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Drug Use Disorders

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Individuals with drug use disorders (DUDs) use all types and combinations of illicit and legal or prescription drugs. Many people use drugs prescribed to family members, friends, or others that they purchase or that are given to them. And many drink alcohol in addition to using drugs.

Legal drugs include alcohol, nicotine, caffeine, and prescription stimulants (Adderall, Concerta, Ritalin), opioids and morphine derivatives (codeine, morphine, methadone, fentanyl, and pain relievers—OxyContin, Percodan, and Vicodin), and depressants and anxiolytics (barbiturates, benzodiazepines, and hypnotics). Illicit or street drugs include cannabis (marijuana, hashish—legal in some states), stimulants (cocaine and crack cocaine, amphetamine, methamphetamine), heroin and opium, hallucinogens and related drugs (LSD, mescaline, psilocybin, Salvia), inhalants (spray paints, markers, glues, cleaning fluids), phencyclidine (PCP), and a variety of synthetic drugs made in laboratories including K2 or Spice (marijuana), bath salts, GHB, ketamine, Rohypnol, MDMA (Ecstasy or Molly), and anabolic steroids. Many people use and/or develop problems with multiple substances.

The effects of substances on an individual depend on the type and amounts of drugs used, methods of use and route of administration, expectations of drug effects, and level of tolerance or physical dependence. Drugs may be taken orally (e.g., pills, hallucinogens, and some forms of cannabis), snorted (e.g., cocaine and heroin), smoked (e.g., cannabis, cocaine, and opium), or injected with a needle (e.g., opioids, stimulants, sedatives).

Although drugs are used for many physical, psychological, and social reasons, once a person is physically dependent, no other reason is needed. Drugs are then used to maintain a level of intoxication or reduce or stop withdrawal symptoms. Like many other disorders, DUDs are caused by a combination of biological, psychological, social, and spiritual factors. Because dependence on drugs (and alcohol) runs in families, there is a genetic predisposition for many individuals who develop a DUD.

Individuals with DUDs are at higher risk for numerous medical problems and diseases caused or worsened by drug use or poor health care habits. Their lifespan may be shortened as a result of death from overdose, accidents, medical diseases, suicide, or being a victim of homicide. A DUD increases the odds of having a mental health disorder or social, family, occupational, academic, legal, economic, or spiritual problems. In addition, DUDs have an adverse impact on children and families. Children of parents with DUDs, for example, are at higher risk for substance or mental health problems as well as academic or behavioral problems. Families are harmed in many ways as a result of problems caused or worsened by the DUD, the behavior of the member with the DUD (especially when violence is involved), and the inability of the non-DUD parent to function.

Screening and Assessment

Individuals can be screened and assessed for a DUD with comprehensive clinical or structured research interviews, the completion of a physical examination and laboratory tests, interviews with family members or significant others, a review of medical and other relevant records, and/or pen-and-paper screening instruments completed by the individual. Screening with questionnaires such as the CAGE (4 questions: Have you ever felt that you should *cut down* on your drug use? Have people *annoyed* you by criticizing your drug use? Have you ever felt bad or *guilty* about your drug use? Have you ever needed drugs to steady your nerves or control withdrawal symptoms, *eye opener*?), Drug Abuse Screening Test (10

questions), the National Institute on Drug Abuse–modified ASSIST (Alcohol, Smoking and Substance Involvement Screening Test), and other brief questionnaires can help determine if a more extensive assessment is needed.

For those physically dependent on opioids or alcohol, structured assessments are used to determine the degree and severity of intoxication and withdrawal symptoms and related medical symptoms. This information is then used to determine medications needed to attenuate withdrawal.

DSM-5 Classification of Drug Use Disorders

In addition to alcohol-related disorders, the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*), includes nine categories of DUDs within the classification of Substance-Related and Addictive Disorders. The essential feature is having a cluster of cognitive, behavioral, and physiological symptoms from among the 11 symptoms that follow, which indicate (a) impaired control of drug use (Criteria 1–4), (b) social impairment (Criteria 5–7), (c) risky use of drugs (Criteria 8–9), or (d) physiological dependence (Criteria 10–11).

A specific DUD is diagnosed if the individual shows a problematic pattern of drug use leading to clinically significant or personal impairment or distress, which shows in at least 2 of the following 11 symptoms within a 12-month period.

- The drug user cannot control how much he ingests and ends up using larger amounts of drugs or for longer periods of time than intended.
- The drug user has trouble cutting down even though he may want to reduce or stop drug use.
- The drug user spends too much time on getting or using drugs or recovering from the effects of the drug high.
- The drug user has strong cravings for drugs even when not using or when motivated to remain drug free.
- The drug user does not meet his responsibilities at work or at home due to effects of drug use.
- The drug user continues to use drugs even though this causes or worsens problems in relationships or worsens the ability to function.
- The drug user stops engaging in activities because drug use is too central to life.
- The drug user ingests drugs in situations where it is dangerous such as driving a vehicle or operating machinery.
- The drug user continues drug use even though this causes or worsens physical or mental health problems.
- The drug user needs more of the drug to feel high (tolerance has gone up) or gets higher with less amounts (tolerance has gone down).
- The drug user gets sick with withdrawal symptoms when cutting down or stopping drug use.

Specific Types of DUDs

A diagnosis of a specific drug use disorder using the 11 symptoms is made for these substances: cannabis, hallucinogens, or phencyclidine; inhalants; opioids; sedatives, hypnotics, or anxiolytics; stimulants; tobacco; or other unknown substances. Any of these substances as well as caffeine include the following diagnoses for a drug-related disorder.

- *Intoxication:* This is a reversible syndrome that results from recent drug use. Signs vary depending on the drugs used and include physiological (e.g., slurred speech, unsteady gait, memory impairment) or behavioral (e.g., elation, euphoria, mood instability, poor judgment, or agitation). Symptoms may last hours or longer, depending on the type and amount of drugs used. Intoxication puts the person at higher risk for accidents or problems. Even individuals who do not meet criteria for a DUD can experience intoxication after using drugs.
- *Withdrawal:* This is a syndrome caused by stopping or reducing heavy or prolonged drug use. Specific symptoms depend on the types, amounts, and frequency of drugs ingested. For example, symptoms of opioid withdrawal include three or more of the following: depressed mood, nausea or vomiting, muscle aches, lacrimation or rhinorrhea (runny eyes or nose), pupil dilating, piloerection (goosebumps), sweating, diarrhea, yawning, fever, and insomnia.
- *Other drug-induced disorders:* The effects of specific drugs can cause depression, anxiety, sleep disturbance, or sexual dysfunction, which often remit when drug use is stopped.
- *Unspecified drug-related disorder:* This category refers to situations in which some symptoms of a drug-related disorder are present that cause distress or impairment in functioning but do not meet the full criteria for a specific drug-related disorder.

Treatment Programs

A continuum of care is used for DUDs and includes therapeutic community, halfway house, short-term residential, partial hospital, intensive outpatient, ambulatory, continuing care (after-care), and specialty programs for pregnant women, patients who are opioid dependent, individuals in the criminal justice system, and individuals with co-occurring mental health or medical disorders. Individual, group, and/or family therapies may be used along with medication-assisted treatments. Many patients with DUDs also benefit from hepatitis C virus, HIV/AIDS, and other medical services in addition to mental health, educational, vocational, family, child care, housing, transportation, legal, financial, or spiritual services, as well as mutual-support programs such as Narcotics Anonymous (NA). According to the American Society of Addiction Medicine, the level of care needed is based on an evaluation of intoxication and withdrawal potential, biomedical complications, mental health complications, motivation, social support, and relapse potential.

Psychosocial Treatments

There are many science-based, effective behavioral therapies for DUDs. These include individual drug counseling (IDC), group drug counseling (GDC), cognitive behavioral therapy, motivational interviewing (MI), contingency management or motivational incentives, community reinforcement approach plus vouchers, motivational enhancement therapy, the matrix model (for stimulants), relapse prevention therapy (RPT), twelve-step facilitation therapy (TSF), and couple and family therapies. Following is a brief summary of a few of these therapies.

Individual Drug Counseling

IDC is based on the disease model of addiction and reflects the twelve-step philosophy of recovery. IDC targets drug use and current problems of the patient. It emphasizes behavior change and helps the patient learn skills or coping strategies to manage and recover from the adverse effects of the DUD. Patients are encouraged to engage in and “work” a twelve-step program. Some key issues that are the focus of sessions include denial; drug cravings;

people, places, or things that are “triggers” to drug use; how to structure time; leisure activities; ways to resist social pressure to use drugs; how to manage anger, shame, and guilt; tools to reduce relapse risk; relationship in recovery; spirituality; how to address employment or money issues; and other addictive behaviors.

Twelve-Step Facilitation Therapy

TSF is conducted in individual and group formats with the primary objective to facilitate patient participation in a twelve-step program. Sessions focus on acceptance of the disease of addiction, surrender to a higher power, acceptance of the fellowship and recovery program promoted by NA, and active involvement in twelve-step meetings, sponsorship, and other program activities. The patient is asked to attend twelve-step meetings, maintain a journal of reactions to meetings, and read recovery material. Many of the concepts and interventions of TSF are integrated into other behavioral therapies or programs for DUDs.

Cognitive Behavioral Treatment

The cognitive behavioral treatment approach teaches the patient coping skills to maintain abstinence. Drug addiction is viewed from a social learning perspective in which patients learn harmful behaviors, such as drug use, to change the way they feel. Over time, patients expect positive feelings from drugs, which motivate their drug-seeking behavior. As addiction progresses, patients have less confidence in their ability to cope without the use of drugs. This treatment helps the patient to identify triggers that increase the likelihood of relapse. The patient also learns problem-solving and behavioral skills to cope with high-risk situations and feelings. This treatment also helps the patient counteract self-defeating cognitions. Strategies used include role plays and homework assignments. Role plays facilitate the use of coping skills in real life. Homework encourages the practice of skills outside the office. Skills are also taught through therapist modeling, verbal presentation, treatment contracts, and self-monitoring. The therapist is active and directive in carrying out this treatment and in encouraging active collaboration with the patient.

Motivational Interviewing

MI is used with many other interventions for drug and other mental health and medical disorders, usually early in the treatment process. MI aims to help patients strengthen their motivation and commitment to change, address their ambivalence about change, and elicit specific goals and reasons for change related to their drug problem in an atmosphere of acceptance and compassion.

Contingency Management

The contingency management approach uses positive incentives to reward patients who abstain from drugs or adhere to treatment sessions. Patients earn points or draws from a fishbowl for which they earn prizes for drug-free urines or program attendance. Prizes are small (worth less than $5), medium (worth less than $20), or large ($25 or more). Patients also participate in counseling. Numerous studies show significant improvements in drug-free urines and session attendance when patients are rewarded with incentives.

Family Treatment Approaches

There are many marital and family approaches for adults or adolescents. A significant body of research shows that family approaches have a positive impact on the family member with the DUD in terms of their (a) engaging in treatment, (b) attending sessions, (c) completing treatment, (d) stopping or reducing drug use or lower rates of relapse, and (e) improved functioning (work, school, family, community). In terms of the family system, these approaches improve family interaction and communication, improve engagement in family treatment, and reduce the burden felt by family members when a loved one has a DUD. A family approach is the preferred intervention when the member with the DUD is an adolescent.

Group Drug Counseling

Groups are the most common form of treatment used in many programs for DUDs, and there are many models of group treatments including GDC. Phase 1 of GDC involves structured weekly group sessions that focus on a specific topic of addiction or recovery. Each topic has a format for discussion along with handouts and written assignments to facilitate learning. Sessions start with a check-in period during which patients give a brief update of the recent week in terms of any drug or alcohol use, level of cravings or close calls, any high-risk situations encountered, and mutual-support meetings attended. Following the check-in, the session reviews information and basic coping skills related to understanding addiction, engaging in recovery, managing cravings, managing people, places, or things, mutual-support programs, establishing a support system, managing feelings in recovery, dealing with guilt and shame, managing warning signs and high-risk relapse factors, and ways to maintain recovery. The group ends with participants stating their recovery plan for the upcoming week. The second phase of GDC involves a weekly problem-solving group in which the members set the agenda. Members discuss current problems and issues with the focus on coping strategies to remain drug free.

Pharmacologic or Medication-Assisted Treatment

Medications are used to manage physical withdrawal from addictive drugs, replace illicit drugs with medically managed drugs, and/or reduce cravings or desires for drugs. The U.S. Food and Drug Administration (FDA)–approved medications for opioid dependence with evidence of efficacy include naltrexone, naltrexone XR, buprenorphine-naloxone, and methadone, which are administered in a licensed narcotic addiction treatment program, usually on a daily dosing schedule. FDA-approved medications for nicotine dependence include bupropion SR and varenicline. Medications with some efficacy but not approved by the FDA for cocaine dependence include modafinil, bupropion SR and XL, desipramine, disulfiram, and topiramate. Medications with some efficacy but not approved by the FDA for cannabis dependence include buspirone and dronabinol. Other medications and vaccines are being tested for certain types of drug dependency. Individuals who are prescribed medications to help treat a substance dependence are also provided psychosocial therapies, and most are encouraged to engage in mutual-support programs as well.

Mutual-Support Programs

There are many mutual-support programs for DUDs. The most common are twelve-step programs such as NA, Cocaine Anonymous, Crystal Meth Anonymous, or Marijuana Anonymous. “Active” involvement is associated with the best outcomes from participation in these programs. This refers to attending meetings, getting a sponsor, working the twelve

steps, and using the other tools of the program. Although there are other non-twelve-step programs (e.g., Rational Recovery, SMART Recovery, Women for Sobriety), many areas do not offer these programs. Online chat rooms are another resource that may help some individuals with DUDs.

Relapse

Most of the therapies for DUDs aim to help the patient reduce relapse risk, deal with adverse effects of the DUD, develop a support network, and improve the quality of life. Although there are many factors that contribute to relapse such as negative emotional states, social pressures to use substances, strong cravings, or interpersonal conflict, not using coping skills ultimately determines if a relapse occurs. Incorporating interventions from RPT is one way to help patients reduce relapse risk. Many behavioral therapies and structured treatment programs incorporate elements of RPT into their clinical programming. RPT helps the patient (a) identify and manage early warning signs of relapse, (b) identify and manage high-risk relapse factors, (c) intervene early in a lapse or relapse to limit the damage, and (d) make lifestyle changes to achieve a better balance. If a patient has a lapse or relapse, the clinical focus can be on learning from it to develop coping strategies to use in the future.

See alsoCannabis Use Disorder; Cocaine Use Disorder; Drug Use Disorders: Treatment; Hallucinogen Use Disorder; Inhalant Use Disorder; Opioid Use Disorder; Phencyclidine Use Disorder; Sedative, Hypnotic, or Anxiolytic Use Disorder; Stimulant Use Disorder; Tobacco Use Disorder

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Further Readings

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