CHAPTER 1

An Introduction to Integrated Group Therapy

This book offers step-by-step guidelines for conducting Integrated Group Therapy (IGT), an evidence-based treatment for patients with co-occurring bipolar disorder (BD) and substance use disorder (SUD). Designed to be delivered by substance abuse counselors as well as other mental health professionals, IGT consists of 12 one-hour group sessions. IGT stresses the importance of dealing with both psychiatric and substance use problems simultaneously, and looks for common themes in the development of these two illnesses as well as in the course of recovery from and relapse to both disorders.

The major goals of IGT are (1) to promote abstinence from drugs of abuse, including alcohol; (2) to promote adherence to medications prescribed for BD; (3) to teach symptom recognition for the purpose of both sustaining mood stability and SUD relapse prevention; (4) to teach skills that facilitate SUD relapse prevention (e.g., drug and alcohol refusal skills, avoidance of high-risk situations) as well as mood stability (e.g., prioritizing protective routines, such as sleep hygiene, over high-risk social behavior); and (5) to improve other aspects of life functioning, including interpersonal relationships. IGT is designed to be administered in conjunction with pharmacological treatment for BD as well as other treatments that a patient may receive, such as individual psychotherapy, other group treatment, and self-help/mutual-help support groups.

IGT fills a need for an effective treatment specifically designed for this population. While there are effective research-based treatments for BD as well as those for SUDs, patients with this comorbidity have posed treatment challenges. IGT has been cited by the National Institute on Drug Abuse (2009) as one of only five examples of "promising behavioral therapies for adult patients with comorbid conditions" (p. 3). It is the only treatment for patients with co-occurring BD and SUDs with a substantial evidence base demonstrating its efficacy, including research showing that it can be successfully implemented by properly trained front-line substance abuse counselors. Patients enjoy IGT, and clinicians like learning it and conducting it. Most importantly, as we detail later in this chapter, patients receiving IGT have been shown to attain better outcomes than have those who received standard group substance abuse counseling.

THE PROBLEM OF CO-OCCURRING BIPOLAR AND SUBSTANCE USE DISORDERS

A number of studies, including surveys of community samples (Grant, Stinson, et al., 2004; Kessler, Crum, et al., 1997) and studies of patients seeking treatment (Cassidy, Ahearn, et al., 2001), have consistently shown that SUDs and BD frequently occur together. In fact, the Epidemiologic Catchment Area study, conducted by the National Institute of Mental Health, revealed that BD was the psychiatric illness most likely to co-occur with an SUD (Regier, Farmer, et al., 1990). In that study, the likelihood of an individual with BD having an SUD was more than six times greater than that of the general population. People with bipolar I disorder (i.e., those who have been hospitalized for mania) had an even higher risk: they were nearly eight times more likely than those in the general population to have an SUD.

What accounts for this? What is it about having a psychiatric illness that predisposes people to having an SUD? Multiple factors may contribute to this phenomenon. One possibility is that BD and SUD carry a common genetic vulnerability; both of these disorders are known to run in families, and a number of studies have pointed to genetic contributions to these disorders. A second contributing factor is the possibility that some people with psychiatric illness may initially find specific substances of abuse to be particularly rewarding. In addition to the usual reinforcing properties of substances of abuse, some people initially find that particular substances temporarily relieve some of their painful psychiatric symptoms. Thus, if someone with BD believes that cocaine temporarily lifts depressed mood, or that marijuana temporarily slows down racing thoughts or reduces irritability, then that person might be more likely to continue taking that drug, even if (as is often the case) the substance later turns out to be both less successful at relieving these symptoms and prone to cause other problems. The use of substances in an attempt to relieve unwanted psychiatric symptoms is frequently referred to as *self-medication*, a term that was popularized by Edward Khantzian at Harvard Medical School in the 1980s (Khantzian, 1985). In our experience, many patients who seek treatment for BD and SUD describe their substance use as an attempt at self-medication.

Although self-medication may successfully relieve psychiatric symptoms at first, drugs of abuse are not effective long-term treatments; they often actually *increase* psychiatric symptoms over time rather than reducing them. This does not always stop people from continuing to use these substances, however. For some individuals who realize that substance-induced mood improvement is no longer possible (because the drugs stop working in this way), mood *change* may become the goal of substance use. Indeed, many patients have described the use of alcohol or drugs during a period of depression as a means of "numbing out," or blotting out feelings rather than experiencing actual mood improvement. As one patient said, "I just don't want to feel anything right now. If I drink enough, I won't have to think about how depressed I am. I know I'll feel worse tomorrow, but I just don't care." This type of statement reveals the sense of hopelessness that many patients feel. Patients with BD and substance dependence often experience what we call "layers of hopelessness" (Weiss, 2004). First, they may feel hopeless about being able to stop using drugs or alcohol. Then they feel hopeless that their lives will improve, even if they actually *do* stop their substance use; they believe that they have dug a deep hole for themselves and cannot escape. Finally, they have the global sense of overarching hopelessness that many patients with depression experience as a symptom of their illness. These layers of

hopelessness lead people to believe that they are unable to improve their lives; it therefore does not matter what they do. This dynamic of feeling hopeless and therefore not taking action is one of the central themes that need to be addressed when treating this population.

Finally, patients with psychiatric illness often display poor judgment. This is most obvious during periods of mania, when people may spend large amounts of money that they don't have, and may engage in sexual indiscretions and other forms of risky behavior, including substance use. People with severe anxiety or depression can have poor judgment as well, because they are not thinking clearly about their future and may act on the basis of panic or a sense of hopelessness about the future. They may thus make poor decisions about substances that they would not make when asymptomatic. This phenomenon represents one of the great challenges when treating patients with co-occurring psychiatric illness and SUDs: people may be highly enthusiastic and motivated for abstinence while engaged in treatment, when their psychiatric symptoms may be under good control. However, they may lose their resolve during a psychiatric crisis, when their decision-making capabilities are compromised.

Multiple studies have shown that patients with BD who also abuse alcohol or drugs are at greater risk for poor outcomes. Such individual are more likely to have a slow recovery from mood episodes (Keller, Lavori, et al., 1986), are twice as likely to require hospitalization (Brady, Casto, et al., 1991), and have a higher rate of poor adherence to their medication regimens (Keck, McElroy, et al., 1997); the latter is known to predict poorer outcomes in this population (Keck, McElroy, et al., 1998). Finally, patients with BD and SUD are also at greater risk for suicidal behavior (Dalton, Cate-Carter, et al., 2003). Thus, finding an effective treatment for this population has been a significant public health priority.

What We Know about Treatment of Co-Occurring Bipolar and Substance Use Disorders

Despite the high rate of co-occurrence of BD and SUDs, very little treatment research has specifically targeted this dually diagnosed population. There have only been a handful of medication trials, and most of them were extremely small (20 patients or fewer). Perhaps the best known study of medication for this population was performed by Ihsan Salloum and his colleagues at the University of Pittsburgh (Salloum, Cornelius, et al., 2005). These researchers studied 59 patients with BD and alcohol dependence, all of whom were treated with the mood stabilizer lithium. In addition to lithium, half of the trial participants were randomly assigned to another mood stabilizer, valproate; half received lithium plus a placebo pill. Salloum and his colleagues found that the patients who received lithium plus valproate had fewer days of heavy drinking and a trend toward fewer drinks on their heavy drinking days. This study has commonly been misinterpreted as showing that valproate was better than lithium for this population; this is not what was found, however. Rather, all patients in this particular study received lithium, and it was the addition of valproate that improved drinking outcomes. A more recent study by E. Sherwood Brown and his colleagues at the University of Texas Southwestern Medical School (Brown, Garza, et al., 2008), found that the atypical antipsychotic medication quetiapine was not better than placebo at improving drinking outcomes in patients with BD and alcohol use disorder. However, quetiapine may have been helpful in reducing depressive symptoms in this population.

In the past 20 years, there has been intense interest in psychotherapy and other kinds of behavioral therapies for people with BD; substance dependence has generated similar research interest. However, as with pharmacotherapy, there has been virtually no research on psychosocial treatments specifically designed for patients with both disorders. A number of different types of psychotherapy have been found to be quite helpful as adjunctive treatments to pharmacotherapy for patients with BD. These include group psychoeducation (Colom, Vieta, et al., 2003), family-focused treatment (Miklowitz, Otto, et al., 2007), individual interpersonal and social rhythm therapy (Frank, Kupfer, et al., 2005), and cognitive-behavioral therapy (CBT; Lam, Watkins, et al., 2003). Overall, these psychotherapies for BD have been shown to produce a lower relapse rate, a reduction in mood symptoms, and better social and relational functioning (Lam, Burbeck, et al., 2009). While most of these psychotherapy studies have included patients with SUDs, and all address the harmful role of substance abuse in BD, none focus primarily on that issue.

A number of behavioral therapies for SUDs also have a strong evidence base of success, including motivational enhancement therapy (Dunn, Deroo et al., 2001; Hettema, Steele, et al., 2005), CBT (Dutra, Stathopoulou, et al., 2008), 12-step facilitation (Ferri, Amato, et al., 2006), disease-oriented individual drug counseling (Crits-Christoph, Siqueland, et al., 1999), contingency management (Dutra, Stathopoulou, et al., 2008), and behavioral couples therapy (Powers, Vedel, et al., 2008), among others. Most studies of patients with SUDs either exclude patients with BD or have a very small number of patients with BD, so it is unclear whether these treatments are useful for that subpopulation.

The treatment of patients with SUD and co-occurring psychiatric illness is frequently divided in its delivery (Drake, Mueser, et al., 1996). It may occur sequentially (e.g., the patient receives SUD treatment, followed by treatment for BD) or in parallel (the patient simultaneously receives treatment for each disorder in two different settings). Sequential treatment offers the advantage of attending to the most acute disorder, but the second disorder may not be addressed adequately. Parallel treatment also presents a number of difficulties. For example, mental health treatment programs may minimize the significance of substance use, while substance abuse treatment staff members may overattribute psychiatric symptoms to substance use. A number of clinicians and researchers have thus recommended *integrated treatment* for dually diagnosed patients—that is, treatment of both disorders at the same time in the same setting by the same treater or group of clinicians, who are familiar with both disorders (Brunette & Mueser, 2006). Although this approach has been advocated for nearly 20 years (Mueser, Bellack, et al., 1992), only recently has there been a substantial number of empirical studies of integrated treatment for dually diagnosed patients.

In the rest of this chapter, we provide information on BD, its definition, course, and treatment, followed by similar information on SUDs. We then discuss integrated treatments in general and IGT in particular, including research on its effectiveness. Chapter 2 reviews the nature of IGT, including its theoretical foundation, major themes, and key considerations in conducting the treatment. Chapter 3 reviews the pregroup interview and includes Handout 1, entitled "Ways to Benefit from This Treatment." Chapter 4 is a step-by-step guide to conducting an IGT session. Part II of the book presents detailed guidelines for conducting the 12 IGT sessions and includes copies of patient handouts. This is followed by three Appendices, including a rating form for therapists to assess their performance in IGT (Appendix A), which can be helpful in supervision for performance improvement; bulletin board material (Appendix B), some for use

in all IGT sessions and some for specific sessions; and a series of frequently asked questions about IGT (Appendix C).

BIPOLAR DISORDER

BD affects approximately 5.7 million American adults each year (Kessler, Crum, et al., 1997), representing 8.1% of all diagnosed mental illness (U.S. Department of Health and Human Services, 1999) in the United States. Previously called "manic–depression" or "manic–depressive illness," BD can present in a variety of ways, making diagnosis challenging. In this section, we define the disorder and its natural course, and review current theories about its etiology. We also discuss important clinical aspects of BD, such as increased risk of suicide and the high incidence of co-occurring SUDs. Finally, we provide a brief review of current treatments in use for BD.

Defining Bipolar Disorder

The active phases of BD are characterized by abnormalities in mood, thought, emotion, and energy; these abnormalities are recognizable by observable changes in behavior and by self-report. The distinguishing feature of BD is the cyclical course between depressive symptoms (most often manifesting as a slowing in thought and energy, and sad or blunted emotion) and symptoms in the manic phase (often manifesting as racing thoughts, rapid speech, increased energy, and labile emotions). The fourth edition of the American Psychiatric Association's (2000) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) lists four distinct subcategories of BD (bipolar I, bipolar II, cyclothymic disorder, and bipolar disorder not otherwise specified), defined by episodes of depression, mania, hypomania, or mixed symptom episodes. The criteria defining these episodes are reviewed below.

Manic Episode

A *manic episode* involves a period of "elevated, expansive, or irritable" mood lasting at least a week and/or causing enough impairment of functioning as to require hospitalization. Manic symptoms may include grandiosity, reduced need for sleep, racing thoughts, rapid, pressured speech, and engagement in risky activities such as spending sprees or sexual indiscretions. Full criteria for these and other disorders described in this manual can be found in the DSM-IV-TR manual (American Psychiatric Association, 2000).

Hypomanic Episode

A *hypomanic episode* can be difficult to distinguish from a manic episode. The major distinction between the two is severity of symptoms, with hypomania characterized by less severe disruption of functioning than mania. The symptom criteria are the same as those for a manic episode (see preceding subsection), but the period marked by elevated, expansive, or irritable mood may be limited to 4 days in duration. As with a manic episode, the symptoms may not be due to the effects of a substance or a medical condition.

Major Depressive Episode

A major depressive episode consists of a 2-week period in which an individual reports being depressed fairly consistently throughout much of the day; symptoms include changes in appetite or sleep (either an increase or decrease), a lack of energy, a sense of restlessness or agitation, a reduced ability to experience pleasure, and morbid thoughts, which may include suicidal ideas or behavior. A major depressive episode ordinarily interferes with functioning, although the level of severity of dysfunction can be highly variable. In severe cases, people with a major depressive episode may struggle to accomplish basic tasks such as getting out of bed.

Mixed Episode

A *mixed episode* is defined as a 1-week period in which a person meets criteria for both a manic episode *and* a major depressive episode. The symptoms listed earlier for a manic episode and a depressive episode may occur simultaneously; thus, a person may report feeling unusually energetic but also feel worthless. Again, this disturbance must impair a person's usual functional capacities and not be due to substance use or a medical condition.

The course and combination of these episodes determine the particular diagnosis of BD a person receives. If an individual has had at least one manic or mixed episode, he or she qualifies for a bipolar I diagnosis. An individual with this diagnosis usually has also suffered at least one major depressive episode; however, a major depressive episode is not necessary for a diagnosis of BD. An individual who has experienced at least one hypomanic episode, as well as at least one major depressive episode, qualifies for a bipolar II diagnosis; any manic or mixed episode excludes bipolar II disorder in favor of bipolar I disorder.

Cyclothymic disorder is diagnosed when symptoms of hypomania and depression are present, but not in quantity or severity sufficient to meet criteria for a full manic, major depressive, or mixed episode. Additionally, an individual must experience these mood symptoms for at least 2 years, while having no more than 2 consecutive symptom-free months. In some cases, cyclothymic disorder may progress to bipolar I or II disorder over time, as symptom intensity worsens. If someone has met these criteria for the initial 2 years of mood difficulties and subsequently experiences a more serious disturbance (e.g., a manic episode), then that individual would be diagnosed with both cyclothymic disorder and bipolar I disorder.

BD not otherwise specified is the diagnosis used for an individual who has identifiable features of BD but does not meet full criteria for any of the previously described disorders. For example, a person shifting between manic and depressive symptoms over the course of a few days without meeting episode criteria, and having significant periods of symptom remission, does not meet criteria for cyclothymic disorder and would receive a diagnosis of BD not otherwise specified. A person with a history of only hypomanic episodes, and no depression, would likewise receive a diagnosis of BD not otherwise specified. The diagnosis of BD not otherwise specified may have particular relevance for the dually diagnosed population that participates in IGT. For patients in whom it is difficult to determine whether mood symptoms would be clinically significant without their substance use, then BD not otherwise specified could be a "working" or temporary diagnosis while they are observed over time. This strategy can be particularly helpful if they are able to achieve abstinence from drugs and alcohol, since the mood symptoms can then be evaluated both on and off substances.

Since many substances of abuse can cause profound changes in mood, thinking, and behavior, diagnosing BD in the presence of active substance abuse can be challenging. This is particularly true among those who abuse central nervous system stimulants such as cocaine and methamphetamine, which can mimic some of the symptoms of BD. Thus, when taking a history in patients with SUDs, it is important to try to determine the relation between mood symptoms and substance use. To the degree that mood symptoms correlate strongly with substance use patterns that could reasonably be expected to produce these symptoms, then the diagnosis of BD becomes more questionable. For example, in someone whose mood symptoms occur only in the context of cocaine binges, a diagnosis of substance-induced mood disorder would likely be most appropriate. Similarly, mood symptoms that occur only in the context of major shifts in substance use (e.g., increases or decreases in drinking) might represent a substance-induced mood disorder as well. In contrast, if someone has experienced symptoms characteristic of BD in the face of relatively steady use (e.g., a regular pattern of drinking six beers per night), or if the intensity or length of symptoms exceeds what would be expected as a result of an individual's particular substance use pattern, then the diagnosis of BD likely should be made. It is important to note that there are many gray areas here. Patients commonly do not remember clearly the temporal relation between their substance use and mood episodes; you are likely to hear answers such as "I've been depressed for a long time and I've been drinking for a long time, and I can't really remember what leads to what." In such instances, following a patient over time may be the only way to distinguish between substance-induced and independent mood symptoms.

Causes of Bipolar Disorder

Bipolar disorder is heritable; individuals who have a family member with BD are more likely to be diagnosed with BD at some point in their lifetime, and there is increasing evidence for the role of genetic variations that contribute to vulnerability to BD (Craddock, O'Donovan, et al., 2005). Environmental factors also play a role in the etiology of BD. For example, while we know that the identical twin of someone with BD is at greater risk to have BD, many identical twins of those with BD do not have the disorder. If BD were a purely genetic disorder, then all identical twins of those with BD would also have the disorder.

The Course of Bipolar Disorder

BD is a chronic mental illness, and appropriate ongoing treatment with medication is ordinarily required to help a person to function normally. In fact, without medical treatment, the average person with bipolar I disorder will have at least four acute episodes (either manic or major depressive) within 10 years (American Psychiatric Association, 2000), resulting in significant morbidity or mortality. Although medication treatment clearly improves prognosis dramatically, many people with BD continue to have difficulties with functioning despite adequate pharmacotherapy, and relapses can occur despite good pharmacotherapy and high levels of medication adherence (Goldberg & Harrow, 2004).

The average age of onset for BD is 25 years old (Kessler, Crum, et al., 1997), although BD may sometimes be diagnosed during childhood or adolescence; this is frequently associated with irritable mood (Birmaher, Axelson, et al., 2009). BD is equally common among men and women. The term *polarity* is often used to describe the course of illness; *mania* and *depres-*

sion are two opposite poles of one disorder (hence the name *bipolar*). Shifts between the two poles can occur either in sequence (i.e., a "manic switch" directly from a depressed episode, or a "depressive crash" at the end of a manic episode) or after a period of symptom remission between episodes (*euthymia*, or normal good mood). Over the course of the illness, depression typically becomes more predominant. Indeed, dealing with depression is a core theme of IGT, since many patients entering this group have had BD for a substantial period of time and therefore suffer more frequently from depression than from mania.

Suicide Risk

Untreated BD can be highly lethal: a recent, large outpatient community study found suicide completion rates of 0.14% per year for bipolar I disorder and even higher, 0.16% per year, for bipolar II disorder (Tondo, Lepri, et al., 2007). The relative risk for completed suicide in this sample was approximately 15 times greater than that of the general population. Thus, suicidal thoughts and feelings of hopelessness, isolation, and despair must be aggressively assessed and treated when working with patients with BD. It is important to note that suicidal ideation can occur during *any* mood episode and is not limited to depressive episodes.

The risk of suicidal behavior in patients with BD increases with a co-occurring SUD (Neves, Malloy-Diniz, et al., 2009), and an individual with BD is up to eight times more likely than the general population to develop a co-occurring SUD during his or her lifetime (Kessler, Crum, et al., 1997; Regier, Farmer, et al., 1990). Patients with BD are more likely to make a violent suicide attempt (hanging, jumping from a high place, cutting themselves) when there is co-occurring alcohol dependence (Neves, Malloy-Diniz, et al., 2009). Therefore, diagnosing a co-occurring SUD and helping an individual to achieve and maintain abstinence is an important aspect of suicide prevention and mood stabilization.

Treatment

The treatment of BD can be categorized into three phases: psychiatric management, acute treatment, and maintenance treatment.

Psychiatric Management

This phase of treatment comes after diagnosis and involves creating a treatment plan, providing individuals and their families and partners with educational information about BD, and teaching them how to identify symptoms of BD and avoid common triggers of mood episodes.

Acute Treatment

When an individual is experiencing a manic or mixed episode, treatment with medication is the first-line response. Several antimanic medications are effective, including mood stabilizers such as lithium carbonate, valproate, and the antipsychotic class of medications. Sedative–hypnotic benzodiazepines are also commonly used acutely as an adjunct to aid with patient comfort and/or behavioral control. A single medication or a combination of more than one may be prescribed.

Electroconvulsive therapy (ECT) may also be administered in severe cases or for individuals who do not respond to medications. A similar approach is used for a patient with a depressive episode, although the mood stabilizer lamotrigine has shown evidence of efficacy for bipolar depression (Geddes, Calabrese, et al., 2009). Maintenance of patient safety and suicide precautions are always prescribed, regardless of the type of acute episode.

Maintenance Treatment

Following acute stabilization of an episode, an individual should remain in an ongoing treatment plan that further supports symptom remission. This plan usually includes a regimen of the medications used to treat acute episodes (perhaps combined with ECT), as well as a psychosocial intervention and behavioral management strategies, including sleep hygiene and avoidance of common triggers such as substance use. Evidence-based psychosocial interventions include group therapy, cognitive-behavioral therapy, and family-focused treatment. IGT is now an evidence-based intervention for maintenance treatment of bipolar disorder and co-occurring SUDs (Weiss et al., 2007, 2009).

SUBSTANCE USE DISORDERS

SUDs (including disorders involving alcohol, drugs, or both) are highly prevalent. In 2009, nearly 22 million Americans age 12 and older (9% of the population) had used an illicit drug during the previous month, and nearly 60 million Americans age 12 and older (about 24% of the population) reported *binge drinking* (defined as drinking five or more drinks on one occasion) during the previous month (Substance Abuse and Mental Health Services Administration, 2010).

As stated earlier, the lifetime prevalence of SUD is approximately six to eight times higher among persons diagnosed with BD compared with the general population (Kessler, Crum, et al., 1997; Regier, Farmer, et al., 1990). This common clinical co-occurrence led to the development of IGT for patients with BD and SUDs. In this section we define SUDs, discuss heterogeneity of the course of SUD, and review current theories about etiology. We also provide a brief review of evidence-based treatments, including group therapies for SUD.

Defining Substance Use Disorder

SUD is defined in DSM-IV-TR (American Psychiatric Association, 2000) by two categories, *substance abuse* and *substance dependence*, distinguished by severity of substance use and extent of loss of self-control over substance use.

Substance abuse involves a problematic pattern of substance use that either results in negative consequences (e.g., family or legal problems) or threatens to do so (e.g., by driving while intoxicated). Substance abuse typically is characterized by some degree of impairment of vocational or academic functioning or difficulties at home. If someone meets criteria for *substance dependence* (described below), then that person cannot also have a diagnosis of substance abuse.

Substance dependence is a syndrome characterized by some or all of the following phenomena:

1. *Loss of control over use* (e.g., a person goes out with the intention of having one or two drinks but has substantially more by the time the drinking episode is over). The lack of control over use may be accompanied by recurrent resolutions to stop or to reduce substance use, sometimes with periods of success followed by recurrences of use.
2. *Increasing preoccupation with substance use.* Increasing preoccupation can be manifest behaviorally in several ways. As drug and alcohol use becomes increasingly important to a person, more time is spent in substance-related behaviors, often to the exclusion of alternative activities. To some extent, the severity of one's substance use can be gauged by the types of activities that are reduced or given up as the result of substance use. For example, milder forms of substance dependence may result in a constriction of non-drug-related recreational activities, whereas increasingly severe substance-related problems may cause people to miss work as a result of their substance use, perhaps lose their jobs, and use drugs or alcohol in situations that are clearly detrimental to their health.

Individuals who meet criteria for substance dependence cannot also meet criteria for substance abuse; the former diagnosis supersedes the latter. Formal diagnostic criteria for substance abuse and substance dependence can be found in the DSM-IV-TR manual (American Psychiatric Association, 2000).

Although these categorical definitions of substance abuse and dependence have clinical utility in assessing the need for specific treatment interventions (e.g., medical detoxification for substance dependence) and/or the urgency of treatment to prevent medical or social risk (usually greater with dependence), the distinction between substance abuse and substance dependence has several limitations when applied practically to individuals or populations of substance users, due to heterogeneity of substance use patterns and risks that may be substance-specific. For example, the injection of opioid drugs or cocaine carries a high risk of accidental overdose and death whether use is infrequent or frequent; likewise, the risk of death is significant for drunk drivers regardless of the pattern and frequency of their alcohol use when not driving.

Individuals with co-occurring psychiatric disorders, including BD, may be at greater risk of harm from any substance use due to both the direct effects of substance use on mental status and the indirect effects of substance use, such as medication nonadherence or drug–medication interactions. In these populations, the distinction between "abuse" and "dependence" may be even less clear, and the distinction may not be meaningful. Since relatively small amounts of substance use may be more harmful in individuals with psychiatric illness than in others (Goldstein, Velyvis, et al., 2006), IGT stresses the desirability of abstinence from substance use, regardless of whether the patient has substance abuse or dependence.

Causes of Substance Use Disorders

The risk for developing an SUD is multifactorial; trends in SUDs differ across substance, gender, and social and regional contexts. Factors that increase SUD risk include family history of SUDs, environmental exposure and access to substances of abuse, early age of first substance use,

absence of caregiver monitoring of childhood activities, peer use of substances, lack of knowledge about SUD risks or perceptions of low risk associated with substance use, school dropout and/or conduct problems, lower educational or socioeconomic status, mental illness, stress and negative life events, certain physical illnesses (especially those associated with physical disability, multiple procedures, and chronic pain), cultural acceptance of substance use, ethnicity that predisposes to substance use via heritable and/or cultural factors, antisocial and other deviant attitudes and behaviors, and—for certain substances—gender and/or sexual orientation. It is notable that women are at higher risk compared to men of experiencing SUD-related medical and social consequences early in the course of an SUD, a phenomenon that has been referred to as a *telescoping* course (Hernandez-Avila, Rounsaville, et al., 2004).

SUDs are heritable; genetic risk factors include both nonspecific vulnerability to SUD (i.e., a common risk for developing any SUD) and specific vulnerability to certain substances, such as nicotine or alcohol dependence (Edenberg, Dick, et al., 2004; Kendler, Myers, et al., 2007; Palmer, Young, et al., 2009). Genetic risk factors appear to be influential at all stages of addiction, including initiation of substance use, continuation of substance use, and progression to substance dependence (Li & Burmeister, 2009).

While genetic factors can confer vulnerability, SUDs require initiation of substance use for their expression; even someone at high risk (e.g., with two alcohol-dependent parents) will not develop alcohol dependence without ever drinking. The prevalence of substance use and abuse increases with age during adolescence and peaks in young adulthood. During adolescence, there are minimal gender differences in substance use; however, this changes by young adulthood, such that men are more than twice as likely as women to be diagnosed with an SUD (Palmer, Young, et al., 2009).

Neuronal activity in the brain is altered with all phases of SUD behavioral expression, which can be divided into three aspects of the behavioral cycle of SUD: (1) preoccupation and anticipation of substance use; (2) substance use and intoxication; and (3) withdrawal, which is associated with aversive psychological and physical states that motivate a return to drug-seeking behavior and renewal of the addictive behavioral cycle (Koob & Le Moal, 1997). Changes in brain activity associated with SUDs involve abnormally high activation of brain reward systems leading to pleasant or euphoric subjective states, and abnormal activation of stress response systems leading to unpleasant subjective and physiological states (Koob, 2009). The chronic nature of SUDs may in part be explained by conditioned learning that becomes part of a person's permanent memory. Environmental contexts and internal states (thoughts, feelings, and physical states) that are present during substance use or withdrawal can become learned memories that trigger activation of substance craving and addictive behaviors even during prolonged abstinence from substance use (Feltenstein & See, 2008).

Environmental influences that also affect the likelihood of development of SUDs include availability and cost of the substance, social and legal prohibitions, religious and cultural mores, and familial influences.

The Natural Course of Substance Use Disorders

Recent research evidence supports multiple subtypes of SUDs, with variability in natural course and outcome. Possible manifestations include (1) episodic "binge" use and abuse, (2) a single episode of dependence, (3) multiple intermittent episodes of dependence, and (4) chronic

and unremitting dependence. SUDs also show significant variability in age of onset, family history, co-occurring psychopathology, and functional consequences (Hasin, Stinson, et al., 2007; Moss, Chen, et al., 2007). While many individuals meeting criteria for substance abuse and dependence do not seek treatment and recover on their own, those having severe substance dependence typically experience a chronic, relapsing course characterized by compulsive drug seeking and use, and progressive loss of social and behavioral functioning. These individuals ordinarily require treatment interventions to arrest the progression of illness and maintenance treatment to sustain abstinence.

Regardless of whether they are episodic and remitting or chronic and relapsing, SUDs are frequently associated with significant medical consequences. These include infectious diseases such as HIV/AIDS, tuberculosis, hepatitis B and C, cellulitis, pneumonia, and endocarditis (infection of the heart valve); gastrointestinal disease, including pancreatitis; liver disease, including hepatitis, cirrhosis, and liver failure; stroke; high blood pressure; seizures; loss of motor coordination; heart failure; and death by accident/injury or due to organ failure or respiratory depression. Additional medical consequences of SUD-related neuropsychiatric syndromes include depression and suicidality, anxiety, hallucinations, and memory disturbance.

Furthermore, SUDs are associated with a high burden of social, financial, and legal disability. Common examples of SUD-related disability include personal isolation, loss of gainful employment, loss of driver's license, divorce and/or loss of child custody rights, domestic and nondomestic violence, criminal activity to sustain substance use, incarceration, and homelessness.

For both males and females of all ages, and virtually all substances of abuse, SUDs increase the risk of death by accident, injury, suicide, and violence; hence, the detection of risky behavior involving substance use and the prevention and treatment of SUDs is a public health and social priority.

Treatment

There are three primary goals of SUD treatment: (1) an explicit goal to reduce or abstain from substance use; (2) reduction in the frequency and severity of substance use episodes; and (3) improvement in psychological, social, and adaptive functioning (Kleber, Weiss, et al., 2007). SUD treatment is delivered in a variety of settings: inpatient care, residential programs, partial hospital or day treatment programs, intensive outpatient and routine outpatient clinics, integration with psychiatric care or routine primary health care, specialized substance abuse treatment clinics, sober houses, halfway houses, therapeutic communities, peer-support settings (e.g., Alcoholics Anonymous [AA], Narcotics Anonymous [NA], or Self-Management and Recovery Training [SMART] Recovery meetings), community and faith-based settings, employee assistance programs (EAPs), college- and school-based programs, homeless outreach programs, and prison and drug court systems.

SUD treatment recommendations are prioritized by consideration of an individual's medical safety and social functioning; to be successful, the actual interventions are typically negotiated with the individual and implemented according to the individual's stated preferences. Four main principles of SUD treatment are (1) preventing progression of substance use, (2) avoiding imminent and severe medical or social consequences related to the SUD, (3) promot-

ing abstinence, and (4) maintaining abstinence or reductions in substance use. These are briefly discussed below.

Preventing Progression of Substance Use to a Substance Use Disorder

Many substance-using individuals receive their first medical education about the risks of substance use from their primary care clinician or pediatrician. Active screening and brief education, advice to stop using substances, and referral to treatment or support groups (e.g., AA) can be very effective in early intervention and prevention efforts, with sustained reductions in substance use and improvements in multiple functional domains observable at 6-month follow-up (Babor, McRee, et al., 2007; Madras, Compton, et al., 2009).

Avoiding Medical and Social Consequences Related to Substance Use Disorder

People frequently enter SUD treatment after experiencing a negative consequence of their substance use. Initial assessment involves screening for (1) the need for medical detoxification from the substances used, (2) the need to treat SUD-related medical illnesses or injuries, (3) the presence of acute SUD-related neuropsychiatric syndromes and/or suicidal ideation requiring acute stabilization for safety, and (4) the necessity of removing the individual from his or her environment to successfully interrupt the SUD cycle or to avoid SUD-related social consequences. An individual is then directed to an appropriate level of care and setting to receive acute treatment services, followed by arrangement for longer-term continuing care designed to help him or her avoid future dangers of continued substance use.

Promoting Abstinence

For at-risk individuals, those with risky patterns of substance use, and those with SUDs, the safest medical goal is to promote abstinence from all substance use. Multiple interventions are used to support this goal, including early education and public awareness campaigns, motivational interviewing to build an individual's commitment to abstinence, assertive community outreach and reinforcement of abstinence behaviors, and social facilitation through family education and peer-support groups (e.g., AA, NA, or SMART Recovery). In addition, several medications are approved by the Food and Drug Administration to help patients stop substance use, including disulfiram, naltrexone, and acamprosate for alcohol dependence; methadone, buprenorphine, and naltrexone for opioid dependence; and nicotine replacement therapies, bupropion, and varenicline for nicotine dependence. These medications can be used effectively in conjunction with medications for BD in patients with these two disorders.

Maintaining Gains in Reduction of Substance Use

Patients with SUDs, especially severe substance dependence, often require maintenance treatment to prevent relapse to substance use, similar to the way patients with other chronic diseases (e.g., diabetes and hypertension) require maintenance treatment for sustained good health. Maintenance treatments for SUD may include (1) professional treatments in the form of individ-

ual or group therapy, family or couple therapy, and medication management; (2) peer-support and self-help groups such as AA and NA, SMART Recovery, and faith-based recovery groups; and (3) structured residential programs that support a recovery environment.

Group Therapy for Substance Use Disorders

Group therapy is the most commonly provided professional SUD therapy intervention. Therapeutic components of group treatments for SUD include the provision of a structured approach, including skills building to maintain abstinence; social facilitation through mechanisms of accountability to group peers and leaders, peer support, and sometimes confrontation of denial and minimization or other relapse behaviors; role modeling of successful abstinence; active and collaborative problem solving among group members; and sustained support and empathy among group members. Group therapy should provide members with an environment that is both safe and confidential; for some individuals with SUDs, this may be a respite from home or other social environments fraught with chaos or conflict.

Although multiple different types of SUD group therapies exist (educational, skills-based, 12-step facilitation, interpersonal, psychodynamic, and check-in groups), most studies have not found differences in efficacy between groups based on specific theoretical models (Weiss, Jaffee, et al., 2004). As described elsewhere in this book, however, a series of studies has demonstrated the efficacy of IGT for patients with co-occurring BD and SUDs. These studies have shown that IGT produces better outcomes with this population than standard group drug counseling.

INTEGRATED TREATMENTS AND INTEGRATED GROUP THERAPY

As stated earlier, many clinicians and researchers have long advocated an integrated approach to the treatment of patients with SUDs and coexisting psychiatric illness. However, there is no single agreed-upon method to accomplish this goal; no "gold standard" characterizes what an ideal form of integrated treatment should be. Rather, integrated models have been developed for patients with schizophrenia, personality disorders, posttraumatic stress disorder, and depression, among others (Kranzler & Tinsley, 2004). These models have provided integrated treatment in a variety of ways. Strategies include alternating between sessions focusing on psychiatric issues and on substance use issues, providing intensive case management, and stressing the importance of medication adherence. IGT integrates the treatment of SUDs and BD in specific ways that we described below.

The Single-Disorder Paradigm

Rather than telling patients that they have two distinct disorders, each of which needs its own treatment, IGT encourages patients to think of themselves as having, in essence, a single disorder called "bipolar substance abuse." The treatment for this disorder involves abstaining from drugs and alcohol; taking medication as prescribed; and engaging in a variety of other "recovery behaviors," such as getting a good night's sleep, recognizing and avoiding situations that present high risk of relapse to either substance use or mood problems, and attending SUD and BD self-help groups. While some recovery behaviors and their underlying thought patterns are specific

to one disorder or the other (e.g., learning alcohol and drug refusal; taking mood-stabilizing medication as prescribed), many behaviors (e.g., getting a good night's sleep) facilitate recovery from both disorders. A concrete example of the way the "single-disorder" paradigm is implemented occurs in the "check-in" at the beginning of each group session (described more fully in Chapter 4). Each patient is asked, "Did you use any drugs or alcohol this week? How was your overall mood? Did you take your medication as prescribed?" The check-in thus illustrates the equal weight that each disorder receives, and the manner in which the single-disorder paradigm integrates the treatment of the two disorders.

A Focus on Commonalities in the Two Disorders during the Recovery and Relapse Process

A major theme of IGT is that there are many similarities in the process of recovery from and relapse to BD and SUDs. Thoughts and behaviors are thus labeled in IGT as either "recovery thoughts/behaviors" or "relapse thoughts/behaviors." Commonalities between the two disorders are then discussed. An example of a relapse thought, for instance, is "may as well" thinking ("I may as well stay in bed all day"; "I may as well get drunk"). This is contrasted with the corresponding recovery thought "It matters what I do" ("It matters if I go to an NA meeting"; "It matters if I take my medication"). As described earlier, IGT does not merely focus on recovery or relapse thoughts and behaviors that are specific to BD (e.g., taking medication as prescribed) or SUDs (associating with drug-free friends). Instead, whenever possible, analogous thought and behavior patterns that are relevant to the *other* disorder are raised by the leader, in keeping with the "single-disorder" (bipolar substance abuse) paradigm. For example, the abstinence violation effect ("I've slipped, so I may as well give up and have a full-blown relapse"; see pp. 35–36) is presented as an example of "relapse thinking." An analogous thought process in patients with BD is then discussed ("I'm depressed even though I've taken my medication as prescribed, so I may as well quit taking medication altogether"). The thought pattern behind the abstinence violation effect is thus subsumed under the broader category of "may as well thinking," which is in turn an example of "relapse thinking."

A Focus on the Relationship between the Two Disorders

The third way in which IGT integrates the treatment of the two disorders is by focusing on the relationship between BD and SUDs. Substance use is seen as a risk factor for return to BD and vice versa. Many patients have difficulty accepting the idea that they have two disorders, particularly if they have had more serious consequences from one disorder than from the other. A patient who has been hospitalized many times for BD but has experienced fewer adverse consequences from substance use may find it easier to abstain from cocaine by viewing this as part of the treatment for BD ("Using cocaine is one of the worst things you can do for your bipolar disorder").

How Well Does Integrated Group Therapy Work?

We have now conducted three separate studies of IGT, all of which have demonstrated its effectiveness (Weiss, Griffin, et al., 2000, 2007, 2009). In the first study (Weiss, Griffin, et al., 2000),

we compared patients who received IGT to patients who did not receive this new treatment. Like the IGT patients, the latter group received their usual treatment, and both IGT and the non-IGT patients were assessed monthly to examine their substance use, mood, and overall functioning. All patients in this study, and in all subsequent studies we have conducted, had to be taking a mood stabilizer to enter the trial; it is important to note that *IGT is designed to be used in conjunction with medication, not instead of medication*. Moreover, many of the patients in our trials engaged in either individual therapy or case management (Weiss, Kolodziej, et al., 2000). IGT is not designed to replace these, but it can serve as an excellent complement to these clinical services. A total of 45 patients entered this study; most had bipolar I disorder (meaning that they had experienced mania in the past), and most had both drug and alcohol dependence.

Results of this study were highly encouraging for IGT: drug use among the 21 patients receiving IGT decreased from an average of 10 days per month at study entry to an average of less than 1 day per month at the end of treatment. At a follow-up visit held 3 months after treatment was completed, IGT patients continued to use drugs on average for less than 1 day per month. The 24 patients who entered the non-IGT comparison group, in contrast, had much less substantial declines in drug use, from an average of 8 days per month at study entry to 5 days at the end of treatment and 7 days at the 3-months posttreatment follow-up. Alcohol use among IGT patients dropped from 14 days per month on average to 1 day at the end of treatment and 3 days at follow-up. For non-IGT patients, however, alcohol use on average was 7 days per month at study entry, 2 days per month at the end of treatment, and 5 days per month at follow-up. When we examined rates of total abstinence in the two groups, we found that 67% of IGT patients maintained abstinence for 3 or more consecutive months, three times the rate of non-IGT patients (22%). Interestingly, mood improvement was less substantial for IGT; although there was a significantly greater improvement in manic symptoms for the IGT patients, there was no significant difference in improvement in depressive symptoms.

As a result of the encouraging results in this first study, we conducted a randomized controlled trial comparing IGT to Group Drug Counseling (GDC; Weiss, Griffin, et al., 2007). GDC was chosen as a comparison group for IGT because it is designed to approximate the kind of group treatment that would ordinarily be delivered in a community SUD treatment program. GDC is structured similarly to IGT (i.e., with an initial check-in and a session topic); however, GDC focuses primarily on substance use, not on mood. For example, although the "check-in" format is similar in IGT and GDC, the latter differs importantly, in that patients do not report their overall mood for the week, nor whether they took their medications as prescribed; these are important components of the IGT check-in.

This study provided excellent evidence for the efficacy of IGT: IGT patients used drugs or alcohol on approximately half as many days as GDC patients during the trial, although, as in our first study, there were no differences in mood episodes between IGT and GDC patients. Thus, IGT outperformed standard, well-conducted GDC. Still, several obstacles to widespread adoption of IGT in SUD treatment programs remained. First, we realized that the 20-week treatment could be unwieldy for many community programs, because third-party payers, such as managed care companies and state funding agencies, often will not authorize 20 sessions of a treatment. Rather, these payers frequently will authorize 12 sessions of psychotherapy before requiring justification for more visits. To make IGT more accessible to community programs,

we thus reduced IGT to 12 sessions. This was not particularly difficult, because our initial version of IGT was in fact 12 sessions; we had initially expanded IGT to 20 sessions in our first study because some of the patients in the 12-session IGT group felt that more treatment would be helpful. But as we describe below, patients did quite well with 12 sessions. Moreover, in a community program that is not part of a research study, patients can stay in the group as long as they find it helpful, and they are not restricted to 12 weeks of treatment.

A second barrier we identified in transferring IGT to community programs was the fact that the group leaders in the first two studies had substantial experience and knowledge about BD and/or CBT. In contrast, many counselors working in community SUD programs have had no formal training in CBT and know little about BD. We therefore modified the IGT manual to include some information about cognitive-behavioral principles and BD. These modifications led to a new question, however: Would 12 sessions of IGT, performed by counselors without training in CBT and without BD experience, still outperform GDC? In our third study we set out to answer that question.

We conducted another study comparing IGT to GDC, using front-line drug counselors without training in CBT or a great deal of knowledge about BD (Weiss, Griffin, et al., 2009). Another modification we made in this study was to conduct IGT as an "open" group, meaning that patients could enter at any time and leave after 12 sessions. The group sessions thus cycled rather than running in a strict sequence in which patients must attend a previous session to acquire the knowledge necessary to attend the current session. We chose an open group format, because this is typically used in clinical settings in which new patients enter a group and others leave on a regular basis. In summary, then, we made three "community-friendly" modifications to IGT, with the idea that if it was successful again, it would be ready for adoption in community programs.

The results of this third study were again very successful for IGT. First, we found that counselors without training in CBT or experience with BD could perform IGT (the version included in this manual) very well. Second, the study showed that IGT patients were nearly three times more likely to abstain from drugs and alcohol completely during all 3 months of treatment (36% vs. 13%) and were more likely to attain at least 1 abstinent month (71% vs. 40%). Moreover, for this study, we developed a measure of what we called a *good clinical outcome*, which we defined as abstinence and no episodes of mania or depression in the last month of treatment. We found that IGT patients were more than twice as likely as GDC patients to be both abstinent and to have no mood episodes in the last month of treatment (45% vs. 20%). These results were highly encouraging. Not only were SUD counselors able to deliver this 12-session version of IGT with favorable outcomes for substance use but improvement was also seen in mood episodes.

Adoption of IGT Elsewhere

With the publication of our results and oral presentation of IGT at a variety of scientific meetings, other programs have begun to adopt IGT for either clinical use or other studies. IGT has been modified for use in a study of patients with both BD and schizophrenia, and has been used clinically in a number of programs in both the United States and Canada. We have spoken with program directors who are using IGT elsewhere, and many of them have made slight changes in IGT to fit their particular circumstances. Some programs have made IGT sessions longer;

indeed, one program runs IGT for 2 hours, with a 15-minute break in the middle. Others have added a parallel program for family members. Some programs have patients read the "central recovery rule" aloud; others have developed "IGT-readiness" groups for patients who are not yet able to achieve maximal benefit from IGT.

We have thus now shown that IGT is an effective treatment for patients with BD and SUD that can be performed successfully by clinicians with different levels of experience and training. IGT can be adapted to meet the needs of specific treatment programs and is enthusiastically accepted by both clinicians and patients. For programs with a sufficient number of patients with these two disorders, IGT can offer an excellent evidence-based treatment approach.