

SEVEN CASE STUDIES OF PEOPLE WITH SUBSTANCE ABUSE PROBLEMS

ABOUT THE CASE STUDIES:

(These case studies are a collaborative effort. The Josiah Macy Foundation in New York City published the original studies. John DiDominico, Head Counselor of the Haight-Ashbury Detox Clinic edited the studies and created questions to make the studies more pertinent for our readers.)

We are presenting case studies in this web site so students may become more familiar with case histories. Case histories are designed to help counselors test their ability to think their way through situations involving drug abusers and addicts. This allows them to make tentative assessments of the patients and eventually to make responsible suggestions for treatment plans and goals. It is a way to see if the knowledge and skills the student has learned in school and from reading the chapters in this textbook can now be applied in a hypothetical case setting. The cases themselves are composites of actual client cases or events.

Even if you are not in a counseling program, it is still valuable to examine the case studies and try and answer the questions. This can give an appreciation of the complexity of assessment, diagnosis, and treatment.

All the names of the actual cases have been changed and only first names are used. Any relation to actual people or events are purely coincidental.

HOW TO APPROACH A CASE STUDY:

While there are no definitive “right” answers, there are some responses that are more appropriate than others. The trick is to first **use only the information given**. Do not make up information that is not in the text of the case study. If the case says they are drinking alcohol, don’t make up that they are also doing cocaine if it hasn’t been mentioned anywhere in the case. **Use only the given information**. If you think a question wasn’t asked, you can say, I would want to ask him or her this. Just don’t fill in their answer.

Think of the person in the case as a real live patient sitting in front of you and asking for help. Put on your best counselor therapist hat or simply thinking cap and approach the case from several levels. Try not to view a case from just a medical pharmacology approach but use or think about other clinical issues that might be involved. Think about other resources you can connect this person to and think about important referrals you would make for this patient or client, e.g., medical referrals, psychological evaluations, urine or toxic screens, etc.

Most of the cases will begin with the patient or client showing up at the clinic. They will give a brief history and have some specific issues embedded in this text. Your job is to pull that information out and use to make a tentative assessment and develop a plan of action.

In reading a case, first **look for dangers**. Is there anything in the body of the information that can be dangerous to the patient or client. An example would be if the patient appears depressed, think about their potential for suicide. That’s a danger. If they have in their position several medications that can be lethal, that’s a danger. Once you have recognized it, how will you handle

it? What are you going to do to remove this danger?

Some of the cases will also ask about transference and counter-transference. Counselors going through masters level training programs should be familiar with these terms. Others may not be. If you are not familiar with these terms, look them up. A good place to start is with Sigmund Freud, but don't stop there. These terms have different meanings to different schools of psychology. Find out what these terms mean in current usage. How are they applied to psychotherapy today. Look in counseling textbooks such as "*Doing Psychotherapy*," by Michael F. Basch, MD, is an excellent book to start from. Ask your professors and teachers in your programs, if you do not find sufficient information to explain these terms to you before tackling these particular questions in these cases.
John DiDominico, Head Counselor, Haight-Ashbury Detox Clinic

Cases 1 & 2 Several Patients

The following scenario occurs at the County Hospital where you are employed as that hospital's chemical dependency expert. You have only one bed available and two patients have been referred to you for triage and admission.

The first patient is a 26 year old heroin addict. He has all the symptoms of withdrawal. He has a runny nose, stomach cramps, dilated pupils, muscle spasms, chills despite the warm weather, elevated heart rate and blood pressure, and is running a slight temperature. Aside from withdrawal symptoms, this man is in fairly good physical shape. He has no other adverse medical problem and no psychological problems. At first he is polite and even charming to you and the staff. He's hoping you can just give him some "meds" to tide him over until he can see his regular doctor. However, he becomes angry and threatening to you and the staff when you tell him you may not be able to comply with his wishes. He complains about the poor service he's been given because he's an addict. He wants a bed and "meds" and if you don't provide one for him you are forcing him to go out and steal and possibly hurt someone, or, he will probably just kill himself "because he can't go on any more in his present misery." He also tells you that he is truly ready to give up his addiction and turn his life around if he's just given a chance, some medication, and a bed for tonight.

The second patient is an older man in his late sixties and is a bit disheveled in appearance. He is accompanied by his landlady. The landlady tells you that she found him earlier this evening trying to enter his apartment door. He was sweaty, his eyes were dilated, and his hands were trembling so badly that he could not get the key in the door. He kept calling her by another name and saying he was trying to get into his office to do some work. She knows he retired years ago, has lived in her apartments for several years, and knows her real name. His blood/alcohol level is low and his speech is not slurred. He can correctly identify himself but, also appears confused. He is unable to tell you the month or season. His nose and cheeks are red with tiny spider veins and his stomach distended and when he extends his hands out in front of him they are very tremulous. His demeanor is polite and apologetic to you and the staff. He tells you he has never had a problem with alcohol but scored high on the CAGE assessment test. He then admits to an occasional drink every now and then. He did have a few drinks earlier today but can't say exactly when. However, he is willing to come into the hospital for a brief stay if really thought it was necessary.

Questions-Cases 1 and 2

1. What preliminary Axis I diagnosis would give each of your patients and why? Use the DSM IV to look up the Axis I disorders and select one or two that best fit the clinical picture.
2. What, if any, medical danger(s), do you see or should you consider for either patient? Why?
3. What transference and countertransference issues would you expect to be present in working with Patient A? What Transference and countertransference issues might present themselves with Patient B?
4. Finally, based on all the above information. Who gets the available bed and why?

Answers-Cases 1 and 2

1. **Patient 1.** The 26 year old is a heroin addict in withdrawal. His signs and symptoms all indicate opiate withdrawal. He has a runny nose, stomach cramps, dilated pupils, muscle spasms, chills, despite the warm weather, elevated heart rate and blood pressure, and is running a slight temperature. He may or may not have other drug issues. A urine analysis may provide some answers to this question. Preliminary Dx: 292.00 Opiate Withdrawal or 304.00 Opiate Dependence

Patient 2. is in his late 50's and has all the signs and symptoms of a late stage alcoholic starting to go into alcohol withdrawal. He was sweaty, his eyes were dilated and his hands were trembling so badly that he could not get the key in the door. He kept calling landlady by another name even though he has lived in her apartments for several years. His blood/alcohol level is low and his speech is slurred, but appears confused. His nose and cheeks are red with tiny spider veins, he has a distended abdomen and when he extends his hands out in front of him they are very tremulous. He probably does not have other drugs in his system like benzodiazepines. They would act as a stabilizer in his condition and these drugs are often given to treat Alcohol withdrawal. Preliminary Dx: 291.00 Alcohol Withdrawal Delirium or 291.80 Alcohol Withdrawal

2. **Patient 1.** Though he is in a good deal of pain and discomfort due to Opiate Withdrawal Patient A is not in any imminent medical danger. He is uncomfortable and will experience alternating cold chills and hot flashes. The cold chills produce "goose bumps" and is how the term "cold turkey" came about. Painful stomach cramps, and diarrhea are also part of the withdrawal syndrome and can be very unpleasant to be sure. Night sweats, muscle cramps and muscle twitching is how the other term synonymous with heroin withdrawal "kicking" came into the lexicon. They are all part of the opiate withdrawal picture. Uncomfortable, painful depressing, but not fatal. Patient A is also exhibiting some classic "drug seeking" behavior in which he is willing to say anything and do anything to get the drugs that will give him some relief from his withdrawal symptoms.

Patient 2 also appears to be in withdrawal from Alcohol. However, because of his age, the probable length of time he has been drinking, and the potential severity of alcohol withdrawal, patient B is in medical danger and should be seen by a doctor immediately. The dangers are delirium tremors or "DT's". The symptoms are as follows: they begin with anxiety attacks, increasing confusion, poor sleep, marked sweating, and fleeting hallucinations or nocturnal

illusions which arouse fear. Some patients may suffer grand mal seizures, several in short succession. There is a trembling of the hands at rest, sometimes extending to the head and trunk. Walls are falling, floors are moving, and rooms will be rotating. Injuries often occur because patients are unable to maintain their balance at this stage. These falls can cause severe head and neck injuries. Animal hallucinations are frequent and often incite terror. It is also typical that in these delirious, confused, states the person will return to a habitual activity usually work related. In this case patient B is imagining himself back at work and trying to get into his office.

3. Transference and counter-transference are terms first used by Freud to describe anticipatory responses to situations that resemble, or seem to resemble, the original conditions that first gave rise to these behavior patterns. It is the unconscious basis for all human relationships. Some schools of psychotherapy narrowly define transference and countertransference. Others see the phenomenon of transference operating on all levels of human relationships, both conscious and unconscious. Given these parameters, you can see that the transference (expectations from client to counselor) are likely to be, for **patient 1**, negative, disapproving and rejecting by staff and counselor. His likely behaviors will be to first present as the good patient and to try and manipulate (con) the medical staff into giving him some drugs to relieve his withdrawal symptoms. In fact, this is very appropriate behavior, and should not be negatively judged for this behavior. To see his behavior from this vantage point can help reduce staff countertransference. This brings us to the countertransference issues regarding staff. Given **patient 1s** manipulative behavior, first seeming to be in compliance and then becoming angry and hostile to staff, most certainly cause staff and counselor to unconsciously punish patient A. It is often helpful for counselor and all staff members to keep this in mind and not get pulled into the negative transference phenomena.

With regard to **Patient 2**, here you have a person well into his retirement years. He may see you and your staff as too young and inexperienced to help him? a defense to treatment. He may feel embarrassed that he is being seen in such a state. Or he may also transfer misgivings he has at either not having children or redressing perceived wrongs to the children he has lost or lost contact with. So numerous layers of transference are all possible with regard to patient B.

Countertransference issues also abound in this case. Patient 3 can easily be perceived by the counselor or staff as a kindly old man, raise the specter of one's own family of origin father countertransference. If positive, the patient gets very nurturing care. If negative, the patient gets average to below average care.

4. The final decision is, "Who gets the one available bed?" It should go to **patient 2**. He is the more serious of the two and in greater medical danger of alcohol withdrawal. He is exhibiting all the signs of delirium tremens that in a person of his age and medical health could be fatal. While you should not minimize the discomfort of opiate withdrawal, **patient 1** is not in severe medical danger. It would be appropriate to refer him to an out-patient drug detoxification program or residential "social model" recovery program.

Case 3-Suzanne S.

Suzanne has come by the free "drop-in" counseling clinic were you work to get some information and advice. Suzanne is a 22-year-old single woman who has been living with her

boyfriend Jack in Manhattan's lower east side for the last four years. She and Jack have been heroin addicts for as many years.

When Suzanne was 10 years old, her father, whom she says was a very heavy drinker, left her mom and the kids and never came back. At 14 she started drinking and smoking marijuana. At 16 she had dropped out of high school and at 18 she moved in with Jack. He introduced her to heroin. She reports using about a 1/2 gram of heroin per day just to be able to function and feel comfortable. In order to pay for the heroin and pay the rent on their apartment, Jack doesn't work, instead, she works the streets at night. She usually drinks four or five beers each night before going out to work. If she can't score enough heroin, she will try to score either some Valium[?] or Klonopin[?] to "*tide me over until I can get some 'horse'*". She says she has tried cocaine but, "*I really didn't care for the high all that much.*"

Suzanne tells you that the alcohol and heroin help to calm her nerves and get her through the night. She and Jack are not having sex all that much. When they do make love he never wears a condom. He says that's what makes him different from her "john's" "*Which is true because I won't work without a condom.*"

Lately she has noticed that her breasts have become swollen and more tender. She also hasn't had her period in the last 12 weeks. She is pretty sure she is pregnant and knows it's her boy friends baby. However she not sure she can stop using dope or work to have the baby even though Jack wants her to keep it. She really confused at what she should do and is her asking for you to help her make some decisions. Her friend who works with her at night told her not to stop using dope if she is pregnant "*Because it's worse for the baby than to keep using.*". "*I just don't know what I should do?*"

Questions-Case 3

1. What drug(s) does Suzanne seem to be most addicted to?
2. Of the drugs she is abusing, which one(s) pose more of a danger to withdraw from? Why?
3. What dangers do you see as you read this case? What are the dangers for Suzanne? What are the dangers for the baby?
4. What treatment options would you offer Suzanne and why?
5. What referrals would you give to her and in what order?
6. Is her girlfriend correct in her advice for Suzanne not to stop her heroin use if she is pregnant? If she is, why?
7. What legal issues are more than likely to present themselves in this case if she decides to keep the child?
8. Do you see any "transference or counter-transference" issues that could effect your judgment in handling this case? Please explain?

Answers-Case 3

1. Heroin, alcohol, & benzodiazepines (Valium & Klonopin)
2. The alcohol and benzodiazepines which are more dangerous than heroin withdrawal. Both these drugs work by enhancing the effect of GABA, a neurotransmitter in the brain that inhibits the neurons in the CNS from reaching action potential. This has a calming effect on the CNS and reduces anxiety, relaxes muscle tension, etc. The sudden withdrawal from these drugs can precipitate severe, even life-threatening withdrawal symptoms, e.g., grand mal seizures, tachycardia, and possible cardiac arrest.
3. The dangers for Suzanne are exposure to all the contaminants and infections inherent in IV drug use. Her continuing use of heroin and the other drugs will also expose her baby to all the dangers of addiction and withdrawal that Suzanne faces, including HIV and hepatitis C. She may also be at risk for legal prosecution for endangering the life of her baby. This may vary from state to state and it is important that counselors have knowledge about their states' child protection laws and mandatory child abuse reporting laws.
4. Suzanne will need to be informed that the only medically approved method for treating pregnant opiate dependent woman in the United States is a methadone maintenance program. Suzanne can be placed in a methadone program until she delivers her baby. The baby can then be detoxed safely under medical supervision. She would also need to understand that she would still be endangering her baby by continuing to be a sex worker.
5. If Suzanne decides to terminate her pregnancy, then a referral to an appropriate clinic and informational counseling regarding her options would be in order. If Suzanne does decide to have her baby then referrals to a clinic and/or medical facility that can monitor and provide medical care for her and her baby through her pregnancy are appropriate. A methadone maintenance program referral to a social worker who will act as the case manager for Suzanne is also appropriate. Referral to any number of counseling and rehab programs designed to transition former sex workers to a safer life is also a possibility.
6. Her girlfriend is correct because if Suzanne is pregnant then suddenly stopping her normal heroin intake could cause severe withdrawals for her fetus and this could greatly increase the possibility of spontaneous abortion and fetal death. That is why the only approved treatment for pregnant opiate dependent addicts is to place them on methadone maintenance. Unfortunately there is also the issue of Suzanne's alcohol dependency. This could result in her baby having FAS at birth. Fetal alcohol syndrome (FAS) is the most widely researched drug related to pregnancy. FAS has been known to cause spontaneous abortions, facial deformities, growth deficiencies, mental retardation, as well as joint and limb deformities. FAE, fetal alcohol effects, a less severe form of fetal damage from alcohol, is even a greater possibility.
7. **Child Protection and child custody issues.** Suzanne may have to realize that once her child is born, it will more than likely become a ward of the court. Most states will have CPS workers step in and take custody of the child. Then Suzanne will have the opportunity to enter a drug treatment program and can eventually be reunited with her baby after she has completed some

type of treatment program and required parenting classes.

8. The **transference** issues for Suzanne will be to see the counselor as trying to take away her baby. She came here for help and now she's in trouble with the law. She will in all likelihood feel set-up, lied to, and betrayed. She may not be ready to give up her life style or her boyfriend. She may decide it would be simpler to just terminate the pregnancy now that she is aware of how complicated her choice to have the child can become. The counselor/case worker will become the nagging parent figure and regaining her trust will require the counselor to be especially skilled in handling this case and managing Suzanne's transference.

The **countertransference** issues for the counselor / case worker might present themselves in being angry and judgmental toward Suzanne for her choice of life style and endangering the health of her baby. There are major issues of moral attitudes and judgments that will play both a subtle and more often blatant role in counselor's treatment of Suzanne and the handling of her case. It would be very important for the counselor/case worker to have supportive supervision and even be in personal therapy to insure that their own moral judgments and concerns for the baby and the type of environment she or he will be born into, do not contaminate their work with Suzanne.

Case 4-Reese C.

Reese is a 18 year old single male who was born in Los Angeles, California, where he still lives with his mother and his brother. His dad is a sales rep and is on the road during the week.

“When he's home on the weekend he just drinks and watches the ball games on TV. When he gets drunk he yells at me and my mom and throws shit around the house. He drinks all the time that he's home but he can't hold his booze. Like he's a total lightweight. Mom also drinks. Watch out when they both get 'lit.' Man, the fur really flies. We've had the cops out several times. I just take off when they start gettin' into it. I started drinking and smoking when I was 13, in the eighth grade. It was a total drag, not that any of the other grades were any better, but all the kids were talking about high school and the classes they were going to take, and me, I was just trying to figure out were I was gonna get money for my next pack of cigarettes. Now I smoke about a pack a day, plus a couple of joints too. I have a cup of coffee in the morning before school and that's it. At night I'll drink 3 or 4 beers plus a few shots of vodka. On the weekends is when I really get down to partying.

I've played around with lots of stuff. You know, trying to see what's out there. I've tried pot, coke, mescaline, XTC, mushrooms. I've even shot up a few times. It's no big deal. When I'm partying, I like to mix things up a bit. Maybe do some tequila and mushrooms, depends on what's going on and who's around. If I drink too much I black out. I've even OD'd a few times. But, hey, it wasn't any big deal or nothing. I do like speed though. If any drug is my favorite, aside from cigarettes and coffee, it'd be 'speed.'

I saw a doctor when I was eight. My folks took me. They said I was out of control. The doctor said I had attention deficit disorder and gave me Ritalin'. It helped a little, I guess. I don't know much about it. Right now, except for partying, I don't take any medication.

Then there's my brother, a complete math 'geek'. Always gotten good grades, never been in trouble; responsible, dependable, healthy and clean. He's a parent's wet dream and I'm his evil twin brother."

Questions-Case 4

1. Based on the information Reese gave you, what other information would you need to determine Reese's level of drug use?
2. Based on what Reese has told you, where would you place him on the Addiction-Compulsion Scale?
3. What in Reese's family history might lead you to suspect that there may be a genetic component to his drug abuse problems and should be evaluated further?
4. What in Reese's medical history might lead you to suspect that he may have a dual diagnosis problem?
5. What in Reese's environment might lead you to believe that environmental factors may also play a role in his drug use?

Answers-Case 4

1. In order to get a better assessment of Reese's level of addiction you would need to know three important areas of information: the **amount** of drugs being used, the **frequency** of drugs being used, and the **duration of time** of psychoactive drug use. By his own words Reese has told you that, "When I'm partying, I like to mix things up a bit," and that he has overdosed on at least two occasions. Though more information is needed, you could suspect that when he does do drugs, he does a lot of them together. He also has done a lot of experimentation, trying different drugs. Lastly he says that if he were to choose one drug, his favorite would be "speed" or methamphetamine. This particular type of drug tends to be used in more of a binge pattern, using the drug very intensely over a period of several days or weeks. Then there is a crash phase, lasting several days to two weeks, and then the cycle begins again.
2. Given just the information Reese has provided, he has clearly moved from the "recreational" stage into the "habitual" stage of drug use. He is using tobacco, alcohol, and marijuana on a daily basis and in an addictive pattern that appears to have begun junior high school. His own comments reflect that this pattern of daily abuse seems normal to him and he is very "matter-of-fact" about it. How much of this is embellishment to impress the case worker/counselor will need to be sorted out as the assessment progresses. Assessment questions should begin "open ended" and become more specific for each of the drugs Reese is taking in terms of amounts, frequency and duration.
3. It is still too early to give a definitive answer but, the fact that both his father and mother use alcohol abusively could mean that Reese has the genetic marker for alcoholism. Another indicator is the hint that from an early age, Reese seemed to hold his alcohol better than his father. It is only a hint but something to note for further follow-up questions. Does he feel his

ability to hold his liquor better than friends his own age? How old was he when he noticed this? It will also be necessary for the counselor to filter out what is adolescent exaggeration and what is factual information.

4. Reese mentions that he was seen by a psychiatrist as a child and put on Ritalin⁷ for ADD (attention deficit disorder) and also tells you that “if any drug is my favorite it would be speed.” These two statements should be followed up for further evaluation. It could be an indicator that Reese has a dual diagnosis problem connected to his drug use and he has been “self-medicating” his disorder. But more information will be needed to confirm this hypothesis.

It is important to keep in mind that these disorders, ADD (attention deficit disorder) and AD/HD (attention-deficit/hyperactivity disorder), continue to be controversial, especially around the use of medication for children. Many medical professionals feel it to an appropriate diagnosis while others feel it has become a quick and easy “catch all” label to put on any problematic child. If present, the onset of ADD is usually by age 5.

Reese reports being seen by a doctor at age eight. This would warrant a referral to medical staff for further evaluation. The diagnosis in adults has also become more popular. At one time, theory held that a child outgrew their ADD when they became adults. However this does not seem to be the case. Though some features of the disorder change as the child ages, many of the core features remain. The hallmark of ADD in most adults is “an inability to keep sustained focus on tasks, easy distractibility, and emotional volatility. The recent edition of the DSM IV (Diagnostic Statistical Manual, Forth Edition) acknowledges that the disorder continues on into adulthood. Though it is still listed in the in Disorders of Infancy, Childhood, Adolescence, several studies have also hinted that there maybe a correlation between children diagnosed with ADD and the use of stimulants such as cocaine or methamphetamines in adulthood.

5. Reese gives a very graphic picture of his home life. When his father is home he drinks beer and isolates by watching TV. When he gets drunk, he yells at Reese and his wife and “throws stuff around the house.” If Reese’s mom is also drinking, they fight and some times the cops have to come to quite things down. So Reese may not only be genetically predisposed but is also living in a stressful home environment and city environment. So, we may be able to assume that Reese has found a way to cope with his environment by using drugs. This is just a working hypothesis. The counselor will need to follow up by gathering more information.

But, what about his brother? Why isn’t he doing drugs and getting into trouble? Does his brother’s behavior of being a straight a student mitigate any environment connection between Reese and his drug abuse behavior? No. In fact it his brother’s behavior that may strengthen the environmental connection by being so immersed in his studies and being a model student. In effect, his behavior is maybe his way of trying to fix the family, by being perfect.

Case 5-Laura

Laura is a very successful businesswoman in the high-stress high-powered world of corporate finance. She has been referred to you by the company’s employment assistance program. Laura presents herself as a no nonsense business professional. She is frank and honest about the events that has brought her to your office.

Laura tells you that although she tells herself that she will only have one or two glasses with dinner, she usually finishes the whole bottle.

“About five years ago I started having trouble sleeping and started to take a tranquilizer (5 mg Valium[?]) I normally take one or two pills every two to four times a week to help her sleep through the entire night.”

In the morning she drinks at least 3 to 4 cups of coffee daily, even on the weekends. She noticed that her sleeping problems developed around the same time her Dad died. He was only in his early 50's and they were very close. His death hit her hard and she says she wanted to give in to a big depression. However, she fought it and lost herself in her work. She makes it a point to work out at least three times a week in the morning before going to work. In addition to the above medications, Laura is also prescribed Xanax[?] as needed for panic attacks and diet pills (amphetamine congeners) to control her weight, a problem she had since she was a child. Over the last year she has become more reclusive. She can barely make it to business dinners and after-work functions. Lately however, she has noticed that she has been steadily increasing her use of wine. Before, she would only have a few glasses with dinner but now

“...more often than not I finish off the bottle before going to bed. I just can't seem to stop. A lot of times I will come home and tell myself that I'll only have one glass and no more but by the time I go to bed, the bottle is empty and I'm deciding whether I should open another or not. I never used to drink to excess or take anti-anxiety medication before. Now I can't seem to stop drinking or taking these 'downers' at social events. I can't seem to control when I take them and things are happening that I'm not too happy about. Of course the alcohol adds to my weight problem which then causes me to take more of my Redux. Then I have to increase my Xanax to calm my nerves and also take my Valium to make sure I get a full nights sleep. It has become a very vicious circle. All this has been going on for about a years but last week put the “cherry on the pie.”

Laura tells you that last week she was to meet the firm's top client at a business luncheon. She could not get out of bed that morning. It took all her willpower to get up and get dressed. As it was, she was still 20 minutes late, "which is inexcusable." She was so nervous and sick she had to excuse herself in the middle of her presentation. In the bathroom she took another Xanax[?] to calm her nerves. Then at the luncheon she could not stop herself from ordering several glasses of wine and had to be assisted to her car after the meeting was over.

"My client spoke to my boss and staff and then canceled his account with me. The next day I met with my boss and he recommended (ordered) I make an appointment with our EAP program (or be terminated.) I'm really scared. Work is all I have. I can't afford to blow it. Do you mind if I smoke?"

Questions-Case 5

1. What would your initial assessment of Laura be?
2. What would you say Laura's main drug of choice is and do you think she will need to be placed in a detoxification program to address this problem?

3. Based on Laura's emotional situation and the medications she is taking, what if any dangers do you need to be aware of?
4. Based on the information Laura has given you who would you need to contact to advise them of Laura's situation and what would you need from Laura to make these contacts?
5. If Laura's boss calls your office to find out how Laura is doing how would you respond to his inquiry? What are his rights to know if Laura did keep her appointment with you?
6. What possible dual diagnosis issue(s) might Laura have and how would you do to confirm this possibility.
7. Are there any other issues that you feel may need to be addressed in this case?

Answers-Case 5

1. Substance Abuse Dependency. Laura exhibits all the classic symptoms of addiction/dependency as outlined in the textbook.
 - a. **Cravings:** The psychological need to have a drink to calm her down, relieve her stress and unwind. i.e. Drinking for emotional / psychological relief.
 - b. **Loss of Control:** Once Laura begins drinking. Intending to have just one glass of wine with dinner, she unintentionally finishes the bottle. Laura is aware of her loss of control. She is becoming more isolated and avoiding social events unless they are absolutely necessary. She is avoiding her social life in order to be at home where she can drink without risking her relationships with friends and business associates.
 - c. **Tolerance:** Laura is aware that her consumption of these drugs has increased and that she is no longer able to control her drinking or her anti-anxiety medication Xanax[?]. In combination, alcohol and a benzodiazepine can have a synergistic effect on the CNS. This creates an increase in tolerance and also pushes the user closer toward a potentially lethal drug overdose.
 - d. **Continued Use Despite Negative Consequences:** Despite Laura's awareness that she has been increasing her drug use and that it was getting out of control for her, she continued to use. This cost her a valuable client and possibly her job. It was only at her boss's insistence that she contact the company's EAP program that Laura is even in your office at this time. Given the above information, it seems fairly certain that Laura has moved from the habitual stage of this disease and is now in the abuse/dependency stage of alcoholism.
2. From the medical / drug history Laura has given you it would appear that she has become dependent on alcohol and benzodiazepines and in all likelihood will need a medical detox. You would always want to get a medical evaluation to confirm if your assessment is correct. A referral to a physician certified in addiction medicine should be a routine part of any substance abuse assessment. Ruling out any other medical information at this point, it seems that the safest course of action to treat Laura would be to place her in an in-patient hospital detoxification program. Failing this arrangement, then an outpatient medical detoxification and recovery

program would be a second option. However, because this is Laura's first attempt at detoxification, and her statements on her previous inability to stop her drug use on her own, the counselor would be advised to set up a contingency contract with Laura before placing her in an out-patient program. This contract would acknowledge that should Laura fail to achieve stability in the out-patient program she would then seek treatment in an in-patient program.

Laura is also taking a fair amount of stimulants too. Prescription diet pills for weight control, caffeine, and nicotine. These may or may not complicate the treatment picture and you would want to get a medical opinion on these medications as well. It would be prudent to also alert her treating physician about your concerns. It would also be important that Laura be counseled as to the potential that she may experience some weight gain while going through the detox process. Reassure her that this is normal out come at first and that controlling her weight will become easier when she is not taking in all the alcohol. Recommend a good nutritional program with exercise based on the recommendations of her doctor and /or nutritionist.

3. The danger is the potential for an accidental overdose. You will need to educate the client as to the synergistic effects of alcohol and benzodiazepines. The purpose of the detoxification is to slowly and safely withdraw her from these medications and lower the risk of such an event occurring. The other danger is intentional suicide. Laura is facing what may seem to her some overwhelming life tasks. Loss of an important client, possible loss of her job, embarrassment in being referred to an employee assistance program, the stigma of being an alcoholic, and needing treatment, and unresolved grief over the death of her father. All these and other issues may appear to Laura, at this point in time, just too much and she may toy with the possibility of suicide. Also, depressant medications and drugs will skew her view of her situation making it appear more hopeless than it really is. The counselor or case worker needs to constantly monitor Laura's statements and affect for clues that she may be contemplating suicide.
4. Laura will need to sign several releases of information so counselors and other treatment providers can contact one other. This allows for a freer exchange of information regarding Laura's situation. It would be necessary that Laura's doctor(s), those prescribing her benzodiazepines and diet pills, to be informed of her being placed in an alcohol treatment program. Since Laura is here at the request of her employer, he or she, will also have a right to receive minimum information as to whether or not Laura is in treatment compliance and keeping her appointments with the EAP program. With regard to issues of patient confidentiality, two sets of rules usually apply. Those of state law, found in the civil codes pertaining to business and professional standards of practice and professional codes of conduct and ethics. A counselor must be especially aware of what the state laws are regarding a patient's right to confidentiality in the state where they practice. Another superseding body of laws that pertain to a patient's right to confidentiality when they are receiving treatment for substance abuse, is the Federal Rules of Confidentiality. This set of laws apply to any federal moneys that support that treatment program. It can even be a non-profit tax exempt organization. In these cases then, the Federal Rules and Regulations will apply and take precedent over state laws. Be sure you know and are familiar with these laws. In cases where the two sets of laws conflict, courts have consistently held with the law that provides the greater protection to the confidentiality of the patient.

5. In the case of Laura and her employer, the employer has the right to know or obtain a limited amount of information regarding Laura's treatment compliance. The employer does not have the right to more detailed personal information on Laura. That she is keeping her appointments when into a treatment program, expected length of that program, and if she participated satisfactorily in that program is all an employer needs to know. Laura is within her rights to refuse signing such a release. But she should then be aware that by denying the right for her employer to receive this information gives her employer the right to terminate her employment.
6. There is certainly the possibility that Laura may have several dual diagnosis issues. It would be important to begin a process of ruling out both Axis I and Axis II diagnoses as she becomes more stabilized in her treatment program. Medical physicians and psychiatrists split on when to begin intervention regarding a dual diagnosis patient. Suggest beginning medications for major depression or bipolar disorder as soon as there is a reasonable suspicion that this component exists and will influence treatment outcome. i.e., if that antidepressant medication will help that person remain in treatment longer, then why wait. Other equally experienced physicians feel it is necessary to wait to get a clearer picture of the patient before beginning a trial of medications. It is vital that such decisions be left to the medical experts.

The therapist's and counselor's job would be to pass on any changes they see in the patients affect or demeanor to the medical staff so they can do further evaluations or tests, if necessary. In Laura's case there are strong indications that she never had the time to grieve the death of her father whom she was very close to. What can start out as uncomplicated bereavement, if not processed properly, can move into depression. In Laura's case this may have occurred as she began self-medicating her grief with alcohol and benzodiazepines.

There is also just a hint that Laura's father may have been an alcoholic. Getting a good family history and genogram would be one way to explore this possibility. If this is true, then Laura may be genetically predisposed to alcoholism. You also want to decide whether Laura is Bipolar (I or II), Cyclothymic, has Major Depression or Dysthymia. Laura is using Xanax[?] for anxiety. Is this a panic disorder? She reports having become less social in recent months. Certainly this can be part of the overall isolation that occurs when a person moves into alcohol dependency. But, you would want to rule out whether she is also suffering from Social Phobia, Panic Disorder with or without Agoraphobia, or Agoraphobia without a history of Panic Disorder.

Another question is "What part does her diet pill, caffeine, and nicotine use and abuse play in this picture." Regarding Laura's sleep medication, several more questions will need to be clarified. To what extent has her alcohol abuse and other substance use caused her sleep disorder. Alcohol is known to suppress REM sleep and disturb the normal sleep cycle. i.e. Substance-Induced Sleep Disorder. However, you would want to rule out other possibilities such as; Insomnia, Sleep Terror Disorder, Parasomnia NOS, or Sleep Disorder Due to General Medical Conditions. All the above will issues will certainly complicate the substance abuse treatment picture for Laura.

Case 6 Lloyd

Lloyd is a 23 year old single male who chose to move to Dallas, Texas instead of going to college. He has been working as a plumber's assistant for the last couple of years and will soon get his union membership. *"Then I could bid on city jobs and make a very comfortable living."* As it is,

he makes pretty good money when jobs are around. During lean times he works on cars and motorcycles on the side. He reports an active social life with his friends and all of them do some type of drug or another. Last year Lloyd tested positive for HIV. He's not really sure how he got it. He is always very careful about his needles *"so someone must have spiked the dope."* He doesn't want to go into it but he was really *"pissed off and angry"* when he got the news. He tells you; HIV is clearly a Republican plot to wipe out the Liberal Democrats. Since he works as an independent contractor, he has no insurance. *"And I sure as can't get insurance today with my HIV status."*

Consequently, paying for his medication that his doctor has prescribed has been sporadic at best. He has prescriptions for AZT and protease inhibitors but he has not been able to take them consistently because they are too expensive. *"Either way you look at it I'm screwed."*

Lloyd prefers to do "speedballs" when he can score those drugs. He loves the rush and even boasts that he can get a full count (1 gram) that's at least a *".....'ten hitter' for a C note"*. *Most "bumpers" on the street will have to pay twice as much for half the quality."*

Lloyd says he doesn't do any other drugs but has tried them all. Occasionally he will drink some Scotch but lately his stomach has been really giving him trouble. Sometimes it will feel like multiple stab wounds in my gut that go on for hours. It really has me scared. He's seen his doctor and she prescribed some Demerol[?] and an antacid. He's pretty sure it's related to his HIV. Lloyd tells you quite frankly that when he gets too bad and too sick from the AIDS he'll take himself out.

"Hey, I think of suicide from time to time. If it gets really bad? I mean the AIDS thing? and life get too unbearable, I know I don't have to take it".

Questions-Case 6

1. Lloyd states that he "prefers to do "speedballs." Based on your readings, please describe what a "speedball" is?
2. Based on the information Lloyd has given you, what would your initial assessment be?
3. What would your recommendation for treatment and medical intervention be for Lloyd based on your assessment?
4. What pharmacological interventions would you suggest Lloyd look into regarding both his medical condition and his drug history?
5. Lloyd uses a number of street terms you may not be familiar with. How would you handle a client like Lloyd who uses street terms you may not recognize or understand? Why do you think Lloyd is using these terms?
6. What possible transference issue that might be connected to Lloyd's use of street terms? What possible Countertransference issues might his use of these terms bring up for the counselor?
7. What do you think about Lloyd's statements of suicide? How would you handle this issue with Lloyd?

Answers-Case 6

1. The term “Speedball” is used to describe the IV injection of heroin and cocaine together. The goal is to get an euphoric rush of pleasure from the combination of the two drugs. In more recent times the term is now applied to any combination of upper and downer drugs used together. So you may get such combinations as heroin and methamphetamine, Ecstasy and GHB, or Methadone and crack cocaine being called a speedball.” Street terms often depend upon the location; neighborhood, city, or state, and the types of drugs available in the area. But for the record the true or classic meaning of the term “speedball” is the combination of heroin and cocaine IV. the process is to first mix up and “cook” the heroin in a spoon, bottle cap or similar metal container. After it cools you add the cocaine and then fill the needle or “rig” and inject it.
2. Lloyd appears to be a classic heroin addict. Though he uses cocaine in speedball fashion, his primary drug of choice and the one he must have in order to function normally, is heroin. The cocaine is always a luxury. As an IV drug user he is in a very high-risk group for contracting HIV which he did get. Since we are not told whether Lloyd is also at risk with his sexual partners, whether he does or does not use safer sex precautions, we will have to assume is likely that this is how Lloyd contracted the HIV virus. Even if he used his own “clean” needles”, if he used to same “cooker” were the drugs are mixed up and heated, with some one who was infected he could become infected himself. Or if he used someone else’s old cotton, he could also contract the disease this way.
3. Lloyd has several options for treatment. One option would be an abstinence based in-patient heroin detoxification treatment program. These programs usually consist of a short term in-patient medical detox from opiates followed by an out patient aftercare program. Another option would be a 21 day methadone out-patient detox program, or an out-patient medical detox and aftercare program or a out patient methadone maintenance program. Any of these programs will also have case managers that will have HIV treatment resources for Lloyd to receive proper HIV care. The real challenge will be working with Lloyd. He may require a great deal of education regarding the realities of this disease, e.g., how it is transmitted, and the importance of being consistent with his medication regimen. It will be up to his counselor / therapist to work with his resistance about being an addict and having HIV. Is he himself being safe with others. Some of Lloyd’s statements and his cavalier attitude may suggest that he could be exposing others to his infection. Is he? What precautions is he taking when he is doing drugs with friends? What precautions is he taking with his sexual partner(s)? Is he aware of his risky behavior with them?
4. First he will have to determine whether he is interested in and motivated to get treatment. If he shows some degree of motivation, the options listed in answer # 2 would address both his heroin “speedball” addiction and his HIV issue.
5. Lloyd may be using street slang in order to test your knowledge. This may feel like he is challenging you. But, what he may really be saying is; “Can I trust you? If you know what I’m saying then there’s a good chance you’ve been there. I will feel safer knowing you won’t judge me or look down on me or my lifestyle.” As the counselor, your task is to get past his resistance and establish a therapeutic relationship or alliance. Therefore you will need to be both honest and real or genuine with the client. If you don’t know a term or expression, say so. It is far worse to pretend you know. It’s better to simply say, *“It’s really important that I get to understand who*

you are so I can provide you with the best possible treatment but, I'm not familiar with the term 'ten hitter,' could you tell me what that term means."

6. Lloyd has told you that he chose not to go to college. He chose instead to work in the trades. It would not be unusual for Lloyd to be feeling in a one-down position with the counselor who most likely went to college. His heavy use of street terms maybe one way he can feel in control of his situation. On the counselor side Lloyds use of street terms and drug slang could make the counselor feel defensive and could be pulled into competing with one another. This is often the case when counseling sessions become nothing more than 'war stories'. If the counselor is not aware of his or her transference issues it could easily disrupt the treatment process.
7. This can be an extremely tricky situation. Given the issues in this case, it would be more prudent for the counselor NOT to jump at Lloyd's talk of suicide. To explore it with him in a natural matter-of-fact way may be what is called for at this point in time. While it is always important to monitor and assess for suicide, when to take action and when to allow it as part of the therapeutic process is always a judgment call. Counselors and therapists need to be unflappable. If you hit the panic button, the client will know "I can't discuss my innermost thoughts with this person" and will leave at the first opportunity. Timing is everything. This issue will also test your personal beliefs and feelings about suicide. What is of primary importance here is that your feelings and beliefs are not projected onto the client and do not muddy the therapeutic waters. The reasons for NOT reacting at this point are; even though he has known about his HIV status for the past year, his comments tell me he has not really grieved over this news and how it has impacted his life and dreams. He believes his future has been taken away from him. What he does not see is that his very actions, his sporadic compliance with his medication, and continued IV drug use will cause the very results he is so fatalistic about. So it may be better to give him the time and encouragement to begin the process that will increase his education about the realities of his diseases.

Lloyd appears stuck. He is dealing with his HIV status by denying his own mortality with a "live fast-die young" attitude. He also projects responsibility and blame for the disease on a "Republican plot," revealing a hint of paranoia lying just under the surface. To react at his talk of a Republican plot and suicide could put you in as a co-conspirator with the Republicans. His talk of suicide is certainly a real issue and is also a test to see what your reaction will be and a cry for help. Therapy is about the relationship between you and the client, and relationships are always subtle, multilayered and complex. (A secret, inside a mystery, wrapped in an enigma.) The task here is to give Lloyd a safe setting where he can begin the process of sorting out all these issues.

Case 7-Jane (The answers for the questions have not been included to let you figure them out and discuss them in class or with other students)

Jane is a 19-year-old University student who has just been transported to the chemical dependency unit at the local hospital. You are asked to do an assessment on her to see if she needs to be admitted for a drug problem or sent to the psychiatric unit for further observation.

You meet with Jane and notice that she is barefoot, wearing loose 60's style clothing and her eyes are very dilated. She tells you the following story in a rapid pressured pattern of speech.

“A few hours ago I was at the Metallica concert and got to thinking that James (lead singer) was talking to me in my head. He told me not to leave the stadium, so I didn’t. Everyone else left, my ride left, but I just couldn’t.

Then I got here somehow. I remember thinking I wouldn’t get through and would really lose my mind, especially when that pay phone I was using started melting in my hand. I felt I had to talk really fast before it melted. I really don’t remember much of the concert or anything from this morning. I do remember that I had trouble getting to my feet to walk up the stairs to my seat. I remember we all passed around something and the next thing I knew, I started feeling really restless. I just couldn’t sit still. I was jumpy, nervous, and sick to my stomach. My heart was racing and I was sweating, even though it wasn’t very warm out. I was high and really got into the people and the whole scene. The scenery was fantastic and I could actually see the sounds—there were waves and triangles dancing in front of my eyes to the music. Then it got scary. Things got blurry and faces started looking mean and ugly. That’s when I started hearing James in my head telling me not to leave the stadium. Then I was all alone and called for help.”

Jane has no previous history of mental health problems and she has no police record. Though young, she does have a long history of drug use. Jane started smoking “pot” daily at age 13. Her weekends were spent doing many different types of hallucinogens. LSD, XTC, mescaline and “shrooms”. Jane tells you her mother and father divorced when she was 10 years old. He was career military and they moved about every two years. She remembers always feeling lonely and started taking drugs because she felt it made her more interesting to be with. It also was a way to relieve the boredom and loneliness. She finished high school with average grades and wasn’t sure what to do next. But, when her Mom was about to get married, she told Jane she had to “go away to college.”

Questions-Case 7

1. What drugs does Jane seem to be using regularly that may be contributing to her present mental health problems?
2. Is it possible for Jane to be addicted to marijuana? What about the other hallucinogens?
3. What part of Jane’s family history and social life seem significant in her decision to use drugs?
4. What mental health condition(s) would you want to rule out before making your decision on where to place Jane for treatment?
5. Would you consider Jane to have a drug problem, a mental health problem, or both? Why?
6. How would the ARRT process developed at the Haight-Ashbury Free Clinic have helped Jane during her crisis at the concert?
7. Based on the case information and your assessment what hospital ward would you more likely to be recommending to Jane for further treatment?