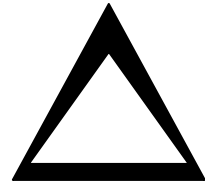


# Module 10E: Comorbidity of Alcohol and Psychiatric Problems



## PARTICIPANT HANDOUT

### Introduction

The term “comorbidity” refers to the co-occurrence of two (or more) diseases, disorders, illnesses, or health problems. Comorbidity can refer to problems that a person experiences over a lifetime (e.g., one problem is in the past, the other problem is current), but this module focuses on issues of current comorbidity. This phenomenon is a significant concern in social work practice. While it is true that each disorder alone may have major implications for how an individual functions, the disorders together may have interactive and overwhelming effects when they coexist. Furthermore, social work interventions may be designed for one of the other disorder, but fail to support the individual who experiences co-occurring problems. For example, a group treatment program for alcohol relapse prevention may not be able to manage the special circumstances introduced by a member who also has schizophrenia.

This state of affairs in social work practice (and other professions) is partially attributable to historical and contemporary reimbursement methodologies that preclude dual diagnoses and multi-faceted interventions. It is also attributable the lack of training in mental illnesses among substance abuse specialists and, vice versa, the lack of training in substance problems among mental health workers (Rosenthal & Westreich, 1999). This module explores the comorbidity of alcohol and mental health problems. It was developed because social work and other professional service delivery systems are often characterized by inadequate assessment, diagnosis, and treatment of comorbid alcohol and mental health problems (McCabe & Holmwood, 2001). The module integrates content related to the epidemiology of comorbidity; screening, assessment, and diagnosis; and, intervention options relevant to social work practice with individuals experiencing comorbidity of alcohol and mental health problems.

### Learning Objectives

By the end of this module, learners should be able to:

- A. Understand the epidemiological data surrounding comorbidity of alcohol and mental health problems
- B. Address issues of assessment and diagnosis related to these comorbid phenomena
- C. Recognize and develop appropriate intervention strategies related to comorbid phenomena

## Background

One way to identify comorbidity is when a client has an alcohol use disorder (abuse or dependence) as defined in DSM-IV, and at the same time, has another psychiatric disorder, also as defined in DSM-IV. The DSM-IV, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, is published by the American Psychiatric Association (2000). It provides standardized definitions of the main mental and psychiatric disorders seen in the United States. The DSM-IV also provides health care providers with a common language that enables them to understand each other when they communicate about psychiatric disorders. For example, it standardizes the use of the common terms “depression,” “phobia,” and “psychosis.”

The DSM-IV defines two major classes of disorders related to alcohol problems: alcohol dependence and alcohol abuse. It is important to know that a condition cannot be considered as a “primary” or independent psychiatric disorder if its features can be entirely accounted for by the expected effects of intoxication and withdrawal. These features are listed in the DSM-IV separately for alcohol and other major drugs of abuse. It is also important to recognize that much more is known about comorbidity in adult populations than is known about comorbidity among adolescents (Kandel, Johnson, Bird, Weissman, Goodman, & Lahey, et al., 1999).

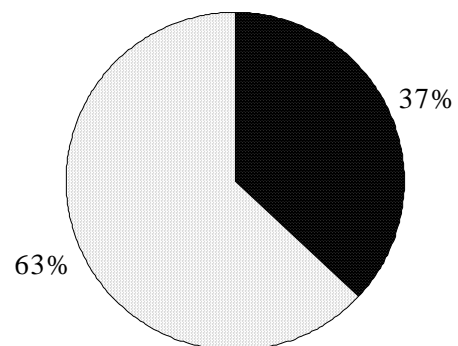
### Epidemiology of Comorbidity

The total number of people in the United States who have had psychiatric problems during their lifetime is substantial, particularly when disorders such as generalized anxiety and depression are considered along with severe, major disorders such as schizophrenia and bipolar disorder. The most recent Surgeon General’s report shows that one in five Americans have had psychiatric problems. Individuals who have one of these types of problems are at greatly increased risk of having another type, as well. For example, alcohol dependence increases the risk of major depression by more than four-fold.

It is likely that practitioners vastly underestimate the presence of comorbidity (Rosenthal & Westreich, 1999). Reiger, et al. (1990) report that 37% of individuals who suffer alcohol dependence or abuse also experience a co-existing mental disorder. In other words, among persons with a lifetime prevalence for alcohol abuse or dependence, comorbid mental disorders occur at greater than expected rates compared to the general population.

According to the National Comorbidity Survey (Kessler, Crum, Warner, Nelson, Schulenberg, & Anthony, 1997), the lifetime co-occurrence of psychiatric disorders with alcohol abuse and dependence is considerable (see Table 1). Among men who have alcohol dependence, 35.8% also have an anxiety disorder (GAD, panic, phobia), 28.1% have a mood disorder (major depression, dysthymia, mania), 29.5% have drug dependence disorders, and 16.9% also

37 % of those with alcohol use disorders also have psychiatric disorders



have an antisocial personality disorder. Among women with alcohol dependence, the relationships are even stronger: 60.7% also have an anxiety disorder, 53.5% a mood disorder, and 34.7% drug dependence disorders. Antisocial personality disorders are observed less frequently among women (7.8%). Attention Deficit Hyperactivity Disorder (ADHD) and Post-Traumatic Stress Disorders (PTSD) are not included.

**Table 1: National Comorbidity Survey** (Kessler, et al, 1997)  
Lifetime Co-occurrence of Psychiatric Disorders with Alcohol Dependence

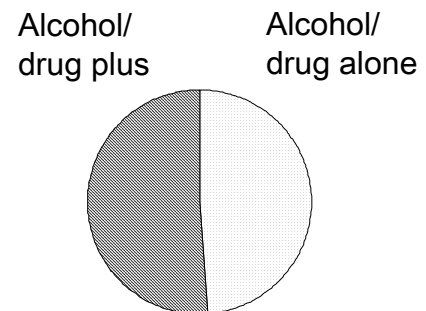
Psychiatric disorder	Individuals with alcohol dependence			
	Men		Women	
	%	OR	%	OR
Anxiety	35.8	2.2**	60.7	3.1
Mood	28.1	3.2**	53.5	4.4**
Drug depend.	29.5	9.8**	34.7	15.8**
Antisoc personality	16.9	8.3**	7.8	17.0**

\*\*Odds ratio significantly different from 1 at .05, 2-tail test

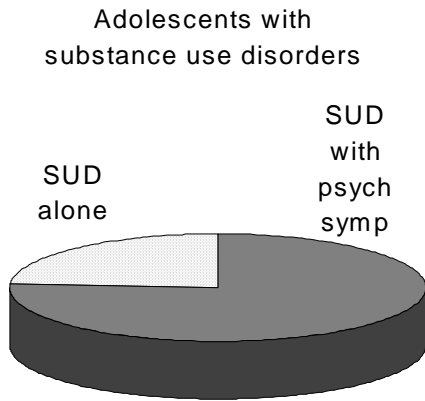
It is estimated that slightly more than 50% of individuals who experience alcohol, drug or mental health disorders will have two or more disorders over their lifetimes. A particularly high prevalence rate of morbidity is concentrated in about one sixth of the population who have three or more comorbid lifetime disorders (Rosenthal & Westreich, 1999).

An important statistic related to comorbidity is the “odds ratio” which shows the extent to which a given factor increases the risk of developing an illness or disorder. The odds ratio is derived from a comparison of rates of the illness among individuals who do and do not also exhibit the factor of interest. A statistically significant odds ratio (significantly different from 1.00 at the .05 level) indicates an appreciable risk associated with a particular factor. For example, an odds ratio of 2.00 indicates a doubled risk of the illness/disorder appearing; an odds ratio of 1.30 indicates a 30% increase in risk.

**Lifetime Comorbidity with Alcohol/Drug Problems**



The odds ratio of lifetime alcohol or drug disorders increases to 2.7 times the normal risk when any mental disorder is present. This jumps to 10-20 times greater than expected when the disorders are schizophrenia, mania, or an antisocial personality disorder. For example, the co-occurrence of schizophrenia and substance abuse or dependence appears to be substantial affecting approximately 50% of individuals with schizophrenia (Swofford, Scheller-Gilkey, Miller, Woolwine, & Mance, 2000). Still more dramatic are the proportions of comorbid disorders observed among individuals seeking treatment (as opposed to the rates above that are based on the general population).



In a study of comorbidity among adolescents, 76% of 14-17 year olds with a substance use disorder also had an anxiety, mood, or disruptive behavior disorder, compared with 24.5% of adolescents with only a substance use disorder (Kandel et al., 1999). In 16 of the 25 youths with substance use disorders, the problematic substance used was alcohol. It is surmised that adolescents with substance use disorders have an even higher risk than adults of also experiencing comorbid psychiatric disorders.

Table 2 shows the current (last 12 months) co-occurrence of a major depressive disorder and drug use disorders with alcohol abuse and dependence. Many individuals with alcohol use disorders also use or abuse other substances. Poly-substance abuse further complicates the diagnostic and assessment picture, as well as the intervention process. This is, in part, due to the fact that each category of abused substance has its own associated intoxication and withdrawal effects, as well as social problems and health risks. A list of intoxication and withdrawal effects recognized for each category of substances can be located in the DSM-IV.

**Table 2. Current (last 12 months) Diagnosis**  
 Percent of individuals with major depression among those with alcohol dependence or abuse.  
 Odds ratios show increased risk compared to individuals without alcohol dependence.

Alcohol Use Disorder	Men		Women	
	% Depressed	OR	% Depressed	OR
Alcohol Dependence	25.38	05.5**	08.3	03.1**
Alcohol Abuse	09.2	02.1**	04.4	03.3**

\*\* Odds ratios significantly different from 1.00 at the .05 level, 2-tailed test  
 Source: Grant and Hartford, 1995.

The lifetime co-occurrence of ADHD and alcohol use disorders ranges from 17-45%. High rates of comorbidity of PTSD and substance abuse are reported among male veterans and women civilians. PTSD increases relapse risk and is associated with relatively poor treatment outcome (Rosenthal & Westreich, 1999).

### Social Work Implications of Comorbidity

Comorbidity of alcohol and psychiatric problems is of significance to social work practice, both because of its frequency and because of its impact. Some psychiatric illnesses serve as risk factors for alcohol use disorders, and others may develop as a result of chronic alcohol use/abuse. However, they do have the power to alter significantly the course and treatment outcomes related to alcohol use disorders (Skinstad & Swain, 2001).

## Functional Impairment

Psychiatric disorders are often associated with considerable impairment. These impairments may affect social, occupational, family, economic, self-care, and/or health functions. Alcohol use problems may further decrease functioning in these domains and leave the individual increasingly vulnerable to legal, community, family, and self-support risks. Furthermore, it seems that individuals who have psychiatric disorders are increasingly vulnerable to hospitalizations when they also have substance use problems (Rosenthal & Westreich, 1999).

Suicide rates are higher among alcoholic individuals with mood lability, depression, and/or dysphoria than among individuals who only experience alcohol use problems (Berglund, 1984). Evidence suggests that comorbid psychiatric disorders are associated with poorer alcohol treatment retention and outcomes (Kranzler, Del Boca, & Rounsaville, 1996). This is particularly evident in the case of personality disorders, which are associated with high treatment dropout and relapse rates (Nace, Saxon, & Shore, 1986).

## Comorbid Disorder Interaction Models

Alcohol use problems and psychiatric disorders can interact in several ways (Rosenthal and Westreich, 1999). The first is a causal relationship in which the psychiatric disorder results in an alcohol use disorder. It is possible that experiencing certain symptoms of psychopathology may place an individual at greater risk of alcohol use disorders, possibly through efforts at self-medication (e.g., individuals “treating” depression or mood disorders with alcohol).

A second causal model is also plausible. A psychiatric disorder or its symptoms may occur as a consequence of alcohol use, and may persist after abstinence. For example, alcohol hallucinosis is substance-induced, but is not self-limited and continues indefinitely after cessation. Substance-induced changes in personality or cognitive capacities might also fit into this category.

A third, more parallel, non-causal process also may emerge. In this model, a person’s problems with alcohol and psychiatric symptoms may develop simultaneously and follow a similar course—symptoms of a disorder emerge while using alcohol but remit with cessation of alcohol use (e.g., hallucinations associated with schizophrenia may increase with use but disappear with cessation). Thus, the individual may not experience a diagnosable comorbid DSM-IV disorder, but does experience symptoms associated with one or more. According to this model, some of the observed vulnerability and risk factors associated with one disorder may also be associated with the other.

In the fourth interactive model, neither disorder caused the other, but the two have become meaningfully linked over time, such that they become an integrated system and each alters the trajectory of the other. Finally, it is possible that the disorders simply co-occur and co-exist with no meaningful interrelationship (e.g., a depressed alcoholic whose symptoms do not remit during prolonged abstinence).

### Interaction Models of Alcohol and Psychiatric Disorders

- Causal: psychiatric disorder results in alcohol use disorder
- Causal: alcohol use disorder results in psychiatric disorder
- Parallel, non-causal: Alcohol and psychiatric problems develop simultaneously and follow similar courses
- Neither disorder caused the other but become linked over time and alter the trajectory of one other
- Disorders co-occur and co-exist with no interrelationship

## Intervention Strategies

In general, treatment and intervention sectors in the U.S. are highly segregated. Social workers (and other practitioners) operating in one sector need to become expert in their own area of specialized practice. As a result, they may not be sufficiently sensitive to the problem of co-occurring disorders, or they may not have sufficient training and skills to operate effectively within the other domain. Furthermore, professionals in one area may experience stigmatizing attitudes concerning the other disorder. For example, mental health workers may not be trained to recognize alcohol use disorders and believe that individuals are “blame-worthy” for their alcohol-related problems. On the other hand, substance abuse workers may not be prepared to work with suicidal individuals and may be intolerant of the behavioral problems associated with many mental disorders. Furthermore, treatment providers tend to believe that comorbid clients are more difficult to treat (Broome, Flynn, & Simpson, 1999). Consequently, clients in many areas of social work practice may be suffering from comorbidity, but the comorbid disorders go unrecognized and untreated and may contribute to treatment dropout.

Persons with comorbid alcohol and mental health problems often differ in their presentation from individuals with alcohol use disorders alone. They may have very different reasons for drinking, as well as different consequences associated with their use of alcohol. For example, alcohol may have potentiating, neutralizing, and/or dangerous health effects in combination with medications prescribed for various mental health problems. Clearly, individuals with alcohol use disorders who are taking medications for co-occurring psychiatric disorders are at risk of dangerous drug interactions. In view of the evidence that comorbidity is associated with additional risks and with poorer outcomes, it is strongly recommended that all individuals with alcohol use disorders also be screened for other mental health disorders.

## Social Work Assessment

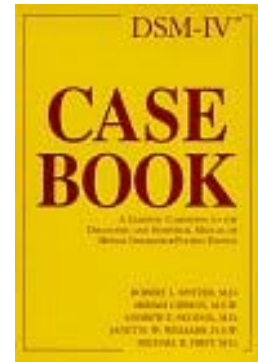
Individuals with comorbid disorders typically present with a confusing array of symptoms and findings (Rosenthal & Westreich, 1999). Assessment is a critical step in planning for intervention. However, it is equally important that social work professionals continue monitoring individuals for symptoms on an ongoing basis. In many settings, evaluation of psychiatric symptoms occurs only at intake. However, psychiatric symptoms may emerge later in the treatment process. An individual may become more comfortable divulging information about a set of symptoms as the course of treatment progresses. Also, achieving abstinence may reveal the existence of a psychiatric problem that was masked by the alcohol abuse. Psychiatric problems that are present during abstinence pose a serious threat to continuing recovery from alcoholism, and thus should be addressed when they occur. Therefore, it is important that social workers remain alert to the possibility of such problems emerging, and that they continue to assess symptoms as treatment continues. It is not wise to assume that a psychiatric problem is the direct result of alcohol problems and that it will remit with abstinence. This needs to be confirmed by ongoing monitoring.

### Assessment:

- Should include both mental health and alcohol/drug measures
- Should occur periodically during treatment, not only during intake  
Should discern mental health and intoxication/withdrawal symptoms
- Should help to avoid over-diagnosing

If symptoms disappear quickly during periods of abstinence from alcohol, they are unlikely to be symptoms of an independent or comorbid psychiatric disorder. Thus, it becomes important to take into consideration the timing of the evaluation in relation to the timing of alcohol use. In some situations, the only way to discriminate between expected effects of alcohol intoxication or withdrawal and symptoms of a comorbid psychiatric disorder is to re-evaluate the symptoms after a period of abstinence (preferably, four or more weeks of abstinence). When this type of comparison is not possible, an earlier period of heavy drinking from the individual's history might be used as a comparative reference point. If the individual did not have the present symptoms at that earlier time, the chances are increased for the onset of an independent psychiatric disorder. The longer the symptoms persist after abstinence begins, the greater this likelihood, as well.

Becoming familiar with these assessment practices is an important step in preventing the over-diagnosis of comorbidity, which may occur when a professional is overly impressed with sub-clinical manifestations of a disorder. Review of the DSM-IV Casebook (Spitzer, Gibbon, Skodol, Williams, & First, 2002) can develop the social work professional's appreciation for true vs. false cases of the disorders.



In addition to using data concerning the timing of the disorders, it is helpful to become informed about the effects of alcohol on the mental symptoms. For example, does alcohol provide relief? Does it cause exacerbation? Does abstinence cause relief or exacerbation of the symptoms? And, does amelioration of the psychiatric symptoms have an effect on patterns of alcohol use? In short, it is important to monitor phenomenology, time course, and etiology (Rosenthal and Westreich, 1999).

Social workers should engage in training opportunities that allow them to become familiar with the symptoms of the most common, as well as the most serious, psychiatric disorders described in the DSM-IV. This would include understanding major depression, phobias, panic disorders, generalized anxiety, schizophrenia, bipolar disorder, and post-traumatic stress disorders. Warning signs of a psychiatric problem may suggest the need for more extensive evaluation or consultation. Such signs can include persistent depressed mood, loss of interest in usual activities, anxiety, or apprehensiveness. They can also include unexplained changes in behavior patterns, or marked worsening of social or occupational functioning.

Numerous structured interviews and questionnaires are available as screening and diagnostic tools for mood, anxiety, and psychotic disorders. Formal training and supervision in the use of a diagnostic interview always sharpens knowledge of the diagnostic criteria and how to apply them. However, even simply reading a diagnostic interview and its associated training materials, or watching training videotapes, can considerably increase one's awareness of psychiatric problems and how to assess them.

Table 3 presents a summary of information on some of the commonly used diagnostic interviews:

**Table 3. Diagnostic Interviews Commonly Used in Research Studies of Comorbidity**

<b>Acronym and Full Name</b>	<b>Diagnostic Coverage</b>	<b>Designed to be administered by:</b>
<b>SCID-I:</b> Structured Clinical Interview for DSM-IV (Axis I disorders)  <a href="http://cumc.columbia.edu/dept/scid/">http://cumc.columbia.edu/dept/scid/</a>	<ul style="list-style-type: none"> <li>▪ Disorders of mood (bipolar, depression)</li> <li>▪ Anxiety (panic, phobia, generalized anxiety)</li> <li>▪ Psychosis (schizophrenia)</li> <li>▪ Substance use (alcohol dependence)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Mental health clinicians (including social workers)</li> <li>▪ Interviewers with some clinical mental health training</li> <li>▪ Physicians</li> <li>▪ Research assistants</li> </ul>
<b>SCID-II:</b> Structured Clinical Interview for DSM-IV (Axis II disorders)  <a href="http://cumc.columbia.edu/dept/scid/">http://cumc.columbia.edu/dept/scid/</a>	<ul style="list-style-type: none"> <li>▪ DSM-IV personality disorders (borderline, antisocial, paranoid)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Mental health clinicians (including social workers)</li> <li>▪ Interviewers with some clinical mental health training</li> <li>▪ Physicians</li> <li>▪ Research assistants</li> </ul>
<b>CIDI:</b> Comprehensive International Diagnostic Interview  <a href="http://www.who.int/msa/cidi">http://www.who.int/msa/cidi</a>	<ul style="list-style-type: none"> <li>▪ Disorders of mood (bipolar, depression)</li> <li>▪ Anxiety (panic, phobia, generalized anxiety)</li> <li>▪ Psychosis (schizophrenia)</li> <li>▪ Substance use (alcohol dependence)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Survey interviewers</li> </ul>
<b>PRISM:</b> Psychiatric Research Interview for Substance and Mental Disorders  <a href="http://www.niaaa.nih.gov/publications/prismd.pdf">http://www.niaaa.nih.gov/publications/prismd.pdf</a>	<ul style="list-style-type: none"> <li>▪ Disorders of mood (bipolar, depression)</li> <li>▪ Anxiety (panic, phobia, generalized anxiety)</li> <li>▪ Psychosis (schizophrenia)</li> <li>▪ Substance use (alcohol dependence)</li> <li>▪ Antisocial and borderline personality disorders</li> </ul>	<ul style="list-style-type: none"> <li>▪ Mental health clinicians (including social workers)</li> <li>▪ Interviewers with some clinical mental health training</li> <li>▪ Physicians</li> <li>▪ Research assistants</li> </ul>

Furthermore, social work training should include recognition of the “expected” effects of alcohol intoxication and withdrawal. Both intoxication and withdrawal can produce symptoms that mimic the symptoms of some psychiatric disorders. Those listed in the DSM-IV include insomnia, anxiety, transient hallucinations, and illusion. While not specified in the DSM-IV, depression often accompanies persistent and heavy alcohol consumption, intoxication, and withdrawal.

Social work education should include developing an awareness of personal and professional biases and beliefs. For example, a social worker who believes that everyone lies about their drinking is unlikely to conduct valuable drinking assessments. Remember that it is highly unlikely that the information will emerge unless direct, unambiguous questions are asked.

Social work training also influences the way that necessary questions are asked. A non-judgmental and non-confrontational manner, with assurances of confidentiality and absence of penalties, greatly improves the quality and quantity of acquired information. Concrete questions that break problems down into small bits are more likely to be successful than complex questions, particularly with those who experience comorbid psychiatric disorders.

Finally, it is important to understand aspects of diversity with regard to the way that symptoms of both alcohol and psychiatric disorders are expressed and experienced. Not everyone follows a stereotypical trajectory. For example, women who develop alcohol dependence syndrome may never manifest symptoms of alcohol misuse such as reckless/drunk driving, or fights/arguments with others.

### **Intervention Options and Comorbidity**

There is, as yet, little scientific validation of the programmatic approaches recommended for individuals who experience both alcohol use and psychiatric disorders (Rosenthal and Westreich, 1999). However, certain principles and rationales have emerged.

#### **Counseling Services**

Non-psychotic alcoholic clients should be able to benefit from the same types of therapy used with the general population of individuals with alcohol use problems, including Cognitive Behavior Therapy, Motivational Enhancement, family therapy, general counseling, and other modalities. However, the treatment should take into account the added psychiatric problems so that their interface with the alcohol problems can be addressed. Furthermore, the treatment setting should be designed to address any behavioral challenges that might be associated with specific comorbid disorders.

Psychotic patients with alcohol problems will probably not be suitable for cognitively oriented treatment, but less structured treatment that deals with both problems and how they can exacerbate one another should be helpful when some control of the psychotic symptoms has been achieved. In this regard, specific information about how alcohol may exacerbate psychiatric problems should be provided (e.g., that alcohol is a central nervous system depressant). Further, concrete and specific discussions about how psychiatric problems may interfere with efforts to achieve and maintain sobriety will probably be needed. Knowledge of good referral sources is important for social workers without specialization in this area.

#### **Medication/Psychopharmacology**

One historical belief system prevalent among alcohol abuse professionals was that psychotropic medications were harmful to alcohol dependent individuals. This was based on an assumption that the use of medication would result in the substitution of one substance dependency for another. Hence, the use of sedatives and other palliative medications for the anxiety and transient hallucination associated with alcohol withdrawal was discouraged. Today, however, terrifically advanced and specific medications are available for the treatment of specific psychiatric problems, and these disorders are increasingly responsive to pharmacological intervention. Provision of adequate and appropriate medication for a psychiatric disorder is believed directly and indirectly to lend support to an individual's efforts to overcome alcohol use problems. Medication is not a substitute for other forms of

treatment, but can be an important adjuvant. However, the principle of parsimony is advised—medicating as little as is necessary without under treating. Hence, it is critical that social work practitioners develop positive referral and consultative relationships with competent psychiatrists and other medical professionals who can evaluate for, prescribe, and monitor appropriate medications.

### **12-Step Groups**

In the past, there have been philosophical differences concerning the use of medication between many mental health professionals and leaders of Alcoholics Anonymous (AA) programs. This resulted in great hesitancy by professionals to refer dually diagnosed individuals to AA groups. Recently, however, parallel independent self-help groups have been developed specifically for people with the “double trouble” of comorbidity. Relatively few of these groups exist (compared to all AA groups), but in communities where they are available, they represent a valuable option. [Potential sources of information include the New York City Intergroup Office of Alcoholics Anonymous (212) 647-1680 or the General Service Office of AA, at (212) 870-3400.] Contact numbers, as well as other helpful information about AA can be found on their website, [www.alcoholics-anonymous.org](http://www.alcoholics-anonymous.org).

It is important for a client to know that the group membership and structure of AA groups differ widely, even within the same local region. Therefore, it is important to try meetings with a few different groups before deciding if AA seems helpful. Some AA voluntary service organizations have an individual or committee that works directly with professionals to provide information about local meetings or groups that might be especially open to individuals with co-occurring alcohol and psychiatric problems.

### **Intensive Case Management**

Clients with comorbid alcohol and psychiatric problems are often in need of many services in addition to their treatment plans. These can include assistance in finding/sustaining housing; financial assistance to cover utility bills and basics such as food, clothing and household items; assistance with accessing entitlement programs like Social Security or disability income; legal advice; child welfare services; health care; and transportation. A case management approach may be essential to organize and maintain coordination of such services for an individual.

### **Additional Considerations**

Some areas have residential care and/or Therapeutic Communities (TC) for substance use problems. However, many of these programs are not equipped to address the challenges associated with comorbidity, and actively screen out these individuals. Social work professionals must advocate for the development of therapeutic communities and residential treatment services for individuals with comorbid disorders, followed by transitional case management support as these persons re-enter community life.

Serial treatment approaches, where one disorder is treated and then the other, and parallel treatments, where each is concurrently treated but without coordination or interaction between services, both appear to be only minimally effective (Rosenthal and Westreich, 1999). Models of integrated treatment have begun to emerge, and treatment with this type of dual focus have been associated with better maintenance of functioning and reduced rates of hospitalization. Integrated treatment is reflected in an individual’s seamless involvement with

programs that have similar philosophical underpinnings, treatment approaches, and psychoeducational content. Service integration of this type appears to improve treatment retention---and treatment retention is a consistent predictor of alcohol treatment success (Broome et al., 1999).

## RECOMMENDED CLASSROOM ACTIVITIES

1. Identify any programs in your area that are specifically designed for the integrated treatment of comorbid alcohol and mental health problems. Identify any programs in your area that are specifically designed for the treatment of alcohol use disorders, but also are responsive to comorbid conditions. Report to your classmates what factors and elements make these programs responsive. If there are none in your area, discuss with your classmates what factors and elements of an existing program could be modified to make it responsive.
2. Select one of the mental health screening instruments and practice (through role-play) administering it to an individual who is being assessed for intake to alcohol treatment. If you need a “case” to relate it to, try case #2 from the comorbidity website: (<http://som.flinders.edu.au/FUSA/PARC/comorbidmain.htm>.)
3. Read and discuss the position statement from SAMHSA regarding the treatment of individuals with co-occurring addictive and mental disorders ([http://www.samhsa.gov/2000archive/centers/cmhs/001011april\\_1999.htm](http://www.samhsa.gov/2000archive/centers/cmhs/001011april_1999.htm)). Also read and discuss the World Health Organization agenda for mental health ([http://www.whomsa.org/it/text3/01\\_agenda.html](http://www.whomsa.org/it/text3/01_agenda.html)).
4. Assign students to visit the dual diagnosis website ([www.toad.net/~arcturus/dd/ddhome.htm](http://www.toad.net/~arcturus/dd/ddhome.htm)). Critique the site for its content related to social work practice with comorbid alcohol and mental health problems.
5. Each student should read the materials on the development of culturally appropriate assessment tools in the study of schizophrenia. Discuss how the content of this material applies to social work practice in the United States. (<http://www.qcsr.uq.edu.au/assessment.htm>)

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