

DOI: 10.21767/2472-5048.100018

Unexpected Gates to Effective Treatment in Dual Diagnosis

Pacini M*

Department of Psychiatry, Pisa University, NFB, Italy

***Corresponding Author:** Pacini M, Department of Psychiatry, Pisa University, NFB, Italy, E-mail: paciland@virgilio.it**Received Date:** July 07, 2016; **Accepted Date:** July 08, 2016; **Published Date:** July 11, 2016**Citation:** Pacini M (2016) Unexpected Gates to Effective Treatment in Dual Diagnosis. *Dual Diagn Open Acc* 1:18. doi: 10.21767/2472-5048.100018**Copyright:** © 2016 Pacini M. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Editorial

Dual diagnosis, intended as an autonomous focus of psychical disregulation adding upon drug-related problems, is often regarded as a source of further behavioural instability and a forerunner of poor therapeutic outcome. Available data suggest a different perspective, which is important to clarify for its implications for the therapeutic management of patients.

Dual diagnosis patients may have experienced poor therapeutic outcome failed to endure within therapeutic programs enough to reach stabilization. However, they also ask for help on both sides, which mean the baseline likelihood of therapeutic engagement is at least twice as much, in terms of generic chances. Curiously, the therapeutic answer they may get neither treatment for addiction, nor treatment for associated psychiatric conditions. Maybe, the interpretation of the co-occurrence being that of a cause-effect relationship, they may be judged as in need for one basic treatment, either psychiatric or anti-craving, so that the "second diagnosis" (whatever it may be) of their problem will come to a solution following control over the "first" diagnosis [1].

For instance, depressed alcoholics may have resorted to both the addiction treatment centre and general psychiatric facilities, and have been advised to detoxify first, in order to start antidepressant treatment, and in the meantime to treat depression in order to call off craving-related urges. Apart from the frequent mistakes in choosing an appropriate anti-craving treatment, and the gratuitous interpretation of the links between this psychopathological ground and that substance use behaviour, with little if any scientific evidence, this splitting therapeutic engagement grants patient with no real engagement.

Patients feel themselves as "one", although they may understand the duality of their illness. What is hampered by the duality is, certainly, the capability to adapt to complex mechanism, and spend time without immediate results. The "one doctor's shopping" model, also described for patients with multiple illnesses such as mental and infective, or drug-related and infective, should be adopted to deal with dual diagnosis, too.

Excessive filters or barriers between the patients and the treatment, weigh twice as much on the dropout rate and attrition rates of the dual diagnosis sub-populations.

Nevertheless, in favourable therapeutic conditions, dual diagnosis patients do not seem to experience a bad outcome. A population of dual diagnosis patients, for instance, was followed up for eight years in a methadone maintenance program. The program was run by psychiatrists, who had also been trained to treat addiction and methadone treatment in particular. The physical location of the treatment centre was part of a University department, with no need for the patient to attend different locations, and the possibility to be evaluated on both grounds while coming to be administered their daily medication or collects their take-away methadone weekly supplies. No unfunded limitations were applied to the programs, such as methadone dose-limitation, or pre-determined duration of the maintenance phase [2,3].

Dual diagnosis patients showed a better retention rate, especially as far as long-term retention is concerned. Their maintenance dosages was 30% higher than the average of single-diagnosis peers (150 mg vs. 100 mg approximately). Thereby, apart from the higher-dose populations which need higher oral doses in order to compensate for faster metabolism, the category of dual diagnosis (in this case mostly bipolar) have a real need for higher doses in order to reach similar rehabilitative results.

A recent study was performed on an anonymous sample of on-line consultations, which dealt with opiate use-related issues. Consultations were classified according to the kind of question: about addiction, about toxic effects or interactions, or about presumably independent psychiatric symptoms (virtual dual diagnosis). Moreover, the kind of thought and position expressed in the consultations (which also included multiple comments and rebuttals written with the virtual physician) was classified with respect to three concepts concerning addiction 1) the automacy of relapsing course; 2) the control over substance use; 3) the continuity of addiction across relapses [4].

Virtual patients with no DD showed to have a lower level of insight, since thinking quite often that addiction was a history of independent episode of problematic use, with no continuity; that each relapse was due to a contingent life condition, or psychological state; and that control over the substance may be restored in favourable conditions. Such a finding indicates that dual diagnosis patients may develop a better understanding of their addictive disease because of an inner "control" represented by the their other psychiatric syndrome. Single

diagnosis addicts, instead, tend to be blind to their disorder, in a way that is proportional to the severity of their addictive symptoms.

Dual diagnosis patients, in conclusion, should be regarded as patients who may benefit from treatment under special conditions. The psychiatric reason for treatment request, as well as the unexpected better insight upon their addiction, should be handled as means to optimized treatment adherence. On the other hand, dispersion of health assistance, conflicting indications between psychiatrist and addiction physicians, and multi-site treatment programs should be avoided.

References:

1. Matteo Pacini, Maremmani I, Luca Rovai, Fabio Rugani, Silvia Bacciardi, et al. (2013) Self-presentation and health issues of anonymous heroin addicts asking for a free internet medical consultation. *Heroin Addiction and Related Clinical Problems* 15: 33-38.
2. Maremmani I, Canoniero S, Pacini M (2000) "Methadone dose and retention in treatment of heroin addicts with Bipolar I Disorder comorbidity. Preliminary Results." *Heroin Addiction and Related Clinical Problems* 2: 39-46.
3. Pani PP, Maremmani I, Pacini M, Lamanna F, Maremmani AG, et al. (2011) Effect of psychiatric severity on the outcome of methadone maintenance treatment. *Eur Addict Res* 17: 80-89.
4. Maremmani I, Pacini M, Lubrano S, Perugi G, Tagliamonte A, et al (2008) Long-term outcomes of treatment-resistant heroin addicts with and without DSM-IV axis I psychiatric comorbidity (dual diagnosis). *Eur Addict Res* 14: 134-142.