Alcohol and Mental Illness
Laurence M. Westreich, MD

Focus Points
• Alcohol dependence co-occurs with mental illness more often than most clinicians realize: >20% of those with mental illness also suffer from alcohol abuse or dependence.
• Alcohol use disorders can cause or exacerbate a wide variety of psychiatric syndromes, from schizophrenia to the anxiety disorders.
• Alcohol dependence, abuse, or misuse can cause or exacerbate Cluster B personality disorders, and alcoholism itself can be mistakenly diagnosed as a personality disorder.
• Treatment of alcohol dependence and a co-occurring mental illness necessitates a coordinated plan which addresses both problems.

Abstract
Alcohol use disorders (AUDs) frequently affect the course of mental illness. Alcohol can both cause and exacerbate symptoms and must be treated concurrently with the psychiatric illness. Similar to personality disorders, alcohol can cause or worsen symptoms, though often in a more hidden manner. Treatment for dually diagnosed individuals with alcoholism and mental illness consists of an integration of addiction and mental illness treatment paradigms, use of peer-led support groups, a “coaching” therapy style, and medication regimens tailored to each patient’s specific syndromes. Specific psychotherapeutic modalities useful for dually diagnosed patients include relapse-prevention psychotherapy, motivational interviewing, cognitive-behavioral psychotherapy, and social skills training groups. The clinician must modify the treatment regimen on an ongoing basis to address symptoms of alcoholism or mental illness as they appear. Using research data and case examples, this article provides a model for the treatment of individuals diagnosed with mental illness and AUDs.

Introduction
A common Alcoholics Anonymous (AA) saying is “There is no problem that alcohol cannot make worse.” Of all the problems that alcohol can exacerbate, mental illness is one of the most common, serious, and frequently missed. Patients with mental illness, irrespective of the diagnosis, can face profound consequences when they misuse alcohol.

According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), the diagnosis of alcohol dependence, abuse, or misuse is no different in the presence of another mental illness. However, when dealing with those suffering from mental illness, the criteria for diagnosing a patient’s problem with alcohol should be quite broad. That is, the depressed individual who only misuses alcohol occasionally should be considered to “have a problem” with alcohol, even if he would not meet strict DSM-IV criteria for alcohol dependence or even abuse.

So when does alcohol worsen a mental disorder and when is it merely incidental? As this review will demonstrate, the answer is that alcohol always plays a part. Alcohol causes some depressive and anxiety syndromes, worsens others, always impairs sleep, and has harmful interactions with psychiatric medications. Thus, a person who drinks any amount of alcohol while receiving psychiatric treatment, especially pharmacologic treatment, should be advised to stop all use of alcohol. Of course, the addicted individual may not be able to stop his or her alcohol use and may need education about the interaction between addiction and mental illness, treatment of the addictive substance use, or even inpatient treatment of the addiction. Cessation of alcohol use is an important clinical goal but will most likely not be achieved overnight.

The cessation of alcohol use does not guarantee the remission of psychiatric symptoms. Nonetheless, discontinuing alcohol use for the psychiatric patient is often necessary, partly to remove an impediment to effective treatment. Mental illnesses often confounds efforts to stop alcohol use: the profoundly anxious person who experiences a quick, short-lived, respite from her anxiety will only reluctantly part with her “medication.” This article reviews the various psychiatric syndromes most commonly linked with alcohol, discusses the relevant research, and recommends some treatment approaches.

Epidemiology
A 1990 epidemiologic survey using estimated nationwide data from a household sample of 20,291 individuals, found that 22.5% of the United States population met lifetime criteria for a non-addiction mental disorder; 13.5% met criteria for alcohol abuse or dependence; and 6.1% met criteria for drug abuse or dependence. Of those who were found to have a mental illness, 22% had a lifetime diagnosis of alcohol abuse or dependence and 15% had a lifetime diagnosis of drug abuse or dependence. Of those with alcohol dependence, 53% had a co-occurring mental disorder (Figure 1).
In a study focusing on the correlation between addiction and mental illness, Helzer and Pryzbeck found that every psychiatric diagnosis they screened for was more prevalent in the alcoholic respondents while using the same data. The highest associations with alcoholism were mania, antisocial personality disorder, and other substance abuse.

Importantly for psychiatrists, approximately one third of general psychiatry patients and up to 50% of emergency room (ER) patients have presenting problems directly related to addiction. Given the high community prevalence of dual diagnosis and the even higher prevalence in treatment populations, psychiatrists should evaluate all of their psychiatric patients for latent or manifest alcohol use disorders (AUDs).

**Depression**

The classic stigma of clinical depression, such as mood impairment, hopelessness, and insomnia, are mimicked by the effects of alcohol use. The diagnosis of an alcohol-induced mood disorder, anxiety disorder, or psychotic disorder should be considered a presumptive diagnosis until proven by symptom resolution after the patient ceases alcohol use. The fact that alcohol causes depression and anxiety is not particularly surprising, given that alcohol is pharmacologically categorized as a central nervous system depressant.

In a study on depressed individuals who also drink alcohol, Schuckit and colleagues delineated two groups: those with independent depression and those with substance-induced major depression. Those with an independent, non-alcohol-related, depressive condition were more likely to have a close family member with depression, and to be married, caucasian, and female. In a study of 50 alcoholics, Dorus and colleagues found that 66% had Beck Depression Inventory (BDI) scores of ≥17 within 24 hours of their last drink. However, when reassessed a little more than 3 weeks later, only 16% had a BDI >17, demonstrating a “spontaneous” remission of depressive symptoms as the effects of alcohol wore off. Of course, this spontaneous remission may have been due to the treatment for alcoholism.

Although it is important to distinguish major depression from depression due to alcohol consumption, clinicians rarely have the opportunity to wait 3 weeks to delineate the two disorders. Allowing a patient to suffer depressive symptoms any longer than necessary while waiting for a firm diagnosis is unnecessary. Rather than waiting for depressive symptoms to resolve, clinicians should treat both alcoholism and depression simultaneously and in an integrated manner. For example, the cessation of drinking should be treated as an essential component of recovery from depression. The clinician should provide clear instruction on how to avoid drinking. This instructive style often involves a paradigm shift for the therapist more attuned to the mental illness alone. Rather than remain neutral or give interpersonal or instructional interpretations, the addiction treater assumes a coaching role, where direct suggestions are made and behavioral change is strongly supported and encouraged. This psychotherapeutic stance is well-described in the motivational interviewing literature. Painful depressive symptoms should not be minimized but regarded as possibly related to the consumption of alcohol.

**Case Study**

Jane, a 29-year-old female lawyer, was referred by her therapist for “postpartum depression.” History taken from both Jane and her husband revealed that up until the eighth month of pregnancy, she had never experienced diagnosable depressive symptoms. In fact, she had never seen a therapist until 6 months after her son was born, when she realized that her sadness had not dissipated and that she was feeling increasingly anxious every day. The couple originally attributed Jane’s sleeplessness to the effects of staying awake with the baby, but even when Jane’s mother came to help Jane could not fall asleep despite the exhaustion that she felt 24 hours a day. Jane also noticed that she rarely felt hungry and worried that her difficulties breastfeeding made her a “horrible mother.”

When she told her husband that she felt that there was no hope that she would ever be a decent mother and that she thought she was better off dead, he called her obstetrics/gynecologist for the name of a therapist. The therapist was a cognitive-behavioral specialist and assessed Jane as severely depressed, but in no danger of actually harming herself or her infant. When the therapist asked about the use of drugs and alcohol, Jane answered that she is a “social drinker.”

Over several weeks of therapy sessions (2/week), the therapist helped Jane reframe some of her inaccurate beliefs about her mothering skills, ignore some of the negative thoughts about herself, and accept the help from her family that Jane had previously rejected. Although Jane felt less alone and beleaguered by her depression, both she and her therapist worried that her anxiety had not abated because her insomnia and low appetite remained. Jane reluctantly accepted referral to a psychiatrist for a medication evaluation. Jane informed the psychiatrist that she was a social drinker but the psychiatrist probed more and the interview revealed that Jane’s definition of a social drinker was someone who never drank alone. In fact, Jane shared a full bottle of wine every evening during and after dinner with her husband. On most evenings she drank “a couple of shots” of vodka before bedtime. Although Jane had always enjoyed fine wines, she acknowledged that her use of wine had increased markedly after she had delivered: “It really takes the edge off and lets me sleep,” she said.

After the psychiatrist explained the depressant and anxiogenic effects of alcohol, Jane immediately agreed to stop drinking alcohol. They decided on the use of the selective serotonin reuptake inhibitor (SSRI) sertraline, titrating the dosage up to 150 mg/day, for the treatment of her anxious depression, and agreed to follow up 3 weeks later. At follow-up, Jane’s anxiety and insomnia were unchanged, despite her taking a therapeutic dosage of the SSRI. When asked about her use of alcohol, she became tearful and acknowledged that...
she had cut down for a few days, but was now drinking at about the same rate. “It's the only thing that makes me feel better...and plus it's the only way I can relax enough to have sex with my husband. He wants me to drink,” she said.

At this juncture the psychiatrist referred the patient to AA and a therapist skilled in dual-diagnosis treatment and the relapse-prevention model. Such a therapist should be knowledgeable about the abundant literature guiding clinician working with dual disorders. Several weeks later, the patient was hospitalized for a 3-day detoxification period, after which she continued with an intensive outpatient program, AA, and sertraline. Two weeks after discharge from the hospital, her psychiatric symptoms improved markedly: “Since I don’t need the relief from alcohol, I no longer get depressed and anxious the next day. I’m not hurting anymore, just tired!” she said.

**Anxiety**

Anxiety spectrum disorders and AUDs often co-occur. For example, even though panic disorder with agoraphobia occurs in the general population at approximately 6.1%, alcoholics suffer from panic disorder at a rate of up to 21%. The similarity of panic symptoms to alcohol withdrawal has led some to hypothesize a causal link between the two, even to the point of suggesting that repeated episodes of alcohol withdrawal may cause panic disorder; posttraumatic stress disorder, although inadequately assessed in the Epidemiologic Catchment Area study, shows significant comorbidity with substance use disorders and, therefore, should be assessed and treated as necessary.

The problem for the anxious alcoholic remains that alcohol initially treats anxiety, which worsens it later on. The immediate-term relief of medicating alcohol withdrawal with a drink in the morning or the reduction of painful anxiety with a few drinks overwhelms the intellectual understanding that alcohol will only make matters worse down the line. At a deeper level, the use of alcohol may function as a medication, as well as a way for the sufferer to assert control over her emotions.

As Khantzian noted:

Rather than just relieving painful affects when they are overwhelming, drugs and alcohol and the distress they entail may also be adopted as way of being in control especially when they feel out of control because affects are vague, elusive and nameless.

Due to the numerous potential interactions between alcohol and anxiety, the clinician must focus on treatments that ensure patient safety and bring quick symptom relief. This rapid symptom relief strategy ensures patient compliance with the long-term treatment plan. As always, less potentially harmful treatments are preferred initially, including supportive psychotherapy, cognitive-behavioral psychotherapy, hypnosis, and acupuncture. The table explains the four classes of anti-anxiety medications that are appropriate for the treatment of anxiety; their use must be considered on an individual patient basis. For example, for the patient addicted to alcohol or another addictive substance, non-addictive medications are preferred. Patients expecting the rapid effect for a benzodiazepine will be disappointed if they are prescribed buspirone, which may account for its poor efficacy among addicted people. However, there are some cases where a potentially addictive substance such as benzodiazepine, must be used to treat an anxiety syndrome in an addicted person. In this circumstance, the treating clinician must carefully weigh the risk-benefit profile of the particular medication for a particular patient, and closely monitor the patient for side effects and addictive behaviors.

Opinions on whether benzodiazepines should ever be used in the addicted patient vary widely in the field, and few studies examine this question. There is scant data-based evidence to support any clear perspective, so each clinician is obliged to make an individual decision based on the patient’s best interests.

**Bipolar Disorder**

Bipolar disorder co-occurs with alcohol dependence more than any other mental illness. In a study of patients

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SSRIs = selective serotonin reuptake inhibitors; MAOIs = monoamine oxidase inhibitors; TCAs = tricyclic antidepressants; LD<sub>50</sub> = the dose of a medication at which half the test animals die.

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with bipolar disorder and alcoholism, patients who had primary alcoholism (unrelated to their bipolar disorder) were less likely to experience remission from their alcoholism. Bipolar patients with alcoholism have been shown to suffer more cognitive dysfunction and attempt suicide more often.

The high prevalence and serious consequences of bipolar disorder combined with alcoholism necessitate aggressive treatment for this combination of illnesses. Since impaired judgment, grandiosity, and irritability all promote excessive alcohol use, the clinician must address the mania and alcohol use together. Psychoeducation often serves as a useful warning about the dangers of further alcohol use. Psychotherapeutic methods can include group therapies with others who suffer from bipolar disorder, and relapse-prevention teaching.

Medications such as valproic acid and carbamazepine are often used as mood stabilizers and can also serve as detoxification agents from alcohol. Although naltrexone can be used as an anti-craving agent, patients should be aware of the potential for a hepatotoxic interaction with valproic acid, and an apparent opiate withdrawal syndrome which may be precipitated by the high endorphine state of acute mania.

Case Study

Bill, a 54-year-old homeless Vietnam veteran with bipolar disorder, frequently ended up in the ER of a public city hospital. On each occasion he was intoxicated, but joked and teased the physicians on call in a pleasant manner, regaling them with long, hilarious tales of his misadventures. In fact, he became quite friendly with some of the ER staff, to the point that they welcomed him into the ER and asked him if he wanted his “regular room” on the alcohol detoxification ward. However, after four such admissions in a 2-week period, the director of the ER asked for a psychiatric assessment of Bill in order to determine the root cause of his recidivism. A brief symptom review revealed that Bill had a clear pattern of 2–3-day depressions followed by an irritated, insomniac state which Bill called “the nasties.” His military service had been cut short by his first manic episode upon his return from a 6-month tour of duty in Vietnam. Although he had been diagnosed as bipolar by a military physician, Bill had ultimately rejected the diagnosis, saying that he had “freaked out” during his Vietnam tour; and he subsequently went to the Veterans Administration Hospitals only for alcohol detoxification.

Bill refused admission to the Dual-Diagnosis Ward, saying “I’m not crazy, just drunk.” He consented to speaking with a psychiatrist in the detoxification ward. During that interview it became clear that Bill’s mother had been diagnosed and successfully treated for bipolar disorder and that his younger brother had symptoms suggestive of bipolar disorder. Bill’s professed satisfaction with his life confounded any attempt to offer him treatment: he said that other than the “nasties,” he felt that the camaraderie of the street was a fine tradeoff for the stability he might achieve elsewhere. Bill and the psychiatrist agreed that they would talk again in 2 days, just prior to Bill’s scheduled discharge.

At that second interview Bill presented in a very different way. Although he was sober, normotensive, and well-groomed, he appeared lethargic and his mood was morose to the point of saying that he saw “no reason to go on.” As Bill talked about his plans for the future, both he and the psychiatrist realized Bill’s only coherent plan was to get a bottle as soon as possible to “drown his sorrows.” The psychiatrist offered Bill a better way to improve the way he was feeling, and Bill reluctantly agreed to follow up in the clinic that afternoon after leaving the Detoxification Ward. At the clinic visit, the outpatient psychiatrist (having been briefed by the detoxification ward psychiatrist) started Bill on a medication regimen including lithium and, subsequently, the antidepressant bupropion. After much discussion, they decided not to use disulfiram, since Bill was “not sure” if he would drink even if he did take disulfiram. They also arranged for an AA meeting that Bill could attend, escorted by another patient in the clinic who attended the same meeting. To his own surprise, Bill enjoyed the AA meeting and was able to engage with several AA members there. Although he experienced numerous short slips over the next several weeks, the medications quelled the mood swings which had interfered with his functioning. When seen in the ER several months later for a hand laceration, Bill reported that he was living in a shelter, going to night school classes, and following up with his psychiatric appointments and AA meetings. He had not had a drink in 2 months.

Schizophrenia

Patients with schizophrenia frequently use and misuse alcohol: a study of 168 individuals presenting with a first episode of psychosis had an alcohol misuse rate of 11.7% as compared to a drug misuse rate of 19.5%. Another study found that among patients with schizophrenia, the lifetime prevalence of alcohol use disorder was in the 50% range. First psychotic breaks are difficult to diagnose and treat, and the addition of alcohol or any other mood-altering substance confuses the issue even further. Avoiding premature diagnostic closure in this scenario is even more important than with other psychiatric illnesses: the person misdiagnosed with schizophrenia because of intervening intoxicant use will face a lifetime of attempting to shed the diagnosis and receive the proper treatment.

Regarding patients who have suffered from a long-term psychotic disorder, Miles and colleagues found alcohol to be the most common substance of abuse (Figure 2). In addition, Miles and colleagues found that alcohol users were more likely than stimulant users to be older, white, and less likely to have a history of violent behavior.

Patients with schizophrenia use alcohol for a number of reasons. First, alcohol is an easily available, fast-acting agent that quells the fears and pain of becoming psychotic, especially during a first break. Second, alcohol use can be one of the few easy social experiences available to long-term schizophrenics with few friends and impaired social skills. The rituals of drinking,
whether in a bar or on a street corner, fosters an easy acceptance among “drinking buddies.” Finally, alcohol is legal, easily obtainable, and relatively inexpensive, making it an attractive intoxicant for the schizophrenic, who may not be able to muster the skills or cash to obtain other substances.

Patients with schizophrenia and other psychotic illnesses must be carefully monitored for their alcohol usage, since alcohol can worsen or even cause psychotic illnesses. Alcohol withdrawal can mimic the hallucinations of schizophrenia, as can the longer term alcohol-induced psychotic disorder with delusions or hallucinations. Since all antipsychotics are metabolized by the liver, patients with schizophrenia may need vigilant monitoring of their liver functioning and a dosage adjustment if they are in liver failure. A period of abstinence from alcohol is important in making definite diagnoses in forming a treatment plan.

Treatment for a schizophrenic using alcohol should focus on avoiding alcohol while maximizing the use of antipsychotics and psychosocial treatments (such as dual diagnosis or addiction-knowledgeable day treatment programs) and assertive case management techniques. Assertive case management techniques involve a clinician engaging with the patient in securing work or education, housing, and structured follow-up with mental health and social services. Although peer-led self-help groups may be useful, a better option for this population is the “Double Trouble” AA groups which cater to individuals taking psychotropic medications.

### Personality Disorders

Although all of the personality disorders are affected by the use of alcohol or drugs, borderline personality disorder (BPD) is the only disorder which mentions substance abuse per se as one diagnostic criterion. In fact, all the cluster B, or “dramatic” personality disorders (ie, antisocial, BPD, histrionic, and narcissistic) are often mixed with alcohol or other drugs. Each of these personality styles involves uncomfortable affective studies and/or maladaptive thought and behavior patterns make the individual vulnerable to self-medication with alcohol. Perversely, these desperate attempts at relief from psychotic suffering lead to a worsening of the patient’s well-being. Research suggests that a manualized form of dialectical behavior therapy is effective in treating BPD and comorbid substance abuse.

Schuckit wrote that alcoholism may be a symptom of antisocial personality disorder (ASPD), may cause behaviors which look like ASPD, or may be caused by the same genetic factors that cause ASPD. Others have suggested that alcoholism, or at least alcohol consumption, conveys an evolutionary advantage for sociopaths by enhancing a “cheating reproductive strategy,” thereby conveying an evolutionary advantage. Whatever the connection, ASPD is highly prevalent among alcoholics and correlates with a more rapid progression of alcoholism and its sequelae.

The clinician treating an alcoholic with a personality disorder must carefully distinguish between psychiatric phenomena caused by alcohol use, versus chronic characterological traits and symptoms independent of alcohol use. Most addicts, irrespective of sociopathic traits, lie and cheat in order to maintain their addiction; however, if the addiction is treated and remits, so does the dishonest behavior.

ASPD and other Cluster B personality disorders evoke strong negative counter transference in therapists because of the patient’s often dramatic and self-destructive behaviors. Alcohol intensifies these self-destructive or deceptive behaviors often leading to greater alienation between the patient and others, including therapists. However, aggressive treatment of the AUD, can significantly ameliorate these adverse behaviors. Since the patient is unavailable for intervention on the charact~erological issues when alcohol is in the picture, the clinician must first focus on helping the patient abstain from alcohol. Although addicted, personality disordered patients are among the most difficult to treat, their often-astonishing gains when they become sober serve as a reward for the persistent therapist.

### Treatment

Treatment of the alcoholic mentally ill patient should strive toward an integrated approach. The treatment should address both diagnoses simultaneously, and “…appear seamless to patients with respect to philosophical underpinning, treatment approach, and psychoeducational content.” By definition, an integrated approach avoids excluding either the addiction or the mental illness from monitoring and similarly avoids mistaken emphasis by the treatment team on non-essential issues. For example, the treatment team inexperienced with mental illness might wrongly minimize an alcoholic’s profound dysphoria as an “expected consequence” of heavy drinking. A more experienced treatment team would probe for, and if necessary, treat an underlying depression or suicidal thoughts.

Individual therapy for the alcoholic mentally ill individual should start at the supportive rather than the expressive (psychoanalytic) end of the spectrum because the powerful affects generated in expressive therapy can precipitate a slip or full-blown relapse. Using more of a “coaching” model, the therapist helps the patient initiate and stabilize his sobriety, while at the same time addressing psychiatric problems. The individual therapy should coordinate peer-led support groups, motivational interviewing approaches, individual psychotherapy, medications, and any necessary group psychotherapy.

AA can play a pivotal role in the treatment of many alcoholic, mentally ill individuals. AA, as a peer-led community, does not treat mental illness, but can support the alcoholic in her search for sobriety. Although AA proscribes the use of any mind-altering substance as a substitute for alcohol, AA does not officially comment in any way on appropriate medical or psychiatric treatment, including medication usage. However, some members may believe that psychiatric medications are unhelpful and express this during AA meetings. The treating clinician should explore with their dually diagnosed patients what the AA group had to say, if anything, about necessary medications. Although many mentally ill individuals experience these and other difficulties with AA, the dually diagnosed patient should probably transfer to a “Double Trouble” AA meeting, which is specifically designated for the dually diagnosed and, therefore, will be supportive of medications which are correctly prescribed.
Medications tailored for the treatment of alcoholism can be of significant use in the mentally ill population. Psychiatric medications rarely have interactions with anti-alcoholism medications. Medications such as benzodiazepines and barbiturates may be used in the acute phase of detoxification. A mood stabilizer can simultaneously effectively treat withdrawal and bipolar mania.57 Naltrexone may be used with the mentally ill patient, as with other patients, with the hope that it will act as an anticraving agent which also increases time to first drink and amount that the relapsing patient drinks.88

Disulfiram, while arguably more effective than naltrexone, does present some problems for the mentally ill alcoholic. Patients prescribed disulfiram must understand that alcohol combined with disulfiram will cause an uncomfortable reaction. The patient must be motivated to avoid that reaction. If the depressed patient is so cognitively impaired that he cannot understand the risk/benefit profile of disulfiram, the medication should not be prescribed. A special consideration for the schizophrenic patient is that disulfiram inhibits aldehyde dehydrogenase activity,59 which might cause an increase in synaptic dopamine and a worsened psychosis. Similarly, if the treating physician believes that the patient exhibits self-destructive traits and might provoke a disulfiram reaction intentionally, the medication should not be prescribed. These problematic scenarios are extremely rare: most mentally ill alcoholics are candidates for a discussion about disulfiram.

Mueser and colleagues59 found that, out of 33 severely mentally ill patients administered disulfiram, 64% experienced remission for at least 1 year. The medication was also associated with a decrease in days hospitalized. However, 28% of schizophrenic subjects experienced disulfiram reactions, and there was no change in work status. The benefits shown in the study demonstrated that although disulfiram must be carefully considered for the mentally ill individual, it has a place in the pharmacopoeia.

Conclusion

Integrated treatment of the dually diagnosed patients and comorbid AUDs, although challenging, can yield great rewards. Since alcohol exacerbates mental illness, abstinence from alcohol or use reduction significantly improves the patient's overall level of functioning, and leads to marked, sometimes astonishing improvement. These benefits, once seen by the clinician and the patient, can be used to promote the behaviors necessary to avoid alcohol, achieve a stable abstinence, and obtain the best possible outcome for the mental illness. PP

References