Begin in March... Out of hell does he come

Only then does the Lost shepherd

To the armies of the Lamb return to do battle

With olive wreath that rests upon head

Sitting in Lotus, staff in hand that brakes then heals

The heart torn from the rib of Adam...

When He who cannot be found but does only rest

Begins the ascent upon White Swan.

Then does a Brahma awaken...

From out of a navel of an Ocean of Consciousness...

That, which began and is again and again...

Always, pulsing through its Crown

First through the ether

Vibrating throughout the astral realms

What first begins as darkness in a karmic field...

Can then verily become Light to its Brachman.

— Robert B. Pereira

Faces of Dual Diagnosis

A Canadian Perspective

Robert B. Pereira, MD

Agio
PUBLISHING HOUSE

Agio
PUBLISHING HOUSE

151 Howe Street, Victoria BC Canada V8V 4K5

The author of this book does not advocate the use of any technique as form of treatment for physical or medical problems without the advice of a physician, either directly or indirectly. The intent of the author is only to offer information of a general nature to help you in your quest for physical fitness and good mental and spiritual health. In the event you use any of the information in this book for yourself, which is your right, the author and the publisher assume no responsibility for your actions.

For rights information and bulk orders, please contact:
info@agiopublishing.com
or go to
www.agiopublishing.com

Faces of Dual Diagnosis
ISBN 978-1-897435-52-6 (laminated hardcover)

For more information, we invite you to visit
www.DualDiagnosis.ca

Printed on acid-free paper that includes no fibre from endangered forests. Agio Publishing House is a socially responsible company, measuring success on a triple-bottom-line basis.

10 9 8 7 6 5 4 3 2 1 0

DEDICATION

This manuscript is dedicated to the memory of my parents:
Philip Pereira, who taught me the importance of virtue, and
Marlene Pereira, who gave me a practical understanding of faith.

ACKNOWLEDGMENTS

I first wish to thank my patients, who have taught me so much over the years, and in particular, the individuals portrayed in the case studies within for sharing their stories.

I wish to acknowledge Dr. Gabor Maté, whose courage and tenacity have been an inspiration to me both personally and professionally, and Dr. Karima Jiwa, my mentor, whose patience and understanding have provided an environment to grow and realize my potential.

I also wish to acknowledge my editor, Diana Holland, who has worked tirelessly with me toward the realization of a dream.

I wish to thank Bruce and Marsha Batchelor at Agio Publishing House for enabling this labor to come to fruition.

Finally, I wish to thank my wife, Lucia Maria, without whose love and support my career and life would not have flourished.

TABLE OF CONTENTS

AUTHOR'S NOTE

My interest in writing this book stems from my professional experience in dealing with dually diagnosed individuals for almost two decades. Some of my patients have managed to springboard themselves into a life of stability and relative contentment. Others, sadly, devolved sooner or later toward a hopeless condition of both body and mind.

What has increasingly captivated my interest has been the role of belief systems in those who have braved the gauntlet and won. I have discovered that in almost every case, a conscious decision on the part of the individual *not* to personalize his or her experiences opened the door to a transformation of consciousness.

In the chapters ahead, we shall witness firsthand this awakening as it has occurred in several of my patients, and perhaps even marvel when we perceive how a deeper intelligence, ostensibly dormant until their awakening, seemed to have been guiding their lives all along.

My hope is that these stories and the accumulated wisdom I share in these pages will serve you well, most especially if you yourself, or a loved one of yours, have been dually-diagnosed. This book is also written to help health professionals – be they physicians, psychologists, nurses, counselors, social workers or other "healers" – to better understand dual diagnosis and the treatment alternatives.

CHAPTER 1

DUAL DIAGNOSIS UNVEILED

"The mind is everything:
what you think, you become."

– Gautama Buddha

"To one who has faith, no explanation is necessary.
To one without faith, no explanation is possible."

– St. Thomas Aquinas

This book is about dual diagnosis, a medical condition that occurs by definition when both a chemical dependency and some form of mental illness affect the same individual at the same time. Each side of the equation includes symptoms that interfere with the person's ability to function effectively. However, not only is that individual affected by two separate illnesses, but these interact synergistically: by this I mean that each disorder exacerbates the other and also predisposes to relapse in the other. At times, the symptoms can overlap or even mask each other, making diagnosis and treatment all the more difficult.

Dual diagnosis is becoming increasingly prevalent in Canada. There are estimates that up to .28% of the Canadian population may be afflicted – over 90,000 Canadians. [1] And yet, rather surprisingly, the topic has received little if any attention from the popular press. There is a vast quantity of media coverage on addiction and on mental illness separately, but only rare articles or features concerning both subjects as they occur concurrently within the same individual.

How mental illness presents within the milieu of addiction is a complex phenomenon. The association reflects the interchange of a myriad of influences that I will shortly outline. As well, the admixture of an individual's ideas, attitudes, beliefs and values – colloquially referred to as his or her "belief system" – plays a definite and central role. To be more exact, how well an individual is coping with his or her illness at any particular moment is directly impacted by the inherent stability of his or her belief system.

I have already mentioned that dual diagnosis affects an estimated .28% of the Canadian population. While this figure may already seem high, what is more surprising yet is that due to greater awareness and vigilance, the condition is being diagnosed and treated at greater frequency in adolescents. This in turn suggests that early childhood experiences play a critical role in the presentation and development of illness.

Despite recent studies [2] indicating that adolescent drug use, and alcohol use in particular, have remained essentially stable, adolescent substance abuse remains a concern overall because it can contribute to the development of subsequent mental health issues. This evidence also suggests that some people use alcohol or other drugs of abuse in part to self-medicate distressing mental states associated with underlying psychiatric conditions.

Whether the chicken came first or the egg, adolescents with substance use disorders (SUDs), like adults, exhibit a higher rate of psychiatric problems as compared to the general population. Some of the following conditions, including Attention Deficit Disorder (ADD), are seen preferentially in adolescents, whereas others, like schizophrenia, are found more in the adult population. The following is a list of mental illnesses commonly associated with SUD:

- Anxiety disorders
- Depressive disorders
- Attention Deficit Disorder (ADD)
- Bipolar Disorder
- Conduct Disorder and other Cluster B personality disorders
- Obsessive Compulsive Disorder (OCD)
- Schizophrenia

Certain factors put children and adolescents at risk for developing a substance usage disorder. These include:

Genetic factors

- Having one or both parents with a substance abuse problem

Constitutional and psychological factors

- Psychiatric problems
- History of physical, sexual or emotional abuse
- History of attempted suicide

Sociological and cultural factors

- Family
- Parental experiences with and attitudes towards drug use
- History of parental divorce or separation
- Low expectations for the child

Peers

- Friends who use drugs
- Friends' attitudes towards drug use
- Antisocial or delinquent behavior

School

- Failing or dropping out

Community

- Community attitudes towards drug use
- Economic and social deprivation
- Availability of alcohol and drugs (including tobacco in cigarettes)

As a counterbalance to these many factors, and despite them, having an entrenched belief system helps to create stability in a person's life. [3] It enables the individual to process his or her life experiences at a deeper level of awareness, to own these experiences, and to sometimes even experience a natural state of euphoria colloquially called "bliss." Without a strong belief system, the same person could just as easily fall prey to the many ill effects of instability including dysfunctional relationships of all kinds, financial failure, jail, institutionalization and premature death.

For the average individual suffering the ill effects of a substance use disorder, whether in conjunction with a mental illness or not, the typical recuperative route to follow is to join a self-help group or fellowship such as Alcoholics Anonymous or its equivalent. Such programs strengthen the fledgling belief system of the individual and provide structure. Working within the framework, the person becomes capable in time of assuming responsibility for his or her own spiritual growth. Support groups of this kind also expressly encourage the development of altruism within the individual by assisting addicts to work with

one another and begin navigating the complexities of healthy relationships under the tutelage of more senior members of the group.

There is a strong component of "sin and salvation" involved in many of these programs, which suggests many would be replacing one form of dependency (drugs, alcohol, etc.) with another, albeit more benign, one. Yet I would argue that augmenting an ounce of brimstone and damnation fear with a pound of dogmatic faith may not be the best long-term therapy. A far more useful proposition would be to eliminate the fear. I believe that the only way to do this is through self-knowledge. Ultimately, whether one chooses to believe in a personal God should be a matter of choice and preference, not dread.

As an aside, the "sin and salvation" approach emphasizes that Adam and Eve disobeyed God when they ate of the fruit of the Tree of Knowledge in the Garden of Eden and were banished from Paradise. Yet that Knowledge has ultimately facilitated the triumphant return of humankind to the open arms of God. The parable of the Fall is thus a powerful symbol for the return to wholeness. A more contemporary rendition is coming to terms with what Carl Jung called the "Shadow." [4]

In my opinion, Jung's concept of Shadow throws light on the spiritual dimension of dual diagnosis. Why? Because at some point, individuals with a dual diagnosis must ask themselves, "Who am I?" This generally occurs sometime after the stirring of consciousness within, and it marks the transition from mundane thought to a state of awareness. Paradoxically, it is at this particular juncture that formal belief systems break down for many people, and the individual will typically seek out the services of a priest or counselor, a modern-day shaman or some other spiritual healer or guide.

To be more explicit, Jung's concept of the Shadow comes into play when an

individual has not yet reconciled his or her natural polarities and experiences inner turmoil or conflict because of the divergent forces battling for supremacy within. This can lead, in and of itself, to a whole range of disorders that give rise to a dual diagnosis.

Some risk factors concerning dual diagnosis have been listed, but what specific behavioral clues should one be on the lookout for? *The Diagnostic and Statistical Manual of Mental Disorders - IV* defines "substance abusers" as people who persist in using mood-altering substances despite recurrent social, interpersonal and legal problems as a result of their drug use. "Harmful use" or "dependency" (further along the spectrum of substance abuse) implies drug use that causes either physical or mental damage. People who have become chemically dependent meet all of the criteria for being substance abusers, but will also exhibit some or all of the following traits:

- Narrowing of the substance repertoire (using only one brand or type of substance)
- Drink- or drug-seeking behavior (only going to social events that will include use of the chosen substance, or only hanging out with others who use)
- Tolerance (having to use increasing amounts to achieve the same effect)
- Withdrawal symptoms (experiencing symptoms of physical discomfort after going a short period without using)
- Using to relieve or avoid withdrawal symptoms (such as using to stop the shakes or "cure" a hangover)
- A subjective awareness of the compulsion to use or the craving for a substance (whether admitted to someone else or not)
- A return to using after a period of abstinence (deciding to quit and not being able to follow through)

Checking "yes" to three or more of the foregoing criteria is strongly suggestive of the presence of a Substance Use Disorder (SUD). Typically, those who are diagnosed as "substance abusers only" (still rather early on along the spectrum of substance abuse) can be helped with a brief intervention, including education concerning the dangers of binge use and substance poisoning. Those who have become "substance-dependent" generally require outside help to stop using, which could include detoxification, medical treatment, institutionalization, counseling and/or self-help group support such as Alcoholics Anonymous. Note that once an individual becomes substance dependent, they cannot then regress and become substance abusers at a later time by definition. This is simply because abstinence remains the goal of medical management; at least over the intermediate term.

What about the mental illness component of a dual diagnosis? Although there is a wide range of possible disorders, some typical "flavors" are presented here. Available evidence [5] suggests that certain mental illnesses tend to be characteristically associated with chemical dependency. Those listed earlier in this chapter will be briefly discussed below.

Anxiety disorders, for example, are among the most common psychiatric conditions co-existing in both adolescents and adults with a substance use disorder. Typical manifestations include **Post Traumatic Stress Disorder** (PTSD), **Social Phobia** and **Generalized Anxiety Disorder**.

Before we continue, a slight digression is in order here concerning adolescents. Many teenagers believe, as many adults do, that drugs and alcohol can reduce anxiety and stress, and this may lead to first use or continued abuse. This does not mean that drug use actually does prevent anxiety. In fact, there are well-founded studies [6] showing that teenagers who never experiment with drugs or alcohol may be at higher risk of developing anxiety problems later in life.

It stands to reason that a young person with a mental health problem such as an anxiety disorder may elect not to engage in social experiments involving drugs, and may tend to stay away from peers who do. However, should an anxiety disorder develop to the point of becoming entrenched, this does not prevent the subject from developing an SUD later. What causes what is the subject of our next chapter.

To carry on with our list of mental disorders that can co-exist with a Substance Use Disorder, both adolescents and adults are at great risk for developing a **Depressive Disorder** or *dysthymia* ("minor" depression). Clinical practitioners are often faced with a chicken-or-egg dilemma in attempting to determine which came first; the mental illness and then the SUD, or vice versa.

Of note, for adults, depressive symptoms oftentimes resolve within a few weeks of the person "drying out" or abstaining from drugs or alcohol. Yet in adolescents this is rarely the case. Depressive symptoms in younger people often require treatment with antidepressants. Moreover, one of the greatest risk factors for teen suicide is intoxication with either drugs or alcohol.[7]

Current research evidence [8] shows that treatment with serotonin-augmenting medications or "atypical" antidepressants has proven effective. When drugs within different classes are combined to improve the overall antidepressant activity, it is rarely necessary to augment the dosages. Additionally, individual psychotherapy may be part of the treatment plan recommended by the psychiatrist or mental health team.

Attention Deficit Disorder (ADD) is the most common psychiatric disorder diagnosed. It affects from 3% to 5% of people globally. The term ADD can be used interchangeably with the older term ADHD (Attention Deficit Hyperactivity Disorder). Scientific findings [9] confirm that pre- and post-natal stresses

are the most important determinants of this condition in children. The impact of early stress on the brain – when the mother is depressed, for example – creates vulnerability to ADD and to addictions.

Children with ADD who are not on medication typically have an attention span of a few seconds only. They are disruptive in class and generally exhibit behavioral problems both in the home and at school. It is perhaps no wonder that as they grow up, they tend to gravitate towards experimentation with substances of potential abuse.

The treatments of choice are psychostimulants such as Ritalin or Dexedrine, which can be a concern as both drugs are amphetamines (commonly known as "speed") and have the potential to be abused. Luckily, alternate medications do exist. Furthermore, it has recently been suggested [10] that appropriate treatment of ADD may lead to a decreased chance of developing a substance usage disorder.

In his highly-recommended book *Scattered Minds*, [10] Dr. Gabor Maté talks candidly about the condition of ADD. Dr. Maté has himself been diagnosed with ADD and is living proof that there is help – and the prospect of a healthy, productive life – for individuals suffering from this often-debilitating condition.

Bipolar Disorder is a tricky diagnosis to make in the presence of co-existing addiction, but in substance-abusing teens, it is complicated even further. Behaviors such as changes in sleeping patterns and mood swings can be symptomatic of this illness, substance abuse, or even normal adolescence. Diagnosis of Bipolar Disorder should certainly be a consideration as concerns substance-abusing youth, particularly those with a binge pattern. Treatment is

often complex, and can be extended to include medications and psychotherapy once stability is achieved.

Conduct Disorder (formerly known as **Antisocial Personality Disorder** or APD) is another manifestation classified medically as a personality disorder. Prevalence varies from 1% to 4% in children between the ages of 9 and 17 depending upon how the disorder is defined. It can affect substance abusing teenagers, and is more frequently diagnosed in boys than girls. [11] The disorder is also more common in urban than in rural populations. [12]

The pathognomonic feature of Conduct Disorder is aggressive behavior associated with a flagrant disregard for the law and the rights of others. Conduct Disorder that persists beyond the age of 18 is frequently diagnosed as Antisocial Personality Disorder. Whatever the age of onset, Conduct Disorder is often difficult if not impossible to treat effectively.

Perhaps the highest risk for the association of a problem with either drugs or alcohol and a mental health problem occurs in individuals with *both* Conduct Disorder and a mood disorder (either Unipolar Depression or Bipolar Disorder). Impulse control is an aspect of self-regulation, and affected individuals generally have problems with both. Disordered self-regulation, in this case, is a phenomenon whereby the cerebral cortex, which typically permits or overrides impulses from traveling from the lower brain centers, does not function optimally. As in Bipolar Disorder, diagnosis and treatment are often complex issues. For this reason, youth with a combination of Conduct Disorder and an SUD frequently require long-term residential treatment.

The other so-called **Cluster B personality disorders** (typically associated together as a group because they exhibit a predilection towards dramatic or erratic behaviors) tend to be characteristically associated with a Substance

Use Disorder. This group includes: **Narcissistic Personality Disorder**, **Borderline Personality Disorder** and **Histrionic Personality Disorder**, all of which tend to be diagnosed later in life. We shall examine these disorders at greater length in future chapters.

Obsessive Compulsive Disorder (OCD) is the fourth most commonly diagnosed mental disorder, affecting from 1% to 2% of the Canadian population. It is an anxiety disorder that has important features in common with addiction, so the underlying mechanisms that govern OCD deserve some explanation.

We tend to believe that we are in control of the decisions we make, but they can also stem at times from emotional drives or subliminal beliefs of which we are not consciously aware. The stronger a person's automatic brain mechanisms and the weaker the part of the brain that imposes conscious control, the less true freedom the individual will be able to exercise in his or her life choices.

When overcome by stress or overwhelming emotions, almost any human will act or react not from intent or free will but from a quasi-instinctual or less-than-fully autonomous impulses stemming from more primitive or instinctual drives deep within the brain. Though these mechanisms are not entirely understood at this time, it is believed that in the case of OCD, the cerebral cortex, the part of the brain that houses volitional functions, does not self-regulate to the degree apparent in other vital processes like the regulation of blood pressure and the control of heart rate, for example. The referral mechanisms that oversee and govern self-regulation are somehow short-circuited and the necessary feedback is no longer available for the afflicted subject to act with conscious intent.

People with OCD experience both obsessions and compulsions. Obsessions

are unwanted and disturbing thoughts, images or impulses that suddenly pop into the mind and cause a great deal of anxiety or distress. Compulsions are deliberate behaviors (such as repeated hand-washing, checking on miscellaneous things or putting them in order) or mental acts (praying or chanting, counting, repeating word phrases and such) that are carried out repeatedly to reduce the anxiety caused by the obsessions. Over time, OCD symptoms can change. For example, a subject may start off washing his or her hands compulsively, but later develop excessive checking behaviors and stop compulsive hand-washing altogether.

Young adults between the ages of 18 and 24 are at highest risk for developing OCD. However, many adults with the disease say their symptoms started when they were children or adolescents. Men tend to develop OCD at an earlier age (usually between the ages of 14 and 19.5 years) than do women (usually between the ages of 21 and 22). Among adults, women report having OCD slightly more frequently than men. [13]

Left untreated, OCD is a debilitating illness. The disease is best treated medically with a class of antidepressants called serum serotonin reuptake inhibitors (SSRI's). Many people with anxiety disorders such as OCD benefit from joining a self-help or support group and sharing their problems and achievements with others.

Stress management techniques and meditation can help people with anxiety disorders to calm themselves and may enhance the effects of therapy. There is preliminary evidence [14] that aerobic exercise can also have a calming effect. Since caffeine, certain illicit drugs and even some over-the-counter cold medications can aggravate the symptoms of anxiety disorders, they should be avoided.

Schizophrenia is another prevalent disorder, affecting about 1% of Canadians or 1 in 100 people. Currently, about 52% of admissions for schizophrenia to general hospitals are for adults from the ages of 25 to 44, and the rates are increasing among young and middle-aged men. The disease also tends to be more severe in men than in women.

Most cases of schizophrenia appear in the late teens or early adulthood. For men, the average age of onset is 25. For women, it is around the age of 30. However schizophrenia can also appear for the first time in middle age or even later. In rare cases, it can even affect young children and adolescents, although the symptoms manifest slightly differently than they do in adults. In general, the earlier schizophrenia develops, the more severe it is.

The 2002 Academy Award winner for Best Picture, *A Beautiful Mind*, brought schizophrenia into the public eye by portraying how the illness progressed in the life of John Forbes Nash, Jr., the 1994 Nobel Prize laureate in Economics. [15] As the film illustrates, schizophrenia makes it difficult for a person to distinguish between what is real and what is unreal, to think clearly and to behave in socially acceptable ways. These obstacles can have a severe impact on one's work, relationships and day-to-day functioning. But with treatment and support, as the film also depicted, a person with schizophrenia can still lead a productive life.

Families with mentally ill relatives whose problems are compounded by substance abuse face problems of enormous proportions. Mental health services are not well prepared to deal with patients having both afflictions. Often only one of the two problems is identified. If both are recognized, the individual may be bounced back and forth between services for mental illness and those for addiction, or worse, the person may be refused treatment by both agencies. The picture to date has not been rosy, but there are signs that dual diagnosis is

now being recognized as such, and an increasing number of programs are trying to address the treatment needs of people with a combination of problems.

Research studies [16] are beginning to help us understand the scope of the problem. It is now generally agreed that as much as 50% of the mentally ill population also has a substance abuse problem. The drug most commonly used is alcohol, followed by marijuana and cocaine. Prescription drugs such as tranquilizers and sleeping medications are also likely candidates. The incidence of abuse is greatest among males and those from ages 18 to 44. Substance abuse complicates almost every aspect of care for a person with mental illness.

In its very comprehensive 2008 Position Paper [17], the National Coalition on Dual Diagnosis reported that people with a dual diagnosis:

- Have complex needs and find themselves entangled in multiple in-depth systems of assessment and management, often unconnected to one another
- Have inadequate access to positive determinants of health (education, housing, nutrition, economic security, work, safe communities and social inclusion)
- Experience the double jeopardy that arises when two disabilities (developmental and/or mental health needs) occur within the same individual, making diagnostic overshadowing more likely. (This means that some symptoms are trivialized or relegated to the status of a developmental problem rather than being recognized as a legitimate mental health concern. As a result, the afflicted person becomes even more marginalized.) Substance abuse within this context simply increases the complexity of the issues involved
- Are more likely than their non-disabled peers to exhibit challenging behaviors such as self-mutilation, aggression, non-compliance or other

destructive and disruptive behaviors that increase social stigma and further compound the marginalization

- Tend to be over-medicated with psychotropic medications to quell their "acting out" behaviors without an in-depth assessment of the underlying reasons why they occur.

What can and should society do? Homelessness, the provision of comprehensive medical services and the containment of infectious diseases, such as tuberculosis, hepatitis and AIDS, are some of the more visible complex social problems today associated with Canada's dually diagnosed population and subpopulations (those who have developmental rather than mental health issues per se). As has been mentioned, however, possibly .28% of adult Canadians struggle with a dual diagnosis (as defined at the outset of the chapter), which represents a significant challenge for society in general and for those afflicted. These individuals could benefit from greater community resources in general and from Harm Reduction incentives in particular that will be covered in later chapters.

Many of the problems we have been discussing are stereotyped as afflicting mainly a down-and-out fringe element of society. Relief organizations such as the Roman Catholic Church and the Salvation Army seem to do some good amongst this element because, despite the evangelical streak that may accompany their services, they do attempt to minister to such individuals based on compassion rather than antagonism. But for society as a whole to truly address the root causes of poverty, hunger, mental illness and addiction in a meaningful and effective way, I believe that the upper strata of our society needs to be mobilized to look the issues straight in the eye and realize that many of the downtrodden do not choose their fate. Were decison-makers' eyes truly open, they would realize, no matter what their outward convictions, that "There, but for the grace of God, go I."

One can imagine how quickly things could change for the better if a majority of Canadians acknowledged and mobilized to send an unambiguous message to the federal government in Ottawa that the right-wing political agenda being advanced today is serving only the privileged few while the many face narrowing horizons, and a growing number of Canadians are falling, disenfranchised, through the cracks.

Unfettered free-market economics have served only to spend our children's birthright, polarize society and entrench a self-righteous entitlement mentality in the halls of power. Materialism is eroding the common decency at the heart of Canadian society and undermining our deep-set compassion for the underdog.

One traditional index of a society's wealth is the standard of health care afforded its citizens. Canada is a wealthy nation today because social democracy has been the reigning political platform for most of our recent political history. Come election time, let us not forget that the health of our people is Canada's most precious resource, and that our social programs, so dearly won, are a beacon of sanity in a dark world today. Let us not be fooled or intimidated into relinquishing them under the flimsy guise of economic reform. Safeguarding our health is not a question of money, and failure is not an option. Otherwise, the short end of the stick will prove to be very long indeed.

THE MASKS OF DUAL DIAGNOSIS

"Oh, life is a glorious cycle of song,
A medley of extemporanea;
And love is a thing that can never go wrong;
And I am Marie of Romania."

– Dorothy Parker

Having introduced two central topics in the last chapter – dual diagnosis and the importance of belief systems in dealing with it – I now wish to discuss the symptoms of dually diagnosed patients, paying particular attention to how an individual's stability is impacted by the quality of his or her beliefs.

But first, let me discuss possible origins of the condition. Rather than simple cause and effect, the relationship between mental illness and substance abuse is in fact extremely complex. Consider four possible scenarios:

1. Mental illness "causes" substance use. (The individual self-medicates to quell the symptoms of the disorder.)
2. Substance use "causes" mental illness. (Substance abuse triggers

neurochemical alterations, stress and demoralization that eventually lead to full-blown mental disorder.)

3. There is common causality. (Something else causes both conditions such as genetics, the environment, etc.)
4. There is no causal relationship. (It is common for the conditions to co-exist and neither causes the other.)

Before we can determine which are more likely scenarios, it is appropriate to begin with a discussion of the underlying dynamics of mental illness during infancy and early childhood development. Why? Because this will lead us to discuss the topic of boundaries, and, as we shall see, boundaries tie in directly with the notion of belief systems, which in turn begin to form quite early in life.

Before birth, there is a conspicuous absence of a physical boundary between the fetus and its mother. This changes abruptly and irrevocably with birth. Research into intra-uterine experiences suggests that trauma sustained at this crucial moment may have lasting ramifications, but the degree to which birth memories are retained is still subject to controversy.

It is generally accepted that in early infancy, the child remains enmeshed with its parental figures, meaning that it does not yet perceive any boundaries. At each successive stage of the developmental process, the immature ego progressively differentiates itself from its attachment figures, the child begins to explore how it is indeed separate from its parents, and the idea of "self" is consolidated. During this period, the infant also acquires a rudimentary sense of "good" and "bad." As early developmental experiences and events unfold, the child ideally learns to construct a healthy self-image with appropriate feedback from the parental figures.

An integral function of a healthy immature ego is the identification of both healthy boundaries and limits. A sense of self and a sense of one's boundaries seem to go hand in hand. The mature counterpart to the immature or libidinal ego encompasses one's capacity for critical thought as well as one's aggressive tendencies and basic sense of sexuality – in short, one's survival instincts. The mature ego, ideally, as normal development proceeds is relegated to serve as a point of reference. It functions basically like radar, screening external events and processing them internally.

In families where boundary distortions are the rule, parents continue to project negatively upon each other and upon the child. In turn, the child continues to perceive him- or herself as an extension of the parents, and the enmeshment issue remains unresolved. As the child gets older, inappropriate mirroring or "feedback" by the parents can furnish inappropriate cues as to what is "good" and "bad," thereby setting the stage for developmental problems down the road.

If the parental figures continue to role model inappropriately, the child will already perceive him- or herself as "different" from other children such that by about the age of two pathology is evident to the trained eye, and henceforth the child will begin to exhibit prominent dysfunctional traits. Children raised in a dysfunctional setting typically have difficulty setting boundaries, experiencing appropriate levels of self-esteem and knowing who they are. Not surprisingly, they are prone to role-playing, as they tend to carry a lot of the family's emotional weight.

Whatever the age at which the complications of mental illness begin to appear, they exhibit across a continuum, at the far end of which is psychosis requiring drug treatment and long-term institutionalization. What exactly is psychosis? The simplest definition is *losing touch with reality*. Substance abuse is one of the

commonest causes of psychosis. Others include illness, infection and brain injury. It is important to identify psychosis early because it is treatable. When it is left untreated, neurotoxicity occurs [i.e. natural and/or artificial substances which are toxic to the nervous system cause damage to the nervous tissue, including the brain] and treatment outcomes are poor due to resistance to the usual agents or irreversible neuron damage.

In the last half-century, there has been a shift in medical thinking from a psychodynamic to a neurobiological understanding of mental illness. In other words, it is not "all in the mind." Matter counts too. The discovery of the opiate receptor centers of the brain in the 1950s was just one in a string of conceptual advances that helped to consolidate this shift. Another contributing factor was the serendipitous discovery of the first anti-psychotic medication, chlorpromazine, which was originally introduced as a surgical anesthetic.

The fate of behaviorally-disturbed psychotic patients prior to the discovery of these so-called neuroleptic agents was involuntary committal and institutionalization. Although a very select few individuals responded somewhat to psychotherapy, it was not a practical solution to the problem of agitation within the acutely behaviorally disturbed psychotic patient.

Second-generation neuroleptic agents like clozapine have fewer harmful side-effects. They act on dopamine receptors in the brain, which, together with other neurotransmitters, govern the manifestation of psychoses, including both hallucinations and delusions.

A hallucination is a misperception. These may be auditory or visual, though the auditory form is by far the more common. A delusion is a false belief. Again, there are various themes, which are characteristically related to a particular mental illness. For example, religious delusions are often seen in manic-

depressive people with psychosis whereas persecutory or bizarre delusions are often seen in people with schizophrenia.

A newer generation of "atypical" anti-psychotic agents was introduced in the 1970s to treat psychosis, and since that time, newer and safer agents have come on the market. The main side effects of these so-called "second generation agents" are weight gain leading to metabolic complications, which in turn can lead to diabetes and possible cardiovascular complications.

The paradigm shift that occurred about a half-century ago has revolutionized the understanding and management of neurobiological mental illnesses. I am not sure however that this development is entirely for the better because the newer neuroleptic agents do not address the underlying psychodynamics of mental illness alluded to earlier when I discussed early childhood development. They deal instead with a superficial understanding of these conditions. To my mind, this is one reason why clinical stability takes so long to achieve, and I will support my argument with clinical cases shortly.

Having introduced the topic of causation and contributory factors to dual diagnosis at the outset of the chapter, let me now discuss in more detail each of the four basic scenarios presented earlier. The first suggests that mental illness causes substance abuse, presumably through some mechanism involving self-medication. In the following case study, it plays a key role.

"Rob" has a long history of depression dating back to his teens. He did not self-medicate these early episodes, but in his early 20's, he sought medical help and was started on antidepressant therapy. Within months, the medication unmasked his underlying mania and he became floridly psychotic. In laymen's terms, he "lost it." For example, he began spending uncontrollably, turned promiscuous, and was ultimately incarcerated for drunk driving. He was then

hospitalized, but as he was crafty enough to evade the appropriate diagnosis, he returned to regular life and his mania continued.

After three years, he was again hospitalized when his colleagues at work complained of strange behaviors on his part. This time, a diagnosis of Bipolar Type 1 Depression (with psychosis) was conferred. "Rob" was started on medication and did well for some time. However, he did not follow up properly with medical care and did not take his medication regularly, and began abusing alcohol in order to self-medicate his symptoms. When he was hospitalized for the third time, a further two years hence, both elements of his diagnosis were addressed. It took five years from initial hospitalization to the final conferment of his dual diagnosis. Today "Rob" is five years clean and sober and he remains for the most part stable on medication.

Why is "Rob" stable? Is it simply because he takes his medication regularly? He himself says, "Call it what you will. I call it faith. I believe 'God' is directing my life and I simply have a hand to play in it." This supports my contention as a long-time clinical observer that an individual's belief system greatly affects his or her stabilization.

Let us now look at the second scenario, where substance abuse is said to cause mental illness, presumably by inducing stress, demoralization and neurochemical alterations. In the next case history, the role of medication is again clear cut, but its effect is somewhat tenuous.

"Kristopher" has Schizoaffective Disorder, a hybrid condition combining some of the elements of schizophrenia and a mood disorder that is not often encountered in general practice. As it turns out, "Kristopher" began abusing substances in his early teens, using mainly pot and LSD socially with friends. At a later stage, he would use anything he could get his hands on, which included

crack cocaine, crystal methamphetamine and Ecstasy. He was diagnosed with Schizoaffective Disorder at the age of 24, after being mislabeled by two different psychiatrists initially and placed on medication. Despite treatment, his social functioning remains marginal. Furthermore, though he now sees the drugs he used in the past as "bad," he still continues to drink and he smokes pot regularly.

It would seem that scenario 2, in which substance abuse causes mental illness, does have some bearing on "Kristopher's" case. He has lost the ability to think for himself, needs constant direction, and more or less functions like a machine. The medical term for this is "pickling." The relevant question is why "Kristopher" ended up this way instead of stabilizing into a more productive life. Let's look at his belief system.

"Kristopher's" mother got pregnant in her early teens. He knows little if anything about his biological father. Raised as a Methodist by his grandparents, he now dabbles in the occult in his spare time. As his treating physician, I posit that in order to keep out of harm's way, ingesting fairly lofty doses of antipsychotic medication is his best defense.

Is there hope for "Kristopher"? These days, he is toying with the idea of giving up alcohol and pot altogether. I have told him that I fully support him in this decision. His main problem is that he is a bit of a recluse. Were he to stop isolating himself and establish a circle of support, he would be greatly aided in his endeavor. He is genuinely likeable, but he lacks self-confidence and he harbors a lot of resentment toward his orthodox religious upbringing. This, however, is not altogether a bad sign: at least he believes, if not acknowledges, there is a God.

The role of psychosocial therapy in "Kristopher's" case would be to help him

consolidate his beliefs in order that they work for him, rather than against him. I firmly believe having seen countless cases like this one that once this consolidation is accomplished and he begins to own his experiences, he can be guided along an appropriate path and ultimately achieve stability in his life. One proof of stabilization would be a growing ability on his part to successfully navigate the difficult area of personal relationships.

At this point, we might ask whether addiction itself is a disease. There is a growing body of evidence in support of this fact. [1] I myself believe that where addiction precedes the onset of mental illness, environmental issues need to be addressed and measures need to be taken to confront the problem of addiction. These may include detoxification, residential treatment and/or psychotherapy.

Let us now look at the third scenario, one which posits that one or more common causes underlie both the mental illness component and the substance abuse leading to abuse including such things as genetic and environmental factors.

"Michael" has been a patient of mine for some time. When he first came to see me, he was not living on the street, but he had gotten involved with the drug subculture and contracted a heroin habit that was costing $80 to $100 a day. He was soliciting as a male prostitute in order to satisfy his dependency.

After a few sessions, "Michael" said something that struck me as quite odd: "A bird in the bush is worth two in hand!" In time, as we developed a therapeutic relationship and he came to appreciate the notion of healthy boundaries, I asked him how many sexual partners he had had. When he told me he was a closet bisexual, I finally understood his strange remark. I also realized that he

had not yet come to terms with his sexuality. Today, "Michael" leads an openly gay lifestyle. Let's look at his history in a little more detail. He comments:

I grew up in an extremely religious household. During my childhood, I recall my parents being rather harsh disciplinarians. Despite the fact that their marriage was stable, it was extremely turbulent. My father was an alcoholic – though he was in recovery when he met my mom – and there is a strong family history of mental illness on her side. She was emotionally abusive, particularly towards my father. Not only that, but my mother has a history of severe depression. In fact, she was depressed during her pregnancy with me.

Early in recovery, "Michael" was diagnosed with hepatitis C, which he acquired through injection drug use. Around this time, he was also diagnosed with Attention Deficit Disorder (ADD). Both issues have somewhat complicated his recovery. He is now on a methadone program and follows up regularly with me. He has supervised urine drug screening which has been negative apart from methadone metabolites for many months, and has now attained sufficient stability that he can be treated for his hepatitis C. He has also graduated from regularly supervised to random monitoring of his urine.

Methadone is a synthetic opiate antagonist that is used therapeutically to combat heroin addiction. Due to the long half-life of the drug (meaning that it persists in the blood stream for quite a while), it can be dosed once a day. This makes it possible for addicts to lead productive, stable lives without having to shoot up several times a day, and without diverting their time and energy into searching for ways to procure their next fix. Typically, an individual is started on a low dose of the drug, and it is incrementally raised until all cravings for opiates have subsided. Participants may choose to stay on the program or wean themselves off methadone as they see fit under medical supervision.

Today, "Michael" holds down a steady job and is going to school part-time

to earn a diploma in electronic business systems management. He is also in a stable monogamous relationship. He got married earlier this year to "Greg." Apart from being significantly older and more tolerant, "Greg" is also patient and understanding. The two make a handsome couple.

All this would not have been possible were it not for the methadone and the psychostimulant medication "Michael" takes for his ADD. Moreover, he has come out of the closet and has developed a value system of his own that he abides by. Curiously enough, he has adopted some of the values of his childhood such as marriage and a belief in a Higher Power. He has managed to counterbalance both genetic and environmental factors in his recovery thanks in part I would contend to the stability within the home and the values he imbibed during childhood.

Now for the final scenario, the one where the two conditions of mental illness and substance abuse are associated in the absence of a common cause. Let's look at how this can occur.

"Jaspreet" recently started using cocaine. As is common, this habit started through peer pressure. Her boyfriend dealt the drug, which made it easily accessible to her. However, the relationship was abusive, and she came in to see me because she was experiencing symptoms of depression. During our first visit, she informed me she was scared of her boyfriend and did not know how to get out of the relationship. On numerous occasions, he had threatened to harm her if she left.

I started "Jaspreet" on anti-depressant medication, which worked marvelously, and also recommended that she look into drug rehab and find a safe house for battered women. She followed up on this advice. Within six months, she was no longer clinically depressed, was off the cocaine, and had made strides

towards a new beginning. Her antidepressant was tapered over the next several months.

The about-face in "Jaspreet's" circumstances leads me to introduce another point about the remarks I make. I work in two addiction clinics, one in downtown Vancouver and the other in a large suburb of the city. In the downtown clinic, I see a lot of co-existing physical disorders, particularly sexually transmitted diseases (STDs), HIV-related illnesses and hepatitis. There is also a higher rate of serious mental illnesses in the downtown population.

In the suburban clinic, I deal mainly with migrant workers who work extremely long hours doing menial jobs. Their addiction is a function of the type of work they do, the long hours they work and the existing social fabric. Many of my patients from this group have a stable family life and belong to the Sikh religious community, which has an extensive social network. I contend that the basic infrastructure that is in place within this community reduces the existence of so-called comorbid conditions (such as HIV-related illnesses, severe mental illnesses and such) and speaks to the need for an entrenched system of values which individuals may imbibe as this confers a predilection toward stability over the intermediate and long term.

Cross-cultural comparison between the two populations reveals that within the sub-population of individuals in the downtown core, in addition to the usual environmental factors, genetic factors are no doubt operative in the majority of cases. This leads me to conclude that so-called genetic factors may only come into play once the usual safeguards such as psychosocial stability conferred within the home and the immediate microenvironment have begun to erode and no longer provide an adaptive advantage. The issue we are dealing with within the subpopulation of individuals within the downtown core is primarily trauma, particularly neo-natal and early developmental trauma. In

contrast, within the suburban community and despite some exceptions, the crux of the problem seems to be an inability to erect and maintain meaningful boundaries, which are oftentimes inbred manifesting if you will as innate cultural phenomena. My point here is to suggest that psychodynamics when viewed socially if not individually do play an important role despite the paradigm shift which has occurred over the last half century or so in favor of a strictly neurobiologic explanation of both certain mental illnesses and related addictive behaviors. Therefore, it is important to weigh psychosocial factors and their potential contribution to the overall management plan in individuals conferred with a dual diagnosis.

It is well known [2] that childhood abuse, and in particular a history of sexual abuse, can lead to the onset of both mental illness and addictive illness later in life. Cultural factors can be equally important in some contexts even though they may surface less often or appear less severe. For example, in some societies, individual expression is virtually submerged by the larger cultural identity when the community, clan or tribe comes first. It is important to consider and weigh the possible effects of cultural factors in dual diagnosis particularly as concerns the more common anxiety and mood disorders which often coexist within the milieu of a Substance Use Disorder. I say this simply because it has been my experience that particularly in the case of anxiety disorders, they tend to predate the onset of an associated SUD. The key point here is prevention of a SUD.

To end our discussion of possible causes, let us now turn to what recourse is available, and in particular, to Harm Reduction as a philosophy of reform. Harm Reduction is based on the recognition that people always have engaged, and always will engage, in risky behaviors including casual sex, prostitution and/or drug use. The main objective of Harm Reduction is to mitigate the

potential dangers and health risks associated with the risky behaviors themselves rather than attempting to eradicate the behaviors themselves. As a public-health strategy, it is intended to be a progressive alternative to the outright prohibition of potentially dangerous lifestyle choices.

And what belief system have I personally evolved? When it comes to spirituality, I seek authenticity over and above all else in my life. I do not necessarily believe something because I have read it or because some authority states that it is so. What I consider to be infallible is that which I myself have lived and know to be true. The truth speaks for itself. If I were to sum up "my" religion in one word, that word would be "faith."

When I am asked what faith is, however, my response is always, "Why are you asking me? Ask yourself!" I do not believe there is any single "correct" answer. Faith is something, like intuition, that everyone possesses and that is important to cultivate. Why? Faith will not help a person change water into wine or walk across water, but it can move mountains when that person comes to believe that God is doing what he or she cannot. An inner transformation occurs. Call it an awakening.

The traditional medical paradigm treats only the periphery of dual diagnosis. In order to achieve stability, I believe that spiritual clarity must be part of the treatment. Faith and self-knowledge are two possible paths to get to it, and at the end of the road, the light of consciousness beckons along with the beacon of love.

I believe there is such a thing as spiritual love or *agape*. It is love devoid of any carnal aspect, which is a concept the dually-diagnosed sometimes have trouble comprehending as they are frequently plagued with sex problems. Most individuals with a dual diagnosis confuse love with attachment. The even deeper

issue is the psychological dependency at the root of the attachment. Underlying all is the ego and its paralyzing, toxic fear. If love was understood and embraced within our Western society as being primarily spiritual rather than carnal I would contend that a lot of the difficulties in comprehending the term would be obviated. However, as it stands this is perhaps wishful thinking because today "love" whether defined in positive or negative terms has become something which is little more than a commodity and as such remains a fantasy at least for the vast majority of our younger generation particularly the dually diagnosed.

At the end of the day, it all boils down to a question of boundaries. When sound boundaries are in place, we may then know, protect and experience our true selves. We can vanquish the fear. But for that to happen, we need to relinquish control, the basic mandate of the ego, and surrender to the reality. With less compulsion and anxiety about running the show, things go the way they are meant to in life, which is often better than good, thanks to the grace of a God of one's own understanding.

THE SCOPE OF THE PROBLEM

"The more choices you have, the more your values matter."

– Michael Schrage

"If death meant just leaving the stage long enough to change costume and come back as a new character ... Would you slow down? Or speed up?"

– Chuck Palahniuk

Having broadened the discussion of dual diagnosis in the last chapter and provided clinical cases to illustrate the condition, I would now like to provide some historical background to put into perspective what causes dual diagnosis. There are two theories of historical significance: Darwin's theory of natural selection and Mendel's theories of inheritance. Each complements the other.

Charles Darwin was a naturalist who studied the adaptive characteristics of various species of finches in the Galapagos Islands. His theory of natural selection, laid out in his 1859 book, *The Origin of the Species,* became the accepted mechanism by which the evolution of all species was presumed to have oc-

curred. However, it was Gregor Mendel, now regarded as the father of modern genetics, who proposed two separate theories – The Law of Independent Assortment and the Law of Segregation – that helped to provide a foundation for Darwin's conclusions. Mendel's paper, *Experiments on Plant Hybridization*, was published in 1866.

In my opinion, it was the identification of DNA, the basis of all life on Earth, by Swiss chemist Friedrich Miescher in the 1860s that consolidated the efforts of Darwin and Mendel. Most people mistakenly assume that DNA was discovered in the mid-1950s by James Watson and Francis Crick of Cambridge University. What Watson and Crick actually did was to elucidate the chemical structure of DNA, a feat for which they received the Nobel Prize almost a century after Miescher's discovery.

Our understanding today is that DNA, or biological intelligence, is not a static entity but a dynamic one. I liken it to an air traffic control tower rather than the blueprint it was originally conceived to be. In this newer model, "time" as we conventionally understand the concept gives way to "space-time," a concept originally coined by physicist Albert Einstein, and hence biological intelligence is considered more virtual than linear. By this I mean that all biological events are posited to be occurring simultaneously within four-dimensional space, including time, such that a single molecule can literally oversee untold biological processes without having to rely upon any external intelligence.

At the level of the mind, cause and effect are also fluid, just as throwing a stone upon water creates ripples. The term "mind" refers in fact to an all-encompassing field that is localizable neither in space nor time as these entities exist in three-dimensions: it is omnipresent, which is to say that it is found anywhere and everywhere within consciousness, with the virtual intelligence of DNA serving as command center.

Using a similar analogy, I would liken a dual diagnosis to the epicenter of an earthquake: once the damage is done, it is irrevocable based on our current understanding, but, from a management perspective, if we wish to localize and confine that epicenter, we first need to have an idea where the fault lines lie. I have defined belief systems as the sum total of an individual's ideas, attitudes, beliefs and values, and I believe they are a core issue to consider.

Let me qualify the above statement by pointing out that ideas, attitudes and beliefs often vary considerably from generation to generation. Values, on the other hand, tend to be much more deeply ingrained. They represent the characteristics of a society that validate and perpetuate that specific social system, so they tend by definition to self-perpetuate until they are obsolete, and even far beyond when their shelf-life expires.

Most people would tend to ascribe a moral connotation to their values. At the risk of splitting hairs, I do not believe that is entirely correct. What then is the difference between morals and values? Morals help an individual decide between what is categorically right and wrong. Ideally, values have a pedagogical function, that of guiding the individual smoothly through the various stages of life.

Values essentially serve an adaptive function. In the case of the family unit, they are imbibed as if by osmosis, and they either can assist the individual in facing and coping with life, or they can prove disabling, in which case the individual succumbs to the life circumstances he or she has been dealt with given the values that have been modeled within the home. Which is not necessarily bleak. Take for instance the gifted artist who gives up his or her avowed true passion and ends up perpetuating the family values by going to Harvard and becoming a brilliant third-generation surgeon.

Indigenous populations of the world have a lot to teach Western society about sustainable values, though these lessons have come at a terrible price. By and large these proud peoples have been stripped of their values and native heritage, decimated by slavery or colonization and the scourge of imported illness, or plundered by the advance of industrialization and racial prejudice. It is only through the rekindling of native spiritual practices that the younger generations are now coming back into their birthright, particularly in North America.

Modern humans themselves are mired in an anguished search for self. Our society is on the cusp of profound cultural changes. People aren't buying set formulas anymore, nor the pious platitudes of eras gone by. We are prone as never before to existential angst, or so it seems, and the beaten track brings neither comfort nor hope, much less awakening. Unfortunately, both mental illness and addiction are symptomatic of this profound deficit.

Many of the diseases of so-called modern humans are both a product and a reflection of their social condition. Curiously enough, addiction was unknown to the aboriginal peoples of the Americas. But how did these cultures deal with the phenomenon of mental illness? Each tribe had its shaman, medicine man or native healer.

Shamans were individuals who, during the course of their early development, either as children or as teenagers, had had a tumultuous psychological experience that catapulted the entire psyche inward. Those who succeeded in integrating the demonic or deistic elements encountered there into their personality emerged strengthened from the experience, and equipped henceforth with deeper and visionary insights to help the tribe survive. Many were then trained by elder shamans and other keepers of the clan's wisdom or through further exploration of their inner worlds, often with the aid of sacred psychotropic drugs.

Whatever the method, shamans became adept at guiding others who were experiencing crises of the psyche to gain a firm foothold on reality, be it through native pharmacopoeia, incantation or ritual, including dream questing. In this sense, aboriginal peoples had a true understanding of mental illness as something that affects the subconscious. To me, the general practitioner (GP) plays the role of the modern-day shaman in many ways.

Western medicine has adopted the scientific method for the study and treatment of mental illness. It is hard to imagine that it still relies in part on Newtonian mechanics devised over 300 years ago. By focusing more on the chemical and mechanical aspects and ignoring the energetic dimension of reality, it limits the understanding of healing to what I consider to be a great extent. Newtonian logic and methods work for disorders that have a physical origin, such as trauma, physical deficiencies, poisonings and infections. But physical illness can also stem from energetic dimensions that are affected by one's beliefs, attitudes and thoughts, and this is often the case with dual diagnosis.

Our current bio-psychosocial model for treating dual diagnosis was first proposed by psychiatrist George Engel in 1977, and it was primarily directed at physicians and health care workers. The model I advocate is more patient-centered: it addresses the energetic component of human illness and recognizes a spiritual dimension that is core to all healing.

To me, what is needed is a model of care in which the general practitioner creates "the spoke in the wheel" so to speak. At the epicenter of this model, unaffected by outward circumstance, is the patient's innate and ever-abiding spiritual connection to a Higher Self or Divine Presence, whatever the name of choice. The primary role of the GP is to facilitate the connection between that epicenter and the outer rim of the wheel, represented by functional sta-

bility in the patient's everyday life. The sturdiness of the wheel equates to the state of the individual's general health and well-being.

I do not believe that one can actually correct or eradicate emotional, mental or spiritual problems with purely material remedies or physical manipulations. Yes, it may be possible to improve the condition for a time or to mask the symptoms and physical effects by such means. But emotional, mental and spiritual disorders *per se* need to be treated at the same or higher level than where the dysfunction originates. In this respect, spiritual solutions best resolve mental problems, and rational understanding more effectively resolves emotional problems. When a condition is treated from below the originating level, it is my experience that negative side effects, complications and unexpected relapses tend to arise.

Fortunately, many of society's ills are just the result of a lack of common sense. Our education system is primarily at fault. Some would argue that acquiring a sense of responsibility, punctuality, respect and discipline are more than adequate end goals along with basic academic proficiency in what used to be called "the 3 Rs." But what of those individuals, including many with a dual diagnosis, who fall between the cracks? Are they to be herded through with the rest of the fold only to be cast aside after high school graduation, if they even make it that far?

It is my belief that every child should be regarded as unique and given the opportunity to climb the ladder of success whether he or she is in need of specialized attention or not. Individuals can be given aptitude testing as required and then directed along the appropriate path. This is not to say that education is about summarily separating the wheat from the chaff for progressively more cutthroat stakes. Rather, it should aim to instill self-esteem, self-confidence and a winning attitude in all. Some may simply be better served by leaving the

traditional school system and being educated in some alternate manner, including the very gifted.

When it comes to the dually-diagnosed, we need to identify not only which individuals have not succeeded within the traditional school system but also *why* they have not succeeded. As it was pointed out in Chapter 1, mental illness and addiction are often all but entrenched by the time a child is in his or her teens. As we saw in Chapter 2, we are often dealing with familial and societal attitudes that address only the surface of the problem. At the stage where neither overt mental illness nor addiction are present, genetic and environmental factors need to be considered and preempted or counterbalanced in some way so that an individual who is battling the odds can have a fighting chance.

Societal attitudes toward the dually diagnosed need to change such that these individuals be afforded the right to hold an esteemed position within society. Just to clarify that point, it is not the position itself but the aptitude and attitude of the individual holding the position that count, plus his or her sense of accomplishment in doing the job well. Once there is a genuine foundation for self-esteem, there will be no need for these kids to look elsewhere to validate their experience.

Whatever course of action one elects to follow in life, there seems to be a magnetic correlation between one's ability to rise to the inevitable challenges and the presence of a functional belief system that is fully integrated. Psychologists now understand that a substantial cross-section of the individual's character traits develop during the formative years, so the longer it takes to identify and confront a potential problem, the more entrenched it becomes. Some 10 or 15 years later, it is often too late to correct troublesome issues that could effectively have been nipped in the bud if identified at a much earlier stage. By the same token, something that would have been considered a minor problem

if identified at the outset is far more difficult to address later in life, sometimes even to the point of being cast in stone.

In the broader arena, I would suggest that before we can overcome many of the prejudices that limit our progress as a global society, we need to re-assess some of our cherished attitudes and beliefs by examining the values that underlie them. Take materialism as an example of an explicit value system.

It is one thing to look upon the plight of the Third World and feel a deep sense of empathy for those who live there under abject circumstances, but how ready are we to acknowledge how much our Western lifestyle is directly responsible for and perpetuating that great divide? At last count, less than 20% of the world's population wastes and usurps 80% of its resources. Is there not some fundamental incongruence here?

Another random example of skewed values is how little depth or credibility many role models possess today. Name three celebrities the younger generation look up to and long to emulate. Do you think any of these people or the fads they represent are likely to be anything more that a footnote to society 50 years from now?

In another vein, the current Western stereotype of adult womanly beauty is unsustainable for all but a minuscule few. I am reminded of a quip circulating on the Internet a few years back to the effect that there are over three billion women in the world today but only seven or eight supermodels. Underlying this sad assertion is that women collectively are still being coveted today as objects of desire or valued as mere chattels – if they count at all – rather than being respected for being who they are.

Another modern-values fallacy is the prevalence of the nuclear family. This is a concept alien to most aboriginal societies and certainly to those throughout the

East, where extended and joint families are the norm. Even in the West, less than 25% of families today fit the pattern of two parents, one of either sex, sharing the duties of child rearing. It would seem as often as not, single young females are now heading up single-parent households. In sum, the so-called "traditional" family is just not the reality anymore.

I still feel that children need a stable family structure in order to develop stable, balanced personalities and best learn to deal with life on life's terms. However, traditional marriage as a social institution does not necessarily guarantee a stable family life. Once again, I stress the importance of putting into place a mature, functioning belief system. An individual who is accountable to him- or herself can then be counted on by and large to be accountable to and for others. Let's take a look at a case study.

"Zoltan" recently celebrated his eighteenth year of sobriety. He is Serbian and was born into the Eastern Orthodox faith. His mother was an alcoholic and his father was an enabler. His family life as a child was turbulent. He was raised a Christian as was "Alexis," his partner, who is also an alcoholic. The difference is that "Alexis" is a practicing Christian whereas "Zoltan" no longer attends church services. Although "Zoltan" and "Alexis" are not married, they have conceived a child together, "Jakob," who is now two years old. "Alexis" has two other children from two separate fathers but she apparently sees something in "Zoltan" that she especially cherishes. I expect that this couple have their ups and downs like most couples do, but it is clear that together they stand for something that neither is capable of generating alone. I am happy to report that both are currently sober.

He may no longer go to church, but "Zoltan" attends on average two meetings of Alcoholics Anonymous (AA) a day. He exhibits prominent bipolar traits and, truth be told, if it were not for these meetings, his life would undoubtedly

fall to pieces within a short time. He would most definitely benefit from mood-stabilizing medication if only he would agree to it.

"Zoltan" is fully aware of the fact that his stability is somewhat tenuous. He knows from experience that when he is glib and does not give the meetings his full attention, his spiritual condition rapidly deteriorates. Still, "Zoltan" is by no means a social misfit and he is spiritually fit, at least for today. Though his life has been filled with struggle, to the point where he recently declared bankruptcy, "Zoltan" has determined that the load is infinitely easier to bear with AA, and has tremendous faith in the power of his meetings. In fact, he gets quite irritated if anything interferes, even his family life.

However, having interacted with baby "Jakob" on several occasions, I can attest that "Zoltan" experiences a genuine release from his conditioned thinking as a result of the meetings. The important thing is that neither he nor "Alexis" is currently using and they care deeply for one another. "Jakob" is growing and developing normally. He is an adorable, happy child and both "Alexis" and "Zoltan" dote on him.

I have chosen this case history to illustrate the importance of having a solid belief system, whatever the basis. Though "Zoltan" has broken with the Church, he is a wholesome man in many ways thanks to AA. Still, his life experience, as mentioned, has been less than ideal and his values continue somewhat to reflect this fact. The sad truth is that "Zoltan" has had to learn everything he now goes by from scratch, and he began to do so only once he entered Alcoholics Anonymous.

To me, it does not matter by what name "Zoltan" calls his Higher Power because his positive actions speak for themselves. There is, however, a caveat. Addiction is a cunning, baffling and powerful disease. Despite his 18 years of

commitment to not drinking, "Zoltan" remains what would typically be considered a true alcoholic. He is "clean" in that he clings for dear life to attending his two AA meetings a day, more or less without fail. His is an example of spiritual progress, not spiritual perfection.

"Zoltan" has realized that he does have a choice; he can wallow in self-pity or he can take a stand. But abstinence is not recovery. It is relationships that form the cornerstone of recovery from both mood-altering substance abuse and mental illness. At the heart of "Zoltan's" unresolved condition are fear and a deep-seated sense of insecurity. I contend that these traits are both a reflection and a product of childhood trauma that no amount of faith can remove, at least not in "Zoltan's" case.

The more deep-seated the insecurity, the stronger the attachment to an answer that brings temporary relief. So although AA has apparently effected a radical transformation in "Zoltan," especially when viewed in hindsight, in truth its influence can be considered a moderating one at best because "Zoltan" is still not whole. He suffers from psychological dependency as well as his bipolar issues.

If more self-knowledge could be counted on to bring about the ultimate resolution of "Zoltan's" ills, how far would I say he is from experiencing his true self? Well, before this can happen, I suggest that he needs to transcend his ego or the image he has created of himself. To his credit, he has travelled somewhat along the path by giving freely of himself in service to other AA members.

Through AA, "Zoltan" has come to appreciate the value of basic life skills and tools such as discipline and accountability for one's actions. Undoubtedly, the fellowship has also taught him the value of humility and opened the door for him to a deeper experience of the human condition. However, what "Zoltan"

still fundamentally lacks is self-control. In many respects, he is an accident waiting to happen. Each time I see him in the office, he is transiting in and out of crisis. His life is melodramatic to say the least, and in a strange sort of way, he seems to thrive on the excitement. Perhaps chaos is what he knows best. Certainly, the insanity in his life is mostly of his own making.

Like "Zoltan," most members of self-help fellowships move through the Harm Reduction paradigm whereby substance abuse is either gradually tapered through consecutive phases of medical management, or they completely abstain with varying levels of success. We will discuss the philosophy of Harm Reduction at greater length later. As far as the mental illness component of a dual diagnosis goes, compliance with the medication guidelines inevitably remains a major component affecting the patient's overall outcome.

In my opinion, though self-help fellowships are useful, they can often merely replace one form of dependency with another. "Zoltan" is just as addicted to his AA meetings as he was to his drug of choice when he was actively using. His life is arguably better, but his stability remains tenuous.

Some may argue that belief in a Higher Power is not a dependency in the regular sense of the word. I beg to differ. In my view what is all-important is faith, which I define as a *reliance* on God, not a dependence. Reliance encompasses the term self-reliance which is based upon the broader notion of self-knowledge used within Eastern parlance, and reinforces the point that in order for real change to occur, one must be willing to do at least some of the work. Real power comes from within, and true understanding implies action.

One overriding criticism of self-help fellowships is that they don't work. Well, that is perhaps a bit harsh. I would just say that there is a general lack of hard statistical evidence or other scientific proof to outweigh the by-in-large anec-

dotal evidence that these programs are effective. In support of the criticism, however, I have met many alcoholics in the AA program who fell off the wagon after many years of consecutive sobriety and ended up leaving a path of devastation in their wake.

What are the values we should be honoring within Canadian society? First and foremost any value system adopted must be sustainable. Social democratic thought has inspired legislation to entrench such benefits as worker's compensation, minimum wage, old-age pension, unemployment insurance, family allowance, subsidized housing and medicare. The welfare state has largely been the product of joint action by new democrats and reform-minded liberals based on a belief that capitalism and democratic rights can coexist in such a way that all segments of society benefit. In recent years, however, social democratic doctrine has come under increasing criticism from both left- and right-wing elements.

The radical and revolutionary Left charges that social democratic reforms are too eclectic, targeting too few and mostly unprofitable industries. They cite detailed analyses to prove that the welfare state has not altered class inequality to the degree expected and that poverty in Canada is more firmly rooted than ever. In sum, social democracy to them has produced only cosmetic changes at best, making capitalism appear more humane and workable, and delaying needed structural changes.

By definition, the goal of the Far Left is socialism, not social democracy. The problem is that the word itself almost universally raises the specter of communism, its dreaded-though-more-or-less-defunct brother. Not very many people in this country have any meaningful conception of what "socialism" might entail as a workable political platform.

The welfare state is also under attack by right-wing neo-conservatives critical of large increases in government expenditure and the size of the civil service. They note that economic growth is now slowing down and that the combination of high unemployment and higher inflation rates not only confirms the menace of reduced productivity, but is the harbinger of funds running out with which to finance social spending. One result is that programs such as universal medicare are being ever more stridently attacked by this faction. This is obviously a concern to someone like me who works closely with a number of marginalized elements within the community including the dually-diagnosed.

How has this clash of political extremes and all of the ensuing political rhetoric affected societal attitudes? Well, instead of the social foment one might expect the battle of ideologies to generate in the body politic, there has instead been an increase in apathy as evidenced by poor voter turnout and a lack of public participation at the municipal and regional levels.

And how much of this vacuum can we attribute to a general absence of media focus on reporting changes in public policy, both contemplated and implemented, so that all sectors of the public know what is going on? Instead of fulfilling a key role as watchdogs in defense of the public good, the radio and television industries have increasingly and rather consistently been morphing into straight-line purveyors of entertainment.

In my opinion, North American society is eroding from a cultural point of view and this is evidenced primarily by a lack of clear-cut identity. We seem to be constantly striving to reinvent ourselves, but the concept is so fractured and fuzzy that we are missing the boat entirely. We just do not know who we are anymore. Our institutions, our ideals and our role models all lack even the most basic credibility, with the inevitable result that as a society, we are floundering for even a whiff of the correct direction in which to move.