Cannabinoids

- Most common illicit drug used in the US
- Signs of marijuana abuse:
  - Inflammation if whites of the eye
  - Rapid, loud speech & bursts of laughter
  - Sleepiness or stupor
  - Forgetfulness in conversation
  - Distorted sense of time passage

- "***Amotivational syndrome***" in marijuana users

Phencyclidine - PCP

- Originally developed as an anesthetic
- Street names: angel dust, embalming fluid, rocket fuel, loveboat, super grass, killer weed
- Mode of administration: smoked or snorted

Phencyclidine - PCP

Effects:

- Unpredictable (stimulant or depressant)
- Hallucinations
- Analgesia

- May be associated with behavioral problems and violence

Inhalants

- Various compounds that are produced and sold for legal purposes
  - Commercial solvents
  - Aerosols
- Cause severe & typically irreversible organic brain disorders

Alcohol

Epidemiology:

- Alcohol use is highly prevalent in Western cultures
- First episode of Alcohol Intoxication is likely to occur in mid-teens
- 30-45% of adults in the US have had at least one transient episode of ETOH-related problems

Etiological Models for Alcoholism

- Prohibitionist
- Moral
- Medical/Disease

Medical/Disease

- Jellinek developed the “American Disease Model” of alcoholism – conceptualized addictions as bodily diseases (1950)
- Genetic studies – efforts to identify one or more genes

Medical/Disease

Stages of alcoholism (Jellinek):

1. Prealcoholic (intoxication for stress relief)
2. Prodromal (blackouts, compulsive drinking, guilt and secrecy)
3. Crucial (loss of control over drinking)
4. Chronic (severe withdrawal; obsession with drinking

Etiological Models for Alcoholism

Psychological:

- Psychodynamic
- Social Learning/Cultural
- Cognitive
- Self-handicapping
- Bio-psycho-social

Culture and Substance-Related Disorders

- World Health Organization (1993) – study of how different cultures define normal vs. pathological drinking
- Findings: great variability across cultures in patterns of use, definition and function of intoxication, as well as effects of intoxication

Diagnosis/Recording Procedures

- Use the code that applies to the class of substances & record *the name of the specific substance*

  e.g., 292.0 Secobarbital Withdrawal rather than Sedative, Hypnotic or Anxiolytic Withdrawal

Diagnosis/Recording Procedures

- If the substance used is unknown, use the appropriate code – 292.89 Unknown Substance Intoxication

Diagnosis/Recording Procedures

304.80 Polysubstance Dependence

- Use sparingly, only for behavior during the same 12-month period in which the person was repeatedly using <u>at least three groups of substances</u> (not including caffeine and nicotine), but no single substance predominated AND Dependence criteria were met for substances as a group but not for any specific substance

Differential Diagnosis Issues

- Distinguish Substance-Related Disorders from nonpathological substance use and from use of medications for appropriate medical purposes
- Repeated Substance Intoxication episodes alone are not sufficient for a diagnosis of either Substance Abuse or Substance Dependence

Differential Diagnosis Issues

An additional diagnosis of Substance-Induced Disorder is usually not made when symptoms of preexisting mental disorders are exacerbated by Substance Intoxication or Substance Withdrawal

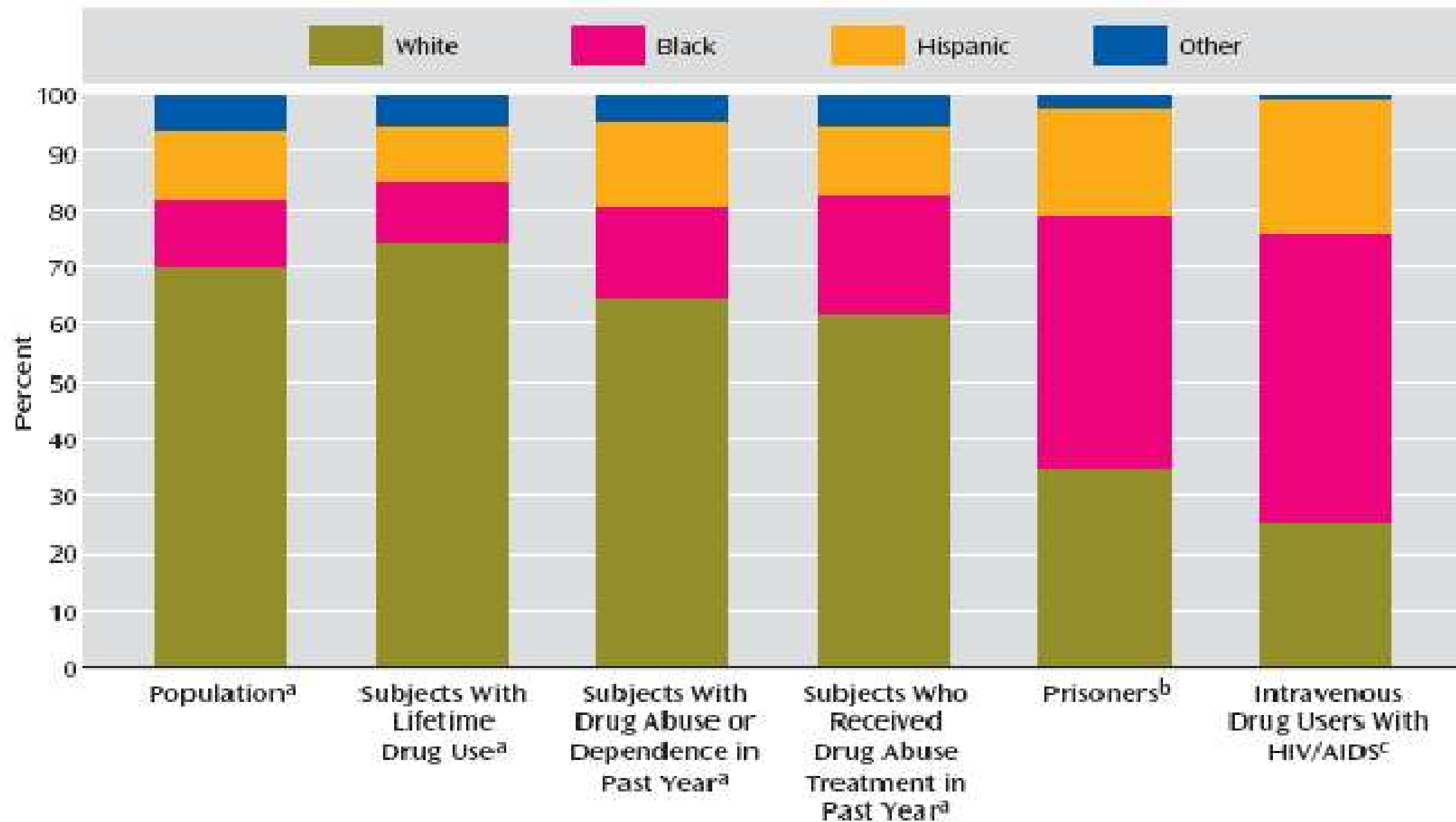
Differential Diagnosis Issues

If symptoms are judged to be
a direct consequence of <u>both</u>
substance use and
a general medical condition
<u>both may be diagnosed</u>

Epidemiology

- Alcohol abuse and dependence = most prevalent mental disorders in the general population
- More common in males than in females (5:1 male to female ratio)

FIGURE 2. Distribution of Selected Variables Related to Drug Use by Race/Ethnicity



[a] Data from 2002 National Survey on Drug Use and Health (5): Population by Race/Ethnicity in 2002, Percent of Persons 12+ Reporting Any Illicit Drug Use in Lifetime by Race/Ethnicity in 2002, Percent of Persons 12+ Meeting Criteria for Drug Abuse or Dependence in Past Year by Race/Ethnicity in 2002, and Percent of Persons 12+ Reporting They Received Drug Abuse Treatment in the Past Year by Race/Ethnicity in 2002.
[b] Data from Bureau of Justice Statistics Bulletin (10).
[c] Data from Centers for Disease Control and Prevention (11).

Comprehensive Assessment

Addiction Severity Index (ASI):

- Drug & Alcohol use
- Medical
- Psychological
- Employment
- Legal
- Family & Social

Biochemical measures

- Breath Alcohol Test
- Alcohol dipstick
- Urine Test
- Alcohol Sweat Patch
- Hair Analysis
- Liver Function Test

Comprehensive Assessment

American Society of Addiction Medicine (ASAM)

Patient Placement Criteria

- Outpatient:
  - Level 1 - < 9 hours/week
  - Level 2 - > 9 hours/week
  - Day Treatment or Partial Hospitalization
- Inpatient: Medical or Psychiatric
- Residential: Social Model Recovery Homes

Assessment instruments

- McAndrew scale on the MMPI (no profile is unique to alcoholics)
- MAST (Michigan Alcoholism Screening Test)
- CAGE (Cutting down, Annoying, Guilt, Eye-opener) – 4 questions

Assessment instruments

- AUDIT – Alcohol Use Disorders Identification Test
- HALT
- BUMP
- FATLDTs

Behavioral assessment (Sobell, 1988)

- Baseline & Target behaviors
- Patterns of use
- Antecedents & triggers
- Maintaining stimuli & reinforcement hierarchy

Behavioral assessment (Sobell, 1988)

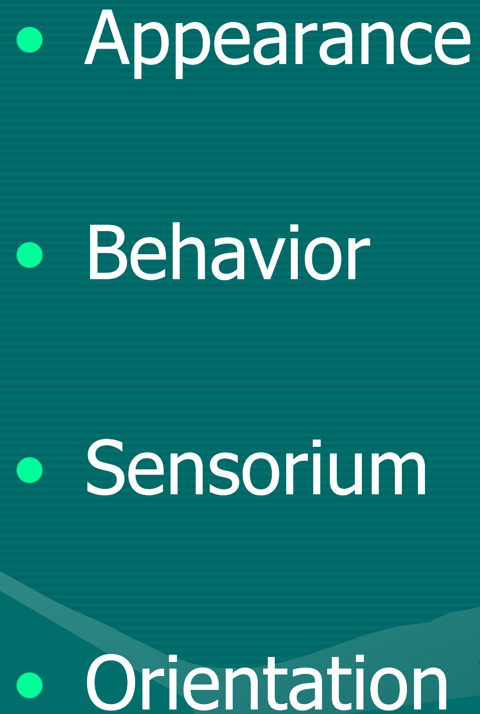
- Potential for remediation
- Previous treatments – for substance abuse, psychiatric
- Anticipated difficulties

Behavioral assessment (Sobell, 1988)

- Medical complications – tolerance, withdrawal,dual diagnosis, last physical examination
- Cost-benefit analysis – social support, life events

Mental Status Exam (MSE)

- Appearance
- Behavior
- Sensorium
- Orientation



Mental Status Exam (MSE)

- Speech
- Affect/Mood
- Thought Processes & Content, Cognition
- Judgment & Insight
- Suicide/Homicide

Stages of addiction

Initiation = Experimentation leading to dependency

- Newcomb's stage theory: entry drugs (legal substances) & sequential progression to harder drugs
- Role of peer group (peer variable mediate family, school & religious values); problem behaviors

Stages of addiction

Maintenance = Continuation of use

- *Pharmacological factors*
- *Psychological factors* – hedonic expectations, low SE, poor coping skills, depression & anxiety (high co-morbidity)
- *Environmental factors* – stress as trigger

Predictors of addiction

- Early life home instability, violence, chaos
- Family history of substance abuse
- Presence of other mental disorders
- Low status occupation of father

Predictors of addiction

- Parental sociopathy & delinquency
- Peer use & pressure & parental drug use
- Low self-esteem
- Stressful life changes
- Lack of social conformity

Treatment considerations

- Intervention Strategies
- Achieving Abstinence (0-6 months)
- Maintaining Abstinence (6-24 months)
- Lifelong Abstinence

Stages of change

- Precontemplation
- Contemplation
- Decision Making
- Action
- Maintenance
- Relapse – Relapse Prevention

Prochaska & DiClemente, 1989

Precontemplation

- Clients are unmotivated for treatment; they don’t think they have a problem; if they participate in tx it is with the desire to change others or their environment.

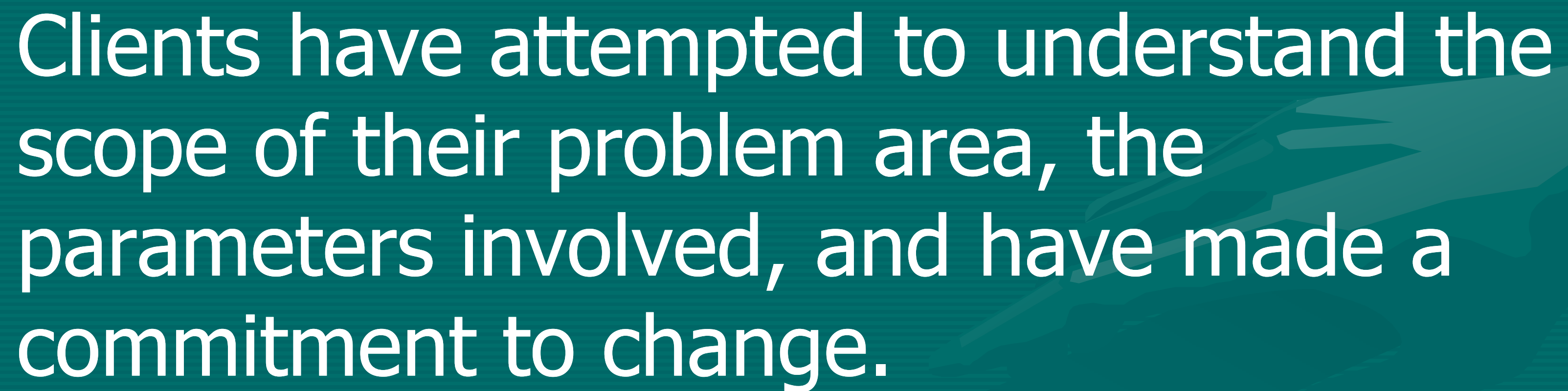
- There may be a slight recognition: “I might have a problem.”

Contemplation

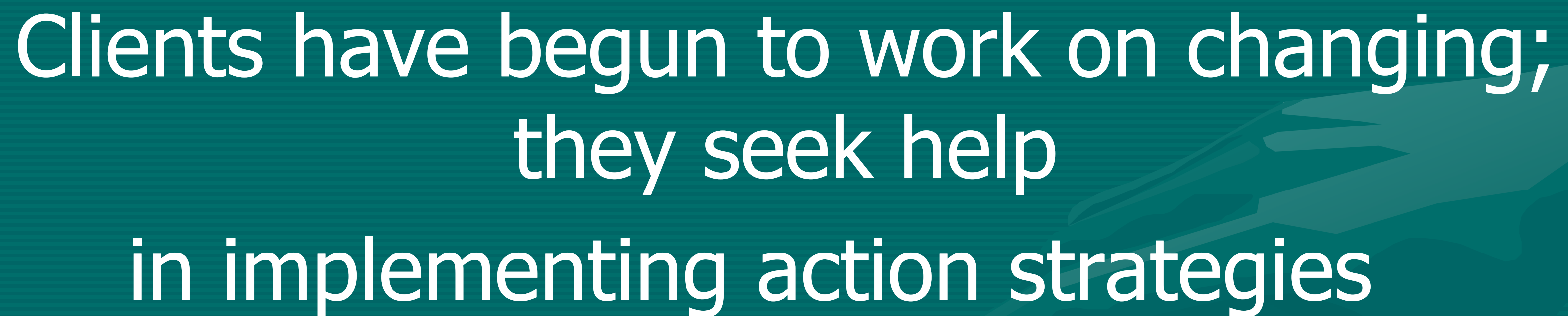
- Contemplators are interested in determining whether therapy could be helpful to them in solving their problems.
- At this stage, clients may think: “I want to do something about the problem I have!”

Decision making

Clients have attempted to understand the scope of their problem area, the parameters involved, and have made a commitment to change.



Action



Clients have begun to work on changing; they seek help

in implementing action strategies

Maintenance

Maintainers have already made changes in the problem area.

Their focus in treatment is to consolidate previous gains and to prevent relapse.

Achieving Abstinence

- Detoxify – if necessary
- Assess/Treat psychiatric disorder, if present
- Supportive psychotherapy

Achieving Abstinence

- Medication support
- Social support
- Peer support groups – 12 steps
- Relapse prevention

Relapse & Relapse Prevention

- Relapse is highly likely
- It is important to be aware of the phenomenon of AVE (i.e., loss of control and ‘lapse’ – with the cognitive attributions and affective reactions likely to follow a ‘lapse’)

Abstinence Violation Effect (AVE)

- Loss of control & lapse
- AVE has an effect on:
  - Cognitive attributions
  - Affective reactions to these attributions

Stages of recovery

- Pre-recovery
- Recovery
  - Crisis
  - Shock
  - Grief
  - Repair
  - Growth

Supportive psychotherapy

- Compliance with medication regimen
- Psycho-education
- Abstinence Therapy – avoidance of all substances

Maintaining abstinence

Supportive psychotherapy

- Cognitive-behavioral – cognitive restructuring
- Reality therapy
- Psychodynamic (if indicated clinically)

Maintaining abstinence

- Relapse prevention – increase intensity of tx during high risk relapse periods
- Taper supportive measures, as needed

Relapse prevention

- Relapse prevention is a process
- Identify triggers & patterns of response to triggers (thoughts, feelings, behaviors)
- Alternative behaviors & coping with the lapse

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