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Phenomena of Relapse -- In Patients with Multi-Diagnosis of Substance Use Disorders and Traumatic Brain Injury

by [Roman Frankel, PhD](#)

We as treating professionals and patients continue to be baffled by the phenomena of relapse in substance use disorders. When a substance abuse disorder is compounded by the sequela of traumatic brain injury, the treatment process, together with the devastating episodes of relapse, is even more difficult to understand.

Very limited information is available on the topic of the effect of acquired brain injury deficits have upon the likelihood of relapse. While it is known that addictive disorders are adversely impacted by acquired brain injury in numerous areas, including impairing the patient's ability to participate in standard addictions treatment programs and the increased susceptibility of the traumatized brain to the effects of addictive substances, to date, no definitive studies have been conducted regarding how to treat this challenging population more effectively.

My own dissertation (Frankel 1999, Columbia Pacific University, "Management of Relapse Rates in Multi-diagnosed Patients") concluded that relapse episodes (attacks) occurred with the multi-diagnosed population with the same frequency as within the group of patients with the single diagnosis of addictive disorders. This finding contradicted my initial hypothesis that multi-diagnosed patients relapse more frequently than the single diagnosis patients. This result, although initially puzzling, did provide me with the opportunity to examine and identify certain clinically significant characteristics of a successful treatment program for multi-diagnosed patients.

In reviewing many case studies, it appeared that frequency of relapse was not the determinative factor which predicted whether a patient would ultimately benefit from treatment. In fact, many patients with a history of frequent relapses were at times successful in overcoming the

challenges of their co-occurring disorders while others with infrequent relapse history continued to struggle long after their initial diagnosis.

In viewing these cases at a more intricate level, it became apparent that the patient's ability to gain insight into their condition was extremely beneficial in generating successful treatment outcomes. Recognizing that patients with TBI experience limitations in their ability to benefit from insight oriented therapy, I realized that compensatory approaches would have to be provided if there was any hope for these patients to find success in their rehabilitative attempts.

We have learned that placing these patients in secured, supervised settings offered them both safety from life threatening situations and provided the predictability of a routine which reduced the frustration of daily uncertainty that is so disruptive to the "concrete thinking" which accompanies traumatic brain injury. Providing therapies, education and information in smaller installments, bolstered by frequent repetition from every member of the treating team has also been shown to produce better outcomes and ultimately lead to a higher likelihood of the patient regaining some level of independence and dignity.

From the vantage point of treating these patients in a structured setting, other extremely important patterns began to emerge. It became apparent that the multi-diagnosed patients had a tremendously limited ability to utilize judgment regarding interactive boundaries, and as a result, we had to compensate by putting external controls into place. For example, we manipulated the vocational environment to limit identifiable stressors, thus making the work adjustment more successful.

These patients typically feel isolated when placed in treatment programs designed to address only one of their conditions. They are reluctant to express their true feelings regarding addiction to a group consisting of only traumatically brain injured patients and/or feel unable to discuss their anxiety and shame regarding their cognitive deficits with a group of substance abusers.

The multi-diagnosed patients seem to benefit from immersion in therapies directed to their specific peer group. The shared insights, failures and successes among the group members became an invaluable tool in developing individual (however limited) insight into their respective conditions. Individual successes were celebrated and provided goal oriented insights. Individual failures (relapses) were examined collectively in a non-threatening and therapeutic environment from which each group member was able to derive benefit. Over time, the group ideally begins to provide enough support to replace the external supports allowing the individual to regain a sense of self-worth.

For patients residing outside the secured setting, the living environment had to be manipulated/controlled as well, often requiring supervised distance between the actual living quarters of each patient to avoid the "domino effect" of relapse. We structured the living spaces in such a way that it would allow us to immediately isolate a relapsing patient and avoid a social "outbreak" of multiple relapses within the patient population until the issue could be addressed in a supportive way within the group. This model of supervised, yet separated, living setting is more favorable to the "group home setting concept" which is too closely quartered to allow for quick intervention and prevention of "group relapse."

Last, but not least, the patient with co-occurring disorders have frequently damaged their personal/familial relationships more severely than the single diagnosis patients. More importantly however, was our awareness that unlike the single diagnosis group, these patients lack social skills and emotional boundaries so needed in rebuilding old relationships and even more so in developing new ones. We begun the process by focusing on the minimal skills needed by these patients to interact with their neighbors in the local community.

Educating families regarding the needs of these patients proved difficult, and attempting to steer these patients towards building healthy relationships proved futile. Family members are frequently fatigued by the difficult task of dealing with the frequent challenges presented by their multi-diagnosed family member, especially if the patient's condition has not been accurately identified by the treatment team. Strangers often view them as somewhat strange and difficult to communicate with. Sexuality for these patients presents its own special challenges. Otherwise physically healthy individuals, with strong sexual desires (some hypersexual), are not capable of communicating their emotional needs and desires to others due to deficits caused by the traumatic brain injury. Problems of impaired judgment, increased impulsivity and an inability to conform to social norms resulting from the brain injury are exponentially magnified if the patient is allowed to abuse addictive, mind altering substances. Unfortunately, despite these obvious problems, the topic of sexuality with the multi-diagnosed population remains taboo and solutions have not been explored adequately. It is unfortunate that most of these patients live out their lives post injury alone as their external supports slowly evaporate each year. Pornographic materials utilized by many of these patients to fulfill their needs are confiscated by staff and the patients are often left to feel ashamed and sinful.

In summary, multi-diagnosed patients experience many roadblocks in their pursuit of recovery from TBI and substance use disorder. Only when their surroundings are carefully controlled to create a safety net by providing an "invisible fence" of supportive resources is there reasonable likelihood that these patients will find quality and joy in life.

Oxycontin -- A Reputable Drug Gone Bad

by Dianne Wright, MSA, CAC II, CEAP

As an addiction therapist, it hasn't been surprising to see adult clients abusing and becoming addicted to OxyContin ("Oxy" and "Oxycotton" are a few of its common street names). Oxycodone, an opium derivative, is used to bring relief to patients who are suffering pain from cancer or other debilitating conditions.

What is surprising and disturbing is the number of high school kids and those in their early 20s who have become addicted. On the East Coast, where the initial abuse hit the hardest, Jay P. McCloskey, U. S. attorney for Maine says, "We're talking about some of the best students, some of the best athletes."

Among youth age 12-17, the incidence rate increased from 6.3 per 1,000 new users in 1990 to 32.4 per 1,000 potential new users in 1998. For young adults 18-25, the rate of first use

increased between 1990 and 1998 from 7.7 to 20.3 per 1,000 potential new users. However, OxyContin, like many other prescription drugs, is another "equal opportunity drug" where age really doesn't matter.

A common painkiller, oxycodone is nothing new – having been used in drugs such as Percodan and Percocet since the early '60s. OxyContin, however, contains a much higher concentration of the highly addictive opium derivative.

A time-released drug, designed to be taken orally, it is being chewed, crushed and snorted by abusers. Because it can be dissolved in water, it is often injected. A central nervous system depressant, it causes analgesia, respiratory depression and euphoria.

According to a 1999 National Household Survey on Drug Abuse (NHSDA), the illegal use of OxyContin has recently increased. The NHSDA reports emergency department mentions increased from 3,369 during January-June 1999 to 5,261 in the first half of 2000.

Purdue Pharma, its manufacturer, says overdose deaths typically involve multiple factors such as alcohol. Purdue Pharma now plans to increase education and oversight of OxyContin to guard against its increasing abuse. For those of us in the field, this is a welcome move.

Sources:

"Substance Report: Oxycodone," Drug Enforcement Administration; "OxyContin Diversion and Abuse; "Prescription Drugs: Misuse, Abuse and Addiction," National Institute on Drug Abuse; Office of National Drug Control Policy and Partnership for A Drug Free America.

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