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DOUBLE TROUBLE IN RECOVERY: SELF-HELP FOR PEOPLE WITH DUAL DIAGNOSES

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Abstract

Self-help is gaining increased acceptance among treatment professionals as the advent of managed care warrants the use of cost-effective modalities. Traditional “one disease-one recovery” self-help groups cannot serve adequately the needs of the dually diagnosed. This article discusses Double Trouble in Recovery (DTR), a 12-step self-help group designed to meet the special needs of those diagnosed with both a psychiatric disability and a chemical addiction. DTR differs from traditional self-help groups by offering people a safe forum to discuss their psychiatric disabilities, medication, and substance abuse. Preliminary data collected at four DTR sites in NYC indicate that DTR members have a long history of psychiatric disabilities and of substance abuse, and extensive experience with treatment programs in both areas. They are actively working on their recovery, as evidenced by their fairly intensive attendance at DTR. Recent substance use is limited, suggesting that participation in DTR (in conjunction with format treatment when needed) is having a positive effect. Most members require medication to control their psychiatric disabilities, and that alone may make attendance at “conventional” 12-step groups uncomfortable. Ratings of statements comparing DTR to other 12-step meetings suggest that DTR is a setting where members can feel comfortable and safe discussing their dual recovery needs.

Introduction

There is a high prevalence of persons diagnosed with both a psychiatric disability and a chemical dependency in the United States, as evidenced by both epidemiological data and studies of treatment-seekers in substance abuse and mental health programs (Dixon, Haas, Weiden, Sweeney & Frances, 1991; Gawin & Kleber, 1985; Greenfield, Weiss & Tohen, 1995; Hesselbrock, Meyer & Keener, 1985; Kleinman, Miller & Millman, 1990; Marlowe et al., 1995; Mirin, Weiss & Michael, 1988; Rounseville, Anton & Carroll, 1991; Rounseville, Kosten, Weissman & Kleber, 1986; Rounseville, Weissman, Kleber & Wilber, 1982; Weiss et al., 1986). There is also evidence that those with lifetime comorbidity are more likely than those with a single disorder to experience major impairments in economic roles (e.g., unemployment,

financial problems) and social roles (e.g., social isolation, interpersonal conflicts; see Kessler, 1995).

Formal treatment and traditional self-help groups have fallen short of meeting the special needs of the dually diagnosed. In this paper, we discuss Double Trouble in Recovery (DTR), an innovative 12-step self-help program designed specially to meet the needs of persons in dual recovery. Preliminary findings about DTR are presented and discussed.

Formal Services and Their Limitations

Comorbidity has many far-reaching treatment implications. There is evidence that comorbid disorders are more severe and chronic than single, "pure" psychiatric disorders (Hagnell & Grasbeck, 1990; Hirschfeld, Hasin, Keller, Endicott & Wunder, 1990; Kessler, 1995; Murphy, 1990). Comorbidity is a predictor of negative treatment outcomes among substance abusers (Brooner et al., 1990; McLellan, Luborsky, Woody, O'Brien & Druley, 1983; Rounsaville et al., 1986; Rutherford, Cacciola & Alterman, 1994; Walker, Donovan, Kiivahan & O'Leary, 1983). Among mental health clients, particularly persons with schizophrenia, a comorbid addiction is associated with a variety of negative consequences including noncompliance with mental health treatment and medication, higher rehospitalization and emergency room visits, the need for higher dosages of neuroleptics, housing problems and homelessness, criminality and violence, suicide attempts, and increased fluctuation and severity of psychiatric symptoms (Bartels et al., 1993; Bergman & Harris, 1985; Mueser, Bellack & Blanchard, 1992; Osher & Kofoed, 1989; Osher et al., 1994; Westermeyer & Walzer, 1975). Another crucial consideration in servicing the dually diagnosed is the interaction between street drugs and medication (for a review, see Ziedonis & Fisher, 1994). The dually diagnosed thus present a greater challenge to service providers than do singly-diagnosed individuals.

Consequently, perhaps, many dually diagnosed clients are excluded from services because the providing agency does not know how to deal with such cases: It is not rare to see psychiatric disabilities among the exclusion criteria for admission in a substance abuse treatment program: similarly, many mental health providers may not serve clients with an addictive disorder.

Both clinical observation and formal research have shown the complexity of the relationships between substance abuse and psychiatric disabilities (Drake, 1995; Lehman, Myers & Corty, 1989; Lehman, Myers, Dixon & Johnson, 1994; Meyer, 1988; Nunes & Deliyannides, 1993). Although the reasons for initial onset of substance use or psychiatric symptoms may vary, careful investigations have found that in some cases substance abuse and mental disorders begin to reinforce each other, while in other cases they describe a relatively autonomous course (Hein, Zimberg, Weissman, First & Ackerman, 1993; Lehman, et al., 1994). Thus, remediating either the substance use or mental disorder will often not automatically resolve the other. Recent research indicates that two thirds of dually diagnosed persons appear to have dual primary diagnoses, that these disorders interact, and that the goal of recovery' in these cases is synonymous with dual recovery (Hein et al., 1993). Mental health providers are becoming more aware of the need to address dual recovery issues holistically (for a review, see Rosenthal, Hellerstein & Miner, 1992). However, recovery is a lifelong process and clients need long-term continuing care beyond program completion. Community-based self-help groups are often included in aftercare planning for discharge from an inpatient treatment program, and used as a complement to formal treatment for clients attending outpatient (day) treatment programs.

Self-Help Programs

The self-help movement, beginning with Alcoholics Anonymous (AA) in 1935, has grown to encompass a wide spectrum of addictions. Participation in self-help groups in the U.S. is

estimated at six million at any one time, with AA participation at 1.6 million (Moos, Finney & Maude-Griffin, 1993); for chemical addictions, Narcotics Anonymous and Cocaine Anonymous are the two largest self-help organizations (Peyrot, 1985). Although relatively new, self-help groups addressing psychiatric disabilities are growing rapidly (Markowitz et al., 1996); Recover Anonymous and Schizophrenic Anonymous are the best known (Chamberlin, 1990).

Self-help groups are based on the premise that a group of individuals who share a common behavior they identify as undesirable can collectively support each other and eliminate that behavior. They learn to accept their problem, and share their experiences, strengths, and hopes. The only requirement for attending a given self-help group is the desire to abstain from the problem behavior. This mutual, honest sharing affords participants a forum where often stigmatized habits can be discussed in an accepting, trusting environment. It also provides a source of strategies to cope with the behavior and an opportunity to help others by sharing experiences and becoming a helper and a role model to others. Most self-help groups follow some version of the 12-step model originally developed by the founders of AA. One of the essential aspects of self-help, in contrast to other, more traditional forms of treatment for addictions, is the absence of “professional” involvement. Individuals come together to share with one another and to help one another—an active, self-enhancing role—, instead of being viewed as service recipients, a passive and often demeaning role in our society.

There is little research on self-help; the anonymity of participants makes formal study difficult and little is known about the “effectiveness” of self-help, (noted exceptions include Khantzian & Mack, 1994; McCrady & Miller, 1993; Ogborne, 1993.) Most research studies have been conducted with AA groups, and have been limited in scope and plagued with methodological shortcomings, overall, empirical research in the area is sparse and inconclusive (Watson, Hamcock, Gearhart, Mendez, Malovrh & Raden, 1997). The recent changes in the health care system and the advent of managed care are converging to make self-help increasingly attractive to service providers who are beginning to recognize it as a potentially cost-effective treatment modality, especially when combined with formal treatment or as aftercare. Despite the paucity of formal effectiveness studies, there is evidence that involvement in a self-help group has a positive effect on recovery: Decreased drinking is associated with AA participation over time (see Emrick, Tonigan, Montgomery & Little, 1993; Hoffman, Harrison & Belile, 1983; Pettinati, Sugerman, DiDonato & Maurer, 1982); increased general well-being and decreased neurotic distress are associated with involvement in Recovery, Inc., a mental health group (Galanter, 1988); further, participation in self-help is associated with better self-concept and improved interpersonal quality of life (Markowitz et al., 1996). There seems little doubt that self-help (especially AA, the acknowledged parent of 12-step) has directly and indirectly set millions of individuals worldwide on the path to recovery.

Limitations of Traditional Self-Help for the Dually-Diagnosed

Traditional self-help groups are based on the premise of one disease, one recovery. This specialization allows group participants to feel understood and accepted. For individuals dealing with more than one illness, however, particularly individuals dually diagnosed with a psychiatric disability and a chemical addiction, such groups often fall short of meeting their needs. This is especially true as it relates to social/emotional support and learning/skills development, two crucial ingredients in self-help. Identifying and bonding with other members is difficult because the experiences associated with dual diagnosis are not shared experiences. Direction and personal guidance from others cannot be obtained, or may be uninformed or misguided. Dually diagnosed members have difficulty following the essential, highly valued norms of openness and honesty about themselves: there is a danger of eventually minimizing, denying, or ignoring the “other half” of their recovery needs. The societal stigma associated

with dual diagnosis may become reinforced in the group and internalized. Dually diagnosed persons who are newcomers to 12-step meetings often find them bewildering, anxiety-provoking experiences, leading these persons to discontinue their participation (Vogel, 1993).

Another area where traditional 12-step groups do not meet adequately the recovery needs of the dually diagnosed is that of prescribed medications. Dually diagnosed members report receiving misguided advice about psychiatric illness and the use of medication in 12-step substance abuse groups (Hazelden, 1993). Although AA as an organization neither endorses nor prohibits use of psychiatric medications, the Alcoholics Anonymous World Service has been quite open about the limitations of AA. Many individual traditional 12-step groups and members have taken an anti-medication stance and believe that those taking medications should not speak at meetings or otherwise participate fully. This view has resulted in members stopping their medication, with consequent psychiatric breaks as well as guilt and shame in being “dependent” on medication (Alcoholics Anonymous World Services, 1984; Bean-Bayog, 1993). An analogous situation occurs in mental health recovery groups, where the “secondary shame” of substance abuse often is insufficiently recognized and addressed (Zaslav, 1993).

In sum, when self-help is a part of the treatment plan for the dually diagnosed, traditional 12-step meetings are often not fully adequate as their benefits for members may be offset by inner conflict. Dual recovery does not fall into their primary goals, and it has become clear that dual disorders cannot be divided into simple and separate parts; a holistic approach is required to deal with two or more linked, interacting recovery needs. Recognizing these limitations, self-help groups for dually diagnosed persons have been emerging in the past decade and are intended to overcome the problems encountered in traditional single-purpose groups. In contrast to the approach in substance abuse groups, in groups for dually diagnosed persons the issues of mental disorders, medication, psychiatric hospitalizations and experiences with the mental health system can be dealt with openly. In contrast to the approach in many mental health groups, in groups for dually diagnosed persons the issues of drug and alcohol dependence can be discussed without shame (Zaslav, 1993). These specialized self-help groups generally follow the AA 12-step process and are intended to be led by a recovering individual. As put forth by Caldwell and White (1991), the groups follow one of three models ranging from traditional self-help recovery group to support/engagement model with staff participation.

Double Trouble in Recovery

Double Trouble in Recovery (DTR) is a mutual aid program adapted from the 12 step method of AA, which specifically embraces those who have a dual diagnosis of substance abuse/dependency and psychiatric disability. The fellowship was spearheaded in New York State by the first author in 1989 out of his own experiences in dual recovery. Having attended traditional 12-step meetings for his addictions, he found that existing groups were not suitable for those with added psychiatric disabilities who have problems unaddressed and often stigmatized in traditional 12-step programs (e.g., psychiatric symptoms, faking medications, dealing with medication side effects). DTR developed as a grassroots initiative, from one individual to one group and growing; over the years and throughout its growth, it has kept and promises to keep this grassroots bend with which consumers feel at ease, thus reinforcing (or perhaps contributing to) the benefits of the fellowship. DTR was developed and functions today with minimal involvement from the professional community. All DTR groups are lead by recovering individuals, even where groups are held in institutional settings.

From the first group formed in New York City in 1989, DTR has grown and spread nationwide by word of mouth, and recommendations from social workers and therapists, as well as through conferences and workshops. Currently, there are over 100 DTR groups in the US (47 in New

York City). New DTR groups are being started constantly, some as a consumers' initiative, others at the behest of professionals who feel that mutual help fellowships are a useful addition to formal treatment, especially for the hard-to-engage population of the dually diagnosed. In the last 3 years, there has been on average at least one new DTR group started each month. This rate of expansion promises to continue or even increase, particularly since large managed-care companies nationwide are expressing interest in adding a self-help component to the menu of services offered to their client companies. DTR, Inc., a small nonprofit organization, supports this growth by training consumers as group facilitators on how to start a DTR group, and by providing ongoing support to existing groups.

DTR is not the only self-help dual-recovery program; other organizations with similar goals include Dual Recovery Anonymous (DRA) and Dual Disorders Anonymous. At this writing however, the authors have been unable to locate an organization with ongoing group meetings in the New York area (where the need is so great) other than DTR. Experience tells us that it is difficult to maintain such specialized fellowships, perhaps more so than for those with a single diagnosis focus; mundane issues such as funding and organization must be addressed and can become insurmountable obstacles for a fellowship of individuals whose own existence is often at risk, dealing not only with psychiatric disabilities and chemical dependency but also with community residence living, entitlements and so on. There are also a few dual-diagnosis meetings conducted under the auspices of Alcoholics Anonymous, most often in halfway houses, according to AA (Alcoholics Anonymous General Services, March 25, 1997, personal communication), these meetings are not considered "groups" and are excluded from the meeting list, as their purpose is perceived to depart from AA's primary goal of sobriety; some states do include such meetings on their list however. As to empirical findings on the effectiveness of self-help for the dually diagnosed, a literature search of the social sciences databases proved fruitless.

While no outcome data on DTR are yet available, two preliminary studies were conducted in preparation for a full-scale evaluation- (A 3½-year, NIDA-funded longitudinal study began in early 1998.)

Preliminary Findings

Study One—This study was designed to obtain background information about DTR members, including sociodemographics, psychiatric and substance use history, and treatment experiences. The instrument was a two-page anonymous, structured, self-administered questionnaire. A sample ($N = 52$) was obtained by recruiting participants at four DTR meetings in New York City in June–September 1996. Three were established 5, 3, and 2.5 years ago; the fourth had started one month previously. The four sites, in the aggregate, were designated as approximately representative of the overall DTR membership by DTR's executive director. By observation, 90% or more of the attendees at each group completed the questionnaire, suggesting that this sample was representative of the population from which it was drawn.

Sociodemographics DTR members are predominantly male (73%) and ethnically diverse: African American (45%), Hispanic (22%), non-Hispanic white (33%). Members' ages range from 22 to 67 (median = 42). Sixteen percent of the sample graduated from college, 28% attended college but did not graduate, 22% graduated high school or the equivalent, while 34% did not. Forty-four percent are currently employed (22% full-time, 22% part-time), 16% are disabled, and 37% are not employed.

1. Ever used: DTR's members' experience with drugs is extensive: 58% have used cocaine, 50% crack, 31% heroin, 81% alcohol, 37% non-prescribed pills to get high,

31% methamphetamines, 65% marijuana, 13% street methadone; 17% have been IV drug users.

2. Past year use: Recent use is very limited; in the past year, 6% have used cocaine, 2% crack, 4% heroin, 10% alcohol, 2% non-prescribed pills to get high, 2% methamphetamines, 2% smoked marijuana, 4% street methadone, and 2% injection.

3) Treatment history: 46% have been in alcohol treatment or detox, 33% in drug detox (7 days or less), 31% in drug rehab (short-term), 46% in a drug-free outpatient program, 15% in a methadone maintenance program, 37% in a residential or therapeutic community; 54% have attended traditional 12-step meetings. Currently, 2% are attending a drug-free outpatient program and 2% are in methadone maintenance.

1. Diagnosis: All DTR members surveyed reported at least one psychiatric diagnosis: 44% have a diagnosis of schizophrenia, 46% unipolar depression, 21% bipolar disorder, 10% anxiety disorder/phobia, and 6% post-traumatic stress (nearly half of members have multiple diagnoses).
 2. Medications: 76% are currently taking prescribed medication for their psychiatric illness.
 3. Treatment history: 63% have been in an inpatient psychiatric treatment program, 56% in an outpatient program, 60% in individual counseling or therapy; 48% have attended group counseling or therapy. Currently, 12% are attending an outpatient psychiatric treatment program, 13% are receiving individual counseling, and 13% are in group counseling.
1. Attendance: DTR attendance among study participants ranges from less than 1 month to over 2 years (median=18 months): 10% have been attending less than 1 month, 16% 1 to 3 months, 12% 4 to 6 months, 10% 7 months to 1 year, 33% 1 to 2 years, and 18% over 2 years. The majority of members attend very regularly: 43% more than once a week, 43% once a week, 4% once every other week. 10% once a month or less. Of those attending for a year or more, 90% are attending a meeting at least once a week. The data suggest an association between DTR attendance and medication status: of those not currently taking medication. 83% attend at least one DTR meeting a week and 73% have been coming for a year or more. The most common routes to DTR are through a therapist or social worker (49%) or a friend or associate (31%); 12% of participants heard about DTR in the community, and 8% at another 12-step meeting— 70% of members surveyed attend a traditional 12-step meeting (AA or NA) at least once a week.
 2. Members' views about DTR: participants were asked to express their degree of agreement with 13 statements designed to assess their experience with DTR as well as with other 12-steps groups (see Table 1).

Study Two—The second study was qualitative and designed to supplement and elucidate the information obtained in Study One. It consisted of a semi-structured ethnographic interview focusing on members' experiences with DTR including what was happening in their lives when they first attended a DTR meeting, comparisons with other 12-steps groups they may attend, what they derive from DTR attendance, and a history of their psychiatric disabilities and substance use from initiation to present.

Eight DTR members were interviewed: six men and two women, all minority members, ranging in age from 29 to 42 years. This is a convenience sample of volunteers obtained at one meeting.

While the details vary, all recounted similar histories, which we have organized by common themes:

“I had no childhood.” Members recount growing up in a neglectful, dysfunctional family, often with one alcoholic parent or guardian; most report first experimenting with alcohol and drugs (from marijuana to heroin) often because of peer and parental pressure (alcoholic parent forcing child to drink) and experiencing psychiatric symptoms (ranging from hearing voices to major depression and suicidal ideations) in early adolescence. About half underwent psychiatric care including medications, although medication was usually discontinued almost immediately due to unpleasant side effects and to the feeling that medications were not necessary and that drugs were better.

“I felt normal for the first time.” The result of using drugs and/or alcohol was a feeling of confidence and “belonging” which led to increased substance use, often of multiple substances such as marijuana and alcohol, LSD and alcohol, or heroin and cocaine or crack. That in turn brought about increased psychiatric symptoms that were disregarded, as individuals were by then caught up in a drug lifestyle including crime, incarcerations, and homelessness. While some members have an extensive history of drug abuse treatment going back to adolescence, the majority of those interviewed did not come to formal treatment until “hitting bottom” (i.e., experiencing some turning point such as having drug-induced seizures, passing out and being robbed in the middle of winter, or attempting suicide). Death felt close at hand, and the individual grasped at treatment as the fast hope.

“My new life.” It is no coincidence that many DTR members refer to the date they “turned around” as their birth date. Most of those interviewed had their turning point about 3 years ago, on the heels of some 20 or more years of substance use and psychiatric disabilities going unchecked. Treatment usually began in a hospital inpatient psychiatric program, from where comorbidity often directed members to a program for substance abusers with a mental health disorder (MICA). For two members, treatment started in a substance abuse program; while they had experienced psychiatric symptoms since early adolescence, no psychiatric diagnosis had ever been made until recently.

Fellowship as “safety net.” It is at that point that those interviewed came to hear about DTR and began attending— some while still in an inpatient unit, others after having moved on to an outpatient program. Most had had superficial experience with AA and/or NA but typically did not feel connected and thus did not share, or shared only about their substance use, which bothered them. Coming to DTR, members felt relieved and exhilarated by being with others who had had the same experiences with drugs, psychiatric symptoms, and medication, and could freely discuss it in a nonjudgmental, supportive atmosphere. For the first time, they report, they feel they can be themselves, be accepted, and trust others; this is in the context of a history where they felt no one could be trusted, be it psychiatrist, drug counselor or peers at 12-step meetings. These members report that DTR allows them to feel more comfortable seeking help for both their addiction and their psychiatric illness; it gives them a more positive attitude toward medication and provides them with a safety net: “When you’re walking a tight rope, if you know there is a safety net under you, you don’t think about falling; DTR is my safety net.”

“My rock of Gibraltar.” Because DTR is a true mutual-help group, members are invited early on to take an active role in the group, be it by “qualifying” (being the main speaker at a meeting and speaking of one’s experiences in front of the entire group), by making a presentation about DTR at another facility, or by becoming a group facilitator (“chairman” in AA parlance, that is, leading the group protocol, opening, closing, etc.) As described by members, the combination of sharing with others who have had similar experiences (mutual support), seeing

chose who are further along in their recovery (role models), and becoming a helper to other newer members (as opposed to being a stigmatized service recipient) brings about a new feeling of self-confidence and empowerment (self-efficacy), which facilitates the struggle for staying clean and taking one's medications. Thus, DTR members credit DTR for giving them the ability to stay on the path of their double recovery: "if it was not for DTR, I would be back in the hospital or using; it's my rock of Gibraltar."

Discussion

Taken together, findings from these two preliminary studies yield a profile of DTR members and give some indication of how DTR fits into members' lives and into their recovery. The first study suggests that DTR members are mostly male, African-American, or Hispanic, with a long history of psychiatric illness and substance abuse as well as extensive experience with treatment programs in both areas. They are actively working on their recovery, as evidenced by their fairly intensive attendance at DTR and sometimes other 12-step meetings. Recent substance use is limited, suggesting that participation in DTR (in conjunction with formal treatment when needed) may have a positive effect. The relatively low level of substance use is supported by the observations of group facilitators, who are familiar with the membership. Most members require medication to control their psychiatric disabilities, and that fact alone may make attendance at "conventional" 12-step groups uncomfortable, as such groups often tacitly equate medications with "drugs." When that is the case, clients are less likely to attend and thus jeopardize the fragile processes involved in recovery, especially as it applies to the dually diagnosed.

DTR members ratings of statements comparing DTR to other 12-step meetings indicate that DTR seems to be a setting where they can feel comfortable and safe discussing not only their addiction but also their psychiatric disabilities, hence increasing the likelihood that recovery will proceed. DTR participation also enables the majority of members to attend other 12-step groups as well, because they do not need to depend on the latter for their entire support network for recovery. Findings from Study Two buttress and elucidate these data: the majority of those interviewed have progressed from a precarious existence to independent living and economic independence. They attend a DTR meeting at least once a week and some now also attend AA and/or NA, where they discuss their substance use issues only. DTR members voice future goals centering on staying in recover, decreasing their medication, enrolling in college, and entering a profession where they can help other dually diagnosed individuals. One member said it best: "DTR gives me a tomorrow."

Study Limitations

Although encouraging, these data have several limitations. First, the sample was one of convenience and, while every effort was made to collect data at sites deemed representative of the DTR fellowship, resulting findings cannot automatically be generalized to all DTR members, numbering in the thousands. Second, the absence of random assignment and of a control group further limits generalizability and precludes causal analyses. Finally while in excess of 90% of DTR attendees completed surveys, speaking to the representativeness of the sample, one needs acknowledge that the 10% who did not may differ significantly from their peers. Thus, the authors caution the reader that the present findings are an encouraging but preliminary step in assessing effectiveness of DTR among the dually diagnosed. A full-scale longitudinal evaluation study is scheduled to begin later this year.

Conclusion

Interest in self-help is growing rapidly in the context of managed care health service delivery. The single focus (one disease, one recovery) of traditional self-help groups is an important part of their appeal to members. However, those suffering from more than one disease (such as addiction and psychiatric disability) may feel isolated and even stigmatized in traditional meetings because of their multiple recovery needs. Preliminary findings suggest that self-help groups designed to embrace the dually diagnosed, such as DTR, provide a safe forum where members feel accepted and are able to discuss both their addictions and their psychiatric disabilities. This in turn allows members to realize the recognized benefits of self-help: honesty, trust, acceptance, and mutual sharing of experiences, strengths, and hopes.

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References

- Alcoholics Anonymous General Services. Personal communication. 1997.
- Alcoholics Anonymous World Services. The AA member: Medications and other drugs. 1984.
- Bartels SJ, Teague GB, Drake RE, Clark RE, Bush PW, Noordsy DL. Substance abuse in schizophrenia: Service utilization and costs. *Journal of Nervous and Mental Disease* 1993;181:227–232. [PubMed: 8473874]
- Bean-Bayog, M. AA processes and change: How does it work?. In: McCrady, B.; Miller, WR., editors. *Research on Alcoholics Anonymous: Opportunities and alternatives*. New Brunswick, NJ: Rutgers Center on Alcohol Studies; 1993. p. 99-112.
- Bergman HC, Harris M. Substance abuse among young adult chronic patients. *Psychosocial Rehabilitation journal* 1985;9:49–54.
- Brooner RK, Bigelow GE, Strain E, Schmidt CW. Intravenous drug abusers with antisocial personality disorder: Increased HIV risk behavior. *Drug and Alcohol Dependence* 1990;26:39–44. [PubMed: 2209414]
- Caldwell S, White KK. Co-creating a self-help recovery movement. *Psychosocial Rehabilitation Journal* 1991;15:3–9.
- Chamberlin J. The ex-patients movement: Where we've been and where we're going. *Journal of Mind and Behavior* 1990;11:323–336.
- Dixon L, Haas G, Weiden PJ, Sweeney J, Frances AJ. Drug abuse in schizophrenic patients: Clinical correlates and reasons for use. *American Journal of Psychiatry* 1991;148:224–230. [PubMed: 1987823]
- Drake, RE. Substance abuse and mental illness. Arlington, VA: National Alliance for the Mentally Ill; 1995.
- Emrick, CD.; Tonigan, JS.; Montgomery, H.; Little, L. Alcoholics anonymous: What is currently known?. In: McCrady, B.; Miller, WR., editors. *Research on Alcoholics Anonymous: Opportunities and alternatives*. New Brunswick, NJ: Rutgers Center on Alcohol Studies; 1993. p. 41-78.
- Galanter M. Zealous self-help groups as adjuncts to psychiatric treatment: A study of recovery, Inc. *American Journal of Psychiatry* 1988;145:1248–1272. [PubMed: 3421346]
- Gawin, FH.; Kleber, HD. Cocaine abuse in treatment population: Patterns and diagnostic distractions. In: Adams, EH.; Kozel, NJ., editors. *Cocaine use in America: Epidemiologic and clinical perspectives*. Washington, DC: NIDA Research Monograph Series; 1985. p. 182-192.p. 61
- Greenfield SF, Weiss RD, Tohen M. Substance abuse and the chronically mentally ill: A description of dual diagnosis treatment services in a psychiatric hospital. *Community Mental Health journal* 1995;31(3):265–277. [PubMed: 7621663]
- Hagnell, O.; Grasbeck, A. Comorbidity of anxiety and depression in the Lunby 25-year prospective study: The pattern of subsequent episodes. In: Maser, JD.; Cloninger, CR., editors. *Comorbidity of mood and anxiety disorders*. Washington, DC: American Psychiatric Press; 1990. p. 139-152.

- Hazelden. The dual diagnosis recovery book. Hazelden Foundation; 1993.
- Hesselbrock MN, Meyer RE, Keener JJ. Psychopathology in hospitalized alcoholics. *Archives of General Psychiatry* 1985;42:1050–1055. [PubMed: 4051682]
- Hien, D.; Zimberg, S.; Weissman, S.; First, M.; Ackerman, S. Dual diagnosis subtypes in urban substance abuse and mental health clinics; Presented in part at the American Psychiatric Association 148th Annual Meeting; San Francisco. 1993.
- Hirschfeld, RMA.; Hasin, D.; Keller, MB.; Endicott, J.; Wunder, J. Depression and alcoholism: Comorbidity in a longitudinal study. In: Maser, JD.; Cloninger, CR., editors. *Comorbidity of mood and anxiety disorders*. Washington, DC: American Psychiatric Press; 1990. p. 293-304.
- Hoffman NG, Harrison PA, Belile CA. Alcoholics anonymous aftertreatment: Attendance and abstinence. *International Journal of the Addictions* 1983;18:311–318. [PubMed: 6874154]
- Kessler RC. The national comorbidity survey: Preliminary results and future directions. *International Journal of Methods in Psychiatric Research* 1995;5:139–151.
- Khantzian EJ, Mack JE. How AA works and why it's important for clinicians to understand. *Journal of Substance Abuse Treatment* 1994;11 (2):77–92. [PubMed: 8040921]
- Kleinman PH, Miller AB, Millman RB. Psychopathology among cocaine abusers entering treatment. *Journal of Nervous and Mental Disease* 1990;178:442–447. [PubMed: 2366058]
- Lehman AF, Myers CP, Corty E. Assessment and classification of patients with psychiatric and substance abuse syndromes. *Hospital and Community Psychiatry* 1989;40(10):1019–1025. [PubMed: 2680876]
- Lehman AF, Myers CP, Dixon LB, Johnson JL. Defining subgroups of dual diagnosis patients for service planning. *Hospital and Community Psychiatry* 1994;45(6):556–561. [PubMed: 8088734]
- Markowitz, FE.; DeMasi, ME.; Carpinelli, SE.; Knight, EL.; Videka-Sherman, L.; Sofka, C. The role of self-help in recovery process; Paper presented at the 6th Annual National Conference on State Mental Health Agency Services. Research and Program Evaluation; Arlington, VA. February; 1996.
- Marlowe DB, Husband SD, Lamb RJ, Kirby KC, Iguchi MY, Platt JJ. Psychiatric comorbidity in cocaine dependence. *American Journal on Addictions* 1995;4:70–81.
- McCrary, BS.; Miller, WR. Research on alcoholics anonymous. Alcohol Research Documentation, Inc; 1993.
- McLellan AT, Luborsky L, Woody GE, O'Brien CP, Druley K. Predicting response to alcohol and drug abuse treatments: Role of psychiatric severity. *Archives of General Psychiatry* 1983;40:620–625. [PubMed: 6847331]
- Meyer, RE. Conditioning phenomena and the problem of relapse in opioid addicts and alcoholics. Washington, DC: NIDA Research Monograph; 1988. p. 161-179.p. 84
- Mirin SM, Weiss RD, Michael J. Psychopathology in substance abusers: Diagnosis and treatment. *American Journal of Drug and Alcohol Abuse* 1988;14:139–157. [PubMed: 3052036]
- Moos, RH.; Finney, J.; Maude-Griffin, P. The social climate of self-help and mutual support groups: Assessing group implementation, process, and outcome. In: McCrary, B.; Miller, WR., editors. *Research on Alcoholics Anonymous: Opportunities and alternatives*. New Brunswick, NJ: Rutgers Center on Alcohol Studies; 1993. p. 251-276.
- Mueser KT, Bellack AS, Blanchard JJ. Comorbidity of schizophrenia and substance abuse: Implications for treatment. *Journal of Consulting and Clinical Psychology* 1992;60:845–856. [PubMed: 1460148]
- Murphy, JM. Diagnostic comorbidity and symptom co-occurrence: The Stirling County study. In: Maser, JD.; Cloninger, CR., editors. *Comorbidity of mood and anxiety disorders*. Washington, DC: American Psychiatric Press; 1990. p. 153-176.
- Nunes, EV.; Deliyannides, DA. Research issues in dual diagnosis. In: Solomon, J.; Zimber, S.; Sholler, E., editors. *Dual diagnosis*. Plenum Publishing Corporation; New York: 1993. p. 287-309.
- Ogborne, AC. Assessing the effectiveness of alcoholics anonymous in the community: Meeting the challenges. In: McCrary, B.; Miller, WR., editors. *Research on Alcoholics Anonymous: Opportunities and alternatives*. New Brunswick, NJ: Rutgers Center on Alcohol Studies; 1993. p. 339-356.
- Osher FC, Kofoed LL. Treatment of patients with psychiatric and psychoactive substance use disorders. *Hospital and Community Psychiatry* 1989;40(10):1025–1030. [PubMed: 2807202]

- Osher FC, Drake RE, Noordsy DL, Teague GB, Hurlbut SC, Biesanz JC, et al. Correlates and outcomes of alcohol use disorder among rural outpatients with schizophrenia. *Journal of Clinical Psychiatry* 1994;55:109–113. [PubMed: 8071247]
- Pettinati HM, Sugerman A, DiDonato N, Maurer HS. Natural history of alcoholism over four years of treatment. *Journal of Studies on Alcohol* 1982;43:201–215. [PubMed: 7120992]
- Peyrot M. Narcotics anonymous: It's history, structure, and approach. *International Journal of Addiction* 1985;20(10):1509–1522.
- Rosenthal RN, Hellerstein DJ, Miner CR. A model of integrated services for outpatient treatment of patients with comorbid schizophrenia and addictive disorders. *The American Journal of the Addictions* 1992;1(4):339–348.
- Rounseville BJ, Anton SF, Carroll K. Psychiatric diagnoses of treatment-seeking cocaine abusers. *Archives of General Psychiatry* 1991;48:43–51. [PubMed: 1984761]
- Rounseville BJ, Kosten TR, Weissman MM, Kleber HD. Prognostic significance of Psychopathology in treated opiate addicts. *Archives of General Psychiatry* 1986;43:739–745. [PubMed: 3729668]
- Rounseville BJ, Weissman MM, Kleber HD, Wilber C. Heterogeneity of psychiatric diagnosis in treated opiate addicts. *Archives of General Psychiatry* 1982;39:161–166. [PubMed: 7065830]
- Rutherford MJ, Cacciola JS, Alterman AI. Relationships of personality disorders with problem severity in methadone patients. *Drug and Alcohol Dependence* 1994;35:69–76. [PubMed: 8082558]
- Vogel, H. *Double trouble in recovery*. Albany, NY: Mental Health Empowerment, Project; 1993.
- Walker RD, Donovan DM, Kiivahan DR, O'Leary MR. Length of stay, neuropsychological performance, and aftercare: Influences on alcohol treatment outcome. *Journal of Consulting and Clinical Psychologist* 1983;51:900–911.
- Watson CG, Hamcock M, Gearhart LP, Mendez CM, Malovrh P, Raden M. A comparative outcome study of frequent, moderate, occasional and nonattenders of Alcoholics Anonymous. *Journal of Clinical Psychology* 1997;53 (3):209–214. [PubMed: 9075048]
- Weiss RD, Mirin SM, Griffin ML, et al. Psychopathology in chronic cocaine abusers. *American Journal of Drug and Alcohol Abuse* 1986;12:17–29. [PubMed: 3788897]
- Westermeyer J, Walzer V. Sociopathology and drug abuse in a young psychiatric population. *Diseases of the Nervous System* 1985;36:673–677. [PubMed: 1192927]
- Zaslav, P. The role of self-help groups in the treatment of the dual diagnosis patient. In: Solomon, J.; Zimber, S.; Sholler, SE., editors. *Dual diagnosis*. New York: Plenum Publishing Corporation; 1993. p. 105-126.
- Ziedonis DM, Fisher W. Assessment and treatment of comorbid substance abuse in individuals with schizophrenia. *Psychiatric Annals* 1994;24 (9):477–483.

Table 1**Members' Opinions about DTR and Other 12-Step Programs**

	STRONGLY/ SLIGHTLY AGREE %	STRONGLY/ SLIGHTLY DISAGREE %
The meetings help me deal better with stress.	98	0
Meetings help me when I get the urge to pick up.	98	2
I feel more comfortable here than at other 12-steps meetings.	86	0
I get along with people better since I started coming.	93	2
I feel more in control since I started coming.	95	2
I really like other 12-steps meetings better.	27	59
I am drinking less alcohol since coming to meetings.	87	10
I am using less drugs since coming.	97	3
Coming to meetings helps me focus on my goals.	93	2
I can relate to people better here than at other 12-steps meetings.	81	9
I take my meds more regularly since I started coming.	81	14
I have learned more about mental illness and addiction.	98	2
I feel better about myself since I started coming.	95	2