Narcotics Addiction as an Unrecognized Primary Diagnosis

Emily Tatum, MD, and Steven Ornstein, MD
Charleston, South Carolina

DR. STEVEN ORNSTEIN (*Instructor, Department of Family Medicine*): Dr. Emily Tatum will present today's Grand Rounds. Her topic is on narcotics addiction as an unrecognized primary diagnosis in a patient with systemic lupus erythematosus.

DR. EMILY TATUM (*Second-year Family Medicine Resident*): My goals for this Grand Rounds are to present a case of narcotics addiction in the context of an individual patient and her family, briefly discuss the epidemiology and some theoretical models of narcotics addiction, and suggest a role for the family physician in caring for patients with this problem. I will also attempt to explain why this patient's physicians were unable to address her problem with narcotics addiction adequately.

The patient was a 23-year-old woman first admitted to the hospital in March 1984 with fever, a 50-lb weight loss, and polyarthritis. Evaluation at that time revealed an increased Westergren sedimentation rate, a positive antinuclear antibody, and low serum complement levels. A diagnosis of systemic lupus erythematosus (SLE) was made. The patient responded to prednisone and was maintained on 40 to 60 mg/d as an outpatient. She was readmitted in July 1984 for septic arthritis, thought secondary to immunosuppression resulting from treatment of her SLE. In October 1984 she was readmitted with a presumptive exacerbation of SLE. The diagnosis of narcotics addiction was recognized at this admission, after the patient admitted that she was on a methadone maintenance program. The patient was again admitted in November 1984 with Staphylococcus aureus bacteremia. An exhaustive search for the focus of infection was inconclusive. The patient was hostile toward the medical staff and persistently demanded narcotic analgesia. She admitted to the continued use of intravenous hydromorphone while in the hospital. A psychiatric consultant made the diagnosis of a borderline personality disorder. She was discharged but returned five days later with fever and a left upper quadrant abdominal mass. An abdominal computed tomography scan revealed the presence of a splenic abscess, and bacteremia with S aureus was again demonstrated. Despite intravenous antibiotics and surgical drainage of her splenic abscess, the patient developed overwhelming sepsis and died.

In retrospect, it is obvious that the patient's primary diagnosis was not SLE, but narcotics addiction. It is possible that the emphasis on treating her SLE, while largely ignoring her narcotics addiction, contributed to her early death.

The patient's family and social history was largely unknown during her hospitalizations. It was obtained one year after her death, when I interviewed her father while preparing this Grand Rounds.

The patient's mother is 45 years old, the daughter of alcoholic parents who both succumbed to alcohol-related illness. She owns a successful restaurant on an isolated island, which is also the family's home. She abstained from alcohol and persistently urged her two children to do the same. The patient's father is a 53-year-old retired naval worker. He has been divorced from the patient's mother for five years, but continues to live nearby and assists her with her restaurant. He denies substance abuse, and there is no history of substance abuse in his family. The patient's brother is 27 years old and is serving his second prison sentence for a drug-related offense. He is an alcoholic and a marijuana abuser—I do not know whether he has abused narcotics.

The patient's social history was also remarkable. She left school in the ninth grade. She began to abuse alcohol at the age of 14 years and was the driver in three serious single-vehicle automobile accidents. By the age of 17 years, she was a heroin addict. She reportedly would spend hours at a time seeking narcotics from physicians around the state, using her arthritis as rationalization for her chronic pain. She gave birth to two children, one when she was

Submitted, revised, January 21, 1987.

From the Department of Family Medicine, Medical University of South Carolina, Charleston, South Carolina. At the time this paper was written, Dr. Tatum was a third-year resident at the Medical University Hospital in Charleston, South Carolina. Requests for reprints should be addressed to Dr. Steven Ornstein, Department of Family Medicine, Medical University of South Carolina, 171 Ashley Avenue, Charleston, SC 29425.

TABLE 1. PRACTICE ACRONYM FOR FAMILY ASSESSMENT

P—Presenting problem or reason for interview
R—Roles and structure
A—Affect
C—Communication
T—Time in family life cycle
I—Illness in family—past and present
C—Coping with stress
E—Ecology and culture

From Christie-Seely[1]

aged 15 years and the other when she was aged 17 years. Both children were given up for adoption. The patient was unmarried but had a serious relationship with a fellow heroin addict. He died from cancer two days prior to the patient's final hospitalization.

Janet Christie-Seely's PRACTICE acronym[1] is a useful model for analyzing this patient's family system. The components of the acronym are summarized in Table 1.

The *presenting problem,* in retrospect, was that of substance abuse. It dated back to when the patient was 14 years old. This problem affected not only the patient, but her brother and maternal grandparents as well.

The family's *roles and structure* can best be described as matriarchal, disengaged, and chaotic. The mother, a successful businesswoman, controlled the family. She disciplined her children by ultimatum. She provided them with material goods but little of her time.

The family's *affect* was one of anger. Anger was apparent between the patient and her mother when they spoke on the telephone. The anger between the patient's mother and father was manifest in their divorce.

The family's verbal *communication* appeared clear and direct. The mother frequently lectured her children about the evils of substance abuse. Their nonverbal communication contradicted this message, as the patient's substance-abusing behavior was tolerated, if not condoned. It is likely that the children's substance abuse was their nonverbal means of communicating distress to their parents.

The family's *time in the life cycle* was the "empty-nest" stage. There had also been a recent divorce between the patient's parents that was not followed by actual physical separation.

The family's *illness* was one of chronic, multigeneration substance abuse. It is unclear what role this illness played in the family system.

The family's *coping* skills were poor. In our interview, the father could not recall any previous significant stressors on the family system. This statement is particularly enlightening in view of the patient's death, her three motor vehicle accidents, and the parents' recent divorce. The patient's accidents and early alcoholism provided no stimulus for change. In fact, neither did her death, which led to a suicide attempt by her mother.

The family's *ecology* is represented by the metaphor of the living environment. They were both physically and socially isolated on their island. They had adequate financial resources, but few resources of other kinds.

Does anyone have any questions or have a different interpretation of the family system?

DR. BRYCE DOWNEY (*Psychiatrist, Assistant Professor of Family Medicine*): One feeling that I got from your presentation of the family system was of the family's bankruptcy: no morals, no religion, no values in the parents beyond success.

DR. TATUM: Yes. In fact the patient's father echoed that feeling in my interview with him. He stated: "I imagine our family is nothing like your family in that it is not much of a family at all."

EPIDEMIOLOGY OF NARCOTICS ADDICTION

DR. TATUM: Narcotics addiction can be defined as the chronic use of narcotics by an individual who subsequently develops physical and psychological dependence. Physical dependence is characterized by pharmacologic tolerance to increasing doses of the drug and withdrawal symptoms when the drug is withheld. Psychological dependence is characterized by a compulsion to consume the substance repeatedly.

Narcotics addiction affects all races, all ages, and both sexes. It is a contagious disease—largely spread from one addict to another. It is both an endemic and epidemic disease, with the supply of heroin predictive of the number of heroin addicts. In the late 1960s there was a surge in opium production, which resulted in an increase from approximately 100,000 narcotics addicts to 600,000 nationwide.[2] In the late 1970s, there was another dramatic increase in the availability of heroin, and it is expected that the number of heroin addicts is about to dramatically increase again.[3] Obviously, narcotics addiction is such a prevalent problem that it is likely that most practicing family physicians will have several narcotics addicts in their practice.

THEORIES OF NARCOTICS ADDICTION

There are numerous biologic, psychological, social, and moral theories concerning the etiology of narcotics addiction.

Most biologic theories of narcotics abuse refer to the dramatic rise of information in the past decade concerning

the brain's opiate receptors and the body's endogenous opiates, endorphins and encephalins.[4] These receptors are known to play a role in pain perception and modulation.[4] It is also hypothesized that these receptors are related to narcotics addiction as well as other psychiatric disorders, such as depression, schizophrenia, and eating disorders.[4] Some biologic theories of narcotics addiction view the opiate receptor in terms similar to the insulin receptor model. Usually, the body is in homeostasis, which is achieved with endogenous opiates attached to the opiate receptors. The administration of exogenous opiates alters this delicate balance, however, by changing either the number or quality of the receptors. This alteration in the receptors, it is hypothesized, eventually leads to physical dependence on narcotics.[4,5]

Most psychological theories view narcotics addiction in terms of maladaptive behavior. Strayhorn[6] views drug addiction as a symptom of maladaptive learning in which a person begins the use of substances with clear, although often unconscious, motives. The habit, however, acquires an autonomy that requires energy to overcome even if the original motive is no longer operative. Many view drug addiction as a form of suicide.[7]

Social theories view drug addiction in terms of its ritualistic, almost religious-like practices. Addicts have a peer group of other addicts who provide identity and support. They have a specific language concerning the acquisition, administration, and effects of the drugs. This group process can be very seductive to addicts who otherwise may have few associates or significant accomplishments in their lives.[2] In fact, the religious-like nature of addiction may be one explanation for the observation that addicts who become successfully abstinent from drugs often substitute a formal religion for their addiction.[2]

DR. ALAN JOHNSON (*Psychologist, Associate Professor of Family Medicine*): You can compare practices in a drug subculture to religious practices. For Christians, the ritualism and liturgy of the Eucharist, and, for Jews, the ritualism of the bringing out and reading the Torah come to mind. Both involve groups coming together, sharing a particular language, and handling sacred elements. Within Christian practices, these rituals also involve physically ingesting elements, some of which, under uncontrolled secular circumstances, are addictive and intoxicating. Similar practices are very much part of the drug culture.

DR. JOHN LANGLOIS (*Third-year Family Medicine Resident*): Some religions advocate converting others to their beliefs, just as those already involved with drugs convert others to drug abuse.

DR. TATUM: The influence of the family in drug addiction has not been studied so well as in alcoholism. One view points to unresolved grief as an important dynamic in families with narcotics addicts. This hypothesis states that the narcotics addict dies the willing and noble death of a martyr for the family. He or she, in some way, acts as a scapegoat who takes on the "sins" of the family, and, by his or her death, purifies them of their evil.[7,8]

The final theory of narcotics addiction that I am going to present is the moral model, in which the addict is viewed as a wrongdoer and a moral failure.[9] I believe that appreciating this model gives me insight into why I was unable to address adequately the patient's narcotics addiction. She was a young, white woman from a middle-class family who, on the surface, had much in common with me. This superficial resemblance may have caused me to overidentify with the patient and rendered me unable to accept the true diagnosis. In terms of the moral model, narcotics addicts are sinners. I was unable to see the patient in this light due to overidentification, and thus was unable to be therapeutic.

MR. ALBERT KELLER (*Ethicist and Minister, Associate Professor of Family Medicine*): I think the reference that describes the moral model is more discriminating than you were in presenting it. "Sinner" does not belong to a moral model. "Sinner" belongs to a particular kind of religious model, and moral and religious are not synonymous.

The moral model understands drug dependencies in terms of the will. When you think about it, moral—the concept of morality—has to do with the ability of a person to act and focus out of his or her integrity, to be intentional with his or her life. It seems to me that there is something to be said for that when we are trying to understand a person who has an alcohol or drug dependency. There is some sense in which these people are responsible human beings, and if you make a statement like that, then you are dealing in a moral model of some kind.

DR. BEN EPSTEIN (*Second-year Family Medicine Resident*): One of the first steps in the Alcoholics Anonymous treatment program is that the person declares himself responsible for his actions.

ROLE OF THE FAMILY PHYSICIAN

DR. TATUM: Westermeyer[10] calls narcotics addiction "the great imitator" of our time because it can present with so many different manifestations: acute or chronic physical illness, family dysfunction, legal problems, or economic duress. The natural history of narcotics addiction is unknown, and the studies that have attempted to address this problem are fraught with methodologic problems.[3] Nevertheless, it is well accepted that narcotics addicts' social networks invariably shrink, as friends, neighbors, and co-workers begin to avoid the addict.[10] In fact, it is believed that an addict's prognosis is directly corre-

continued on page 23

continued from page 21

lated with the size of his or her social network—addicts who remain employed and live in an intact family system have a more favorable prognosis than those who do not.[10,11] The family physician may be most efficacious if he can diagnose addiction early and recommend intervention prior to the inevitable contraction of the patient's social network.

DR. DOWNEY: By the time physicians get in contact with these patients, they've usually fallen out of their normal social network. Their substitute social network consists of people who are all related to the drug culture. It is difficult to remove patients from this network—they usually don't have the strength, resources, or money to do so. Getting these patients into a treatment center is usually the best thing for them. It provides an immediate network of people who are now not active narcotics addicts and who will be there for the patient 24 hours a day. Patients can begin to thrive in this network until they develop their own network outside the drug culture.

DR. TATUM: Balint[12] describes the "collusion of anonymity"—the observation that psychological diagnoses are often ignored when many physicians are involved in a patient's care and none assumes primary responsibility. In this case, many physicians were involved: internists, rheumatologists, infectious disease specialists, psychiatrists, and several others. This multitude of physicians allowed everyone to feel that they were not ultimately responsible for the decisions that occurred in the care of this patient. I think that this "collusion of anonymity" also contributed to the inadequate treatment of the patient's primary problem.

The family physician is trained to address difficult psychosocial problems often ignored by other specialists. Preventing the "collusion of anonymity" and focusing on the true primary problem may be the most important role for the family physician in the care of hospitalized patients.

References

1. Christie-Seely J (ed): Working with the Family in Primary Care. New York, Praeger Scientific, 1984
2. Milby JB: Addictive Behavior and Its Treatment. New York, Springer Publishing, 1981
3. Frank B, Lipton DS: Epidemiology of the current heroin crisis. In Serban G (ed): The Social and Medical Aspects of Drug Abuse. New York, Spectrum Publications, 1984, pp 93–99
4. Simon EJ: Opiate receptors and opioid peptides: Are they involved in drug addiction? In Serban G (ed): The Social and Medical Aspects of Drug Abuse. New York, Spectrum Publications 1984, pp 9–20
5. Serban G: Social stress and drug abuse. In Serban G (ed): The Social and Medical Aspects of Drug Abuse. New York, Spectrum Publications 1984, pp 125–133
6. Strayhorn JM: Foundation of Clinical Psychiatry. Chicago, Year Book Medical, 1982
7. Stanton MD: The addict as savior: Heroin, death, and the family. Fam Proc 1977; 16:191–197
8. Finley BG: Substance abuse problems throughout the life span. In Bennett F, Vourakis C, Woolf DS (eds): Substance Abuse: Pharmacologic, Developmental, and Clinical Perspectives. New York, Wiley Medical, 1983, pp 119–134
9. Siegler M, Osmond H: Models of drug addiction. Int J Addiction 1968; 3(1):3–24
10. Westermeyer J: Role of the family physician in the diagnosis and treatment of substance abuse. Semin Fam Med 1980; 1(4):237–247
11. Goldfried MR: Prediction of improvement in an alcoholism outpatient clinic. Q Stud Alcohol 1969; 30:129–139
12. Balint M: The Doctor, His Patient and the Illness. Old Working, Surrey, Pitman Medical, 1971