

How to Start a
Double Trouble
in Recovery
Group



A GUIDE FOR PROFESSIONALS

How to Start a Double Trouble in Recovery Group

How to Start a Double Trouble in Recovery Group



A GUIDE FOR
PROFESSIONALS

HAZELDEN®

Hazelden
Center City, Minnesota 55012
hazelden.org

© 2010 by Hazelden Foundation
All rights reserved. Published 2010
Printed in the United States of America

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means—electronic, mechanical, photocopying, recording, scanning, or otherwise—without the express written permission of the publisher. Failure to comply with these terms may expose you to legal action and damages for copyright infringement.

ISBN: 978-1-59285-839-2

Editor's note

This publication is not intended as a substitute for the
advice of health care professionals.

Alcoholics Anonymous, AA, and the Big Book are registered trademarks
of Alcoholics Anonymous World Services, Inc.

14 13 12 11 10 1 2 3 4 5 6

Cover design by David Spohn

Interior design and typesetting by Ryan Scheife, Mayfly Design

Contents

Acknowledgments	vii
Introduction: A New Beginning for People with Co-occurring Disorders	1
Chapter 1: Co-occurring Disorders: An Overview	5
Chapter 2: The Role of Peer Support Groups in the Continuum of Care	13
Chapter 3: Peer Support Groups: The Twelve Step Model	25
Chapter 4: How Professionals Can Support a Double Trouble in Recovery Group	41
Pamphlets (reproducible versions can be found on the CD-ROM)	
Suggestions for Starting a Double Trouble in Recovery Group ..	65
The Role of Sponsorship	71
Additional Resources (reproducible versions can be found on the CD-ROM)	
Sample Script for Double Trouble in Recovery Meetings	77
Sample Meeting Notice	83
The Twelve Steps of Double Trouble in Recovery	85
The Twelve Traditions of Double Trouble in Recovery	87
Where to Learn More	89
Notes	91

Acknowledgments

Grateful acknowledgment is due to the following individuals and organizations whose support, encouragement, and resources have made this manual possible:

- Edward K., member, board of trustees, Double Trouble in Recovery
- Carolyn P., friend and colleague, who provided support over the years
- David N., freelance writer and dear friend, who has helped from the very beginning to develop Double Trouble in Recovery
- Howard V., executive director of Double Trouble in Recovery, Inc.
- Sid Farrar, editorial and trade director at Hazelden Publishing
- Doug Toft, writer and editor

Countless survivors of the mental health system, working toward their own recovery, whose experience, perseverance, courage, and struggle make up the heart and soul of this work.



INTRODUCTION

A New Beginning for People with Co-occurring Disorders

This letter came to us. It was signed by Andy:

I am a recovering alcoholic. I hear and see things, too. I am in Alcoholics Anonymous and have admitted I am powerless over alcohol and my mental disorder, like the program's First Step suggests. I am sober, but I still hear voices talking to me always. Other members of AA don't have these experiences, and I feel alone. They tell me to "let go and let God," and I feel I have tried very hard to, but it just doesn't help. I must have done something terribly wrong to have these voices for eight years. I must be viewed in an unfavorable light by God. I must have many sins in my soul. I wish so much that there was somewhere to go where others have experienced both these problems.

There is such a place.

I write this for Andy and the rest of the people like us.

Double Trouble in Recovery is a special interest meeting that has been adapted from the Twelve Steps of Alcoholics Anonymous. It is a fellowship for men and women who share their experience and hope with one another so that they may solve their common problems. Double Trouble specifically embraces those alcohol and other drug users who also have a diagnosis of a mental disorder.

2 How to Start a Double Trouble in Recovery Group

Double Trouble in Recovery began in New York State in 1989 in humble circumstances—at a city hospital in Brooklyn, New York. At the time, I was working in a dual-diagnosis day treatment program. There I met Dr. Ed Knight, who, during a presentation about self-help groups, openly disclosed his diagnosis of paranoid schizophrenia and boldly took from his pocket his vial of medication. That presentation changed my life.

Double Trouble in Recovery provides a missing link. Too many of us experience other Twelve Step meetings as bewildering, anxiety-provoking events that are difficult to endure. In Double Trouble in Recovery, newcomers find an environment in which issues of medication and mental disorders can be dealt with openly. This environment encourages recovery instead of active addiction and hospitalization. It is my firm belief that this is a breakthrough, and that it is working for us.

A common thread in self-help groups is the way that peers help each other embrace a new identity and sense of purpose. The structure offered by Double Trouble in Recovery can help people move toward higher levels of functioning and social competence. Peers can teach each other concrete social skills, promoting confidence and self-respect for everyone involved.

I started Double Trouble in Recovery to help promote autonomy and independence for those of us who live with dual disorders rather than let our fellowship be taken over by the professional community. I struggled to get groups started and keep them running, facing resistance from both professionals and consumers. Groups run by clinicians, therapists, and recovering alcoholics and addicts who work as treatment professionals blocked our path to recovery from co-occurring disorders. These people are no doubt well intentioned, but we who are dually diagnosed are more than what popular opinion would have us be. Those of us who follow the spiritual path of Double Trouble in Recovery know that only honesty, open-mindedness, and willingness are needed to help us begin recovery.

God bless you, Andy, because you leave us all asking about stigma. Stigma and discrimination prevent us from returning to the community. Stigma can become a debilitating handicap and is something that must be changed. I have had the pleasure of meeting other recipients who have taught me through their bravery that our suffering can be seen as the shadow of spirituality. In the words of recipient Sally Clay, who was inspiring to me: “I have come to realize that the shame of stigma comes from the repression of the subjective reality within madness that deserves not contempt, nor pity, but respect.”

As members of Double Trouble in Recovery, we are beginning to stand on our own. While making full use of professional services, we are outgrowing our dependence on institutions and retrieving our brothers and sisters from learned helplessness. As we make spiritual progress, we will feel more emotionally secure and work in partnership with those who support us. This will only work if we give of ourselves to the task without repayment. When we persistently do so, our program of attraction and suggestion will bring many newcomers. Unity and effectiveness will ensure our survival as long as we give of ourselves and let go of our personal ambitions and desires. Our aim is the common safety and welfare of the group.

We must think deeply of all those dually diagnosed fellows who have yet to come to Double Trouble in Recovery. When any brother or sister reaches out for help for a co-occurring disorder, our hearts will be open to them, and we will lend a hand along the road.

Double Trouble in Recovery is not a panacea. It is not an end. It is a new beginning. To all my brothers and sisters in recovery who have helped create and sustain Double Trouble in Recovery by sharing their strength, hope, and experience—thank you.

—Howard Vogel
Founder, Double Trouble in Recovery



CHAPTER ONE

Co-occurring Disorders: An Overview

Any diagnosis that points to problems with substance use and mental health is called a *dual diagnosis*, *dual disorder*, or *co-occurring disorder*. At least ten million Americans live with a substance use disorder and one or more mental health disorders. Co-occurring disorders are common in the general population and even more common among persons seeking medical treatment. More specifically:

- About half of the people treated in mental health settings have had at least one substance use problem in their lifetime.
- About 25 percent to 33 percent of people treated in mental health settings have current substance use problems or have experienced such problems within the past year.
- As many as 75 percent of people in addiction treatment settings also live with a current mental disorder.¹

Co-occurring Disorders Can Be Defined and Diagnosed

Substance use disorders can both mimic and mask mental health disorders. This complicates any diagnosis of co-occurring disorders. However, some typical symptoms of co-occurring disorders do exist. To understand what they are, first consider the following definitions.

Substance refers to alcohol and other drugs.

Substance use disorders include both substance abuse and substance dependence as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision*, published by the American Psychiatric Association.

Substance abuse is diagnosed when a person's use of alcohol or another drug consistently interferes with daily functioning or a medical condition, or when the person uses substances in dangerous situations.

Substance dependence refers to a person's repeated failure to control substance use despite significant and negative consequences. In some cases, dependence includes tolerance and withdrawal. Substance dependence is a more severe condition than substance abuse.

People are diagnosed with a *mental health disorder* when they have distressing problems with thinking, feeling, and behavior that are not due to drug use or another illness. Some examples are schizophrenia, bipolar disorder, schizoaffective disorder, depression, anxiety disorders, adjustment disorders, and personality disorders.

A *co-occurring disorder* is present when a person's mental health disorder worsens due to substance use—or when a substance use disorder worsens due to a mental health disorder. Substance use might offer short-term relief from a mental health disorder. In the long term, however, this strategy usually backfires.

There appears to be common genetic risk factors for substance use and certain mental health disorders. Yet genes alone cannot explain all cases of co-occurring disorders. Other factors are environmental, such as traumatic life events, poverty, and early loss of significant others.

Clients with Co-occurring Disorders Present Special Challenges

Diagnosis of a co-occurring disorder is greatly complicated by several factors. For one, people with a mental health disorder may try to stop using

all substances, including prescription drugs. As a result, the symptoms of the mental health disorder can return or worsen. In addition, complications can result from the interaction of street drugs with medications. Even if people with co-occurring disorders do manage to get into treatment for a substance use disorder, they might experience stigma related to diagnosis of a mental health disorder. In the end, these people might wonder why they should ever bother to get “clean and sober.”

Treatment is also complicated by the heterogeneous nature of co-occurring disorders. A man diagnosed with bipolar disorder and marijuana abuse has a co-occurring disorder. So does a woman with obsessive-compulsive disorder and alcohol dependence. Yet the differences in their conditions can translate into widely varying experiences of stigma, disability, access to treatment, and peer group support.

Another challenge is that a co-occurring disorder can be present even though a mental health and substance use disorder do not occur at the same time. In fact, a co-occurring disorder can exist even when symptoms of a mental health or substance use disorder temporarily fall beneath a diagnostic threshold.

Among people being treated for a mental health disorder—particularly schizophrenia—a co-occurring disorder is associated with the following:

- noncompliance with treatment
- higher rates of hospitalization
- more emergency room visits
- the need for higher dosages of neuroleptics
- housing problems
- criminality
- suicide attempts
- increased fluctuation and severity of psychiatric symptoms²

People with co-occurring disorders also face possible exclusion from treatment. An agency that offers treatment for substance use disorders

might turn away people with a mental health diagnosis; substance use disorders might be on the list of exclusion criteria for a program that treats mental health disorders.

The challenges in defining and diagnosing co-occurring disorders pose a constant challenge to researchers as well as treatment providers. Some studies examine the interaction of specific disorders—for example, cocaine dependence and post-traumatic stress disorder. Yet the findings are difficult to apply in real-world settings when people are dependent on more than one substance, and when they experience more than one mental health disorder.

Treatment for Co-occurring Disorders: Four Models

Treatment for co-occurring disorders has evolved along four lines:

1. *Treating one disorder as primary.* This model is based on the theory that people self-medicate with substances in order to experience relief from a mental disorder. Treating the mental health disorder, then, should lead to decreases in substance use. In this model of treatment, substance dependence is not seen as a primary disease. However, recent findings about the way that substance dependence changes the mesolimbic dopamine system (“pleasure pathway”) in the human brain has discredited this approach.³ Treating the mental disorder as primary will not by itself reverse those changes.
2. *Treating one disorder at a time.* This model involves sequential treatment—attending to either the mental health disorder *or* the substance use disorder until the related symptoms decrease significantly. For example, a drug treatment provider might require that a client be “psychiatrically stable” before admitting a client diagnosed with major depression. Or, an alcohol-dependent client might be required to go

through “detox” before gaining access to group therapy for a mental health disorder. While this model does not state that one disorder is primary, it suggests that only one disorder can be successfully treated at a time.

3. *Concurrent treatment.* Some treatment programs offer services for mental health and substance use disorders at the same time. For instance, a counseling psychologist might refer a client to an addiction treatment center. Or, a chemical dependence counselor might refer a client to a psychiatrist for an evaluation. In any case, treatment for mental health and substance use disorders run parallel. However, the services are offered by different providers in different settings. Clients may be shuttled from program to program, and communication among providers might be poor.
4. *Integrated treatment.* This has been recognized in recent years as the most effective model of treatment for co-occurring disorders. It occurs when treatment for a mental health disorder and substance use disorder takes place in the same setting with a core set of professionals. Both sets of disorders are addressed in the same treatment plan and documented in the same medical record. In some cases, clients see practitioners trained in both substance use and mental health treatment.

Because it has proved the most effective, integrated treatment has emerged as the favored model for treating co-occurring disorders. *Achieving the Promise: Transforming Mental Health Care in America*, a report from the President’s New Freedom Commission on Mental Health, states that “treatment for co-occurring disorders must be integrated.”⁴ An earlier report to Congress from the Substance Abuse and Mental Health Services Administration makes the same point.⁵ The conclusions of both reports are supported by a series of studies from the Dartmouth Psychiatric Research Center.⁶

The Promise of Peer Support and Double Trouble in Recovery

People who live with co-occurring disorders can experience a continuum of care. One end of that continuum includes services delivered by professionals in clinical settings. At the other end are natural, reciprocal, and supportive relationships with relatives and friends that develop outside the clinic.

Between these poles is another option that can deepen a client's experience of integrated treatment for a co-occurring disorder. This option is variously referred to as a self-help, mutual aid, or mutual help group. These groups, many of them modeled on the Twelve Step program of Alcoholics Anonymous (AA), are referred to in the following pages as *peer support groups*. Through such groups, integrated treatment programs can enlist consumers of mental health care—even people with debilitating disorders—as partners in their own treatment. This sends an empowering message to clients that professionals are not the only experts.

This manual focuses in particular on a peer support group called Double Trouble in Recovery. By attending Double Trouble in Recovery, your clients can access the kind of “experience, strength, and hope” that comes only from people currently living with co-occurring disorders. There are two other established peer support groups specifically for people with co-occurring addiction and mental health disorders: Dual Diagnosis Anonymous (DDA) and Dual Recovery Anonymous (DRA). DDA groups are most prevalent in Oregon (www.ddaoregon.com) and DRA groups are scattered across the United States. Check the DRA Web site (www.draonline.org) to see if there is a group in your area. As with any peer support group, the quality of individual meetings vary, so check out a group before you recommend it to a client.

The rest of this manual explains what you can do to support the mission of Double Trouble in Recovery. Chapter 2 zooms out to a larger context—a closer look at the features and potential benefits of

peer support groups in general. Chapter 3 explores the Twelve Step model of peer-supported recovery and why people with co-occurring disorders can benefit from a group created specifically for them. Finally, in chapter 4, you will find suggestions for introducing clients to peer support groups and helping clients start and run a Double Trouble in Recovery group of their own.



CHAPTER TWO

The Role of Peer Support Groups in the Continuum of Care

To me, mental illness meant Dr. Jekyll and Mr. Hyde, psychopathic serial killers, loony bins, morons, schizos, fruitcakes, nuts, straitjackets, and raving lunatics. They were all I knew about mental illness, and what terrified me was that professionals were saying I was one of them. It would have greatly helped to have had someone come and talk to me about surviving mental illness—as well as the possibility of recovering, of healing, and of building a new life for myself. It would have been good to have role models—people I could look up to who had experienced what I was going through—people who had found a good job, or who were in love, or who had an apartment or house on their own, or who were making a valuable contribution to society.

The quotation above is from Patricia Deegan, a woman diagnosed with schizophrenia as a teenager.⁷ Deegan eventually earned a Ph.D. in clinical psychology and went on to direct community-based programs for the Massachusetts Department of Mental Health.

Today, there are places where people who find themselves in the treatment system can look for the kinds of role models that Deegan describes—peer support groups such as Double Trouble in Recovery (DTR). To understand the dynamics of DTR, first consider some essential elements of peer-supported recovery.

Hazelden, a national nonprofit organization founded in 1949, helps people reclaim their lives from the disease of addiction. Built on decades of knowledge and experience, Hazelden offers a comprehensive approach to addiction that addresses the full range of patient, family, and professional needs, including treatment and continuing care for youth and adults, research, higher learning, public education and advocacy, and publishing.

A life of recovery is lived “one day at a time.” Hazelden publications, both educational and inspirational, support and strengthen lifelong recovery. In 1954, Hazelden published *Twenty-Four Hours a Day*, the first daily meditation book for recovering alcoholics, and Hazelden continues to publish works to inspire and guide individuals in treatment and recovery, and their loved ones. Professionals who work to prevent and treat addiction also turn to Hazelden for evidence-based curricula, informational materials, and videos for use in schools, treatment programs, and correctional programs.

Through published works, Hazelden extends the reach of hope, encouragement, help, and support to individuals, families, and communities affected by addiction and related issues.

For questions about Hazelden publications,
please call 800-328-9000
or visit us online at hazelden.org/bookstore.

Double Trouble in Recovery (DTR) is the only evidence-based peer support group created for those with co-occurring disorders. DTR offers a forum for people who have a substance use disorder as well as a mental illness to address the challenges and issues specific to them in an understanding, inclusive atmosphere.

Many DTR groups are formed through the encouragement of professionals who recognize peer support as a critical tool in a client's recovery management. Yet, these groups are designed to flourish as the result of peer leadership.

Informative and easy-to-follow, *How to Start a Double Trouble in Recovery Group* provides the information and resources professionals need to help clients establish and maintain DTR groups in their community, including

- an explanation of the benefits of integrated treatment of co-occurring disorders and the critical role of peer support in an individual's recovery continuum of care
- an in-depth look at the principles and practices of the Twelve Step recovery model
- proven guidance in identifying and training peer leaders, providing meeting spaces and materials, and ongoing maintenance of established groups
- reproducible materials (on a CD-ROM) that include pamphlets on starting a group and the role of sponsorship, a meeting script, a sample meeting notice, and posters of the Twelve Steps and Twelve Traditions of DTR

Enhance your professional and peer leader training with *Starting and Running a Double Trouble in Recovery Group*, a Hazelden DVD that walks you through the benefits and functionality of DTR groups, and shows groups in action.

HAZELDEN®

hazelden.org
800-328-9000

Order No. 3868

