STEMSS (Support Together for Mental and Emotional Serenity and Sobriety): An Alternative to Traditional Forms of Self-Help for the Dually Diagnosed Consumer

By Kathleen A. Hastings-Vertino, M.S., R.N., C.S.

Approximately 2.8 million Americans suffer from a chronic mental illness. An estimated 54 to 63% of these persons abuse substances and/or alcohol.\(^1\)\(^-\)\(^7\)

Mental health consumers with substance abuse problems are identified as MICA patients—patients with a “primary mental illness diagnosis and either a secondary substance abuse diagnosis or an admission for substance abuse treatment during the same fiscal year”\(^6\) (p. 237). These are patients with highly specialized needs, too often shuffled between mental health treatment settings and addiction treatment settings. Mental health and substance abuse professionals are well aware of the exorbitant amounts of time, energy, and institutional resources, in terms of recidivistic inpatient stays and out patient visits, that are utilized in treating the dually diagnosed consumer.\(^8\)\(^-\)\(^10\)

Rosenheck et al.\(^6\) reviewed discharge data on the inpatient treatment of MICA patients from 135 VA medical centers over a 12-year period (1976–1988). They found that the number of VA patients identified as MICAs doubled from 1976 to 1988 (from 22.6 to 43.6%). They further stated that these numbers were most likely conservative “because clinicians tend to underdiagnose and under-document secondary substance abuse diagnoses in patients hospitalized for other primary psychiatric illnesses” (p. 246). These authors further reported that, “by 1988 almost half of all VA primary psychiatric patients were MICAs” (p. 244). It has been said that dually disordered patients are “twice as difficult to treat and twice as likely to fall.” These patients typically have poor short-term outcomes in “traditional” mental health programs and “do not readily fit into traditional substance abuse treatment programs”\(^11\) (p. 314).\(^1\)

Challenges to service providers lie in structuring programs for MICA patients so that the patient’s two problems are addressed concurrently. Historically, the dual-problem patient has been treated in the single-problem system. This does not work for several reasons. First, before the advent of the MICA patient, substance-abusing or alcoholic patients were treated by mental health providers. Clinicians, historically trained in one area, would address whichever problem (either the mental illness or the substance abuse) was presenting at the time and labeled that the “primary” problem, while the other problem was negated, minimized, or ignored.\(^6\)

This is a serious mistake because, as Bricker\(^12\) and others have stated, substance abuse and alcoholism and mental illness are overlapping and mutually reinforcing. As McKelvy et al.\(^9\) explain,

The pitfall of focusing on the “primary” question is the implicit assumption that treatment of the primary disorder will have an automatic ameliorating effect on the “secondary” disorder. In fact, both issues must be addressed. Even though there may be a relationship between symptoms, mental illness and chemical dependency are in one sense separate entities. Treating one does not automatically remove the other. (p. 23)

As Bricker\(^12\) states, the illnesses must be treated “separately together.” And Mihkoff stated\(^13\) “Patients with a dual diagnosis of major psychosis and substance dependence have two primary, chronic, biologic mental illnesses that require concomitant and equally intensive and specific treatment” (p. 1032). Therefore, what came first is really a moot point except as a research question. The key to successful program planning could be to creatively integrate relevant theories and treatment modalities from each discipline, to plan treatment strategies which directly target the patient’s chronic mental illness and the alcohol/substance abuse concurrently, and to find or train clinicians who are cross-trained in both areas to deliver services.\(^1\)\(^,\)\(^14\) Jerrell and
Ridgely\textsuperscript{15} agree with this approach as they found positive outcomes with their "very disabled clients . . . and of increasing their compliance with prescribed treatments that are intensive and that offer integrated treatment of comorbid disorders" (p. 237).

Kernker\textsuperscript{16} and Snow et al.\textsuperscript{17} have written insightful articles describing the process of acculturation in Alcoholics Anonymous (AA). Ninety percent of public opinion survey respondents consider AA to be the treatment of choice for alcoholism.\textsuperscript{17,18} Remarkably, the number of persons attending AA is reported by Snow et al.\textsuperscript{17} to double every 10 years, and current estimates of membership are approximately 1.5 to 2 million. The proliferation of self-help groups has also been noted by Kingree and Ruback,\textsuperscript{9} Kernker,\textsuperscript{16} and Humphreys et al.\textsuperscript{18} Such a phenomenon should raise the curiosity of professionals and not be easily dismissed or disregarded, yet some professionals still doubt AA’s value in treatment.

The prologue to the 12 steps may explain the reason for the attraction in saying, "The principles they embody [referring to the 12 steps] are universally applicable to everyone whatever his/her personal creed." Snow et al.\textsuperscript{17} suggest that studies addressing the process of self-change inherent in long-term recovery of AA members are scarce and superficial. They also report that "more frequent attendance at AA meetings positively relates to days of sobriety" and that "AA is cited as a primary factor in the maintenance of recovery following treatment" (p. 370). And, McKay et al.\textsuperscript{20} found that patients "do benefit from a continuity of care approach and that follow up treatment outcomes are much more positive for those patients who participate in self-help groups" (p. 258). Yet others have felt that certain persons do not affiliate well with AA, for example, some veterans with PTSD and comorbid alcoholism,\textsuperscript{21} and those who have a problem with the "spirituality" aspect of the 12 steps.\textsuperscript{22} Alfs and McClellan\textsuperscript{23} report that "dual diagnosis patients do respond over time to a nonconfrontational therapeutic group approach that is supportive and non-judgmental even if the patient is unable to maintain abstinence from abused substances completely" (p. 244). In general, MICA patients have found little understanding, acceptance, or support at 12-step recovery group meetings and have been left feeling shunned, stigmatized, and with very few options. With nowhere to turn, the needs of mentally ill chemical abusers can create a very heavy burden on both mental health and substance abuse treatment programs and their providers, in addition to costs to institutions due to increased hospitalizations. When treatment programs (whether servicing primarily psychiatric or substance abusing patients) do not accept patients because of a "secondary" problem, a system failure could exist. Due to this, these patients can "fall between the cracks." When MICA patients fall between the cracks, they, with little hope for recovery, frequently end up rehospitalized, impoverished, homeless, incarcerated, or socially isolated. And because of their drug or alcohol use and unstable emotional condition, these patients are vulnerable to robbings, beatings, prostitution, fights, motor vehicle accidents, etc.

STEMSS (Support Together for Emotional and Mental Serenity and Sobriety) was developed by Bricker and Erikson of Milwaukee in 1984. STEMSS follows a supported self-help group model that was developed for the expressed purpose of empowering the mental health consumer to become a "prosumer";\textsuperscript{24} a producer of what he or she consumes. This is made possible by providing an environment that is conducive to growth and is non-threatening, thereby, assisting the consumer to take risks and assume responsibility for his or her recovery from both illnesses. STEMSS grew out of a need, among other things, for groups for the mentally ill person typically because fellow AA or Narcotics Anonymous (NA) members did not understand that some persons with mental illness need to take prescription medications. The accepted assumption in AA and NA seems to be "drugs are drugs." Furthermore, drugs and alcohol are readily available, and they work. People simply drink or do drugs to alleviate symptoms like social anxiety. Sometimes mentally ill persons drink to combat the side effects of their prescribed psychotropic medication or to "make the voices stop." People may also drink or do drugs to get a sense of well-being, enhance feelings of normalcy, and/or for acceptance by peers. Mentally ill patients may go to a bar and drink so they can simply feel like "one of the boys." And to complicate the picture, there can be idiosyncratic reactions and paradoxical effects with drug and alcohol use as well as withdrawal and rebound effects and residual effects that may be very different for a mentally ill person than for the average person [case vignette].\textsuperscript{25} And many sources agree that "symptoms of anxiety, depression, restlessness or confused thinking can interfere with the individual’s ability to effectively ‘work a program’ and may directly trigger a relapse"\textsuperscript{15} (p. 15). Self-help recovery groups such as STEMSS serve to "plug up the cracks" in the system, and provide drug-free social/recreational and psychoeducational opportunities for the dually diagnosed consumer.\textsuperscript{26}
Case vignette: 46-year-old chronic schizophrenic, served in Vietnam, drinks regularly, occasionally uses marijuana, has tried cocaine. This patient usually had some mild tremors of hands and legs, but this particular visit his legs were shaking so vigorously he could not sit in the chair. Was it alcohol withdrawal? Was it side effects from his Prolixin? He was trying to stay sober, but if he were to go to an AA meeting he wouldn't have been able to sit down and he was frankly quite embarrassed stating "they would all think I'm some kind of freak and be staring at me." He had used alcohol initially to combat symptoms, his use progressed to abuse and then to addiction. (A common picture describing the insidious and pervasive progression of alcoholism.) Would it be a realistic treatment goal to ask him to have complete permanent abstinence from his social painkiller/anxiolytic (alcohol)?

Some problems with respect to treatment for the MICA patient were shared at a conference of providers. They were (1) Services simply not available; (2) Services that are available are not coordinated; (3) Clients lack of ability to assume increased responsibility for their recovery; (4) Treating multiple disorders concurrently; (5) Entry point into treatment can be difficult due to criterion and gatekeeping. Sources in the literature echo these concerns.

Moreover, controlled outcome studies that focus on program evaluation and/or prognosis of MICA patients are sparse, and controlled studies of treatment efficacy have not been encouraging. In general, the research suggests: (1) pretreatment characteristics (including severity of abuse), and (2) corollary social influences (including social support systems) seem to influence how well a person is going to do rather than the treatment activities themselves. Further, mentally ill individuals who abuse substances may differ greatly from one another. This clinical diversity has not been fully appreciated or well documented until recently. Recent research indicates that alcoholics and drug abusers as a group are extremely heterogeneous. In terms of family history, age of onset, clinical course, medical and psychological sequellae (both long and short), there is great variability. The issues of lack of link between controlled treatment outcome studies and current methods of treatment as well as appreciation for the clinical diversity of this population pose interesting areas for future research. Finally, much of the literature focuses on "new" approaches to clinical treatment of the MICA patient and/or reports on the development of new programs and approaches. In the future managed mental health-care environment, it may be more fiscally advantageous and prudent to reevaluate, improve, collapse, revamp, or integrate existing programs rather than to create more new programs. Bricker suggests mental health treatment in the "land of managed care" must offer hybridized treatment options at varying levels of intensity, providers must be flexible, utilizing a variety of techniques and theories, and treatment planning must be solution-focused. STEMSS begins to address these issues.

As stated earlier, Bricker suggests an Interactive Diseases model that poignantly addresses the specialized needs of the MICA patient because he sees the chronic mental illness and chemical dependence diagnoses as separate but overlapping and mutually reinforcing disorders (see Figure 1, 2, 3).

The STEMSS (Support Together for Emotional and Mental Serenity and Sobriety) model of supported self-help utilizes the interactive diseases model, as well as has its theoretical underpinnings based on a combined approach of the psychiatric rehabilitation and consumer empowerment models. Although many studies have been generated over the past decade addressing treatment of the MICA patient, few are holistically oriented clinical studies that purport an integrated approach to treatment, such as the one proposed by Minkoff in 1989, and Drake et al. in 1991. In order to survive in the future managed mental health-care environment we need holistic, integrated, comprehensive, cost-effective services. And, "integration needs to occur at the treatment level, the program level, and the system level."

Fisher discusses health-care reform for psychiatry based on an empowerment model of recovery. Consumer empowerment seems to be at the "growing edge" of a new treatment philosophy. As
Kaufmann\textsuperscript{31} states, "the concept of empowerment has emerged as a key issue" in the revamping of the mental health system. Thus, providers are well advised to involve consumers and family members in their future program planning. She continues by saying that the "newest research initiatives . . . involve consumers in design and implementation of research" and use "consumer experiential knowledge as a basis for inquiry and understanding of mental illness and its treatment" (pp. 154, 170).

Schubert and Borkman\textsuperscript{32} agree that empirical research based on experiential knowledge is viable and should be explored further in the future. And Rappaport's\textsuperscript{33} sentiments are even stronger here: "As a practical matter, smart, sensitive, and politically astute researchers are increasingly able to enlist members of the self-help community and the consumer movement into the service of traditional research aims" (p. 115). He further states that "narrative studies" have "profound implications, for the world of action, including practice in clinical and community psychology, applied social psychology, social work, psychiatry, and pastoral and other forms of counseling" (p. 132–133).

STEMSS is a fellowship of men and women who come together to share their common experiences and support one another in a consumer-driven, non-judgmental group environment. The STEMSS model is now in place in approximately 80 sites in the United States, and several in Canada, and there is a newly developed clearinghouse. The STEMSS model was introduced to the Buffalo area in 1988 and this process has been described elsewhere.\textsuperscript{34} The Buffalo VA Medical Center STEMSS group began in March 1994 through the collaboration of Osterstrom and this author and continues to meet weekly at this site. The group meets for 1 hour every week and is open to veterans, nonveterans, inpatients, outpatients, and others from the community. Currently, in Buffalo, there are 20 weekly STEMSS meetings that take place in social clubs, community residences, partial hospital settings, inpatient units, and a satellite addictions clinic. All the meetings are well attended. Referrals are plentiful and come from a variety of providers. Attendance is voluntary. Interested spouses, significant others, and professionals are welcome provided confidentiality is maintained. In addition to its therapeutic benefits, STEMSS is cost effective because meetings are facilitated by consumers with ongoing support and nurturance from professionals.

Because the STEMSS group is similar to traditional AA and NA groups, I encourage consumers to also participate in 12-step recovery groups in addition to STEMSS, or as an adjunct to it. This concept is entitled "interweave." "Interweave" is a stepwise progression enabling STEMSS participants to work themselves into AA/NA or other 12-step groups. The goal of interweaving is to offer a hybridized approach that focuses on removing barriers for MICA consumers to more comfortably attend and become engaged in traditional 12-step meetings. At STEMSS, however, consumers will find major differences from some 12-step meetings, as they have the freedom and group acceptance to discuss mental illness, coping with symptoms, and prescription medications. It is frequently a difficult task to maintain the delicate balance between controlling the symptoms of mental illness and the urge to "self-medicate" with substances. As stated in the fourth step of STEMSS, members are not criticized for taking prescription medications, but are encouraged to comply and work collaboratively with their physi-
cians, discussing fears and concerns as they arise rather than stopping medication on their own.

STEMSS groups are attended by a very diverse population, and self-help in general has been documented to appeal to a diverse population, including the homeless. STEMSS participants are not expected to disclose anything they are not comfortable sharing. It really does not matter if the person has been diagnosed as schizophrenic, bipolar, anxious, depressed, or another problem; members are told, “We really don’t get into labels here.” If an individual feels she or he has had symptoms of mental illness that have affected his or her ability to stay clean and sober, the criteria for “wanting to lead a nonaddictive lifestyle,” as stated in the STEMSS preamble has been met. Thus the screening and referral processes are smooth and unencumbered, making STEMSS user-friendly for staff and participants. This unpretentious approach has been documented as attractive to consumers.

Theoretical underpinnings of the STEMSS model are based on a combined approach, utilizing the psychiatric rehabilitation model and consumer empowerment movements. In addition, several of Yalom’s "therapeutic factors," or ingredients that are necessary for successful group work, are present in the STEMSS group experience. In particular, instillation of hope and universality are the forerunners of catharsis, group cohesiveness, and altruism. As these group factors manifest over time, their integration can be demonstrated through interpersonal learning and an existential point of view (that is, I am responsible for my choices, and ultimately my life). Interpersonal learning and existential factors, shown by personal acceptance of situation/choices and responsibility, seem to be necessary elements for prolonged recovery and “improved” quality of life and relationships with others.

For professionals to utilize the STEMSS model successfully, a major paradigm shift in the traditional “asymmetrical, one directional” treatment relationship needs to occur, from that of provider and passive recipient to treatment collaborators. The concept is quite simple. A generally accepted notion is that authoritarianism begets dependency, and premature interventions can invite helplessness, but self-help generates empowerment. Thus, consumers will be more likely to assume personal responsibility (“ownership”) for their choices if the power to make those choices is shared by them, and the consequences of those choices is felt by them. With empowerment comes responsibility. The principles of the empowerment model have been documented and discussed by Fisher and others.

The six steps of STEMSS together with the preamble and ground rules are read at the start of each meeting. The steps are as follows:

1. I admit and accept that my mental illness is separate from my chemical dependency and that I must work a double recovery program. (Task: Members work at acceptance of mental illness and chemical dependency as separate but overlapping entities.)

2. As a result of this acceptance, I am willing to accept responsibility for my life and help for my recovery. (Task: Members work on acceptance of BOTH mental illness AND chemical dependency; some persons can accept drug addiction/alcoholism more readily than mental illness. Also this step shifts thinking from accepting help [passive role] to accepting responsibility [active, empowering role].)

3. As a result of this willingness, I came to believe that with help and understanding, recovery is possible. (Task: Members work on empowerment through surrender, a paradox; however, this is a major theme in 12-step recovery programs; by “letting go” and surrendering control of the problem/illness one is actually more likely to gain control of his or her life [empowerment].)

4. As a result of this belief, I accept the fact that medical management must play a large part in my recovery programs, perhaps including prescribed medications. (Task: Members work at developing and enhancing trusting relationship with treatment providers, accepting that medications may be necessary for life in some cases.)

5. As part of these recovery programs, I accept the fact that I must maintain a lifestyle free from all “recreational chemicals.” (Task: Members work at permanent abstinence as the long-term goal, but it is not necessary to be accepted into a STEMSS group; persons are only asked to come to the meeting free of drugs and alcohol, “for today,” and are only expected to work on recovery “ONE DAY AT A TIME.”)

6. In following these steps throughout my life, I will reach my goals and help others to begin the recovery process. (Task: Consumers become “prosumers”—producers of what they consume—but giving back to others the support, hope, and encouragement they have received; consumers derive tremendous psychotherapeutic benefits in terms of improved self-esteem and
feelings of competency, or a "positive social identity" as termed by Kaufmann et al.36)
The primary characteristics of STEMSS groups are:
1. Secure, safe environment—free of alcohol and drugs, free of moralizing/judging.
2. Structured format—somewhat concrete, moderately structured and facilitator directed. The meeting format is usually as follows: preamble and steps are read, members introduce themselves by first names, members state what they are grateful for, table is open for any topic or problem by an individual, member describes problem and gets feedback from other members, meeting closes with "serenity prayer."
3. Strong peer support—goal is to facilitate bonding between members, rather than the professional answering the questions and providing the support.
4. Social and recreational opportunities—mostly planned and organized by the "consumer council," for example, annual picnic, dances, recognition dinners, etc. Facilitator training is periodically arranged through local STEMSS network, this is a combined educational and social activity.
5. Heavy emphasis on medication compliance and abstinence.
6. Psychoeducation—facilitators and members can participate in educational activities that are used to actively engage persons who are not ready to "admit and accept" their illnesses.

STEMSS is NOT a therapy group, but has been described as "closer to an AA meeting than group therapy and closer to group therapy than an AA meeting."

Many individual members have shared their feelings and experiences from STEMSS group with me. Participants have felt that STEMSS works because (1) attendance is voluntary, (2) consumers are not labeled by their disorder, and (3) consumers have had trouble feeling accepted into traditional 12-step recovery groups. These will be discussed here.

Voluntary Participation
In some cases "court-mandated" treatment has been assumed to be necessary and productive. However, according to Hasin,37 "few empirical studies have addressed the validity of this assumption with general population samples" (p. 660). Rather, voluntary participation in recovery groups is highly desirable, and theoretically consonant with the STEMSS supported self-help model. Responsible choice making and owning consequences of choices made, whether positive or negative, is part and parcel of the empowerment phenomenon. Although some consumers, those who need structure in their lives, may respond well to firm "direction or suggestions" from treatment providers, in the long run this behavior may create unnecessary dependency upon the provider and not serve the consumer in the best possible way. That is, by not assisting him or her to develop the necessary skills for becoming able to accept personal responsibility.

Keeping the Focus on the Positive

STEMSS participants also felt it works because the focus of the group is not on "what's wrong with me" like MICA group. The focus of the group is on people coming together to "share experience, determination and hope," it "helps people to help themselves." This in essence, refers to Yalom's35 "universality." As Yalom so eloquently states here, "it is not only the discovery of others' problems similar to one's own, and the ensuing disconfirmation of one's wretched uniqueness, that is important; it is the affective sharing of one's inner world and then the acceptance by others, that seems of paramount importance" (p. 50). Universality, so readily observed in STEMSS groups is powerfully healing, and serves to breakdown the isolation so commonly experienced by persons with chronic mental illness and/or substance abuse. The common bond is that they have suffered—some in a very far-reaching and pervasive way; the sharing of significant life events binds people together in a profound way that is not easily explained or studied.

Feeling Out of Place
Finally, STEMSS participants have found it difficult to "find a home" in AA. Thoughts such as the following have been shared by STEMSS members of AA or NA, "They are nosy;" "I don’t fit in;" "They don’t understand my need to take medicine." Other members have stated that the harsh confrontation experienced in AA has contributed to an exacerbation in his or her psychiatric symptoms, and the intense introspection required to "work steps 4 and 5" too difficult. Hoffman et al.8 agree in saying the CMI patients are unable to tolerate intense interactions . . . or learn better in a less stressful setting" (p. 82). Others agree.5,21,23 Yet Noordsy et al.11 state it is
“unclear” as to whether persons with severe mental illness are “less able to tolerate a rigid and confrontive approach than other individuals or how the treatment conditions compare to those in traditional settings.” They suggest “a more meaning-centered approach to the treatment of substance abuse among mental health clients which would emphasize listening to clients’ explanatory models of their distress, rather than trying to teach a specific model of addiction to clients” (p. 322).

Also at the start of AA meetings, although not required, it is a norm that those who have come to terms with their addiction state to the group they are “alcoholic.” At STEMSS groups it is not required of members to state they are “mentally ill” in order to be accepted by the group. This is not to say in any way that 12-step programs are not extremely valuable for individuals who are committed to working hard at recovery, are capable of being honest with themselves and others, and are characterologically able to tolerate the intensity of working the 12 steps. However, not all individuals are able or capable of doing this to the degree that is suggested by most 12-step groups.14,21,38

In sum, the STEMSS model is holistic, nurturing, experiential, and spiritual. STEMSS fosters self-esteem by focusing on the growth, potential, and gifts each member brings to the group, rather than on members’ singular or collective disabilities. STEMSS offers a viable cost-effective, therapeutically sound alternative or adjunct to 12-step meetings for many. In order for self-help groups such as STEMSS to thrive in an institutional setting, professionals need to be aware of and/or have an understanding of the basic concepts of 12-step groups; have respect for and/or believe that self-help is a viable and credible option for many people to achieve recovery; or to have a certain open-mindedness with respect to considering new treatment alternatives that may involve “coloring outside the lines.”

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Kathleen A. Hastings-Vertino, M.S., R.N., C.S., is a community mental health nurse at the Intensive Psychiatric Community Care Program at VA Western New York Health Care System.