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Examining the Perceptions of Counselor's Work with Persons with Single or Dual Diagnosis

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Poem to Elijah

I dreamed you into me

I dreamed you into your own existence
I loved you into my world
My belly began to nurture and an adventure unfolded
My world began to transform
My steps became more watchful because I had a fresh responsibility
A new sense of duty, a grand obligation
I was carrying a modest miracle
I marvel your life
My Son, My Happiness
And in this short time,
All that you have taught me lil' Elijah
I promise to mold you into more than you are now
Now you are my hero, later you will be a Man
You learn from me
Or do I learn from you
You've taught me patience,
You've taught me to take a seat and enjoy being
You've demonstrated what it means to be untroubled
You've confirmed the true beauty of love without reservation
You've showed me the satisfaction of taking care of needs and wants other than my own
You are marvelous
With all the education I have, You…
You've taught me to be free
You are my silent partner with my heart in your hands
You are the biggest part of me,
When I pray I thank God because at last
I have proof that
My dreams do come true

Signed: Komekia E. Peterson

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Abstract

The prevalence of persons with dual diagnosis has considerably increased throughout the past 20 years. Adequate counseling and treatment services are necessary to assist these persons with a successful recovery. This paper outlines areas of concern by counselors and clients; Prevalence, Homelessness and dual diagnosis, Reason for use, Reason for use Triggers and relapse, Medication, Treatment challenges, and Counseling challenges. Adequate treatment therapies and programs are outlined. Results of a questionnaire are included along with the implications for counselors.

Review of the Literature

Definitions

Throughout research there were several terms to describe the occurrence of mental illness and substance use disorder within an individual. Throughout this paper this incidence will be referred to as mentally ill chemically addicted (MICA), co-occurring, co-morbidity for they all hold the same meaning. Brems, Burke, and Johnson (2002) noted that the co-occurrence of substance use and other psychiatric disorders has been labeled in a variety of ways, including co-morbidity, dual diagnosis, and “mentally ill chemically addicted” (MICA). Kranzler and Rosenthal (2003) stated that dual diagnosis and co-morbidity is defined as the presence of any co-occurring condition in a patient with an index disease. McKeown and Stowell-Smith (1998) stated that dual diagnosis is becoming a fashionable term to describe and demarcate groups of service users who have severe and enduring mental health problems and concurrently use substances. The term dual diagnosis “is rapidly achieving prominence in the dualistic practice arenas of mainstream psychiatry and drug treatment services; pointing to the need for both improved professional training and focused research” (McKeown & Stowell-Smith, 1998). Clancy, Crawford, and Crome (2003) reported that comorbidity is the co-occurrence of two or more disorders; Psychiatric symptoms must be distinguished from psychiatric disorders: many drugs cause psychiatric symptoms that do not persist as disorders. This project described the prevalence of dual diagnosis along with defining specific disorders for the reader. The scope

of the problems facing individuals with Dual Diagnosis will be examined along with reasons this population is so greatly affected. Theoretical models, counseling implications, and consumer concerns will be presented as possible preventive measures and treatment goals.

Prevalence

Fioritti and Solomon (2002) stated that in the United States, during the past 20 years, there has been an increasing interest in the treatment of patients who have both a psychiatric and a substance use problem. It is extremely common for individuals with mood disorders to self medicate their disorder with alcohol or drugs. McDermut, Mattia, and Zimmerman (2001) reported that cormibidity among mental disorders appears to be the norm, especially for mood and anxiety disorders, and to significantly impact on treatment approach, prognosis, and outcome. In addiction, Degenhardt, Hall and Lynskey (2001) found that multiple drug use and multiple substance use disorders also occur at a high rate in community and treatment samples. It is believed that approximately 4 million adults in the United States suffer from serious mental illnesses and are either abusing or dependent on psychoactive substances (Substance Abuse and Mental Health Administration, 2003).

Research has proven a powerful correlation between substance use disorders with other psychological and personality disorders. Farrell (2001) noted that drug dependence, among all the substance use disorders, holds the strongest association with other mental disorders. Research specifies a high

incidence of personality disorders along with other precursors in substance abuse. “Similar personality dimensions appear to act as risk factors, mediators, moderators, or consequences of the development, progression, and outcome of both substance abuse and personality disorders“ (Barnes, 1983). These findings are also found in various age groups for insistence adolescent and young adults. Abrantes, Brown, and Tomlinson (2004) found that numerous studies have highlighted the elevated co-occurrence of psychiatric disorders and substance abuse in adolescent treatment samples. Mood disorders; anxiety disorders; attention-deficit/hyperactivity disorders (ADHD); and conduct disorders (CD), which is the developmental precursor to adult antisocial personality disorder (American Psychiatric Association, 1994), all have very high rates of comorbidity with SUD’s among adolescents in treatment (Abrantes, Brown, & Tomlinson, 2004). In the National Comorbidity Survey, Kessler, Nelson, McGonagle, Edlund, Frank, and Leaf (1996) estimated that approximately 51% of those with a lifetime mental health disorder also had a lifetime substance use disorder; likewise, about 51% of those with a lifetime substance use disorder also had a co-occurring lifetime mental health disorder.

Dually diagnosed clients make up the majority of clients receiving services from mental health agencies. Kahn (2007) noted it is estimated that a third of patients in mental health services have a substance misuse problem and half of patients in drug and alcohol services have a mental issue. There is an immense need for therapy among dually diagnosed persons. Clients of addiction

treatment services who have co-morbid disorders tend to be more severely affected and to have worse treatment outcomes (McLellan, Luborsky, Woody, O'Brien & Druley, 1983). Kessler et al (1996) noted that the considerable overlap of substance use disorders and other mental disorders has been conclusively shown in community and treatment samples. It is vital that Counselors are aware of the needs of persons with dual diagnoses and the importance of effective treatment. El-Guebaly (2006) stated that there is a large number of people with mental illness also struggle with substance abuse…mental health and addiction services, have traditionally operated in their own silos—often to the detriment of patients who suffer from what is commonly referred to as "concurrent disorders". These persons may also have multiple disorders, which need to be addressed and treated by mental health care providers as well. It has also been shown in community samples that having multiple mental disorders is associated with a higher level of distress and lower quality of life (Gamma & Angst, 2001) and with the use of community mental health and addiction services (Kessler, McGonagle, Zhao, Nelson, Hughes, &, Eshleman, 1994). Dickey, Normand, Weiss, Drake, and Azeni, (2002) have shown further that persons in clinical settings with concurrent mental and substance use disorders are also at higher risk for a range of other physical illnesses.

The following section will provided definitions of substance abuse disorders along with psychiatric and personality disorders**.** The literature review

will explore definitions of Substance Related Disorders, Mood disorders, psychotic disorders and personality disorders, scope of the problem, reasons for use, homelessness and dual diagnosis, medical and social needs, treatment, client concerns and counselor challenges when working with dually diagnosed persons.

Defining disorders

The Substance-Related Disorders include disorders related to the taking of a drug of abuse (including alcohol), to the side effects of a medication, and to toxin exposure (American Psychiatric Association, 2000). According to DSM-IV; American Psychiatric Association (1994) substance abuse is described as being diagnosed when an individual has at least one of four symptoms representing recurrent negative psychosocial consequences of use or hazardous use. Dependence of several substances will be described because of the significance of dependence in Substance related disorders. "The essential feature of Substance Dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems" (American Psychiatric Association, 2000).

American Psychiatric Association (2000) defined the following:

- Physiological dependence on *alcohol* is indicated by evidence of tolerance or symptoms of withdrawal. Especially if associated with a history of withdrawal, physiological dependence is an indication of

a more severe clinical course overall (i.e., earlier onset, higher levels of intake, more alcohol-related problems). (p. 213)

- *Cocaine* has extremely potent euphoric effects, and individuals exposed to it can develop dependence after using the drug for a very short period of time. An early sign of *Cocaine* Dependence is when the individual finds it increasingly difficult to resist using cocaine whenever it is available. (p. 242)
- A commonly used form of cocaine in the United States is "*crack*," a cocaine alkaloid that is extracted from its powered hydrochloride salt by mixing it with sodium bicarbonate and allowing it to dry into small "rocks."… *Crack* differs from other forms of cocaine primarily because it is easily vaporized and inhaled and thus its effects have extremely rapid onset. (p. 240)
- Acute *Amphetamine* Intoxication is sometimes associated with rambling speech, headache, transient ideas of reference, and tinnitus. During intense Amphetamine Intoxication, paranoid ideation, auditory hallucinations in a clear sensorium, and tactile hallucinations (e.g. formication or a feeling of bugs under the skin) may be experienced. *Amphetamine*-Related Disorders and other stimulant disorders are often associated with Dependence on or Abuse of other substances, especially those with sedative properties (such as alcohol or benzodiazepines),

which are usually taken to reduce the unpleasant, “jittery” feelings that result from stimulant drug effects. (p. 229)

- Clinically significant maladaptive behavioral or psychological changes (e.g. impaired motor coordination, euphoria, anxiety, sensation of slowed time, impaired judgment, social withdrawal) that developed during, or shortly after, *cannabis* use. *Cannabis* is often used with other substances, especially nicotine, alcohol, and cocaine. (p. 238)
- Most individuals with *Opioid Dependence* have significant levels of tolerance and will experience withdrawal on abrupt discontinuation of opioid substances. *Opioid Dependence* includes signs and symptoms that reflect compulsive, prolonged self-administration of opioid substances that are used for no legitimate medical purpose or, if general medical condition is present that requires opioid treatment, that are used in doses that are greatly in excess of the amount needed for pain relief.

The mood disorders includes disorders that have disturbance in mood as the predominant feature (American Psychiatric Association, 2000). Examples of these disorders are Major depressive disorder, Depressive Disorder Not Otherwise specified, Bipolar I Disorder, Bipolar II Disorder, Substance-Induced Mood Disorder.

- The American Psychiatric Association (2000) defined the following: Major Depressive Disorder is characterized by one or more Major Depressive Episodes (i.e., at least 2 weeks of depressed mood or loss of interest

accompanied by at least four additional symptoms of depression). The pathophysiology of a Major Depressive Episode may involve a dysregulation of a number of neurotransmitter systems, including serotonin, norepinephrine, dopamine, acetycholine, and gamma-aminobutyric acid systems. (p. 353)

- Bipolar I Disorder is characterized by one or more Manic or Mixed Episodes, usually accompanied by Major Depressive Episodes. A Mainic Episode is defined by a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood. Bipolar II Disorder is characterized by one or more Major Depressive Episodes accompanied by at least one Hypomanic Episode. (p. 357)
- Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme stressor involving actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close association. (p. 463)

American Psychiatric Association (2000) described Substance-Induced Mood Disorder as characterized by a prominent and persistent disturbance in mood that is judged to be direct physiological consequences of a drug of abuse, a medication, another somatic treatment for depression, or toxin exposure.

The American Psychiatric Association (2000) stated that the narrowest definition of psychotic is restricted to delusions or prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature. Psychotic disorders are Schizophrenia, Schizoaffective, Delusional Disorder, Substance-Induced Psychotic Disorder will be defined.

The American Psychiatric Association (2000) defined the following:

- Schizophrenia is a disorder that lasts for at least 6 months and includes at least 1 month of active-phase symptoms (i.e., two (or more) of the following: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms i.e. affective flattening, alogia, or avolition. (p. 312)

The American Psychiatric Association (2000) defined Schizoaffective as a disorder in which a mood episode and the active-phase symptoms of Schizophrenia occur together and were preceded or are followed by at least 2 weeks of delusions or hallucinations without prominent mood symptoms. Substance-Induced Psychotic Disorders, the psychotic symptoms are judged to be direct physiological consequences of a drug of abuse, medication, or toxin exposure (American Psychiatric Association, 2000).

The American Psychiatric Association (2000) noted the following:

> The essential feature of a Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture and is manifested in at least two of

> the following areas: cognition, affectivity, interpersonal functioning, or impulse control. (p. 686)

Paranoid Personality Disorder, Antisocial Personality Disorder, Borderline Personality Disorder, Dependent Personality Disorder and Obsessive-Compulsive Personality Disorder will be defined.

American Psychiatric Association (2000) defined Paranoid Personality Disorder as “a pattern of distrust and suspiciousness such that other’s motives are interpreted as malevolent” (p 690). Antisocial Personality Disorder is a pattern of disregard for, and violation of, the rights of others (American Psychiatric Association (2000). American Psychiatric Association (2000) defined Borderline Personality Disorder as “a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity” (p. 706). “Dependent Personality Disorder is a pattern of submissive and clinging behavior related to an excessive need to be taken care of” (American Psychiatric Association, 2000 p. 721). American Psychiatric Association (2000) defined Obsessive-Compulsive Personality Disorder as “a pattern of preoccupation with orderliness, perfectionism, and control” (p.685).

Scope of the problem

Kessler, Crum, Warner, Nelson, Schulenberg, and, Anthony (1997) noted the rate of co-occurring substance misuse and psychiatric disorders is high. Drug use disorders have been shown to hold a stronger association with psychiatric disorders (Kessler, Nelson, McGonagle, Liu, Swartz, & Blazer, 1996).

Seigfreid (1998) found that an individual with schizophrenia is three times more likely have an alcohol use disorder and six times more likely to have a substance use disorder than the general population. Mueser, Bellack, and Blanchard (1992) stated that alcohol is the most commonly used and abused drug among people with mental disorders. Increasingly, mental health professionals recognize the need for assessment and treatment of alcohol and other drugs use disorders in their clients (Lehman & Dixon, 1995; Solomon, & Zimberg & Shollar, 1993).

Dually diagnosed persons are more prone to life stressors. Drake, Bartels, Teague, Noordsy, and Clark (1993) found the following:

> Persons with co-occurring serious mental illness (SMI) and substance use disorder (SUD) have greater depression, sociality, and proneness to violence; more noncompliance with medication and other treatments; increased risk of HIV infections; increased family burden and legal troubles; and higher serious utilization and cost. (p. 181)

Physical illness is also a concern among individuals with dual diagnoses because the rate of illnesses is higher. Dickey, Normand, Weiss, Drake and Azeni (2002) have shown further that person's in clinical settings with concurrent mental and substance use disorders are also at higher risk for a range of other physical illnesses. American Psychiatric Association (2000) found that seizures, HIV infections, malnutrition, gunshot or knife wounds, nosebleeds, and cardiovascular problems are often seen as presenting problems… a history of Conduct Disorder

and adult Antisocial Personality Disorder may be associated with the later development of Amphetamine-Related Disorders.

Stress and medical concerns

Research has shown that there is a strong link between stress and substance abuse. Goeders (2004) stated that people exposed to stressors other than combat, such as unhappy marriage, dissatisfaction with employment, or harassment, also report higher-than-average rates of addiction.

Goeders (2004) noted the following:

> One explanation for the high co-occurrence of stress-related disorders and drug addiction is the self-medication hypothesis, which suggests that a dually diagnosed person often uses the abused substance to cope with tension associated with life stressors or to relieve symptoms of anxiety or depression resulting from a traumatic event. (p. 33)

Zaslav (1994) also found the following:

Combat veterans, especially those with posttraumatic stress disorder (PTSD), appear to have an elevated risk for substance abuse…veterans with PTSD typically report more use of alcohol, cocaine, and heroine than veterans who do not meet the criteria for diagnosis of PTSD.

The Laudet, Knight, Magura, and Vogel (2004) study sought to examine stated reasons for initiation of, cessation of, and relapse to substance use to explore the perceived association between substance use and mental illness among dual diagnosis persons. Peer pressure or the need to “fit in” was the major influence

among adolescence. Becker and Luthar (2002) stated that the roles of peers has long been acknowledged as a prime, if not the strongest influence on adolescents in the initiation of substance use.

Persons with dual diagnosis have a great need for medical attention overall. Hoff and Rosenheck (1998) cited that…cormorbid patients have significantly higher overall health care cost than those with substance-use disorders alone.

Homelessness and dual diagnosis

The dual diagnosis population has a high tendency to also suffer from homelessness. Drake, Robert, Osher, Fred, Wallach, Michael (1991) noted that people with comorbid conditions have difficulty maintaining stable housing and are, therefore, prone to homelessness. Drake, Robert, Osher, Fred, Wallach, Michael (1991) also reported that people who are dually diagnosed with severe mental illness and substance use disorder constitute 10-20% of homeless persons. Homeless people with dual diagnoses are often overlooked due to their financial circumstance. Fischer (1990) reported that in addition to mental illnesses, and substance use disorders, many homeless persons have general medical illnesses, legal problems, history of trauma, behavioral problems, skill deficits, and inadequate or anti-social support systems. Due to the additional support needed to assist these individuals, they are often provided with multiple services. “Programs for the dually diagnosed homeless population generally offer an amalgam of services elements adopted from mental health or substance

treatment programs (National Resource Center on Homelessness and Mental Illness, 1990). Drake, Wallach, Teague, Freeman, Paskus, and Clark (1991) reported that common program elements include comprehensive assessment, intensive case management, supported housing, peer groups for support and therapy, training in independent living skills, and mental health and substance abuse treatment. Person's dual diagnosis benefit greatly from intense treatment. In a recent study Gonzalez and Rosenheck (2002) found that among homeless persons with diagnosis of SMI with and without a co-occurring SUD found that among clients with dual diagnoses, those who reported extensive participation in substance abuse treatment showed clinical improvement.

Reason for use

Reasons for substance use is vital when understanding and treating dually diagnosed persons. Laudet, Knight, Magura, and Vogel (2004) noted that what substance users believe concerning what drives their substance use may be a crucial determinant of substance use behavior, including whether they continue or return to substance use. Titus, Dennis, White, Godley, Tims, and Diamond (2002) found that wanting to use also refer to wanting to "get high," often cited by substance users as a reason for continuing to use. Negative emotions like sadness, anxiety and anger have been founds as reasons for dually diagnosed persons to use. Havassy, Wasserman, and Hall (1993) noted that it may be even more difficult to handle for dually diagnosed persons, who are also experiencing

psychiatric symptoms and/or medication side effects and who may not have adequate skills to cope with negative emotions.

Substance use is typically motivated by short-term considerations in persons with co-occurring SMI and SUD, as in their single disorder counterparts (Drake, Wallach, Alverson, Mueser & 2002). Across studies conducted, Addington and Duchak (1997) found that among both current and past substance misusers with a psychiatric disorder, reasons for substance use include to increase happiness, energy, and emotions, to relax and to go along with the group; to decrease anxiety; to increase pleasure; to get high; and to reduce depression. Many persons with dual diagnosis do not have a social support system. Test, Wallach, Allness, and Ripp (1989) found that social isolation has been previously associated with substance use among persons with SMI. Boys Marsden, and Strang, (2001) also found that boredom is frequently cited as a reason for substance use by both single disorder and dually diagnosed substance users.

Research has shown that typically dually diagnosed individual's drug use is due to wanting to use as apposed to having a physical dependence. Physical cravings may not play a major role in substance use among persons with co-occurring SMI and SUD, as many use rather small amounts of drugs and are less likely than other substance abusers to develop the physiological syndrome of addiction (Drake, Osher, Noordsy, Hurlbut, Teague & Beaudett, 1990). In a study conducted between recent substance users with psychotic disorders

Warner, Taylor, Wright, Sloat, Springett, Arnold, and Weinberg (1994) reported a significant association between lack of structured activity and cited boredom as the most significant reason for substance use.

Triggers and relapse

Triggers pose a major threat to the recovery of dually diagnosed persons. In a recent study Laudet, Knight, Magura, and Vogel (2004) described triggers as perceived reasons for relapse: “What was going on inside of you (thoughts, feelings) that triggered you to use”. Results from this study show the “two most frequent internal reasons for returning to substance use were loneliness/boredom and the desire to use (cravings)” (Laudet, Knight, Magura, & Vogel, 2004). Laudet, Knight, Magura, and Vogel (2004) described the external circumstances perceived to have been associated with relapse, temptation to use, stress, and increased responsibility. Relapse to addiction occurs frequently when the individual is exposed to outside imagery, for instance exposing an addict to a familiar atmosphere. Robbins, Ehrman, Childress, and O’brien (1999) noted that simply exposing an addict to environmental stimuli or cues previously associated with drug taking can also produce intense drug caving.

Geoders (2004) found the following:

> Such environmental stimuli include locations where the drug was purchased or used, the individuals the drug was purchased from or used with, and associated drug paraphernalia. In fact, the cycling, relapsing nature of addiction has been proposed to result, at least in part from

exposure to environmental cues that have been previously paired with drug use. (p. 34)

Theoretical Models of Substance Use

There are several models and theories "implicating a broad range of factors have been advanced to explain increased co-occurring SUD among persons with mental illness (Drake & Wallach, 1998). There is an association between family and drug use among persons with dual diagnosis. Drake, McHugo, Biesanz (1995) added that family history has been shown to be associated with SUD among dually diagnosed persons: A number of studies have found that such persons are more likely to have relatives with SUD than are similar patients with SMI only.

Lieberman, Kane, and Alvir (1987) described the *supersensitivity model*, as biological vulnerability due to psychiatric disorder results in sensitivity to small amounts of alcohol and drugs, leading to substance misuse.

Self-medication model is a theory that individual's drugs use is directly link to alleviate particular painful affects. The self-medication hypothesis is described by Khantzian (1985) as "dually diagnosed persons often uses the abused substance to cope with tension associated with life stressors or to relieve or suppress symptoms of anxiety and depression resulting from a traumatic event". Anderson, Brown, Marlatt, McCathy, and Tomlinson (2005) added that individuals are motivated to use alcohol and other drugs in attempt to alleviate distressing symptoms.

A more general explanatory model commonly referred to as "*alleviation of dysphoria*" holds that persons with SMI are prone to dysphoric states that also make them prone to the use of psychoactive substances (Laudet, Knight, Magura, & Vogel, 2004). Drake et al. (1998) also explained dually diagnosed persons are considered to be like others with SUD in that they initiate substance use to feel good or to alleviate feelings bad before the process of addiction supervenes.

There is evidence that cormorbidity can be a result of drug use. Crome (1999) reported the following:

- Substance use (even one dose) may lead to psychiatric syndromes or symptoms
- Harmful use may produce psychiatric symptoms
- Dependence may produce psychological symptoms
- Intoxication from substances may produce psychiatric symptoms
- Withdrawal from substances may produce psychiatric symptoms
- Substance use may exacerbate pre-existing psychiatric disorder
- Primary psychiatric disorders may lead to substance- use disorders
- Primary psychiatric disorders may precipitate substance-use disorders, which may, in turn, lead to psychiatric syndromes. (1999b)

Counseling Implications

Overview Treatment

Up until relatively recently, dually diagnosed patients often fell through the cracks of the treatment system, where mental illness and addiction were typically

addressed independently in different programs by clinicians with and therapeutic training. In a study, Green (2001) diagramed for us the serious inadequacies of our divided systems, and the resulting deterioration and anguish for the consumer; In contrast, her participation in an integrated dual diagnosis program that was accepting of all of her symptoms led to her attainment of sobriety and stability. In order for consumers to receive adequate treatment service providers need to be well trained and knowledgeable to assist persons with dual diagnosis. Seigfried (1998) agreed that integration refers to the provision of comprehensive services by a single service with staff who are competent in both mental health and drug and alcohol skills.

By the late 1980's clinicians and researchers began to recognize that the separation of the mental health and substance abuse treatment programs was a significant part of the problem encountered in treating clients with co-occurring disorders (Alverson, Alverson, Drake, 2002). Mueser, Drake, and Miles (1997) found that interventions that are successful at reducing substance misuse among dually diagnosed persons may also reduce psychiatric symptomatology, emergency service utilization, and the costs of treatment and increase community functioning. Clark, Drake, Mueser, and Wallach (1996), stated "Ten years ago, the only treatment options available for people with co-occurring substance abuse and severe mental illness were parallel treatments in separate programs" (p. 49*).* Brooke et al. (2007) noted that professionals in both the mental health and substance abuse fields should regard co-occurring substance

abuse and mental health disorders as common enough that clients should be screened consistently for both conditions.

There is a great need for treatment among dually diagnosed persons due to the consequences of substance abuse. Knight, Lauded, Magura, and Vogel (2004) stated that the most frequent motivations to quit substance use were the desire for a better life and the negative consequences of drug use. It is also necessary for Counselors to address the basic needs of dually diagnosed clients such as supports within the community. Laudet, Knight, Magura, and Vogel (2004) found that treatment needs to endorse to long-term perspective and involve psychosocial processes that build on natural pathways to recovery, including a combination of substance abuse counseling, social network interventions, and comprehensive attention to other needs, such as employment, housing, or physical health. The initial visit between the counselor and client holds to be the most important because of all the critical history that the client can provide to interpret a treatment plan. Laudet, Knight, Magura, and Vogel (2004) agreed that when initiating treatment it is crucial to receive the history from the consumer to assist with the plan of treatment. Kahn (2007) also shared that it is vital to "elicit a thorough history of recent alcohol and/or drug use to differentiate symptoms of substance misuse from those of mental illness; however symptoms can only be fully discussed when the patient is not under the influence." (p. 37)

Family and social support has a great influence on the course of a client's recovery. Service providers find it important to get close family and friends

involved in treatment in gain a larger scope of the client's life circumstances. Mueser, Drake, and Miles (1997) stated many maintain close involvement with the client's family, employ behavioural strategies to help clients resist social pressures to use substances and approach treatment in stages to ensure optimal timing of clinical interventions. Counselors also face the challenge of educating family members on dual diagnosis. Daley and Douaihy (2006) noted that family members battle different challenges than the stricken client; support for the family members requires information regarding why someone takes drugs, what causes mental illness, and what is the likelihood that their family member will live their life sober. There are many mechanisms that build a successful treatment process. Consumers report several characteristics that are important for Counselors to have when working with them, which are empathy and understanding, and respect.

Brooke et al. (2007) cited the following research studies:

> Consumers have identified critical components of treatment including beneficial therapist characteristics, such as compassion, respect, communicating an expectation of success, and willingness to go into the communities in which their clients reside (Arnkoff & Glass, 2000) as well as specific treatment strategies facilitative to recovery including psychoeducational efforts, social skills training, and stress management techniques. (Barnes, Carey, Carey, Maisto, & Purnine, 1999)

Treatment models and approaches

It is essential that treatment teams work closely together when using the various models. Majority of the models include case management, outreach, and group interaction and intervention. Treatment teams, which are, are consistently organized and stable are most helpful to individuals with dual diagnosis. Mueser, Drake, and Miles (1997) noted central to all integrated treatment models is the principle that mental health and drug and alcohol treatments are simultaneously (not sequentially) provided by the same person, team or organization.

Given the complexity of dual diagnosis Counselors often assimilate several approaches to counseling. Many clinicians integrate elements of supportive therapy, cognitive-behavioral therapy (CBT), and motivational techniques in their psychotherapeutic approach to the dual diagnosis patient (Kranzler & Rosenthal, 2003). Therapists often combine techniques specifically for the addiction and mental illness, which can begin during the detoxification process of treatment. It is vital that the clients are equally involved in their treatment as their Counselor for successful recovery. It is best to for Counselors to have clients involved during the beginning of treatment to assist in establishing a sense of responsibility for the client. Kranzler and Rosenthal (2003) agreed that efforts to enhance motivation for recovery can be initiated during the first contact with the patient and can be accomplished by providing non-judgmental feedback to the patient on the specific medical, social, interpersonal, or psychiatric effects of his or her drinking. Additional treatment techniques can be added once the relationship between the client and counselor is established. For example Kranzler and Rosenthal (2003) shared that relapse prevention (i.e.,

CBT) strategies can be added after detoxification is complete, assuming that the patient is adequately motivated for such treatment. CBT is a therapy that concentrates on the application of skills that can be used to manage high-risk situations or reduce psychiatric symptoms. There is a need to focus on both disorders equally, which was described in Minkhoff treatment model for the dual diagnosis population. Minkhoff (1998) emphasized the similarities rather than the differences between the two systems, pointing out that both the addiction and psychiatric treatment models require a focus of engaging the individual in active participation in the treatment and rehabilitation process. During the same year, Osher and Kofoed (1989) outlined, “a conceptual model of integrated treatment and since then many services in the United States have moved towards the integration of mental health and substance abuse treatment” (Drake et al 1990). Motivational interviewing is another intervention, which is based on assisting individual consumers with a dual diagnosis to develop and sustain a commitment to reach a decision to change. This intervention has been designed for individuals with dual diagnosis, which are aware of the need for change, but struggle with implementing change. Fioritti and Solomon (2002) described motivational interviewing as a technique to assist individuals in recognizing and becoming active in dealing with actual or potential problems…techniques are derived from strategies used in client-centered counseling, cognitive therapy, systems theory, and the social psychology of persuasion.

Medication

In many cases clients with dual diagnosis are often prescribed medication to assist in relieving mental health symptoms. Allen, Sajbel, and Stuyt (2006) stated that medications are an essential part of the treatment of patients with both addiction and other mental disorders such as schizophrenia and bipolar disorder. Kranzler and Rosenthal (2003) noted that as with the pharmacotherapy of alcohol dependence, the efficacy of medication treatment of co-morbid disorders is enhanced by concomitant psychosocial interventions, including those that increase medication compliance. Clients are urged to wait until the detoxification process is complete in order to begin medication therapy. Since many psychiatric symptoms subside with abstinence, the use of medication to alleviate such symptoms should generally be postponed until at least one or two weeks of abstinence have been achieved (Kranzler & Rosenthal, 2003).

Consumer's Treatment Concerns

Treatment challenges

Discrimination from service providers is an obstacle that persons with dual diagnosis face. Vaillant (1983) cited that alcohol and drug treatment developed outside the traditional medical care system and, to a significant extent, in reaction to the perception that the medical community, and particularly mental health providers, viewed substance abuse as a moral or characterological problems. In the Laudet et al., (2007) they found that the most mentioned system barrier to recovery was a poor therapeutic environment…poor therapeutic environment was characterized by ineffective treatment strategies that hinder recovery, including a lack of acceptance of relapse and the harm reduction approach to

treatment. Consumers also face a frequent turnover among their service providers, which reduces the belief of dedicated service providers. Laudet et al. (2007) found that clients reported a diminished trust with their case managers due to high turnover rates...thus, given the long term treatment needs of this population, revolving case managers unlikely to establish the much needed rapport with these patients.

Consumers also face life stressor, which make it difficult to fully engage and commit to treatment. Laudet et al. (2000) stated that socioeconomic issues such as poor employment options and finances as well as an inability to handle emotional difficulties were viewed as primary recovery challenges by dually diagnosed individuals.

Self-help

Persons with dual diagnosis attend Alcohol Anonymous (AA) or Narcotics Anonymous (NA) to assist with support during recovery. Some co-morbid persons do not seek the support of these self-help groups because they do not feel as though they belong. “Dual-diagnosis patients may find it difficult to relate to other AA members whose lives may improve more rapidly than theirs as a consequence of abstinence from alcohol” (Kranzler & Rosenthal, 2003, p. 533). Despite the benefits of AA and NA self help groups this population is often hesitate before attending such self-help meetings. Therefore it is helpful if service providers support and encourage clients to attend self-help groups. Kranzler and Rosenthal (2003) reported that although alcoholics with co-morbid

disorders may find AA useful, they often require extra encouragement to initiate and continue attendance at fellowship meetings.

Consumer's assistance to treatment

Client contribution and input adds to treatment advancement by assisting service provides with a alternative point of view regarding which treatment strategies are helpful. Brooks, Malfait, Brooke, Gallagher, and Penn (2007) agreed that consumer input offers a unique opportunity to generate firsthand knowledge about the challenges and successes of current COD treatment programs. Consumer in recovery often become dual diagnosis services providers as a mean of enhancing existing programs. Brooks et al (2007) noted that some former consumers are now mental health professionals, and their criticisms of the oppressive nature of previous treatment models have helped to pave the way for the development of client-centered approaches.

Evidence has shown that clients are likely to have success in recovery when facets of the lives are satisfied. Alverson and colleagues (2000) found four factors that negatively correlated with future relapse: regular engagement in an enjoyable activity (e.g. job, school, hobby), decent and stable housing, a loving relationship with someone sober who accepts the client's mental illness, and a positive relationship with a mental health professional.

Stages of change

It is important for consumer and services providers to be aware of the stage of change a consumer is in. In knowing these the Counselor can address the individual needs of the client. There are five stages of change;

precomtemplation, contemplation, determination, action and maintenance and relapse. Fioritti and Solomon (2002) described client in the precontemplation stage are not yet thinking about changing…they may not yet see a serious problem or conflict or feel its impact. Contemplation is defined by Fioritti and Solomon (2002) as when clients are beginning to consider the current situation as a problem…they may also be aware of the possibility of change; they are open to information but not yet ready to use it or begin changing. Determination- the hallmark of this stage is the decision to take steps to correct a problem; this commitment to correction is made through an assessment of strengths, resources, and activities (Fioritti & Solomon, 2002). The action stage focuses on the developing beneficial and practical activities to become involved in. Fioritti and Solomon (2002) described action, as the implementation of a plan developed in the previous stage is the major feature of this stage; helping clients develop their sense of self-efficacy is an important task of this stage. Maintenance and relapse is the final stage, which promotes the building of new patterns to assist in maintaining stable recovery. Fioritti and Solomon (2002) described the final stage as the activities developed and implemented often lead to new activities which solidify the change.

Counseling challenges

Non-compliance

Overall treatment is challenging for Counselors working with persons with dual diagnosis. Torrey, Drake, Cohen, Fox, Lynde, Gorman, and Wyzik, (2002) described persons with co-occurring disorders are prone to relapse, are less

compliant with medication and treatment, are impaired by social and economic stressors (e. g. homelessness), experience more negative outcomes (e.g., incarceration, HIV, hepatitis C) and often do not respond well to accepted treatments for single diagnoses.

The beginning of treatment can be the most challenging for service providers in regards to engaging consumers. Clients are often noncompliant to treatment rules and guidelines. Kahn (2007) noted that lateness, rudeness and demanding behaviour are common during the initial consultation. The initial meeting is often the most difficult do to the negative behavior of the consumers. “History-taking at the initial consultation can be difficult and frustrating because misusers may be defensive, hostile, frightening and in denial, determined not to admit their addiction, or anything else, including psychiatric symptoms” (Kahn, 2007, p. 37).

Dually Diagnosed persons are difficult to treat due to their non-compliance of outpatient programs. Helmus**,** Saules, Schoener (2003) conducted a study to evaluate the effectiveness of a CM protocol in a community-based dual-diagnosis treatment program. Program therapists have expressed complaints of chronic absenteeism and frequent intoxication among this patient population. Myers, Brown, and Mott (1993) found that poorer coping skills and lower self-efficacy for stress or temptation situations, which are common among youth with mental health disorders, also place adolescents at risk for substance use relapse following treatment.

Lack of Education

Due to the uniqueness of co-morbidity some service providers lack the education and experience of working with both diagnoses. Kahn (2007) noted that research has demonstrated that community alcohol teams are confident when dealing with patients with alcohol-related problems but feel de-skilled when having to help patients with mental health problems as well. Given the commonality of dual diagnosis it is extremely imperative that services provides screen multiple disorders if one is found. Brooks et al (2007) agreed that professionals in both the mental health and substance abuse fields should regard co-occurring substance abuse and mental health disorders as common enough that clients should be screened consistently for both conditions.

Barnard (2002) found that dual diagnosis is often viewed differently by staff in general adult psychiatry and drug services, with different priorities for services input and little liaisons between the two. It has been suggested that there might not just be a gap in services provision, but a chasm. The relationship between staff and clients is often challenged by powers struggles. Brooks et al (2007) stated that negative interactions with staff and an antagonistic (i.e., “Us vs. Them”) power structure between clients, providers, and policy makers also had a deleterious impact on the therapeutic environment. There are many people that oppose the use of medication while in substance abuse recovery. They believe that person’s that take a pharmacotherapy approach to recovery are still self-medicating. Kranzler and Rosenthal (2003) noted that some members of Alcohol Anonymous hold the view that recovery should be medication free and

may discourage patients from taking psychotropic medications prescribed for a co-morbid disorder. Counselor when treating clients with dual diagnosis should address this challenge. Kranzler and Rosenthal (2003) stated that service providers ought to talk with the consumer regarding "the potential for criticism to be leveled against the use of medication. Strategies should be considered that allow the patient to derive the benefits of AA attendance without having it disrupt the treatment of co-existing disorder" (p. 533).

Burn out

There is also a high incidence for Counselor burn out due to the demands of the work with the individuals with dual diagnosis. Dumaine (2003) noted that they consume a greater proportion of time, money, and resources than other populations, yet with worse outcomes; this in turn leads to increased stress on those treating them, resulting in higher levels of burnout in treatment staff.

Summary

There is a great need for dually diagnosed treatment programs to address these diagnosed persons' needs. Laudet, Knight, Magura, and Vogel (2004) stated that the effectiveness of therapeutic interventions is likely to be enhanced if the field can gain a greater understanding of the causes of substance abuse. Universal therapeutic programs have been proven ineffective when treating dually diagnosed persons.

Drake (1990) found the following:

> It is important to investigate this question specifically among dually diagnosed persons rather than generalize from data obtained among

single disorder substance users, because the usual dimension of substance abuse- pattern, consequences, dependence syndrome, and subjective distress are qualitatively different among dually diagnosed persons.

Effective treatment programs will provide coping skills, and support to assist in maintaining recovery. Laudet, Knight, Magura, and Vogel (2004) discussed the need for dually diagnosed persons to develop sobriety-supporting peer networks to help them learn adaptive strategies to deal with the stress and recovery. Treatment will also provide connections among individuals that they may not receive outside the bonds of recovery. Treatment programs should install hope for recovery and provide opportunities for meaningful activities and relationships (Laudet, Knight, Magura & Vogel, 2004).

Method

The review of the literature clarifies the difficulty in treating persons with dual diagnosis. Given the intense need for treatment, the primary investigator chose to use a questionnaire to determine if the needs of treatment differ between individuals with single and dual diagnosis. The following section provides a description of the setting, admissions process, services, outpatient services, participant description, and investigation procedure.

Setting

The organization that these Counselors are employed is viewed as the beacon of Drug and Alcohol rehabilitation treatment. They provide addiction prevention and treatment services through a host of programs designed to

provide help when it's most needed. They are known for treating the entire person, not just the illnesses. They also assist individuals with legal, family, vocational, educational, and interpersonal concerns. They make referrals to appropriate agencies in the community for those who require concentrated treatment.

Admissions process

During the admission process a detailed assessment is received from the consumers to identify all pertinent information. This involves any special needs of the clients; the programs are modified to serve the unique necessities of women, men, people with HIV/AIDS, bilingual consumers and clients with co-occurring mental health and Substance Use disorder diagnoses. Following the assessment, the programs utilize group and individual therapeutic approaches intended to support and encourage consumers.

Services

Services include detoxification; a medically supervised withdrawal service, Inpatient Rehabilitation, Outpatient Services, Esperanza Latina; an Outpatient Services for Spanish-speaking consumers, Community Residential Services, and Supportive Living Apartments.

Outpatient Services

Given the large size of the organization the primary investigator focused on the outpatient program. The outpatient program concentrates on personal rehabilitation while setting objectives that will encourage a sober and drug-free

lifestyle. The outpatient therapeutic program provides services, which address family, interpersonal, medical, mental vocational and educational needs.

Participant Description

In order to protect the participant's identity the primary investigator refers to the participants as Single Diagnosis Counselor #1, Single Diagnosis Counselor #2, Dual Diagnosis Counselor #1, and Dual Diagnosis Counselor #2. These participants were selected for this study following the primary investigator's two semesters of internship. During the internship the primary investigator became familiar with the clients that these Counselors serve as well as the training and educational background of these Counselors. After consulting with the director of the organization and the selected Counselors, it was agreed that they were a suitable fit for the study.

Single Diagnosis Counselor #1 is a master level graduate from a psychology program at a local University. He received a bachelor degree in social work from an out of state University. He began working at this organization seven years ago. Within these seven years he has worked with individuals with single and/or dual diagnoses. He is presently working on his doctorial degree from an online University.

Single Diagnosis Counselor #2 is an associate level graduate from a liberal arts program at a local college. She has worked at the organization for six years. Within these six years she has worked with individuals with single diagnosis only. She received a CASAC certification after two years of

employment at this organization. To maintain her certification she continues educational courses in drug and alcohol education.

Dual Diagnosis Counselor #1 is a bachelor level graduate from a Drug and Alcohol Counseling program at a local University. He has worked at the organization for one year. While employed at this organization he has worked only with individuals with dual diagnoses. He intends to continue his education by pursuing a CASAC certification.

Dual Diagnosis Counselor #2 is a master level graduate from a Counseling program at a local University. She has worked at the organization for two years. While employed at the organization she has worked only with individuals with dual diagnosis. She intends to pursue Licensure and open a private mental health practice.

Investigation procedure

The primary investigator chose to distribute a questionnaire to the Counselors at the organization described above. The primary investigator selected four Counselors. Two counselors served persons with dual diagnosis and two served individuals with single diagnosis. The primary investigator experienced working with consumers with single and/or dual diagnosis. The primary investigator noticed a difference in treatment. That is, clients with dual diagnosis received more education than those with single diagnosis. Prior to research the primary investigator inquired about the reasons for the difference in treatment. The primary investigator concluded that individuals with dual diagnosis benefit from a more intense treatment program.

The primary investigator prepared a questionnaire, which addressed differences in treatment of persons with dual diagnosis and single diagnosis. The questionnaire was assembled after all research in the review of the literature. The research along with the internship experience assisted the primary investigator in developing a questionnaire, which addressed the major counselor concerns of individuals with single and dual diagnosis. The goal of the questionnaire was to identify major areas that individuals with dual diagnosis differ from individuals with single diagnosis. This evidence would in turn defend the need for persons with dual diagnosis to have a more intensive treatment program.

The participants were given the questionnaire during work hours at each Counselor's personal work area. The participants were given a consent form that they signed prior to filling out the questionnaire. By signing the questionnaire with their job title and the clients they serve they gave the primary investigator consent.

Results

The most relevant results will be presented. The answers on the questionnaire varied in the responses of, *yes, no*, and *somewhat*. The Counselors were asked to explain any somewhat responses. The participants provided the Counselor with additional comments to most of the questions. This assisted the primary investigator with a more complete view of their perceptions.

Counselors- Survey Results

Five areas of Counselor's perceptions of their work with clients will be examined, which included attendance and compliance with treatment, stages of changes, rate of relapse, and mental health treatment.

Counselors of: Single and Dual Diagnosis clients.
Number of Counselors surveyed: 4.
Number of responses: 4.

		Single Diagnosis Counselor #1	Single Diagnosis Counselor #2	Dual Diagnosis Counselor #1	Dual Diagnosis Counselor #2
1.	Do you think you were properly trained and educated to work with the population that you serve?	YES	SOMEWHAT	SOMEWHAT	YES
2.	Do you think your clients have difficulty with attendance?	YES	SOMEWHAT	YES	YES
3.	Do you think your clients struggle with their compliance with treatment guidelines?	YES	NO	YES	YES
4.	Do you think that of your clients enter the program while they are in the pre-contemplation stage of change?	YES	NO	NO	YES
5.	Do you think you clients you serve relapse and drop out of treatment at a high rate?	YES	NO	YES	YES
6.	Do you think your clients are receiving adequate mental health treatment and support?	NO	YES	NO	YES

7.	Do you perceive the dually diagnosed population to be a more challenging population to work with than those with a single diagnosis?	YES	YES	YES	YES
8.	Do you think there are valid reasons for person's dually diagnosed to have more intense treatment than those with a single diagnosis?	YES	YES	YES	SOMEWHAT
9.	Do you understand the need to separate the dually diagnosed population from those with a single diagnosis?	YES	YES	YES	YES

10. In your own perception, what is the most challenging part of working with the population you serve?
Single Diagnosis Counselor #1: Keeping clients in treatment.
Single Diagnosis Counselor #2: Keeping them focused in Group treatment.
Dual Diagnosis Counselor #1: Being available to assist them in general, because there are not regulations specific to this population. We are often between following mental health, and chemical dependency regulations. There are none specific to dual disorders.
Dual Diagnosis Counselor #2: Their struggle for awareness

Additional Explanations for Questions 1-9

1. Do you think you were properly trained and educated to work with the population that you serve?
Single Diagnosis Counselor #1: None
Single Diagnosis Counselor #2: CASAC training emphasizes CD elements more that MH behavioral and co-occurrence.
Dual Diagnosis Counselor #1: My degree is in addiction therapy, but I have perused training in mental health and dual diagnosis.
Dual Diagnosis Counselor #2: I think I am properly trained and educated but I am always open for new knowledge and skills.

2. Do you think your clients have difficulty with attendance?
Single Diagnosis Counselor #1: None
Single Diagnosis Counselor #2: Some do and some don't
Dual Diagnosis Counselor #1: For many reasons, medication effects, multiple appointment, mental health symptoms.
Dual Diagnosis Counselor #2: Do to the nature of this population there are struggles with attendance.

3. Do you think your clients struggle with their compliance with treatment guidelines?
Single Diagnosis Counselor #1: None
Single Diagnosis Counselor #2: Their behavior indicates choice vs. struggle with behavioral change
Dual Diagnosis Counselor #1: Most individuals in early recovery struggle to remember expectations, at the issues listed in last question, and this becomes even more difficult.
Dual Diagnosis Counselor #2: Because many struggle with rules

4. Do you think that of your clients enter the program while they are in the pre-contemplation stage of change?
Single Diagnosis Counselor #1: None
Single Diagnosis Counselor #2: Most clients are clear about their need to change.
Dual Diagnosis Counselor #1: I think most of my clients are contemplating
Dual Diagnosis Counselor #2: Many clients are mandated by Dept. of Social Services

5. Do you think you clients you serve relapse and drop out of treatment at a high rate?
Single Diagnosis Counselor #1: None
Single Diagnosis Counselor #2: Not at a high rate
Dual Diagnosis Counselor #1: Because they struggle with having to treat multiple diagnoses at one time.
Dual Diagnosis Counselor #2: 85% consistently relapses and /or drop out.

6. Do you think your clients are receiving adequate mental health treatment and support?
Single Diagnosis Counselor #1: None
Single Diagnosis Counselor #2: Most are connected with MH services.
Dual Diagnosis Counselor #1: It is difficult for them to connect with mental health therapy, and there are not enough dual counselors to serve this population.
Dual Diagnosis Counselor #2: At least the hope is that they are receiving the best care.

7. Do you perceive the dually diagnosed population to be a more challenging population to work with than those with a single diagnosis?

Single Diagnosis Counselor #1: None
Single Diagnosis Counselor #2: routes to behavior change are more complex.
Dual Diagnosis Counselor #1: It is important to treat both disorders, which is more challenging.
Dual Diagnosis Counselor #2: Mental illness feeds the addiction and visa versa.

8. Do you think there are valid reasons for person's dually diagnosed to have more intense treatment than those with a single diagnosis?
Single Diagnosis Counselor #1: None
Single Diagnosis Counselor #2: None
Dual Diagnosis Counselor #1: They need treatment for both at the same time.
Dual Diagnosis Counselor #2: It depends on the percentage of mental illness to addiction ratio.

9. Do you understand the need to separate the dually diagnosed population from those with a single diagnosis?
Single Diagnosis Counselor #1: None
Single Diagnosis Counselor #2: None
Dual Diagnosis Counselor #1: Yes, it is important for dual clients to understand their mental illness.
Dual Diagnosis Counselor #2: None

Discussion

Interpretation of findings

This thesis reported on the treatment of individuals with dual diagnosis and counseling implications that could be effective when serving this population. Data from the questionnaire was collected to find out if the primary investigator's research was valid. Overall there is evidence from the four questionnaires that indicates persons with dual diagnosis benefit from a more intensive treatment plan than those with single diagnosis.

All four of the counselors answered *yes* to perceiving the dually diagnosed population to be a more challenging population to work with than those with a single diagnosis. All four also answered *yes* to understanding the

need to separate the dually diagnosed population from those with a single diagnosis.

These findings support the primary investigator's review of the literature. Three counselors answered *yes* to the question whether they think there are valid reasons for people dually diagnosed to have more intense treatment than those with a single diagnosis. Polcin (1992) agreed that chronically mentally ill clients who present with major mental illness and substance abuse have presented major challenges to clinicians in community health settings. The other counselor (Dual Diagnosis #2) answered *somewhat* and further explained, "It depends on the percentage of mental illness to addiction ratio". Single Diagnosis Counselor #3 answered *no* to whether she thinks her clients struggle with their compliance with treatment guidelines, while all other questionnaire participants answered *yes*. Being that both Dual Diagnosis Counselors answered *yes*, it is concluded that person's with dual diagnosis struggle with attendance more so than individuals with single diagnosis. The response to question # 4, which asked whether Counselor thought the clients they serve were in pre-contemplation phase of change, was split 50/50. Contrary to research, this indicated that there is no clear evidence to whether clients with dual diagnosis more likely enter treatment in the pre-contemplation stage of change. Counselors were also split on their responses to question #6, which asked whether they think their clients are receiving adequate mental health treatment and support. However, the primary investigator did not find evidence during research that individuals with

single diagnoses are not receiving adequate mental health treatment and support. The review of literature also showed that counselors are not properly trained or educated to work with persons with dual diagnosis, yet all counselors reported *yes* or *somewhat* to question #1, which asked whether they were properly trained and educated to work with the population that they serve.

Limitations

The most important limitation of the study was the use of four subjects. Given the time constraints of the primary investigator, there were only four subjects. Questioning more subjects would provide a vast view of numerous Counselors' perceptions. Care ought to be applied when broadening these results across all counselors who work with individuals with dual or single diagnoses.

Another significant limitation was the lack of input from the consumers. It is thought that given more time the primary investigator could have also received feedback from the consumers themselves regarding their treatment. Since the questionnaire was only given to counselors, there is no clear understanding of the client's perceptions of their treatment.

The result information is limited because it does not provide rating scales. Also, results are from individuals that work primarily with one group or the other, therefore there may be some bias in the perceptions.

Counseling Implications

Overall, the effects of individuals with dual diagnosis receiving adequate counseling are promising. However, there are key elements that counselors must be aware of; it is vital to educate these individuals on their mental illness and substance abuse disorder equally. Polcin (1992) noted that until more definitive research is available, administrators, clinicians, and professional training programs are advised to adopt a broad clinical perspective of work with dual diagnosis clients that incorporate both mental health and substance abuse treatment modalities. The primary investigator suggests that during the counseling process, it is necessary for counselors to educate, but never lose sight of the whole person they are serving. Individuals with dual diagnosis will benefit from working with counselors that possess adequate education, empathy and an open mind. Renner (2004) added that successful clinical care is based on three critical elements (the "clinician's triad"): an adequate knowledge base, a positive attitude toward the patient and the benefits of treatment, and a sense of responsibility for the clinical problem. Clients with dual diagnosis also benefit from additional treatment, which address their goals, and overall compliance with treatment. In A Feasibility Study (2003) researchers found that other successful targets for reinforcement have included completion of treatment goals (Petry, Martin, Cooney, & Kranzler, 2000), therapy attendance (Helmus, Rhodes, Haber, & Downey, 2001), job training attendance (Silverman, Svikis, Robles, Stitzer, & Bigelow, 2001), and medication compliance (Liebson, Tommasello, & Bigelow, 1978).

Counselors and those they serve would greatly benefit from comprehensible treatment plan specifically for persons with dual diagnosis. The primary investigator did not find any definite evidence of this during the review of literature or research, however it is suggested that counselors and all other service providers create a principle for treatment. Polcin (1992) stated that a great deal of uncertainty currently exists about what kinds of treatments dual diagnosis clients are receiving and on what theoretical models clinicians are relying for guidance in treatment. Kramer (1995) added that the mental health and addiction fields must be knowledgeable about each other's perspective…that guidelines for appropriate care are needed…also we need to create a battery of assessment, diagnostic and placement instruments.

Conclusion

Given the research and the primary investigator's evidence, it is apparent that individuals with dual diagnosis benefit from intensive treatment programs. It is essential for these persons to have service providers that are well trained, educated, empathic, and willing to learn new techniques of counseling for successful treatment. Levy and Mann (1987), Minkoff (1987b, 1989), Pepper and Ryglewicz (1984), and Pepper, (1987) agreed that the elements of both substance abuse and mental health treatment philosophies were argued as necessary for effective treatment of dual diagnosis clients…also workers should broaden their own treatment approaches as well as learn to validate and incorporate other treatment approaches. Individuals with dual diagnosis also

benefit from additional outside support and resources such as, self-help groups, vocational, housing, medical, family and social supports.

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APPENDIX A

Examining the Perceptions of Counselor's Work With Persons with Single Diagnosis or Dual Diagnosis

The purpose of this project is to examine the perceptions of Counselor's work with their clients; these clients may be diagnosed with either a single or dual diagnosis. This investigator will compare the perceptions of Counselors that work with clients diagnosed with a single diagnosis to those diagnosed with dual diagnosis. Four areas of Counselor's perceptions of their work with clients will be examined, which included attendance and compliance with treatment, stages of changes, rate of relapse, and mental health treatment.

INSTRUCTIONS FOR THIS SURVEY: PLEASE CIRCLE YES/NO OR SOMEWHAT. IF YOU ANSWER SOMEWHAT GIVE A BREIF EXPLANATION. Do not write your name on this survey. Thank you for your time.

1. Do you think you were properly trained and educated to work with the population that you serve**?**

YES/NO/SOMEWHAT

Explain**:**

_____

_____

2. Do you think your clients have difficulty with attendance**?**

YES/NO/SOMEWHAT

Explain**:**

_____

_____

3. Do you think your clients struggle with their compliance with treatment guidelines**?**

YES/NO/SOMEWHAT

Explain**:**

_____

_____

4. Do you think most of your clients enter the program while they are in the pre-contemplation stage of change**?**

APPENDIX B

YES/NO/SOMEWHAT

Explain:

_____
_____
_____

5. Do you think the clients you serve relapse and drop out of treatment at a high rate**?**

YES/NO/SOMEWHAT

Explain**:**

_____
_____

6. Do you think your clients are receiving adequate mental health treatment and support**?**

YES/NO/SOMEWHAT

Explain**:**

_____
_____

7. Do you perceive the dually diagnosed population to be a more challenging population to work with than those with a single diagnosis**?**

YES/NO/SOMEWHAT

Explain**:**

_____
_____

8. Do you think there are valid reasons for person's dually diagnosed to have more intense treatment than those with a single diagnosis?

YES/NO/SOMEWHAT

Explain:

_____
_____

APPENDIX C

9. Do you understand the need to separate the dually diagnosed population from those with a single diagnosis?

YES/NO/SOMEWHAT

Explain:

_____
_____

10. In your own perception, what is the most challenging part of working with the population you serve?

Explain:

_____
_____