Detox does not equal treatment: Withdrawal management and treatment of substance use disorders

Many patients with a substance use disorder will be physically dependent on the drugs they are taking and will experience withdrawal symptoms when they stop or reduce the amount they are using. For certain drugs, especially alcohol and sedatives (including benzodiazepines), this withdrawal syndrome potentially can be fatal. The medical management of withdrawal syndromes was formerly known as detoxification, or “detox” for short. In many cases, withdrawal management is medically necessary before a patient can proceed with a formal treatment program. Even though withdrawal management may be necessary, that process is only a precursor to the actual substance use disorder treatment process.

Within substance use disorders, the class of drug influences the withdrawal experience, with many people assuming heroin withdrawal is the most painful and life threatening. That actually is not the case. Patients going through withdrawal for heroin or other opioids may think they are dying -- and without appropriate medical treatment they may feel like they are dying -- but opioid withdrawal rarely leads to death unless there was a serious underlying medical condition such as heart disease. Withdrawal from alcohol and sedatives such as Ambien, Xanax, Ativan, Klonopin and Valium is much more likely to be life-threatening, especially if not appropriately medically treated. For this reason, it is important for people not to go “cold turkey” and attempt to “detox” at home when physically dependent on alcohol or sedatives. Even in a hospital setting with good medical care, the risk of dying from withdrawal from those substances can approach 7 percent.

In many cases, depending on the class of substance on which the patient is dependent, physicians can prescribe medications that relieve most withdrawal symptoms. If the long-term plan is for maintenance therapy for opioid addiction, they also may stabilize the patient on medicine such as methadone or buprenorphine.

The first phase of treatment begins when the patient enters a treatment facility for evaluation for a substance use disorder. Clinicians take the patient’s history of past and recent drug use, measure his blood alcohol level and test urine and saliva samples. A physical exam, including a mental status exam, along with additional lab testing, identifies evidence of intoxication, withdrawal or impending withdrawal, as well as any co-occurring medical issues that may be affected during withdrawal. Malnutrition and dehydration can exacerbate the effects of withdrawal; clinicians must identify and treat these maladies. The duration and severity of acute withdrawal symptoms varies depending on the class of drug and the amount, frequency, duration and potency of the drug used.

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the drug or combination of drugs used as well as individual factors unique to each patient. Symptoms can last several days or even weeks.

Many patients mistakenly believe that simply stopping their drug use and getting through the withdrawal process equals treatment. That is only the first phase of treatment, which readsies the patient for the actual process of learning to remain abstinent and to become healthy, happy and productive members of society. Going through the withdrawal process without continuing on to phase two almost always leads to relapse. In one study, researchers followed 100 patients who were successfully medically “detoxed” off methadone but did not receive any additional treatment. One year later, 99 patients were using opiates again. The one who did not attributed his success to a spiritual awakening.

Addiction is a chronic brain disease and should not be treated as an acute disease that can be cured. The only way to successfully treat a chronic disease is to provide treatment that will put the disease into remission and keep it there. Maintenance therapy is required for alcohol and drug addiction in the same way that it is required for a chronic disease such as diabetes. Diabetics can be treated in a hospital to normalize blood sugar levels, but if that patient goes home and does not continue maintenance therapy (by following diet and lifestyle restrictions, monitoring blood sugar levels, taking prescribed medicines and following up regularly with healthcare providers) the patient will either almost certainly end up back in the hospital or dead. For patients with substance use disorders, maintenance is the third phase of treatment following the successful completion of intensive therapy (phase two) preceded by the withdrawal management and initial assessment and stabilization of co-occurring medical and psychiatric conditions (phase one).

Patients must successfully complete these three phases to reach the desired goal of long-term recovery. Phase one, which most people know as “detox,” allows a patient with a substance use disorder to reach the physical and mental state necessary for the second phase to be effective. When a patient is in withdrawal or unstable from a co-occurring medical or psychiatric disorder, they are not capable of engaging in the intensive work required to successfully complete phase two. During all three phases of treatment the brain begins to heal but may take several years to return to normal. Thinking, reasoning and impulse control begin to return toward baseline, which allows patients to progress in group and individual therapy and develop the skills necessary to try to keep the disease of addiction in remission. Abstinence-based 12-step programs have emerged as one of the most effective foundations for patients to enter and remain in long-term recovery. Research shows patients who enter 12-step programs and do more than just attend meetings, who actually “work a program,” (getting into and working through steps with a sponsor and developing networks of recovering individual for support) fare well.

The second phase of treatment is extensive, comprehensive and can be summarized in six domains. The first domain is containment, in which abstinence from use of addictive substances is established. After successful management of withdrawal and stabilization of psychiatric and medical conditions, the patient must remain abstinent because if he or she continues to use the substance, the likelihood of success with any level of treatment is very small. Containment can be physical, in which the person is in a locked or highly monitored hospital ward or residential facility with no access to alcohol or drugs, or a facility that is not locked but is remote enough that residents cannot easily leave and find the desired substance. Another option is social containment, in which the patient is accountable to someone else for remaining abstinent. Contractual containment, most commonly used with physicians and other professionals with addictions, involves a written agreement stating that the patient will follow the treatment plan or suffer specific consequences such as losing a job or professional license. The agreement also includes rewards, such as less frequent drug testing, for compliance. Biological containment involves medications that help the person abstain, such as naltrexone to block opiate receptors and lessens the enjoyment of Antabuse, which

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results in a significant adverse reaction if the patient drinks alcohol.

The second domain is recovery basics, which varies according to the patient’s prior experience and familiarization with the recovery process. Some patients arrive with no prior history of treatment and require a thorough education on the 12-step recovery process. Others have been through treatment before and need only a refresher. Recovery basics also include connecting patients with others who are excelling and can serve as mentors and trusted advisors.

The third domain is emotional resiliency, which is important because most people with substance abuse disorders have lost their ability to tolerate emotions that one encounters on a daily basis. For the patient addicted to drugs and/or alcohol, the default reaction to emotions, both positive and negative, has been to use drugs. Drugs blunt emotions. When a patient remains abstinent from her usual coping response, she begins experiencing the full emotional response. Learning to experience the full range of positive and negative emotions is a skill set that must be developed to avoid relapse.

The fourth domain is internal narrative. Everyone engages in “self-talk” (or internal running dialogue) throughout the day. For most, this internal narrative is usually somewhat negative and, when healthy, serves to help us improve our daily performance. In patients with addiction, that self-criticism is often amplified. Without substances to shield them from some of that self-criticism, patients can feel extreme levels of guilt and shame. Another part of the internal narrative involves the way the hijacked or addicted brain minimizes or even completely ignores the severity of the chaos that their addiction has caused in their lives and in the lives of those who care about them. For years, the recovery community has called this denial and dealt with it in a very confrontational manner. Breaking through that denial is a key step in helping patients rewrite their narrative, but it must happen in a supportive way so that they aren’t left alone to cope with the full truth of their addictions.

Spirituality and connectedness make up the fifth domain of treatment. Connectedness is the patient’s ability to enjoy healthy interpersonal relationships, which people usually lose when they become addicted to drugs or alcohol. Patients often say they are never comfortable around people unless they are under the influence of alcohol or drugs, so they must work to understand why and develop healthy ways to connect with others. Spirituality involves connectedness to a power outside oneself. Twelve-step recovery programs identify a “higher power,” whether that is God or a support group of recovering addicts.

The last domain is relapse prevention. To reduce the risk of relapse, patients must learn coping skills and identify cues and triggers associated with drug and alcohol use. Patients learn to recognize and avoid places that are likely to be dangerous for them (in 12-step vernacular, their “playgrounds, playmates and playthings”), as well as strategies for declining drugs and alcohol when they are available.

Learning and operationalizing the skills covered in the six domains of treatment can only be successful when the person is stabilized from the physical and mental changes caused by substance abuse and its withdrawal, but the “detox” itself should never be confused with treatment. A medically safe “detox” is only the first step toward entering successful treatment for a substance use disorder.
The potential for becoming dependent on pain medications is well known, but it can be difficult to distinguish between pain-related dependence on medication and an addiction. Some fear becoming addicted to powerful pain medications so much that they will avoid using medication when necessary, allowing pain to interfere with recovery from surgery or ongoing medical treatment.

Dependence is an unfortunate side effect of opioid pain medication, but it is not the same as an addiction to opioids. Physicians can prescribe pain medications legimately, and patients can use such medication appropriately yet still develop a physical dependence that requires medical intervention when the drug is no longer needed to control pain.

Patients on pain medication can become dependent and progress to addiction, but difficulty stopping pain medication does not in itself make the person an addict. Understanding the difference is important for patients, their families and their healthcare providers because a misinterpretation can lead some to blame patients unnecessarily for a condition that is not within their control, as well as people avoiding pain medications that they need.

Opioid drugs bind to opioid receptors in the brain, spinal cord and other areas of the body. The drugs interfere with the transmission of pain messages to the brain and reduce feelings of pain. Opioids treat moderate to severe pain, such as the pain after surgery, as well as painful illnesses such as cancer.

Almost all patients who use an opioid pain medication like fentanyl, hydrocodone, morphine, oxycodone, OxyContin and Dilaudid for more than a month will experience physical withdrawal symptoms when they stop taking the medication. Only about 15 percent of patients using opioid pain medications become addicted. People taking opioid pain medications for long periods often wonder if they are addicted.

Patients often will tell their doctors that they’ve been taking the drugs so long and are so dependent on them that they don’t know any more if they are just taking the drugs for pain or because they are addicted.

Loss of control, use despite knowing the harm, preoccupation and craving all signal addiction to pain medication. Those addicted to pain drugs may or may not be physically dependent. Abuse of prescribed opioid medications is not rare, but patients with prescriptions usually do not abuse the drug. The Substance Abuse and Mental Health Administration (SAMHSA) reports 70 percent of those abusing pain relievers obtained them illegally.

Withdrawal symptoms include agitation, anxiety, muscle aches, insomnia, runny nose, elevated blood pressure, dilated pupils, rapid heart rate, sweating, abdominal cramping, diarrhea, nausea and vomiting. Although painful, withdrawal from opioid medications is not usually life threatening. Physicians can ease the discomfort with treatment for anxiety, cramping, diarrhea and other symptoms.

Once withdrawal symptoms pass, which could take several days, the person is free of any physical drug dependence. Physicians prescribing opioid pain medications usually will try to minimize the effects of withdrawal by tapering the patient’s dosage once pain is no longer an issue. Physicians progressively lower the dosage to zero, which helps many patients avoid severe withdrawal symptoms.

Dependence and physical withdrawal symptoms are the body’s reaction to opio-
Addiction opioids and have nothing to do with mental weakness, willpower or lack of character. Patients taking pain medication may also fear that their need for increasingly higher doses indicates an addiction, which is not the case. As with many other drugs, patients develop a tolerance for opioid pain medication over time and need a higher dose to receive the same effect.

Patients who use opioid pain medication also may develop a condition called opioid-induced hyperalgesia, in which pain medications create more pain instead of relieving it. Patients who suffer from opioid-induced hyperalgesia may experience increased sensitivity to painful and non-painful stimuli, worsening pain and a decreased pain threshold. This condition will ease and disappear as physicians wean the patient off the opioids.

The vast majority of opioid users will be able to stop taking the drug when appropriate, travel with their doctor down the road of withdrawal road and eventually lose total interest in the drug. But an addict will continue craving and obsessing over the drug after the pain and withdrawal symptoms subside.

That is the distinction between two starkly different patient populations: both may share similar experiences with the drug up to the point at which someone cuts off the medication. Everyone else is able to put the experience behind them and move on. But the addict cannot let go.

Some behaviors indicate a patient is at higher risk for addiction to pain medications. An “unsanctioned dose escalation” means the patient takes an extra pill once or twice without the doctor’s approval. When the physician realizes the patient is short a couple pills before time to refill the prescription, he or she will explain that what the patient did is unacceptable and that the patient must never repeat it. An ordinary pain patient will not take an extra pill again, whereas a patient with an addiction problem won’t be able to resist temptation.

Other behaviors suggesting addiction include selling medications, obtaining drugs from other people, falsifying prescriptions, injecting medications meant for oral use, use of illegal drugs or controlled substances that are not prescribed for the patient, repeatedly reporting lost prescriptions and requests for early refills.

A normal pain patient usually will not break the law to obtain medication, but the addict may doctor shop, steal prescriptions, obtain drugs illegally online and use illegal drugs when they can’t obtain prescription pain pills.

Another indicator of a substance use disorder is when a patient claims that an increase in dosage has no effect. Providing more opioids is bound to provide at least some small amount of pain relief, so regard patients who claim no benefit with caution. The patient is not lying just to obtain more pills; he or she truly did not sense any improved pain relief. A regular patient gets better when provided more pain medication, but a drug addict gets worse.

Physicians must handle carefully pain management for patients with known substance use disorders. These patients deserve good pain management as much as anyone else. Enduring pain without medication is not a healthy option because pain causes stress and physiological reactions in the body that can interfere with recovery.

Physicians might prescribe opioids for these patients after surgery or an injury, but regardless of the patient’s substance of choice, he or she will be at high risk of abusing the drugs without strict safeguards. Surgeons or other physicians should work closely with the patient’s addictionologist to develop an opioid program that effectively relieves the addict’s pain but also minimizes the chance of drug abuse.

Specific strategies include trusting someone other than the patient to possess and control pain pills, forbidding the patient from touching the pill bottle or prescription, destroying any remaining medication after the patient no longer needs it and reinforcing substance abuse therapy afterward in case the pain medication awakens old urges.

However, physicians should avoid opioid pain medications for chronic pain treatment in patients with substance abuse disorders. Opioids tend not to be as effective for chronic pain, regardless of whether the patient is a substance abuser, and the ongoing access to such drugs can be too tempting to those in recovery. In these cases, the patient in recovery should address chronic pain with non-opioid medications and other methods such as yoga, meditation and physical therapy.

If those alternatives do not provide adequate relief for chronic pain, the best opioid option for patients in recovery are long-lasting opioids such as buprenorphine, which helps patients end their dependence on other opioids.

**FURTHER READING**

Use of personality traits to identify addiction risk and individualize treatment

Treatment for substance use disorders is most successful when it takes into account unique characteristics of the individual, and personality testing can be an effective aid in developing the most appropriate care plan.

Personalities are unique and extremely complex. Personality variables influence the likelihood of developing a substance use disorder, the severity of addiction and the risk for relapse.

Addiction professionals largely agree that personality traits of addicted individuals are important in understanding their disease and determining treatment.

Unfortunately, some physicians and therapists assume an individual’s personality is static, that nature and nurture have set the personality in stone.

However, research data indicates a person’s personality traits can change, and professional experience bears that out. Personality traits change significantly with help from therapists and participation in 12-step programs.

Research shows certain personality traits increase an individual’s susceptibility to addiction and others decrease it. A person is more likely to develop an addiction if he or she has high levels of novelty-seeking, impulsivity, neuroticism and harm avoidance (the need to escape from distressing stimuli).

Additionally, addicts often exhibit lower levels of positive personality traits, such as conscientiousness and persistence. C. Robert Cloninger, MD, conducted some of the most significant research in this field. Since the 1970s, Cloninger has researched the effect of personality on individuals and confirmed personality traits affect behavior.

A landmark study published in 2014 examined how genetics and personality traits combine to lead an individual down the substance abuse path.

The authors from the National Institutes of Health and the Virginia Commonwealth University School of Medicine concluded that as physicians explore the genetics of substance use disorders, the genetics are so complex that the best way to understand the subtypes of various addictions is through personality traits.

That research, which confirmed clinicians’ experience using personality traits to best tailor the treatment provided to people with substance use disorders, concerned endophenotypes – indirect ways to measure genetic contributions to a trait or behavior.

The authors identified three endophenotypes that indicate variable risk for addiction. The highest risk personality traits concern negative emotionality, low positive emotionality and low conscientiousness.

Researchers noted likely genetic links to personality traits causing individuals to be susceptible to or resilient from substance use disorders.

One example involves positive emotionality/extroversion (PEM/E), which is a condition of high motivation, positive affect and feelings of excitement and optimism. PEM/E differences may occur in the central dopaminergic system, and high levels of PEM/E are protective against addiction, researchers found.
Researchers also studied the effects of negative emotionality/neuroticism (NEM/N). People who score high on this trait are angry, anxious and depressed, and have poor responses to stress. Addicts often have high levels of NEM/N. People who are highly disinhibited and unconstrained also are more likely to experience substance abuse problems.

Does this mean some people exhibit an “addictive personality”? The link between personality traits and substance use disorder is not that sharply defined.

There is no single personality type that leads to addiction; rather, a number of personality traits that vary in significance from person to person influence one’s susceptibility to addiction and experience once addicted.

Addiction actually can cause some personality deficits, such as impulsivity and poor coping skills, rather than the other way around.

This leads to a “chicken or egg” debate with some patients when it is not clear which came first, the personality disorder or the addiction.

Many patients with negative personality traits may exhibit some germ of that trait before sliding into substance abuse. Chronic substance abuse also creates neurological damage that affects personality traits.

Because deficits in the neurochemistry and reward circuitry that involve social attachment affect personality traits, some researchers believe this influences how patients in recovery create strong, supportive social bonds.

As research further defined the link between personality traits and substance use disorders, the Institute of Medicine released a report titled “Improving the Quality of Health Care for Mental and Substance-Use Conditions,” which recommended that clinicians providing mental and substance abuse treatment “increase their use of valid and reliable patient questionnaires or other patient-assessment instruments that are feasible for routine use to assess the progress and outcomes of treatment systematically and reliably.”

Psychologists Paul Costa Jr. and Robert R. McCrae developed the Neuroticism, Extroversion and Openness (NEO) Personality Inventory, a tool that measures an individual’s personality traits in five areas – neuroticism, extraversion, openness to experience, agreeableness and conscientiousness. This tool captures endophenotypes in the 2014 study mentioned earlier.

There are other similar tools, but in all cases it is more productive to involve the patient in the process of identifying personality characteristics rather than simply instructing him or her to take a questionnaire and receive the results.

Patients take the NEO test upon entering treatment. By working in groups and with the Positive Sobriety workbook, they can understand their personalities and how their strengths and weaknesses will affect recovery.

Working with the patient both individually and in groups elucidates subtle variations in personality.

Throughout treatment, there are opportunities for patients to gain a deeper understanding of their personality traits and integrate that knowledge into the group process.

Patients enjoy learning more about their personalities and how they interact with others, partly because the goal of a personality inventory is not to score well but to find out what works for the patient and what doesn’t.

There is no right and wrong with personalities, but it can be extremely helpful to know that certain treatment approaches or communication methods work better with a particular patient and how that person is likely to perceive and react to recovery strategies. The clinician benefits from this knowledge, but it is equally important for the patient to understand his or her own personality.

Patients should repeat the personality test when they leave treatment so that they can understand whether they were able to improve any of their personality traits.

Test patients again at six-month, 12-month and two-year intervals, allowing patients to compare their results over time and understand what they mean.

If a patient realizes he is backsliding in conscientiousness, a therapist can remind the patient how he improved that trait in therapy and become less impulsive.

Patients show improvement in personality scores after treatment. Many patients said they felt more engaged in treatment programs because they used personality testing to understand their addiction better.

Monitoring their progress in these personality traits is an effective way to help people with substance use disorders set goals for improvement and maintain the progress they make in therapy.

FURTHER READING


• http://1.usa.gov/1WI3tyU.
“Whole person care” is a treatment approach that has become the gold standard for patients coping with substance abuse disorders and psychiatric illnesses, part of serving all patient needs rather than just one.

The philosophy on treating substance use disorders has evolved over many years, moving away from what used to be the predominant thinking on how to treat a person who has more than disorder or problem. As recently as 20 years ago, the common approach was to treat a person’s substance abuse and psychiatric issues separately. That was called “sequential treatment,” and it often meant that when a person with substance abuse sought treatment the psychiatric illness became a roadblock. The patient might seek help at a substance abuse treatment facility – probably a big step that took a lot of courage.

During the screening process physicians would ask the patient questions to identify other potential issues. If the screening revealed the likelihood of a psychiatric illness, that was a red flag to substance abuse professionals. Substance abuse treatment was unlikely to be successful if the patient had untreated psychiatric issues. Addiction specialists believed a psychiatric condition caused a substance abuse issue. Specialists believed the addiction issue would subside after receiving psychiatric help. Physicians advised patients to seek help for the psychiatric condition first and come back for substance abuse treatment afterward, if necessary.

That was very discouraging for those patients, and many never sought psychiatric care or returned for substance abuse treatment. But even if patients sought treatment for the psychiatric condition, the message might be the same. Mental health professionals would say that they could not treat the psychiatric condition until the patient was clean and sober, because until then it was impossible to know if there truly was a psychiatric condition or if the symptoms were related to the substance abuse.

That no-win situation existed for decades, leaving many patients with untreated co-occurring disorders. Patients fell through the cracks of the healthcare system. Some died as a result. The fault lay not with patients but with the medical community that operated in discrete silos, focusing only on one area of expertise and leaving the patient to find a way to manage other problems. No treatment teams addressed all the patient’s health issues.

About 20 years ago, the medical community changed the approach to a patient’s multiple disorders, moving to an approach in which a patient would receive treatment concurrently at a mental health facility and a substance abuse center. This “parallel treatment” approach achieved limited success but the teams didn’t work together.

In addition to being less effective than coordinated care, the two treatment programs put stress on the patient. Full involvement in a treatment plan requires significant patient time and energy. Participating in two simultaneously was daunting and less successful.

In the last 10 years, the medical community has embraced whole person care, better known as integrated treatment. Integrated treatment combines the best healthcare solutions in one treatment plan for the patient. In this model, a patient seeks treatment at one facility to address both substance abuse and psychiatric disorders simultaneously.

Rather than placing the patient in two different treatment plans, specialists integrate them into a single plan that addresses both issues. This streamlines treatment from a practical perspective, but more importantly helps treatment professionals address a patient as a whole person and not just an illness. Physicians and thera-

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**What is whole person care?**

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*Dr. Steele reports no financial relationships relevant to this field of study.*
pists investigate the common factors that play into substance abuse and the psychiatric disorders, resulting in much more effective treatment of each.

Addressing these co-occurring disorders is important because the situation is so prevalent. Research indicates that between 55 percent and 70 percent of patients grappling with substance use disorders also suffer from a psychiatric disorder, but professionals in substance abuse treatment know that those figures are significantly underreported. Integrated treatment of co-occurring disorders often involves an interdisciplinary team that includes psychiatrists, psychologists, social workers, therapists and case managers.

Physical illness also plays into integrated care. This approach allows physicians to simultaneously treat physical illnesses, many of which directly relate to substance use or psychiatric disorders. Physical illness may have existed before other disorders, or it may be a symptom. In many cases, the physical illness will impede a patient’s ability to recover from substance use or psychiatric disorders.

For example, a patient may arrive for help with a prescription drug addiction. This is the fastest-growing category of drug addiction in the country. Most people addicted to prescription drugs – usually opioid pain medications such as fentanyl, hydrocodone, morphine, oxycodone, OxyContin and Dilaudid – began using them legitimately to treat pain. People naturally develop a tolerance to drugs over time and require higher doses for pain relief.

It is normal for almost all patients who use an opioid pain medication for more than a month to experience physical withdrawal symptoms when they stop taking the medication, which often require treatment from a physician. About 15 percent of patients using opioids actually develop an addiction. This leads to additional substance abuse along with psychiatric issues such as anxiety, depression and psychotic symptoms.

On top of all that, the patient may still suffer from the physical problem – a chronic illness or recovery from an injury or surgery – that initially prompted the drug use.

This is a patient who needs integrated care. This patient’s disorders and physical issues are so interwoven that it will be cumbersome to separate them for different treatment plans. Ideally, this patient would receive treatment for all issues under one roof and with the same team of health professionals, but there are bureaucratic and practical limitations to including the treatment for physical issues with treatment for substance abuse and psychiatric disorders.

Even if the patient requires treatment from different types of medical professionals, and maybe even at different facilities, the healthcare providers should work together with the patient’s overall wellbeing in mind.

The medical community is working toward the day when it use a whole person approach to treat a patient with physical illness at one facility, with the same medical professionals.

A patient who seeks help for substance abuse today will not be told to come back after physicians address his or her psychiatric problem. Instead, physicians will welcome that person into a holistic treatment program. After all, patients are not the disorders they have. They are human beings with multiple needs. Treatment specialists should act accordingly.

FURTHER READING

Addiction double trouble: Co-occurring psychiatric disorders

Addiction is one of the most common diseases worldwide. In 2013, 46,471 died of drug overdoses in the United States, more than car accidents and gun violence (PsychNews, Feb. 19, 2016). Like many other medical illnesses, patients suffering from addictive disorders often have co-occurring psychiatric diseases, such as depression and anxiety disorders, that drive up this sobering statistic every year. The topic is so important that the National Institute on Drug Abuse (NIDA) is conducting a four-day lecture series May 14-18, 2016, at the APA Annual Meeting titled Biological Underpinnings of Comorbid Psychiatric and Substance Use Disorders: How Research Can Inform Diagnosis and Treatment. The Agency for Healthcare Research and Quality (AHRQ) reports that almost one in eight of all U.S. adult visits to emergency departments are due to a mental health and/or substance abuse problem. In one study, the most common reason for these visits was a mood disorder (42.7%), followed by anxiety disorders (26.1%), alcohol-related problems (22.9%) and drug disorders (17.6%) (http://1.usa.gov/1LGw2fO). Substance use disorder and psychiatric disorders sometimes share risk factors. The National Institute on Drug Abuse lists these examples:

- **Overlapping genetic vulnerabilities**: Predisposing genetic factors may make a person susceptible to both addiction and other mental disorders or put her at a greater risk of a second disorder once the first appears.
- **Overlapping environmental triggers**: Stress, trauma (such as physical or sexual abuse), and early exposure to drugs are common environmental factors that lead to addiction and other mental illnesses.
- **Involvement of similar brain regions**: Brain systems that respond to reward and stress, for example, are affected by drugs of abuse and may show abnormalities in patients with certain mental disorders.
- **Developmental changes**: Drug use disorders and other mental illnesses are developmental disorders. That means they often begin in the teen years or even younger — periods when the brain experiences dramatic developmental changes. Early exposure to drugs may change the brain in ways that increase the risk for mental disorders. Also, early symptoms of a mental disorder may indicate an increased risk for later drug use.

The importance of identifying both disorders is critical, but can be challenging for the clinician. Patients seeking help for a mood disorder may not disclose they are self-medicating with alcohol and drugs, while patients seeking treatment for an addiction may not discuss their anxiety or depressed mood. Treating only one of the disorders will result in a less than optimal therapeutic response in both. Clinical research has demonstrated many patients who do not respond to known effective treatments are often suffering from an undiagnosed co-morbid condition. An undiagnosed illness actually may interfere with the treatment of one the clinician has identified. In some cases, the clinician may be aware of other diagnoses, but assumes someone else is treating it.

The importance of treating both illnesses may be overlooked as family and clinicians focus solely on the addiction, particularly when problematic behavior is the initial chief complaint. In these cases, the addiction seems so serious that other diagnoses appear minor or to be the result of the life consequences of addiction. Thoughts such as, 'I'm addicted to drugs, so of course I feel sad about it', or 'I'm anxious because my addiction might cost me my family and career' are not uncommon. Both of those statements may be true for patients with an addiction, but suffering from comorbid depression or anxiety acts as a magnifier. This results in frustration for family and care givers, and a greater sense of despair for the patient, who may become so frustrated he abandons treatment and returns to using. As the patient becomes demoralized, experiencing one failure after another in their attempt to maintain sobriety, he spirals further into depression or anxiety. Clinicians who diagnose and
treat patients with any addiction disorder should screen for other related forms of psychopathology. If a patient is unresponsive to treatment for depression, consider addictive disorders. Self-medicating with drugs and alcohol may be an attempt to relieve their psychic pain.

Early identification of a dual diagnosis requires a proactive approach from family members and clinicians. Despite incremental improvement, society associates significant stigma with addiction. Don’t expect patients to volunteer another problem. Even directly asking the patient may not be enough. Asking yes or no questions will result in “no” answers, which leads nowhere. Clinicians or family members may feel they have fulfilled the duty to discover a dual diagnosis, but that is insufficient. It is far more productive to probe with questions about types of behavior or feelings that may indicate a second diagnosis even without the patient declaring one.

Many patients do not realize they have more than one disease. The right questions can reveal the information a clinician needs to recognize the proper diagnosis. Those questions include concerns about appetite, sleeping, interaction with family and friends, use of alcohol and other substances, repetitive thoughts, feelings of frustration, anger or guilt, and other factors that lead to a diagnosis.

Drug-related symptoms can mimic symptoms of mental disorders, further complicating matters. When a person enters treatment for substance abuse, clinicians may be unable to distinguish between the two. Sometimes, clinicians can’t accurately assess a patient until there has been a period of abstinence. A dual diagnosis does not necessarily mean the patient must seek care for each problem individually, or from two healthcare providers. On the contrary, the patient with a dual diagnosis is most successfully treated at a single facility that has expertise in treating both conditions, tailoring a treatment plan to accommodate both diagnoses. Treatment for both illnesses must go hand in hand; patients can’t wait to successfully address one condition before moving on to the other. It is virtually impossible to successfully treat a mood disorder when the patient continues to use. Similarly, the addicted patient who is struggling with depression or anxiety will have a very difficult time staying sober. The goal in all treatment is to guide the patient back to their highest level of functionality. Attending to all existing diagnoses will ensure an optimal long-term clinical outcome.

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2. Please visit https://education.rivermendhealthinstitute.com/a/CD-2016-04-01 to access the online test.
3. Pass the online tests with a score of 100 percent; you will be allowed to answer the questions as many times as needed to achieve a score of 100 percent.
4. After you successfully complete the test, you will be directed to the activity evaluation form.
5. Once you have completed the evaluation, you will immediately receive your credit letter online.

CME QUESTIONS

1. Which of the following statements is true?
   a. Substance addiction is a chronic brain disease.
   b. Substance addiction is an acute disease.
   c. Substance addiction can be either a chronic or acute brain disease, depending on the individual.
   d. Substance addiction is not a disease of the brain.

2. What percentage of patients using pain medication for pain management are likely to develop an addiction?
   a. 5 percent
   b. 15 percent
   c. 25 percent
   d. 35 percent

3. According to research and the author’s experience, which of the following statements is true?
   a. Personality traits are established in early childhood and cannot be changed.
   b. Personality traits can only be changed in children, not adults.
   c. Personality traits can be changed significantly with the help of therapists and 12-step programs.
   d. Personality traits can change, but only in insignificant ways.

CME OBJECTIVES

Upon completion of this educational activity, participants should be able to:

• identify risk factors of addiction in their patients;
• make evidence-based decisions for treating and managing addiction in their patients; and;
• understand evidence-based approaches to evaluation and treatment of impaired professionals.
Addiction [ALERT]

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3 Free CME Credits Inside

Addiction Alert

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Editor-in-Chief: Mark S. Gold, MD

FEATURED ARTICLES

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Stacy Seikel, MD

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Lisa Steele, PhD

PAGE 10 Addiction double trouble: Co-occuring psychiatric disorders
David Baron, MEd, DO

UPCOMING EVENTS

Wednesday, April 27
4 p.m. EDT
Healing the Healer
Daniel Angres, MD

Friday, May 6
3:30 p.m. EDT
Advances in Addiction Medicine: Lessons from Jimi, Janis and Jerry
David Smith, MD

Thursday, June 23
3 p.m. EDT
Pain and Addiction
Stacy Seikel, MD

Register at RiverMendInstitute.com