances: pain (Mayfield, 1985); depression or anxiety (Dackis & Gold, 1983); panic attacks and phobic disorders (Powell, Penick, Othmer, Binghan, & Rice, 1982; Quitkin, Rifkin, Kaplan, & Klein, 1972); shame in response to negative societal reactions (e.g., stigma) to the chronic mental patient (Bachrach, 1986-1987); the struggle to cope with the poverty of the chronic mental patient; the discomfort resulting from hallucinations (Freed, 1975); insomnia, social isolation and withdrawal, and psychophysiological symptoms (Westermeyer, 1979); absent or weak ego

structures and functions (Frosch, 1979); and uncomfortably low or high levels of stimulation (leading, respectively, to amphetamine and heroin use) (Frosch, 1979).

The irony of attempts to self-medicate with alcohol is that it generally lead leads to more, rather than less, depression (Lutz & Snow, 1985). The link between psychological problems and substance abuse may thus be mediated by a (faulty) belief that chemicals reduce dysphoria. Nevertheless, it is the presence of psychological problems which serves as a trigger for substance abuse.

Further, psychopathology may contribute to substance abuse by potentiating the positive reinforcement of substance use for a given individual. Dysphoria (Dackis & Gold, 1983), the poverty and social isolation in which the chronic mental patient often lives, and an undermining of ordinary constraints against substance use stemming from psychopathology (Schuster, Renault, & Blaine, 1979) may all mean that alcohol or drugs play an unduly large role in an individual's life.

None of this is to suggest that in all cases substance abuse stems from psychological problems, or

that the elimination of psychological problems will automatically eliminate substance abuse. A biopsychosocial model of substance abuse (e.g., Zucker & Gomberg, 1986) suggests that a variety of etiological and treatment factors must be considered. It is, however, crucial to examine this and other possible problem interactions.

2. Substance use creating or exacerbating psychopathology. Substance use may create psychological problems, either as a result of the physiological effects of the substance of choice or as a result of the psychosocial problems which are a consequence of drug use. Substance use may also exacerbate other psychopathology, for instance, schizophrenia. The difference between creating and exacerbating psychological problems is twofold: Psychological problems created by substances would not have developed without the substance use, whereas problems exacerbated by substance use exist apart from the substance use. Secondly, substance abuse treatment will likely eliminate psychological problems created by substance use, but will likely not eliminate problems merely exacerbated by it.

Substance abuse and dependence may result in a

variety of symptoms which may closely resemble almost every form of mental illness (Bean-Bayog, 1987; Estroff & Gold, 1985-1986). For this reason, it is important that the presence of, for instance, sad affect not be mistaken for major depression (Schuckit, 1986). Sad affect may simply be a product of substance abuse and not be a problem when the substance abuse is under control.

The psychological problems stemming from substance abuse may be physiological in origin or the result of the psychosocial consequences of substance abuse in a person's life (Meyer & Hesselbrock, 1984). Psychosocial consequences may include legal, familial, occupational, and health problems, and guilt-inducing lifestyles (e.g., Schuster, Renault, & Blaine, 1979). If, for instance, depression results from substance abuse, it may be a realistic response to those life problems (Gibson & Becker, 1973).

When a patient presents with psychological problems, however, it is often difficult to ascertain whether the psychological problems are created by substance abuse, exacerbated by it, or entirely independent of it. Because this differentiation has clinical implications (Do you aggressively treat the

psychological problems or not?), it is important to make (Mirin, 1984). Client history of mental disorder, the order of problem development, and response to treatment may help make the distinction. Often it is necessary to observe how long psychological problems persist after detoxification and substance abuse treatment are initiated. Generally, a decrease in psychological symptom level occurs in treatment, resulting from physiological adjustment to the absence of the substance, treatment effects, or a combination of the two (Lutz & Snow, 1985). However, if an individual is among the 20% of drug-free patients whose symptom level fails to decrease in substance abuse treatment (Mirin, Weiss, Sollogub, & Michael, 1984), it is likely that the psychological problems are an independent phenomenon, perhaps exacerbated by, but not created by, the substance use.

A variety of psychological problems, such as depression (Dackis & Gold, 1984), schizophrenia (Alterman, 1985b; Estroff & Gold, 1985-1986), and others (Bachrach, 1986-1987; Westermeyer, 1979), may be exacerbated or potentiated by substance use. A failure to recognize that the presenting symptoms result from a combination of substance abuse and, say, a diathesis

for schizophrenia, will result in less than optimal treatment.

3. Symptoms of Psychopathology preventing effective use of substance abuse treatment. Some persons may be psychotic or so depressed that they cannot make effective use of substance abuse treatment. Further, characterological issues may make problematic the utilization of group or other standard substance abuse treatment approaches (Balcerzak & Hoffman, 1985). A particular problem is an individual's use of a psychiatric diagnosis to deny his or her substance abuse problem and need for treatment (Bean-Bayog, 1987).

4. Substance use, withdrawal, or treatment preventing effective use of psychological therapies. Treatment progress will be impeded by clients who use or abuse mood-altering substances (Balcerzak & Hoffman, 1985). For instance, Alterman and his colleagues (Alterman, 1985b; Alterman, Erdlen, & McLellan, 1980) have documented a variety of ways in which substance use has a negative impact on the treatment of schizophrenics who use while hospitalized. Substance use may also interfere with compliance with psychotropic medication (Bean-Bayog, 1987). Alcoholics

Anonymous groups or substance abuse treatment centers may subtly or vigorously oppose the use of psychotropic medication. A chemical dependency diagnosis may be used to deny the existence of a major mental illness and the need for treatment thereof. If a person is in psychotherapy but using mood-altering substances, therapy will most likely be ineffective because a person will not be experiencing sufficient pain or anxiety, or will not be able to understand or retain what is being discussed in therapy sessions.

Complex Interactions

The examination of simple problem interactions accounts for a large proportion of the interactions between substance abuse and other psychopathology. It is helpful for research and teaching purposes. In the clinical setting, however, the interactions between problems are often substantially more complex than heretofore discussed. Problems become convoluted and mutually reinforcing, requiring much more sophisticated treatment approaches. Bean-Bayog (1987), for instance, gave an example of a schizophrenic attempting to handle anxiety about psychosis through the use of alcohol, becoming addicted, and going through withdrawal, during

which psychosis developed, about which the individual had much anxiety, with which he or she attempted to deal by further alcohol use. And so forth. In the case of such complex problem interactions, a vicious downward spiral results.

Similarly, Schuster, Renault, & Blaine (1979) pointed to an individual in whom depression led to heroin use, which produced more depression, which led to more heroin use, and so forth. In such an example, all four types of simple interactions discussed above may be present concurrently. An individual attempts to deal with a psychological problem, depression, through chemical use, which chemical use produces further problems. Substance abuse treatment may be made difficult, if not impossible, by the deep level of depression. But the person's ongoing heroin use may render traditional treatment of depression entirely ineffective. In such an instance, a determination of which disorder is primary becomes moot, because each problem worsens the other (Bean-Bayog, 1987). The reasons for continuing substance abuse may be quite different from those which initiated it (McMillan & Lynn, 1986); the reasons for the ongoing depression may be quite different from those responsible for its

initial appearance. Problem interactions are multi-directional rather than unidirectional and systemic in nature rather than linear.

Assessment Categories

To summarize this discussion of the assessment of persons with concurrent substance abuse and other psychopathology, both problems and their interactions must be thoroughly assessed. A given individual will fall into one of the following categories:

1. Substance abuse diagnosis or severe problem only
2. A non-substance abuse psychiatric diagnosis or severe problem only
3. Substance abuse diagnosis or severe problem, associated with another less severe (not diagnosable) psychological problem
4. A non-substance abuse psychiatric diagnosis or severe problem, associated with a less severe (not diagnosable) substance abuse problem
5. Concurrent substance abuse and other psychopathology (diagnosable or severe problems)

    A. No Interactions

    B. Interactions

1. Simple Interactions

    a. Psychopathology contributing to substance abuse
    b. Substance use creating or exacerbating psychopathology
    c. Symptoms of Psychopathology preventing effective use of substance abuse treatment
    d. Substance use, withdrawal, or treatment preventing effective use of psychological therapies

2. Complex Interactions

TREATMENT

In this section, I will first discuss the various treatment approaches which have been suggested to work with persons with concurrent problems, then discuss the treatment approaches which most closely correspond to the needs of persons falling into the assessment categories discussed above.

Treatment Approaches

Three general treatment approaches exist for persons with concurrent problems: One traditional treatment approach (either standard substance abuse or psychiatric treatment), sequential treatments (first treatment for one problem, then another type of

treatment for the second problem), and concurrent substance abuse and mental health treatment (with those treatments either modified to take into account the special needs of the client population, or unmodified).

One Traditional Treatment

The first issue on which advocates of various treatment approaches vary is whether one or both sets of problems need to be addressed in treatment. Some argue that only one approach is necessary, that if substance abuse problems are properly addressed the psychological problems will be resolved, or that if the psychological issues are properly addressed the substance abuse problems will resolve on their own. Bean-Bayog (1987) suggests that the treatment team wait two-to-four weeks to see if the psychiatric symptoms of the alcoholic patient in a psychiatric unit remit before treating the psychiatric symptoms, since those symptoms may well be withdrawal phenomenon. Likewise, Schuckit (1985) urges that primary and secondary (meaning temporal order) psychiatric syndromes be distinguished, because secondary psychiatric symptoms will likely clear on their own and therefore need no

treatment.

Others have suggested that, given the present state of the data on proper treatment, it is an error to consider one problem to be the consequence of the other and treat only one of them (Liskow, Mayfield, & Thiele, 1982; O'Sullivan, 1984). Some have argued that both sets of problems may need to be addressed (LaPorte, McLellan, O'Brien, & Marshall, 1981; Woody, McLellan, & O'Brien, 1984) without specifying the precise manner in which both problems are to be addressed. McLellan, Woody, Luborsky, O'Brien, & Druley (1983), for instance, concluded that, in the case of high psychiatric severity patients, psychiatric interventions need to accompany standard substance abuse treatment.

Sequential Treatment

Sequential treatment is recommended by some, with treatment for one problem to be followed by treatment for the other. Most urge that substance abuse treatment come first (O'Sullivan, 1984; Meyer & Hesselbrock, 1984). McLellan, Erdlen, Erdlen, & O'Brien (1981) argue that traditional psychiatric treatment does extremely poorly with the psychiatrically

complicated alcoholic, but that if such a person first completes some alcohol treatment, sufficient stability and improved general status may develop to permit beneficial treatment in a standard psychiatric setting.

Kofoed, Kania, Walsh, & Atkinson (1986) suggest that the choice of treatment sequence is arbitrary.

Bean-Bayog (1987) argues that the choice of which treatment comes first should depend on which problem is more life-threatening or is blocking treatment. The acutely suicidal or psychotic patient, for example, must have sufficient psychiatric treatment to be able to participate meaningfully in a substance abuse treatment program. In such instances, psychiatric treatment clearly needs to precede substance abuse treatment. In other instances, the sequence of treatment may be decided by determining the treatment for which the client is most motivated or which is most likely to be successful.

Concurrent Treatment

Finally, some argue that concurrent substance abuse and psychiatric treatment is ideal (Balcerzak & Hoffman, 1985; Schuster, Renault, & Blaine, 1979).

Several such treatment programs have been described (Balcerzak & Hoffman, 1985; Harrison, Martin, Tuason, & Hoffman, 1985; Kofoed, Kania, Walsh, & Atkinson, 1986; Weinstein & Gottheil, 1989). Concurrent treatment can range from integrated inpatient treatment units specializing in the treatment of patients with concurrent disorders to periodic psychological or psychiatric consultations in a substance abuse treatment setting or periodic substance abuse counselor consultations in a mental health treatment setting.

Concurrent treatment approaches are of two kinds: one in which traditional substance abuse and mental health services are simply provided concurrently (an unmodified concurrent approach), and one in which both sets of problems and their interactions are addressed in a form which represents some form of alteration of both traditional psychiatric and substance abuse treatment (a modified concurrent approach). Kofoed, Kania, Walsh, & Atkinson (1986) argue for the superiority of an approach in which a unified team provides concurrent treatment in the same setting over one in which concurrent treatment occurs in different treatment facilities.

These different approaches to treatment must, of

course, be seen on a continuum, with many treatment facilities specializing in either substance abuse or traditional psychiatric disorders actually treating both disorders, at times in ways which represent a modification of standard treatment approaches.

Treatment Implications for Persons in Various Assessment Categories

So, what treatment approaches are indicated for clients falling into the various assessment categories outlined above?

In some cases (Categories 1 and 2, only one diagnosis or severe problem), only the primary problem requires treatment because the other is essentially inconsequential. An existing treatment approach is thus appropriate. Only one (traditional) treatment need be provided.

If a diagnosis or severe problem is accompanied by a less severe (non-diagnosable) problem of another type (Categories 3 and 4), a careful assessment of the interactions between the two problems needs to take place. Even a minor psychological problem (for instance, anxiety or depression) can stymie effective substance abuse treatment. In such cases, that problem

and its role in perpetuating the substance abuse (the interaction between problems) need to be addressed in treatment as well as the principal problem. Likewise, a relatively minor substance use problem from a diagnostic perspective (such as drinking which does not satisfy the requirements of the full substance dependence syndrome but occurs before psychotherapy sessions or on an inpatient unit) may have a substantially deleterious impact on the treatment of the other psychopathology. Where such interactions occur, treatment of the minor problem and its interactions with the principal problem needs to occur concurrently with the treatment of the major problem.

Where concurrent substance abuse and other psychopathology exists (diagnosable or severe problems, Category 5), several general treatment considerations apply. (Ideally, these treatment considerations will be addressed by all professionals and treatment facilities encountering patients with concurrent problems, by specialized treatment programs and by traditional inpatient or outpatient substance or mental health settings. This may entail tailoring existing treatment approaches to meet the particular needs of persons with concurrent disorders.)

Of paramount importance is that both sets of problems be addressed. The best treatment approaches for each problem must be provided (Liskow, Mayfield, & Thiele, 1982). Realistic expectations for progress must be developed, that is, modest expectations. Patience is essential, with progress occurring at the patient's own speed (Harrison, Martin, Tuason, & Hoffman, 1985; Ottenberg, 1980). In addition to the substantial difficulties ordinarily faced by a person working to overcome a substance abuse or a mental health problem, such persons are faced with a second major problem, which will impede progress and increase a sense of isolation and hopelessness. Thus, Harrison, Martin, Tuason, & Hoffman (1985) suggest increased flexibility and special efforts to combat hopelessness. Ziegler-Driscoll, Say, Deal, & Ostreicher (1980) argue for the importance of increased nurturance and support and less confrontation. It is important that the individual accept the presence of both problems, so he or she will receive the necessary treatment. Denial of either problem can lead to serious regression, as in the case of schizophrenic alcoholics who either deny their alcoholism and return to drinking or deny their schizophrenia and discontinue the medication required

for intact thought processes. Finally, to the extent possible, commonalities across the two treatment approaches should be sought. In the case of a severely anxious substance abuser, for example, a cognitive behavioral approach to the treatment of both is vastly preferable to, for instance, concurrent treatment of anxiety by a very biologically oriented psychiatrist who only prescribes medications and treatment of substance abuse in an Alcoholics Anonymous group which regards all medication as a tool of the devil. If the same philosophical approach cannot be used for both problems, blatant contradictions between treatment philosophies should at least be avoided.

Ideal treatment of persons with concurrent disorders varies, depending on the presence or absence and type of problem interactions.

Concurrent, non-interactive primary problems (Category 5A) may be treated by either sequential or concurrent (unmodified) treatment approaches. Special treatment approaches need not be devised provided both problems are addressed.

Optimal treatment of concurrent, interactive problems (Category 5B) depends on whether the problem interactions are complex or simple, and on what type of

simple interactions are present. In all instances, some kind of modified intervention which draws upon both substance abuse and mental health treatments and addresses the interaction may aid in treatment. In the case of simple interactions, minor modifications of existing treatment approaches may be made. In the case of complex interactions, specialized treatment approaches are ideal.

I will first discuss treatment for the four kinds of simple interactions discussed above, then treatment for persons with complex problem interactions.

1. In situations in which psychological problems contribute to substance abuse, treatment needs to focus on (a) abstinence for a sufficiently long period of time that a person can both be motivated to obtain treatment for the psychological problems and have some experiences of success in doing so; (b) clients recognizing the destructive consequences of not resolving their psychological problems in a more adaptive fashion, including the consequences which result from their substance abuse; (c) the alleviation of the underlying psychological symptoms; and (d) the development of a new set of skills to handle future psychological problems in non-using ways. A variety of

standard mental health interventions may be employed to assist with the last two goals. Standard pharmacological treatment may be necessary with severe symptoms. One study (Quitkin, Rifkin, Kaplan, & Klein, 1972) found that imipramine was helpful in treating persons who abused drugs in an attempt to self-medicate chronic anticipatory anxiety. McLellan, O'Brien, Kron, Alterman, & Druley (1980) argue for the necessity of psychotherapy for those who attempt to medicate underlying psychopathology. Harrison, Martin, Tuason, & Hoffman (1985) suggest the utilization of behavioral techniques, including information about alternative coping mechanisms, behavioral rehearsal, and role play to handle anxiety without drinking or using drugs. Education about the increased anxiety and depression generally associated with heavy drinking (which runs contrary to the drinker's belief system) (Lutz & Snow, 1985) may be provided to clarify the ineffectiveness of substance use as a way to cope with psychological problems.

Treatment of psychological problems in a person with concurrent problems does not, however, mean that, if the underlying psychological issues are resolved and the client develops more effective coping skills,

substance abuse treatment becomes unnecessary. A substantial number of factors may serve to perpetuate substance abuse; it may develop a kind of "functional autonomy," existing even when the reason for its origin, for instance, covering over psychological pain, no longer exists. Treatment of both the substance abuse and the other psychopathology is therefore needed. When both problems are addressed the likelihood of a successful substance abuse treatment outcome is increased because the interactions between psychological and substance abuse problems are addressed.

2. When substance abuse has created other psychopathology, that problem interaction may be a focus of treatment in the following way: The client needs to see that their psychological problems are a serious consequence of the substance abuse, and thus as part of his or her reason for eliminating or minimizing use. This intervention may be made even in situations where psychopathology remits following detoxification. If it does not remit, however, more active treatment of that psychopathology is indicated. In such instances, the substance abuse may well have exacerbated underlying psychopathology. Estroff & Gold's

(1985-1986) suggestion of frequent evaluations of psychopathology during detoxification seems a sound response to the debate over the point in detoxification at which treatment (usually meaning medical treatment) for non-substance abuse psychopathology should be instituted. Again, however, if the approach to treating substance abuse is very similar to that used for treating other psychopathology, treatment of the other psychopathology would be well underway by the time detoxification is completed.

When substance abuse has exacerbated other psychopathology, treatment needs to focus on both problems. Clients need to work through and accept the reality of their mental disorder, the negative consequences of their use of mood-altering substances on that disorder, and their substance abuse. In particular, they may need to recognize that they are "different" from others in terms of their capacity to use substances. Often, they must work through the "unfairness" of having a major mental disorder as part of accepting their need to minimize or eliminate substance use.

3. If symptoms of psychopathology prevent effective use of substance abuse treatment because of

psychosis or severe depression, psychological and (usually) biological treatments must precede substance abuse treatment, although the latter may need to follow closely upon reconstitution.

If characterological issues interfere with substance abuse treatment, treatment must be tailored to those characterological issues, without, however, failing to address the destructive impact of substance abuse. A person with a diagnosis of borderline personality disorder, for instance, will require interventions concerning substance abuse which take into consideration and deal with such characteristics as impulsivity, splitting, and self-damaging acts.

4. Where substance abuse prevents the effective use of treatment for psychopathology, total abstinence, or, at a minimum, abstinence prior to therapy sessions, is essential for treatment. If a person is in withdrawal, it is essential that due consideration be given to the medical problems faced by such a person, and that those not be pathologized. Treatment of psychological problems is of necessity slower with such persons, but must proceed nevertheless, lest the psychological problems not be addressed.

Concurrent, complexly interactive problems

(Category 5B2) require a combination of standard substance abuse and mental health interventions, a strong emphasis on the interventions (discussed above) to address simple problem interactions, and a clear awareness on the part of the treatment staff of the particular sets of interlocking interactions which perpetuate a given person's multiple problems. Specialized treatment settings (with staff addressing multiple issues, trained in multiple approaches, and communicating extensively) and substantial tailoring of treatment to the dynamics of an individual's situation are ideal. Any attempt to oversimplify such complexly interactive problems by focusing only on one problem or on unilateral problem interactions will likely mean ineffective treatment. However, it is also crucial that the complexity of such a persons' problems not paralyze the treatment staff; a clear focus to treatment is essential. That focus must develop from an awareness of the dynamics of a given individual's complexly interacting problems. Finally, for the psychologically minded client, education about, and acceptance of, the interactions between problems is important.

SUMMARY

Assessment of the particular nature of the problems experienced by persons having concurrent substance abuse and other psychopathology is essential if optimal treatment is to be provided. Interactions between problems must be assessed and, where present, addressed in treatment.

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