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CORRESPONDENCE

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To the Editor:
James *et al*. (2004) reported excellent results for group therapy with 63 patients with dual diagnosis of psychiatric illness and drug addiction.

Although what constituted the criteria for their good result has not been clarified, every psychiatrist/therapist dealing with patients with dual diagnosis will welcome their findings since such patients are notoriously difficult to help.

Difficulties conducting group therapy for patients with dual diagnosis stem from many sources. Possible complications in group therapy were not the focus of the paper, therefore, they were not discussed by James *et al*. We restrict ourselves to mentioning only two important issues.

First, any communication related to drugs functions as conditioned stimulus for ex-addicts increases the chance for relapse (Wikler, 1973; O'Brien *et al*. 1992; Gerevich *et al*. in press). Second, difficulties in group therapy for psychotic patients arise from the lack of treatment adherence known in patients with both psychosis and drug addiction.

These problems would mount up in the process of group therapy for dual diagnosis patients.

Significant therapeutic success with such a difficult to treat population has long been awaited. James *et al*.'s findings should be replicated by methodically sound studies.

Declaration of Interest

None.

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JÓZSEF GEREVICH, ERIKA BÁCSKAI AND KATALIN MEGGYES

Address correspondence to:
Dr J. Gerevich,
Addiction Research Institute, *Budapest*, *Hungary*
(gerevichj@axelero.hu)

The Authors reply:
Gerevich and colleagues raise two issues with respect to group therapy for people with dual diagnosis of psychosis and substance misuse.

(1) The statement that 'any communication related to drugs functions as conditioned stimulus' that might enhance the chance of relapse, whilst perhaps true, leaves us in a difficult position with respect to dealing with people with problematic use. One surely needs to disseminate information, at the very least, and avoidance of all potential drug-related cues is hardly practicable.

(2) Adherence was not a major issue in our study, as it happens, with relatively few dropouts and generally good attendance and completion of homework. Groups were chosen for our study because: (*a*) the participants learn much from each other about strategies to reduce use; (*b*) they are cost-effective; and (*c*) we had a well-established group programme at the facility in which the study was conducted, so patients were well attuned to group process. This latter issue might have contributed to the good adherence rates in our study.

We agree fully that our study requires replication in other settings. As it happens, we have found translation of this programme into a generic mental health service in Melbourne, Australia, more problematic in terms of engagement. Some of this relates to a reluctance of some people to attend groups. Responsive to

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this, we are now developing and testing in a randomized controlled trial, the efficacy of a 1 : 1 adaptation of the programme, for people who do not wish to do group work: our experience thus far suggests good efficacy.

DAVID J. CASTLE

Mental Health Research Institute and University of Melbourne, 155 Oak Street Parkville, Vic 3052, Australia

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