Addiction Treatment

Avoiding Pitfalls—
A Case Approach

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An Overview

Medicine has been involved with addiction treatment since ancient times. Archaeological and anthropological evidence reveals that societies around the world had access to psychoactive substances that were associated with abuse long before people knew how to communicate through writing. In ancient Greco-Roman times, physicians described alcoholism and opiate addiction. Their knowledge of these conditions suggests that alcoholic and addicted patients sought help from them. Even in peasant and tribal societies of today, shamans, herbalists, and other healers provide care to alcoholic and drug-addicted patients by whatever means is available to them. Through an understanding of the history of psychiatric medicine and drugs, we can gain a fuller appreciation of the contradictions and conflicts facing us today.

History of Psychiatric Medicine and Addiction

Physicians in the United States have treated addiction more frequently than did physicians in most other countries. Benjamin Rush, a physician in the Revolutionary War and father of American psychiatry, developed a typology of normal drinking and various degrees of abnormal drinking two centuries ago. Imported from Europe, where it applied to psychiatric disorders, the concept of moral treatment extended to alcoholism in the early history of the United States. This method consisted of rest, nutrition, and respite from drinking sites and drinking friends. Treatment occurred in a context of acceptance, support, and optimism. This “asylum” approach to the care of alcoholics continued in
private and public settings up to the present (although current health policies have recently turned against its application in high-cost hospital settings).

During the late 1800s, opiate addiction affected hundreds of thousands of people in the United States. Many suffering veterans of the Civil War had become addicted to morphine during and after the war. Women of that era became addicted through the purchase of the over-the-counter nostrums containing opiates for various common maladies (including menstrual conditions); addicted females outnumbered addicted males. The availability of purified opiate compounds (i.e., morphine, heroin) and the use of parenteral injection from the mid-1800s may have contributed to the problem as well. The federal government’s Narcotic Act of 1914 turned hundreds of thousands of “legal” opiate addicts into illegal addicts.

The psychoanalytic movement, which fostered humanistic attitudes toward most psychiatrically ill persons during the first half of the twentieth century, was often less than understanding toward alcoholic or addicted patients. Psychoanalysts widely viewed these patients as having “personality” or “character” disorders or, more specifically, psychopathic or sociopathic personalities. This diagnostic stance suggested that alcoholic patients were generally not treatable, that they chose to be the way they were, and that they had to choose to change themselves. An alternative view among some psychoanalysts held that alcoholic patients would spontaneously stop drinking once they “understood” or had insight into their problems or once they had a “corrective therapeutic experience” with an analyst. Although these latter theories made some sense and were both humanistic and optimistic, in fact they met with little success. During this period, a number of nonmedical, and sometimes antimedical, self-help groups evolved. One of these nonmedical groups was Alcoholics Anonymous (AA), which formed in the United States during the 1930s and possessed some of the characteristics of similar groups that had begun over the previous two centuries in Europe and Asia.

In the 1960s, psychiatric medicine began to develop new directions in treating addiction. Several factors led to this change. One factor was the rapprochement between local medical facilities and AA, which made it possible for alcoholic patients to receive at least acute care in hospital settings. A second factor was the creation of the Division of Alcohol and Drug Abuse within the National Institutes of Mental Health—a focus of support that eventually led to separate institutes for alcoholism and drug abuse. Third, the extent of alcoholism and drug abuse grew to epidemic proportions during the period 1960–1980, and it became impossible to ignore the problem. Fourth, several medical and psychiatric associations appeared during this time: American Society for Addiction Medicine (ASAM), Association of Medical Educators and Researchers in Substance Abuse (AMERSA), and American Association of Addiction Psychiatrists (AAAP). Fifth, outstanding physicians established themselves as experts in the field (e.g., Drs. Morris Chavez, Sidney Cohen, Edward Gottheil, Jerome Jaffe, Benjamin Kissin, Joyce Lowinson, Jack Mendelson, Mansell Pattison, Abraham Wikler). Inspiring younger colleagues to emulate their career choice.

Morbidity and Mortality

The consequences of addiction during the last half of the twentieth century resemble the outcome of the Great Plague in many parts of the world, including the United States. If the Opium Epidemic in China from the early 1600s to 1954 can be seen as a precedent, addiction could threaten the stability of our nation—although some observers disagree that drugs per se could be that powerful. Like the great scourges before it (e.g., tuberculosis, syphilis), addiction can cause, mimic, and present with diverse medical, psychiatric, and surgical disorders, and thus it may not immediately be recognized. Addiction can undermine family life through interpersonal strife, spouse and child physical abuse, and financial loss, ultimately producing family dysfunction, separation, and divorce. Alcohol and drug abuse can produce a myriad of behavioral, psychological, and social problems among youth—many with life-long consequences. Finances that might be spent to enhance our culture, enhance education and child development, or contribute to improved social justice instead are lost to the consequences of addiction. The Robert Wood Johnson Foundation stated that, in 1993, “Every man, woman and child paid $3,000 to cover the cost of unnecessary health care, extra law enforcement, auto accidents, crime, and lost productivity resulting from substance abuse.”

Treatment Benefits

Despite the seriousness and chronicity of addiction, recovery is possible. Spontaneous recovery without outside help can and does occur, albeit
inrequently.\textsuperscript{17} Short-term abstinence is common, and some people may
demonstrate an episodic relapsing pattern consistent with productivity
and longevity.\textsuperscript{18} Although we do not know the exact number of those
able to cease substance abuse on their own, it is almost certainly a minority
of all cases—probably less than 10\% (although this may be as high as
20\%–25\% in higher socioeconomic groups). Thus, spontaneous recov-
erry is not a reliable answer to this widespread problem in our society to-
today. Moreover, spontaneous recovery may occur only after many years
or even decades have passed and damaged the individual, his or her
family, and the community.

Nonmedical interventions, such as self-help groups, offer assistance
to many. These include AA, Narcotics Anonymous, Cocaine Anony-
mous, and others. These have the advantage of low cost and long-term
affiliation for the recovering persons. However, they also have certain
limitations as a sole source of help. Although the fellowship of these or-
ganizations can be a powerful psychosocial resource, they do not pro-
vide professional services, withdrawal treatment, protection from harm
against self or others, early case finding, or care of substance-related
medical and psychiatric problems. These organizations must wait until
the individual seeks their assistance voluntarily. Fewer than 20\%
of those who participate in AA remain affiliated with it.\textsuperscript{19} A variety of other
resources, such as employee assistance programs, clergy, and school
counselors, can greatly facilitate early recognition of the problem and
support eventual recovery. However, to be most effective, these agen-
cies and groups require access to professional treatment resources.

Treatment for alcoholism includes numerous modalities, depending
on the phase of the disorder, the presenting problem or complica-
tion, the type of substance, and severity or chronicity. Early on, treatment
may involve detoxification, addressing psychosocial crises or medical
emergencies, and helping the patient cease substance abuse. Next, stabi-
lization requires family and community support, attention to associated
psychosocial and medical problems, and aid in establishing a sober life-
style. Last, but certainly not least, patients may need assistance with
long-term rehabilitation, enjoying sobriety, finding meaning in their past and present life, and finding rationales for future sobriety and so-
cial contribution.

The intensity of treatment should be tied to the type and severity of
the problem. The ASAM has developed widely employed Patient Place-
ment Criteria, including the following:

- Brief hospitalization for life-threatening substance-related prob-
  lems (e.g., drug-precipitated psychosis, suicidal or homicidal intent,
  withdrawal convulsions or delirium)
- Residential placement (e.g., halfway house, therapeutic commu-
  nity) for those who live alone, are about to lose their family contacts,
  or have failed to recover in less restrictive settings; employment and
  school participation can continue or be reestablished from these set-
  tings
- Day program attendance for those unable to function as worker,
  parent, or student; person may live at home or in a residential facil-
  ity
- Evening or weekend program for those able to function as worker,
  parent, or student but requiring an early recovery period of intense
  treatment and psychoeducation
- Outpatient clinics, counseling, or “aftercare” programs for patients
  who are well established in their sobriety and recovery, who are in-
  volved with other forms of recovery (such as a halfway house), or
  who are in an early phase of assessment or “pretreatment” (i.e., mo-
  tivation to treatment)

After treatment, most recurrences of addiction occur within the first
6 weeks to 6 months.\textsuperscript{20} Once recovering persons have 1 or 2 years of sta-
ble sobriety outside of a residential facility (such as a hospital or halfway
house), their long-term recovery is likely.\textsuperscript{19,21} Thus, in order to assess
treatment effectiveness, follow-up studies must track patients for at least
6 months and preferably for 1 or 2 years. Interpretation of existing stud-
ies is complex, because “treatment success” is variously defined. Benefit
should involve more than abstinence alone (i.e., it should also include
stable or improved health and quality of life). There also appears to be a
strong patient–treatment interaction in that some treatments work for
some classes of patients but not for others.

In numerous studies, employment, competent parenting, and/or ac-
tive participation in school at the time of entry into treatment predict im-
proved treatment outcomes.\textsuperscript{19} This general finding suggests that timely
entry into treatment, before these social functions are lost, may improve
treatment outcome. This strategy goes against the traditional practice of
allowing the alcoholic or addicted person to “bottom out” (i.e., have se-
vere losses and problems) before seeking care. Providing timely help is
the basis for early diagnosis in medical settings and early detection in
the school or the workplace. Alanon and parental support groups have
evolved to assist families in facilitating the timely seeking of help for their affected family member.

Improvement rates with treatment vary from as low as 15%–20% to as high as 85%–95% at the end of 1-year or 2-year outcome studies. Factors associated with improved outcome, in at least some patient groups, include the following:

- Higher education and socioeconomic status
- Employment and married status at the time of entry into treatment
- Completion of treatment or compliance with treatment
- Being part of certain occupational groups in which intense monitoring occurs, such as airline pilots and physicians
- Existence of certain characteristics of the treating staff with regard to the patient (e.g., alcoholism counselors do as well as mental health professionals in treating patients who have alcoholism only, whereas mental health professionals have better clinical outcomes treating alcoholics with comorbid psychiatric disorders
- Matching of certain treatment modalities to the patient
- Use of particular forms of pharmacotherapy, such as methadone maintenance, disulfiram, and naltrexone, for selected patients
- Use of behavioral modification techniques, such as contingency contracting, with families or employers
- Reconstruction of social network, including development of recreation and social activities free of substance use

Successful treatment is associated with many benefits for the individual, family, and community. Medical costs, which can rise during the first year of recovery, eventually drop.

Predictors of Clinical Outcome

Detecting and then managing addiction present special challenges for the clinician. Unrecognized biomedial conditions may complicate psychiatric diagnosis and care. Apparent personality problems may or may not resolve with stable abstinence and recovery.

Poor outcomes can result from the nature of the disorder and its myriad of associated problems and consequences, even if the clinician properly manages the patient’s care. Patients and family members may fail to recognize the existence of the substance abuse or may hide or minimize it, complicating the diagnostic efforts of the clinician. Especially in the early weeks and months of abstinence, transient “slips” or serious recurrences are commonplace. Even patients with stable recoveries can experience a recurrence during a crisis, such as death of family member, retirement, or other reversal.

Clinicians who depend upon their patients’ honesty for accurate diagnoses and effective therapy often find that their alcoholic and addicted patients are dishonest. This may give rise to adverse clinician-patient relationships, leading to inadequate care, premature discharge from care, or hostile doctor-patient relationships that dissuade patients from subsequent healing relationships. Clinicians working in this field must accept the fact that their patients may relapse, have emergencies during weekends and evenings and holidays, harm themselves and others, and even die from any of several causes.

Patients’ and families’ inability or failure to recognize the presence and severity of addiction can be contagious. Minimizing of the problem, denial of the obvious diagnosis, and unrealistically assuming a smooth recovery are typical, expected, and major pitfalls. Signals that the clinician may be minimizing the patient’s clinical condition are as follows:

- Using euphemisms such as “problem drinking” or “drug experimentation” when the data support a diagnosis of alcoholism or substance abuse
- Failing to address the family’s fears behind their enabling and rescuing behaviors (e.g., fear of death, abandonment, assault, blackmail)
- Failing to convey to the patient and to the family the diagnosis and its prognosis if left untreated
- Lack of awareness regarding the risk of becoming an enabler or rescuer (instead of an effective clinician)

Many addicted patients come from families in which one or both parents were substance abusers. Parental competence and care were compromised, leading to the children’s lifelong distrust of helpers and authorities. These patients may experience profound difficulties in trusting and otherwise relating to the clinicians trying to assist them. Such patients may be litigious, which grows out of their rage toward
parent surrogates or their wish for unearned gain as recompense for a poor preparation for life during childhood.

**Conclusion**

The history of addiction treatment is filled with approaches that are now viewed as unhelpful at best and harmful at worst. Such examples include treating opiate addiction with heroin (in the mid-1800s) and recommending cannabis smoking or hallucinogens for alcoholism (in the 1960s). Addiction treatments have changed dramatically over time, and they continue to change. Many treatment advances have occurred only through trial and error. Modalities once considered as optimal treatment (such as mandatory 90-day inpatient stays) have become obsolete. This history suggests that we must remain open and flexible in considering novel treatment approaches yet also maintain a scientific approach to the careful evaluation of addiction treatment.

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Screening, Diagnosis, and Assessment

The psychodynamics of addiction greatly complicate the process of screening, diagnosis, and assessment. At the core of these dynamics is personal attachment, even commitment, to the drug or drugs. This attachment in turn leads to those manifestations that make screening and diagnosis difficult (i.e., dependence on and continuing desire for the drug, denial of the consequences of drug usage, and the fear of living without the drug). This "need" for a drug should be appreciated by the clinician, yet detected for what it is—a deadly process.

Screening

Specific Inquiry

For decades, clinicians have been taught to inquire about their patients' use of alcohol or other drugs through the use of

- A combination of open-ended and closed-ended inquiries
- Nonjudgmental phrasing of questions designed to elicit factual information
- Questions aimed at obtaining information regarding the type of substances used, doses, duration, and patterns of use

Experience has demonstrated that this approach is most apt to elicit detailed, relevant clinical information about substance use in addition to
Case Report 2.1

A general surgeon performed a cholecystectomy on a 42-year-old engineer for chronic abdominal pain, although diagnostic procedures had failed to indicate any lesions or dysfunction in the gall bladder. The surgeon failed to screen for substance use or abuse, although the patient's history showed many indicators of alcohol abuse, including treatment for alcoholism on three occasions. In addition, the patient had lost several jobs and was experiencing marital discord and financial problems. The patient's continued alcohol abuse impaired his healing as well as his ability to cooperate with postoperative recommendations. Subsequently he developed an incisional hernia (requiring additional surgery), “dumping syndrome” (leading to parenteral nutrition), and more chronic pain. The patient sued the surgeon for damages resulting from chronic disability, leading to a long and costly trial.

Proper techniques that the surgeon might have used include the following:

- Asking specific questions: “What has been your use of alcohol in the last month?”
- Asking questions that do not lead to or force a particular response: “Do you use any recreational substances besides alcohol?”
- Asking questions that exclude words with negative connotations: “Do you ever use your medication to get an emotional lift?”

Errors in technique commonly made by clinicians include the following:

- Asking vague questions: “Are you a social drinker?”
- Asking leading questions: “You don’t use marijuana, do you?”
- Asking judgmental questions, using terms with negative connotations: “Are you an alcoholic or an addict? Do you get drunk or abuse drugs?”

Proper techniques will help clinicians consider substance use in their evaluations, as evidenced in the following case.

Case Report 2.2

A 25-year-old woman saw a series of mental health professionals over a 1-year period to deal with “emotions and marital problems.” During this time, as her condition deteriorated, she saw one psychiatrist, two social workers, and three psychologists. Finally, one psychologist asked her about her alcohol use, took a thorough history, and informed her that she was an alcoholic. She subsequently made a full recovery over the following 2 years, is in her fourth year of sobriety, and is married and raising her first child.

Patients who are ambivalent regarding their use of psychoactive substances or who are having problems in relation to their use tend to provide uninformative responses. Such responses are apt to be general, unacceptably abstract, or off the topic. Examples include the following:

- “I don’t drink any more than my friends.”
- “I’m just a social drinker.”
- “I’ve cut back to just drinking on weekends and holidays.”
- “I probably don’t drink any more than you do, Doc.”

Case Report 2.3

A 48-year-old woman presented to the hospital for an elective removal of her gall bladder, following unsuccessful medical management of her recurrent gall bladder stones and inflammation. The surgeon asked her about her use of alcohol and drugs. According to her chart, she responded that she “drank a little wine on weekends and took some medications for pain and relaxation during her gall bladder problems.” On the third postoperative day, she became agitated, developed rapid pulse and low-grade fever, and was noted to hallucinate fearful visual objects in her room. Further history (confirmed later by her husband) revealed that she had been taking benzodiazepines prescribed by three different physicians and Fiorinal for pain (which contains a barbiturate). In addition, she drank five glasses of wine each Friday, Saturday, and Sunday evening, with two or three glasses of brandy at bedtime during the week. Fortunately, her alcohol-sedative withdrawal illness cleared within hours of a diazepam withdrawal regimen, and she made an uneventful postoperative recovery. Subsequently, she was transferred to a treatment program for a substance-related disorder (SRD).
Upon receiving an uninformative response, the clinician should educate the patient regarding the need to know his or her alcohol and drug use in order to assess adequately the clinical problem. Then the question should be repeated. It may have to be repeated a few more times before a specific response is obtained. Even if inaccurate, the specific response can be compared with other sources of data (e.g., collateral reports, liver function tests). It may then provide the basis for a subsequent confrontation in which the patient’s self-report and other sources of data do not jibe. If vague responses are accepted uncritically, the foundation for a subsequent successful confrontation is lacking.

**Routine History Taking**

At times the screening described above is not productive because patients may blatantly misrepresent the amount of alcohol or drug they consume. The following case exemplifies the latter dilemma but also illustrates how routine history taking can yield clues for the presence of an SRD.

**Case Report 2.4**

A 35-year-old remarried teacher presented to the emergency room with a 3-day history of abdominal pain and vomiting. Her serum amylase was elevated, and a diagnosis of pancreatitis was made; appropriate acute treatment was instituted. She volunteered that she drank about two glasses of wine per day. Her history revealed that her father was an alcoholic; her parents were divorced when she was young; she had been sexually abused by an uncle; she had two previous marriages ending in divorce, two convictions for driving while intoxicated (DWI), and a work history that showed a long series of jobs lasting not more than a few years; and her current husband drank to excess once or twice a month. Laboratory tests revealed elevated liver enzymes (including γ-glutamyltranspeptidase [GGT]), elevated bilirubin, and a reverse albumin:globulin ratio. However, her surgeon and internist made no further inquiries regarding her alcohol use, either of the patient or her husband. Although she developed hallucinations and a persistent low-grade fever on days one and two of her hospitalization, no withdrawal regimen was instituted. Subsequently early on day three she seized and stopped breathing on two occasions (with no detectable pulse or blood pressure). She was successfully resuscitated, but was left permanently demented. In the midst of this crisis her husband volunteered that she drank a half gallon of wine per day. Although she survived to leave the hospital, she could not speak, required around-the-clock nursing care, could not care for her two school-age children, was lost as a companion to her husband, and could not resume her career as a schoolteacher.

Even in the absence of positive answers from screening questions, routine history taking can provide clues, as in the above case. For examples, routine inquiry as follows can elicit symptoms that often accompany SRD.

- Review of systems: frequent headaches, weakness, insomnia, irritability, weight loss or gain, memory problems, lowered pain threshold
- Past medical history: frequent infections, malnourishment, falls, accidents, fights, taking sedative or pain medications for prolonged periods
- Family history: alcoholism, drug abuse, anxiety disorders, mood disorders, or antisocial personality disorder in family members
- Social history: loss of parents during childhood by death, divorce, or separation; child abuse or neglect; marriage to an alcoholic or drug abuser (especially in the case of women); deterioration in occupational and financial functioning over time; legal and financial problems; abandonment of former religious, social, and avocational activities
- Physical exam: elevated pulse or blood pressure, bloating, flushing, acne rosacea, odor of substance on the person (e.g., alcohol, volatile inhalants, cannabis, opium), poor grooming, slurred speech, ataxia, illogical speech, repetitions, mood lability, enlarged or tender liver, peripheral neuropathy, ecchymoses, or abrasions of the extremities

Based on clinical evaluation, the diagnosis of particular conditions should alert the clinician to seek more information, even in the absence of a positive history. Examples of such diagnoses include hepatic cirrhosis, pancreatitis, bacterial endocarditis, pneumonias or other infections in an otherwise healthy person, repeated trauma, malnutrition, and other combinations of history, physical findings, or diagnosis that increase the index of suspicion. For example, a person who has major depression and panic, whose father was alcoholic, and who recently lost a
job for unexplained reasons might be considered for further evaluation of SRD.

**Laboratory Assessment**

Another method of evaluation includes laboratory assessment to detect the acute or chronic concomitants of substance use or abuse. The preceding case report exemplifies the potential value of this approach. Other examples are as follows:

- Acute effects: examination of urine or blood for alcohol or other drugs; Breathalyzer for alcohol, mental status examination, coordination
- Chronic effects: GGT, mean corpuscular volume of the red blood cells, amylase, triglycerides, urea-creatinine ratio, bilirubin, and albumin-globulin ratio. Other measures have been developed using transferrin and platelets.

**Collateral Sources of Information**

Yet another method is to utilize collateral sources of information, such as the husband in the preceding case. Other collateral sources may include friends, family, co-workers, roommates, or neighbors. In the case of adolescents, friends or roommates may know more about the person’s substance use than the family knows.

**Rating Scales**

Rating scales are often useful in screening for SRD. Although patients may falsify their answers, such instruments establish a threshold score beyond which there is a high probability that a disorder exists. The Michigan Alcoholism Screening Test (MAST) is an example. This 25-item questionnaire lists common lifetime signs and symptoms of alcoholism. Scores 5 or under can be considered to be within normal limits, 6–8 are borderline, and 9–12 indicate probable alcohol abuse now or in the past. A score of 12 or more strongly suggests alcohol dependence.

The MAST can also be modified to include use of a drug besides alcohol. The Addiction Severity Index (ASI) is a structured interview that requires 30–45 minutes to administer. The ASI assesses six domains impacted by alcohol or drug abuse and has been utilized for diagnosis, treatment matching, and outcomes. A much simpler interview technique is the CAGE, which includes four questions related to alcohol abuse:

- Have you ever felt you should Cut down on your drinking?
- Have people Annoyed you by criticizing your drinking?
- Have you ever felt Guilty about your drinking?
- Have you ever taken an “Eye-opener” (drink in the morning) to steady your nerves or get rid of a hangover?

A positive answer to three of the four questions strongly suggests alcoholism.

Through completing a screening instrument, some patients gain a greater appreciation of the impact alcohol or drugs has had on their lives. Such increased awareness on the part of the patient can assist the clinician in conducting a thorough assessment. Increased awareness can also further the patient’s decision to initiate treatment.

Although a valuable adjunct to diagnosis and assessment, screening instruments cannot replace skilled judgment, nor can they replace the interview or collateral information from relatives and others.

Rating scales for other psychiatric disorders commonly associated with SRDs, such as major depression, anxiety disorder, or organic mental disorder, are also useful. Crises associated with alcohol or drug problems may overshadow comorbid psychiatric disorders. Screening instruments such as the Beck Depression Inventory or the Mini-Mental State Exam can detect problems that otherwise might escape detection, as in the following case.

**Case Report 2.5**

A 24-year-old man and his mother sought help following a recent conviction for a DWI. Additional history revealed an arrest 6 months previously for public intoxication, several recent fights while drinking, a minor car accident 1 month ago while driving intoxicated, and a deteriorating work record over the last several months. A Beck Depression Inventory done 1 month after his last drink revealed a score of
The conventional wisdom among many clinicians is that alcoholism and addictions will eventually manifest themselves, so early detection is not important. This belief is related to the idea that alcoholic or addicted patients must “hit bottom” before being amenable to sobriety. The problem with this attitude is that the actions of the patient might cause severe and irreversible results in the meantime. The following case from our survey is an example.

Case Report 2.6

A 22-year-old woman wrote from state prison, where she had just received a 15-year sentence for manslaughter. Although she drank infrequently, she drank heavily when she did drink. After consuming a large amount of vodka and orange juice on her birthday with friends, she proceeded to drive in order to pick up her boyfriend at work. Along the way, she passed out, crossed the center line, and killed a woman driving in the other direction.

In this case, the woman learned in prison that she was an alcoholic and joined Alcoholics Anonymous. Because she drank much the way many of her associates did, she had not believed previously that she might have a drinking problem.

Diagnosis

Overdiagnosis and Underdiagnosis

Assessment for SRDs has been subject to two common errors. One of these is the problem of overdiagnosis, also known as the false-positive or Type I error. The other problem involves underdiagnosis, known as the false-negative or Type II error.

False-positives involve errors of overinclusion; that is, the clinician automatically diagnoses SRD in anyone who presents with a problem related to alcohol or drug use. This infrequent error occurs most often among clinicians 1) who are trained only in the alcoholism-addictions field, 2) whose clinical work is devoted entirely to addictions, and 3) who are nondrinkers and perceive any use as abnormal. Their perceptions are overly influenced by their limited knowledge and experience base.

Case Report 2.7

A 35-year-old physician was confronted by two members of the Impaired Physicians’ Committee of a county medical society for drinking while practicing medicine. Two separate reports over the previous 4 months by nurses, both of whom had observed him smelling of alcohol in clinical settings, prompted the intervention. The committee ordered the physician to enter an out-of-state treatment facility the same day, threatening to inform the Medical Practitioners Data Bank if the physician refused. The physician complied because he saw no alternative, but he disagreed with the assessment. Supported by his wife (who also disagreed with the diagnosis), the physician left the treatment facility and consulted a psychiatrist who had treated him for a major depression several years earlier. Another fact-finding committee was convened, with members who were familiar with psychiatric disorders and combined psychiatric-substance disorders. A more thorough assessment was conducted, including interviews with the physician’s partners, his wife, and his former psychiatrist. The committee found that the physician was experiencing a return of his depressive symptoms, in association with his treatment regimen for arthritis. Alcohol or drug abuse was not present. The physician made an uneventful recovery with outpatient care from his psychiatrist.

Case Report 2.8

A 28-year-old veterinarian was referred by her state licensing board following a complaint from an anonymous source in the rural county where she conducted a private practice. The “dry” county had prohibition laws in force until fairly recently. The complaint stated that the woman 1) drank on the job and 2) drank in public and conducted herself in an unprofessional manner. Collateral information was sought from several sources, including her female roommate, other professionals in the community, and several of her clientele. In addition, a thorough evaluation for possible SRD and other psychiatric disorders revealed that 1) on one occasion, at the invitation of a farm family, she
joined the family in having a beer at the end of her professional hours on a Friday evening; and 2) she and several female friends often went to a "two-step" dancing hall (where beer was served) in a nearby community. No evidence for alcohol abuse or psychiatric disorder was found. On follow-up 1 year later, she had married and moved to another community.

Case Report 2.9

A physician referred his 19-year-old son, his eldest child, who he thought had begun abusing drugs while away at his first year of college. The physician-father reported a change in dress (more loosing-fitting clothes), grooming (long hair, beard), and personality (more remote, less conforming) as evidence of substance abuse. Evaluation included a thorough evaluation, collateral information from the patient's roommate and siblings, an assessment of his college performance (in both academics and extracurricular activities), and several days of observation in a treatment program. No evidence supported a diagnosis of substance abuse or other psychiatric disorder. In fact, he was separating from his parents in an appropriate fashion. The parents were supported in permitting this maturational step. At the time of a 1-year follow-up, the son continued to do extremely well in college, and his parents continued to support his efforts in establishing his own persona.

Case Report 2.10

A 17-year-old high school student was referred for drug abuse by his parents, both of whom were alcoholism counselors. Their son had become increasingly withdrawn. He behaved and dressed in a strange fashion, his grades had fallen, and he spent most of his time alone in his room. Although they had not observed him abusing drugs and had not found drugs in his room, he reminded them of adolescents with hallucinogen or cannabis abuse. Clinical evaluation revealed the presence of auditory hallucinations and grandiose delusions, but no evidence of alcohol or drug abuse. He required high doses of neuroleptic medications over several weeks before his hallucinations and delusions resolved. In time, his course proved to be consistent with schizophrenia.

These cases offer some clues to the common scenarios associated with overdiagnosis of SRD. Often the patient is a professional person, a person with high community standing, or the child of such a person. Other psychiatric conditions occur in some of these people. Because it can be difficult to rule out SRD in its early phases, following the individual over a year or longer can aid in confirming or undermining the original diagnostic impression.

Underdiagnosis occurs most often in traditional mental health settings. Staff training in SRD is usually sparse, and other diagnoses are more familiar or more acceptable.

Case Report 2.11

A female middle-level manager presented for outpatient treatment of depression precipitated by a recent move and a hostile relationship with her new supervisor. A medical and psychiatric evaluation was consistent with a major depressive disorder. Psychotherapy and trials of several antidepressant medications at adequate dosages and durations produced no improvement. Over a period of several months in treatment, she continued to be highly achievement-oriented, sober-looking, and meticulously dressed. An emergency room visit clarified the dilemma. After a bout of heavy drinking, the woman awoke to discover a large burn on her thigh that had occurred while cooking the previous evening. The psychiatrist focused on her drinking history. Alarmed at her burn and her increasing loss of control over drinking, the patient provided a full history. The psychiatrist referred her to an alcoholism treatment program, which she entered.

Overdiagnosis and underdiagnosis of SRD can be minimized as clinicians appreciate the common signs and symptoms of SRDs and the common comorbid disorders. Obtaining adequate historical information from all relevant sources is a key antidote to misdiagnosis. Observation over time, especially if any doubt exists, is another crucial technique.

Overdiagnosis of associated psychiatric disorders can be a problem in patients with SRD. Often anxiety and depression symptoms associated with an SRD resolve within 2-4 weeks of abstinence. At the other end of the spectrum, the treating clinician should not dismiss persisting mental, emotional, or behavioral symptoms as evidence for a "dry drunk" (i.e., persisting manifestations of alcoholism or addiction despite
abstinence). A favorable appearance and high community standing does not eliminate the possibility of an SRD. Vigilance and objectivity remain the clinician’s guides in preventing diagnostic errors.

Associated Psychiatric Disorders

A common cause of mistakes is failure to recognize coexisting psychiatric disorders. Virtually any psychiatric disorder can impede recovery from SRD. However, the detection of coexisting psychiatric disorder can be difficult for one or more of the following reasons.

First, SRD can produce the same signs and symptoms as virtually any other psychiatric disorder. The overlap in symptoms among these disorders adds to the complexity of assessment and calls for observation and reassessment of the patient over time. It is often not feasible to distinguish the presence of comorbid psychiatric conditions at a single point in time. However, with repeated observations conducted in an informed manner, such distinctions are not only feasible but unavoidable.

Second, symptoms of a coexisting psychiatric condition may appear to be due to SRD rather than to another psychiatric condition. If the clinician prematurely attributes all symptoms to SRD alone, the diagnosis of a coexisting psychiatric disorder may be missed.

Third, some SRD patients fail to report all of their symptoms to the clinician. This failure to report symptoms can have many causes. Patients may interpret the “symptom” (e.g., persistent fatigue, irritability, anxiety) not as a pathological condition but rather as an inherent state of their nature or personality. Thus, they may not complain of what they perceive to be an inherent condition of their character, because that is something that they must battle alone or accommodate (or take alcohol or drugs to relieve).

Fourth, the patient may develop the condition insidiously during the abstinence period. Abuse of substances may have delayed the appearance of the condition (e.g., mood disorder), or the many difficult aspects of recovery may lead to the problem (e.g., an adjustment problem). The staff in a rehabilitative program may see the problem unfold gradually—unlike the usual cases that present to clinical settings in their full-blown state. Staff may not correctly identify the source of symptoms early on, seeing them as resistance to recovery or as character-based rather than due to an independent condition that requires its own assessment and care.

Several coexisting psychiatric diagnoses appear especially apt to confuse clinicians and lead to errors in diagnosis. These diagnoses are reviewed below.

Mild mental retardation and borderline intelligence. Cognition, memory, and adaptation are often impaired in the early weeks and months of recovery. Thus, staff may perceive mild impairment as being expected rather than a problem requiring separate consideration. However, intellectual impairment can seriously undermine recovery—especially if recovery is built on conceptual models of recovery such as those in many self-help groups. Mildly retarded people are apt to be impulsive and to resume drinking with minimal stresses before adaptation to abstinence has had a chance to develop. Although people with mild retardation are quite evident in academic settings, they “disappear” into the population once they leave school. Many of them marry and have children. They can have stable employment in a variety of unskilled jobs in which supervision is adequate.

Case Report 2.12

A 28-year-old divorced mother of three had failed in over 20 alcoholism treatment programs. She was referred for assessment after she had been beaten severely by a man who picked her up in a bar. History revealed that she had required special academic placements throughout her education. IQ testing from childhood, confirmed by current testing, indicated an IQ ranging from 60 to 65. Treatment was modified to include the following: inclusion in a recovery group of other mildly retarded people, monitored prescribing of disulfiram, and placement in a residence for other recovering substance abusers with mild mental retardation. She did well during the subsequent year in treatment, obtaining a job and returning to her own apartment. Subsequently she was able to resume her parenting with the aid of a homemaker and close supervision by her social worker.

Clinicians should screen routinely for cognitive impairment. The Mini-Mental State Exam is useful, because mentally retarded people typically score in the low 20s or below. The Shipley can also serve this purpose.
Mood disorder. Mania can present particular diagnostic problems when the disorder begins insidiously during the course of treatment. The patient may manifest intrusiveness, flirtatiousness, and other indicators of poor social judgment before manifesting more gross delusions, hallucinations, and disordered behavior. In early stages, the staff may believe that the patient is sociopathic or narcissistic rather than hypomanic or manic.

Recovering substance abusers with depression often manifest their mood disorder as irritability, accusations against others, rages, and even fights. Such patients do not appear sad, and they deny feeling depressed if asked. Rather they look and feel angry—almost all of the time. It is their prevailing mood. This is quite a different clinical picture from the expected crying spells, self-blaming, and social withdrawal. Yet such rageful patients may also have insomnia, weight change, feelings of worthlessness, hopelessness, helplessness, and suicidal ideas (perhaps with combined suicidal-homicidal ideas). Although more frequent in men, this clinical picture may occur in recovering women as well. Such patients may be erroneously labeled as narcissistic, paranoid, or aggressive personalities. The following case involves a patient who was thought initially to have a personality disorder but who eventually manifested a manic disorder that responded well to medication.

Case Report 2.13

A 22-year-old single hairdresser presented with repeated DWIs, conflict with her parents over her weekend alcohol binges, loss of friends, and inability to sustain a romantic relationship. She complied well with treatment and was a model patient for the first few weeks. In her second week of evening treatment, however, the staff became alarmed at her seductive behavior toward male patients and male staff. She also appeared to “take over” group discussions and occupied large blocks of staff time with one-to-one discussions. Staff believed that she had narcissistic and sociopathic personality traits and wanted to discharge her “before she wrecked the whole evening program.” Psychiatric assessment revealed that she also had racing thoughts, excess energy, elation, hypersocial interests, weight loss of several pounds despite adequate food intake, and the belief that she was responsible for all the patients and the evening staff. A conversation with her parents revealed that they had never seen her like this, that she ranged from euphoric to irritable at home, and that she could be heard roaming around the house at night. One cousin was on lithium for manic-depressive disorder, and an aunt had been treated for depression. After a brief hospitalization for lithium therapy, she resumed her former demeanor as a compliant, appropriate member of the evening recovery program.

Delirium, dementia, amnestic and cognitive disorders, and mental disorders due to a general medical condition. Patients with SRSs can encounter these conditions from any of a variety of sources. A small number will become “prematurely senile” in their 50s or 60s, even after some years of sobriety—apparently due to an accumulation of old alcohol-related brain insults plus “normal” aging. Nutritional problems may cause peripheral neuropathies or alcohol amnestic disorder secondary to thiamin deficiency. Normal pressure hydrocephalus may result from small bleeds (due to trauma) or adhesions from meningitis. Subdural hematomas may present acutely or chronically. Because these problems may not be grossly disabling in their early stages, the condition may be missed. Substance use may result either from poor restraint over impulses or in association with frustration over an inability to maintain routine responsibilities.

Case Report 2.14

A 56-year-old married executive was referred by his daughter, who had taken a college course on alcoholism. She was concerned that he drank excessively, was “forgetting things” (such as how to drive home if his usual route was blocked), and was generally “going downhill.” One year earlier he had an episode of pneumococcal pneumonia, associated with headache and coma. He was gravely ill, recovered gradually, and was in the hospital for several weeks. Hospital records made no mention of his use of alcohol. After that, he had considerable difficulty with recent memory loss, although his immediate memory and past memory were intact. Intelligence testing revealed a high IQ with no deficits. On magnetic resonance imaging, he had enlarged ventricles with evidence for normal pressure hydrocephalus. Throughout the past two decades, including the year since his hospitalization, he drank one fifth of wine each evening with dinner (about five glasses) with an additional four or five drinks per evening on weekend evenings. Treatment consisted of thiamin (with little change in his mental status) and abstinence-oriented alcoholism treatment. Neurosurgeons recommended that surgical intervention for his normal pressure hydrocephalus was not warranted. His wife and his employer were included in steps taken to correct for his recent memory impairment (e.g., his
wife drove to unfamiliar places; two secretaries and an extensive filing system substituted for his recent memory impairment). This approach was successful, and he was able to function for several more years in an executive capacity until his retirement.

Cases like this one often pose difficult diagnostic challenges for the clinician. The most significant obstacle lies in the clinician's failure to consider alternative diagnoses.

**Miscellaneous conditions.** Virtually any psychiatric disorder may coexist with SRDs. A common presentation consists of treatment failure for the identified "other" psychiatric disorder while the SRD remains covert. This is a common problem in the treatment of schizophrenia, because up to 50%-60% of identified patients with schizophrenia meet diagnostic criteria for SRD. Coexisting SRD can also complicate the care of the other behavioral disorders, including eating disorders, pathological gambling, sexual dysfunction, and various personality disorders (such as antisocial personality disorder). The prognosis is poor unless these coexisting disorders can be addressed concurrently by professional teams familiar with their separate and combined treatment.

**Case Report 2.15**

A 29-year-old single woman was brought to the emergency room in a dazed, intoxicated condition. Because she was unable to provide identifying information regarding herself, the psychiatric physician on call arranged an inpatient admission. At the time of admission she was aggressive, spoke with a gravelly voice, and was definitely uncooperative. The next morning, she was quiet, demure, and compliant and spoke with a soft, high-pitched voice. She had no recollection of the previous evening but was able to provide additional information about her work, place of residence, and past history. She had been admitted several times for detoxification after relatively brief drinking episodes lasting less than 24 hours. She had no close friends or co-workers, but she did have a number of superficial acquaintances. Further history revealed that she had been abused physically and sexually as a child. Confronted about her various "personas," she admitted to several "personalities" that she manifested depending on social and psychological circumstances. Her "drinking persona" was a man (the only male in several "personalities") who went on binges when her "working persona" was fed up with work, loneliness, and life in general. During subsequent treatment and rehabilitation, her evolving "executive persona" took full form in order to prevent her "drinking persona" from being manifested. Over a few years, she was able to obtain benefit from a rehabilitation plan that progressed from a full-time day program (over several months) to a part-time evening program and eventually to a self-help group with monthly supportive visits.

There are several keys to proper diagnosis of associated psychiatric disorders. First, the clinician must consider factors that might predispose to certain psychiatric diagnoses, including family history, social history, and past medical history. Second, the persistence of certain signs and symptoms despite several weeks or months of sobriety may warrant further psychiatric evaluation. Third, repeated "slips" back to alcohol or drug abuse despite appropriate SRD treatment should raise the question of comorbid psychiatric disorder. Fourth, routine psychiatric reassessment after several weeks of sobriety will aid in the timely identification of psychiatric disorder. Last, but probably most important, clinicians caring for the recovering SRD patient must be able to entertain the possible presence of a psychiatric disorder. Failure to consider such a diagnosis can effectively head off any recognition. Staff descriptions such as "white knuckle recovery," "dry drunk," "not working the program," "sociopath," and other negative or rejecting labels should at least raise the consideration for further psychiatric assessment.

**Anxiety disorders.** Among the five anxiety disorders, panic disorder and phobic disorder (especially social phobia) occur most often. Untreated, these disorders can cue craving and precipitate recurrences of drinking or using drugs. Among trauma victims (e.g., combat veterans, rape victims) with posttraumatic stress disorder (PTSD), the rate of comorbid alcohol-drug abuse is high. However, in any general group of alcohol or drug abusers not selected for trauma, the rate of PTSD tends to be relatively low compared with panic and phobic disorders. Generalized anxiety disorder can be difficult to diagnose during early recovery from substance abuse because virtually all recovering people have mild-to-moderate anxiety symptoms that abate spontaneously over several months. Obsessive-compulsive disorder tends to be relatively infrequent in any group of substance abusers, despite the widely held opinion that repeated drinking or drugging despite consequences must be a "compulsive" disorder.
Assessment

Fundamentals of Assessment

Assessment goes beyond diagnosis. Diagnosis alone is usually adequate for acute management and referral. However, diagnosis alone is rarely sufficient for planning further treatment and rehabilitation of SRD. Further assessment should include the following:

- Detailed information regarding the substances of abuse and the dose, duration, and pattern of use
- Physical assessment for biomedical complications, depending on the individual patient
- Collection of relevant information from significant other people who have past and/or present knowledge of the patient
- Consideration of resources as well as impairments that may facilitate or retard the patient’s recovery

Additional information regarding course, severity, previous attempts at recovery, personal and social resources, associated health problems, and concurrent life crises should be appreciated in planning treatment and recovery. Complete assessment demands extensive, accurate information. Even well-intentioned clinicians will find assessment of SRD patients riddled with pitfalls.

Case Report 2.16

In her late 20s, a woman with a long history of sedative abuse experienced delusions and hallucinations when attempting to cut down her dose or withdraw entirely. For several years, her condition was diagnosed as an endogenous psychosis, long delaying the recognition of and intervention for SRD. During periods of abstinence, she would break off treatment relationships; pursue career objectives as her primary goal, and neglect personal needs. Persistent ideas of reference, suspiciousness, and mistrust of others were present during periods of abstinence. Unexpectedly, she died by suicide at age 39 after numerous relapses and occupational failures.

Crucial in this patient’s poor course and tragic outcome was the delay in diagnosis. Years passed before one of her psychiatrists related her psychotic symptoms to drug abuse. Persisting paranoid symptoms during her better periods further complicated the picture, contributing to the initial delay in diagnosis and later poor compliance.

Collateral Data

Perhaps in no area of medicine and psychiatry is collateral information more important than in cases of SRD. It may be fairly stated that any SRD assessment is incomplete if it excludes collateral sources of information. It may be necessary to proceed with incomplete data (in certain settings, such as emergency rooms), but the general principle still pertains. One should attempt to obtain collateral sources of information as soon as possible in assessing the SRD patient.

Case Report 2.17

A 20-year-old man began acting strangely during his third year of college. His father brought him home and had him admitted to the local hospital. There was no family history of schizophrenia, and the patient’s premorbid personality was inconsistent with schizophrenia. The physician made a diagnosis of drug-precipitated psychosis. Neuroleptic medication alleviated the man’s delusions and inappropriate behavior but left him severely restricted in his speech and motor activity. Following discharge from the hospital and discontinuation of the medication, he again began to behave in a bizarre, frenetic fashion. A psychiatrist rehospitalized him, took a detailed family history and premorbid history, and spoke with the patient’s college roommate and friends. The family revealed a history of recurrent depressions on the father’s side and premorbid cyclothymia in the patient. The patient’s friends indicated that, although he sometimes drank socially on weekends, he did not use drugs. Lithium was started for bipolar disorder, with excellent effect. He was able to return to college and subsequently did well.

Diagnosis in the case of “first break” psychosis is always a challenge for clinicians. Collateral information from family and friends can be key in narrowing the diagnostic possibilities.

Case Report 2.18

A PGY1 (postgraduate year 1) resident physician was referred for psychiatric evaluation following an inappropriate display of anger in the
emergency room. Although hospital personnel suspected alcoholism, the intern succeeded in convincing the psychiatrist that he had stopped drinking a month earlier and that he was depressed following a recent breakup with his fiancé. Although the psychiatric physician expressed interest in meeting with collateral sources of information, the resident physician said he had no friends locally, he was alienated from most of his family, and no other relatives lived in the area. The psychiatrist initiated antidepressant medication and psychotherapy for major depression. The resident physician's crisis continued, however, eventually involving blatant intoxication. He admitted his ongoing alcohol abuse in the face of being threatened with termination from his residency.

The original evaluating psychiatrist in this case erred on the side of obtaining information solely from the patient. Further information could have been obtained from hospital staff, who had reliable information supporting their impression. Moreover, the clinician was too readily dissuaded by the patient from obtaining collateral information. At some point, the clinician should consider whether the patient's restrictions on a thorough evaluation are so restrictive as to preclude an adequate assessment, as occurred in this case.

Intercurrent Biomedical Disorders

Biomedical conditions increase in association with the following circumstances: inpatients (as compared with outpatients), patients in public institutions (as compared with those in private institutions), older patients, and emergency psychiatric patients (as compared with patients with regular appointments or elective admissions). Conditions that should alert clinicians to the potential presence of SRD include the following:

- Trauma (falls, vehicular accidents, fights)
- Gastrointestinal conditions (ulcers, hepatitis)
- Infections (lower respiratory infections, genitourinary infections, skin infections)
- Nutritional deficiencies (muscle wasting, low serum protein, B vitamin disorders)
- Neurological disorders (seizure, head injury, peripheral neuropathy)

Case Report 2.19

A 62-year-old woman received an accurate diagnosis of alcohol dependence, followed by a safe, effective withdrawal regimen. Her appetite improved, and she began eating regular meals. Several days post-withdrawal, she became disoriented and confused. Medical evaluation revealed unrecognized hepatic failure. A high-protein diet, coupled with alcoholic cirrhosis, had exceeded the capacity of her liver to metabolize ammonia and other by-products of protein digestion. A more careful initial evaluation of her liver function could have eliminated this expensive and life-threatening complication.

The medical care of patients with SRD requires an holistic approach. Psychiatric physicians engaging in such work should be able to recognize medical and surgical complications, just as surgeons, internists, and other physicians serving this population should be able to recognize psychiatric conditions.

“System” Demands

An important part of assessment lies in understanding the social systems in contact with the patient. Such systems may influence the evaluation in various ways. The clinician may need to know how one or more of these social systems perceives the evaluation. Also, one or another system (e.g., family, employer, licensing board, court) may initiate the assessment.

Case Report 2.20

A 47-year-old physician sought an assessment about whether he might be impaired from alcohol abuse. He had applied for membership in a county medical society. In doing so, he revealed his recovery from prior drug addiction. He had not sought formal treatment but had been abstinent from drugs for 5 years. Invited to appear before the Physicians Impairment Committee, he readily admitted drinking two beers per day, two or three days per week. The committee ordered that he complete treatment before being admitted to the society. Angered by this recommendation, the physician consulted an addictions psychiatrist, who conducted a thorough evaluation. Although no current evidence of alcohol or drug abuse was evident, the psychiatrist recom-
mended that the physician attend a 6-week evening program for SRD in order to ease the political tension that had been generated. Both the physician and his wife found this program highly informative and personally useful. The physician became a member of the society.

This “recovered but untreated” physician was trying to solve a problem that he perceived as political. The committee could not accept the notion of a stable “spontaneous recovery” without treatment. Further, some committee members could not believe that a former drug abuser was able to maintain control over alcohol use during a 5-year period. Attending the evening program provided an escape for all parties from what had become an impasse. In addition, the physician learned from the program that he was at high risk to subsequent alcohol abuse in light of his previous drug abuse. He made a decision to discontinue all alcohol use, given his new knowledge about the risks that he was assuming.

Conclusion

Denial will thwart the assessment process by the patient’s minimizing of the concerns and consequences of alcohol/drug use; by a condescending, petulant, or wounded approach to the interview process; by delays in setting appointments; and by resistance to involving others in the assessment process. Perseverance on the part of the clinician is essential. One may be provoked into anger or rejection by the attitude of the presenting patient, but these attitudes are best seen as reflecting the patient’s effort to avoid a confrontation with the shameful yet “necessary” attachment to his/her drug(s) of choice. Once these basic features of addiction are well known by the clinician, it is possible to undertake screening, diagnosis, and assessment. All three steps rely upon adequate information, including salient negative as well as positive information. Screening should be undertaken in curious, open-ended fashion, rather than eliciting a negative response in a perfunctory fashion. Diagnosis requires all of the finesse and intellectual honesty required of any medical diagnosis. Assessment goes beyond diagnosis, providing an abundance of information to support not only accurate diagnosis but also prognosis and treatment planning.

References

Managing and Monitoring the Phases of Treatment and Recovery

The care of people suffering from addiction requires careful strategy. The clinician cannot simply start off with one approach or modality and expect that recovery will follow automatically over time. The need for a phasic approach to treatment makes the care of addiction complex, sometimes difficult, occasionally frustrating, and—when successful—enormously rewarding for all concerned.

A first step in developing a treatment strategy lies in discerning the severity of the patient’s disorder. Those who quickly proceed into heavy or “pathogenic” use typically require different intervention than those who have acquired numerous social or biomedical problems as a result of prolonged psychoactive substance abuse. If tolerance and withdrawal are present, attention to both short-term withdrawal (e.g., delirium tremens or opiate withdrawal) and longer-term “subclinical” withdrawal (e.g., sleep disturbance, emotional lability) may be needed. End-stage addiction, with social deterioration and physical ill health, demands yet another planning approach.

A second step consists of plumbing the patient’s readiness for the rigors of recovery. Some patients are committed to continued use and are not yet ready for recovery. Motivation toward recovery can be enhanced by alerting the patient to the predictable consequences of a pathogenic use pattern. If problems have already developed, the clinician can link these problems to the patient’s substance use—often an obvious linkage that the patient has ignored, denied, or minimized. The
family can be oriented to the importance of not enabling the patient’s continued use, to the dangers of continually rescuing their relative from the consequences of substance abuse, and to the means for supportively confronting their relative in such a way as to make their concern, misery, and fear clearly evident.2

Third, the clinician develops an ongoing recovery plan with the patient and the family. Each phase depends on the successful previous phase. Despite everyone’s best efforts, some patients get “stuck” in phase one or two. Remaining too long in a recovery phase eventually produces a vulnerability to relapse. As recovery proceeds, monitoring can be less frequent.

Phase One: Getting Safe and Healthy

Providing Adequate Medical Care

Early in treatment especially, addicted patients may present with any and all medical problems. Extremely common diagnostic problems include the following:

- Acute and chronic infections: lower respiratory and urological infections most common; less frequent infections including sexually transmitted infections, meningitis, tuberculosis and other fungal infections, AIDS, subacute bacterial endocarditis, abscesses
- Trauma: fractures of long bones, ribs, and pelvis; subdural hematoma
- Nutritional problems: iron deficiency anemia, protein deficiency, various vitamin deficiencies (i.e., pellagra, beriberi, isoleucine deficiency, pernicious anemia, Korsakoff syndrome)
- Miscellaneous medical problems: occult cancer, endocrinopathies (e.g., overactive or underactive thyroid), alcohol-related dementia

Despite the increased risk of addicted patients to virtually all medical conditions, some therapists in this field remain so focused on addiction and recovery that they fail to view patients holistically. This can lead to drastic, even fatal, complications. The following case exemplifies delay and neglect in attending to a seriously abnormal laboratory finding in a patient who died of a reversible medical condition.

Case Report 3.1

Over the previous 2 years, a 38-year-old married, employed, middle-class alcoholic patient had experienced numerous losses, including his job, marriage, and home. His mother made arrangements for an evaluation at a Community Mental Health Clinic. Upon presentation there, he complained of severe chest pain. A medical evaluation was arranged, along with blood tests, a chest X ray, and an electrocardiogram (EKG). The laboratory tests were completed, but medical evaluation and intake interviews were delayed due to staffing limitations. The patient’s mother, alarmed at his continuing complaints of chest pain, called and arranged for an intake interview the following day—8 days after the laboratory tests and original evaluation were scheduled. The patient failed to show up for the evaluation and was found dead at home. The chest X ray taken several days before his death and the autopsy revealed “tumminating and acute bronchopneumonia.”

This case reveals the need for early and thorough medical evaluation of each newly admitted patient, especially when any health complaints are present. Many of the possibly fatal diseases for which addicted persons may be at risk are reversible if detected and treated in a timely fashion. Addicted patients often manifest the same kind of denial regarding health problems that they manifest toward substance abuse. This puts an additional burden on the clinician to avoid colluding with patients in minimizing health concerns.

Case Report 3.2

A 40-year-old man was admitted to his rural community hospital with acute alcohol withdrawal. After appropriate acute management, he was assessed as being suicidal, depressed, and requiring further hospitalization. Because he was a veteran and qualified for care, an evaluation was arranged at a nearby Veterans Administration (VA) facility. Accordingly, he was discharged from his community hospital, and his wife drove him to the VA hospital. The physician at the VA admissions office interviewed the patient for about 15 minutes but did not interview the wife or review the man’s medical records from the previous facility. Much to the wife’s amazement, the physician reported the husband was “fine” and could go home. The wife pleaded with the physician, who reassured her and told her not to worry. Unable to elicit further help from anyone involved in her husband’s care, the wife took him home. She found him dead of an overdose the next morning.
This case demonstrates how patients can "fall through the cracks," with lethal results. Typically, an addicted person is accustomed to dealing with physical and emotional symptoms by use of an addicting substance, not by consulting a clinician. The notion of relying on a clinician for health care is foreign to the average addicted person during active substance abuse and even early in treatment.

Residential and Hospital Treatment

Physicians can effectively use hospital and residential care in establishing a stable sobriety. Hospitalization may be critical if severe withdrawal or complicating medical, psychiatric, or surgical conditions are present. However, physicians may overuse residential and hospital care. Referral to a remote facility can be an inappropriate means for families to deal with the social shame of having an addicted relative. This may seem an excellent means to "get the patient safe" from drug use and to ensure that the patient is well enough (physically and psychologically) to become stable and attempt sobriety. Many patients are sufficiently healthy when they enter treatment and can become safe from substances in their own homes and communities.

Excessive reliance on inpatient treatment can immobilize the patient, family, and clinician in dealing with recovery issues. An inordinate emphasis on hospital and residential care can drive a wedge between patients and their families as well as between clinicians and their patients’ families. It can also drive up the cost of care. If the patient is parenting young children, a temporary homemaker may help to keep the family together and functioning. Effective means of early intervention and community-based treatment, rather than asylum in a distant facility, should be the cornerstone of care.5

Continuity With the Next Phase of Treatment

Many hospital programs simply discharge the patient with a referral to a self-help group. This is often inadequate for the patient as well as the family. At the minimum, ongoing monitoring of recovery and self-help activities should occur until both the patient and the family are stable, with good behaviors established supporting sobriety and recovery. In the following case, several hospital treatment teams repeatedly referred the patient and family without ongoing follow-up by the treating clinician, with very poor (and expensive) results.

Case Report 3.3

A 38-year-old alcoholic and his family reported that their acute hospital care, including assessment and treatment, were high quality and helpful in several programs. However, the patient had failed to recover. Upon discharge, each treatment team had referred the patient and family to Al anon and Alcoholics Anonymous (AA), with no professional follow up. This occurred repeatedly over a period of years, during which several relapses occurred. Eventually the patient and family received care at a facility that provided ongoing monitoring in all cases and appropriate therapy as needed. The patient received individual therapy for several months, and the family participated in several family sessions and 10 educational sessions during the patient’s first year of sobriety. Stable recovery then ensued.

Some patients can and do recover with self-help alone. However, as yet we have no way of identifying who those patients and families will be. Until such data become available, treatment programs are obliged to provide monitoring as a routine service until recovery is stable, with referral to appropriate treatment to meet specific patient needs. Failure to do so results in such a program appearing to be more concerned with fostering income and ongoing employment rather than assisting addicted persons with recovery.

Phase Two: Getting Stable and Sober

Importance of Sobriety

Many patients say that they will get sober as soon as they feel better or their problems get solved. Clinicians may accept this way of thinking, which can be faulty. A period of sobriety is usually necessary before recovery can proceed. Patients may need a stable environment in which this can occur. Comfort and problem-solving must often await a period of sobriety and stability. As demonstrated in the following case, clini-
cians sometimes focus on comfort and stability as necessary precursors to sobriety, whereas these typically occur in the opposite order.

Case Report 3.4

A 36-year-old married woman had been drinking heavily since her teenage years. She sought treatment from a psychologist, who insisted that she and her husband solve the problems that caused her to drink (e.g., marital problems, emotional instability). During this period her husband continued to supply her with alcohol. Following 2 years of continued drinking on this regimen, the patient began to see an alcoholism counselor. She also began to attend an AA group and to read about alcoholism. Since that time she has had 7 years of increasingly satisfying sobriety, without marital problems or emotional distress.

Patients can rarely, if ever, solve problems while they continue to drink. Moreover, it may require months or even years of sobriety before they have the social stability and emotional strength to deal with other problems. During this period, they can benefit from a guide who can help them day to day, week to week, as they build their sobriety a day at a time.

Addressing Other Behavioral Conditions

Patients with addiction are at increased risk for other behavioral conditions. These include eating disorders, pathological gambling, conduct disorder (in children and adolescents), and various forms of sociopathic behavior, including violence against others and criminality. Routine inquiry should be made regarding these conditions. Failure to address them may undermine the patient’s recovery and destroy the social and economic resources that might facilitate recovery.

Case Report 3.5

A 34-year-old man was admitted to a hospital inpatient program for alcoholism. The family was involved in his assessment, which revealed pathological gambling (around $1500 per month) in addition to alcoholism. The treatment program did not address the gambling problem and reassured the family that abstinence alone would ameliorate the problem. At discharge, the family was referred to Al-Anon and the patient was referred to AA. The patient’s gambling increased following discharge, with worsening of the family’s economic plight. Eventually the patient resumed drinking. The wife became depressed and required several weeks of inpatient care. After recovery from her depression, the wife sought a divorce.

Some long-term psychological and interpersonal problems may have to await the third phase of recovery before the patient has the strength, time, and social stability to deal with them. However, behavioral problems (e.g., eating disorder, pathological gambling, family violence) need immediate attention because the patient is not likely to recover from addiction if the other pathological behaviors persist. If left untreated, other pathological behaviors often increase in frequency or severity during a period of abstinence from alcohol or drugs.

Access to Least Restrictive Treatment Alternatives

Patients often receive overly restrictive or expensive treatment, such as admission to the hospital (i.e., away from family and work) when outpatient care would suffice. This situation often occurs because the treatment facility provides only the most restrictive or expensive forms of care. In order to avoid unnecessary expense and restrictions on patients’ responsibilities, clinicians should ensure that patients receive the least restrictive and least expensive form of treatment appropriate to the clinical situation. In the following case, the initial treatment team wanted to admit the patient into their particular program, although other less expensive alternatives appeared reasonable and even desirable.

Case Report 3.6

A 43-year-old man did well during a 10-day hospitalization for alcoholic withdrawal and associated respiratory infection. This was his first alcohol-related problem, and he and his family had previously perceived his drinking as “heavy” but not necessarily a problem. Upon discharge he was referred to a 3-month day program that would prevent his continued attendance at his job. This would present a financial hardship to his family and would probably lead to his discharge at work. Moreover, the man had been functioning well as parent, spouse, and worker. When the patient and family resisted participation in the
program, the hospital staff strongly confronted them for their “bad attitude” and “enabling.” However, the family made arrangements to attend a 6-week evening program in their community, with ongoing monitoring of the husband’s recovery and the family’s adaptation to his recovery. The patient and family have done well over the last several years, with no recurrence of his alcoholism.

This case demonstrates that the least restrictive alternative is often successful. If such approaches fail, more restrictive and expensive treatment alternatives may then be appropriate. However, beginning with the most expensive and restrictive treatment alternative—especially in a patient such as the husband in this case—indicates a lack of appreciation of treatment methods and outcomes.8

Phase Three: Getting Comfortable and Functional

Recognizing Associated Psychiatric Disorder

Patients may complete the early phases of recovery, achieve several weeks or months of sobriety, and still experience almost constant mental, emotional, behavioral, or interpersonal distress. This is sometimes referred to as “white-knuckle recovery” because the patient is barely holding onto his or her sobriety despite great effort. Such patients may be seen by the treatment staff as doing well, even though they remain highly vulnerable to relapse. The following case reveals the importance of progressing eventually to a stage of reasonable comfort in one’s sobriety.

Case Report 3.7

A 22-year-old married woman presented to an alcohol treatment program in a private medical facility. She received excellent care during the first and second phases of recovery. Because she was addicted to both alcohol and drugs, she was detoxified for 1 week on an inpatient unit. Then she began a 12-step program that included group sessions, psychoeducation, and AA 12-step sessions. At the completion of this program, she was discharged and told to continue with AA self-help groups. However, she continued to be anxious and dysphoric and to have problems with interpersonal relationships. On the advice of a friend, she sought an opinion at a woman’s mental health program. Under the care initially of a psychiatrist and later a psychologist she recovered from major depression and panic disorder. She has been sober for 4 years and is getting along well with her husband and family.

If worsening problems do not receive attention, the patient may relapse. We have seen patients who continue sober for years without treatment for their psychiatric disorder. The longer such problems have been in existence, the longer and more difficult (and more expensive) the treatment tends to be.

Routine Screening for Psychiatric Disorder During the First Year of Abstinence

Patients often do not identify their symptoms during early abstinence as warranting psychiatric assessment or care. Because they are not experts, and abstinence itself is stressful, they cannot identify whether they are in routine recovery or in the beginnings of an abstinence-onset psychiatric disorder. Some patients suffer from an inability to discern their own anxiety, frustration, or other emotional symptoms until these symptoms are extremely severe. The following case, expressed in the patient’s own words, provides an example of a patient who failed repeatedly in alcoholism treatment (including 10 months of weekly hour-long therapy with a psychiatrist). During this time, her AA sponsor and group members accused her of being a “dry drunk.”

Case Report 3.8

“It became clear to me that if I didn’t hurry up and find someone who knew what it was, I would be making ‘fearless moral inventories’ right up until the moment I put the pistol in my mouth! It was that horrible. In my desperation I became quite angry, combative, and loud. I am convinced now that that’s the only thing that saved my life.

“Finally, after 3 months of incessant howling on my part, one of the head psychiatrists at this facility called me into his office and remarked that he was ‘concerned’ that after all this time I was still feeling so wretched. He wrote me a prescription for fluoxetine (Prozac) . . . . I felt the horrible crushing fatigue lift within a week. My preoccupation with killing myself began to evaporate. My concentration improved
dramatically and my tearful, sick, black mood gradually lifted. I felt
that I'd been dragged out of a black, suffocating pit by some superhu-
man force. And last but not least, the drug made abstinence from
mood-altering chemicals (like alcohol) much, much easier. I now found
my marriage and most other social situations, such a chronic torture
before, much easier to tolerate. I was noticeably more confident, calm,
and yes!—"NORMAL."

Later she explained her view of what had transpired between her
first drinking and her eventual condition:

"I was mildly depressed; I behaved oddly; people reacted badly; I
drank to relieve my symptoms; I became more depressed and the cycle
endlessly repeated and entrenched itself... I had finally attached a
name and a face to my distress... DEPRESSION. As an added bonus, I
was now able to apply some of the helpful messages I'd received dur-
ing all those months of psychotherapy but had been too sick to assimilate.
I was now free to use the wealth of information that had come my
way."

This case points up the problem that clinicians often have in recog-
nizing psychiatric symptoms and disorders in recovering alcoholics and
addicts. In this case, the woman had previously been in weekly hour-
long psychotherapy with a psychiatrist for 10 months, but he had not
recognized her condition as depression. During her 3 months in a
hospital-based day program (before receiving fluoxetine), she had been
in daily contact with nurses, social workers, psychologists, and psychia-
trists. Until her behavior became blatant, her caregivers perceived her
misery as being her "resistance" as well as a "normal" part of recovery.

Monitoring Abstinence and Recovery

Monitoring Body Fluids

Monitoring patients with a variety of methods has been shown to be an
effective adjunct to treatment and recovery. Monitoring helps in assure-
ing that expensive treatment efforts are serving a therapeutic end rather
than simply "enabling" the patient to continue substance use and abuse
under the guise of apparent recovery. Monitoring also provides a
means for supporting the patient in continued recovery, for intervening
early in the event of a recurrence, and for providing the clinician with
opportunities to appreciate the patient's "baseline" function and to im-
plement measures aimed at preventing a recurrence. As the following
case shows, monitoring is not always a simple or automatic process.
Wise clinicians do not trust patients inordinately, because patients in
early relapse can be difficult to recognize and are extremely clever in
fooling their clinicians.

Case Report 3.9

After a crisis inpatient hospitalization, a 17-year-old boy entered
weekly psychotherapy with a psychiatrist reputed in the area to prac-
tice "addiction psychiatry." The psychiatrist agreed with the patient
and family that, in addition to weekly individual psychotherapy,
weekly group sessions and weekly urine monitoring would be a neces-
sary part of treatment. The patient did well for 2 months, but then su-
ddenly he came home intoxicated. In clarifying the situation with the
patient and the psychiatrist, the following facts came to light.

- During the first month in which the patient did bring urine speci-
ments, he obtained specimens from a "clean" friend who was not
abusing substances. No efforts were made to monitor the samples
or to ensure that they were fresh samples (by recording the tem-
perature of the urine). During this period, the patient began to
slowly use small doses of alcohol and marijuana on weekends
only.
- During the second month, the clinician stopped taking urine
specimens "because the patient was doing so well and seemed
trustworthy." At this point, the patient's alcohol and marijuana
use increased in amount and frequency. Eventually, he lost con-
trol over his use one evening, resulting in his coming home in-
toxicated.

Following a period of residential treatment, the patient eventually
recovered and is now doing well, several years later.

This case exemplifies the problem that clinicians often have with
insisting upon monitoring. They may feel ill-at-ease with distrusti-
g a patient when a productive doctor-patient relationship rests on a foun-
dation of mutual trust. Patients often discern this and contribute to the
problem by insisting that monitoring is expensive and troublesome, as
well as evidence that “you don’t trust me.” We respond to this challenge by reaffirming the following with the patient:

- “We wish fervently to trust you and do believe that what you tell us at any point in time is what you believe, want to believe, and/or wish us to believe.”
- “However, your substance disorder is not trustworthy. You cannot trust it, and I cannot trust it. If either of us thinks or acts as though it cannot reestablish itself, that is the beginning of a relapse.”

**Working With Families**

**Family Assessment**

Family members often possess information about alcohol or drug problems. However, it is necessary to meet with the family in order to obtain this information. Especially in the case of older adults who are single, divorced, or widowed, this crucial step may be overlooked. The following case reveals the danger in treating addicted patients as though they were socially isolated.

**Case Report 3.10**

A 38-year-old single woman with recurrent depressions lost her job with a police department due to alcohol abuse. Admitted to a state hospital for treatment of depression, she recovered uneventfully from her depression in the hospital. However, the physician whom she saw over the subsequent 2 years began to add various benzodiazepines (Xanax, Valium) to her antidepressant medication. When she developed migraine headaches, her physician arranged for her to obtain meperidine (Demerol) shots intravenously at a local hospital. During this period, a traffic policeman arrested her on a charge of driving while intoxicated (DUI). She lost her friends and her membership in an athletic association that meant much to her. Although the family knew about the role of alcohol abuse in the patient’s job loss, they did not inform the physician. Unaware of past substance abuse, the physician thought that prescribing benzodiazepines and opiates for this patient was safe because the patient was a woman and never appeared intoxicated in her (the physician’s) office. With no access to family information, the physician thought it unlikely that a middle-class, employed woman would be likely to have a substance abuse problem. Although the family perceived their relative’s social deterioration and warned the physician by phone, these data did not jibe with the physician’s more limited observations in the office, where the patient always appeared on time and was sober and well dressed. At age 38, the patient committed suicide.

Although some cases can end fatally despite clinicians’ best efforts, many difficult cases do well once the clinician and family are operating from the same knowledge base and understanding of the problem.

**Including the Family in Treatment**

Excluding the family from assessment and care is a common lapse. Failure to meet regularly with the family can seriously impede the treatment process, as in the following case.

**Case Report 3.11**

A 16-year-old boy was in an after-school outpatient program for alcohol abuse. Initially, the patient did very well at home and at school. His grades rose to their former level, and he again became pleasant and amiable at home. This continued throughout the following summer. Once school began, despite 4 months of apparent recovery, he began to show many of his former behaviors: missing school, receiving declining grades, showing irritability at home, and spending unexplained periods of time away from home. The family contacted the treatment program and was informed that “your son is doing fine.” Moreover, his Breathalyzer tests remained negative. Later in the fall, his father found a precision scale and cocaine in his son’s room. An inpatient evaluation with another program revealed that he was abusing drugs and supporting his habit by selling cocaine. Following several months of residential treatment in another state, he made a stable recovery.

This case carries three important messages. One is that patients can often mislead people in one or two areas (such as the school and the treatment program in this case), but eventually they manifest problems in some area. Thus, monitoring should occur in three areas if possible (e.g., home, school or workplace, clinic). Second, communication is crucial among those monitoring various aspects of the person’s life, because problems may appear in any part of the person’s life. Clinicians working
in this field avoid excessive reliance on their own observations, based solely on the patient in the treatment setting. Third, early intervention tends to be the best intervention. Lengthy and expensive residential treatment occurred in this case, during a period in his life when he could have been at home with his family and going to high school with his peers.

**Expectations of Families**

Although families want to be involved, it is also evident that families have limits in terms of the extent of involvement they can manage. They want to be included, informed, and guided, but in most cases they do not want to become the therapist or the expert. The following report by a family member expresses the reluctance of most family members to become expert in the addiction field.

**Case Report 3.12**

One mother of a daughter with sedative and alcohol abuse wrote the following advice for clinicians: “Give the family decent answers to their questions of what exactly their role is in the patient’s recovery. I have been pretty much pushed aside as though I am supposed to smile the while. I am quite drug illiterate but willing to learn. However, I am not willing to read 100 books nor to attend 100 meetings. I think my making a career of drug education and focusing too much of my attention on the drug problem does not help my daughter.”

Families typically want to be involved in their family member’s care, and they want to help. However, their involvement needs to be reasonable in terms of time and realistic in terms of expectation. Astute clinicians discern how much effort family members can devote to their relative’s recovery and still continue with their own ongoing responsibilities and health. If we ask too much of relatives, we can undermine their contributions to our patients’ recoveries.

**Child Abuse**

Child abuse can and does occur in association with addictive disorders. However, families may be accused of neglect, physical abuse, or sexual abuse that never occurred. Although this situation is relatively infre-quent, the consequences for the patient, the parents, and the family can be devastating, as in the following case.

**Case Report 3.13**

A 16-year-old Asian immigrant objected to her family’s insistence that she attend school, spend weekday evenings at home, and avoid bad company. When her parents continued their insistence on these house rules, the daughter told a counselor at school that her father was abusing her sexually. The father was arrested, detained for several weeks, and lost his job. The family lost face in the local community. They had to declare bankruptcy and lost their car. During a family evaluation for “incest,” it became evident that the daughter was abusing alcohol and marijuana heavily and had become sexually active with a drug pusher. She was also remorseful about what had happened to her father and her family, stating that she only wanted to “scare” her parents and force them into facilitating her drug-alcohol use and her sexual relationship.

Incest and other forms of childhood abuse occur with some regularity among patients with addiction (up to one-third or more of women with alcoholism).10

**Identifying Psychiatric Problems in Family Members**

Family members of recovering alcoholic patients and addicts are at high risk for a variety of psychiatric disorders, because recovery can be as stressful on the family as the period of active drinking or drugging. Relying on the family as a resource can add further stresses on them, precipitating psychiatric disorders. Clinicians need to consider the mental health of families, warn them about possible consequences in themselves, and be available for discussion and possible referral. The following case exemplifies this problem.

**Case Report 3.14**

A 41-year-old woman was involved in her husband’s care at a nearby facility, where he was receiving treatment for his alcoholism. The couples and family sessions were an embarrassment and a stress for her. She felt as though a particular counselor was singling her out for ridi-
cute, accusing her of irresponsible behavior and providing religious suggestions that she found offensive. At the time her husband sought treatment, she had moderate anxiety symptoms, but no symptoms indicative of depression. During his treatment, she developed sleep disturbance, loss of appetite, weight loss, crying spells, and hopelessness. A friend recommended that she seek outside assessment, which she did. She recovered completely following treatment for a major depression.

The wife in this case persists in having extremely negative views about the treatment staff and the program where her husband received care. In the end, such negative attitudes toward societal institutions serve no one. Fortunately, in this case the patient, wife, and family all did well.

Conclusion

Thoroughly understanding the process of recovery is a critical element in becoming a competent clinician in the addiction field. Such comprehension requires years to acquire and cannot be hastened, although it can be impeded or facilitated. To be effective, clinicians need to appreciate the phasic nature of recovery. Certain pitfalls are apt to occur in each phase of recovery. Awareness of these pitfalls can aid the clinician in avoiding them, or at least in recognizing them before they become disastrous.

References

Some form of psychotherapy or counseling is critical in treating any individual, couple, or family with a substance abuse problem. Psychotherapy can be effective in helping patients increase their motivation to stop using substances, maintain abstinence by changing addictive behaviors, and develop a healthier life approach in their recovery. Psychotherapy approaches vary and are tailored to the patient's substance abuse problem, including phase of recovery and motivational level. The term psychotherapy can mean different things to different therapists, depending on the clinician's theoretical orientation. In this chapter, psychotherapy is not limited to psychodynamic psychotherapy; instead a more general use of the term is used, representing a vast range of "talk" therapy approaches across various treatment modalities, such as individual, group, family, or couples.

In addition to supportive-expressive psychotherapy, a variety of psychotherapy techniques and approaches have evolved, including motivational enhancement therapy (MET), cognitive-behavioral therapy (CBT), psychoeducational approaches, relapse prevention therapy, rational emotive therapy, 12-step self-help/recovery approaches, family therapies, network therapy, and community reinforcement therapy. These therapies can be integrated or administered concurrently, and most have been described in treatment manuals. Psychodynamic psychotherapy alone is not usually effective substance abuse treatment until after patients have a substantial period of abstinence and progress in their recovery.
Psychodynamic psychotherapy approaches have been successfully modified and integrated into both individual and group psychotherapy approaches for substance abusers.1,2

Although the utility of psychotherapy for the addictions has been well demonstrated,4,11,15 actually undertaking psychotherapy in such cases involves considerable sophistication. Psychotherapy for addicted patients is both challenging and rewarding. This chapter includes common themes encountered when psychotherapy goes awry in the care of an addicted person.

Some therapists have attempted to avoid treating individuals with a substance use disorder because of their own negative attitudes, limited training, and negative past experiences, including difficulties encountered in treating these patients and poor outcomes. Some clinicians have generalized all addicted patients as “too narcissistic to form a transference” or “not motivated.” Addicted people tend to evolve through different motivational levels and abilities to trust therapists, and these issues should be addressed in therapy. Fortunately, clinical training can provide clinicians with the knowledge and techniques needed to help clients better with addiction problems, including realistic goals and a sense of hope.14

Making a Diagnosis

A cornerstone for selecting a specific psychotherapy approach is proper assessment and diagnosis. Clinicians who do not specialize in addiction encounter many patients who present with a specific complaint and do not spontaneously mention their substance use problem.

Case Report 4.1

A distinguished senior psychiatrist referred a patient to a younger colleague, a former supervisee. The referral comment was that the young woman suffered from anxiety and a variety of other neurotic difficulties and was suitable for a psychodynamically oriented treatment. He did not give further details, thinking that to do so would potentially distort the young therapist’s perception of the patient and her problems. The young therapist did not think to question his mentor’s judgment and neglected to take a thorough history or to do a complete psychiatric examination. After a brief inquiry and agreement concern-
Case Report 4.2

A successful junior college teacher in her mid-40s presented at an emergency room with an acute panic attack. It was the culmination of a series of milder episodes occurring in the context of pressure at work, where she had recently become chair of her department. She had also been experiencing increasing difficulties, mostly denied, with her unemployed, dependent husband. Based on presumptive diagnoses of panic disorder and generalized anxiety, she was given a short course of benzodiazepines and started in psychotherapy. Despite marked improvement in work function, she still experienced increasing anxiety that began in mid-afternoon and continued until her after-dinner drink. The psychiatrist, alerted by her history of a severely alcoholic father who had died from cirrhosis, asked her to measure the exact size, in ounces, of her "one drink" each night. To her surprise, and the psychiatrist's, she was drinking between eight and eleven ounces of scotch each night between supper and bed. Her anxiety and panic attacks resolved with abstinence.

Despite a proper examination and asking the right questions, the answers may not provide the needed information. Alertness to unexplained findings or results and the willingness to reassess earlier conclusions will help to arrive at the proper diagnosis. In this case, a complication of alcoholism was mistaken for a primary anxiety diagnosis. Alcohol withdrawal can masquerade as an anxiety disorder. In addition, the patient's major depressive disorder became apparent only after a period of abstinence. When confronted with the reality of her alcohol problem, this client was able to commit to becoming abstinent. In other dual diagnosis cases, the identification of a substance use problem will be met with more resistance and minimization.

Increasing Motivation to Change

In helping the less motivated client, who is unaware of the impact of his/her substance abuse or ambivalence about treatment, the therapist may benefit from using motivational interviewing techniques from MET. MET suggests specific treatment goals and approaches based on the patient's motivation to change his or her behavior. For example, goals for the less motivated patient may be to increase his or her awareness of the impact of the substance use and the possibility that change is possible. The clinician maintains an empathic approach that supports the capability to change and the patient's responsibility for change.

In some cases of low motivation, external motivators such as family, the legal system, or the employer may facilitate the change process needed to engage in treatment. Internal motivation must still be addressed. For many dually diagnosed patients, engaging, persuading, and getting a commitment to become abstinent may take years of incremental work by a clinician. These early intervention phases of treatment can be frustrating for clinicians not using a MET approach and related skills. Clinicians without realistic goals and expectations become angry and discouraged. Untrained clinicians may choose to not even focus on the substance abuse problem and just attribute the usage to other psychological or physical issues.

Case Report 4.3

A 30-year-old man with comorbid schizophrenia and alcohol-cocaine dependence complied poorly with treatment, resulting in multiple re-admissions to a community mental health center. He "burned out" several clinicians who either ignored his substance abuse or confronted him and referred him to 12-step meetings and a dual diagnosis treatment program. He did not believe that he abused substances and consequently did not follow through on these referrals. Moreover, he did not perceive that his substance use was related to his psychotic relapses, his homelessness, or his legal problems. On the contrary, he stated repeatedly that the drugs and alcohol helped him reduce his "voices" (auditory hallucinations) and deal with his social problems. Eventually, a clinician trained in addiction and psychiatry attempted MET. She assessed him to be not motivated for treatment but in the stage of thinking that he might have a problem with drugs and alcohol. She used a motivational enhancement approach by focusing on developing a therapeutic alliance, providing crisis intervention, and helping him to recognize the linkage between his substance use and each of his problems (as he was experiencing these problems). After several months of this empathetic, realistic approach, she was able to engage the patient in discussing the consequences of his alcohol-drug use. He admitted to some detrimental effects, as well as positive effects of his substance use—the "ambivalent phase." Over the subsequent several months, he reduced his substance use and increased his clinical visits. After a half-year of outpatient visits, he agreed to enter the Dual Diagnosis Program. Although occasional substance abuse persisted, he committed himself to a long-term goal of abstinence. He has had no re-
hospitalizations or legal problems for 1 year, and his episodes of substance abuse have continued to decrease.

Patients with dual diagnosis may benefit from hybrid therapies that bridge mental health and substance abuse psychotherapy approaches. For example, individuals with schizophrenia and substance abuse problems appear to benefit from the integration of motivational enhancement, relapse prevention, and psychiatric social skills therapies.17,18

Addressing Drug Use

The therapist may view addiction as a symptom of an underlying psychological disorder. From this perspective, the therapist may believe that the alcohol or drug abuse will cease spontaneously once the primary psychological disorder has been alleviated. Unfortunately, this theory—despite its apparent logic in some cases—rarely leads to a successful therapeutic outcome. The following case exemplifies the extent to which the therapist's denial can have unintended consequences.

Case Report 4.4

A 15-year-old boy entered intensive psychotherapy after his school informed his parents of increasingly poor attention, failing performance, and seeming indifference. Over subsequent weeks and months the parents were struck by his change of friends and loss of interest in his previous enthusiasms. They discovered marijuana in his room and requested an appointment with his therapist. The therapist informed them that he had known about the boy’s drug use, labeled it “normal phase related exploration,” and suggested that they not confront their son and instead ignore it. He told them that as their son came to understand its meaning, he would stop. The son continued in treatment for several years, during which time he continued to use drugs and ultimately became addicted to intravenous heroin. Although finally placed on methadone accompanied by treatment with a therapist skilled in treating substance abuse, his life continued to deteriorate. He died from an overdose in his mid-30s.

Insight, or the psychological understanding of oneself, can be helpful in giving motivated patients a reason to change their behaviors. However, it alone is often not adequate to promote the needed changes in most addicted persons. The therapist’s failure to understand the power of drugs in this young man’s life permitted the development of a serious and intractable addiction. In addressing the substance abuse problem, psychotherapy appears to be more successful when targeted to the patient’s motivation and level of abstinence.

Modifying Psychotherapy to the Problems of Addiction

In the early phases of treatment, the focus on the here-and-now, moment-by-moment, and day-by-day often remains the central emphasis of treatment much longer than in the treatment of the ordinary patient whose problems are uncomplicated by drug use. CBT approaches such as relapse prevention therapy can help the patient to identify triggers to their use, develop coping strategies to manage or avoid these triggers, and substitute adaptive behaviors in place of addictive ones. Relapse prevention therapy can be performed in a group therapy format.3,4,17,18

Treating alcoholism and drug abuse should not be “psychodynamic psychotherapy as usual.” The nature of the psychopathology, combined with both the direct and indirect effects of the drugs, requires a specifically phased set of treatment approaches. Even in the presence of coexisting psychiatric illness, such as a major depression or character disorder, the alcohol or drug problem must receive its own individually planned course of treatment. For example, common “triggers” to relapse include particular people, places, things, and mood states. Patients have unique triggers that they can learn to avoid or manage. Some triggers may be more easily managed than others: a patient may be able to avoid specific places but have more difficulty with anger or loneliness.

The clinician must first achieve enough of a working alliance to have the patient’s attention. The next task lies in helping the addicted person move toward abstinence. This often requires active intervention, directly involving the patient’s family and friends. The therapist must be willing to be directive as well as supportive. At this stage some negotiation may be appropriate, with the therapist agreeing to certain forms of assistance in return for the patient’s agreement to certain abstinence-directed goals.
Case Report 4.5

A psychoanalytically trained, experienced psychiatrist had correctly diagnosed a patient as alcohol dependent and referred him for detoxification. Following withdrawal treatment, the psychiatrist began bi-weekly sessions with the patient. This plan seemed to go well, until the psychiatrist offered an interpretation that enraged the patient. Rather than express his rage directly, the patient went on a 2-day drinking binge. The psychiatrist consulted with a colleague who worked with addicted patients. The consultant suggested increasing the sessions to weekly, providing more support-direction-education and less interpretation, meeting with the patient and his wife biweekly, and requiring that the patient attend Alcoholics Anonymous (AA). The patient achieved remission on this regimen.

Dynamic psychotherapy can be threatening to the newly abstinent patient, leading to a relapse. Thus, the therapist must exercise caution in moving from a supportive-directive-informational role to insight-oriented psychotherapy. In the case of the addicted patient, early therapy often addresses the impact of substance use—its reinforcing qualities, both physiologic and psychological, its alteration of memory and cognition, and its interference with both judgment and activity.

Early involvement in the drug subculture or having an addicted parent may have deprived the user of some normal developmental experiences. Therefore, early treatment may require education about the world and about the consequences of one’s behavior. This educational effort should also include accurate information about drugs and their physiologic and psychological effects. It is typically only later in the treatment, in the setting of abstinence and a secure working alliance, that the therapist can begin to try to help patients understand something of the origins and meanings of their behavior and the roles the use of drugs played for them.

Early treatment often includes the family and others who are close to the patient. Network therapy is an approach that enlists family and friends to provide ongoing support and to facilitate attitude change.

Marital Involvement

Involving significant others in substance abuse treatment is usually helpful and revealing. Family and friends can provide important information during the assessment phase; however, they are also part of a system that requires change. In some cases, the person is not immediately helpful and may actually sabotage the patient’s and clinician’s effort. The term “codependence” is used in the substance abuse treatment community to label a cluster of symptoms found in friends and family, including unhealthy enmeshment in the relationship, boundary distortions, assuming responsibility for meeting the substance abuser’s needs, and continued investment in trying to control both oneself and the addicted person. Family involvement in self-help groups such as Al-Anon can help educate and provide support. Overall, involving family and friends in the therapy appears to facilitate improvement for all through the recovery process.

Adequate evaluation can become difficult and even impossible if the addicted patient insists on complete confidentiality and refuses to permit the clinician to contact relatives, friends, and perhaps others (e.g., probation officer, co-worker, personnel director at work). One or a few refusals can be reasonable, especially if accompanied by plausible reasons. Refusal to contact most or all significant persons usually indicates a problem of some sort. The most common problem is the patient’s unwillingness to surrender a secret, addiction-centered lifestyle and to allow the clinician and others to share their individual information. Although less common, other causes for a patient’s refusal may also be present (e.g., a paranoid disorder, criminal activity).

Recovery as a Process

A working knowledge of the 12-step process and recovery is important for both patient and clinician. An increased knowledge of the 12-step and addiction recovery community’s language and values builds bridges for the therapist. In early recovery, the clinician’s role includes monitoring the patient’s abstinence status on a routine basis and having a plan to respond to a relapse or to “addictive” behaviors (such as pathological gambling) that can lead to relapse. Evaluating the status of the patient’s recovery includes assessing abstinence, the patient’s program of recovery, the nature of attendance and participation at 12-step or the self-help meetings, the step being worked on, and the relationship with a sponsor. Once aware of the patient’s phase of recovery, the clinician can approach the treatment task in a more efficient, informed fashion.
Therapy alone is often inadequate to help the patient maintain abstinence, once achieved. Involvement in self-help groups, such as AA or Narcotics Anonymous (NA), reduces the likelihood of relapse and creates a recovery network of peer support. This network encourages an abstinent and sober lifestyle and serves as a major bulwark against relapse. In the 12 steps, a patient “works a recovery program” that addresses his or her unique issues. Recovery is a process and not a goal. At the core is an increased sense of spirituality and healthier connection to others. After a beginning period of abstinence, the second phase of recovery focuses on changing self-defeating learned behaviors and learning to make relationships work better.

Facing one’s inner, and often hidden, self is never easy. It is crucial that the patient achieve sufficient control of drug use and that adequate support systems exist before beginning the hard work of truly understanding. An effort to interpret too early risks either intellectual incorporation without understanding or, if the insight is painful, a return to drug use. After an extended period of abstinence (often more than 1 year), patients may be more willing and able to participate in a more psychodynamic-oriented psychotherapy. An understanding of psychodynamic/psychoanalytic concepts of transference and countertransference is helpful at any phase of recovery.

Transference and Countertransference Issues

Treatment of substance abusers can be difficult for clinicians, who bring their own backgrounds (including experience or naiveté with alcohol and drugs) to the treatment relationship. In addition, few substance abusers are “ uncomplicated cases.” Addiction is often a chronic illness or at best a series of remissions followed by relapse and recurrence.

For many patients, involvement in groups such as AA or NA helps to diffuse the intensity of feeling that they tend to develop about their therapist. This diffusion of the emotional context of complex, often intense transference and countertransference feelings may help maintain an appropriate working relationship between patient and therapist. It is also particularly helpful if therapists understand the multiple ways in which their individual and group past interacts with the present to result in distortions of understanding, feeling, and response. Such understanding is likely to prove helpful in establishing the boundary between patient and therapist that is essential to their work together. Another support may lie in consultation or supervision with an experienced colleague.

Case Report 4.6

An adolescent girl with a history of increasing conflict with her parents, a decline from her previously excellent record at school, and some minimal flirtation with beer and marijuana was admitted to a mixed adolescent and adult psychiatric inpatient unit for an intensive evaluation and formulation of a treatment plan. The unit was run by an older psychiatrist who had little experience in the care of either adolescents or substance abusers. His rule was that anybody who used drugs on the unit or who returned from a pass intoxicated would be immediately discharged. “Alcohol and drug use are not to be tolerated. Abstinence is essential to treatment.” During the course of the first week it became apparent that there was considerable marital discord between the patient’s parents, that her symptoms were in large part in response to this situation, and that she was experiencing a moderate depression, expressed in the behavioral arena. Following a week of good collaboration in her evaluation, she was allowed to leave the unit for the day on a therapeutic pass, discovered her boyfriend had taken up with her best friend, and returned to the unit stating that she had just drank a bottle of beer. She was immediately discharged to the custody of her parents.

In this case the premature discharge deprived the patient of the opportunity to begin to understand her maladaptive mode of responding to real difficulty. Rather than reinforcing limit-setting, the discharge subjected her to an experience of rejection and abandonment. The attending psychiatrist, during the case review that followed her discharge, came to realize that he was lacking in knowledge about, and was biased against, substance abuse and substance abusers. He went about correcting this deficiency and changed the practice of his unit.

Conclusion

In clinical situations, as in the rest of life, rules, boundaries, and limit-setting are important. However, as each situation has its unique features, rules must be applied with understanding, a modicum of sensible
flexibility, and a sense of the end they are meant to serve. Although abstinence is indeed important to treatment, it is essential that it also represent a goal, one that is not immediately achievable in most cases. All clinicians have the experience of having both reasonable and unreasonable feelings aroused by patients. This occurs particularly when the patient’s problems closely interact with the clinician’s problems. Clinicians with a personal or family history of substance abuse must be alert to the possibility of distortion and contamination of treating addicted patients. Without self-reflection, clinicians may be overly punitive or overly supportive and indulgent. The best and most effective prevention against such inappropriate responses are self-knowledge, consultation, supervision, and continued education.

References


Pharmacotherapy and Other Somatic Therapies

This chapter addresses common therapeutic challenges in the management of patients who are stabilized on somatic therapies to maintain abstinence from abused substances. The focus is largely on maintenance, the phase of treatment in which knowledge of pharmacology must be complemented by behavioral strategies aimed at strengthening the physician-patient relationship and compliance.

The vignettes presented highlight the use of medication in two clinical contexts: the treatment of comorbid psychiatric illness and the prevention of relapse. Occasionally, a patient will receive medication targeted at both the primary psychiatric symptoms (e.g., neuroleptics for psychosis) and at relapse (e.g., disulfiram) or craving (e.g., naltrexone).1

The sections of the chapter are divided according to substance of abuse. Commentary on the vignettes addresses commonly encountered pharmacologic problems associated with that substance and, where appropriate, dilemmas in behavioral management. The following vignettes do not constitute an exhaustive compendium of all potential "pitfalls," but they do represent a common array of problems and frustrations that, if anticipated, may be avoided altogether or handled more effectively if they occur.
Alcohol

The following vignettes describe cases that are complex but are nonetheless fairly common to psychiatric practice. Alcohol-dependent persons with comorbid conditions (Axis I and II) and concurrent diagnoses are discussed in the context of disulfiram/alcohol interactions as well as iatrogenic medication-related problems.\(^2\) Indications for electroconvulsive therapy (ECT) to treat depression in an alcohol-dependent individual are also described.

Case Report 5.1

An unemployed 42-year-old single female had a history of alcohol and opiate dependence; she was also diagnosed as having a severe personality disorder. While being maintained daily on 70 mg of methadone, she was detoxified from alcohol and then given 250 mg of disulfiram daily. She received disulfiram daily from the staff of the methadone clinic in order to ensure compliance. During the first month of disulfiram treatment, the patient abstained from alcohol and attended counseling sessions regularly.

The patient requested that her 12-year-old son, removed from her care by local child protective services, be returned to her. The custody hearing was held after her first month on disulfiram, but the judge denied her custody until she attained 6 months of sobriety. Following the hearing, the patient went home and consumed a pint of vodka; she collapsed in the hallway of her apartment building due to a severe disulfiram reaction. The patient manifested a classic and extreme disulfiram reaction characterized by cardiovascular collapse.\(^3\) She was relatively healthy (e.g., no cardiac, respiratory, renal disorders or diabetes) and so her recovery was uneventful and she left the hospital in 3 days.

Individuals manifest varying degrees of sensitivity to disulfiram; some react to a small amount of alcohol even on low-dose disulfiram (125 mg/day), whereas others are able to consume an entire drink while taking 500 mg/day. Highly reactive patients can experience nausea, headache, flushing, dizziness, or lightheadedness even when their skin comes in contact with perfume or alcohol-based solvents or if they ingest traces of alcohol in food. Consumption of a pint of vodka will most likely produce a severe reaction. The patient in the preceding case probably drank the pint extremely rapidly; otherwise intake would have been interrupted by vomiting, retching, or faintness.

The use of disulfiram in borderline patients dictates careful attention by staff to the potential impact of psychosocial stressors. For example, in this case in preparation for the custody hearing, it might have been appropriate to consider discontinuing disulfiram. Had the patient initiated drinking, intoxication would likely have been detected when she came for her methadone dose. In fact, Breathalyzer monitoring should have been planned in view of patient's history of alcohol abuse. The patient's daily visits to the methadone clinic would have permitted rapid intervention before the need for alcohol detoxification.

Case Report 5.2

A 47-year-old divorced man with a 20-year history of alcohol dependence was admitted to a psychiatric hospital for melancholic depression with psychotic features. Previously he had been given unsuccessful trials of a wide variety of antidepressant medications including tricyclics and serotonin reuptake inhibitors. In his early 20s, the patient had a similar depressive episode that had responded to ECT. However, during the current episode, the patient manifested striking cognitive deficits in memory and abstraction. The treatment team speculated that his cognitive impairment was also a function of his heavy alcohol intake and not solely due to the affective disorder.

The team believed that ECT would heighten the risk of further deterioration of intellectual capacity and, accordingly, pursued further medication trials, undertaking lithium augmentation of antidepressant agents. Trifluoperazine was also added to target psychotic symptoms. After 7 weeks of unremitting symptoms, ECT was instituted at three times per week. After six ECT treatments, the patient showed considerable improvement in mood, memory, and psychosis. (Lithium was continued as a pharmacotherapy in this case.)

Even with mild cognitive impairment, alcoholism is not a contraindication to ECT, particularly in patients who have a history of unresponsiveness to antidepressant medications. Irrespective of prior ECT success, a melancholic patient or one with a psychotic depression who abuses alcohol can generally be treated with a success rate comparable to that in patients without alcohol abuse. Should postictal confusion or memory loss be significant, the frequency of ECT sessions can be decreased and the total trial lengthened.\(^4\)
Case Report 5.3

A 55-year-old woman was admitted to the hospital for alcohol dependence complicated by major depression. She was given a 'social' alcohol detoxification (i.e., no medication) but after 10 days remained significantly depressed, with symptoms of sleep and appetite disturbance and vague suicidal preoccupation. The treatment program embraced a 12-step philosophy that was intolerant of psychotherapy.

After 28 days, the patient was discharged to aftercare with weekly support group and Alcoholics Anonymous meetings in 90 days. At 2 weeks later, the patient made a serious suicide attempt by intentionally driving her car off the highway.

Patients who continue to manifest significant depressive symptoms after initial detoxification (i.e., after 7–10 days) can be considered for antidepressant therapy. Some addiction psychiatrists suggest a period of 4–6 weeks of abstinence before instituting medication in a depressed individual. Severity and course are also factors in discerning whether (and when) to initiate somatic treatment for depression. Greater severity and a deteriorating course call for earlier action; moderate symptoms and an improving clinical picture augur for “wait and see.” Although sleep and appetite disturbance alone may represent residual toxic influences of alcohol, additional symptoms of major depression should alert the psychiatrist to the potential need for antidepressant treatment. Aftercare options include transfer to a psychiatric unit or dual diagnosis unit or, if the patient is not suicidal and is capable of self-care, enrollment in a day hospital. At minimum, weekly outpatient visits to the psychiatrist are warranted.

Cocaine

The symptoms associated with cocaine (depression and paranoia, in particular) can be mistaken for primary affective and psychotic disorders. Thus interpretation might prompt a psychiatrist to prescribe medication that can have serious side effects when the patient continues to use cocaine. The vignettes below reflect these clinical problems.

Case Report 5.4

A 39-year-old woman with cocaine abuse within the last 5 years presented with major depressive disorder after 1 year of abstinence. She was refractory to selective serotonin reuptake inhibitors (SSRIs), monoamine oxidase inhibitors (MAOIs), and tricyclic antidepressants (TCAs). Augmentation of MAOI and TCA with lithium and later thyroid hormone produced no significant improvement. The psychiatrist decided to add methylphenidate to the tricyclic antidepressant. He warned the patient of the risk in prescribing methylphenidate, given her past abuse of cocaine, and told her to report immediately any euphoria from the methylphenidate like that produced by cocaine. He continued to see her on a monthly basis and prescribed a 30-day supply of methylphenidate. Within 3 weeks the patient said she lost her pills but then admitted that she had been taking twice the daily prescribed number of pills. At her next appointment, the psychiatrist recognized her developing addiction to methylphenidate, insisted on tapering the drug, and gave her a 2-weeks supply of medication, during which time she was to follow a tapering schedule. Within 3 days, however, she called to tell him that she had exhausted that supply, and he prescribed her yet another supply with instructions to taper. The next day she called the psychiatrist to say that she had lost the prescription. Finally the psychiatrist recognized a pattern of methylphenidate abuse and initiated detoxification.

At sometime, most psychiatrists are confronted with the question of whether to use an addictive medication to treat a primary psychiatric disorder in a patient who also has a history of substance abuse. For example, a psychiatrist may determine that an alcohol-abusing patient suffers from an underlying generalized anxiety disorder and that the patient’s drinking may be fueled, in part, by efforts to subdue the anxiety. The patient, who craves alcohol when abstinent, is given a trial of buspirone, which proves ineffective for anxiety. Several clinical questions then arise: Is use of addictive medication flatly contraindicated in patients with any kind substance abuse history? Is such medication prohibited only in instances of same-class drugs (e.g., benzodiazepines in alcohol abusers; meperidine [Demerol] in heroin abusers)?

As a general principle, we believe that the clinician should not automatically rule out use of an addictive drug if there are good symptom-based reasons for prescribing it. Nor should the clinician assume that an addicting drug of one class, such as opiates, will be safe for an individual
who has abused a drug of another class, such as stimulants. However, in any situation where a potentially addicting drug is considered for use in a remitted substance abuser, considerable caution is warranted. In the context of the preceding case, accepted approaches to minimizing the chance of such an untoward outcome (or of detecting it earlier) include the following:

1. The doctor could have increased the frequency of visits when starting a high-risk patient on a stimulant. Minimum frequency should have been weekly. Semiweekly phone calls probably would have been a good idea.
2. The doctor should not have given the patient such a large one-time supply of pills. It would have been better to see the patient twice a week—even if only for a brief contact—and prescribed medication for only several days at a time.
3. When it became clear that the outpatient taper was not working, the doctor might have encouraged inpatient supervision.
4. When the doctor found himself writing extra prescriptions, he should have made a contract with the patient that included stringent limits-setting (e.g., would not continue to treat her unless she entered a hospital, would not continue to prescribe stimulants for her if she remained an outpatient, would decline to treat her if she refused to follow his recommendations and would refer her to another psychiatrist who was willing to evaluate her for possible treatment).

Case Report 5.5

A 38-year-old remitted cocaine-dependent male was treated with a neuroleptic for severe generalized anxiety after he failed a trial of buspirone; he had also refused a benzodiazepine trial because he did not want to be treated with an addictive medication. Accordingly, the patient was treated with 200 mg of thioridazine without experiencing extrapyramidal symptoms (EPS). During the course of treatment the patient resumed cocaine use while continuing to take the thioridazine, as he found the thioridazine useful in attenuating cocaine-induced paranoia and the "wired feeling" produced by the drug.

The patient noticed that, after completing a cocaine binge, his muscles would stiffen and he would drool occasionally. Also he felt especially restless. During one particularly severe episode, the patient presented to the emergency room where he received benztprine. He then began to take excessive doses of the benztprine.

The patient developed EPS while undergoing cocaine withdrawal. The emergency room psychiatrist might not have given the patient a prescription for benztprine if he had considered the possibility that the patient could have then used it to self-medicate future cocaine-related EPS associated with terminating a cocaine binge. EPS was not produced by the neuroleptic alone, which blocks dopamine activity, or by the cocaine crash alone. Together, however, the compound reduction in dopaminergic activity lowered the threshold beyond which EPS developed.

Case Report 5.6

A 42-year-old man had used freebase cocaine for 3 years but had been abstinent for 9 months when he sought psychiatric help for signs and symptoms of moderate depression. He was somewhat surprised about feeling depressed because he had expected to feel better after achieving abstinence. By the patient’s report and as confirmed by urine toxicology screens, he had not relapsed and so was prescribed a tricyclic antidepressant (desipramine) for unipolar depression. The starting dose was 50 mg, with instructions to increase the dose to a target of 200 mg/day on his own by increasing the dose by 50 mg every other day. On the third day of desipramine, while the patient was up to a 100-mg dose, he reported feeling jittery and anxious and described the experience as reminiscent of the sensation of cocaine. The psychiatrist told the patient to continue with the medication as prescribed; the patient did so, and within 1 week, he had resumed cocaine use.

The patient exhibited a "jitteriness syndrome" very similar to that described for patients with panic disorder when they begin tricyclic medication. Although this patient never had cocaine-induced panic attacks, he did experience a syndrome that has been reported in recently abstinent cocaine abusers. This discomfort can easily lead to craving for cocaine prompted by the jittery feeling that serves an interoceptive cue. Such cue-induced craving may lead to relapse.

Although tricyclic medications can be used to treat major depression in recently remitted cocaine abusers, the patient should be warned of possible side effects and instructed to stop the medication immediately should these effects develop. The beginning dose should be mod-
For the ER staff to await the toxicological results, suspicion of a dangerous drug interaction should have been aroused when a young, otherwise healthy person manifested hypertension and a clouded sensorium. A quickly placed call to her dentist might have provided valuable information about the meperidine as well.

Certainly a patient with an MAOI-stimulant interaction could present with hypertension, which might be treated best with nifedipine and/or an intravenous benzdiazepine. However, given the patient’s history of polysubstance abuse and recent ingestion of unidentified pills, it is prudent to prepare for the “worst-case drug interaction.”

**Benzodiazepines**

The benzodiazepines, with their considerable abuse potential, are cause for special vigilance when they are used in the management of individuals with a substance-related disorder (SRD) who also suffer from moderate to severe anxiety. Benzodiazepines can play a role in the treatment of psychosis—targeted at akathisia or anxiety or as an adjunct to antipsychotic medication so that a lower dose may be used—and in the treatment of neuroleptic-induced EPS. However, caution must be exercised when using benzodiazepines in patients who have a known substance-abuse history or who are actively addicted.

**Case Report 5.7**

A 35-year-old single unemployed male with a high school education was admitted to the hospital for alcohol and cocaine abuse in addition to acute psychotic symptoms of hallucinations and paranoid ideation. The patient had a 10-year history of schizoaffective disorder, depressed subtype, and had been treated with haloperidol, 10 mg daily, for the last 10 years. He had been repeatedly admitted to the hospital for exacerbation of psychosis due to poor medication compliance in the context of cocaine abuse. Most recently he was admitted in a floridly psychotic and agitated state and required restraints even after haloperidol was restarted. While in restraints he finally responded to a combination of lorazepam (6 mg/day) plus haloperidol (10 mg/day) and was discharged 12 days after admission. At discharge from the hospital, his antipsychotic medication was switched to intramuscular haloperidol decanoate depot form, and lorazepam was discontinued because of

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A 20-year-old single female with borderline personality disorder and mixed substance abuse in remission was maintained on the MAOI phenelzine for major depression. She had a recent history of speedballing (opiate and cocaine injected simultaneously) and, according to her friends, had taken some pills prescribed recently by her dentist when she had oral surgery. She was brought into the emergency room (ER) hypertensive, agitated, and delirious. There she was given supportive care and chlorpromazine for the hypertension and agitation, which were ascribed to an MAOI/cocaine interaction, but within 8 hours she died.

The pills prescribed by the dentist for the patient were meperidine (Demerol) for postoperative pain. Although there was not enough time
the treatment team’s concern about potential benzodiazepine abuse by
the patient.
Within 1 month after discharge, the patient continued to receive
haloperidol decanoate but was restless and agitated. His treatment
team again did not consider adding a benzodiazepine, and within 2
weeks the patient required readmission for psychotic decompensation.
His urine toxicology screen on admission was negative.

The team might have considered discharging the patient on a ben-
zodiazepine plus haloperidol decanoate, as he was willing to take the
medication and had no history of benzodiazepine abuse. The patient
appeared to develop akathisia (i.e., restless legs and pacing) secondary
to haloperidol; this adverse effect was attenuated by the addition of a
benzodiazepine. Small, frequent supplies of benzodiazepine could have
been prescribed in the early weeks after discharge. With evidence of re-
 sponsible use, 2- to 4-week supplies could be dispensed. Although the
patient did use alcohol in conjunction with cocaine, his cocaine use ap-
ppeared to be triggered by haloperidol-induced dysphoria. By virtue of
their antipsychotic-augmenting effect, benzodiazepines may have al-
lowed the use of lower doses of haloperidol, thereby reducing dyspho-
ria. It is possible that the patient’s agitation and restlessness was a
manifestation of protracted withdrawal from the rather high doses of lo-
razepam received during the 12-day hospital stay. In that situation, rein-
statement of benzodiazepine with gradual tapering would be indicated.
However, if symptoms reemerged at the end of the taper, it would still
be difficult to distinguish between akathisia and low-level benzodi-
azepine withdrawal symptoms. Discontinuing the neuroleptic might of-
fer an indication of symptom etiology, because akathisia would be
expected to either rebound or resolve, but the risks of removing the neu-
roleptic might not justify the risk of exacerbating psychosis. Finally, a
benzodiazepine with a long half-life, such as clonazepam or chlordi-
azepoxide or diazepam, would probably be the optimal choice in a pa-
tient on benzodiazepine maintenance. Shorter half-life drugs, such as
lorazepam and alprazolam, have higher abuse potential due to inter-
dose withdrawal.

Case Report 5.9

A 23-year-old homeless, cocaine-dependent male presented with an
acute paranoid episode. In the emergency room he was managed with
oral lorazepam, 25 mg over 48 hours, for sedation. After 2 days in the
emergency room he was discharged with a 10-day supply of loraze-

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pam totaling 100 mg and instructed to taper the dose on his own. The
patient again presented 3 days later to the emergency room with a
benzodiazepine overdose, which was reversed with intravenous
flumazenil.

In individuals without an underlying psychotic illness, paranoia is
almost always resolved within 12-24 hours of cocaine use. Benzodi-
azepines are generally effective in managing transient cocaine-induced
paranoia. Indeed, they are probably more efficacious than neuroleptics,
because individuals in the “crash” phase of cocaine intoxication may be
especially vulnerable to extrapyramidal effects.7

In this case, the patient received lorazepam over 24 hours in the
emergency room. However, at discharge there was no need to prescribe
a tapering dose, because even high-dose lorazepam can be terminated if
administered for only a few days. Also, no effort was made to determine
whether the patient had a history of benzodiazepine abuse or of selling
his medication on the street. Had one of these two possibilities been sus-
pected or confirmed, there would be further cause to withhold a taper-
ing dose.

When there is indication to gradually discontinue benzodiazepine
(e.g., the patient has undergone at least 10 days of lorazepam treat-
ment), one or more of the following options should be considered: 1) ex-
tend inpatient stay, if possible; 2) switch to an agent with a longer
half-life so that there is less frequent dosing and a smoother descending
plasma level; 3) give the patient renewable 1-day supplies of medica-
tion; and 4) arrange for daily visits to a clinic or case manager who can
supervise ambulatory detoxification.

Because the patient in this case is homeless, he is at high risk for a
number of problems, including “revolving door” readmissions, which
are expensive and usually ineffective. This pattern can be broken by one
or more of several strategies, including intensive case management,
long-term residential treatment, and/or supervised housing.

Opiates

Methadone is the primary maintenance medication used in opiate-
(mainly heroin-) dependent persons. The two most common clinical
problems arising in methadone-maintained patients are managing pain and recognizing when methadone has interacted with other medications. Naltrexone is available as a blocking agent; it is very effective, but compliance with it is notoriously poor in the absence of contingency contracting and other psychosocial modalities.¹

Case Report 5.10

A 25-year-old African American woman who was maintained on 80 mg of methadone daily was admitted to the hospital for sickle cell crisis. She was in extreme pain, but the physicians were reluctant to administer narcotic medication because they believed that the patient was already on high-dose opiate (methadone) and might experience respiratory depression if medicated. Finally the patient was prescribed pentazocine with naloxone (Talwin NX), because this medication was considered to have low potential for central respiratory effects. The pain relief was minimal, and the patient experienced mild opiate withdrawal secondary to the pentazocine with naloxone (Talwin NX). Both of these agents can precipitate withdrawal: naloxone as an opioid antagonist, and pentazocine as a mixed opioid agonist-antagonist. Once in withdrawal, the patient was in even greater pain.

Methadone-maintained patients who are in significant pain require short-term opiate medication in doses at least equivalent to those received by patients who are not on methadone. Indeed, they may need higher doses to compensate for both acquired tolerance and a higher rate of liver metabolism.⁸ Hospitalized methadone-dependent individuals should receive their regular daily dose of methadone plus whatever short-acting analgesic (e.g., morphine, meperidine [Demerol]) is needed for pain control. Opiate preparations that have mixed agonist-antagonist properties (e.g., pentazocine or pentazocine with naloxone [Talwin NX]) or pure opioid antagonists (naloxone, naltrexone) should not be used.⁹

Another common mistake made in the management of substance abusers who are in acute severe pain is thinking that a narcotic will worsen the underlying dependence or provoke a relapse in someone in remission. Proper medical management calls for alleviating acute severe pain, and it is unlikely that the pattern of premorbid substance use will be affected by a short course of medication in hospitalized substance abusers. Nevertheless, physicians and nurses should note if such patients complain of drug or alcohol craving or persistently request analgesia after all other evidence of the acute trauma or illness is largely resolved. If this occurs, it is prudent to obtain consultation or to transfer to a brief inpatient substance abuse treatment. If the patient is ready for discharge and relapse appears imminent, referral to a day hospital or to a clinic that would see the patient semiweekly for the first few weeks after discharge is indicated.

Case Report 5.11

A 38-year-old woman on methadone maintenance at 60 mg daily was abusing diazepam, up to 100 mg daily. It was necessary for the patient to undergo ambulatory detoxification from diazepam due to limited inpatient resources. The program physician had recently read about the use of carbamazepine for benzodiazepine detoxification and decided to try this approach because of previous difficulties encountered with outpatient lapers (e.g., patients tended either to consume several days worth of pills at once or to sell their medication). The patient was begun on 400 mg of carbamazepine tid and within 1 week complained of inability to sleep, sweating, nausea, and anxiety. The program psychiatrist became concerned that these were symptoms of emerging benzodiazepine withdrawal and concluded that carbamazepine was insufficient to control withdrawal and that seizures might develop. Carbamazepine was continued, and 5 mg of clonazepam was added to the daily methadone dose. Although acute withdrawal symptoms abated somewhat, the patient developed increasing sedation. This raised concern about continued diazepam abuse. Finally, the patient was admitted to the hospital because of a confusing clinical picture characterized by continuing mild autonomic arousal and increasing sedation, which was impairing the patient’s ability to function.

The main problem in this case was the physician’s failure to recognize that carbamazepine increases the metabolism of methadone after 7–10 days of administration. Accordingly, the patient was receiving a methadone dose that was functionally lower than her maintenance dose; this led to mild opiate withdrawal, which was interpreted as benzodiazepine withdrawal. When carbamazepine is taken for more than 1 week by a patient maintained on methadone, the dose of methadone should be increased to compensate for its enhanced metabolism.

Also, this patient returned to benzodiazepine use. Although this relapse may have represented an attempt to self-medicate the symptoms
of opiate withdrawal, it became clear that ambulatory detoxification was not possible in this case. Inpatient detoxification is often needed to break the cycle of abuse when a methadone-maintained patient also abuses other substances.

**Case Report 5.12**

A 27-year-old male maintained on 65 mg of methadone daily was diagnosed with AIDS-related complex and tuberculosis. It was known that several fellow patients in the methadone clinic had already developed infections resistant to standard antitubercular medication, and so multiple-drug therapy including isoniazid (INH) and rifampin was initiated by the patient’s physician in the local AIDS clinic. Within 2 weeks, the patient developed morning sweats and difficulty sleeping at night. These symptoms were initially attributed to lack of response to the antitubercular therapy, and consideration was given to adding further experimental medications to control the tuberculosis.

Rifampin induces methadone metabolism and produces opiate withdrawal symptoms. Better communication between the AIDS clinic and the methadone maintenance program was clearly needed. Providing primary care and medical services within a methadone program is the ideal treatment setting for AIDS patients on methadone.

**Prescribing Benzodiazepines Over Prolonged Periods**

Proper detoxification of alcoholic and sedative-dependent patients may require administration of benzodiazepines or other sedative drugs. However, chronic prescribing of these drugs may merely replace one addiction with another. Common themes in these cases involve chronic administration of benzodiazepines over years for chronic psychiatric conditions and switching from one addictive drug to another (e.g., alcohol to diazepam, diazepam to phenobarbital).

**Case Report 5.13**

A 40-year-old salesman had difficulty rousing himself out of bed the morning following an extended period of intense drinking. The severity of post-binge nausea, headache, and general malaise prompted him to call his physician. After taking a medical and drinking history and performing a physical exam during which he detected a tender and, he assumed, inflamed liver, the doctor made a diagnosis of alcoholism. His advice to the patient was to stop drinking and attend AA meetings. In his view there was no need for inpatient treatment, but he did prescribe chloral hydrate to help his patient through withdrawal. Initially, the patient was troubled with the benzodiazepine medication. He was able to abstain from drinking for 5 days, the longest continuous period of abstinence that he had in 15 years. Soon, however, he needed alcohol to put himself to sleep—one of the important functions it had previously served—but the alcohol had no effect. He discovered that an extra pill in addition to the bedtime alcohol was extremely effective at first, but then the sedative effect of the combination wore off.

After 2 weeks of taking chloral hydrate and alcohol, the patient became increasingly erratic. He managed to obtain another prescription for chloral hydrate from the physician during his first return visit, 4 weeks after the diagnosis of alcoholism was made. At 1 week later, an executive manager recognized that the patient was agitated, emotionally labile, inattentive, and forgetful. He talked with the patient’s physician, who then decided to admit him to the hospital. The patient’s subsequent recovery went well.

The following cases involve another common problem—failure to take an adequate history for past alcoholism and other addictions before prescribing an addictive medication.

**Case Report 5.14**

A 52-year-old recovered alcoholic woman consulted a rheumatologist for her increasingly severe rheumatoid arthritis. Her physician noted that familial stress appeared to precipitate the arthritis, but she failed to elicit the patient’s history of alcoholism. Consequently, she prescribed alprazolam (Xanax) and an analgesic drug containing codeine. Moreover, the physician failed to monitor the patient’s use of these addicting medications, giving prescriptions freely. The patient subsequently became addicted to both medications. Hospitalized for a stroke 10 years later at age 62, she went into withdrawal in the hospital. Her withdrawal was not corrected during, and over the subsequent 6 months she was in and out of hospitals and nursing homes, treated for a variety of psychiatric conditions with diverse psychotropic medications.
The iatrogenic addiction in this case might have been avoided by following the treatment principles recommended above.

**Conclusion**

Major issues in somatic maintenance and pharmacotherapy of newly abstinent substance abusers and in those maintained on disulfiram and methadone can be summarized under the following topics:

- Drug-drug interactions (see Tables 5–1 and 5–2)
- Need for monitoring treatment compliance
- Acute pain management
- Treatment for depression in substance abusers
- Medication use in early cocaine abstinence
- Medication treatment of adverse effects of abused substances
- Use of addictive medications in dually diagnosed patients

Each of these somatic modalities requires that the clinician understand both the clinical course and manifestations of SRDs as well as the pharmacology and physiology of the somatotherapies.

| Table 5–1. Common drug interactions with disulfiram |
|----------------|----------------|----------------|
| **Drug**      | **Effect**     | **Proposed mechanism**          |
| Alcohol       | Disulfiram reaction | Acetaldehyde buildup            |
| Metronidazole | Psychosis, confusion | Unknown                        |
| Phenytoin     | Phenytoin toxicity | Disulfiram inhibits phenytoin metabolism |
| Amitriptyline | Psychosis, confusion | Unknown                        |
| Diazepam<sup>a</sup> | Sedation | Disulfiram interferes w/diazepam metabolism |
| Isoniazid     | Nausea, lethargy, ataxia | Unknown                        |
| Perphenazine<sup>b</sup> | Breakthrough | Disulfiram enhances perphenazine metabolism |

<sup>a</sup>Benzodiazepines that do not undergo hepatic N-demethylation (e.g., lorazepam, oxazepam) are safest.

<sup>b</sup>No evidence of adverse effects with other neuroleptics.

*Source.* Adapted from Shinn 1988–1989.†

**Table 5–2.** Common drug interactions with methadone

<table>
<thead>
<tr>
<th><strong>Drug</strong></th>
<th><strong>Effect</strong></th>
<th><strong>Proposed mechanism</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rifampin</td>
<td>Withdrawal</td>
<td>Rifampin enhances methadone metabolism</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>Withdrawal</td>
<td>Carbamazepine enhances methadone metabolism</td>
</tr>
<tr>
<td>Cimetidine</td>
<td>Sedation</td>
<td>Cimetidine inhibits methadone metabolism</td>
</tr>
</tbody>
</table>

**Commonly used medications without interactions:**

- Antitubercular drugs (other than rifampin)
- Benzodiazepines
- Monoamine oxidase inhibitors
- Neuroleptics
- Phenytoin
- Zidovudine

**References**

Building a positive relationship between patient and clinician is an important and difficult task, especially when the clinician is treating addicted patients. The most frequent errors in treating these patients are made because of the feelings and attitudes that the clinician has toward the patient (countertransference). The latter can take the form of inadequate empathy with the patient or overinvolvement in the patient's problems. The clinician may uncritically accept the roles projected onto the patient by the patient. A clinician's reactions to a patient may reflect the clinician's previous problems with other important people or experiences (i.e., alcoholism in the clinician's family or the clinician's own previous problems with alcohol). Inadequate training and knowledge of the substance abuse field may produce feelings of inadequacy in the clinician. Perhaps the most frequent countertransference problems depend on past negative experiences with addicted patients. Those who have not had much professional exposure to clinical problems and frustration with addicted patients may be more objective in some ways, but they also have more to learn about the nature and course of the disease.

Some clinicians choose alcoholism as their field because of a personal problem with substances that has been overcome, a family history positive for substance abuse, or experience with a loved one. It is not surprising that clinicians who have not adequately worked through their own problems with alcoholism are likely to have difficulties dealing with it in their patients. Typical mistakes in this category include too much self-revelation of personal problems and an inability to see the pa-
Patient's problem clearly because of a need to see everyone as having the same problem as the clinician.

Clinical Approaches

Self-Revelation by the Clinician

The clinician should carefully consider what information about himself or herself is beneficial for the patient to know and when it may be harmful to share such information. Any area of clinical work requires such judgments. However, clinicians often reveal their own past experiences with addiction or addicted behavior as a way of establishing rapport or showing empathy for the patient. This approach can be detrimental to the doctor-patient relationship.

Case Report 6.1

A 47-year-old certified alcohol counselor had 12 years of alcohol recovery and had worked as a counselor for 6 years. While treating a 54-year-old alcoholic man who was having a problem in his relationships with his three angry teenage daughters, the counselor revealed in a discussion about parenting daughters that he had sexually molested his own daughter when she was a teenager. This abuse had stopped with his recovery and only recently had she been able to talk with him about her rage and shame. Rather than being reassured by the counselor's sharing this information, the patient was shocked that someone who had been a child molester was permitted to be a clinician and felt that the counselor was more troubled than himself.

Here the clinician's efforts to reduce stigma and get the patient to share backfired and the clinician damaged his ability to be helpful. Although this is an especially egregious example, such inappropriate self-revelations occur often. Clinicians should assume that such admission of their own problems and foibles will undermine trust rather than foster it. Supervision by an experienced clinician can prevent such untoward outcomes. Careful selection of case assignments to counselors can also avert these problems.

Flexibility

Clinicians in recovery can sometimes suffer from overzealousness and a need to see other people's recovery as having to take the same form as their own. This overvaluing of one's own mode of recovery may lead to an inflexible approach and an unwillingness to attempt alternative solutions to problems. Clinicians must beware of applying their own experiences to their patients.

Case Report 6.2

A psychiatrist, who had gone through recovery with Alcoholics Anonymous (AA), had difficulty diagnosing and treating a recovering alcoholic patient with appropriate medications because of his view that all anxiety and panic were the result of drinking. Alcohol-induced anxiety had been the cause of his own panic attacks, which resolved spontaneously with abstinence. The patient, who suffered from severe panic disorder, kept relapsing until he was referred to an anxiety disorders program, where the problem was recognized.

Perhaps after more time and work on his own recovery, and with more experience, the recovering psychiatrist would be able to integrate his personal experience with his original good psychiatric training to the benefit of his patients. However, patients should not suffer inept treatment as recovering physicians work through their own problems. As indicated above, training and supervision can avert such problems.

Collusion With Patients (Enabling)

One dangerous form of collusion between a recovering or nonrecovering clinician and a patient with an addiction is that the clinician does not explore vulnerable issues in the patient as long as the patient also stays away from certain issues dangerous for the clinician. Clinicians in recovery must constantly watch their reactions to substance abuse and their own feelings while monitoring the feelings of the patient.

Case Report 6.3

A 47-year-old woman continued to smoke a pack of cigarettes a day 1 year after recovery from alcoholism. She sought treatment from a psy-
Misdiagnosis and Overdiagnosis

Like other clinicians, clinicians in recovery can have problems with under- and overdiagnosis. This difficulty can sometimes relate to the level of severity of their own problem when it was detected. For instance, a clinician in recovery may view a patient’s problem as minor in relation to his or her own substance abuse. There are also cases in which clinicians in recovery assume that every problem is related to addiction and ignore other difficulties that are present because they do not obtain a careful history.

Case Report 6.4

A 54-year-old policeman was a heavy drinker. A recovering clinician made the mistake of not evaluating the policeman for organicity because his problems were assumed to be entirely due to drinking. In time, a neurologist, who was consulted for worsening headaches, diagnosed the policeman’s brain tumor. The recovering clinician had assumed that the headaches were also a result of hangovers.

Starting out with a broad differential diagnosis is critical. Errors can be avoided by carefully working up patients without assuming addiction to be the cause of all problems. Another error of clinicians in recovery can be to assume that their personal knowledge of addictive behavior qualifies them in some special way, as compared with other clinicians who have not had that experience. This attitude can lead to inadequate pursuit of additional knowledge about the subject of addictive disorder or to arrogance in working with teams of clinicians who have not had this experience. There are excellent clinicians who have had recovery as part of their experience, and there are others who do not have this experience but who have an equal capacity to empathize with patients and understand them.

Clinicians Without a History of Addiction

What about the typical problems of clinicians who are not recovering from addiction? Well-trained and experienced clinicians who are not in recovery may not have specific problems working with addicted patients. They are likely to have developed appropriate empathy as well as the appropriate distance needed to maintain a neutral but active position. The term “neutral” is used here in the sense of not getting overinvolved, yet being active enough to engage the patient and provide appropriate concern and support when needed. However, some beginning clinicians who do not have much experience with recovery may have problems in developing adequate empathy and knowledge of addictive diseases.

In addition to good training, a wide exposure to literature, movies, and theater, as well as experience with case material, may help some clinicians develop a deeper capacity for empathy. The greater the knowledge of the disease, the disease process, the life history, and the clinical course of addictive disorders, the better able the clinician will be to treat difficult cases.

Whereas some patients in recovery complain about trainees who do not seem to understand anything about alcoholism, others complain that they cannot trust or be understood by a practitioner who has a problem greater than their own. Both complaints may serve as resistance to a patient’s dealing with addiction. Beginning clinicians who have come from a psychoanalytic model and psychoanalytic training may be handicapped by an exaggerated sense of therapeutic neutrality. This approach can lead to not taking an adequate history, to long periods of silence, to passivity on the part of the clinician, or to an inability to connect to the patient’s pain and fears. Any of these clinician failures can present a barrier to cementing a relationship with the patient.

Sexual Issues

At the other extreme, clinicians may be unable either to step back into an objective mode when necessary or to control their own emotional reactions. Consequently, clinicians may be drawn into overinvolvement with vulnerable substance-abusing patients. At its worst, overinvolv-
ment can lead to sexual or other acting-out, which can be devastating to
the patient and to the career of the clinician.

**Case Report 6.5**

A psychiatric resident evaluated an attractive actress with an addictive
disorder and referred her to inpatient treatment. Several months into
her recovery, the actress called the resident and asked whether he
would like to attend one of her performances at a local theater. The
resident, married and a father, went to the performance and soon
found himself having coffee with his former patient. He felt flattered
that such a beautiful young woman would be interested in his atten-
tion and soon began an affair. This relationship ultimately resulted in
her complaint to his psychiatry department chairman and his termina-
tion from the residency training program.

There are accounts of many experienced clinicians, even those who
are well trained, who at times of personal vulnerability have succumbed
to temptation. Substance abuse patients often have character pathology
and/or childhood histories involving sexual abuse. Patient vulnerability
and desire to repeat an old pattern in a masochistic way may lead the cli-
nician to be attracted by this vulnerability and take advantage of the
situation, invariably with disastrous results. These predicaments can
present in other therapeutic situations and cause untoward results, but
for patients with substance abuse problems there is the added risk of the
patient’s relapsing to substance abuse. Such complications comprise an
additional rationale for careful education, training, and supervision of
trainees conducting this type of work.

**Transference Issues**

Clinicians need to be especially sensitive to the issue of trust between
doctor and patient. Because patients with substance abuse problems fre-
quently lie to themselves as well as to others, it is appropriate for the cli-
nician to be skeptical and to consider a history complete only when
collateral sources of information are involved. Countless stories of
overly naive clinicians and wasteful, lengthy, and excessive treatment
are marked by the patient’s misleading the clinician about thoughts,
feelings, and behavior.

**Case Report 6.6**

A 37-year-old woman with alcoholism and an anxiety disorder claimed
to be doing well and not drinking; however, her panic attacks wors-
ened. After 6 months of ineffective treatment with cognitive therapy,
medications, insight therapy, and group therapy, the clinician asked
the patient to bring in her husband. After at first avoiding allowing him
to come in, she finally admitted to having lied about stopping drink-
ing. After permitting her husband and others to establish a support
network, she was able to maintain sobriety. She stated that she was
afraid her doctor would abandon her if she told the truth earlier.

Clinicians can sometimes become overly punitive and rejecting
when they find out the truth about a patient who has lied to them. Du-
plicity should be considered usual for patients who have long-standing
problems with being honest. Having grown up in families in which
substance abuse and dissimulation were common can also comprise a
significant source of mistrust.

**Bases of Trust and Mistrust**

Patients with substance abuse problems frequently come from families
in which there is a positive family history of addictive disorders. Their
childhood included experiences of inconsistency from parents, who
were sometimes wonderful and sometimes terrible. In such settings,
family life was often more fun when drinking was occurring. It is not
surprising that as children they did not trust their parents. Mistrust
could have extended to teachers, nurses, and other authority figures.
They tend to trust their peer group more and sometimes grow up wishing
that they will not be like their parents but like their friends and their
friends’ families. Unfortunately, their friends’ families often have sub-
stance abuse problems as well, because individuals tend to choose
friends who are struggling with similar issues. As they grow up, they
have not only a biologic risk but also exposure to environmental influ-
ences and peer groups that are at high risk for developing substance
abuse. If they develop a problem, they may not be able to trust parental
figures, including clinicians. Instead, they may preferentially seek peer
group support. Perhaps this is one of the reasons for the success of 12-
step programs. Some patients want to recover with the same kinds of
people with whom they drank in the past. A clinician should be aware of potential transference reactions, including the need for the patient to constantly disappoint the clinician just as the patient felt disappointed as a child; the need for the patient to defeat the clinician’s efforts just as the patient felt defeated in trying to help an alcoholic parent; and the need of the patient to seduce the clinician just as the patient may have felt seduced by a parent. Children of addicted parents may also have difficulty recognizing and communicating about their own affect—a disability that can cripple attempts at counseling and psychotherapy.

Case Report 6.7

A 24-year-old male factory worker repeatedly failed at getting help from treatment programs for cocaine addiction and alcoholism. He began using drugs and drinking heavily at age 15. He was the oldest of four children, and both his parents had problems with alcohol. At age 20, he made a serious suicide attempt and then, against advice, signed out of the hospital after 2 weeks. He was married to an unrecovered alcoholic who also used marijuana heavily. He had arrests for driving while intoxicated; on one occasion, a police officer arrested him for fighting. He had determined never to turn out like his parents, whose drinking he despised, yet he found himself becoming more and more like them. Although several of his friends had been doing well in AA, he trusted no one, including some fine clinicians. He was hoping to find a sponsor and start the AA and Narcotics Anonymous programs.

In seeking independence from his parents and other people, this patient depended heavily on substances. It will be a challenge to move that dependence on substances back to dependence on people. Diffusion of negative transference through use of a peer support group can be a good place to start.

Interaction of Transference and Countertransference

Addicted patients frequently manifest regression in several areas, including their conscience and values. Patients with active substance abuse often lie, are extremely demanding, are controlling or seductive, attempt to split a treatment team, and tend to see all things in terms of black or white. They can overvalue or devalue the clinician; set the clinician up to react with moral indignation, envy, or greed; and stimulate the sadistic and sexual needs of the clinician. In fact, some patients will look for ways to frustrate or gratify the clinician in order to get his or her permission to have their own needs met and stay out of control.

Several kinds of countertransference problems are prominent. One of these may be the clinician’s response to the patient’s transference to the clinician (i.e., the patient puts the clinician in the role of controlling parent, and the clinician then acts that way). This type of response by the clinician makes it possible for the patient to act out with the clinician the difficulties that he or she had with one or both parents.

Case Report 6.8

Early in alcohol recovery, a prominent manic-depressive businessman checked every decision with his clinician, who at first accepted the role, feeling that this dependency was a step up from depending on chemicals. Moreover, the clinician related to the patient’s strong dependence on both his controlling mother and his former wife. As the patient’s recovery proceeded, his clinician began to struggle with him. As treatment progressed, the patient grew more assertive in his plans, including scheduled vacations that led to missed sessions. Finally, the clinician, aware of having replaced the patient’s mother, was able to back off and reflect on the changing role they both had in the course of his recovery.

At first the patient needed support and structure from the clinician. However, over time this support and structure became a burden. Fortunately, the clinician learned when to back off.

Second, the clinician can respond to the patient as though the patient represented somebody important in the clinician’s past life. With emotional overinvestment in the patient, therapists may behave in a way that is both inappropriate to the doctor-patient relationship and antitherapeutic to the patient.

Case Report 6.9

A clinician who had an alcoholic father attempted to rescue a 64-year-old alcoholic surgeon, a patient of his who reminded him of his own father. The clinician became extremely disappointed, even furious at the surgeon when rescue attempts failed. This emotional response led to
the physician punitively and prematurely discharging the surgeon from treatment.

This clinician needs to avoid repetition, needing to fail at rescuing someone.
Third, the clinician’s inadequate education and knowledge of problems relating to substance abuse may lead to negative attitudes, failure to diagnose the addiction, and treatment mistakes.

Case Report 6.10

A prominent 65-year-old female attorney went to a leading hypertension expert, who diagnosed her as having essential hypertension. Over a 5-year period, the doctor never asked about her drinking, nor did she volunteer the information. Although the high blood pressure might have tipped him off to her alcoholism, the doctor did not consider that such a prominent woman could possibly have a problem with drinking.

The clinician who is poorly trained is more likely to project his or her own problems onto patients and to make mistakes. In addition, clinicians are unlikely to diagnose conditions whose existence they do not suspect. This type of clinician is at greatest risk of being the target of litigation.

Anticipating Potential Problems

Education, Training, and Supervision

It can be helpful for a clinician to do a thorough self-exploration both in personal therapy or analysis and in supervision to deal with the inevitable unconscious reactions to patients. It is only by working through his or her own prejudices and problems that the clinician can overcome resistances to do the work required to help the patient.

Case Report 6.11

A conference in which psychiatrists in training were videotaped showed their interviews with addicted patients. Discussions of their attitudes toward patients proved to be a very useful exercise for all. In one interview, the psychiatric resident for an 18-year-old cocaine and heroin addict and professional car thief appeared to be irritable, judgmental, squirming a great deal in his chair, and showing little empathy for his patient’s needs. On viewing the tape, the resident was surprised at the degree of his obvious negative reaction. He explained that his car recently had been broken into repeatedly, and his reactions were colored by the feeling that he was interviewing someone like his tormentor.

In cases like this one, the combination of learning an illness model, the efficacy of methadone maintenance in reducing crime, the value of psychosocial treatment that can help patients readjust their life, and the resident’s awareness of his own intense anger can lead to better work with patients. Parenthetically, recovered clinicians should not assume that their own personal experience with addiction will adequately prepare them for clinical work with addicted individuals.

Maintaining a Healthy Personal Life

The second protective measure is for the clinician to have as sound and secure a personal life as possible. The latter involves a good support system, including family, spouse, and friends.

Case Report 6.12

A recently divorced 37-year-old clinical psychologist, who had been married to an alcoholic man for 10 years, developed a sizable practice of addicted patients after she became interested in Alanon. She noted that she had frequent sexual fantasies about one of her male patients, and this frightened her. In addition to discussing the problem with a colleague who greatly assisted her, she began spending more time with her mother and sister and several close female friends, all of which gave her a strong sense of support. Six months later, one of her friends introduced her to a man to whom she became engaged. She worked through her brief infatuation and was able to continue working with the patient successfully. Without the help of her support system (i.e., her colleague, relatives, and friends), she might have terminated the treatment or may have acted in ways that would have been detrimental to the patient.
In cases where these issues cannot be worked through, transfer of the patient needs to be carefully arranged to ensure that the patient is not abandoned. The clinician’s responsibility not to abuse the patient’s trust does not stop when the treatment ends.

Working as Part of a Team

A third kind of support is provided by working in a system in which there is a lot of opportunity for quality improvement and peer supervision, which is usually the case when a team approach is employed. This supportive setting allows clinicians who work together to point out each other’s blind spots and assist each other in improving technique. Most organized treatment programs have a team approach.

Case Report 6.13

A 28-year-old certified alcoholism counselor frequently championed the demands of adolescent substance abuse patients who had authority problems. He also frequently complained about the program director and took advantage of periods of staff conflict to avoid work and claim that the director was running the team poorly. A senior social worker told the counselor that, in her view, he overidentified with the teenagers, thereby ignoring their need for a structured program. She further explained the importance of the staff’s working together to avoid being split. The counselor agreed this was happening and began to try to combine support of the adolescent patients with a firmer hand. He found that he got better results and that the work was easier when everyone cooperated.

The following example also points to the value of making supervision available.

Case Report 6.14

A 47-year-old internist had 6 years of recovery from a combined addiction to opioids and alcohol and was also in recovery from manic-depressive illness. He was stabilized on lithium for 5 years with no manic episodes and only occasional attenuated lows. Before his recovery, he was in a very busy solo practice, which he experienced as a burden. He was quite lonely in this situation. After a period of 1½ years of unemployment followed by a year of performing insurance physicals, he got a job in a health maintenance organization (HMO) that had a team approach. He reported that he not only enjoyed the support of the team and the realistic hours but also felt that the systems in operation in the clinic provided him with the structure he needed. There were social workers with whom he could discuss the frustrations he sometimes felt working with addicted patients. He also felt that in some ways the fishbowl atmosphere at the HMO contributed to his compliance with his full program of 12 steps, therapy, and medication. It also enhanced his ability to resist the temptation to use the plentiful supply of drugs available at work.

This physician was aware that any slip or mistake could be disastrous to both his patients and his career. He also felt that having staff around provided valuable feedback so that his doctor could adjust his medication if needed. Also, he no longer had the world on his shoulders but could share the burdens of practice with his colleagues. The doctor was enormously gifted, talented, and caring, and his recovery was of great benefit to society as well as to himself.

Accepting Criticism From Patients and Their Families

Another source of supervision for the clinician is the patient. A wise clinician always listens closely when a patient points out the clinician’s errors. The clinician must be constantly on guard to avoid making mistakes, and the wise clinician realizes that although everybody makes mistakes, they should be made as infrequently as possible.

Case Report 6.15

A 45-year-old married businessman with 4 years of recovery from cocaine addiction and alcoholism had severe, recurrent depression combined with a depressive characterologic style. He obtained a modest gain from each new antidepressant or mood stabilizer and then resumed his suffering, often combined with suicidal ideation and an абhorrence for hospitalization. Somehow he always seemed to suffer through and, surprisingly to all concerned, did not hurt himself. After trying a wide range of pharmacologic approaches and several consultations with experienced colleagues, the psychiatrist began to share the patient’s helplessness and provided only support. The patient and his
wife, both increasingly desperate and angry, demanded a session with the psychiatrist. Together they vented their frustration that nothing had helped. They finally suggested that the doctor might try electroconvulsive therapy (ECT), which he had recommended in the past. The psychiatrist admitted his error (in giving up too quickly), and together they agreed to try ECT. After eight treatments, the deep depression lifted, but dysthymia remained. Antidepressants were then able to ameliorate the patient’s chronic depression.

This patient was angry that his doctor was giving up hope for him. He believed that he needed help from his wife to communicate the depths of his despair. To the psychiatrist’s credit, he quickly seized the opportunity to use ECT, which would have been an obvious choice had he not felt so hopeless about the efficacy of anything new. The psychiatrist also learned from the experience that he should be more vigorous about recommending ECT when it is indicated. Whereas the doctor’s persuasion had previously failed, another serendipitous factor here was a public television special on ECT that impressed both the patient and his wife and helped convince them to seek this treatment.

Professional Associations and Committees

Professional societies and impaired-clinician committees are a source of help for clinicians. They are also places where unprofessional behavior is likely to be censured. Through fostering professional boundaries, they can deter transgressions. In addition to helping clinicians who treat addicted persons, they can sometimes help addicted professionals.

Case Report 6.16

A 32-year-old criminal attorney was referred to treatment for a cocaine and alcohol problem by a committee of attorneys serving attorneys, who threatened to report him to the bar if he continued using drugs. The attorney group and the clinician developed a tight contingency contract in which the addicted attorney wrote a letter to his senior partner and to the Bar Association admitting his use. He gave this letter to his clinician to send in the event of a confirmed positive urine test. Four years later, the letter had never been sent.

The positive rewards of a satisfying profession can be a powerful incentive toward recovery. This type of association can be used in contingency contracting in conjunction with monitoring and other treatment.

Continuing Professional Development

Personal ongoing effort at continuing education can protect clinicians against mistakes in caring for addicted persons. These efforts can include reading (i.e., books and journals), seminars, peer supervision groups, and course work.

The greater the knowledge regarding addiction and addiction treatments, the smaller the chance of staff burnout when faced with difficult challenges and the less likely clinicians are to project their needs onto their patients. In summary, the more the treatment becomes a science as well as an art, the less chance there is that human error will lead to a catastrophe.

Frances and Franklin have listed 10 clinician attributes that they felt facilitated substance-disorder treatment. Some of these appear rather more constitutional or character based, but others clearly can be acquired through experience, commitment, learning, teaching/supervision, or consultation:

1. A caring relationship
2. Informed optimism on the part of the clinician
3. Capacity to tolerate anxiety and depression
4. Flexibility
5. Knowledge of addictions
6. Intellectual curiosity
7. Wisdom
8. Persistence and patience
9. A capacity to listen
10. Honesty and integrity

These characteristics can be nurtured and developed in the context of training programs and clinical practice and can bring out the best that a clinician has to offer. The most important element in the treatment of patients with addiction is a compassionate relationship with a well-trained, skilled clinician who is flexible and who can avoid the pitfalls of
overinvolvement, of distancing, and of not exploring or managing conscious and unconscious reactions to the patient.

**Conclusion**

The clinician may need to recognize and change negative attitudes in working with patients with substance abuse problems. This process includes attaining the ability to deal with the patient’s addictions properly and ultimately helping others who have had similar problems. Staff burnout does not have to happen when clinicians have adequate support systems and when there are opportunities to deal with and use the clinician’s feelings appropriately in treating patients. It is clear that the clinician’s recognition of countertransference feelings may be an important tool when used positively in the patient’s treatment. Through self-awareness regarding anger and other feelings provoked by addicted patients, the clinician may be able to recognize the patient’s level of desperation, despite, and masochism.

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**Social Networks and Addiction Treatment**

Social factors may or may not operate as potent etiologic agents in substance-related disorder, although substance abuse can fundamentally affect the size and composition of the patient’s social network. Effective recovery, however, is almost always associated with a transformation in patients’ social relationships. The treatment of addiction is therefore generally a socially grounded process and sometimes also a cultural network process. Compliance with treatment, from the early stages of a decision to address the illness on through to stabilization in a drug-free life, deeply affects one’s social environment.

In this chapter, we will consider some of the ways in which treatment decisions are formulated and the errors that are sometimes made particularly involving the patient’s social context:

- The immediate environment of the clinician-patient interaction
- The use of family and friends in the therapeutic setting
- The ways in which the patient and treatment system interact

Although this is a broad context, some specific examples will serve to illustrate differences between the clinical management of substance dependence and other psychiatric diagnoses.
Social Network in Substance Abuse

Addicted patients are generally quite reluctant to part with their primary symptom of drug use because it is this very symptom that alleviates the dysphoria they feel. In addition, alienation from others has typically left addicted persons bereft of social support. Although depressed or anxious patients turn to the clinician for relief when their symptoms are aggravated, addicted patients are likely to turn away from the treatment when the symptoms get worse, because the clinician stands between them and their habitual source of relief. Because of this paradoxical problem, other levers of influence must be employed by the clinician to retain the patient in treatment and secure compliance. With this in mind, we can consider some examples of “pitfalls” if appropriate options for social therapy are not employed.

 Psychotherapy and Social Networks

Traditional psychotherapy is designed to exert a beneficial influence on the patient’s attitudes and behavior. Although this approach might include intruding into the patient’s life circumstances, concerns about boundary issues and the more passive/consultative/teaching/guiding role of the therapist might limit or preclude such intrusion. Because the patient feels protected from direct intervention, he or she can discuss material that otherwise might be compromising. Clinicians in this therapeutic mode do not impose value judgments, nor do they insist that their patients undertake a specific course of action. This classic therapeutic stance is of great value when patients are dealing with intrapsychic conflicts and are otherwise compliant with the treatment regimen.

This nonintrusive aspect of traditional psychotherapy can tie the clinician’s hands when treating a patient with substance abuse, because intervention may be important in developing a strategy for change. This is clear in the case of patients who relapse into drug use after a successful course of treatment, only to distance themselves from the clinician and potentially nullify the benefits of further care. The gains that were made in prior treatment may be entirely lost, because the patient may withdraw from treatment for an extended period, during which time he or she may suffer great physical or social harm.

Case Report 7.1

A 37-year-old schoolteacher had become addicted to stimulant drugs during adolescence when she was trying to lose weight. Her father, a pharmacist, inadvertently abetted her in the early stage of her illness. She had access to stimulant medications in his pharmacy, because he did not take proper steps to monitor his supply of drugs. When stimulant supplies were less available, cocaine became her drug of choice. Within a few months of entry into treatment, she became abstinent, was involved in ongoing psychotherapy, and attended Cocaine Anonymous (CA). She was pleased with the progress she had made and was eager to continue in treatment. Two occasions during treatment stand out regarding her vulnerability to relapse.

On one occasion, after a disappointing exchange with her boyfriend, she did not appear at her therapy appointments on 2 successive weeks. Her clinician called her, but she did not respond. She came to her next session, but was intoxicated from cocaine. Her clinician let her spend time in his waiting room to compose herself. They then formulated a plan for how she would break out of this episode of drug use.

On the basis of this exchange and some phone calls over the following days, the patient was able to terminate her episode of drug use and return to treatment. She did well over the ensuing months and also returned to CA meetings. She was able to effectively address a number of issues related to her social life and work. She developed a positive outlook on sobriety. Treatment ended with an understanding that she could reestablish contact at any time.

After 2 years, the clinician received a letter in which the woman described a positive course, but then she stated that she had recently returned to use of cocaine. She indicated that she could take care of the problem by herself. The clinician believed that her current problem with the drug was substantial and called her immediately, hoping that the letter had reflected an oblique plea for help to deal with her problem. She did not want to speak with him further, and a subsequent call met the same response.

The experience with this patient illustrates how therapeutic contact with a patient in isolation from other sources of support can sometimes be beneficial but under other circumstances can leave the clinician with limited options in the face of relapse. Much of the leverage available in treating the substance abuser in isolation from other supportive figures resides in the dependency that the patient develops on the clinician. This social dependence serves as a substitute for reliance on the drug of
Choosing Network Members

The cohesiveness and advice offered by a social network can help the clinician implement a treatment plan. At the outset of treatment, the clinician and patient choose a number of people close to the patient who will come to therapy sessions with the patient at designated intervals. It is important that the network members offer the clinician a balance in perspectives so that different views are available. In this way, responsibility for treatment is not borne too heavily by one person. The network thus becomes an instrument for treatment.

When this approach is chosen, mistakes sometimes made in the choice of network members are given here.

Case Report 7.2

A 36-year-old man had done most of his heavy drinking at home during evenings and on weekends, resulting in his withdrawal from interaction with his wife and their four young children. During the initial stages of forming a network with the patient and the clinician, the patient's wife stated that she had ceased to feel any love for him. An aspect of the treatment plan was the use of disulfiram on a daily basis, an approach that can work well if a patient's spouse or significant other person observes him or her taking the daily dose each morning. The clinician did not attend to the negative feelings of the wife, and she was relied upon as a sole network member. She also missed some of their initial sessions, claiming that her schedule did not allow her to attend. This was an inadequate excuse, however, as the clinician and patient were willing to accommodate her schedule. Finally she withdrew from cooperating in the treatment. The patient continued to take his disulfiram regularly and maintain his abstinence, in good part hoping to reengage his wife's affection. This strategy did not have much effect on the relationship, although it did secure his abstinence and involvement in treatment over a period of several months. But he became disillusioned and decided to leave treatment, with uncertain stability ahead.

The clinician should have included additional members in the network. This would have provided a broader base of support. Whenever instability is anticipated, it may be necessary for the clinician, the patient, and other network members to introduce some additional members.

Another source of instability in the network is the inclusion of a member who is a substance abuser. The tendency of a member's addiction problem to undermine the treatment will generally emerge in the free exchange of observations among members.

Case Report 7.3

A 34-year-old college teacher, a longtime heroin addict, had used the drug by insufflation since his college years and continued to do so thereafter, while also using crack cocaine over the previous 2 years. He had managed to function at work until several months before seeking treatment.

After a brief detoxification in the hospital, he and his network met, and the clinician began naltrexone treatment. Although the patient
had been told that it was important that network members not be substance abusers themselves, he had invited a woman to join the group, not realizing that she had a significant problem with cocaine.

This woman’s undermining of the treatment process became apparent the first time the clinician met with the network, shortly after the patient had left the hospital. The issue came up as to whether he had to be fully abstinent from all substances, including alcohol. The network and the clinician made clear that this was necessary.

Three other members were in the network: two other friends of the patient and his mother. They were open to a requirement of abstinence, only because it was presented by the clinician, who was responsible for the patient’s care. The woman, however, introduced the issue of the patient’s “personal liberties” and his right to contribute actively to formulating his treatment. Although the idea might be appealing in theory, the clinician was never clear that it would undermine treatment.

The woman solicited the patient to support her position, throwing him into conflict. He was willing to comply with the announced regimen, but he also wanted to continue with some drinking. A rather heated and awkward exchange ensued, with the clinician in the end pressuring the patient and the group to accept the concept of full abstinence until the next network session, when it could be considered further.

The problematic team member was absent from the next session, and the clinician suggested that the patient not make any effort to secure her return, sensing that she represented a serious problem for the network. A few weeks later, the patient reported that he had become aware that the woman was more deeply involved in cocaine than he had thought. He and the clinician were now able to discuss how this person’s involvement had promoted his rationalizing the promotion of a plan that might have undermined his recovery.

The selection of network members is an active process carried out by the clinician and patient together. It is important for the clinician to be attentive to the background of potential participants and for the patient to understand the need to avoid including a substance abuser. In addition, it is important that members be selected who have an ongoing, supportive relationship with the patient, are not appreciably troubled psychiatrically, and are willing to make a long-term commitment to attending network sessions. If all these criteria are applied, the network can serve as a remarkably effective instrument for support for a therapeutic regimen.

The Addiction Clinic Milieu

Patients who enter an addiction treatment program are used to communicating with peers about the availability and use of drugs, whereas other types of patients may be reluctant to share their experiences. Thus, the treatment of a patient in a substance abuse clinic has an impact on other patients. Potential problems in this regard are illustrated by the experience of one psychiatrist who had worked primarily in a traditional medical setting and later tried to transpose his experience into that of a methadone program.

Case Report 7.4

A psychiatrist had previously been involved in consultation-liaison work on medical wards. He was well aware of appropriate dosing of medications for pain and anxiety in such settings and had also addressed these issues in methadone-maintained patients hospitalized on general medical services.

When the psychiatrist began to provide consultation in a methadone maintenance clinic, he encountered a variety of patients with ongoing anxiety symptoms and associated insomnia. Drawing on his experience in the general medical setting, he cautiously prescribed modest doses of benzodiazepines to certain patients who were clearly suffering from appropriate target symptoms, as he might have done if they had been seen in office practice or on an inpatient unit.

The patients appeared to fare well, but the word soon spread throughout the clinic that relief from anxiety was available from this psychiatrist through the prescription of medications that were familiar to them and that many had abused. Initially the psychiatrist prescribed medications for a few patients, but the number of patients requesting psychiatric consultation in the clinic escalated. The other clinic staff observed a tide of demands for drugs for anxiety and sleeplessness that was disruptive to their ongoing counseling. In time, the staff had to end this excessive prescribing, and with great difficulty most of the patients who had been prescribed the benzodiazepines had to have their doses tapered.

Medications with reinforcing qualities may produce different effects based on the context in which the patient is treated. Addicted patients respond to medications that allay anxiety, and many have come to ascribe magical qualities to them. The substance abuse clinic can become
extremely volatile when new opportunities for drug use are introduced—all the more so when they are introduced and sanctioned by the treating parties themselves. Therefore, any decisions regarding the use of reinforcing agents in a substance abuse clinic are best discussed among staff members as a group, and a decision to prescribe these drugs should be considered only in the context of all the patients in the clinic.

**Reliance on Milieu Treatment**

Problems in the management of individual psychopathology can often take place when the addiction treatment milieu is overly emphasized and the psychiatric disorders of its respective members receive inadequate attention. Such difficulties often arise in settings with a strong orientation toward the 12-step model, where staff may too frequently translate issues of individual pathology into Alcoholics Anonymous (AA) language.

**Case Report 7.5**

A 27-year-old polydrug abuser had severely compromised her beginning career in sales. Her primary care physician admitted her to a residential treatment program strongly oriented toward the AA model. From the outset, staff and patients in the encounter-oriented setting subjected her to intensive scrutiny. They ignored her apparent depressive symptoms, largely because of her ability to express herself well and to shrug off her problems. However, she had little enthusiasm for establishing open communication with her peers, and she became increasingly withdrawn over the following days. Her depressive feelings deepened. The staff and patients in the residential setting pointed out to her that she was “writing her own program” and not expressing herself sincerely. However, this discussion did little to alleviate her distress, although she did not express her feelings of hopelessness when confronted with her seeming noncompliance.

On the afternoon of the fourth day of her residential treatment, the patient went off on her own onto the hospital grounds and hanged herself with a belt. Fortunately, a passer-by discovered her before she incurred any permanent injury. Her primary clinician later noted in her chart that she was transferring her to a unit for patients who were more acutely distressed, because of her suicidal ideation. The apparent discrepancy between his description (i.e., suicidal ideation) and the actual fact (i.e., an almost fatal suicide attempt) reflected the staff’s propensity to underrate serious psychopathology.

Two levels of problem are apparent. First is the obvious problem of an ideologically oriented treatment program that is beneficial for most who enter it but can fall short for a patient whose needs do not conform to its ideological orientation. In this case, staff viewed the noncompliance as a reason for confrontation. Because of this, the staff failed to appreciate the patient’s depression and suicidal risk. The concept of cognitive dissonance is useful in understanding this. Members of the treatment milieu tended toward seeing problems as reflecting noncompliance with the 12 steps, rather than the reality that the 12-step orientation does not necessarily address all the problems confronting an addict. Potential observations of this patient’s severe depression were therefore dissonant with the program’s operative ideology, and therefore the staff ignored her symptoms.

Second, the clinician’s chart notes reflect the potential for denial of reality in the treatment program structure, which can lead to failure to take appropriate responsibility. The treatment program should have provided means to review, understand, and address situations like this properly. In this particular treatment system, the staff did not accept the possibility that a failure in treatment had taken place because of the inadequacy of the program’s operative ideology.

**Organizational Context of Treatment**

In addition to the direct social context of the patient’s life, the organizational context within which treatment occurs can have a significant impact on the patient’s clinical course. Of most concern is the availability of a true continuum of care for the patient’s treatment. The ability to access ambulatory, residential, and acute care resources as appropriate depends on what is available. In the past, nonambulatory treatment tended to be centered in acute care settings with prescribed programs and defined lengths of stay. The 21- to 28-day inpatient treatment setting was often seen as the “definitive intervention,” with ambulatory care subsequent to hospitalization labeled as “aftercare.” The vicissitudes of funding for care have radically altered this picture. Although some of these changes have been salutary, other changes have caused
problems for some patients. For example, ambulatory treatment, now being promoted as the intervention of choice, is often of limited duration and may not be effective for everybody.

**Case Report 7.6**

A 44-year-old separated automobile mechanic presented for treatment at a medical center in a small urban area. He had a 20-year history of heavy drinking that had resulted in the loss of several jobs. Drinking also was a factor in the breakup of his marriage about 5 years earlier. He acknowledged a drinking problem when he became aware of blackout periods for which he had no recollection of his activities. He had never sought treatment.

At the time of his admission to a publicly funded inpatient substance abuse treatment program, he lived alone and was essentially indigent. During his 21-day hospitalization, the patient did quite well and participated actively in treatment. As discharge approached, staff initiated planning for posthospitalization treatment. Within the patient’s community, the ambulatory options available to him were limited to two community-based treatment programs. The only halfway house in the area was full. During his hospitalization the patient participated in AA meetings. He found the meetings useful, but he indicated they did not meet his needs or expectations adequately.

At the time of his discharge, the earliest possible appointment with an ambulatory treatment program was 1 month later. The attending physician discharged the patient, who insisted that he could maintain himself with AA until his appointment. Approximately 2 weeks later he experienced a significant relapse with binge drinking, and his physician rehospitalized him.

Given this patient’s situation, the lack of ready access to outpatient treatment or a stabilizing residential environment was an important factor in his relapse and rehospitalization.

**Case Report 7.7**

A 24-year-old secretary lived with her family in a large urban setting. While in high school she began using drugs, initially trying marijuana and alcohol, but later using cocaine on a regular basis. Her family had only recently become aware of her problem and insisted on her getting treatment. Reluctantly, the patient made arrangements to see a psychiatrist through the managed care group with which she was insured.

After examining the patient, the psychiatrist was concerned not only with her drug use, but also with some long-standing depressive symptoms. Whether these were secondary to her drug use was not clear. The psychiatrist recommended a period of hospitalization to assess the patient under controlled conditions. When the psychiatrist sought approval for hospitalization from the patient’s case manager, the “gatekeeper” indicated that a period of outpatient treatment should be tried before hospitalization would be approved. The patient, who initially had agreed to hospitalization, began outpatient treatment. She saw the psychiatrist for two sessions, continued to use cocaine, left her parents’ home, and broke off treatment.

In this case, the probable “window of opportunity” was lost because of organizational issues impinging upon clinical judgment and the treatment process.

These two vignettes are illustrative of two increasingly important factors affecting substance abuse treatment. The first, a lack of adequate treatment resources, promises to become more prominent in a period of constricting funding. The second, a lack of access to available resources because of organizational constraints, is also assuming greater prominence.

**Conclusion**

Different levels of social organization in treatment are highly relevant to the management of the substance abusers. Lack of attention to the circumstances inherent in such social issues can lead to troubling problems in treatment strategy. Often a lack of resources compounds this problem. The clinician must be aware of clinically relevant social forces on the level of the patient, the dyad of patient and clinician, the immediate social network of the patient, the overall treatment milieu, and the organizational context of treatment. With experience on this issue, and an openness to such observations, more effective treatment can be achieved.

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Self-Help Groups in Recovery

As emphasized in other chapters, clinicians treating substance-related disorders (SRDs) must be familiar with self-help groups. These groups, often derived from religious movements, can provide invaluable support for patients during recovery. Some supportive community organizations have integrated the principles of self-help into their organizations. Many of these groups involve weekly meetings, but some are residential. Among these groups, Alcoholics Anonymous (AA) has had special popularity in the United States and comprises a model self-help group.

Patients successfully recovering from SRD usually affiliate with one or more self-help groups for 5–10 years and in some cases for decades or even the rest of their lives. Research has shown a positive correlation between AA participation and reduction in alcohol use. By the same token, clinicians must not have blind faith in the power of self-help groups to effect a recovery. The clinician who is aware of both the potential strengths as well as the potential liabilities of self-help groups can better guide the patient through the early months and years of recovery.

Affiliation With an Appropriate Group

Self-help groups differ widely from one to another qualitatively, even within a single group such as AA. This variation is to be expected in an organization in which the charisma and personalities of the group lead-
ers and elders often play a critical role. The formal quality control activities that occur among professionals and accredited treatment programs do not occur among self-help groups.

Case Report 8.1

A 38-year-old married, employed woman living in a rural area was required to attend an AA group for 6 months after her second offense for driving while intoxicated (DWI). She expressed the following criticisms regarding her group and her sponsor:

- The members of her group were largely unemployed and unmarried. In contrast, she had worked for the same employer for 21 years and was in a stable relationship.
- Her fellow members had engaged in behaviors that had led to incarcerations for most of them—a homicide, child abuse, spouse abuse, fraudulent bankruptcy, and check passing. They were not people with whom she would have associated voluntarily.
- Her sponsor and the group leader used psychological terms, concepts, and models in a fashion that she felt to be naive or inappropriate (she worked in a psychiatric institution and had professional training).
- She had difficulty accepting the marital advice of her sponsor, who had been married and divorced four times.

After her mandatory attendance in AA, she left the group believing that they were alcoholics but she was not, because she differed from them in so many ways. Subsequently, she resumed drinking, although not as heavily as before and with no DWIs. Eventually, she affiliated with another AA group with age, gender, and demographic characteristics similar to her own. She could see them that, like them, she was an alcoholic.

In this case, the woman did not want to affiliate with a group so unlike herself, and she used the differences to rationalize her belief that she was not alcoholic. In other cases, an individual may seek out a disparate group for secondary gain.

Case Report 8.2

A 38-year-old pilot entered a treatment program after his fellow pilots and his wife confronted him about his episodic excessive drinking. Following treatment, he was referred to an AA group composed of pilots and called “Birds of a Feather.” Instead of following the recommendation, he joined a center city group of largely homeless alcoholic people. Many of his group members continued to drink episodically, and they did not have the lifestyle or resources of the pilot. Moreover, they had little intuition about the state of his recovery. Compared with them, he seemed to be doing extremely well. He became the “star” of his AA group, and the group leader wrote glowing reports to his airline, his monitoring physician, the Federal Aviation Agency, and the Airline Pilots Association. However, he began drinking episodically virtually from the onset of his affiliation with this group. In fact, he even drank heavily after the group meeting once or twice a week. Eventually his drinking progressed to the point where his control wavered and he began to drink more than he had planned. A DWI arrest following one of his weekly AA meetings led to an awareness among all concerned regarding his drinking and his unusual selection of this particular AA group.

Clinicians should assist recovering persons in finding self-help groups appropriate to them, where they can connect with other members. Affiliation with occupational groups (e.g., pilots, parents of small children, teachers, physicians, nurses, attorneys, factory workers, truckers) can be especially valuable.

Addressing Marital Problems

AA and other self-help groups aim to help the alcoholic patient to recover. Likewise, Alanon and other family support groups help the spouse or other family member to attain some acceptance and serenity with the situation he or she faces. However, these groups do not focus on the recovery of the couple or family as a unit. Consequently, each partner may recover within a self-help group while the marriage or family erodes.

Case Report 8.3

A married male accountant experienced growing family, interpersonal, and occupational problems in association with his drinking. Following a brief period of treatment, he was referred to AA and his wife was referred to Alanon. Both were successful in their individual recovery.
programs. He achieved sobriety and, after a few years of stability, obtained an excellent job and began to devote himself to his work. His wife also became more self-reliant, graduating from nursing school and establishing herself in her new career. During this period, however, their marriage deteriorated. The wife initiated divorce proceedings although her husband had been sober for 4 years.

In this family, problems may have ensued even if the treatment facility had continued to have contact with the patient and his family. By the same token, marital counseling or therapy might have given these two people an opportunity to retain their marriage. Clinicians should be aware that there are at times negative outcomes related to family issues.

Psychotropic Medications

Most psychiatrists in the addiction field have numerous stories about patients who were doing well on medications but who were pressured into discontinuing them by their self-help group. Such opposition may have been relevant or may still be relevant for patients who have received benzodiazepine and other addicting medications. However, it is not relevant when nonaddicting medications are prescribed to treat psychiatric disorders. In the case below, the words of an alcoholic patient who began to recover when her depression was recognized and treated provide insight regarding this problem.

Case Report 8.4

A 28-year-old woman, the daughter of an alcoholic professional man, found sobriety and considerable improvement when a psychiatrist treated her depression with medication. She brought this information to her AA group, expecting them to be as enthusiastic as she was. She wrote later, "Were my compassionate comrades in group therapy pleased by my discovery? Absolutely not. They in their AAtindoctrinated absolute certainty, turned up their noses at therapeutic drugs. 'A crutch!' they sniffed. This is patently idiotic. It's rather like calling insulin, dialysis, or eyeglasses a 'crutch' . . . . These people, veterans of decades of ineffectual whining at AA meetings and endless trips to the shrink, were wagging their fingers at me for depending on a therapeutic drug!! . . . After several meetings, where I was roundly nagged and censured by that sympathetic and caring 12-step congri-

gation, I gave up in disgust . . . . I had to lie to the head psychiatrist in charge of my case to gain access to this drug. I had to say that I attended meetings of AA. When I openly refused to do so, I was subjected to punitive urine tests. But it was worth it, because I got well. My depression is in remission and I have returned to my life with few lingering ill effects."

This case is an extreme example of a patient being caught in a double-bind between a clinician and a self-help group. Fortunately, the patient recovered; but unfortunately, she became alienated from self-help groups. Through timely interventions and referral to particular self-help groups, such untoward outcomes can be avoided.

Self-Help Guidelines

The AA slogan "one drink away from a drunk" may instill the problem drinker with a belief in the absolute inevitability of a total loss of control after any amount of alcohol has been consumed. Having this expectancy may lead to relinquishing all self-control and responsibility after any slip, no matter how small or brief. It may also lead to a sense of despair in the recovering person.

Case Report 8.5

A 28-year-old physician had been 18 months in stable recovery when her senior medical partners informed her that they would not be continuing her clinic contract beyond 2 years. That Saturday night she resumed drinking. Sunday, convinced that she could never recover from her alcoholism, she attempted suicide. Fortunately, she survived the attempt and was transferred to an addiction psychiatry unit. With treatment, she was able to reinterpret her "slip" as a serious event and a warning sign but not a harbinger of lifelong alcoholism.

This patient was able to reinterpret her slip as a behavioral overresponse to a professional reversal. In treatment, she was able to look at the positives in her situation, including time to make other work arrangements, the reestablishment of a positive professional image, improvement in her finances, and job offers from several other groups and institutions. Even her slip and nonlethal suicide attempt could be viewed as a "plea for help" in a person whose personal style had been to
cope with her own stresses alone rather than call on others for support. She was able to learn that, when faced with such reversals, she should intensify contact with her self-help support system and alert her physician to her crisis.

Abstinent Time After a Relapse

The emphasis should be on resuming abstinence after a slip or even after a longer-lasting recurrence of substance abuse. "All-or-none" thinking (i.e., "I am either a sober, recovering person or a hopeless drunk") can lead recovering people to not give themselves credit for prior abstinence. The following case report illustrates how the absolutist or polarized thinking may exacerbate and prolong drinking behavior.

Case Report 8.6

A 30-year-old salesman with a history of daily and morning drinking, DWIs, and poor job performance had completed inpatient treatment. Vowing to improve his reputation, he diligently followed up with aftercare and AA meetings, worked especially hard at his job, and remained abstinent over the following year. At his company’s annual employee recognition party, he was surprised to have been voted salesman of the year. Without thinking, he took a small sip of champagne as part of the customary toast.

Having been taught about the inevitability of a full-blown relapse after the first taste and having remembered that he had to start counting his abstinent days all over again, the salesman thought he might as well get the best out of this minor unintentional indiscretion. He proceeded to finish his entire glass along with two bottles on the table.

Although many alcoholic patients lose control after the first drink, it is not true for all individuals. Not all consumption leads to a full-blown relapse. Teaching the expectancy that this will occur allows the individual to abdicate his or her responsibility and self-control and to surrender to the inevitable.

Even though the salesman had a year of sobriety with a minor unintentional slip, he had been taught that regardless of the amount that he had consumed he would again have to start off at square one. If minor and major infractions are penalized equally and the individual receives more immediate pleasure from the major infraction, there is no incentive not to commit the major infraction. Thus, the alcoholic person thinks, “Well, if I am going to drink, I might as well do it up right.”

Slips and Relapses

Often psychiatrists focus only on the difficulties that patients have had in the past without examining those difficulties that may occur unexpectedly in the future. Patients are often referred to AA or Narcotics Anonymous meetings as though they were safe havens and are not made aware that there are potential pitfalls even in this context.

Case Report 8.7

A 60-year-old retired salesman had a 30-year history of alcoholism but always returned to indulgence because of his enjoyment of alcohol and of the camaraderie with his friends on the golf course. After an accidental overdose with a blood alcohol level of over 300 mg/dL, he agreed to enter another program.

The program stressed identifying triggers to relapse and AA attendance. Because a major trigger was the patient’s desire to play golf with his old drinking friends, the strong emphasis was on the need to stay out of this high-risk situation and to find new sober friends through AA.

The patient finally realized the dangers of playing golf with his drinking buddies and faithfully attended AA on a daily basis. He gradually drifted back to seeing his golfing friends but was able to admit to them that he could no longer drink. After the third month of sobriety, the physician received a telephone call from the patient’s distraught wife who stated, “He’s drinking again.” The patient himself stated that he had a few drinks with an old AA friend after one of the meetings. Afterwards he and the friend felt that it was a “stupid thing to do,” and both went home.

At the next office visit, he stated that he had remained abstinent since the slip and talked about it with his sponsor and at his regular AA meeting.

This is an example of the intense examination of one high-risk situation without addressing other opportunities for alcohol consumption. In this case, AA was stressed as the key to sobriety without assessing its dangers.
The Overconfident Clinician

A physician’s self-assuredness may lead to an unwillingness to accept information from other health professionals, counselors, family members, and even the patient. This strategy may stand in the way of providing effective treatment. The following case report is an example.

Case Report 8.8

An AA sponsor contacted a physician who had been prescribing sedative medications for a recovering alcoholic patient. The sponsor stated that the person had begun to abuse these drugs as he had abused alcohol. The physician refused to listen to the sponsor, who had a wealth of information. When the sponsor tried to suggest that another patient’s anxiety attacks might be related to excessive consumption of alcohol, he was met with patronizing tolerance and scorn. The patient in this case was an alcoholic man who convinced three separate physicians to prescribe diazepam, lorazepam, and triazolam, which he washed down with bourbon.

Some physicians may fail to incorporate the evaluations and observations of other professionals and of lay people into their assessments and treatment plans. However, the lack of important information may adversely affect patient care. This problem seems especially apt to occur in cases involving a physician and an AA sponsor or an alcoholism counselor.

In the next case, the psychiatrist limited his awareness regarding important aspects of the patient’s recovery by ignoring her enthusiasm for AA.

Case Report 8.9

An attractive 36-year-old female secretary had a history of episodic excessive drinking accompanied by sexual indiscretion and promiscuity. Having become concerned about waking up with strange men in her apartment, she entered a day treatment program and remained abstinent for 6 months with no recurrence of the previous high-risk sexual behavior.

On follow-up, her psychiatrist questioned her in detail about her previous liaisons but seemed disinterested when she volunteered how much she had been helped by her woman’s AA support group.

Psychiatrists may fail to make full therapeutic use of the patient’s compliance or noncompliance vis-à-vis attending support groups. In this case, the psychiatrist made no attempt to understand the therapeutic impact of the group and thus missed an opportunity to learn about the factors that influenced his patient’s thoughts and feelings with regard to the group. If the patient does attend support groups, he or she should be asked to discuss feelings about the meetings. Are the meetings useful? How are they helpful in maintaining abstinence? If the patient does not attend support groups, the reasons for this nonattendance should be explored.

Limitations of Self-Help Groups

Mental health providers at a neighborhood health center were concerned by the inability of chemical dependency self-help groups to serve their patients with psychosocial, socioeconomic, and psychiatric problems. Clearly more than support groups was needed; yet these same groups advocated that chemical dependency alone was responsible for all suffering and that only abstinence, attendance at meetings, and obedience to the creed were required for relief. The following case reports illustrate the concerns of these mental health workers.

Case Report 8.10

A 25-year-old single African-American woman with three children had bipolar affective disorder and cocaine dependence; she had no means of support, no insurance, no family support, and no friends and was very suspicious about the intentions of others. She refused to attend self-help groups because of their inability to deal with the “real” world (e.g., homelessness, hunger, no hope).

Case Report 8.11

A 26-year-old single Caucasian woman had major depression, borderline personality, and alcohol, cocaine, and marijuana dependence. She
had been in treatment 13 times and had attempted suicide 7 times. Her mother had supplied her with marijuana when she was 6 years old, and she had a child who may have had fetal alcohol syndrome. The client had been involved with a self-support group for 6 years; however, she could not carry out the directives, and the sponsors were unable to deal with her multiple problems.

Case Report 8.12

A 55-year-old Caucasian man had major depression, alcohol and cocaine dependence, and scores of casual sexual relationships with women, including having spent large sums of money on prostitutes. He had been in treatment three times and had a history of violence with women. He abused substances sporadically and believed that he was different from the other drug users in recovery, who told him to throw away his antidepressants.

The mental health workers for these patients pointed out that many of the lay members and sponsors in self-help groups had neither the training nor the expertise to handle these complex cases appropriately. It is clear that support groups must either acknowledge their limitations or improve their ability to deal with comorbidity and its myriad of psychosocial and socioeconomic complications.

A useful strategy to address comorbidity might be the formation of alliances between chemical dependency and mental health support groups to establish certain meetings that address both issues. AA already has open meetings, closed meetings, and gender-specific meetings. A logical addition would be “comorbid” meetings aimed specifically at individuals with other psychiatric disorders. In one city, the Depressive and Manic-Depressive Association and AA sponsor a weekly meeting for individuals who have chemical dependency with or without affective disorder. This group is accepting of those taking psychotropic medication and having a history of manic or suicidal behavior, and it is extremely valuable in reinforcing both abstinence and psychiatric compliance.

Conclusion

Self-help groups are an invaluable aid to recovery from addiction. Moreover, these groups can greatly facilitate the clinician’s efforts in treatment of SRD. By the same token, clinicians should be knowledgeable regarding the limitations of self-help groups, the special problems to which they can give rise, and the various strategies for preventing such problems or dealing with them once they are identified.

References

The Training Experience

Research suggests that substance abuse problems occur in 15% of medical outpatients, 20%–30% of medical inpatients, and 40%–60% of hospitalized trauma patients. Other research indicates that alcohol is involved as a causal or associated factor in 20%–50% of general hospital patients in the United States with only 5% of these patients being diagnosed as alcoholic.\(^1\) Given such data, the need for training in the area of substance abuse becomes apparent.\(^2,3\)

Health care professionals need training in the identification of patients with substance abuse. Equally important is the acquisition of skills for interacting helpfully with this population and the opportunity to become aware of our own attitudes concerning those who abuse.\(^4-6\) Research addressing physicians’ attitudes toward substance abuse has revealed that “the further along in residency training physicians progress, the poorer their attitudes become regarding alcohol and drug abuse.”\(^7\) Attitudes toward the addicted patient, whose disorders often complicate and frustrate clinical efforts, deteriorate when trainees receive limited training in identifying and treating the addictions.\(^8,9\) Direct experience has more impact upon attitudes than do didactic activities.\(^10,11\) Thus, appropriate supervision in the clinical training context is key to developing attitudes as well as skills that are therapeutic.

The clinical vignettes reported here occurred within the context of the training experience. Their themes reflect similar problems outside of the educational setting but with the additional complexity of students, residents, and other trainees. They serve to focus our attention upon is-
sues that are important for the development of adequate knowledge and appropriate attitudes regarding substance abuse. In several places, we pose questions for the clinician-supervisor, clinician-teacher, and clinician-educator to consider in conceptualizing the learning-teaching task.

**Fostering Patient Orientation**

Health care trainees encounter patients in specific departments, wards, or clinics, and they often have a particular specialty or even subspecialty focus in the clinical setting. Thus, the training situation may program them to think of the clinical problem within narrow confines. Instead of being broadly patient oriented, they may become narrowly disease oriented.

**Case Report 9.1**

A first-year psychiatry resident was on night duty in the emergency room. Along with the many other patients the physician was asked to examine, a man in his early 40s was sent for evaluation from the local detoxification center. He was obviously intoxicated, and the physician was informed by staff from the detox center that he was well known there and had a long history of alcohol dependence. Their concern was that he did not seem to be "himself." It was a very busy night, and the resident had seen other patients in the past who were belligerent and smelled heavily of alcohol. Unless there was some history of delirium tremens or withdrawal seizures, physicians sent most of these patients to a detoxification unit to "sleep it off." The physician obtained what history he could, examined the previous medical records, did a brief physical examination and decided that there was nothing to warrant admission to the hospital. Consequently, the patient was sent back to the detoxification center.

Later that evening, the same patient again showed up in the emergency room accompanied by a staff member from the detoxification center, who stated that the patient’s “rambling speech and confused state are not typical.” The resident was tired and had other pressing concerns on his mind. Again the patient was examined, but the physician found nothing different from the previous examination. The patient was still intoxicated, so the physician sent him back once again, hoping to have seen his last “drunk patient” for the night.

**The Training Experience**

The staff members of the detox center were persistent, however, and 2 hours later the same patient was again back at the hospital. By this time it was apparent that he was delirious and that his ataxia, dysarthria, and confusion were not typical of alcohol intoxication. A computed tomography examination of the head revealed subdural hematomata. The man was sent immediately to surgery and fortunately made an uneventful recovery.

A number of issues are revealed in this case. The first and most obvious is the need for a thorough physical examination, including a more complete neurological assessment. There should always be a high degree of suspicion of trauma and associated medical complications when intoxicated patients are brought to an emergency room. Assuming that an alcohol-dependent individual is only intoxicated can lead to misdiagnosis and mismanagement. Physical trauma and serious medical complications may not be apparent on cursory medical examination. The obtunded patient may not report symptoms of such catastrophic problems. Addicted patients may not perceive accidents as significant or even remember that they occurred. The patient also may wish not to disclose relevant information, such as a fight.

Also missing was the effective use of collateral information. This patient was well known to staff members of the detoxification center, and they described him as “not himself.” Although they were persistent in offering this information, the resident physician appeared to have already come to a diagnostic conclusion, so he did not pursue collateral information further. Those staff on call at night and over the weekend are under a great deal of pressure to make diagnoses, prescribe treatment, and move on to others who need their attention. Such pressures can make it expedient to discount comments from others who are not medically trained. Circumstances forcing brief evaluations and rapid decisions are especially apt to occur when dealing with the intoxicated patient, whom many staff find distressing, unpredictable, and possibly dangerous.

The failures in this case may seem purely medical and obvious, but the most important point has to do with negative attitudes. Staff may communicate their attitude that the patient is just another “drunk” taking up valuable emergency room time. Perhaps an alcoholic relative or friend has frustrated and disgusted the clinician. Perhaps the clinician uses alcohol excessively and is unable to deal objectively with situations that might challenge this usage. Negative attitudes can lead to treatment
mistakes. We do not know if the resident in this instance had similar countertransference difficulties. Though slow to act, he did eventually provide appropriate diagnostic intervention, and he did ultimately save this patient’s life.

Appropriate supervision for a case like this should start before a clinician assumes clinical responsibility. With exposure during training to supervisors experienced in working with addicted individuals, trainees learn not only from their knowledge of such patients but also from the attitudes that they project. Intoxicated patients present a tremendous challenge to the trainee who is inexperienced in recognizing and in managing the impact of negative countertransference.

Establishing a Standard of Care

Clinical preceptors teach trainees an acceptable standard of care—something that they cannot learn from journals and textbooks.

**Case Report 9.2**

A fourth-year medical student doing a rotation in emergency medicine was on duty one night in a large county hospital emergency room (ER) and was given the responsibility of monitoring the condition of a homeless person who arrived at the ER with a blood alcohol level of 0.50 mg/mL—a potentially fatal level. The patient was asleep, and the resident asked the student to make sure the patient “keeps breathing.” After some time the patient woke up, and the resident told the student to recheck the patient’s blood alcohol level. The lab report indicated that it had dropped to 0.40 mg/mL—still a markedly elevated level. When the resident in charge received this information, she discharged the patient back to the street. When the student questioned the resident’s decision, she told the student that this was necessary so that the patient could resume drinking and thus prevent development of delirium tremens.

The medical student, now a practicing psychiatrist, who told the above story recalls being appalled by what seemed to be a lack of staff interest in dangerous alcohol abuse. (In fact, it motivated his interest in addiction psychiatry.) This kind of story occurs in busy emergency departments, however, and students who are faced with the pressure of

an emergency room environment often learn to do what seems to be acceptably expedient. Unfortunately, this can develop into an unacceptable standard of care for some trainees.

**Considering Comorbid Psychiatric Disorders**

Many, perhaps as many as half, of patients presenting to medical settings with a substance-related disorder (SRD) also have a comorbid psychiatric condition that requires attention. If half of these patients had tuberculosis or AIDS, we would screen them carefully for these disorders. However, it is commonplace to ignore the possibility of a comorbid psychiatric disorder. One might even say that it is “the standard of practice” in many clinical settings at present.

**Case Report 9.3**

Staff on an inpatient substance abuse treatment unit asked a first-year resident to evaluate a 62-year-old retired man. The addiction counselors had noted that the patient could not stay awake during group sessions and seemed more withdrawn on the ward.

The patient had spent most of his life working the oil rigs off the coast of Alaska, drank abusively much of this time, and was known to be the life of most parties. Ill health and muscle weakness had recently forced him to leave the oil rigs, and he had returned to his hometown area. He now lived by himself in a small rural community in the Midwest. He continued to drink daily and had been in and out of substance-abuse treatment programs but never managed to stay sober for a significant period of time.

The patient was friendly and cooperative, and he denied feeling depressed or experiencing problems with sleep or appetite. He did not affirm the presence of any of the key criteria for a major mood disorder, did not demonstrate thought disorder, and did not manifest either psychomotor retardation or agitation. However, he had trouble explaining how he did feel and answered many inquiries with “I don’t know.” The resident concluded at this point that he could diagnose only the obvious alcohol addiction.

The patient completed the inpatient treatment course without further incident, although he complied with the requests of the program without much energy or seeming investment. It was not clear that he really understood the intent of the group sessions or the didactic mate-
A number of unfortunate events occurred during the initial treatment of this patient. Although the addiction treatment staff suspected the presence of comorbid psychiatric illness, the patient denied depressive symptoms and was vague about his feelings. Nonetheless, it is important to recognize the extremely high comorbidity between substance-use disorders and other psychiatric disorders. In the recently completed National Comorbidity Survey, 48% of respondents reported at least one lifetime psychiatric disorder, with more than 17% reporting a history of a major depressive episode and more than 14% reporting a history of alcohol dependence. Of particular significance, 79% of the lifetime psychiatric disorders in this study were comorbid disorders. It has been estimated that between one-quarter and two-thirds of alcoholic patients have at some time had depressive symptoms severe enough to interfere with functioning. Comorbidity of substance abuse and other Axis I psychiatric disorders is extremely common. Armed with this knowledge, a clinician should be suspicious of a coexisting affective or other psychiatric disorder.

Conversation with this patient revealed that he could not describe his feelings in words—an especially common problem in addicted patients. His description of himself regardless of the situation did not seem to change and was devoid of much information. The clinician accepted his assertions and denials at face value. The almost routine use of denial as a defense among addicted individuals also makes it easy for the developing clinician to collude with the patient in ignoring symptoms of psychopathology.

**Adequate supervision may have been lacking in this case. When inexperienced clinicians conduct initial interviews with addicted patients, they need close participation by attending supervisors. Supervisors should examine the trainee’s perceptions and misperceptions regarding psychoactive substance abusers. Trainees are vulnerable to the projections of their patients and susceptible to overidentification as well as to inadequate empathy.**

**Acquiring Comfort With Unfamiliar Patients**

In caring for patients with SRD, trainees inevitably encounter patients whose race, ethnicity, family background, lifestyle, and economic pursuits are not familiar. Such lack of familiarity may, through curiosity, lead the trainee to greater efforts aimed at understanding the patient. Conversely, the trainee may back-pedal away from the patient or make erroneous assumptions based on stereotypes.

**Case Report 9.4**

Emergency room staff at a large metropolitan hospital called a junior resident in psychiatry to the emergency room to assist with the evaluation of a 28-year-old man of an ethnic group different from his own, whom police had brought into the hospital. The patient had reportedly been making homicidal threats and expressing suicidal ideation. In addition to a history of alcohol dependence and crack cocaine abuse, he has been depressed for the last 2 weeks. On interview, he appeared anxious. He had 12 years of formal education and a positive job history before his present homelessness and alcohol and crack dependence. Before completing a psychiatric evaluation, the resident suggested to the patient that he needed only alcohol and drug rehabilitation. There was little attempt to establish a dialogue with the patient or to come to some agreement about therapeutic goals.

The resident came to a premature conclusion regarding treatment needs—a possible outcome when a trainee’s inexperience produces personal discomfort. Of course, premature closure, overly rapid decisions or dispositions, and the trainee’s discomfort should be “grist for the mill” in supervision, enabling the supervisor to help the trainee to understand the patient better. From the trainee’s perspective, curiosity
about one’s reactions to such patients can provide helpful information about the patient as well.

Immediate supervision in this case helped the resident recognize that this patient’s history was consistent with panic disorder. This resident also failed to address the possibility of depression and utilization of alcohol and crack as means of self-medication. The supervisor in this case helped the resident to understand his countertransference feelings with this patient and to perceive his prematurely “closing out” this patient from an accurate diagnostic assessment and more effective treatment. With supervision, the resident began to realize that his lack of familiarity with this patient’s ethnic group and the nature of his problem (i.e., drug and alcohol dependence) prevented him from considering relevant diagnostic and treatment issues. Countertransference can be a strong force. In this case, a joint interview of the patient with the resident and supervisor led to an appropriate evaluation and the development of a successful treatment plan.

Providing Adequate Staff Support

At times, hospitals and clinics place clinical trainees in the untenable position of providing care for the most challenging and complex patients but with little staff support. In the following case, a potentially supportive clinician did exist. However, the latter clinician worked in a remote outpatient setting where support was not readily available. Support by the outpatient clinician might have made a difference for this patient as well as for the training experience of the resident.

Case Report 9.5

Outpatient staff admitted a 43-year-old single male patient, who was complaining of bilateral upper extremity numbness and episodic dysarthria, to the service of a second-year resident in psychiatry assigned to a Veterans Administration inpatient ward. These symptoms developed after a court appearance in which evaluation for alcohol treatment was ordered. This patient’s extensive inpatient records indicated that he had a past psychiatric diagnosis of bipolar disorder not otherwise specified (NOS), episodes of major depression, severe alcohol dependence, polysubstance abuse, somatoform pain disorder, and personality disorder NOS with avoidant, dependent, and borderline traits. He was known to have chronic suicidal ideation and had been admitted to the hospital several times in the past after suicidal gestures or attempts, typically in situations of acute stress and while intoxicated. He had consistently resisted entering treatment for his alcoholism.

A neurological consultation subsequently ruled out the presence of any contributing neurologic or medical illness. The provisional diagnosis at this point was conversion disorder (versus possible malingering), and the resident discharged the patient on the fourth day of admission.

Outpatient staff again admitted the same patient 2 days later; this time he appeared psychomotor retarded and disoriented to time, and he demonstrated a shuffling gait. He denied having taken excessive amounts of alcohol, prescription medications, or illicit drugs. A urine drug screen was negative except for benzodiazepines (he had been given Valium 5 mg im shortly after admission). A computerized tomographic scan of the head and an electroencephalogram revealed no abnormalities. By the next morning his confusional symptoms had cleared.

The resident decided at this point that malingering was the most probable diagnosis and began to doubt that this patient had a bipolar disorder. Accordingly, she discontinued his carbamazepine, lithium, and sertraline. After the resident refused to give the patient benzodiazepine for sleep problems, the patient requested that he be given a different doctor, stating that he believed that the resident did not understand his illness.

The attending physician requested consultation from the Substance Abuse Treatment Program, and inpatient treatment was recommended. Upon being requested to attend group lectures on substance abuse, the patient reported recurrence of disorientation and hallucinatory experience and refused to continue in the treatment program. The resident was extremely frustrated with the patient’s refusal to accept help. She placed him on 72-hour hold for the purpose of involuntary commitment to addiction treatment. The county court, however, denied the commitment request, and the resident discharged the patient the following day, telling the patient that future access to either outpatient or inpatient psychiatric care at this facility would be contingent upon his participation in outpatient substance abuse treatment. Further, she informed him that if he should present for emergency care, he would be referred to another facility or committed for involuntary substance abuse treatment, depending upon the circumstances of his presentation. She confirmed the plan in a chart note.

At 1 month after discharge, relatives found the patient dead in his home. One of the patient’s friends stated that the patient had begun to
drink heavily two days prior to his death. His parents reported that he had been distressed by his apparent loss of access to his customary psychiatric care and was having severe mood swings. He had a long-standing relationship with his outpatient therapist and had often used outpatient contacts for effective crisis management support.

Review of the patient with his outpatient therapist revealed that he did episodically drink alcohol to excess and did meet criteria for alcohol dependence and that he also had a clearly diagnosable mood disorder and borderline personality traits. His therapist also stated that he was vulnerable to exaggerated feelings of abandonment.

All trainees encounter patients who frustrate their best therapeutic intentions and who test their ability to form a therapeutic alliance. It is particularly important at such times that they receive supervision, not only to appreciate better the pathology of such a patient but also to help in understanding their own feelings and responses. Adequate supervision was lacking in this case. As the resident became more and more involved with the patient, she was unable to appreciate that an adversarial relationship was developing. The resident needed supervision to understand the harmfulness of her frustration at having to work with a patient whose care she found quite upsetting. Work with this patient was an excellent opportunity for her to learn the value of diffusing negative emotions in the care of such patients. In the process of the power struggle which ensued, the resident began to focus narrowly on the addiction diagnosis. In retrospect, it appears likely that the denial of outpatient treatment, denial of readmission, rejection of the bipolar disorder diagnosis, and discontinuation of lithium and carbamazepine exacerbated this patient's fear of abandonment. To assume that alcohol addiction was the only important component of the patient's pathology and to insist on treatment that emphasized only alcoholism stripped the patient of components of his previous treatment plan that had held meaning for him and had proven therapeutically beneficial.

Consultation with the patient's outpatient therapist would have provided a clearer perspective on the diagnostic complexity of this patient and on the treatment measures that had proven effective. The resident's failure to pursue such consultation was again likely a product of frustration and countertransference. In addition, the lack of integral coordination between inpatient and outpatient services fostered a "mutual noncommunication pact." Although the resident had tried her best, it seemed to her that the patient, and even the judicial system, had sabotaged all her efforts.

The effect of this tragic outcome on the trainee is also important. This experience would probably have a lifelong effect on the resident's future clinical interactions with addicted patients. Although it was the faculty's responsibility to alleviate the failure experienced by the resident, faculty are often not closely involved in such cases, which tend to present in the evenings and on weekends. Trainees need help in processing and coping with such experiences, which—despite their tragic and indelible effects on the trainee—can become opportunities for learning more about patients and themselves.

In order to provide such remedial educational experiences, the clinical and training system must provide more readily accessible supervision. In too many training situations, residents are left to cope with the most overwhelming problems during evenings and weekends without the presence of adequate supervising staff. Adequate after-hours support requires collaboration with a multidisciplinary team, adequate security, access to holding beds in which patients can recover from their intoxication, and ready consultation with or supervision by a psychiatrist trained in psychiatric emergencies, including the acute care of addictions.

Conclusion

To practice effectively and comfortably in today's clinical settings, trainees should learn to understand the complexity of patients who present with prominent psychoactive substance abuse, along with learning the medical responsibilities inherent in treating such patients. This particular aspect of clinical training is especially challenging, because trainees bring to the task personal and cultural biases that can facilitate rejection of these patients. Appropriate supervision must be provided, supervision that confronts trainees with the harmful effects of their negative countertransference and points out to trainees the helpful insights that awareness of countertransference can provide. Such supervision will help trainees learn the difference between empathy and overidentification and between clinically appropriate objectivity and avoidance of the patient. Although trainees need to struggle with diagnostic issues and prejudices and to make benign mistakes, they need to work in the presence of a supervisory safety net that corrects treatment errors and ensures acquisition of desired treatment skills.
Common Myths and Misconceptions in the Treatment of Addicted Women

In most times and places, addicted men have outnumbered addicted women, and the social problems associated with men’s addiction have often been more public or socially visible than those problems associated with women’s addiction. As treatment programs have evolved to meet the problem of addiction, they have largely focused on men’s problems. The classical studies in the field have predominantly involved male populations. In this chapter, we list many of the mistaken notions about addicted women and describe means for helping such women.

Addiction Is a Man’s Problem

Most research on the addictions, treatment models, and actual clinical care has focused on addicted men. This has reduced the sensitivity of many clinicians to the possibility of addiction in women, especially if they are middle class, employed, married, or professional women. Clinicians must inquire routinely about substance use in their female patients and be sensitive to the possibility of addiction among women.
Case Report 10.1

A 38-year-old attorney consulted her primary care physician with a chief complaint of insomnia and "stress." Recently, she had been made a partner in a law firm and was putting in long work hours. She had been married about 2 years earlier and was having difficulty deciding whether to try to have children. Her husband was not in favor of attempting to conceive, and this was the source of further stress for the patient. In taking a history, the physician did not ask about drinking. On a history form completed in the waiting room, she filled in the word "socially" in a blank next to the words "Do you drink alcoholic beverages?" The physician missed the diagnosis of alcoholism and prescribed a minor tranquilizer and a hypnotic. The patient's alcoholism progressed without treatment and was complicated by dependence on benzodiazepines.

Research shows that the less a patient resembles the stereotype of an "alcoholic" (usually a male, middle-aged derelict), the more likely it is that his, or even more often her, alcoholism will not be diagnosed. Women develop alcoholism with a somewhat later onset than men, but once the disease begins, it progresses more rapidly. Unfortunately, diagnosis is often delayed until a later stage of the disease, when the diagnosis becomes obvious, but physical, psychological, and social damage have already progressed.

As stated in previous chapters, laboratory testing complements history, physical examination, and screening tests. Among alcoholic women, as among alcoholic men, either elevated serum γ-glutamyltransferase or elevated mean corpuscular volume of red blood cells correctly identifies about two-thirds of early cases. These tests are also of value in pregnant patients. However, the most important factor in successful early recognition is attitudinal on the part of the clinician. An understanding of the frequency of addictive illnesses across all social classes and in both sexes creates a high index of suspicion. An acceptance of these disorders as treatable diseases creates a positive, hopeful frame of mind.

Epidemiological studies of alcoholism, using a variety of definitions, reveal that about 5% of adult women in the United States may satisfy a diagnosis of alcohol abuse or dependence during the preceding 12 months. In 1993, approximately 4% of women in the United States admitted to some illicit drug use (including nonmedical use of prescription drugs) during the month prior to a household survey. Women of childbearing age reported a higher prevalence: 8% for ages 18–25 and 6% for ages 26–34.

Data from the Epidemiological Catchment Area study reveal a lifetime prevalence of drug abuse/dependence (other than alcohol) of 4.8% for adult American women. For those aged 18–29, the rate is 10.9%. An estimate of the 12-month prevalence for women based on the same data set was 1.4% for adult American women.

Studies of women in health care settings have shown uniformly higher rates of alcohol problems and other drug use than among the general public (see Table 10-1).

Case Report 10.2

A 31-year-old woman who had been sexually abused as a child reported the following: "I began drinking alcohol as early as age 6, and the addiction had set in at age 13, quite distinctly. At 17, I tried to commit suicide by overdosing on drugs. After the coroner's care unit and the psychiatric hospital, I was committed to drug rehab, otherwise known as hell. A complete physical exam was mandatory, and even though a nurse was present, the doctor made a couple of lewd remarks during my pelvic exam. I was put in pajamas for the first 4 days, as all new patients were. I was also on the juvenile wing, which is coed. Appearing in this garb in front of boys my own age was awful! Worse yet,

<table>
<thead>
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<th>Authors and year</th>
<th>Sample</th>
<th>Diagnosis</th>
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<td>Halliday 198612</td>
<td>Gynecology patients</td>
<td>Alcoholism</td>
<td>12%</td>
</tr>
<tr>
<td>Halliday 198612</td>
<td>Premenstrual symptoms</td>
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<td>21%</td>
</tr>
<tr>
<td>Moore 19891</td>
<td>Obstetric (556) and gynecologic (241) patients</td>
<td>Alcoholism</td>
<td>12.5%</td>
</tr>
<tr>
<td>Cyr and Wartman 198813</td>
<td>Primary care, first visit</td>
<td>Alcoholism</td>
<td>17%</td>
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<td>Medical outpatients</td>
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<td>11%</td>
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<tr>
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<td>14%</td>
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<tr>
<td>Chasnoff et al. 199016</td>
<td>Private obstetric patients</td>
<td>Drug abuse</td>
<td>13%</td>
</tr>
<tr>
<td>Chasnoff et al. 199016</td>
<td>Public obstetric patients</td>
<td>Drug abuse</td>
<td>16%</td>
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this is what I was required to wear to the mandatory unit AA meeting, which mostly consisted of older males. It was terribly humiliating. At one point the counselors said I was grieving alcohol, so I was sent to 'Grief Group.' I ended up being the only minor, and the only female in the room. I was terrified. The men were grieving ex-wives, mothers, girlfriends, etc. Each time one of them read a letter they had written to their significant other, I was asked to respond as to how I would feel if I was his wife, girlfriend, mother, etc. I did not profit from my stay at this facility.7

Because addictive disorders are more prevalent in males, much of the currently available treatment has been based on models of intervention originally designed for men. Furthermore, most of the research upon which our knowledge of these diseases is based has been performed with predominantly or exclusively male populations. For example, both Jellinek’s7 classic study of the clinical characteristics and progression of male alcoholism and Vaillant’s10,11 intensive longitudinal investigation of the course of alcohol problems over 50 years have had a central role in the formation of our conception of alcoholism. Both included only men.

Facilities display male orientation in subtle ways. Treatment methods based on vigorous confrontation may be counterproductive for women suffering from depression with feelings of worthlessness. Shame and depression are more prevalent in addicted women than in men.20 In addition, placing a woman in a residential unit or therapy group composed mainly of males will make it very difficult for her to share personal information. This becomes almost impossible if she is the only female in the group. Other residential programs may promulgate sex-related societal stereotypes by assigning chores on a gender basis. Cooking and cleaning functions are assigned to women, and men do maintenance and managerial jobs.

One response to this male-orientation problem has been to develop female-only programs and treatment methods.21-25 An alternative approach is to increase the sensitivity of all treatment personnel to the special needs and problems of women and adolescent girls. In one woman’s case, a difficult experience in attaining recovery in Alcoholics Anonymous (AA) led her to form an all-women self-help movement, Women for Sobriety.24 Although early in its history the founders of AA debated the wisdom of admitting females,25 AA’s membership is currently about 35% female, and all-female groups are available in many areas.26

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Special Issues in Caring for Addicted Women

Case Report 10.3

A 47-year-old woman was treated in a residential rehabilitation program for alcohol and sedative dependence after detoxification in a general hospital. On initial evaluation she complained of poor appetite and sleep problems, feelings of hopelessness and helplessness, decreased energy level, anhedonia, and persistent thoughts of death. Her mood was depressed, and she denied suicidal ideas. The evaluating physician attributed her depression to her alcohol/sedative dependence and reassured her that her mood would improve. Several weeks later she was referred for the treatment of depression, showing little improvement in her mental status since admission. A more complete history was taken during the second evaluation, and it was discovered that she had a previous, untreated bout of severe depression in her early 20s before her alcohol dependence developed. Her diagnosis was changed to major depression, recurrent, and she was treated with an antidepressant drug. Significant progress in her addiction treatment did not occur until her depression began to improve, and the patient felt that she had lost weeks of treatment time because of the delay in treating her depression.

Much recent attention has been devoted to the phenomenon of psychiatric comorbidity (dual diagnosis) in addicted patients. In general, women have shown higher rates of psychiatric comorbidity than men. This result has been found in general population groups,27 a group of research volunteers,29 and clinical populations.28 Rates differ based on sex, particularly in the prevalence of major depression and among individuals with alcoholism.

Based on Vaillant’s study of alcoholic men10,11 and other male populations, it is often believed that the alcoholism is almost always primary (that is, it precedes the depression) and that the depression seen in this population is secondary. This assumption underlies the common advice that a definitive psychiatric diagnosis not be made until the patient has been “clean and sober” for anywhere from 3-6 weeks to several months. In dealing with women, this is not very good advice. When the three populations of alcoholic individuals with comorbid major depression mentioned above26-28 were examined from the point of view of primary versus secondary diagnosis, important sex differences were found. Among patients with a lifetime diagnosis of both alcohol abuse and/or
dependence and major depression, men were more likely to have primary alcoholism, whereas women were more likely to have primary depression. For the general public, major depression was primary in 66% of the women, but in only 22% of the men. For the research volunteers, the major depression was primary in 60% of the women, but in only 38% of the men. In the clinical population 65% of the women and only 41% of the men reported their episodes of major depression to precede their symptoms of alcohol abuse/dependence. The same phenomenon of major depression preceding alcoholism in females has been reported in adolescent patients who, by definition, have an early onset of both alcoholism and major depression.30

These data make the taking of a detailed history, with emphasis on the timing of the onset of comorbid psychiatric disorders, a particularly important part of assessment. In those whose depressive disorder preceded the addictive disorder, the likelihood of the existence of two independent disorders is much greater than in patients with primary addiction. In such patients there is little reason to delay diagnosis and treatment if the severity of symptoms justifies such treatment. In fact, postponing the use of psychoactive medication for depression until a patient has been clean and sober for several weeks may lead to the notion in which the patient is unable to achieve initial abstinence because of her depressed mood. In the case described above, the patient was in a protected setting. In an outpatient setting, she may well have dropped out of treatment or experienced a series of relapses.

Clinicians should be aware that, although there are many similarities among the clinical manifestations of addictive disorders in men and women, there are also many significant differences, including these:

- Women experience a later onset of alcoholism.
- Women have a more rapid development of both the symptoms of alcoholism and the symptoms of its physical complications.31-34 It is not clear whether this same compressed course, sometimes referred to as "telescoping," also occurs in other addictions.35
- Female alcoholic patients and cocaine addicts are more likely than males to date the onset of their addiction to a particular event or situation.32,35
- Women in treatment are more likely to be living with an alcoholic or addicted significant other.35,36
- Alcoholic females are more likely than males to present themselves for treatment with a comorbid dependence on another drug, particularly prescribed drugs of dependence such as benzodiazepines and other depressants. These are often prescribed for symptomatic relief by physicians who are either unaware of the patient's alcoholism or of the dependence-producing properties of these medications in alcoholic patients.
- Women are more likely to have a history of physical and/or sexual abuse, both in childhood and adulthood. In a general population study, Winfield37 found that a history of sexual assault in women increased the risk for a lifetime diagnosis of alcohol abuse/dependence by a factor of 3.5 and for other drug abuse/dependence by a factor of 4.

Case Report 10.4

A woman presented to a psychiatrist at age 24 years on the recommendation of her sister. She had recently related to her sister that her father and two uncles had repeatedly abused her sexually over a period of several years. Her psychiatrist treated her reports of incest as fantasies. She subsequently discontinued therapy and, over a period of years, began to drink excessively, in her words "to blot out her incest memories" and to deal with certain problematic aspects of her life (especially relationships with men and authority figures). Years later, in detoxification for her alcoholism, she revealed her incest history to a nurse. The nurse reinforced the importance of receiving support from other incest victims. She recommended various means for achieving her sobriety and eventually coping with her incest history and its sequelae. After achieving 2 years of sobriety, the patient began psychotherapy to deal with her incest experience and its effects on her personality, her relationships, and her life.

In this case, the nurse's sensitivity to the patient's abuse history greatly facilitated the patient's recovery.

Case Report 10.5

A 23-year-old woman had a history of being abused by her stepfather and an uncle. The abuse appears to have consisted primarily of some fondling and being paraded around naked. She began abusing alcohol as a young teenager and moved on to cannabis and cocaine. She eventually found herself in a treatment program that included monitored
urine testing. Her prior voyeuristic sexual abuse prevented her from being able to provide urine specimens while being monitored.

When a female patient has a particular problem with some aspect of physical contact, body image, or sexual functioning, a history of abuse should be considered. Because many women have problems in revealing this aspect of their past experience, it is important to continue a sensitive exploration of the subject after the initial assessment period. A check-off question on an initial history questionnaire or a routine interview may not reveal the abuse history of the patient. Once the patient's abuse history is known and the connection is made between past events and present problems, as in the case above, special privacy arrangements or temperature-sensitive urine containers may make urine testing possible. This procedure will help prevent driving the patient away from treatment.

Additional important issues in treating female addicts include the effects of societal sexism, including underemployment, the lack of societal value accorded to "women's work" such as housekeeping and child care, limited opportunity for employment and advancement, and the expectation that women will be caretakers who prioritize their own needs as secondary to the needs of others. Because many women today are single parents, the need for reliable child care is often an important prerequisite for the patient's ability to take part in treatment. Residential facilities that accommodate both mothers and their children and outpatient programs that provide child care are rare, in spite of this documented need.

Pregnancy and Treatment for Addiction

Alarming, pregnant women with addiction have had more difficulties getting into treatment for their addiction. This has occurred despite the fact that many addicted women are likely to enter treatment when they are pregnant.

Case Report 10.6

A 29-year-old pregnant woman tried to discontinue her use of cocaine as soon as she found out that she was pregnant, but was unable to "stay stopped." She called a free help line to ask for a referral and was given several telephone numbers of programs that treat cocaine dependence. When she stated that she was pregnant and on Medicaid, she was told by each of the programs that they could not accept her. She continued to try to remain cocaine-free on her own but relapsed frequently and gave birth prematurely to an infant who suffered neurological damage during the perinatal period.

Facilities prepared to treat pregnant women who are dependent on alcohol or other drugs are difficult to find in many areas. Fear of malpractice suits if the infant is born with birth defects is often cited as a reason to avoid these patients. However, as of this writing, we know of no evidence that professionals treating pregnant addicted patients are at risk for such suits. Another reason given for not treating pregnant addicted patients is a lack of knowledge and experience. The Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services has published a practical guide for such treatment.38

An Alcoholic Is Someone Who Drinks a Quart of Liquor a Day

Case Report 10.7

A 25-year-old woman was evaluated for an anxiety syndrome characterized by trait anxiety and occasional panic attacks. She stated she drank several times a week, up to a maximum of five drinks a day, and very seldom drank more than that. The therapist assumed that she could rule out alcoholism.

Women drink less than men. This is true in the general population as well as among alcoholic individuals.39 This difference relates to the fact that women are more sensitive to alcohol than men are (i.e., they reach higher levels of blood alcohol, given equal amounts of alcohol to drink). There are several reasons for this observation. First of all, women weigh less than men. Because the alcohol that is absorbed into the bloodstream is distributed in total body water, it will be less diluted in a lighter subject. Second, women have less body water per pound of body weight. This creates an even smaller relative amount of body water in
which to distribute the dose of ethanol. Finally, men have more of the enzyme alcohol dehydrogenase in the lining of their stomachs. This enzyme metabolizes alcohol to acetaldehyde. Alcohol metabolized in this way is not absorbed into the hepatic portal system and therefore never reaches the bloodstream. This so-called first-pass metabolism, less evident in normal women than men, was found to be entirely absent in the alcoholic women studied. As a correlate of this increased sensitivity to alcohol, it has been observed that women with alcoholism develop comparable levels of symptoms and physical complications of their disease at lower levels of alcohol intake over fewer years of drinking compared with men.

York and Welte compared the alcohol intake of adult men and women, including 273 alcoholic individuals and 13 nonalcoholic social drinkers in the sample. Men reported significantly more drinks per drinking day but, when corrected for body water content, estimates of grams of ethanol per kilogram of body water per drinking session were almost identical, so that it is likely that average blood alcohol levels attained by male and female drinkers are quite similar.

Another reason for lower alcohol intake in alcoholic women is the high frequency of comorbid dependence on prescription sedative drugs such as benzodiazepines, barbiturates, and other sedative/hypnotics. The morning drink for an alcoholic male is often substituted by a morning diazepam (Valium) or analgesic-barbiturate (Fiorinal) in the alcoholic woman.

It is not surprising that clinicians who have limited experience with alcoholism in women assume that very high levels of alcohol consumption are a necessary condition for a diagnosis of the disease. DSM-III, -III-R, and -IV criteria have varied in the amount of alcohol intake required for a diagnosis. A 1980 study of 150 alcoholic women recruited from treatment programs and AA groups found quite a varied picture of actual alcohol intake in these women. Whereas 25% of the alcoholic women reported drinking 15 or more drinks per "usual" drinking day, 17% usually drank fewer than 5 drinks. When asked about the most they ever drank on a single occasion, 10% of the women (three-fifths of those who reported usually drinking less than five drinks at a time) said that they never drank more than five to seven drinks on a single day.

Considering the above information, the wisest course in evaluating both male and female patients, regardless of chief complaint, is to have a high index of suspicion for alcohol/drug problems and to consider the entire range of psychoactive substance use as well as the sex, age, and physical condition of the subject in making the assessment.

**Alcohol Is a Sexual Stimulant for Women**

**Case Report 10.8**

A 32-year-old woman entered outpatient treatment because of loss of control of her drinking and mounting problems in her personal relationships. She gave a history of shyness, low self-esteem, and feelings of inferiority dating from childhood and persisting in spite of superior school and job performance. Both parents drank to excess, although they had received no formal diagnosis or treatment for alcoholism. The patient began to drink in her teens "to overcome my shyness" and "to fit in with the crowd." She was sexually inhibited and afraid of physical contact. During her freshman year at college she was the victim of a traumatic date rape while mildly intoxicated. During the subsequent decade she had occasional sexual relations, seldom reaching orgasm and always while drinking. She was convinced that alcohol increased her sexual arousal and pleasure. She became alarmed when her fiancé complained about her increasing alcohol intake and threatened to break off the relationship. The therapist encouraged the patient to stop drinking entirely and to join AA. The patient stopped drinking and also stopped sexual contact with her fiancé. An AA sponsor encouraged her to refrain from sex "until she was ready." She felt conflicted about depriving her fiancé of sexual relations but considered herself incapable of enjoying sex without alcohol. She dropped out of treatment and AA and resumed drinking.

The belief that alcohol stimulates women to lustful feelings and behavior has deep roots in Western thought. It can be traced through the Talmud, the laws of Romulus in ancient Rome, and Chaucer's Canterbury Tales to Hollywood movies. Modern research also documents this expectation in contemporary society. Both men and women rate a young woman in a videotape scene pictured with a single alcoholic drink more sexually available than one pictured with a soft drink. Both alcoholic and nonalcoholic women express the opinion that alcohol improves their sexual enjoyment. This expectation is contrary to the reality that alcohol exerts a dose-related depressant effect on both sexual arousal and orgasm.
Young women participating in a study in a university setting kept diaries of their food and drink intake and their activities for a 90-day period. At the close of the study, they were asked to predict what relationship would be found between their alcohol intake and sexual arousal. Although only a single negative relationship was found upon analysis of the diaries, the subjects expressed the belief that alcohol would be demonstrated to increase their sexual desire, enjoyment, and activity. Thus, experience did not correct their false expectation.

Alcoholic women have high rates of sexual dysfunction, including complaints of premenstrual dysphoria, lack of sexual interest, anorgasmia, vaginismus, and dyspareunia. At the same time, these women believe that alcohol improves their sexual performance, and they fear that they will not enjoy sex if they are sober. Clinicians can be helpful by explaining alcohol’s depressant effects and reassuring them that abstinence from alcohol and other drugs is likely to improve their sexual functioning rather than impair it. If functioning does not improve significantly with sobriety, specific sex therapy can be helpful. In the case described above, the patient would have profited from a much fuller discussion of her sexual problems and some concrete education about the interaction of alcohol and sexual arousal. Couples counseling could have been undertaken with her fiancé to help her deal with her fear of sexual relations without drinking. All of these measures might have helped her to maintain abstinence and might well have prevented her from dropping out of treatment. A 1993 study of 58 alcoholic women who had achieved abstinence found improvement in sexual desire, arousal, and ability to reach orgasm, even after relatively short periods of recovery (less than 1 year).

Drugs other than alcohol are also expected by social convention to act as sexual stimulants, especially cocaine, although chronic cocaine use is associated with sexual dysfunction in both sexes. Female addicts are stereotyped as women who trade sex for drugs or who work as prostitutes to finance their drug habits, and female alcoholics are thought of as “fallen women.” These societal stereotypes have a range of negative effects on addicted women and their families. Those alcohol-dependent and other drug-dependent women who do not match the stereotype are often misdiagnosed as suffering from anxiety or affective disorders. Individual and family denial are reinforced by the stereotype when the addicted woman is not a sexually promiscuous, irresponsible person.

Perhaps the most destructive result of the stereotype is our society’s acceptance of both physical and sexual victimization of women who drink and/or use drugs. When a group of men were prosecuted for raping an intoxicated young woman on a billiard table in a bar in New Bedford, Massachusetts, members of the community picketed outside the courthouse with signs saying that the victim “deserved what she got.” In a study of the reactions of university students to a rape scenario, both male and female students rated the rapist less responsible for the rape when he was portrayed as intoxicated, whereas the victim was rated more to blame when she was portrayed as under the influence of alcohol. Date rape on college campuses is commonly associated with alcohol and other drug use. Societal expectation dictates that when a woman is drinking she really desires sex, in spite of her statements to the contrary.

Therapists are not immune from these prejudices. If these expectations are not understood and overcome, inappropriate and ineffective treatment of female patients is likely to be the result.

**Pregnant Addicts Are Child Abusers**

**Case Report 10.9**

A 29-year-old pregnant woman went to a police station to file a complaint after being beaten by her husband. She expressed concern that the beating might have harmed the fetus, and she was sent to a hospital emergency room. When it was discovered that she had alcohol in her system, she was arrested, jailed, and charged with criminal child abuse.

**Case Report 10.10**

A 23-year-old cocaine-dependent woman was unable to find a treatment program willing to accept her during her pregnancy. After giving birth to a normal infant, she was arrested in the hospital and charged with delivery of a controlled substance to a minor. Based on her admission to a physician of her cocaine use and a positive urine test in her infant. Only after her conviction on these charges was she able to obtain addiction treatment, under court order. The controlled substance in question was benzoylecgonine, a cocaine metabolite, which she was
convicted of delivering through the umbilical cord during the heartbeats between the delivery of the newborn and the tying of the cord.

Case Report 10.11

A 38-year-old woman delivered a full-term infant in a large inner-city public hospital. Without her knowledge or consent, the infant’s urine was tested for drugs and found positive for morphine. The infant was put into the custody of the Department of Social Services and transferred to a foster home, without any effort to ascertain the mother’s ability to care for the child and without any evaluation, diagnosis, or offer of treatment to the mother.

Instances of women charged with criminal offenses as a result of alcohol or other drug use during pregnancy have been recorded since at least the mid-1950s. During the years 1985–1992, more than 150 such cases were initiated in 24 states. Countless other pregnant women were coerced by being threatened with arrest or pressured into pleading guilty to a lesser charge and serving an undeserved prison or probation term. Among cases recorded, the vast majority involve minority women and those who live in poverty. In many jurisdictions, the definition of child abuse and/or neglect includes the habitual abuse of alcohol and/or other drugs. Under mandatory child abuse reporting laws, allowed without patient consent under the federal confidentiality regulations covering alcohol and drug treatment, reports to governmental authorities may be made and subsequent action taken that is in the best interest of neither parent nor child. Policies of this kind act as an additional barrier to both obstetric care and addiction treatment for alcohol- or drug-dependent women and tend to destroy the already tenuous trust these women have in the health care system. We must all examine the ethical implications of public policies that include the application of criminal sanctions to pregnant addicts and strive to make appropriate, culturally sensitive treatment services accessible to these women. In cases in which a mother may be unable to care for her child because of addiction, professional evaluation and treatment should be part of the plan, with an effort to preserve the family where feasible. Society’s failure to provide adequate prevention and treatment of alcohol and drug problems in women will not be solved by turning these women into criminals.

Women as Destructive Codependents
Who “Enable” Their Male Relatives

Case Report 10.12

A 42-year-old mother of two found out that her husband’s use of cocaine had become a serious problem. During her first treatment in a structured outpatient program, she was referred to as an enabler, “in denial,” “a secret-keeper,” and “nothing more than a codependent.” She was told to get a job and get a divorce. She was expected to attend meetings all day Saturday but could not bring the children and was offered no options for babysitting. A program therapist wanted her to promise that she would divorce her husband, that her father would fire him (her husband worked for her father), and that their friends with whom her husband was living would kick him out. They met as a group and were advised that they were all going to corner him at the same time with their collective threats. “There wasn’t one of us that felt comfortable with this approach. What it all came down to was, I had to do what was in the best interest of my children and myself. Throwing the kids and myself into 40-plus hours of day care, divorce, single parenting, roommates, working full-time, etc., was NOT the right thing to do.” She engaged in parenting activities and told her family and friends to do what they felt comfortable doing for her husband. She arranged specified days on which she and her children would spend time with her husband, provided he was clean and sober. She set up goals of establishing credit in her own name and paying off bills. She devoted the next 5 years to being at home with her children and getting them into school full-time. “I spent that time looking inside myself for strength and knowledge. I did what I felt good about and what felt right. I followed a path that told me my children were the most important thing.” Her husband initially failed at treatment, but he did enroll in another program and followed through with Narcotics Anonymous meetings. He remained off cocaine and eventually returned to live at home with his family.

Currently a popular concept, “codependence” consists of being emotionally involved or overinvolved with a person suffering from an addictive disorder. In practice, this concept is often applied inappropriately in the provision of family counseling as an adjunct to addiction treatment, as in the above case. Each relationship is different, and every family member and significant other must be evaluated individually.
Generalizations about “alcoholic families” or “co-alcoholics” can be countertherapeutic. Finally, the autonomy and preference of each individual must be respected in the provision of advice or guidance. No patient or significant other should be given the impression that he or she is being blamed for the disease of another. That attitude is just common sense and applies to all ages and both sexes. However, because most family members who attend addiction family programs are female, and because some of the “caretaker” aspects of behavior designated as codependent are part of the normal female role, the misuse of the concept is most often applied to women. Thus, it is not only the addicted woman but the female family member that suffers from a lack of understanding in addiction treatment.

Conclusion

As with most medical and psychiatric disorders, understanding the manifestation, course, and treatment of addiction in women requires specific knowledge. Our understanding of addictions among women involves more than mere extrapolation of available knowledge regarding addiction among men. Currently, the assessment and care of addicted women is often flawed by certain myths and misconceptions. Proper care of addicted women requires that clinicians have factual information and show sensitivity to those special issues concerning women.

References

52. Federal legislation, 42 CFR Part 2

Special Populations

Although the typical alcoholic individual or substance abuser in this country may be an adult Caucasian heterosexual man in a lower or middle economic class, a great many substance abusers do not fit this picture. Alcohol and drug abuse is not limited by age, race, or socioeconomic status. In this chapter, we review some of the pitfalls in assessment and treatment specific to a variety of special populations. People may be considered to be in a special group based on their age, race or ethnicity, wealth or status in society, sexual orientation, developmental disabilities, physical handicaps, or comorbid medical disorders. The particular problems of those people dealing with a comorbid psychiatric disorder are discussed in Chapter 2.

Patients belonging to one or more of these special groups are vulnerable to many of the errors that have been mentioned in previous chapters. The groups that will be reviewed here include children and adolescents, the elderly, racial and ethnic minorities, people with developmental disabilities or physical handicaps, the homeless, very important persons (VIPs), physicians and other health professionals, gays and lesbians, and people infected with human immunodeficiency virus (HIV). Some of the difficulties such patients encounter are common to many of the groups, such as being stereotyped as either alcoholic or nonalcoholic people based solely on their background. Also, many of these patients find that standard support and recovery groups do not address their specific needs.
Children and Adolescents

Johnston and colleagues at the University of Michigan have conducted an annual survey of illicit drug use among high school students for the past 20 years. A general decline in drug use beginning in the early 1980s has unfortunately been followed by a resurgence of drug use in American teenagers since 1992. The rise in marijuana use has been particularly pronounced, though gradual increases have been seen with LSD and other hallucinogens, inhalants, stimulants, barbiturates, and cocaine.

Case Report 11.1

A 16-year-old boy was admitted to a psychiatric hospital after assaulting a staff person at his residential treatment center. As a young child he had been severely abused and neglected. Despite being adopted out to a “good home” at age 5, he continued to do poorly. He received outpatient treatment for disruptive behavior and mood lability. He was eventually placed out of the home at age 13. In the hospital he admitted to being high during the assault. He explained that he began abusing inhalants, specifically dry erase markers and cleansers, several months previously. He denied any other substance use. This information was communicated to staff at the facility who denied the possibility of access to such items despite detailed information that the youth provided regarding how he obtained his “drugs.” He was returned to the same facility, with no provision to inhibit his access to these materials. He required hospitalization shortly thereafter.

This youth was able to continue his drug abuse easily because his staff were initially unaware and later in frank denial of the problem. Children frequently fall through the cracks. If they have families, the families may be impoverished or dysfunctional. Residential staff may see the behavior but deny substances as the cause. The teacher and/or school counselor may focus on the substances only as a symptom of a developing character disorder. Adolescents may abuse alcohol or drugs for years before their substance disorder is acknowledged as a primary problem.

Although erring on the side of missing the substance disorder is perhaps more common, mistakes are also made by overemphasizing the substance use. Most adolescents experiment to some degree with drugs at some point. A great majority do not develop dependence or even abuse of these substances.

Case Report 11.2

A 15-year-old girl, who had previously not used any drugs or alcohol, was discovered by her parents to be smoking marijuana with a friend. She was referred to a drug abuse program that advertised its ability to get to the addictive personality of the adolescent. She was expected to attend weekly group sessions that included a mix ranging from teenagers who had only socially experimented with cannabis and alcohol to those who were hard-core heroin addicts. Despite protests that she felt out of place and that the “treatment” did not apply to her, the staff continued their attempts to convince her that she had a major drug problem.

This case exemplifies the error of overdiagnosis. The young woman’s substance use was incorrectly diagnosed as substance dependence. She was lumped into a treatment program with no thought for her individual needs based on the severity of her use and the type of drug she used. There is no widely accepted consensus as to when substance use becomes abuse. Not all experimentation and recreational use develops into later dependence, though some consider any substance use in early adolescence as abuse. Adolescents with alcohol and drug problems will also be at different stages in their substance disorder and have vastly different treatment needs than adults. An example in which a standard that may be appropriate for most hard-core adult addicts was inappropriately applied to an adolescent girl is found in Chapter 4 (Case Report 4.5).

Substance abuse and dependence in adolescents is often comorbid with conduct disorder. Attention deficit hyperactivity disorder (ADHD) is also more prevalent in conduct-disordered youth and is associated with psychoactive substance disorders.

Case Report 11.3

In grade school, Carl was easily distractible, inattentive, and frequently aggressive with his peers. One of his teachers referred him to the school counselor for an evaluation of behavior that was disruptive to the class. Other than acknowledging that Carl was a “problem” child,
no further assessment or treatment recommendations were made. His
difficulties in school worsened over the next few years. He got into
more serious trouble and was frequently sent to the principal's office.
He became truant more and more. He began spending time with a peer
group that was known for "causing trouble." By age 10, he was experi-
menting with drugs, including marijuana, alcohol, inhalants, and later
 crack cocaine. He also started participating in criminal activity with his
"gang." By 12 he had his first arrest for stealing a car. At age 15 he was
dead as a result of a gang related shooting.

In this case, the diagnosis of ADHD was missed early in Carl's pro-
gression into trouble. The substance disorder that came later became
intertwined with the ADHD and probable conduct disorder. Early
assessment and adequate treatment of the comorbid disorder may be
essential to controlling or treating the substance disorder, and vice
versa.

Case Report 11.4

A 16-year-old girl was seen by her pediatrician for her regular check-
up. In the course of the evaluation it became clear that she was de-
pressed. She had been withdrawn and irritable and was no longer
active in school clubs, and she was occasionally absent from school or
late coming home. She was also using cannabis heavily and alcohol
and cocaine regularly. The doctor diagnosed both a depressive disor-
der and a substance problem. Concerned that the depressive disorder
was caused by the alcohol and drug use, her physician's assessment
was that the girl would need to gain stable sobriety from substances
prior to even considering an antidepressant medication. She was un-
successful in becoming abstinent and made a serious suicide attempt
2 months later.

In this case the substance disorder was not the causal agent, al-
though it was likely to have worsened the depression. Depression in
conduct-disordered boys generally did not remit after 3 weeks of absten-
ence from substances. Many clinicians are scared away from treating a
depressive disorder or ADHD because of a concurrent substance disor-
der. Adequate treatment requires treatment of both disorders: a method
to develop and ensure abstinence, aggressive treatment of the mood or
attention disorder, and education regarding their relationship.

Case Report 11.5

A 12-year-old child was found dead as a result of an overdose on her-
oin. He had been injecting the drug intermittently for a year and regu-
larly for the past month. He had obvious track marks along both arms.
He had lived with his mother and grandmother, both of whom had
been chronic heroin addicts. The mother was currently using heroin
and the grandmother was on methadone. The whereabouts of his fa-
thor had been unknown for the past several years. He had two older
siblings, both of whom essentially were living on the streets and had
rare contact with the family.

A great number of substance-abusing children grow up with
substance-abusing parents or family members. A child can expect mini-
mal parenting from a father who is absent and a mother who is high;
parenting is erratic and poor at best. Seeking a nurturing figure, the
child in such a situation frequently turns to other children, usually older
and in gangs, where they are likely to be taken advantage of further.

The Elderly

Significant substance abuse does occur in older people. Community
prevalence rates for heavy alcohol use by older people range from 6% to
14% . Alcohol abuse may remain concealed from family members or fel-
low nursing home residents until physical signs or complaints become
apparent to others. Even then, such signs or symptoms are frequently
mistaken for exacerbations of a medical problem or are simply over-
looked.

Case Report 11.6

An elderly resident of a retirement community had a history of alco-
holism and a family history that included a husband who committed
suicide and two children who abused her psychologically and finan-
cially for many years. One son was alcoholic and blamed his mother for
not telling him the truth about his father’s death. She attempted to take
her life by a drug overdose. She was medically stabilized at a hospital
and transferred to a psychiatric unit. She was discharged back to the re-
irement facility within 2 weeks with no provisions for controlling her
alcohol use or for protecting her from her children.
In this case, the woman's alcohol disorder was either missed or ignored by the inpatient treatment team. Vigilance for a substance disorder should be maintained by family members, staff at the nursing home or retirement facility, and the patient's physician.

The elderly are frequently prescribed benzodiazepines to treat insomnia and anxiety. A survey of 850 residents in intermediate care facilities revealed that 28% received a regularly scheduled sedative-hypnotic. 1 In a large United States survey, 71% of the patients who were prescribed benzodiazepines for longer than a year were more than 50 years old. 2

Case Report 11.7

A 72-year-old woman was admitted to a general hospital after sustaining a hip fracture. She had fallen in her retirement apartment, where she lived alone. During the second day of the hospitalization, she became increasingly irritable and complained of a headache. That evening she was found screaming at the wall. She was experiencing vivid hallucinations. She had denied excessive alcohol use on admission, claiming to drink only an occasional nightcap. Her daughter confirmed that information, though also reported that she had found current prescription bottles for two pain relievers and three sleeping medications from a total of four different physicians in the medicine cabinet. The woman was started on an appropriate medication regimen to treat alcohol and sedative-hypnotic withdrawal and improved dramatically.

The elderly are more likely to be on multiple prescribed psychoactive medications than are younger people. Although some older persons may in fact be abusing their prescribed medications and obtaining them from several doctors by deception, many of the elderly who have become physiologically dependent on addictive psychotropics have simply been following their physician's orders. Treatment in a milieu that focuses on their dependence as substance abuse or addiction is inappropriate and potentially harmful to that person.

Elderly persons may also develop difficulties secondary to substance use, which has not escalated over the years, due to gradual impairment of the ability to clear these drugs from their systems or to increased sensitivity to the effects of the psychoactive substance. The elderly are more susceptible to the adverse effects of daytime sedation, ataxia, and cognitive impairment.

Case Report 11.8

A 73-year-old man drank two martinis a day for years. His drinking had never significantly increased beyond that amount for the past 35 years. His alcohol use did not present any problems until his mid-60s, when he began having occasional falls at home. At the next appointment with his family physician, laboratory examination revealed elevated liver enzymes. His daily alcohol use was confirmed by his children. The patient was told he was an alcoholic and that he needed to attend Alcoholics Anonymous (AA) meetings. The patient refused treatment but did cut his alcohol intake down markedly with no further problems.

In addition to accentuated effects of alcohol and drugs in the elderly, the medications used to treat withdrawal symptoms may also have deleterious effects when liver or renal functioning is impaired. The standard dose of clorazepate or chlordiazepoxide for alcohol withdrawal may work well in a younger patient, but it may result in confusion, unsteadiness, and falling in elderly people.

Similar to other populations discussed in this chapter, elderly alcoholic patients may have difficulty in a typical AA group other support group in which the members have values or mores notably different from their own (see Case Reports 11.12 and 11.40 in this chapter, as well as Case Reports 8.3 and 8.4 in Chapter 8).

Case Report 11.9

A 69-year-old woman developed alcoholism over the 4 years following the death of her husband to a progressive dementia. She agreed with her daughter, who was a recovering alcoholic patient, to attend AA meetings with her. She gained little support or satisfaction from the meetings, reporting to her daughter that she was frightened by the "rough language" of the group, which was dominated by much younger participants. Her daughter helped her find another AA group that had more older people. She found this group of peers more helpful in understanding her life situation and supporting her sobriety.

Particular attention to the various needs of the elderly person, including possible medication side effects, potential drug interactions, and appropriate treatment settings, are necessary to provide safe care and promote sobriety.
**Ethnic and Racial Minorities**

On the surface, minority ethnic and racial groups appear to have similar overall prevalence rates of alcohol and other substance disorders to non-minority groups. A 1990 National Institute on Drug Abuse survey reported that 68.3% of whites, 64.5% of Hispanics, and 55.6% of blacks used alcohol. However, different patterns of use and abuse among different minorities exist and underlie these numbers. Clinicians can and should take ethnicity into account in assessing patients. The clinical epidemiology associated with a particular group should guide the clinician in considering the common presenting problems within that group. Failure to do so leads to inefficiency and poor care. However, knowledge of a group's clinical epidemiology should not substitute for careful assessment and diagnosis. Stereotypes are not diagnoses. See Chapter 9 regarding training in cross-ethnic clinical care.

A common stereotype without basis is the assumption that all Native Americans or all Hispanic males are prone to alcoholism. This mind set prevents a thorough assessment of the presenting problem.

**Case Report 11.10**

The ambulance brought a 59-year-old Native American man to the hospital emergency room. He had been found lying in the snow between two cars outside of a well-known “Indian bar” in a large city. Mumbling incoherently, he was admitted to the alcohol-addictions unit as an alcoholic patient. Blood alcohol testing revealed a low alcohol level, consistent with only one or two drinks. Moreover, his systolic blood pressure was high and his pulse was slow. A translator from his tribe was obtained, and the patient described a “terrible headache.” It was possible to conduct a mental status exam, which was consistent with an acute brain syndrome. A funduscopic examination revealed swelling of the optic nerve, consistent with increased pressure on the brain. A neurosurgical consultation was obtained, and emergency surgery soon confirmed the diagnosis of a subdural hematoma from a skull fracture. Psychosocial evaluation following surgery revealed that the man had a stable job, visited the local “Indian bar” each Saturday night but did not drink to excess, and had no other evidence of alcoholism. In addition, his ability to speak English (a second language for him) returned following the surgery.

In this case, the admitting physician relied on several factors to decide that the patient was alcoholic (i.e., he appeared to be Native American, he was brought in by the police, he had been found lying in the snow outside of a bar, and he was mumbling incoherently). However, he initially failed to obtain the additional basic medical data that would provide a proper basis for medical diagnosis.

Perhaps less commonly, but no less detrimentally, the opposite false assumption can lead to poor treatment or no treatment. For example, many Asian Americans and people of Jewish heritage have a low consumption of alcohol.

**Case Report 11.11**

A woman and her husband, both Jewish, were having difficulties that she felt were secondary to his drinking. The woman’s parents, her rabbi, and even her therapist assured her that she was exaggerating her husband’s drinking behavior. Her therapist explained that her husband did not have a drinking problem “because he is Jewish and Jews don’t become alcoholic.” She did not trust her own instincts to leave the relationship, partly because she had three small children and no way to support herself. During the next 20 years the husband continued to drink, frequently to the point of blacking out. Years later, she found out that he had also routinely sexually abused their daughters during that time.

In this case, because the therapist had a fixed stereotype that Jewish people drink in moderation, he was unable to diagnose a severe case of alcohol dependence. As a result, the entire family suffered the devastating consequences of the patient’s drinking.

Both cases just described exemplify stereotyping when diagnosing is called for. In other cases, the clinician may accurately recognize alcoholism or addiction but may shut down his or her further diagnostic thinking. Routine diagnostic procedures may be omitted, with unfavorable results.

**Case Report 11.12**

A 63-year-old African American woman was brought to an emergency room intoxicated and smelling strongly of alcohol. She had been picked up on the street by the police, was apparently unable to walk, and was brought to the hospital emergency room. The physician on
call made an immediate admission to the alcoholism-addictions unit. During evaluation on the latter unit, the admitting physician noted a shortening and external rotation of one leg, a sign suggestive of a fractured hip. Vital signs revealed a fast pulse and low blood pressure. Following fluid replacement, she went to surgery for her fractured hip. Subsequently, she was found to have undertaken a drinking binge after having recovered from alcoholism 3 decades earlier. Her binge was precipitated by the death of her youngest child and only son during a military combat mission. Subsequently, she recovered from her brief alcoholic recurrence, returned to her home, and resumed an important role in her church.

In this case, the emergency department physician did actively identify the patient's acute alcoholism. However, despite possessing information as well as physical signs that called for further assessment, he prematurely ended his appraisal of the situation. Alcoholism does not preclude having other medical problems, nor should it preclude careful diagnostic evaluation and treatment.

Having a role model from one's own culture can be extremely beneficial to the recovery process. Hearing from someone whose background is akin to one's own, whose substance disorder was similar, and who has climbed from those depths to achieve abstinence can be a strong motivating force. A typical 12-step program or recovery group, although containing persons who have struggled to develop their sobriety, may be without such a person from the same cultural background. Particularly at the onset of recovery, when issues of self-esteem are paramount, ensuring the same cultural background in a treatment group may be invaluable.

Case Report 11.13

A 45-year-old ex-marine Native American man used cannabis extensively while in Vietnam and progressed to injecting heroin when he returned to the States. He was in and out of treatment programs for years through the Veterans Administration medical system, including methadone maintenance. Although he felt a connection with other Vietnam veterans, he did not connect well to other clients or staff. While growing up he had been close to his grandfather, who had been a tribal elder. The patient felt that his treatment staff and other patients were ignorant of his cultural background. He was eventually referred to a rehabilitation center for Native American people, where he progressed well in treatment.

Although he identified himself as a Vietnam veteran, treatment limited to that arena did not adequately address his identity as a Native American. Involvement with others from his cultural group appeared to make the difference in his motivation to sustain treatment and abstinence.

Immigrants to this country deal with special stresses. If they come as refugees, the traumas they suffered in their home country may include war, famine, and human rights abuses. Once here, they may have economic hardships, seemingly endless bureaucratic red tape, feelings of being unwanted by their neighbors, and the struggles of learning a new and complex language. Depending on where they come from, alcoholism may have been endemic in their homeland. If not, the availability and acceptability of alcohol in this country may lead to its use as a way to cope with their stressful lives. Treatment in an only English-speaking setting is difficult at best, and perhaps impossible, for the immigrant whose command of the language is poor. Recovery groups that are specific to the ethnicity at hand may provide a road to sobriety that would otherwise not be possible.

Case Report 11.14

A 28-year-old Ethiopian man was admitted to the hospital with pneumonia related to HIV infection. He was actively abusing alcohol and marijuana. He had been severely tortured before moving to the United States, and consequently he was unable to trust authority figures. He perceived attempts at intervention as threats. He did not trust even a male social worker of African American heritage and was lost to follow-up after his discharge.

If a treatment group for other Ethiopian immigrants were available, perhaps this patient would have felt safe enough to accept help. Unfortunately, except in the largest metropolitan areas, such highly specialized treatment programs are not possible.

Case Report 11.15

A 32-year-old single Navajo man was convicted of driving while intoxicated and ordered by the court to complete a 30-day program in a
nearby border town. He had also begun treatment with a native healer who used herbal preparations to assist in returning his “balance” and to reduce alcohol craving. The inpatient program was staffed by Caucasians and there were no other Native Americans in the treatment program. His staff emphasized the need to have control over all substances and to develop complete abstinence. He felt their insistence on total abstinence meant they would be disapproving of his use of traditional herbal remedies. He did not tell them about his visits to the native healer, and this widened the split between the two forms of treatment he was receiving. The staff viewed him as unmotivated, yet they made no attempt to explore the cultural issues relevant to his sobriety. He completed the program, receiving little benefit, and returned to his native healer. At follow-up 2 years later, he was regularly employed and had remained sober.

Western-oriented treatment and traditional therapies may have marked differences, but they are not necessarily incompatible. In this case, if the role of native healing had been addressed early in his treatment, it may have been possible to incorporate that treatment into his 30-day program or at least to validate it and defer the remedies until completion of the program.

There are other ways in which knowledge of specific cultural uses of substances may be essential for appropriately assessing treatment needs. The Native American Church, which began in the Oklahoma and Texas tribes and has extended further north, considers peyote to be an essential sacrament, the physical embodiment of the Great Spirit. The frequency and amount used during ceremonies are carefully prescribed by the church leadership, or “roadman.” Unless the therapist is familiar with this information, he will be unable to determine whether the substance is being used in a culturally appropriate fashion. This knowledge will be invaluable to the therapist, regardless of whether the person fits the criteria for a substance disorder (see also Case Report 11.45 for a related issue).

**Developmentally Disabled Persons**

Those with developmental disabilities (i.e., learning disabilities and mental retardation) are not immune to substance disorders. In a study comparing 88 students with learning disabilities and 103 students with-out, chemical dependency was seen in a significantly higher proportion of learning disabled students. Another study found no difference in alcohol use between 123 students with learning disabilities and 138 non-disabled students, though it did show proportionally higher use of tobacco and marijuana for adolescents with learning disabilities.

**Case Report 11.16**

A 28-year-old developmentally disabled person living in a group home was noted by his staff to have increasingly aggressive behavior toward others and somnolence during the day. After approximately 3 weeks of escalating behavior problems, he was admitted to a psychiatric unit for a reevaluation of his medications. On the unit he was initially noted to be irritable, but not out of control. His blood pressure was also mildly elevated for the first 48 hours. He had not had any changes in his medications for the past 18 months. Serum levels of his medications were in the normal ranges. Without any changes of his medications, his behavior returned to baseline over a few days and remained there. His mother came to visit several times and asked the staff at one point if it would be acceptable to bring her son a wine cooler, as she usually did when she visited him at the group home. She revealed that he had been asking her for this favor more frequently over the past month.

The patient’s mother was inadvertently the indirect cause of his escalating aggressive behavior. The staff were unaware that he was being provided with alcohol. The mother appreciated the education of the deleterious effects of alcohol and drugs in those with limited cognitive functioning. The staff were able to use this reminder that substance disorders do occur and can have enormous consequences in this population. Staff must also be alert for the misuse and abuse of unusual substances, as the next case illustrates.

**Case Report 11.17**

A 36-year-old male nonsmoker with profound mental retardation was admitted to the hospital for evaluation of mental status changes. Normally he was an alert man who participated actively in his programs at the residential facility; however, he had been much less active, drooling, and intermittently glassy-eyed for the past several days. There was no history of falling, medications errors, or ingestion of alcohol (which
was available in the group home for others). His sister (who was his
guardian) strictly forbade his use of alcohol, in part due to a family
history of alcoholism. There was no evidence of seizure activity, current
infection, or other central nervous system disturbance. His neurologi-
cal examination was unremarkable and a computed tomography scan
of his brain showed only mild atrophy. The attending physician con-
cluded that the patient has “usual deterioration seen in the retarded.”
Several days later the patient was sent to the emergency room by am-
bulance after losing consciousness on a community outing. A toxicol-
ogy screen was ordered automatically, though emergency room staff
unsuccessfully attempted to cancel the test when they realized he had
mental retardation. The test was positive for toluene and nicotine with
very high quantitative levels. A more careful review of his recent his-
tory revealed that he had been surreptitiously sniffing vapors from
multiple sources (readily available in his environment) and eating ciga-
rette butts. When his access to these substances was prevented, he re-
turned to his previous state of alertness.

A person predisposed to substance abuse may very likely use whatever
is available, and even the seriously mentally retarded may be quite
resourceful and successful in their attempts to find abusable substances.
The developmentally disabled population also appears to be more sen-
sitive to the effects of psychoactive substances, in regard both to psych-
ologic-social problems and health problems. 18

Mentally retarded persons with alcoholism or another addiction are
often only mildly retarded. They can read, write, and perform simple
mathematics. They may marry, and many are employed. It may be diffi-
cult to distinguish these patients from other patients. However, it is im-
portant to recognize their special needs in order to implement effective
treatment and rehabilitation (see Case Report 2.12 for an example of the
need for adequate assessment of cognition).

These patients may not do well in acquiring the cognitive models
associated with AA and other self-help groups, although most of them
do like the regular group meetings. Some continue to attend their “men-
tal retardation” group as well as a local “regular” group. Relapse preven-
tion exercises must be structured into the person’s life by a guardian,
parent, social worker, or other guide.

Disulfiram (Antabuse) has been found helpful for mentally retarded
alcoholic patients. Many of these patients drink impulsively on disulfi-
ram once or a few times despite an ongoing commitment to abstinence
and recovery. A few alcohol-disulfiram reactions decondition the men-
tally retarded alcoholic person to the strongly conditioned alcohol ef-
effect. This is in contrast to most alcoholic patients on disulfiram who are
not mentally retarded, who merely stop taking disulfiram a few days be-
fore they intend to resume drinking.

Although less common today, many institutions that have cared for
the mentally retarded have used addictive substances to reward their
residents for good behavior. It is important to explore the multiple
meanings that the substance use may have for both the individual and
the institution.

Case Report 11.18

A 57-year-old man with severe mental retardation was referred for an
evaluation due to declining health. He was found to have ataxia,
wheezing, vascular changes and neuropathy in the hands and feet,
and frequent infections. Further history revealed that he was smoking
four packs of unfiltered cigarettes and drinking a pint of vodka daily.
Thought to be incompetent to make an informed decision about the
use of these substances, he was restricted from using them. A short
time later he was referred for evaluation of crying spells, loss of interest
in activities, and sleep disturbance out of proportion to what would be
expected for withdrawal. During that evaluation he waved his hands
in front of his face, cried, and dropped to his knees. The examiner de-
termined that this was drug-seeking behavior and recommended in-
creased vigilance for surreptitious use. Shortly thereafter, the client
attempted suicide by placing a plastic bag over his head. He survived.
A closer examination of his history revealed that his institution rou-
tinely used alcohol and cigarettes as rewards for good behavior and
withdrawal of these substances as punishment. The gestures seen in
the second evaluation was his sign for “I’m sorry,” presumably because
he thought the removal of the cigarettes and alcohol were punish-
ments. A behaviorist completed a reinforcement survey, identified
nontoxic but potent reinforcers, and built them into the client’s pro-
gram. His recovery proceeded without further incident.

Here, the failure to adequately understand the role of this client’s
abuse of substances in the context of the institutional behavioral pro-
gram nearly proved to be a fatal error. It is just as important to explore
the role that a client’s family may have in substance abuse.
Case Report 11.19

A 19-year-old woman with moderate mental retardation was brought to an emergency room by her brother after getting into a fight. She was found to have several lacerations and was intoxicated. Following repairs of her injuries, she was referred to the psychiatry service and admitted to a detoxification unit. There she was remarkably compliant, which the team speculated was related to her low IQ. She sat in on all the meetings, spoke only rarely, and seemed comfortable with all of the outpatient plans. After discharge she attended all groups as planned. She was taken to the hospital 3 days later, after having a seizure in one of the "mental retardation" AA meetings. She was intoxicated. Further evaluation revealed that her mother consumed one quart of vodka per day and expected her daughter to accompany her. The patient had been trained and socialized to comply with anyone who was older. It was possible for her to recover only after she had assertiveness training and after her mother received treatment.

Many people with developmental disabilities have learned to survive by complying with people in power, and almost everyone has more power than they do. Thus, anyone in the system may be able to influence the person to use substances. Additionally, persons with developmental disabilities are sexually and physically abused more often than other people, and alcohol or drugs may be used to increase compliance with abuse.

Physically Disabled Persons

The literature regarding the prevalence of substance abuse in physically disabled persons is without a consensus at present. Some studies report increased substance abuse among handicapped persons,\textsuperscript{19,20} whereas others have found either no difference\textsuperscript{21} or no significant difference\textsuperscript{22} of drug use in adults with major disabling conditions. Moore and Palsgrove note that an 8% chemical dependency prevalence in this population is a conservative estimate.\textsuperscript{23} Regardless of whether disabled persons are more likely to abuse drugs, people with physical disabilities, including those with hearing or visual impairment, who also have a substance disorder may have their recovery hampered by a number of obstacles.

This population is vulnerable to a number of specific medical problems that may be caused or exacerbated by drug misuse, including compromised drug tolerance, self-medication, overmedication, iatrogenic drug misuse, and potentiation with prescribed medications.\textsuperscript{23} Persons with disabilities are also prone to a number of medical problems, such as chronic infections, circulatory problems, poor motor coordination, and digestive disorders that can be exacerbated by even small quantities of alcohol consumption.\textsuperscript{23}

Case Report 11.20

A 47 year-old man had suffered a spinal cord injury secondary to a fall while intoxicated. He was paraplegic and was using a wheelchair to get around. He continued to drink, wheeling himself to the local liquor store. On several occasions neighbors found him either wandering on the street or passed out. He refused participation in AA or other alcohol treatment. As his drinking worsened, his compliance with physical therapy also deteriorated. He was last hospitalized for a recurrent and severe decubitus ulcer.

Here the recurrent medical problems were indirectly due to the alcohol. In others, the effect is more direct. Regardless, adequate medical care requires attention to the substance disorder. His ulcers are unlikely to properly heal until his alcoholism is adequately addressed.

Individuals with physical disabilities are at higher risk to self-medicate. Commonly they are prescribed medications of high abuse potential, including narcotics and sedative-hypnotics. Chronic pain is a frequent ailment, and perceived inadequate relief from prescribed medications may lead to self-medication, either by misuse of the prescribed pain relievers or by illicit drug use, further resulting in substance dependence. Persons with disabilities generally face greater stress than nondisabled persons, related to problems of personal adjustment, normalization, and socialization.

Case Report 11.21

A 44-year-old man became paraplegic after a hunting accident at age 26. He had a history of occasional narcotic use prior to the accident, though it was never treated. His medical course following the accident was marked by four surgical procedures and intermittent difficulties with pain control and opioid dependence. He has received a variety of narcotic prescriptions from many different physicians to treat his complaints of pain. He was most recently admitted to a substance abuse
treatment program but left against medical advice after being con-
fronted by the staff for his "drug-seeking behavior."

A consultation from a pain clinic service or other pain specialist may
be helpful in clarifying whether a patient's complaint of pain may stem
from legitimate medical causes. After such an assessment, more ap-
propriate limit setting and confrontation may be provided. Prescribed
medications may also be potentiated with use of alcohol or other non-
prescribed drugs. This population is both particularly susceptible to
pressures leading to drug misuse and often has access to abusable drugs
in the form of prescribed medications.

Individuals with physical handicaps are at higher risk to be associ-
ated with other factors that will increase the individual's risk for sub-
stance abuse. Low self-esteem, self-defeating behavior, inadequate
self-control, excessive free time, loneliness, and isolation may all contrib-
ute to a disabled person's use and abuse of substances.

Case Report 11.22

A 36-year-old woman who became paraplegic following a motor vehi-
ble accident 4 years previously has continued to have problems related
to her use of alcohol. She progressed slowly in physical therapy and
was frequently frustrated by her new limitations. She avoided social
contacts and discouraged friends and family to the point of receiving
only rare visits. Although alcohol abuse appeared to predate her injury,
the context of her drinking changed. She drank at home and alone. Her
physical therapist became concerned and initiated further assessment
of the alcohol problems. The patient achieved sobriety with AA, continued
to improve physically, and developed a wider social network in-
cluding other handicapped people.

The passive acceptance of a handicapped person's perceived nega-
tive fate can be detrimental to his or her ability to overcome the obstacles
of both the handicap and a substance problem.

Homeless and Impoverished Patients

The current number of homeless people in this country is staggering. It
is estimated that up to one million men, women, and children may be
homeless on any given night, and twice that number are homeless at
some time in the year. Many in this impoverished population have
substance disorders. Alcohol or drug use was reported by 93% of a
meal-line population, most of whom were homeless. In that same
study, severe substance abuse was reported in 39%. In a study of 412
homeless and marginally housed adults, 13% drank more than 20 drinks
a day. A study of impoverished medical patients revealed that 24%
were frequent alcohol users and 18% had recently used illicit drugs.
Johnson and Barrett's survey of almost 500 homeless people charac-
terized 30% as having alcohol-related treatment needs and 27% with treat-
ment needs associated with drug use behavior.

Homeless persons run a high risk of receiving inadequate medical
attention in hospital settings. The physician may focus on a disheveled
appearance and the smell of alcohol or the needle tracks on the arm and
forsake a thorough evaluation of concurrent and potentially life-
threatening medical problems.

Homeless individuals also run the risk of having their substance dis-
order ignored even after a clear diagnosis has been made. The as-
sumption that someone living at a shelter has no desire to quit abusing
substances is as faulty as the assumption that the person resides in a
shelter because that is what he or she desires.

Case Report 11.23

A 36-year-old woman had been living at shelters off and on for the past
6 years. She had a long history of alcohol abuse, drinking when she had
the money or with acquaintances at the shelters. She had begun using
crack cocaine 6 years earlier, with approximately a dozen detoxifica-
tions since. She had also been in "rehabilitation" twice, completing the
program once. She was admitted to an emergency room in an intox-
icated state from both alcohol and cocaine. The physician on call spent
little time with her and curtly asked if she wanted treatment for her
substance disorder. She replied ambivalently, and the doctor did not
address the issue further. He commented later to one of the nurses with
his assessment. "She's not going to stop using. She just wants three
hops and a cot."

Certainly this patient is at extremely high risk of relapse. There are
few treatment and rehabilitation resources available, particularly for in-
digent patients. However, she did successfully complete a treatment
program in the past. Who is to say that this would not have been the be-
inning of her next long period of abstinence or even complete recov-
ery? It is important to remember that the homeless population includes women, both single and with families. Although they are less frequently substance abusers, those that are will have psychosocial needs very different from many of the men (see Chapter 10 for more discussion and cases exemplifying special issues in women substance abusers, and see Chapter 3 for discussion about the role of families in treatment).

Shelters may represent a window of opportunity to get a homeless person treatment, not just for their substance disorder, but also for medical ailments and mental illness. They may provide safety, support, and a sense of community to people when they need it most. This can foster an attempt to regain sobriety. On the other hand, shelters can also be havens of drug use. Persons trying to eliminate alcohol or drugs from their lives may find it hard to do at such a place.

Case Report 11.24

A 52-year-old man was admitted to a detoxification unit because of mildly complicated withdrawal from alcohol. He appeared to have lost much over the years to his drinking, including three wives, his military career, and numerous jobs. He had been living in shelters intermittently for several years. On the unit he agreed with his need for sobriety and his need for treatment. He started taking disulfiram to avoid impulsive drinking. He appeared genuinely motivated to remain abstinent. He took passes to AA meetings and found them uplifting. Unfortunately, the only alcohol treatment program he was eligible for had an extensive waiting list. Ready for discharge, and with no other disposition option, he returned to live at the shelter. Despite his good intentions to remain on the disulfiram and attend AA regularly, he returned to drinking within days of his discharge.

Although every attempt to assist in someone’s development of abstinence should be made, one cannot afford to forget the environment to which an addicted and susceptible patient is returning. Limited resources add to the frustration that is common to treating this population.

Wealthy and Very Important Patients

There are dangers that can lead to special errors when treating a Very Important Person (VIP). VIPS range from people who are wealthy, famous, and powerful to patients involved in some way with one’s own family or friends, to referrals from esteemed colleagues and former teachers. Some therapists feel that it is the wealthiest and most powerful patients that seem to evoke the most mistakes from them and the treating systems. These patients, who should be able to gain access to the most expensive if not the best places for care, may also directly or indirectly stimulate pressures that can corrupt a treatment system and lead to alteration of care in directions that are harmful to the patient and provide a poorer prognosis for a favorable outcome.

The stigmatization that results from having others know about the patient’s alcohol or drug problem may be seen as a particular threat to a VIP’s career. The VIP may have trouble acknowledging his or her own substance disorder out of simple denial. Denial in the patient may be especially prominent in a VIP whose climb to success has been accompanied, if not aided, by certain personality traits, such as narcissism or sociopathy. Adequate insight into his or her behavior, including his or her substance abuse, may be difficult to attain. Additionally, a VIP may recognize the problem, but request or demand that he or she be treated in such a way as to minimize the substance issue. This includes being treated for a substance disorder on a treatment unit that does not routinely or specifically treat alcohol or drug abuse. Placing the patient in the wrong kind of unit or program because of this fear often results in inadequate treatment for the drug problem.

Case Report 11.25

A 42-year-old woman who was a renowned opera singer was admitted to a general psychiatric service under the diagnosis of depression because she did not want her long-standing problem with alcohol and multiple substances to be known to others and did not accept that she needed help for her substance dependence. Rather than allowing direct confrontation of her problem, she was permitted to choose the unit to which she would go and a treatment plan that did not address her real problems. Three months after discharge, she was rehospitalized at another institution, where her addiction problem was addressed. At that point, she became furious that she had not been confronted before and that her previous hospitalization was a waste of time.

Some patients prefer to be labeled as psychiatric when their problem is addiction, whereas others may prefer to be labeled alcoholic
when their real problem is other mental illness. The VIP patient can intimidate those around them to do things they would not do ordinarily, and this evokes mistakes and poor treatment. Honesty is crucial to getting any patient’s trust, and treatment suffers when honesty is compromised for any reason.

Confrontation of a patient’s addictive behavior or a family member’s codependent behavior may be particularly difficult when dealing with a very powerful or influential person. Although this may stem from simple intimidation by the patient, the therapist may fear offending the patient or eliciting retribution from the patient.

Case Report 11.26

An 42-year-old attorney who was well known in the community was in therapy for issues related to marital discord and dissatisfaction with his work. He made occasional references to drinking two or three drinks during lunches and to looking forward to relaxing in the evening with “a scotch or two.” When asked about his alcohol use he minimized the amount and appeared defensive, saying that his wife “nagged” him too much. He exclaimed that he was paying for the therapy and wanted to “desist with all this talk of booze.” The psychiatrist did not press the issue further, nor did he call the patient’s wife to clarify his alcohol use. The patient’s alcoholism did not come up again until after he had a serious car accident while intoxicated.

The therapist may fail to treat the patient as an individual with a substance disorder or fail to obtain collateral data even when that is a part of the usual assessment.

In dealing with VIP patients, one of the dangers is in crafting special arrangements for the patient. Many VIPs are used to having others wait on them; their sense of entitlement may be immense if not overwhelming. Control issues may abound, with the VIP reluctant to allow subjugation of his power. “Special” aspects of the treatment may be demanded by the patient as necessary but turn out to be major obstacles to successful treatment. Special treatment can take the form of excessive rigidity when flexibility is required or inappropriate, perhaps indulgent, treatment. VIP patients may have realistic constraints on their time, such as extensive traveling, that need to be considered. Overly rigid treatment may result in the patient’s deciding to end treatment prematurely.

One example of special treatment includes referrals to special treatment units that are distant enough from the patient’s home that the patient may remain essentially anonymous. Though there are some facilities that cater to VIP patients and can provide excellent care and treatment for some people, such absolute confidentiality, to the point of complete anonymity, may have less than desired results.

Case Report 11.27

A 53-year-old physician was sent to an alcoholism treatment program in a state approximately 800 miles from his home. He had been a “model patient” at the facility and was discharged home with a recommendation to join the local physician’s AA group. Within 48 hours of returning home, he returned to heavy drinking and committed suicide.

Anonymous care at a distance from home can be costly, as in this case. The patient and his or her family and friends may have valid concerns related to potential discovery of the patient’s substance problem by others, such as the media or colleagues. These issues and concerns need to be addressed. However, long-distance recovery may be difficult, especially when resources close to home are needed. Patients are most apt to “fall between the cracks” when transitions occur from one phase of treatment to another. Out-of-the-community treatment is often poor at helping patients to bridge these transition points.

Other forms of special treatment range from wanting unusual meeting places and times to the involvement of inappropriate persons in the treatment.

Case Report 11.28

A well-known middle-aged president of a local health maintenance organization (HMO) was confronted by concerned colleagues and family about his alcohol abuse. He agreed to further evaluation, but he arrived at that appointment accompanied by his lawyer who insisted on sitting in on the evaluation interview. The psychiatrist went along with this arrangement, feeling intimidated by the lawyer, but on the other hand feeling a necessity to accomplish some level of evaluation. The interview did not reveal much because of the presence of the lawyer, and appropriate treatment recommendations could not be made. It was only later, when the executive’s personal life had further deterio-
rated, that an appropriate evaluation and referral for treatment was accomplished. By that point, the problem was so obvious that the executive lost his job.

Here, the presence of the patient's lawyer impeded the psychiatrist's assessment and initial treatment. Appropriate medical care requires that a confidential interview assessment be performed.

Another example of changing the usual boundaries is seen in the treatment of persons with whom objectivity will be difficult to maintain. This category may occur with referrals from a very esteemed colleague, the head of an organization, or a person that the therapist knows socially. It may be very important to make a referral out of one's own system, if necessary, to preserve treatment boundaries. This should be done whenever the therapist feels that his ability to give professional care may be compromised by his relationship to the patient. For example, it might be obviously foolish for a neurosurgeon to operate on his mother-in-law; similarly, it would be inappropriate for an addiction therapist to do substance-abuse treatment on a close relative. In such an instance, it is wise to find a more appropriate therapist.

Another example of special treatment may be related to the fee, where either the psychiatrist or therapist extends treatment without due cause simply because the patient can afford it or because it is prestigious for the facility to associate itself with the VIP. The hospital may feel that the patient's presence there is good for marketing or fund raising. The therapist may have a narcissistic investment in treating prominent or wealthy people, or he or she may simply be acting criminally. Alternatively, treating a colleague or other VIP gratis may be fraught with difficulties as well.

**Case Report 11.29**

One therapist billed for frequently scheduled missed appointments by a wealthy alcoholic patient who rarely showed up but paid his bills. The therapist did not adequately confront the patient's drinking problem for fear of losing personal income.

**Case Report 11.30**

A therapist treated a colleague gratis but felt resentful of the demands and energy required to treat this patient. This resentment led to a cold attitude toward the patient, which in turn may have contributed to treatment failure.

The therapist may be tempted to enter into a social relationship with the famous patient or may harbor wishes that the patient gratify his needs with donations, fame, or favors. This is subversive to the treatment. In fact, it is important that the treatment be protected as much as possible from a program's need for gain, such as in filling beds or treatment slots, or a program's excessive need to dole out limited treatment resources in capitation systems in which pressures exist to provide minimal levels of care.

**Physicians, Nurses, and Other Health Care Providers**

Nearly 20 years ago, it was estimated that 7% of physicians would become alcoholic and 1% would become addicted to narcotics during their careers. More recently, Hughes and his colleagues surveyed 9,600 physicians and reported that 10% drank daily but only 0.6% consumed five or more drinks daily, and nearly 5% had used minor opiates in the past month. Almost 8% of the doctors in their study reported substance abuse or dependence problems at some time in their lives. Various factors may predispose physicians and other health care providers to substance disorders, including frequent easy access to controlled substances and familiarity with the use of these drugs through either medical or nursing training. Additionally, the demands of these professions can be severely taxing, with long hours in stressful conditions. The decisions they must make can have dire consequences, often of a life-or-death nature.

The health provider's denial that his use of substances is a problem warranting treatment is a major factor in the delay of treatment. Early referrals and self-referrals are rare. Many physicians have a tendency to self-diagnose and self-medicate. Although they may be able to diagnose a problem that they deem indicative of treatment with a controlled substance, they may be unable to diagnose the resultant substance disorder. Others may know they are not treating any illness but are unable to see that their "recreational" use of drugs has developed into dependence.
Knowledge of the acute and chronic effects of alcohol, sedative-hypnotics, and narcotics does not prevent the addiction from occurring.

Case Report 11.31

A 25-year-old nurse relapsed into alcoholism after 5 years of sobriety. "During those 5 years that I was sober I went to school, obtained my nursing license, and worked in the field of psychiatry and chemical dependency. This knowledge of psychology and alcoholism did not help in preventing my relapse or help in my returning to sobriety."

Treatment may be further delayed by denial in family members and colleagues. Spouses may falsely attribute signs of the addiction to the stress of the work. They may not wish to see the fall from grace for someone who has worked so hard and so long to achieve their educational goals, often through support from the spouse. Colleagues may not wish to label a friend as ill or as an "addict." They may be unwilling to confront the person for fear that the confrontation would be unnecessary and hurtful or embarrassing. They may overidentify with their abusing colleague, who suffers from the same pressures that they do.

Case Report 11.32

A 35-year-old senior psychiatric resident had an alcoholic supervisor who arrived at their weekly supervisory sessions obviously intoxicated about two-thirds of the time. These meetings took place in a public hospital, and the supervisor's obvious intoxication must have been noted by many people as he went through the lobby and rode the elevator to the floor where the appointment was held. The resident felt that he would get in trouble if he reported this problem to the residency hierarchy and, instead of reporting, just eagerly awaited the end of the year. Two years after the resident graduated, the supervisor, who was in his early 50s, died of alcoholism.

Even after care is initiated, inadequate diagnosis and insufficient treatment are common. Of 98 recovered alcoholic physicians, one-third reported that their previous psychiatrist did not identify their principal problem as drug or alcohol abuse.31 The therapist may go out of his way to avoid taking a stance that his colleague would consider overly intrusive or offensive. Maintaining a therapeutic balance of empathy and objectivity can be extremely difficult in these situations. The "conspiracy of silence" is a problem in dealing with impaired professionals because the physician's peers and colleagues are either unable to see the problem when it is right in front of them or afraid to do anything about it.

Identification with a physician in treatment is an advantage in terms of understanding the patient's problems and dynamics but also a disadvantage because of the possibility of its engendering feelings in the therapist about his or her own vulnerability to illness, thus leading to denial.

Case Report 11.33

A 35-year-old physician was in recovery from alcohol dependence for 2 years with monitoring at an impaired physician's treatment program. He was a likable, handsome, and narcissistic man who behaved as if the psychiatrist were monitoring his urine more as a friend than a monitor. When his girlfriend broke up with him and he started having signs of a budding relapse, infrequent monitored urine screening only for alcohol was started, presumably to save him money. He ultimately relapsed on opiates and had to enter residential treatment.

Countertransference that prevented the psychiatrist from ordering urine screens that tested for all substances and from performing them more frequently was problematic, especially with the indications of beginning relapse.

The manipulative behavior of addicted professional persons, combined with their medical knowledge, can prove disastrous to the treatment.

Case Report 11.34

A 35-year-old physician abused both alcohol and opiates. His first rehabilitation consisted of outpatient treatment with a psychiatrist and included personally observed urine monitoring. His initial relapse was followed by a second and more thorough program. He progressed from residential treatment to intensive outpatient treatment with monitored urine. He began abusing buprenorphine, which he knew was not tested for in the standard urine screen. It was only when his office staff discovered and reported this activity that his second relapse came to light.
Case Report 11.35

A 45-year-old prominent physician was in a role that allowed him to have an impact on the funding of the program in which he was being seen. He was pleasant and cooperative when being interviewed, but when away from the program he manipulated processes such as his disulfiram monitoring and urine monitoring. For example, it required 3 months to obtain a copy of laboratory studies that were ordered initially to both document his substance use and clear him for the prescription of disulfiram; in addition, he managed to convince his disulfiram monitor that the dose should be cut in half when there was actually no clinical indication for such a reduction. This allowed him to continue to drink some alcohol.

Many therapists have difficulty tolerating the criticism, rationalizations, and projections that are common in the addicted health professional's armamentarium of defenses. It is important to deal with clinician-patient issues when working with prominent patients, especially physicians. Supervision may be helpful in dealing with the problem. The prominent physician needs the same limits and structure that any other patient needs and deserves our best care instead of our friendliness.

Supervision and consultation may be essential to the delivery of acceptable treatment, particularly in difficult or complex cases.

Case Report 11.36

A 50-year-old prominent physician was in treatment with an equally prominent local psychiatrist and because of concerns from family members about his continued drinking, agreed to a consultation at their request. A consulting psychiatrist felt strongly that this patient needed to be in formal alcohol treatment as well as in his ongoing psychotherapy. He made that recommendation to the physician patient and even met together with the physician and his psychiatrist to discuss that plan. The treating psychiatrist resisted this plan, saying that what he was doing was perfectly adequate. As a result, the physician did not enter substance abuse treatment, although, from all reports, he dramatically decreased his drinking for a period of several years. However, he resurfaced later with more severe alcohol problems.

Supervision for both the treating psychiatrist and the consulting psychiatrist could have helped sort out the issues related to dealing with prominent colleagues. It might have allowed the treating psychiatrist to be more receptive to input and the consulting psychiatrist to be more forceful about his recommendations, avoiding the subsequent deterioration of the patient. Impaired physician programs and physician-helping-physician groups can provide invaluable assistance in such cases.

Medical problems complicating the substance abuse of physicians may contribute to countertransference issues interfering with the treating psychiatrist's objectivity.

Case Report 11.37

A 30-year-old family practice resident became HIV positive, apparently as a result of a needle stick. She was an articulate and well-liked woman who, when evaluated, clearly had polysubstance abuse problems and actually entered methadone maintenance treatment because she was unable to stay away from opiates. Her treating psychiatrist and internist frequently had difficulty setting limits on her use of alcohol, which she claimed was the use of Nyquil (which contains 10% ethanol) for the purposes of going to sleep at night. She would appear at the methadone clinic with blood alcohol levels in the range of 100 mg% and would attribute this to having taken Nyquil the night before. She told the treating psychiatrist at the clinic that she could not take disulfiram because her internist had told her it would be bad for her liver. It was only when her drinking became bad enough that her T-cell count was starting to fall dramatically and she was looking more physically sick that the treating psychiatrist and the treating internist began to collaborate closely enough to keep the patient from playing them off against each other. In fact, the internist strongly supported the use of disulfiram.

Failure to recognize substance abuse, seeing it instead as substance use, is a repetitive theme in the treatment of professional and other VIP patients. As in the above case, it prevents earlier integration of all aspects of the treatment.

The ultimate “hitting bottom” for a physician or other health professional person may well be the loss of his or her license to practice as a result of the seriousness of the substance abuse problem. In treatment settings, appropriate steps and limits may not be undertaken because of the fear on the part of the caregivers that the physician might lose his or her license.
Case Report 11.38

A 40-year-old radiologist had a long history of polysubstance abuse. After failing probationary status with his licensing board because of positive urine tests, he had his license revoked. The treatment team had resisted reporting him to the licensing board for failure in treatment and for his dirty urines over a period of months because they were afraid of the implications of the loss of his license for his identification as a physician and they feared that he might become suicidal if he were to lose his career. In fact, however, loss of his license was the first time that he truly had “hit bottom,” and his subsequent recovery was quite successful. He worked briefly outside the medical field, and then he went back into residency training to become qualified as an internist to practice addictionology. He is currently relicensed and enjoying a successful and happy recovery.

Loss of license should be viewed objectively as an appropriate consequence to continued substance abuse and should be seen as not only an administrative procedure but also as a clinical intervention that may finally help the physician enter into recovery. The treating psychiatrist needs to avoid identifying with the physician patient’s negative reaction to the loss of the license and instead should view this intervention as the possibility for a new beginning.

Gays and Lesbians

It remains unclear if there is a higher prevalence of psychoactive substance disorders in homosexuals, both gays and lesbians, than in the general population. Estimates of the incidence of chemical dependencies of all types for gay men and lesbians from a number of studies range from 28% to 35%, compared with 10% to 12% for the general population. A more recent study, which argues that many of the preceding estimates were based on convenience samples, found no difference in a measure of heavy drinking among bisexuals/lesbians and heterosexual women. Several theories have been put forth to explain the possible greater use of substances in the gay community. They include the traditionally central role of the gay bar in homosexual life, the need for release of tension due to societal oppression of homosexuals or the internalization of that oppression, and, especially for someone just beginning to reveal homosexually publicly, the need for intoxication in order to venture into homosexual relations.

The following case illustrates how the alcohol or drug use may be used to ease the discomfort associated with unresolved conflict regarding one’s sexual orientation.

Case Report 11.39

A 36-year-old graduate student who had been married for 12 years to his high school sweetheart had become increasingly aware over the past 3 years of his sexual attraction to men. He began questioning his sexual orientation and started to explore the gay community where he lived. Cocaine was sold in the parking lot of the bar frequented by homosexuals, where he began to “test the waters.” To gather his courage to go inside, he began purchasing more and more cocaine. As he attempted to connect with the gay community, his use of cocaine, which had previously been occasional, quickly escalated to much heavier use. He soon separated from his wife. He began treatment both to deal with the change in his acknowledged sexual orientation and to abstain from using cocaine. However, he remained fearful that his homosexuality would be discovered by his heterosexual peers and that he would be rejected by both them and his potential homosexual peers. He relapsed several months later into heavy use of cocaine in a pattern similar to before.

In this case, although the seeds for cocaine abuse already existed, the emotional upheaval involved in changing his public behavior vis-à-vis his sexual orientation provided the catalyst for the development of a serious drug problem. Here the inability to fully accept his homosexual identity limited his ability to remain abstinent from cocaine. His treatment needed to focus simultaneously on his drug problem and the changes in his publicly acknowledged sexual orientation.

A gay person’s ability to accept that he is an alcoholic or an addict may be hampered by issues of identity and self-esteem. A person who has not revealed his or her homosexuality publicly may feel too uncomfortable to be selectively open about admitting to having a drug or alcohol problem. Twelve-step groups that foster self-revelation may discourage homosexuals who are unsure about their sexual orientation or are ambivalent or even reticent about disclosing that information to others, especially those who are not homosexual.
Case Report 11.40

A 24-year-old gay man agreed with his doctor that his use of alcohol was both problematic and out of control. He desired a support group, but had difficulty with the idea of attending an AA group of mostly heterosexual orientation. He commented, “It is hard enough that I would have to go and admit that I have a problem with alcohol, without also having to admit that I’m gay.” He accepted a referral to a substance recovery group at the local gay and lesbian community center.

Additionally, gay men are at higher risk than the general population for contracting HIV and developing acquired immune deficiency syndrome (AIDS). Once a person becomes HIV-infected, additional difficulties in the assessment and treatment of substance disorders may present themselves, as discussed in the next section.

HIV-Infected People

There is a considerable overlap between substance abusers and HIV-infected people. Substance abusers have an increased risk of acquiring HIV. Sharing used needles is the most concerning risk factor associated with substance use. Nearly one-third of the intravenous drug abusing clients in one drug program had HIV. Additionally, alcohol and other drugs may play a role in the facilitation of high-risk sexual behaviors. The number of HIV-infected persons in a sample of drug treatment program clients who had not injected drugs intravenously was 7.3%. In another study, 6.8% of clients in an alcohol treatment program were HIV positive. Another estimate of the seroprevalence of HIV infection in heterosexual clients in alcohol treatment has been placed at 5%. For comparison, the United States 1992 census was estimated at 253.6 million; that same year there were 45,474 reported cases of AIDS. This represents 0.02% of this country’s population. Substance abusers, even excluding those who have injected drugs, have an HIV risk 250–350 times that of the general population.

There is also a high prevalence of alcohol and substance use in HIV-infected people. An anonymous questionnaire of HIV clinic patients revealed a heavy consumption of alcohol: 99% drank in the prior 3 months and 68% drank at least twice a week. Of these patients, 78% used cannabis and 46% used cocaine regularly.

Knowledge of HIV infection may also adversely affect substance treatment. A survey of adolescents and young adults undergoing treatment for alcohol or drug problems were asked what they would do if they were found to have a positive HIV test. Most said they would likely stop their substance abuse treatment (69%), and a majority answered they would be more likely to continue using alcohol or drugs (62% and 64%, respectively).

HIV-infected individuals are susceptible to myriad infections and medical complications. The retrovirus alone may cause encephalopathy or may cripple the immune system, leaving the person vulnerable to a variety of opportunistic infections. Many of the different antifungal, antiviral, and other medications used to treat these infections may result in disconcerting and confusing side effects. A careful diagnostic evaluation is required to distinguish which disorder or medication is etiologic when new symptoms arise.

Case Report 11.41

A 35-year-old employed HIV-positive gay man with insomnia and fatigue was referred by a psychiatric nurse to have a medical evaluation and begin antidepressant medication. Further history obtained from the psychiatrist revealed that in addition to suffering the loss of a cousin to AIDS and concurrent treatment with zidovudine (AZT), he had also been drinking 6–12 beers daily. He wanted antidepressant medication and was angry when told that he first had to stop drinking. An abrupt decline in the number of his T cells a few weeks later precipitated his attempt for sobriety. He developed stable sobriety over the next 3 months with the assistance of AA. His depressive symptoms abated and an antidepressant medication was not needed.

Insomnia, fatigue, anxiety, and anorexia are symptoms that are common to more than one disorder. These symptoms may be due to the HIV infection, the antiretroviral agent AZT, an opportunistic infection such as Mycobacterium avium-intracellulare, a concurrent major depressive disorder, or, as in this case, alcohol abuse.

Medical complications and preexisting side effects to current medications may limit the pharmacologic means of treating an HIV-infected person’s substance disorder.
Special Populations

Case Report 11.42

A 25-year-old man with AIDS was being treated with acyclovir, an antiviral agent, for disseminated herpes. On this medication he developed elevated liver enzymes, approximately 20-fold from normal, indicative of a chemical hepatitis. He also abused alcohol, primarily in the form of weekend binges. He was ambivalent about receiving alcohol treatment and unsure that he had an alcohol problem. Disulfiram was recommended by his psychiatrist. The patient was quick to point out that his abnormal liver tests precluded treatment with disulfiram, having previously discussed this same issue with his internist.

In this case the elevated liver functioning caused by the antiviral medication precluded use of disulfiram, which is metabolized by the liver. Except on an emergency basis, the medical and medication status of a patient should be fully assessed for potential adverse drug-drug interactions prior to the initiation of a pharmacologic intervention, whether to treat intoxication, withdrawal, or dependence.

HIV disease was once thought to be an acute illness with complete mortality after a brief symptomatic stage. It has emerged as a treatable and chronic disease. One may remain HIV positive without developing AIDS for years. Even after the onset of AIDS, relative health may continue for months to years.

Case Report 11.43

A 40-year-old gay man with moderately symptomatic AIDS was admitted to a hospital with his second episode of *Pneumocystis carinii* pneumonia. He also had a long history of alcoholism with no intention of curbing his use. At 2 days before expected discharge, the medical intern requested a psychiatric consultation for alcohol treatment. The resident providing the consultation reviewed the case with the intern’s attending, noting, “I don’t see why we should go to the trouble to petition the court for alcohol treatment when this patient is going to die anyway. It’s a waste of resources.” The attending physician disagreed with this assessment and initiated involuntary alcohol treatment measures.

Condoning alcohol or drug use and ignoring treatment needs in persons with HIV or AIDS are gross errors on the part of the health care provider. Sobriety from substances can actually result in marked improvement in the quality of life and overall health of the HIV-infected person.

Continued use of alcohol and drugs can actually result in progression of HIV disease. Alcohol, cocaine, and opiates have all been shown to have immunosuppressive properties. HIV replication has been shown to be augmented by alcohol, *P. carinii* infection, and morphine. Continued intravenous drug use also increases the risk of reinfection with other strains of the virus.

Case Report 11.44

A 32-year-old gay man with a history of intravenous drug abuse was seen in an HIV clinic complaining of insomnia and depression. His drugs of choice were alcohol and intravenous cocaine. His physician strongly recommended that he enter a substance treatment program, informing him of the negative effects of both cocaine and alcohol on his immune status. He disagreed, explaining that many of his friends who had died from AIDS “were fine until they quit using. Six months later they were dead.” He refused treatment and was lost to follow-up.

The connection between HIV patients discontinuing their drug use and acceleration of their illness was perceived readily by this patient, though with faulty causality. Many HIV-infected individuals who abuse drugs realize at some point in their illness they cannot tolerate the drug effects that had been previously desired. Acceleration of the illness with a resulting deterioration in one’s physical condition may precipitate the decision to quit. Contrary to the myth around which this case revolves, discontinuation of injected drugs has actually been shown to slow the progression of HIV disease in infected subjects.

People with HIV often deal with anorexia, whether due to the illness or its treatments. It is common in the HIV/AIDS community for marijuana to be used to counter a poor appetite and forestall weight loss. Although it may be considered benign by these patients, it may not be without adverse consequences.

Case Report 11.45

A 36-year-old man with advanced AIDS, including Kaposi’s sarcoma and *Pneumocystis carinii* pneumonia, came into the HIV clinic for a routine visit. He had some signs of HIV encephalopathy, particularly poor concentration and short-term memory loss. He had previously also
been dependent on cocaine but had been able to abstain from that drug after 6 months of inpatient treatment. He continued to use cannabis daily to stimulate his appetite. He had developed increased paranoia with delusions that spirits communicated with him. He was resistant to stopping the marijuana, sure that his use of the drug was purely medicinal in nature. He remained paranoid, left treatment, and died 6 months later of AIDS-related complications.

It can be extremely difficult to convince someone that a drug they are using is harmful when it is sanctioned by the subculture to which that person belongs. Although there may be people who use the drug “appropriately” and who do not appear harmed by its use, it is important for the clinician to be on guard for more than “medicinal” use and for side effects such as paranoia.

Conclusions

Many of the particular needs of these “special” populations stem from a recognition that substance use disorders do indeed occur and that the individual abuser needs to be treated as such, as an individual. Uniqueness may arise out of one’s gender, age, race, ethnic background, childhood, living situation, concurrent medical disorders (and psychiatric disorders), physical handicaps, or cognitive abilities. Full benefit may not occur if standard treatment techniques and programs are applied without thought to the unique aspect of the person.

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Summary

Alcoholism and addictions are chronic, relapsing disorders. Difficult to recognize early, they are often complicated by comorbid psychiatric or medical illness, presence or lack of support systems, and negative social attitudes. Even with timely treatment, there are no simple or easy cases. Consequently, clinical care involves a myriad of potential pitfalls that may lead to poor outcomes. Failed treatment typically results in disability or premature death.

The preceding chapters have attempted to categorize key areas where potential pitfalls exist in the treatment of alcoholism and addictions. It has been our intent that these pitfalls might be best learned through cases analysis, rather than via a sterile repetition of statistical outcomes. While addiction psychiatry is a relatively new field, it is becoming more sophisticated as we learn more and improve our methods both of study and treatment of the addictions. In keeping with our goal of improved clinical care, salient teaching points and general recommendations from each chapter are outlined below.

Screening, Diagnosis, and Assessment

- Take a complete history that includes current substance use, especially if there is a history of past abuse. Get details and don’t accept vague answers, such as, “I’m a social drinker.”
- Use collateral sources of information and history.

• Pay attention to risk factors.
• Do a thorough physical exam, with special attention to signs and symptoms of abuse and withdrawal and their associated biomedical conditions.
• Use appropriate rating scales.
• Remember that overdiagnosis can be as harmful as underdiagnosis.

Principle: The presence of comorbid psychiatric disorders can make diagnosis difficult.

Phases of Treatment and Recovery

• Provide appropriate medical care during all phases of treatment.
• Consider all treatment options for each phase of recovery.
• Patients with untreated comorbid disorders are very vulnerable to relapse.
• Monitor urine and/or blood toxicology screens when appropriate.

Principle: Use and include patients’ support systems in realistic and appropriate ways to help in recovery.

Psychotherapy

• Evaluate each patient thoroughly, even if the patient comes to you with a diagnosis.
• Don’t minimize any drug or alcohol use and, in the presence of a substance-related disorder (SRD), insist on abstinence before psychotherapy starts.
• Be flexible about using different types of therapy depending on the patient’s phase of recovery (e.g., behavioral vs. supportive vs. family vs. insight oriented).
• Pay close attention to countertransference/transference.

Principle: Keep in mind cultural issues/differences and how they may affect treatment.

Summary

Somatic Therapies

• Observe patients off substances for several days, weeks, or months before treating with medications; remember that many abuse/withdrawal syndromes can mimic psychiatric disorders.
• Although addictive medications can be used to treat psychiatric illness in an addicted patient, especially during withdrawal, extreme caution and frequent monitoring are necessary for maintenance treatment.
• Be aware of interactions between certain substances and medications, including adverse reactions and changes in metabolism.
• Opiate-tolerant patients may need more pain medication and should get it for the treatment of acute severe pain, but they also need to be observed for medication-seeking behavior.

Principle: Pharmacotherapy and other somatotherapies should not be undertaken too readily or deferred inordinately.

The Doctor-Patient Relationship

• Consider your own feelings towards addicted patients and addiction to ensure that they don’t interfere with treatment, especially if you are recovering yourself.
• Be aware of potential transference reactions, such as the need for the patient to destroy the treatment or to disappoint the therapist.
• Get supervision or work in a team setting whenever possible and get further training when necessary.
• Listen to the patient’s and family’s criticism—it may be transference, but it also may help you avoid mistakes.

Principle: Be flexible but consistent.

Social Networks

• Help the patient set up other social/therapeutic supports to avert relapse, and help them to choose willing participants.
- Make sure proper follow-up and continuity of care are established to help patients avoid relapse and rehospitalization.
- Certain aspects of patients’ social networks auger against recovery, whereas other aspects can provide strong allies in the recovery process.
- The clinician can play a key role in initiating, negotiating, and perpetuating recovery-oriented relationships in the patient’s social network.

**Principle:** Social networks can exacerbate substance disorder or facilitate recovery. Experienced clinicians utilize the strength inherent in patients’ social networks.

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**Complications in Self-Help**

- Remember that self-help group members can be using substances-of-abuse and attending meetings at the same time.
- Self-help groups vary—help the patient find one that is a good match for her/him.

**Principle:** Self-help groups can provide an important social and therapeutic support system that help patients in recovery and can be a useful adjunct to other treatments.

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**The Training Experience**

- Take the time to examine each patient and to think of all possible diagnoses; intoxicated individuals have a high rate of concurrent trauma and illness.
- Pay attention to your own feelings and attitudes toward addicts; awareness of them should prevent their interfering with clinical judgment.
- Health professionals in training need supervision in treating addictions.

**Principle:** Addiction is an illness and requires treatment, like any other illness.

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**The Treatment of Addicted Women**

- Addiction is not limited to a particular gender, culture, or age group; everyone deserves screening.
- Women may require different treatment environments or programs than men.
- Addicts who are pregnant or who are mothers may need special programs that take their special needs into account and allow them to be near or with their children.

**Principle:** Be aware of stereotypes about addicted women (e.g., that pregnant addicted women are child abusers and intoxicated women deserve any crimes committed against them).

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**Special Populations**

- Certain populations are susceptible to particular types of substance-related disorders and to particular comorbid psychiatric disorders.
- Increased age may cause increased sensitivity to or reduced metabolism of certain substances, putting the elderly at greater risk of abuse from lower doses.
- Avoid stereotyping as addicts on the basis of race, ethnicity, or socio-economic class.
- People with physical disabilities are at high risk to self-medicate.
- Health care workers can be especially difficult to treat secondary to a knowledge of how to manipulate the system and our own identification with them.
- Substance abuse is associated with an increased risk of AIDS.

**Principle:** In order to serve all patients well, clinicians must possess knowledge and sensitivity to the special dimensions of psychoactive substance use and abuse among youth, the elderly, various ethnic groups and subcultural groups, and those with certain medical disorders.
Legal Issues

- Be circumspect about prescribing addicting medications in individuals with a history of addiction.
- Remember the interactions between medications when treating addiction and withdrawal.
- Always screen for substance abuse/addiction as part of any physical or psychiatric exam.
- Always screen for comorbid psychiatric disorders.

Principle: Keep records confidential unless the patient or others are at risk.

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