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Addiction Medicine & Psychiatry

Where Addiction and Illness Intersect

A basic problem with treating alcoholics and other addicts is that some of them appear mentally ill when they first enter treatment. It raises questions: Is this patient (1) a mentally ill drug addict, (2) an alcoholic in relapse or (3) a depressed patient who has been self-medicating? Which came first? the therapist wonders: The drink or depression? Cocaine or paranoia? PCP or psychosis?

From Witch Doctors to Counselors For a better understanding, let's take the long view. In our cave man days, the witch doctor treated all comers: The drunks, the deluded and the demented. During the Middle Ages, religious conversion helped some alcoholics. But people who had mental problems were chained up in mental asylums or locked up in the family attic. At the turn of the 20th Century, psychotherapy came on the scene. It worked so-so for neurotics, poorly for the deluded, and not at all for the drunkards. Finally, in the 1930's Alcoholics Anonymous was born. AA worked well for alcoholics -- if they stuck with it; less well for neurotics; and rarely for the deluded, and the demented -- but only if their perceptual distortions were caused by the intermittent brain effects of substance abuse or heavy drinking, if they stayed clean and sober.

A new system to treat alcoholics In the 1960's, hospital-based treatment units for alcoholics became the vogue. Treatment became "rehabilitation". The programs were built around the lay counselor who was usually a recovering alcoholic man who wore two hats: AA member and alcohol abuse counselor. Many of these counselors, though zealously sober and pure of heart, had their own personality flaws: They hated drug addicts, resented women or had trouble with authority figures. (Today we call them un-treated dry alcoholics.)

The counselors' most serious flaw was that they had no training in psychopathology. While this caused some to be frightened or turned off by patients who had mental symptoms, the AA community loved them because they bussed fresh-caught prospects into local AA meetings; and the hospitals loved them because they filled hospital beds with paying customers. ("Heads in beds" was the telemarketers' mantra.) A predictable by-product was that psychiatrists and psychologists were gradually phased out of the alcoholism/addiction treatment field. Why? Because many mental health professionals had failed their alcoholic or addicted patients by maligning AA as a religious fad and by inappropriately prescribing mood-altering drugs to patients who were already addicted to or abusing mood-altering drugs.

Clearly, this new "system" wasn't working, either. It was too dogmatic and devisive. The counselors were pushing AA dogma; and mental health professionals were selling psychotherapy. AA counselors told their toxic mental patients "You're not mentally ill – you're just a drunk," and the mental health professionals who saw addiction as "symptomatic of an underlying disorder" told their patients: "If we treat your mental illness, your drinking problem will go away;" or worse yet . . . "you will then be able to drink like normal people."

In this new system, the purely alcoholic and the mildly neurotic got better, but the rest kept getting sicker.

The Latest New Answer The latest and most successful approach is called dual diagnosis. It turns out that some of the substance abuse cases (in AA terminology those who (1) keep falling off the wagon, (2) are not ready for treatment or (3) are "sicker than others") often have additional "co-morbid" emotional/psychiatric problems that are severe enough to interfere with standard 12-Step rehabilitation programs.

To make the treatment of these dual – or multiple, as I call them -- patients more effective, "lay counselors" have to become professionals (or be phased out, like the shrinks who wouldn't change). They've learned to recognize psychopathology and to ask for a psychiatric consultation when appropriate. In the same way, mental health professionals are learning about addictive behavior and how to guide some of their patients to appropriate 12-Step programs, combined with appropriate psychotherapy and carefully prescribed – and monitored – psychoactive medication.

This unified approach is successful in those hospital where trained counselors and mental health professionals have learned to give up their personal need for total control of dual-diagnosis patients, and instead, cooperate and share the control, responsibility and professional satisfaction that comes from treating such patients successfully through a team approach.

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