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ADDICTIONS SERVICES

The Role of Gender in Engaging the Dually Diagnosed in Treatment

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ABSTRACT: Individuals with both a serious mental illness and substance abuse are particularly difficult to engage in treatment. Given known gender differences in both substance abuse and schizophrenia, we examined the impact of gender on treatment engagement. Qualitative interviews with ten males and eleven females focused on how the client perceived the engagement process, and what obstacles they faced. While both males and females are difficult to engage, the interviews suggest that they experience the process differently and that they face different obstacles. We discuss the implication for service providers.

Addictions Services is a special section within *Community Mental Health Journal* devoted to issues relating to addictions practice in community settings. The intent of the section is to stimulate interest and dialogue regarding dual diagnosis and addictions programs and populations.

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INTRODUCTION

Although women are more likely than men to seek medical care (Mechanic, 1978), this has apparently not been true for those with comorbid substance abuse and a serious mental illness, the "dually diagnosed." Clinically, the typical dually diagnosed individual is often thought to be male (Bachrach, 1987). Whether this represents a difference in prevalence or a difference in treatment participation is unknown. Alexander (1996) recently reviewed the literature on gender and treatment participation and concluded that while some studies show a higher prevalence of dually diagnosed males in treatment than females, other studies found no significant differences. However, studies of the dually diagnosed seldom report either treatment participation or treatment outcomes by gender, so it is unclear whether gender affects treatment participation or outcomes. In addition, studies rarely, if ever, report on how a woman's role as mother and primary caregiver affect her participation in treatment.

Gender differences in clinical presentation and treatment access and response have been documented for both schizophrenia (Goldstein & Tsuang, 1990; Mueser, Bellack, Morrison, & Wade, 1990; Franzek & Beckman, 1992) and substance abuse (Weisner & Schmidt, 1992; DeJong, Brink, & Jansen, 1993; Hser, Anglin & Booth, 1987). It is likely, therefore, that gender may influence both clinical presentation and how and why the dually diagnosed seek and enter treatment, although there are no studies reporting this. Gender differences do exist between dually diagnosed women and men's histories, as well as among dually diagnosed women, singly diagnosed women and women in the community (Test & Berlin, 1981). Compared to other women and men, women with substance abuse or women with a serious mental illness (SMI) are more likely to have been exposed to sexual, physical or emotional abuse as children (Miller, Downs, Gondoli, & Keil, 1987; Wallen, 1992; Wilsnack, 1984; Boyd, Blow, & Orgain, 1993). Women with comorbid substance abuse and a SMI have the highest rates of all (Alexander, 1996). Victimization may continue into adulthood, with studies of adult homeless, mentally ill women (about one half of whom also abuse substances) reporting exceedingly high rates (i.e., 97%) of physical abuse and sexual assault. Studies of substance abusing women in treatment found similar results (Goodman, Dutton, & Harris, 1995; Wallen, 1992).

The high levels of both childhood abuse and adult victimization suggest that victimization and violence are normative experiences for many dually diagnosed women, while they are not normative experi-

ences for dually diagnosed men. We wondered whether this experience of abuse influenced a dually diagnosed woman's ability to seek and engage in treatment. We also wondered in what other ways gender might affect engagement, for both men and women.

Broadly, engagement refers to the process through which people who were contemplating change seek help and begin making changes (Minkoff, 1989). The goal of the engagement phase is for clients to develop comfortable and trusting relationships with treatment providers in either a mental health or substance abuse setting. Because it is a time when multiple contacts are often made with a treatment system, it represents an opportunity to develop a working partnership. Unfortunately, many of these opportunities are missed, with people frequently cycling in and out of treatment before finally engaging. This is particularly true for the dually diagnosed (Drake & Noordsy, 1994; Drake, Mueser, Clark, & Wallach, 1996). Given the almost 50% lifetime prevalence rate of substance abuse in people with schizophrenia (Regier, Farmer, Rae, Locke, Keith, Judd, & Goodwin, 1990), it is critical to develop more effective engagement and treatment strategies for this population.

Several strategies have been developed to engage the dually diagnosed in treatment and include non-confrontational approaches to denial and resistance, acceptance of the clients stage of readiness and motivation, provision of educational materials which the clients can critique, and motivational interviewing (Sciacca, 1997; Miller and Rollnick, 1991). These strategies however are not gender-specific, and it is unclear whether the same strategies work equally well for men and women. In this paper we describe a pilot study that examined gender differences in the engagement process with the aim of generating gender-specific hypotheses as to how to engage this difficult-to-treat population. We were particularly interested in learning to what degree men and women have similar or different processes of engagement. We defined treatment as any formal mental health or substance abuse treatment, and examined the engagement process from the client's point of view. While some literature describes the engagement process from the provider's perspective (Lamb, 1984), little is known about the engagement process from the client's point of view.

METHODS

Participants were drawn from three sites in approximately equal numbers: a Veterans Affairs outpatient dual-diagnosis program for people with psychosis and substance use

disorders, a county mental health clinic, and a shelter for homeless mentally ill women. Thus, we sampled from a primarily indigent population. Program staff identified all subjects with a chronic psychotic illness and either current or prior substance abuse or dependence. Subjects were selected by program staff to be interviewed based on their willingness to participate and availability on the day the interviewer was on site. Therefore they represent a convenience sample. We present data from ten men and eleven women. Three women refused to participate, although no males refused.

We paid subjects $5 for their participation. The interviewer confirmed diagnostic eligibility during the interview process. About one third of the subjects were engaged and actively participating in treatment, while the remaining subjects were either unengaged or at some point in the engagement process. We defined engagement and actively being in treatment as being in either mental health or substance abuse treatment, and regularly keeping appointments. We defined being `at some point in the engagement process' as voluntary contact within the last month with either mental health or drug abuse treatment, but not attending regularly. `Unengaged' was defined as not being in voluntary contact with either mental health or substance abuse treatment, although they might be using other resources such as soup kitchens or shelters.

The interview progressed from initial general questions to later specific questions. This allowed the participants to discuss what was most important to them before being constrained by specific questions. Initially, the interviewer asked about what kind of "help" people were looking for, and the linkage between "help" and treatment as a form of help was not made until the second half of the interview. `Help' could refer to psychiatric or drug treatment, or to social service, legal or medical help. The interviewer asked subjects to identify the problems in their life they wanted help with, what kind of help they wanted, and what their prior experiences with help had been. We also asked whether individuals had experienced obstacles to seeking help. If not previously discussed, the interviewer then asked direct questions about whether they were receiving either mental health or substance abuse treatment, how and why they first came to treatment, what their experiences of treatment were and what the treatment was for. The interview was semi-structured in nature, and used prompts to help focus the discussion. The first author conducted all interviews, and interviews were taped and later transcribed for analysis. Subjects gave written consent.

RESULTS

Table 1 shows selected demographic characteristics of the sample, needs identified by clients and reasons to engage with treatment by gender.

Sample Characteristics

Ages ranged from the early twenties to late forties, with a mean age of thirty-nine. Most subjects had repeated psychiatric treatment experiences, often involuntary. Polysubstance dependence was ubiquitous, with all but one female identifying either current or previous difficulties with multiple substances. The most commonly abused substances were alcohol, cocaine or crack, and marijuana.

TABLE 1

Comparison of Male vs. Female Subjects

	Males	*Females*
Selected Demographic Characteristics		
Total interviewed	10	11
Mean age	38	39
Homeless	4	4
Engaged in treatment*	4	5
On psychotropic medications	8	8
Current substance dependence	9	5
Payee or conservator	2	2
Needs Identified by Clients		
Housing	8	7
Finances	9	5
Food/Clothing	0	3
Symptoms Management	6	5
Substance Abuse Treatment	4	0
Relationship problems	2	3
*Reasons to Engage with Treatment**		
Legal Problems	9	8
Mandated Treatment	3	2
Prevent return to jail	7	5
Family Pressure	5	1

*Defined in text.

Needs Identified by Clients

In many respects the needs of males and females were similar. Overall, housing was the most frequently identified problem, and was often the first problem mentioned. Three fourths of the sample mentioned housing as a problem, whether or not they were homeless. Mental health treatment was sometimes seen as a way to get housing—one individual was told that if you "went inpatient" you could more easily get section 8 housing, so he was contemplating a trip to the hospital.

As expected, homelessness and poverty were closely related and participants often saw treatment as a means to correct both problems. "I'm here because it will improve my `loan service active claim,' and

give me enough money to afford a living place," said one veteran. Another subject saw both mental health and substance abuse treatment as helping him to afford a home of his own. Money and subsistence problems were also frequently mentioned as a need for both men and women and, many participants mentioned the need for help with money management. In some cases, the need for money management was a direct link to treatment. For example, one woman who was too paranoid to agree to psychiatric treatment, had a representative payee at the clinic and came in to pick up the rent check. She agreed to the payee because she recognized that it helped her with her paranoia over whether somebody might steal her check from the mailbox. The staff was hopeful that she would agree to treatment for schizophrenia at a later date.

Needs could be extreme. One woman who had been homeless and out of treatment for five years returned to treatment only after she was raped while intoxicated and became pregnant. Deeply troubled by the rape and the abortion, she left the `safety' of her home under the bridge and paced the streets. Finally, she wandered into a drop in center for mentally ill individuals. "I came up from under the bridge and I seen the sign on the door . . . and I didn't have anywhere to go . . . I thought it might help instead of walking around . . . just doing nothing . . . I am just trying to survive day to day."

In summary, the needs identified by both men and women were similar. Almost everyone was concerned about housing, and many were concerned about food, clothing and money. Usually they wanted help with these things and considered them more important than traditional mental health services. In addition however, women also mentioned difficulties with raising children, and often had histories of either domestic violence or rape.

Obstacles to Seeking Help

For many, the most significant obstacle was fear, whether real or imagined. This was particularly true for women, and may have contributed to three women's refusal to participate in the study, whereas no men refused. Two of those who refused were clearly paranoid, and seemed afraid that the interviewer would hurt them. Another woman who ultimately consented to the interview thought the interviewer might have ulterior motives; her experience with AA finally allowed her to trust the interviewer and participate. This fear could also affect their ability to stay in treatment. One woman's paranoia led her to

leave a treatment program for alcohol. She said "I got too mentally sick, because contact everyday is too much for me. It's just overwhelming for me." Elsewhere she explained, "I thought everybody was against me."

Mistrust was also common, whether based in reality or the result of paranoia. Every woman spoke in some way about trust and paranoia, as exemplified in the following quote. "I really don't trust . . . It's very hard to deal with. Lift up the mask and let that real stuff come out. Because of the lack of trust that I have." Sometimes asking for help involved overcoming mistrust of people in authority. One woman, who was pregnant, had a history of sexual and physical abuse. For her, learning to ask for help involved learning that she could trust the staff. Another woman's first contact with mental health treatment was when a mental health worker picked her up out of jail. She reported that he subsequently approached her sexually and consequently she fled. For many years thereafter she avoided any contact with either the mental health or social service systems.

Other women identified their own personality styles as obstacles. Several described themselves as loners, who wanted to do things by themselves, and therefore did not want to ask others for help. This appeared to be related to paranoia, although it may also have been related to a history of abuse. "I am just a loner . . . I try to work things out on my own," was a frequent theme.

Men also mentioned paranoia as an obstacle, although less frequently. One said "I have been paranoid for a while . . . just fear of people . . . and then the mounting fear makes it a lot harder for me to get out and to get around." Some of his fear may have been real as opposed to imagined, as he used cocaine and was in debt to drug dealers. As a result he was afraid to take certain bus routes to get to treatment.

While men mentioned paranoia, problems with motivation figured more prominently. Many men either specifically mentioned problems with motivation, or in their inability to describe what they wanted from treatment demonstrated a lack of motivation. One man specifically said how this was a problem. "I'd be a multimillionaire if I'd quit taking drugs for two years. Because you know I don't have any motivation . . . I think I have always known that drug abuse and alcohol abuse were a problem for me . . . I think I have always known that it has taken all of my money and my motivation . . ." Another male was unable to say why he was in treatment—he just wanted to be "around the environment." Frequently male clients were unable to describe

why they wanted help, and lack of motivation appeared to be a significant problem.

Clearly, fear, mistrust and paranoia were significant obstacles to overcome. Many individuals were paranoid, although others had real reasons to be fearful and to mistrust people in authority. This seemed to be a more consistent obstacle for the women. While several men mentioned paranoia, men also gave other reasons, such as a lack of motivation.

Conceptions of Treatment

Whether referring to either mental health or substance abuse treatment, subjects often conceptualized treatment as a means to an end. Their objectives often had little to do with improved mental health or sobriety. This was true for both men and women. A man participating in a money management program in exchange for getting help with public housing said, “It's really not helpful to have anyone take care of my money, but if I have to go along with their program (to get housing) I will. It's a game to me—its a game of mind, reaction—you want to control me through my housing and my money—I'll give you these things because I want to see what you're going to do with them—now when I get tired of the game, I'm gonna . . . go pull them up.”

For others, treatment was low on a list of priorities, to be undertaken after other more important things. As a consequence, especially for those in the early stages of engagement, treatment was often intermittent—used to solve crises or as a last resort to provide for basic necessities. In contrast, clients engaged in treatment often saw mental health treatment as valuable in and of itself. Several of those individuals cited treatment as “saving my life.”

Reasons for Engagement in Treatment

Most commonly, participants continued in treatment because they worried about the consequences of their behavior. Seventeen of the people interviewed either had legal problems or had been to jail, usually on forensic units. For some of them, fear of going to jail profoundly affected their continued participation in treatment. This fear was common to both men and women. “Something that still concerns me to this day is that if I lose my temper, I might be taken to jail, because initially before visiting the clinic I was incarcerated for a brief period of time . . . it was the psychiatric ward of the jail . . . I still have nightmares to this day of the experiences that I had during that periods of

time . . . I feel that by attending the clinic it will keep me from that threshold. It is a deterrent from that threshold."

Another person said, "The law placed me on psychiatric review . . . and it was mandatory for me to take those prolixin shots . . . and if I didn't take the prolixin shots they were going to put me in jail because of my violence." Yet another finally participated in AA, after a judge sentenced him to attend ninety meetings in ninety days after his conviction for driving under the influence. This was the beginning of sobriety and eventually of psychiatric treatment.

For men, but not women, continuing in treatment was often motivated by a fear of becoming violent. "The only reason I actually take the medication is because I realize that with my temper . . . I could hurt somebody and then be in jail." "I take the medication so that I don't suffer delusions that cause me to be a danger to others . . . I caused an incident in a federal installation because I didn't take my medication." Several came in after altercations with their family, which led to the families insisting that they seek treatment.

DISCUSSION

This study is limited in that it was exploratory, and was conducted to generate, rather than test, specific hypotheses. We interviewed a convenience sample that included many homeless or near-homeless people who are often those most in need of material resources. Therefore the results may not be applicable to non-indigent populations. As we paid people to participate, we may have selected for individuals with subsistence problems. Despite these limitations, we found that both males and females with co-morbid substance abuse and a serious mental illness have difficulty engaging in treatment. Both have a tendency to cycle in and out of treatment multiple times before finally engaging. While it is likely that some individuals will always have difficulty engaging, this study suggests that there may be specific strategies which providers can use to help engage this difficult to treat group. Some of these strategies are different for men and women.

(1) The offer of concrete, practical assistance is essential, especially early in the engagement process. Indigent people who are in need of mental health care are often far more concerned about meeting their basic day-to-day needs than in specifically seeking mental health treatment. Providers could use this information as "leverage" that ultimately benefits their clients by initially addressing these needs as a means to engage individuals in treatment. For example, programs

could explicitly offer housing assistance or hot meals in the initial phases and only subsequently emphasize mental health treatment. For many indigent patients, treatment begins as a means to an end, and it is only after they are engaged that treatment becomes an end in itself.

(2) A safe and non-threatening environment is especially important for indigent, dually diagnosed women. Even though most subjects expressed a desire for help, many were reluctant to become engaged. Gender differences were clearly important here. While women experienced a desire or need for help, they feared being harmed, abused or victimized in the process of asking for help. When they denied needing help it was because they said they were more comfortable doing things alone. When men denied needing help, they explained it as a "lack of motivation." Mental health providers might consider creating programs specifically for dually diagnosed indigent women and deliberately assigning female mental health workers as case managers for this population. To engage and maintain women in treatment, both mental health and substance abuse treatment may need to address the psychological sequelae of victimization. Future research should test these hypotheses.

(3) Strategies that increase motivation, such as motivational interviewing, or strategies that acknowledge the need for control, may be particularly effective for dually diagnosed men. Men tended to see themselves as coerced into treatment by external forces, or as needing treatment as a means of obtaining external control of either violent or criminal behavior. They stay in treatment because they are worried about potentially violent behavior, and see treatment as a way of moderating this behavior. Many individuals appear to become engaged as a result of the legal system, and not because of clinical interventions. Thus strategies to facilitate appropriate referral and monitoring from the criminal justice system may also foster engagement. Providers should view the criminal justice system as an ally in treatment engagement, and explicitly make use of the leverage provided in these situations. Future research should test the effectiveness of referral from the criminal justice system.

CONCLUSIONS

Successfully engaging and retaining dually diagnosed individuals in treatment is important both for improving treatment outcomes and for

decreasing health care costs. Cycling in and out of treatment leads to an increased use of acute care services that are generally more costly than outpatient services. This drives up overall costs without obvious long-term benefit to the patient. Therefore, programs that are more effective in engaging and retaining dually diagnosed clients would likely be more cost-effective, as well as improving outcomes. Our research suggests that men and women engage in treatment for different reasons, and have different needs.

Providers who are aware of these differences and how they may affect an individual's ability to engage in treatment may be able to tailor their clinical interventions to assist clients with the engagement process. If we can help clients engage, we may be able to both improve their quality of life, while at the same time reducing costs. Attention to the differences between males and females will help with this process.

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