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# An Integrated Treatment: Treatment for Dual Diagnosis And Childhood Abuse Trauma

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AN INTEGRATED TREATMENT:  
TREATMENT INTERVENTION FOR DUAL  
DIAGNOSIS AND CHILDHOOD ABUSE  
TRUAMA

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A Research Paper  
Submitted in Partial Fulfillment of the  
Requirements for the  
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Department of Rehabilitation Administration in the  
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**RESEARCH PAPER APPROVAL**

**AN INTEGRATED TREATMENT: TREATMENT FOR DUAL  
DIAGNOSIS AND CHILDHOOD ABUSE TRAUMA**

**By**

**Timothy S. Rittenhouse**

**A Research Paper Submitted in Partial**

**Fulfillment of the Requirements**

**for the Degree of**

**Master of Science**

**in the field of Rehabilitation Administration**

**Approved by:**

**Carl Flowers, PhD, CRC, LCPC**

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## INTRODUCTION

The conceptual understanding and application of the dual diagnosis model of substance abuse treatment has evolved since its' inception in the New York State mental health system during the early 1980's (Sciacca, 1996), and its' subsequent expansion throughout the substance abuse treatment field through the present. The same need to provide a more comprehensive and complete treatment model which prompted the initial development of the dual diagnosis treatment model is still a motivating factor in refining known practices, as well as searching out and defining the unknown factors to be addressed to ensure that dual diagnosis clients receive the optimal treatment necessary for successful recovery from a life of substance abuse and addiction. In order to reach this ideal of optimal level of treatment other factors beyond mental illness and addiction must be investigated within the dual diagnosis model of treatment. The factors that will be addressed in this research will be the compounding effect of childhood abuse and the long term of effects childhood trauma on dual diagnosis clients in regards to addictive behaviors and substance abuse treatment and recovery success.

The term dual diagnosis is used to describe the co-morbidity of substance abuse issues and the presence of Axis I, and Axis II psychiatric disorders. Axis I disorders are classified as clinical disorders, whereas Axis II disorders are classified as personality disorders and/or mental retardation. The clinical disorders include

Schizophrenia and Psychotic Disorders, Mood and Anxiety Disorders, Dissociative disorders, Sexual and Gender Identity Disorders, Eating Disorders, Adjustment Disorders, and other conditions that may be a focus of clinical attention. Personality Disorders are defined as “prominent maladaptive personality features and defense mechanisms”, (Diagnostic and Statistical Manual of Mental Disorders, Fourth Ed., Text Revision, APA 2000). Statistics have shown that up to 50% of those with mental illness have some form of substance abuse problem, and that up to 37% of alcoholics and 53% of drug addicts are actively suffering from a mental illness, (National Alliance Mental Illness [NAMI], 2003). The National Institute of Mental Health (NIMH, 2006) has released statistics indicating that 26.2% of Americans age 18 and older, (1 in 4 adults) have some form of diagnosable mental disorder within a given year, and the statistics further indicate that those with a chronic, serious mental illness is about 6%, (1 in 17) of the United States population. Additionally studies on the subject of childhood abuse have indicated that up to 25% of American women, and up to 16% of American men have experienced some form of sexual abuse as children, (Finkelhor, 1994).

The numbers of those in the population with mental illness, the number of those with mental illness and substance abuse issues, and the prevalence of childhood abuse warrants an examination of the effects of childhood abuse and related trauma within the scope of the dual diagnosis treatment model. An examination of the effects of childhood abuse and the experiencing of childhood

trauma within the dual diagnosis spectrum will provide a foundation for building more effective treatment models for those dual diagnosis clients who have experienced childhood abuse and/or childhood trauma, which will further increase the potential for successful treatment outcomes.

In order to address the aforementioned needs of more effective treatment models for dual diagnosis clients, this research will review both historical and current studies on the dual diagnosis population and treatment, as well as reviewing studies involving the effects of childhood abuse and childhood trauma. The goal of this research is to provide a foundation for further research into determining the most effective synthesis of treatment models to provide more need specific, successful treatment models for use within the dual diagnosis population.

In order to grasp the impact of childhood abuse and trauma an understanding of what constitutes abuse and the types of trauma must be reached. The typical definition of childhood abuse is comprised of emotional abuse, physical abuse, sexual abuse and sexual exploitation, and neglect occurring to those under the age of 18. The World Report on Violence and Health (Krug, 2002) defines sexual abuse as “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person’s sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work” (p. 149). Traumatic stress is a term which defines the physical and emotional response of an individual to the events that threaten the life and the physical or psychological integrity of that individual or

someone critically important to them, (The National Child Traumatic Stress Network [NCTSN], 2008). The effects of traumatic stress will be examined within the categories of acute trauma, traumatic grief and chronic/complex trauma. The term acute trauma refers to a single, time limited traumatic event, (NCTSN, 2008). Traumatic grief is defined as the loss of someone critically important such as parents, siblings or close friends, in which symptoms of Post Traumatic Stress Disorder manifest and impede the natural grieving process, (Cohen & Mannarino, 2004). The term chronic trauma is defined as the experience of multiple traumatic events, such as prolonged exposure to violence, abuse and/or neglect, (NCTSN, 2008). Complex trauma is a term relative to chronic trauma which is used to describe both the exposure to chronic trauma, usually perpetrated by adults entrusted to with the child's care such as parents or care givers, and the impact of such exposure on the person, ( Cook et al., 2005). Children and adolescents who have experienced complex trauma typically have endured multiple traumatic events such as sexual and physical abuse or profound neglect over an extended period of time, often beginning before the age of 5 years, (NCTSN, 2008).

## DUAL DIAGNOSIS AND CHILDHOOD ABUSE

The concept of dual diagnosis had been prevalent within the rehabilitation and psychiatric literature since the early 1980's. Throughout the development of the concept of dual diagnosis several terms have been used such as "co-morbidity", "co-occurring addictive and mental disorders (COAMD)", and "dual diagnosis", (Bachrach, 1982). These various terms have been used to describe a population of clients who present difficulties in treatment due to experiencing severe mental illness in conjunction with substance misuse/addiction. The term dual diagnosis falls short in that the term only applies to the debilitating impact of the addiction and mental illness in the clients' life. Marshall (1998) found that those within the dual diagnosis population are also faced with issues such as physical illness due to medication side effects and lifestyle, behavioral and forensic problems, personality difficulties and homelessness. In the historic Epidemiological Catchment Area (ECA) study it was revealed that 29% of individuals with a lifetime history of any mental disorder (withstanding a diagnosis of substance use disorders) reported a history of substance misuse—22% an alcohol disorder and 15% a drug disorder. The lifetime prevalence for history of substance misuse by individuals with no history of any mental disorder was 13%--11% an alcohol disorder and 3.7% a drug disorder, (Regier, Farmer, & Rae, 1990). This study established that the presence of any mental disorder experienced by an individual doubled the risk for having an alcohol

disorder, and quadrupled the risk for a drug disorder in comparison to those without any mental illness. In cases of schizophrenia, arguably the most debilitating mental illness, the risk of having an alcohol disorder was found to be three times as high as the general population, and six times as high for a drug use disorder, (Marshall, 1998).

In regards to patterns of abuse within the dual diagnosis population alcohol is the most common substance of abuse, followed by cannabis and cocaine, (Lehman, Myers, Dixon, & Johnson, 1996). There are differing viewpoints in regards to the underlying motivation towards substance use in dual diagnosis clients. A prevailing viewpoint within the field was the self medication model in which it was believed that dual diagnosis clients use substances of abuse to alleviate symptoms of the mental illness itself or to counteract the side effects of psychiatric medications. Interestingly it has been found that dual diagnosis clients self report similar motivations for abusing substances as those with substance use disorders within the general population, namely to combat loneliness, emotional pain, social anxiety, boredom, and insomnia, (Drake, Mueser, Clark, & Wallach, 1996; Khantzian, 1997).

Prior to the advent of the dual diagnosis model the client with co-occurring mental illness and substance abuse typically had to treat one condition before receiving treatment for the other, that is active symptoms or related issues to the clients' mental illness had to be addressed and stabilized before admission into substance abuse rehabilitation programs, (Mueser, Drake, & Noordsy 1998a). In this system of treatment dual diagnosis clients had lower rates of treatment completion,

shorter stays in treatment and higher rates of relapse and re-hospitalization after treatment, (Drake et al, 1996). An underlying lack of stability and success in this segregated treatment model led to the development of the Integrated Treatment model. The Integrated Treatment model is a system of treatment in which clinicians provide coordinated mental health and substance abuse interventions. Integration is accomplished through the use of multidisciplinary teams that include both mental health and substance abuse specialists, (Drake & Mueser, 2000). Not surprisingly Friedmann, Hendrickson and Gerstein (2004) found that those dual diagnosis clients that received the greatest number of comprehensive services while in treatment, particularly if the treatment was targeted to the clients' specific needs produced improved outcomes. These findings support the supposition that the more therapeutic needs that are met in the client, aside from solely focusing on their mental illness and addiction, the greater the potential for long term treatment success.

Individuals with mental illness are often faced with the additional burden of being marginalized by society and at times preyed upon and victimized. Unfortunately for many of these individuals who have a mental illness this pattern of marginalization and victimization begins early in their life. Research has revealed a range of variance in percentage of abuse among men and women with a serious mental illness. In female clients between 43-52% reported a history of childhood sexual abuse and 33-52% reported a history of childhood physical abuse. In male clients between 29-36% reported childhood sexual abuse and 38-59% reported childhood physical abuse, (Cloitre, Tardiff, Marzuk, Leon, & Potera, 1996; Mueser

et al. 1998b). Regardless of the variability in these statistics due to sampling and data collection differences it is clear that a significant portion of those who have a mental illness also have a history of some form of childhood abuse. The rates of self reported history of childhood abuse among those with mental illness, in both men and women, are significantly greater than the same self report rates of childhood abuse among the general population. In the general population self reported rates of abuse among women were 13-32% for childhood sexual abuse and 20-21% for childhood physical abuse. The rates of self reported abuse history among men in the general population were 4-18% for childhood sexual abuse and 15-31% for childhood physical abuse, (Briere and Elliot 2003; Chartier, Walker, & Naimark 2009). The disparity of childhood abuse rates between those with mental illness and those in the general population may in part be skewed by individuals who are manifesting mental illness such as depression, and anxiety or dissociative disorders which are linked to their abuse experiences, rather than chemical imbalance disorders such as bipolar disorder and schizophrenia type disorders. The potential for a causal relationship between childhood abuse and manifestation of mental illness is supported by research findings which reveal incidents of childhood sexual and physical abuse are associated with mental health problems and psychiatric disorders in adulthood, (Molnar, Buka, & Kessler 2001). For practical purposes in the provision of treatment to dual diagnosis clients clinicians should avoid focusing on a “which came first—the chicken or the egg?” type of philosophy and instead focus on the fact that for a significant number of those with mental illness addiction

and the effects of childhood abuse and trauma are ever present areas in need of treatment interventions. A history of childhood abuse has been associated with greater psychiatric symptoms, including depression, psychosis, dissociation, and post-traumatic stress, (Craine, Henson, Colliver, & MacLean 1988; Malow et al. 2006).

Childhood abuse and trauma disrupts normal childhood development and behavior, which consequently adversely effects later adult life. In both adolescence and later adulthood individuals that experienced childhood sexual abuse exhibit poor impulse control, depression, low self esteem, hopelessness, and anxiety, any of which can lead to or exacerbate substance abuse issues, (Blankertz, 1993). Reiker and Carmen (1986) found that children who are abused must reinterpret their worldview to incorporate the abuse. In cases in which the abuse is ongoing, unrecognized by others, and when the child is given no support there is often a subsequent manifestation of long term loss of self esteem, fragmented identity, and an inability to form trusting relationships, (Jacobson & Richardson, 1987; Reiker & Carmen 1986). This inability to form trusting relationships can have a direct effect on treatment effectiveness, as the ability to form therapeutic relationships is compromised.

Despite the slight variance in the percentage of self-reported incidents of childhood abuse between males and females with a mental illness, there is no difference in the long term effects of childhood abuse between genders. Banyard, Williams, and Seigel (2004) found that male and female survivors of childhood

abuse had similar risks for adverse mental health outcomes. The study suggested that experiencing sexual abuse leaves the child with little control over what happens, and creates a sense of “powerlessness” that acts as a stressor which impedes neurodevelopment irrespective of gender, (Banyard et al. 2004).

Commonly used treatment interventions for recovery from childhood abuse, regardless of gender of client, are based in addressing the traumatic stress caused by the abuse. Traumatic stress is the reaction to having experienced an event that is beyond the ability of the normal coping mechanisms of the individual to process. Steele (2000) further expounded on this stating, “Post traumatic stress reactions are a set of emotions and behaviors directly and often specifically associated with it [traumatic event]. A post traumatic disorder occurs when such reactions congeal into personality altering manifestations” (p. 73). An effective treatment model which was originally developed as an intervention for adult victims of rape that addresses the traumatic stress of abuse is Cognitive Processing Therapy (CPT). CPT enables individuals to become re-exposed to the traumatic event in a safe, supportive environment, so that the trauma and associated emotions can be expressed and processed. CPT also allows the client to work with a therapist on resolving the conflict between their worldview prior to the event, and the trauma distorted worldview after the event, such as having viewed the world as a safe place prior to the traumatic event and now viewing the world as completely dangerous and threatening after the event, (Resick, and Scnicke, 1992)

The conflict resolving aspect of CPT has also been applied to Cognitive Restructuring interventions. Cognitive restructuring has been found to be an integral component in the treatment of trauma related to childhood abuse. In Cognitive Restructuring clients work on applying adult reasoning and resources to process and interpret the abuse, replacing the perceptions which had been based in underdeveloped childhood reasoning skills. Typical faulty perceptions include beliefs that the clients were responsible for the abuse, or that they are dirty, or of no value, (Elmone, Lingg, & Schwartz 1996). These interventions based in cognitive application and emotional processing of the traumatic event allows adult survivors of childhood abuse to build and implement the developmental tools that were compromised by the abuse, (Blankertz, 1993).

## MOVING TOWARDS A COMPLETE TREATMENT

The knowledge and understanding of the needs within the dual diagnosis population has grown throughout the past several decades. This increase in both empirical and practical knowledge has revealed the challenges facing dual diagnosis clients due to the synergistic effects of mental illness and substance abuse/misuse. Research has clearly revealed the increased risk for substance abuse/misuse among those with a mental illness, as well as the symptoms of mental illness presenting difficulties in adherence to and completion of traditionally oriented substance abuse programs. In the early stages of the development of the dual diagnosis concept the underlying motivation for substance abuse/misuse was solely attributed to the individual's illness, i.e. the "self-medication model". Through time and experience it was revealed that those within the dual diagnosis population more often than not abused and misused alcohol and drugs for much the same reasons as those in the general population, namely to alleviate emotional and social discomfort. This new perspective prompted the field to view those within the dual diagnosis population as a more whole and unique individual with unique needs and motivations, rather than an individual illness and type of addiction.

The concept of Integrated Treatment came out of these developmental steps in understanding the needs of the dual diagnosis client. Integrated Treatment provided

mental health services and addiction treatment concurrently. Research findings have supported the efficacy of this treatment model. The advent of Integrated Treatment yielded higher treatment completion rates, higher sustained recovery rates, and lowered re-hospitalization rates. The core of Integrated Treatment is providing need specific interventions within a concurrent, rather than sequential format.

An area of need that has not received due attention is treating the long term effects of childhood sexual and/or physical abuse and trauma in the context of dual diagnosis. The self reported rates of childhood sexual and/or physical abuse among those with mental illness is nearly twice the rate of those within the general population. Based on this information it is a logical supposition that a significant number of dual diagnosis clients have a history of childhood sexual and/or physical abuse and related trauma. The destructive, debilitating impact of childhood sexual and/or physical abuse has been established through multiple empirical studies. Childhood abuse and trauma is definitively linked with later manifestation of mental illnesses such as Post Traumatic Stress Disorder (PTSD), depression, dissociative disorders, substance abuse, and eating disorders. Childhood abuse has also been shown to exacerbate the symptoms found in depression, and psychosis.

The social development of those with a history of childhood sexual and/or physical abuse is also severely hindered. A direct link between loss of self esteem/self worth, development of fragmented identity, and an inability to form trusting relationships later in life and having experienced childhood sexual and/or

physical abuse has been established. Anyone of these factors in themselves could influence an individual towards substance abuse/misuse, and when combined with the presence of a mental illness that influence grows exponentially. The compromised ability to build trusting relationships found in those who have experienced childhood sexual/physical abuse is of particular concern to clinicians, as this impedes the therapeutic process, and must be addressed for any treatment interventions to be effective.

The development of a trusting therapeutic relationship is essential for the interventions for treating the long term effects of childhood sexual/physical abuse. The most direct, effective interventions are based in a cognitive/ emotional treatment model, such as Cognitive Processing Therapy (CPT). In this model the client and clinician work through the traumatic event, processing the emotional aspects related to the abuse, while cognitively re-structuring perceptions and attributions the client has regarding the event, such as self-blame, or feelings of self-hate, de-valution of self, etc. This treatment model allows the client to process the traumatic event in a safe, supportive environment. The clinician must develop a therapeutic rapport with the client in this treatment model. This is best accomplished by the clinician demonstrating “warmth, positive regard, and empathy, and to create a safe environment in which the survivor knows he or she is being heard and validated” (Elmone, Lingg, & Schwartz, 1996, “Relationship between”, para. 1).

Admittedly there are challenges that could arise in applying these treatment models for some dual diagnosis clients due to active symptoms of mental illness. A

cognitive based approach might prove difficult when working with a client exhibiting psychotic symptoms, as delusion or hallucinations interact with memories and beliefs regarding the traumatic event. The importance of the therapeutic relationship also applies in this instance, as a skilled clinician who can use information from the client's case file, and their own knowledge and experience gained from having worked with the client might still be able to use the clients' delusional belief system as a window into how the client is processing the traumatic event, and thereby begin the work of cognitive restructure at the client's current level of understanding. Additional areas that might require the deft touch and understanding of a skilled clinician is in the emotional processing component when working with clients who are experiencing blunted or flat affect symptoms relative to the schizophrenia spectrum disorders. Therapeutic relationship and clinician skill are also factors in this instance. The blunted or flat affect is not indicative of absence of emotion, it is indicative of difficulties in processing and expression of emotions. In a best case scenario a client who has a history of affect issues could possibly not only benefit from treatment for the traumatic event, but also gain more understanding and ability with their emotions, as evidenced by the positive impact of psycho-social rehabilitation interventions for those with schizophrenia spectrum disorders.

A cost effective consideration for both clinicians and administrators in the furtherance of the goal of providing the most need specific, integrated treatment would be to train clinicians in the application of treatment interventions such as CPT. CPT is a course facilitated by a trained clinician working with clients through a

module of treatment exercises over a relatively short course of time. Resick and Schnicke (1992) reported positive reduction of PTSD related symptoms in female rape survivors as far 6 months after treatment with as few as 12 sessions when they were initially constructing the CPT treatment model. If administrators purchased the necessary resources such as texts, modules, and providing training for staff to facilitate CPT groups/individual interventions more cost effective services could be provided to dual diagnosis clients with this particular need on site, rather than forcing the client to find needed treatment after addressing the treatment needs of mental illness and addiction. The core concept that initiated the dual diagnosis treatment philosophy was comprehensive, integrated treatment. Research has shown that those clients who receive the most comprehensive, need specific treatment interventions have the highest long term recovery success rates.

The concept of inclusion of treatment interventions for childhood sexual/physical abuse and trauma in the dual diagnosis context provides areas for future research. Initially research into the effectiveness of such all-inclusive treatment in regards to long term substance abuse recovery and general life satisfaction reported by clients, would provide support for or areas in need of improvement in this treatment proposal. The reliance on therapeutic relationship inherent in CPT type interventions could be an area to explore—does this increased exercise in empathetic bond by clinicians improve other aspects of clinician service delivery? Would an increase in emphasis on the therapeutic relationship result in greater clinician job satisfaction and reduce feelings of “burn-out”? An additional

area of research could be into the effect and effectiveness of CPT type interventions on those dual diagnosis clients with schizophrenia spectrum disorders. This research could possibly influence the way in which those with schizophrenia type illnesses receive services throughout the whole field of mental health services.

In providing more need specific interventions to clients who are in need of treatment clinician and client both receive benefits. Clients gain the added respect and feelings of value and worth by knowing they are being seen as individuals with unique needs and strengths they bring into treatment. Clinicians become even more effective healers learning to look beyond a diagnosis and set of symptoms and see a unique individual with strengths that can be built upon to empower that individual to live the most fulfilling, rewarding life that they are capable of.

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