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
304.80 Polysubstance Dependence

- Use sparingly, only for behavior during the same 12-month period in which the person was repeatedly using at least three groups of substances (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.
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 both substance use and a general medical condition, both may be diagnosed.
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


Data from Bureau of Justice Statistics Bulletin (10).

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


References