Case Study #2
Psychopharmacology
Saybrook Course #2505
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A 35-year-old woman named Michelle comes in seeking individual counseling sessions. Michelle complains that she is having great difficulties concentrating and focusing her thoughts, she often feels tired and lethargic and she complains that she is hyperactive and full of energy one minute then suddenly she is sad and depressed the next. Michelle also complains of symptoms constipation and loss of appetite. She reports that she was in a car accident three years ago which left her left foot and ankle deformed and difficult to use. Additionally, this resulted in some mild brain damage that has affected her short-term memory.

When I asked her about the circumstances of her accident and Michelle tells me that she was driving home from her bartending job late one night, after having a couple of drinks, when she reached down to get a cassette tape off the floor and ran into the back of a large truck. Michelle tells me that she is a recovering drug abuser and alcoholic. The night of the accident Michelle had just gotten her license back after a three-year suspension for drunk driving and being under the influence of controlled substances.

I ask Michelle to tell me about the medication she is currently taking. She tells me that she was prescribed OxyContin for the pain she is constantly under due to the injuries she sustained. Michelle tells me that because of her brain injuries from the car wreck she find that she is forgetful and does not always take her pain medications on time. On occasion, she finds herself in great pain and when this happens, she admits that she grinds the OxyContin tablets up and then either snorts the medication or places it under her tongue and lets it dissolve. This pattern of usage is consistent with that of a person who has become addicted to this drug (Hays, 2004). This and other factors seem to indicate that Michelle likely has developed a usage problem with this drug.

I ask Michelle to tell me about her prior drug use and she explains to me that she started out in her teens drinking and smoking marijuana. In her early twenties; she drank heavily, was addicted to marijuana, took ecstasy and tried LSD. When she was 26, she started dating a man who was a heroin addict. She reports trying to help him quit using heroin, by getting him interested in drinking and smoking pot with her but, found her self gradually sucked into his world instead. She was tried heroin on her 27th birthday and found herself hooked. Within a year she lost her art gallery, was kicked out of her house and ended up living in a residential hotel with this man for the next three years. When he got himself in a major car crash her life changed, she found herself alone. She decided to go back home to New York, move in with her mother and attempt to clean her life up. After being home for three weeks, she was caught driving under the influence and for heroin possession. Her license was taken away for three years. Additionally she was court ordered into a rehabilitation program for her drug and alcohol problem. She completed the rehabilitation program successfully, finished her probation, and then got her self a new job working in a bar. She admits to me that her rehab only lasted about six months before she was smoking marijuana and drinking again. Her car accident happened about a year after that.

Michelle now considers herself clean and sober but, does not understand why she still feels the way she does. Michelle confides that she is afraid that she is addicted to the OxyContin and wonders if the continuous use of it could be the reason she is feeling so bad lately. She states that she has wanted to stop taking it for along time but is afraid of the withdrawal symptoms associated with opioid addiction.

Objective

Observing Michelle during the interview, I notice that she is agitated and disorganized with her thoughts. She repeats items in her story, gets lost and sidetracked easily and, has difficulty getting to the point. I notice that she has pupillary constriction. Michelle complains that she is constipated and has a loss of appetite. All of the above symptoms are consistent with the known side effects of taking opioids (Catell, 2004).

The objective of this case study is to look at Michelle's current symptoms and consider the likelihood that the abuse of her current pain medication is more consistent with that of a drug addict. Given that she is using medication inappropriately what if any are the treatment options for her addiction. Looking at Michelle's history, we need to think if there is any possibility that she could overdose from the amount of opiates she is currently taking. Additionally, we will need to determine if Michelle is suffering from any kind of depressive disorder and if so, it will need to be determined what kind (or if) medication should be prescribed to her.

Pain and the abuse of Pain Medication

Michelle stated that after *many* pain medications she tried failed to work for her, her Doctor prescribed OxyContin. OxyContin is one of the many opioids derived from the opium poppy seed or Papaver Somnifereium (Drugs.org). Derivatives from the poppy seeds also include morphine, heroin and codeine (Catell, 2004). Opiates contain both natural and synthetic compounds that bind themselves to the receptors in the central nervous system inhibit pathways. Opiates are typically used when other forms of milder pain medications like aspirin, ibuprofen and Transcutaneous Electrical Nerve Stimulation or TENS are not affective on severe pain (Catell, 2004).

It seems that Michelle has developed a physical dependence on this drug as she finds herself in great pain without it (Passik & Kirsh, 2004). Part of the pain she experiences when she

misses the medication is clearly related to her injuries. It also appears that Michelle experiences additional pain without the medication, be it psychological, physical, or a form of opioid withdrawal. I question how much of her discomfort is related the psychological factor of addiction. Michelle clearly has a past history of, by her own self-report, becoming addicted to a substance, marijuana, that in itself does not have physically addictive properties. In summary Michelle is dealing with two types of addiction to OxyContin; the physical addiction from built up tolerance that causes withdrawal symptoms, and the mental addiction to the substance that provides her comfort, as marijuana has done in the past. A physician should deal with the physical addiction but, I believe that therapy can help Michelle deal with the more emotional components of her addiction.

There are few options Michelle can consider when choosing other forms of pain management. Catell (2004) tells us that there is new drug currently being tested and laboratory animals that combine opioids and ultra low opioid antagonist to help with withdrawal symptoms after prolong use. There are also analgesic implants that would allow her to receive pain medication in a time released form so she would not have to remember to take the pill. Pain medication is more effective when taken before pain has become severe Catell (2004). The fact that Michelle is taking OxyContin, after many other medications were found ineffective, indicates that there are *likely* few if any other medications that work for her level of pain.

As a therapist I would advise her to consult her physician about other possible drugs that may work for her as well as a form of medication that could be implanted or in patch form so that perhaps she could use lower dosages of medication but still have pain relief. While it would be ideal if Michelle could visit a pain clinic or pain specialist this is unlikely as she has limited medical benefits and inadequate financial resources for expensive medical treatments. As a

therapist the most I can do is strongly encourage her to seek other forms of treatment for her pain by consulting her primary care physician in addition to any other qualified medical professionals that she has access to. Finding the best medication and treatment for her could be complicated but necessary. She will likely not be successful in therapy if she is in too much pain or, if she is on a drug that prohibits her from concentrating.

If it is determined by the client and her doctors that she should remain on OxyContin there are several therapeutic goals. If she can not get the drug in another format I would brainstorm with Michelle ways of organizing her medication routine in order to eliminate missed doses which lead her to use the pill inappropriately. I would first solicit ideas from the client on how to resolve this problem. I would later suggest solutions such as charting medication in an organizer that she carries with her at all times. I would also suggest the usage of a timer on her watch to reminder her to take this powerful medication at the appropriate time. Regulating the medication could help to address some of the cognitive or concentration issues troubling her which would make her better equipped to engage in the therapeutic process. Additionally, Michelle will benefit emotionally from the success of overcoming her problem with responsible substance use.

Michelle needs to be aware of all of the components and side effects of this medication. Morphine and opium derivatives both have sedative and analgesic properties. They are water-soluble and cannot pass easily though the blood-brain barrier, making it more difficult to get into the brain (Catell, 2004). Tolerance to respiratory depression and pupillary constriction can develop with opioid consumption. Opioids metabolized in the liver and are excreted through the kidneys. If a person, who is taking opioids, is suffering from any liver of kidney disease then there is a risk of toxic and overdose due to the liver or kidneys inability to metabolize the opioids

(Catell, 2004). As her therapist I would advise Michelle to seek regular medical evaluations to ensure that she does not have hepatitis, liver, or kidney problems that could hinder her body's ability to process this drug making it possibly fatal. I would also talk with Michelle about the symptoms of a drug overdose such as respiratory depression so she can be attentive to such problems in the unlikely event that they arise. If she continues on the drug, in order to prevent further misuse, the drug should be given to her in a very structured manner to prevent abuse (Passik & Kirsh, 2004). I would have Michelle work with her physician to discuss despising this medication in a manner that decreases the likelihood of abuse. This exercise would have her take responsibility for creating an environment that is conducive to success. Success for Michelle would be using this medication responsibly and consistently while eliminating the possibility of abuse.

Most people get addicted to opioids because of the euphoric feeling and dulling of pain it provides. Through daily use, tolerance of the drug can begins within a week, some physical dependence can begin within two to three days of use, but for those using opioids over weeks or months, complete physical dependency is inevitable (Catell, 2004). It is not uncommon for opioid users to become addicted to and use several drugs at the same time (Flaherty, Kotranski & Fox, 1984). This brings up a strong concern in Michelle's case considering she is currently using OxyContin in a dangerous and non-prescribed manner. OxyContin should only be taken orally in a pill form, if taken in an alternative format the controlled release mechanisms are defeated, making this pill potentially lethal (US Food and Drug Administration, 2001). In addition to the potential lethality of this medication I am concerned that her usage of this medication *could* act as a gateway to additional alcohol and drug abuse as her history has noted a strong propensity for such addictions and abuses.

If she does determine that she would like to stop OxyContin withdrawal symptoms can begin as early as 6 to 12 hours from the time the last doses of opioid were taken. The symptoms peak with in 48 to 72 hours (Drugs.com). Symptoms of withdrawals include anxiety, hot and cold flashes, loss of apatite, muscle pain, sleeplessness, nausea, vomiting, diarrhea and dehydration (Drugs.com). Finally, after 7 to 10 days the symptoms slowly lessen and then disappear. Withdrawal from opioids is an unpleasant and painful experience but not a life threatening process, unlike alcohol and barbiturate withdrawal (Catell, 2004). Though not medially necessary, due to her fear of withdrawal, I would suggest that Michelle be monitored by her physician if she chooses to quit using the drug.

For some people treatment of addiction of opioids can be dealt with through cognitive therapy, a 12-step program, psychodynamic therapy, behavior modification, pharmacological intervention or any combination of these (Catell, 2004). When considering the best form of treatment one needs to consider the gender differences between typical male and female users (Beswick, Best & Rees, 2001). Females tend to have different usage patterns and substances of choice. Getting Michelle to attend a treatment program that is attentive to such differences or includes only women could help in her treatment. Since past treatment has been unsuccessful, it seems key to pay attention to all of the many factors that could deter her from making the necessary changes to prohibit further addiction problems. Given that Michelle's treatment compliance issues I would like to consider using behavioral approaches in therapy as this method is shown to be successful in improving outcomes among clients especially those with dual-diagnosis (Carroll, Sinha, Nich, Babuscio & Rounsaville, 2002)

Michelle's case is additionally complicated as the substance she is currently abusing is used for pain treatment. She is dealing with the same problem faced by many OxyContin addicts;

the lack of dialogue between the pain treatment community and the addiction treatment community (Hays, 2004). Treating her addiction is not as simple as the treatment of other illegal drugs as her dependency is based on need.

For Michelle eliminating oxycontin or her current addiction would not resolve all of her problems. She needs to continue with therapy to address her propensity for addiction or her addictive personality. Michelle seems to be working towards addressing her addiction problems but I am concerned that she has not developed a strong enough desire to prevent her from using again in the future. Given her draw towards substances throughout her life, as her therapist I would want to work with positive behavioral reinforcements to help her become self soothing and not depend on substances to regulate her emotions. Clearly other treatment attempts have failed, perhaps by focusing on positive incentives and rewards for continued success Michelle could succeed in treatment. It has been shown that using this positive approach to behavioral interventions can be very successful (Slaght, Lyman & Lyman, 2004).

Possibility of Depressive Disorder

Michelle confides in me that her original reason for smoking pot, trying ecstasy and heroin is the constant emotional pain she feels. We discuss together discovering and exploring the origin of these emotional pains. She seemed responsive to this discussion and the possibility needing to send her to work with a psychiatrist in order to fully evaluate her depression issues.

Though Michelle may have initially been self medicating using illicit drugs to deal with her depression issues, her drug abuse may have caused additional chemical imbalances. Some of Michelle's extensive past drug usage could have changed her biologically leading chemical imbalances that cause depression. There is a link between marijuana usage and subsequent depressive episodes (Chen, Wagner & Anthony, 2002).

As her therapist I will seek additional time with Michelle to evaluate the presence of chronic depression or any personality disorders. At this early point in the therapeutic relationship I am still learning more about this client before I think about labeling the issues she is dealing with. If Michelle does have a personality disorder this in itself could account for her aberrant medication usage pattern. Patients with a personality or other type of disorder often self medicate to deal with depression, anxiety or even loneness (Passik & Kirsh, 2004). The more aberrant the drug misusage patterns are the more likely it is that the patient is dealing with an addiction to the medication (Passik & Kirsh, 2004). I still need to develop a full understanding of how often Michelle uses this drug in a non prescribed manner. Then Michelle and I need to work on depression issues once she has either eliminated the mediation or used the medication consistently for some time. I believe many of her current emotional problems are related to the drastic drug inconsistency within her body.

Conclusion

In seeing Michelle, I would want to work in conjunction with her primary care physician and her psychiatrist. The goal between myself and the other providers would be to help her find ways to eliminate her pain while attempting to address her addiction and misuse of this drug.

Overall, there are several issues that overlap making Michelle's case complicated and very difficult to evaluate with absolute certainty at this point. It seems like she is a critical juncture where much will be determined shortly. Given an imperfect set of information and limited medical and financial resources to deal with her problems there are only a few ways I can help her as a therapist. Connecting with Michelle and forming a therapeutic bond could allow her to accurately report her usage which will allow the problem to be accurately addressed (Passik & Kirsh, 2004). Even given the difficulties of this case I remain optimistic about the possible

outcome because Michelle seems to be open to discussing her problems and working towards a solution.

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