RELAPSE: RECOVERY UNRAVELED

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ALCOHOL – DRUG USE DISORDERS

PITFALLS IN AND TO SOBRIETY

EVALUATION DIAGNOSIS
TREATMENT RECOVERY

PITFALLS

1) Evaluation
   I. Mental
   II. Emotional
   III. Physical
2) Diagnosis
   I. Primary
   II. Secondary
   III. Dual

PITFALLS

3) Treatment
   - I. Abstinence vs Moderation
   - II. Treatment Selection
     - A) IOP
     - B) Residential
     - C) Individual
     - D) CBT - MET
4) Recovery
   - I. Post Acute Withdrawal
   - II. Relationships
   - III. Medical Care and Supervision
   - IV. 12-Step Participation

EVALUATION

I. Mental
   1) Cognition
      - A) Neuropsychological evaluation acute
      - B) Toxic dementia acute
   2) Post-Acute Withdrawal Syndrome
      - A) Short term memory
      - B) Simple problem solving
      - C) Stress management
      - D) Sleep disturbance

All of these will clear - 6 months to 3-5 years
   - E) Critical to have evaluator who knows and respects these limitations
   - F) Critical to have MD (psychiatrist and/or primary) who knows medications that are safe and warranted

EVALUATION

II. Emotional
   1) Depression
      - A) 100% initially
        50-60% clear 4-6 weeks off toxin
      - B) 32% clear one year with new way to live
      - C) 10-20% reveal clinical depression at one year

   2) Anxiety
      - A) Panic
      - B) OCD - health, work, golf
      - C) Agoraphobia
      - D) PTSD
      - E) General chronic anxiety syndrome

   3) Personality Disorders
      - A) Antisocial - constitutionally incapable of being honest
      - B) Narcissistic - self centered
      - C) Mixed bag

irritable

restless

discontent

98-100% alcohol drug abuse/dependency patients have significant affective mood problems prior to use-abuse-dependency

Critical to have therapist, MD, addiction psychiatrist in concert to make critical decisions about meds, treatment, and diagnosis

EVALUATION

III. Physical
  1) Baseline physical evaluation
    A) Frequent blood pressure problems
    B) Hyperlipidemia
    C) Liver involvement - acute and chronic, Hepatitis C
    D) Cardiac - muscle, rhythm and coronary problems
    E) Muscle - joint - atrophy and arthralgia
    F) Gastrointestinal - ulcer, pancreas, colon
    G) Breasts - ↑ risk cancer
    H) Nutritional - multiple

Critical to have ASAM and/or knowledgeable MD

DIAGNOSIS

I. Primary
II. Secondary
III. Dual

COMPONENTS CRITICAL TO TREATMENT & RECOVERY

FACTS:

1) Professional treatment based on 12-Step model plus 12-Step participation after treatment gives best results for recovery (Emrick 1993) (Mooney 1990)
2) Spiritual foundation critical and seminal
3) Abstinence model consistently superior to other models (moderation management - harm reduction)

TREATMENT

I. Abstinence vs Moderation
II. Treatment Selection
    1) IOP
    2) Residential Project Match
    3) Individual
    4) Implement CBT, MET, in addition to - not in lieu of - spiritual treatment

TREATMENT

III. Aftercare
    1) Individual
    2) Group
    3) ACOA
    4) Family

IV. 12-Step Contract
    1) Spiritual Commitment
    2) Contact

RECOVERY

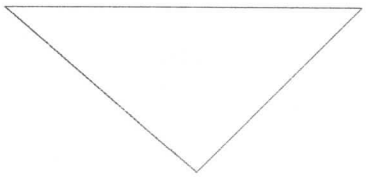
I. Post Acute Withdrawal Syndrome
II. Relationships
    1) Brain Chemistry
    2) Dependencies
III. Medical Care and Supervision
    1) Selection of physician
    2) Management medication
    3) Pain management
    4) Physical care. Diet, exercise, sleep hygiene, regular checkups

RECOVERY

IV. Immediate Participation All Aspects 12-Step Activity
  1) Meetings (fellowship)
    A) Frequency
    B) Home group - be a part of
    C) Develop support group, trust, and love
    D) Hear what you need to hear
    E) Be present to help somebody
  2) Alcoholics Anonymous textbook
    A) Study group
    B) 12-Step repetition
  3) Mentor (sponsor)
    A) Same sex (role modeling)
    B) Exemplary participant in principles of 12-Step model
V. Premature Additional 12-Step Activity and ACOA Therapy
VI. CBT; MET; Additional - never in lieu of

TRIANGLE OF SPIRITUAL BALANCE

SPONSOR MEETINGS



BIG BOOK

HONESTY	TODAY

PAIN MANAGEMENT FOR THE RECOVERING ADDICTED PATIENT

VI. Management Strategies

Table 4. Guidelines for Directing Effective Acute Pain Management*

Avoid opioid agonisl-antagonist in known or suspected active opioid addicts
Maintain structured control of access
Focus endpoint of treatment on effectiveness of pain relief
Put less emphasis on maintaining maximum level of function
Prescribe pain medication and oilier psychotropic medications in sufficient doses
Institute more frequent dosing intervals when necessary
Change to nonopioid and nonpsychotropic medications when possible
Use opioids with a long half-life when pain management may be prolonged
Inpalient management when necessary
Encourage the individual in recovery to enhance his or her recovery program
Educate patient and family on the goal of the pain management program
Ensure that comorbid psychiatric disorders are effectively managed
Ensure that comorbid medical disorders are effectively managed
Ensure that underlying pain-producing disorder is effectively managed
"Adapted from Savage,3 Agency for Health Care Policy and Research,18 Passik et al.,14 and Portenoy.19

Table 5. Measures That Enhance the Recovery Program

Being active in recovery-related support systems (ie, aftercare, outpatient treatment programs, 12-step programs)
Having an active sponsor
Actively participating in a spiritual program
Maintaining stability in the workplace
Maintaining stability at home
Maintaining medical and psychiatric support
Avoiding sleep deprivation and hunger (chronic pain)
Maintaining an active exercise program (chronic pain)