CHAPTER 8

Redefining the Treatment of Dual Disorders

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Despite the enormous literature on dual or co-occuring disorders, there is still no theory of etiology or principles of treatment that have captured the complexity of people who suffer from them. The only consistent theme seems to be an agreement that dually diagnosed people must be fully and permanently abstinent in order to be accurately diagnosed and adequately treated. Most authors don't count any intervention as "treatment" until abstinence from psychoactive substances has been achieved (see, e.g., Drake et. al 2003; Minkoff & Drake, 1991). This type of thinking parallels the general attitude of our society about substance use: that we should have a drug-free America. We should all be pursuing this ideal in whatever professional or citizen role we adopt. Just as in society, where the war on drugs has caused incredible harm by incarcerating thousands of casual drug users while failing to curtail substance abuse, in treatment settings, the abstinence effort has limited our creativity and left thousands of people to suffer without professional aid. We allow no distinction between casual use and dependence. We have no formal treatments for mild problems, thus missing the vast majority of people who might benefit from treatment. We refuse to understand the important role that substances often play in the lives of people with emotional disorders. In summary, we don't work well in the

gray areas of human experience. American culture is decidedly dualist in nature. We prefer "yes or no," "right or wrong," "win or lose," "clean or dirty" to the less quantifiable realities of human behavior. We want answers that fit all scenarios, not the answer "it depends." In treatment settings, as in American society, we begin the discussion with the assumption that abstinence is the right way, and every other way is wrong. In society at large, we decide that drug users, and especially those who sell drugs, are bad, evil. We then incarcerate them rather than treat those with actual drug problems. While drug courts offer some respite from automatic incarceration, they operate with the constant threat that if a person does not comply with treatment recommendations, they will be sent to jail. In California, Proposition 36, the "treatment not jail" ballot initiative requires that a person plead guilty to the drug charge *before* being offered treatment. Only if the person successfully completes the treatment is the conviction expunged. So far, it appears that putting people in jail for substance misuse isn't a cure. This failure to respect individual differences and individual rights is the hallmark of our society and of drug treatment to date. Harm reduction approaches never lose sight of the political and cultural realities in our approach to treatment.

More than 50% of people who have serious mental health problems also suffer from substance misuse (Drake et al., 2003). This rises to 70% if one includes all psychiatric disorders. Despite this prevalence, much in the dual diagnosis area actually exists in the context of an evolving field of substance abuse treatment. While community mental health systems first noticed and attempted to create services for these clients, what has evolved is, in essence, psychiatric considerations generally being layered on top of traditional understandings of substance abuse, with the American disease model and 12-step methods the primary orientations. This has unreasonably influenced the development of treatment models for co-occurring disorders, with substance use retaining the most intensive focus. The result of such design is disappointing outcomes (Drake, Mercer-McFadden, & Mueser, 1998). These outcomes mean continued suffering for the client and increasing expenses for society.

There are several noteworthy clinicians who have detailed treatment strategies for people with co-occurring disorders. Sciacca (1991) first understood the importance of lowering levels of confrontation when she began developing an integrated model in 1984. Sciacca (1991) has more recently incorporated motivational interviewing as a core element in her model (1991). However, she continues to phase her interventions according to what she refers to as a "denial to abstinence" assumption. Minkoff and Drake (1991), along with others, have created both a treatment model as well as a model for the reorganization of service delivery systems. Minkoff uses the National Consensus "quadrant" model. Central to this is the grid of "quadrants" that assess the relative weight of substance abuse and psy-

chiatric issues for each person. While it is a sophisticated paradigm with staged interventions, it still relies on the language of disease and recovery, with "treatment" only beginning after abstinence has been achieved. This model is discussed further in the section on models of dual-diagnosis treatment.

What is missing? Why are current approaches still not reaching many with dual disorders, and why are outcomes still disappointing? There are a few clues to this question. First, it may be that the use of a disease and recovery model, taken from substance abuse traditions, actually limits the creativity of clinicians and ties them to the old paradigm of abstinence first. Second, we minimize the complex interactions that exist between a person's feelings, behaviors, thoughts, symptoms, and the drugs he or she might use. And last, our categorical approach to diagnosis, where each "disorder" has a separate DSM code, ensures that we will be unable to think differently about this subject. A new paradigm has been needed for a while, one that can capture the complexity of these clients and offer compassionate, pragmatic, and effective care.

Harm reduction psychotherapy (HRP) is a new paradigm. It has emerged over the past 15 years out of the intersection of psychotherapy, public health, and advocacy movements. HRP starts from complexity rather than layers it in. A harm reduction approach to dual-diagnosis treatment recognizes that so-called dual disorders are multidetermined and inseparable, so that the very word *dual* is misleading. People don't have *both* a mental health diagnosis and a substance abuse disorder. They have a single problem; they are immersed in a biopsychosocial process in which the relative weight of each factor is different for each person. The treatment, then, depends on the particular mix of elements that each client presents. HRP includes different assessment and treatment strategies than standard addiction treatments. It flows from the belief that clients have the right to address their problems without the imposition of predetermined goals such as abstinence. HRP starts from an understanding that we will seldom have the luxury of a clear psychiatric diagnosis. It is a model that embraces ambiguity and relativity. Our best information comes from our clients. We begin where the client is, take their descriptions of their problems at face value, and use their wisdom to guide the treatment.

CONTRIBUTIONS OF THE DUAL-DIAGNOSIS FIELD THUS FAR

Models for Understanding Dual Diagnosis

The state of the art of dual-diagnosis treatment is perhaps best spotlighted by our continuing struggle to settle on a term for those people who present with a constellation of substance misuse and emotional/psychiatric syndromes. In addition to the points made above, the terms dual diagnosis,

dual disorders, comorbid disorders, co-occurring disorders, and the values-laden "double trouble" all indicate our confusion, our hostility, and our general unease with these clients.

According to all published studies, the rate of co-occurring disorders in treatment settings ranges from 50 to 80%. How do we account for and understand such a preponderance of complex clients? Those clinicians and researchers who struggle to define and characterize the nature of dual disorders provide what Mueser, Drake, Turner, and McGovern (2006) call "four sets of overarching meta-models: secondary psychopathology models, secondary substance abuse models, common factor models, and bidirectional models" (p. 117). Each of these models attempts to explain not only the high comorbidity rates, but attempts to point to needed changes in both our treatment modalities and our treatment systems.

Secondary psychopathology models posit that substance use disorders cause some mental disorders in vulnerable populations: LSD leading to schizophrenia or alcohol dependence leading to depressive disorders, for example. The opposing theory, secondary substance use models, points to the role of self-medication, supersensitivity, dysphoria, and other psychosocial phenomena in the development and maintenance of substance use disorders. No matter what the specific nature of these phenomena, it is well known through human history that we tend to use psychoactive substances to quiet all kinds of emotional distress. This model would be the corollary to Khantzian's (1985) self-medication hypothesis. Common factor models include the much-loved genetic predisposition theories, or the "brain disease" theories that characterize American addiction medicine since the 1970s. Finally, the bidirectional model offers an intriguing and complex way of understanding the mutual initiation, maintenance, and increasing sensitivity to exacerbation of these disorders over the person's lifetime.

The best example of a bidirectional model is the co-occurrence of post-traumatic stress disorder (PTSD) and substance abuse. A literature review by Jacobsen, Southwick, and Kosten (2003) concludes that there are two pathways that account for the high comorbidity of substance abuse and PTSD (up to 70% in clinical populations). In one pathway, substance use precedes the development of PTSD and contributes to its development because of the often traumatic experiences and lifestyle that accompany addiction. In this scenario, the chronic stress suffered by those with chaotic lifestyles may sensitize the brain to be more susceptible to developing PTSD than would otherwise occur in response to traumatic events. This sensitization could occur because of the chronic activation of the "fight–flight" norepinephrine system. The second pathway is a self-medication hypothesis in which the trauma occurs first and leads to a search for a soothing, healing, or energizing experience that can often be found with substances (Khantzian, 1985). Withdrawal experiences, then, mimic the symptoms of PTSD

and lead the person back to the substance, creating a feedback system that resists intervention.

Other than the above research on PTSD, none of the four models has gained significant research support with the general population of people with dual disorders. This is to be expected if one believes, as does HRP, that these disorders have more heterogeneity than similarities. It is also to be expected when one adds medical disorders to the mix of comorbidity. Diabetes, heart disease, and chronic pain add their own chords to this complex symphony of life for those suffering with emotional disorders and substance misuse.

Models of Dual-Diagnosis Treatment

The literature shows that, in general, people with comorbid disorders tend to seek treatment more often than do those with stand-alone substance misuse or psychiatric disorders. We also know that dual disorders tend to have a longer, more serious course resulting in significant biopsychosocial consequences to the individual, their family, and society. Clients with co-occurring disorders also have worse treatment outcomes (see, e.g., Haywood et al., 1995).

As mentioned above, several noteworthy clinicians have detailed treatment strategies for people with co-occurring disorders. Minkoff and Drake (1991) have utilized a national consensus quadrant model for assessing patients and planning treatment. This matrix categorizes patients based on the severity of each of their two disorders—psychiatric disorders and substance abuse disorders—in four combinations.

Both high severity	Personal disorder low severity Substance abuse disorder high severity
Personality disorder high severity Substance abuse disorder low severity	Both low severity

The quadrant model allows for more complexity in diagnosis because it forces the clinician to be more precise in diagnosing the relative severity of the substance use and the psychiatric disorder in each individual. Systems of care are then built around these quadrants. For example, individuals in quadrant I are seen in integrated outpatient and primary care settings, indi-

viduals in quadrant II are followed within the mental health service system, individuals in quadrant III are served primarily in the substance system, and so forth. Each system will be dual-disordered competent in terms of assessment, but usually have priority populations.

The treatment practices in this model range from case management to medications to 12-step involvement. Individual psychotherapy is meant to be supportive and skills based rather than insight building and character restructuring. Motivational interviewing and the stages of change are incorporated, though, and a recovery model rather than a symptom-based model is used. The strength of a recovery model is to empower the client. How this works in practice, however, seems less sophisticated and less likely to lead to core changes in personality and in life development. In the hands of clinicians with limited expert training, the treatment looks most like Minnesota model substance abuse treatment with recovery-oriented mental health and medication-driven psychiatric services. Of concern in this and other models of care that incorporate Miller and Rollnick's work (1991, 2002) is that motivational interviewing was never meant as a way to move a client toward a predetermined agenda. Indeed, in the second edition of their work, Miller cautions clinicians to refrain from using motivational interviewing to guide or manipulate a client toward a defined goal.

A dual-diagnosis treatment model developed by Sciacca (1991) emphasizes the importance of lowering levels of confrontation when working with emotionally fragile clients. Motivational interviewing and the stages-of-change model are both core elements in her work. However, she continues to work within the "denial to abstinence" assumption even though much of her design is more sophisticated than many. She has continually updated her treatment methods and yet still manages to hold firm to the assumptions of a recovery-oriented model.

Limitations of the Dual-Diagnosis Field

The controversy over sequential or parallel treatment has been mostly won by the research that shows that only simultaneous or integrated treatment methods yield positive outcomes. Both Minkoff and Drake's and Sciacca's models are integrated and are described in better detail than most. Even in those models that incorporate motivational interviewing and cognitive-behavioral components such as skills building and relapse prevention, client retention may be limited by their emphasis on achieving and maintaining abstinence from illicit drugs and adherence to psychiatric medications. Most programs in the United States, even those that claim expertise in dual disorders, often use few of the many creative integrated treatment strategies available, tending to add psychiatric medications and social-skills training to the basic 12-step-driven treatment philosophy.

The dual diagnosis literature has not yet integrated motivational interviewing into a coherent theory of treatment. The term *pretreatment* has been coined to allow the use of motivational approaches and stages-of-change applications with clients still actively using drugs and alcohol. The concept of staging treatment interventions according to Prochaska's (Prochaska, DiClemente, Norcross, 1992) model seems to arise partly from the knowledge that many clients will enter treatment still using and come with different goals. Staging is also used to segregate those clients who do recycle through treatment many times or who most likely will not become or remain abstinent. The rationale for this segregation is to allow those who are abstinent to be free of triggers. Such separation, however, feeds the fear of "contagion" that is evident in most substance abuse treatments, which caution clients to avoid "people, places, and things" that could tempt them to return to use. Even with the use of newer, evidence-based components, most treatment models cannot break free from the traditional assumptions of substance abuse treatment: the treatment always pursues abstinence as a primary agenda, as if that is the key to all other improvement.

HRP: AN INTEGRATIVE PARADIGM

HRP is a relative newcomer to the substance abuse treatment field. Only since 1991 have clinicians begun to describe and develop this unique way of viewing people with complex, interacting difficulties. Since then, many psychotherapists and treatment professionals, particularly those with an interest in dual diagnosis, have joined in the development of HRP with writings, training, seminars, and professional conferences dedicated to this new paradigm.

History and Context of HRP

HRP was developed specifically to take into account the lack of clarity and direction in the field of dual disorders. The principles and practices of HRP allow for both the flexibility and the creativity necessary to understand and treat people with complex problems.

HRP has a relatively short history in the field of substance use disorders. It has been developed by several clinicians and researchers over the past 16 years. Edith Springer (1991) was the first to introduce harm reduction concepts and practices to the United States after she visited and interned at revolutionary harm reduction clinic in England. Her treatment ideas were first applied to counseling with people with HIV. Alan Marlatt (1998, Marlatt & Tapert, 1993) brought harm reduction from the Netherlands after spending time studying their system of care for addictive behav-

iors. Much of what was written prior to 2000 was specifically related to public health principles or to care of injection drug users to stop the spread of HIV and other blood-borne diseases. Andrew Tatarsky (1998) may have been the first clinician to coin the term *harm reduction psychotherapy*. In his seminal paper and later in his book (2002), he describes some of the basic principles and techniques used by many practitioners, particularly those with a psychodynamic orientation. In her 2012 book, this author critiqued traditional treatment models and outlined the first comprehensive assessment and treatment model (Denning, 2012). This model of HRP utilizes cognitive-behavioral methods, neurobiological data, and motivational enhancements within the framework of a psychodynamic understanding of the nature of human suffering and change. This model has been translated into a book for the general public and for clients seeking an alternative to addiction treatment (Denning, Little, & Glickman, 2004).

In addition to the above people and the approaches mentioned previously, many others have been developing like-minded methods under terms such as life skills (Peele, 1991), responsible drinking (Rotgers, Kern, & Hoeltzel, 2002), rational recovery (Ellis & Velten 1992), Addiction Alternatives (Kern, 1994), SMART recovery (Knaus, 1998), and comprehensive life skills (Horvath, 1998). These are primarily self-help methodologies, but practitioners such as Jeff Foote, who started the Center for Motivation and Change, have contributed greatly to the field. Indeed, much of HRP has borrowed heavily from the work of these authors.

The clinical principles of HRP have been derived from the principles of the harm reduction movement (both the public health and advocacy arms). This author, in collaboration with Jeannie Little (2001, 2006), both founders of the Harm Reduction Therapy Center in San Francisco, developed the following set of clinical principles to guide the work we do with clients with complex disorders.

Principles of HRP

1. Harm reduction is any action that attempts to reduce the harm of drug abuse and drug prohibition.
2. There can be no punitive sanctions for what a person puts in their body or refuses to put in their body.
3. People use drugs for reasons and not all drug use is abuse.
4. People can, and do, make rational decisions about important life issues while still using.
5. Denial is not actually denial. It is a product of shame and punitive sanctions and is usually quite conscious.
6. Ambivalence and resistance to change are "human." It is our job to work *with* someone's ambivalence, explore it, *not* confront it.

7. Addiction is not a disease, but a biopsychosocial phenomenon in which the relative weight of the biological, the psychological, and the sociocultural aspects are different for each person.
8. Substance use represents a relationship, an attachment that offers significant support to the person. Treatment must offer that support, as well as respect that maybe we can't do it as well or with such reliability.
9. Motivation toward change is the mutual job of the treatment provider and the client. People need relationship, self-esteem, and self-care to increase their motivation to reduce harm or more toward "recovery."
10. Success is any positive change—any step in the right direction.
11. Change is slow, incremental, with many setbacks. Relapse is the rule, not the exception. Plan for it. Help people stay alive and healthy and connected to treatment *during* their process of change and their relapses.

Objections to these principles, and to harm reduction in general, arise from several sources. First, recent brain disease concepts, which in treatment settings are combined with traditional 12-step ideas, characterize addictions as progressive, fatal diseases. This leads clinicians to fear that any "soft" approach to moderation or risk reduction is doomed to failure and is tantamount to assisted suicide. Second, many counselors in drug treatment are products of 12-step recovery themselves and believe strongly that no other approach could have worked for them, and since 12-step did, it's the right thing for everyone. Third, there is often a concern about the collateral damage to families and communities from substance abuse. Clinicians engage in legitimate arguments about whether at times it may be more important to prevent such harm than it is to focus solely on the individual.

To address the issue of collateral damage, practitioners have been studying bioethics and using this to conduct an analysis of HRP (Rotgers, 2007). Current models of bioethics have similar principles as those in HRP, most notably the principles of client autonomy and practitioner nonmalfeasance (i.e., do no harm). Other models, however, emphasize the importance of considerations of client competency as well as the impact on family and community in making complex clinical decisions. As the new field of HRP struggles with such important issues, we will further refine and develop a sophisticated paradigm and effective treatments to replace what is outmoded.

An important work regarding the etiology and treatment of substance abuse (Miller & Carroll, 2006), while not specifically intended for dual disorders, nonetheless reflects many of the same beliefs espoused by harm

reduction. They describe 10 broad principles, including: drug use is a chosen behavior; drug problems emerge gradually and form a continuum of severity, with severity tending to be self-perpetuating; drug problems do not occur in isolation and there are factors that promote or protect against substance misuse; and finally, that motivation and relationship are important factors in treatment.

Components of the HRP Model

HRP was developed specifically to understand and treat complex, interacting drug, psychological, and medical disorders and environmental circumstances. HRPs uses a biopsychosocial system to understand the intricate interactions of all of these factors in the initiation and maintenance of comorbid disorders. The evidence basis and clinical techniques of HRP have been detailed elsewhere and apply equally well to single or multiple diagnosis clients (Denning, 2012; Denning et al. 2004). What is often most difficult for clinicians is teasing apart the relative importance of mental disorder, emotions, drug influences, and environmental stressors in each individual client. While there are few hard-and-fast rules, experience and thousands of conversations with clients have provided some guidelines that help us to begin treatment whether or not we have a firm diagnosis to guide us.

HRP is based on the knowledge that substances can mimic, increase or decrease, or alter one's emotions and the expression of mental disorders. And the effects of substances can be modified by the presence of strong affect, expectations, or psychiatric conditions. In addition, noting the research in the area of client retention, the therapeutic relationship takes a central part in HRP. Without this relationship, the treatment can neither begin nor continue with positive results. With these considerations in mind, the practice of HRP follows these principles:

- *Collaboration:* Clinician and client work together to prioritize a client's needs and create a treatment plan. HRP starts *where the client is at*.
- *Continuum:* Drug and alcohol use occurs across a continuum, just as motivation to change behavior spans the continuum from a desire not to get AIDS to a desire to be "clean and sober."
- *Complexity:* Understanding and addressing the different biological, psychological, and social issues that factor into each person's unique *relationship* to using drugs and alcohol.
- *Change:* Research shows that behavior change is typically gradual, especially for people who are dually diagnosed. HRP is designed to understand a client's change *process* and thus increase their motivation to change behaviors.

- *Compassion:* Confrontational approaches do not help the psychologically vulnerable.
- *Commitment:* Treating people who may still be using is not "enabling" continued drug use, but helping desperately needy people to engage with and stay in treatment. Dead addicts never recover.

One of the challenges in developing a diagnostic and treatment model that takes into account the complex interactions of many dimensions of human experience is how to organize all of the clinical data without ascribing *a priori* value to any one cluster. In addition, experience tells us that changes in one factor or dimension affects the whole system, for better or worse. The best fit for this need to organize and understand data is a model called drug, set, and setting (Zinberg, 1984). Zinberg's research showed that the drug experience, as well as the harms often associated with drug use, was not usually caused by the drug itself, but by a combination of the drug, the set (the person using), and the setting. This model also is a good representation of the combined effects of biology (drug), psychology (set), and sociocultural factors (setting). By filling in information from interviews, assessment tools, lab results, and so on, it is possible to get a visual representation of the internal complexity of each individual clients.

- *Drug.* A client may be smoking crack and drinking alcohol. In addition, she may be taking retroviral therapy for HIV, and an antipsychotic for paranoia and agitation (which may or may not represent a functional or a toxic psychosis).
- *Set.* This client may carry a diagnosis of borderline personality disorder, and has a clear history of physical abuse as a child and as an adult. She also suffers from depression. She is also very religious and berates herself for not living a more Christian life. She is shy and overly compliant except when it comes to abstaining from drugs. She is also very helpful with some of the other clients in the center.
- *Setting.* She regularly comes to the treatment center and interacts with staff and other clients. She lives alone in a hotel and uses her drugs by herself. She sometimes attends church services but feels the judgments of others there.

There are many opportunities for engagement and treatment planning with this woman that do not necessarily involve her drug use, which is firmly entrenched at this moment. She may benefit from increasing her church attendance and working in counseling on her own judgments about her lifestyle so that she can do so. She can be encouraged to take on a more formal role as peer support counselor or advocate to give her a sense of duty and responsibility that will increase her self-esteem and self-efficacy. These are both setting interventions, with some set benefits.

Understanding the role of the substances in our clients' lives is essential to helping them make changes. Often with dually diagnosed people, there is a complex set of interactions that can be viewed through a self-medicating/pharmacological lens. In the preceding case, it may be that she is drinking alcohol to soothe herself from the effects of traumatic experiences that overly activate the norepinephrine system. And she may be using the stimulant cocaine to enliven her rather depressed self. Unfortunately, the crack is also activating her norepinephrine system, resulting in both agitation and dopamine-related paranoia. It would most likely be beneficial if she were to abstain from both alcohol and crack, given this brain scenario. At this point, such a suggestion would likely result in her not returning. It is up to us to work with her to come up with reasons why she may have to want to make changes.

It is important to note that, for the most part, HRP as practiced by this author does not separate treatment into an assessment phase and then treatment planning. Because of the complex and ever-changing interactions, and because of the centrality of the therapeutic relationship, formal objective assessment measures are not used at the beginning of treatment (except for baseline data that is used for outcomes research and not part of the clinical record). From the beginning, clinical techniques and treatment strategies are layered on a foundation of information gathered in a collaborative conversation with the client. This conversation, and the relationship that develops, is guided by motivational interviewing (Miller & Rollnick, 1991). Client and therapist determine the wish and need for changes in all areas of a person's life and use the stages-of-change model (Prochaska, DiClemente, & Norcross, 1992) to recognize areas that will have a better chance of successful short- or long-term changes. Barriers to change as well as incentives for change are examined. For example, a client might be in the contemplation stage with regards to stopping using alcohol because it is soothing, but in the preparation stage for taking regular psychiatric medications because he or she thinks that doing so would be beneficial. Allowing a client to set the pace of change as well as the nature of that change then sets the clinician free to do what we should do best: develop specific therapeutic strategies to craft the changes. Focusing on substance use management regarding to alcohol consumption circumvents resistance to change while at the same time suggests safer ways to drink. Social skills training to improve the client's communication skills might enhance the few relationships she now has. Education about taking care of one's liver could motivate the client to consider changes in alcohol consumption. In addition, changing her housing to a group situation might improve her mood by decreasing social isolation. All of these interventions, whether directly focused on drug use or not, will have beneficial effects that can build on one another.

The use of specific verbal and somatic therapies for the treatment of trauma is a newer addition and is based on the writings of many authors as well as on the ongoing work at the Harm Reduction Therapy Center (see, e.g., *Seeking Safety* [Najavits, 2002]). *Seeking Safety* consists of 25 topics that can be conducted in any order, in group or individual formats, including: Taking back your power, When substances control you, Honesty, Asking for help, Setting boundaries in relationships, Healthy relationships, Creating meaning, Integrating the split self, Taking good care of yourself, Commitment, Respecting your time, Coping with triggers, Self-nurturing, Red and green flags, and Detaching from emotional pain (grounding).

Central to this work is an understanding of the neurobiology of arousal systems that are deranged by traumatic experiences. In addition, chronic trauma at the hands of caregivers results also in serious attachment difficulties that drive both reenactments and substance misuse to calm and soothe. Therapeutic techniques must work to reduce arousal, modulate affect, and help the client feel safe. This is more important than the telling of the traumatic story. Clients are taught how the brain works and the interacting effects of naturally occurring brain chemicals, substances, and emotions. Armed with this information, clients can construct their own understanding of how drugs might be helping or harming them.

One of the most vexing problems that clinicians face is determining the relative impact of substances on symptoms and vice versa. It is often impossible to know whether alcohol is improving a seriously depressed person's mood or if it is adding a pathological dimension to a less severe depression. We know that stimulant drugs can improve some of the symptoms of schizophrenia and we also know that it can make other symptoms worse. HRP offers both insight and assistance in this area. Because the treatment is not predicated on a firm answer to the chicken-or-egg questions that we have, treatment techniques can be used and both client and clinician can follow the changes to build a story of what might be true for each client. For some, reduction or elimination of alcohol will greatly improve their mood, thus "proving" an etiological fact and suggesting a recommended course of action that can be discussed. Other times we will continue to be blind to the interactions and have to rely on the therapeutic relationship and trial-and-error interventions to achieve improvement.

CONCLUSION

This chapter has offered a way of looking at the complex interactions between the substances people use, emotional reactions or psychiatric symptoms they may have, strengths that may go unnoticed, and the unique

context of their lives. While many others have contributed to the field of dual disorders, HRP represents both a paradigm shift and a series of clinical principles and practices that is unique in this country. Further development should include, among other things, treatment outcome research and qualitative studies to tease apart what might be most useful in this method and suggest improvements over time.

REFERENCES

Denning, P., Little, J, & Glickman, A. (2004). *Over the influence: The harm reduction guide to managing drugs and alcohol.* New York: Guilford Press.

Denning, P. (2002). *Practicing harm reduction psychotherapy: An alternative approach to addictions* (2nd ed.). New York. Guilford Press.

Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., et al (2003). Implementing dual-diagnosis services for clients with severe mental illness. In R. Rosenthal (Ed.), *Dual diagnosis: Key readings in addiction psychiatry* (pp. 53–68). New York: Brunner-Routledge.

Drake, R., Mercer-McFadden, C., & Mueser, K. (1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin, 24*(4), 589–608.

Ellis, A., & Velten, E. (1992). *When AA doesn't work for you: Rational steps to quitting alcohol.* Fort Lee, NJ: Barricade Books.

Haywood, T. W., Kravitz, H. M., Grossman, L. S., Cavanaugh, J. L. Jr., Davis, J. M., & Lewis, D. A., et al. (1995). Predicting the "revolving door" phenomenon among patients with schizophrenic, schizoaffective, and affective disorders. *American Journal of Psychiatry, 152*, 856–861.

Jacobsen, L., Southwick, S., & Kosten, T. (2003). Substance use disorders in patients with postraumatic stress disorder. In R. Rosenthal (Ed.), *Dual diagnosis: Key readings in addiction psychiatry* (pp. 111–123). New York: Brunner-Routledge.

Kern, M. (1994). *Take control now! A do it yourself blueprint for positive lifestyle success.* Los Angeles: Life Skills Management Publishing.

Khantzian, E. (1985). The self-medication hypotheses of addictive disorders: Focus on heroin and cocaine dependence. *American Journal of Psychiatry, 142,* 1259–1264.

Knaus, W. (1997). *SMART recovery: A sensible primer* (3rd ed.). Longmeadow, MA: William Knaus.

Little, J. (2001). Treatment of dually diagnosed clients. *Journal of Psychoactive Drugs, 33*(1), 27–31.

Little, J. (2006). Harm reduction therapy groups: Engaging drinkers and drug users in a process of change. *Journal of Groups in Addiction and Recovery, 1*, 69–94.

Marlatt, G. A. (Ed.). (1998). *Harm reduction: Pragmatic strategies for managing high-risk behaviors.* New York. Guilford Press.

Marlatt, G. A., & Tapert, S. F. (1993). Harm reduction: Reducing the risks of addictive behaviors. In J. Baer, A. Marlatt, & R. J. McMahon (Eds.), *Addic-*

tive behaviors across the life span: Prevention, treatment and policy issues (pp. 243–273). Newbury Park, CA. Sage.

Miller, W., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior.* New York: Guilford Press.

Miller, W., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.

Miller, W. R., & Carroll, K. M. (Eds.). (2006). *Rethinking substance abuse: What the science shows, and what we should do about it.* New York: Guilford Press.

Minkoff, K., & Drake, R. E. (1991). *Dual diagnosis of major mental illness and substance disorder.* San Francisco: Jossey-Bass.

Mueser, K. T., Drake, R. E., Turner, W., & McGovern, M. (2006). Comorbid substance use disorders and psychiatric disorders, in W. R. Miller, & K. M. Carroll (Eds.), *Rethinking substance abuse: What the science shows and what we should do about it* (pp. 115–133). New York: Guilford Press.

Najavits, L. M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse.* New York: Guilford Press.

Peele, S. (1991). *The truth about addiction and recovery.* New York: Simon & Schuster.

Prochaska, J., DiClemente, C., & Norcross, J. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*(9), 1102–1114.

Rotgers, F. (2007, August, November, and December). *Ethical considerations in practicing harm reduction psychotherapy.* Presentations at American Psychological Association conference, 2nd National Harm Reduction Therapy conference, and the Drug Policy Alliance International conference.

Rotgers, F., Kern, M., & Hoetzel, R. (2002). *Responsible drinking: A moderation approach for problem drinkers.* Berkeley, CA: New Harbinger.

Sciacca, K., (1991). An integrated treatment approach for severely mentally ill individuals with substance disorders. In *New Directions for mental health services, dual diagnosis of major mental illness and substance disorders.* San Francisco: Jossey-Bass.

Springer, E. (1991). Effective AIDS prevention with active drug users: The harm reduction model. In M. Shernoff (Ed.), *Counseling chemically dependent people with HIV illness* (pp. 141–158). New York: Harrington Park Press.

Tatarsky, A. (2002). *Harm reduction psychotherapy.* Northvale, NJ. Jason Aronson.

Tatarsky, A. (1998). An integrated approach to harm reduction psychotherapy: A case of problem drinking secondary to depression. *In Session: Psychotherapy in Practice, 4*(1), 9–24.

Trimpey, J. (1992, rev.). *The small book.* New York: Dell Trade Paperbacks.

Zinberg, N. E. (1984). *Drug, set, and setting: The basis for controlled intoxicant use.* New Haven, CT: Yale University Press.