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# Opium Use Disorder

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## Description of Opium Use Disorder

Opium use disorder is a diagnosis listed in the chapter Substance-Related and Addictive Disorders in the *Diagnostic and Statistical Manual of Mental and Emotional Disorders* (DSM-5; American Psychiatric Association [APA], 2013). Opium use disorder, like all substance use disorders (SUDs), is characterized by a loss of control over consumption of the substance, obsessive thoughts about the substance, and continued use despite negative consequences (APA, 2013). Opium use disorder is diagnosed on a continuum from mild (i.e., two or three of the diagnostic criteria), to moderate (i.e., four to five of the diagnostic criteria), to severe (i.e., six or more diagnostic criteria).

Opioids fall into three broad classes: (a) natural opiates (e.g., morphine); (b) semisynthetic opioids (e.g., heroin); and (c) synthetic opioids (e.g., fentanyl; O'Neill, 2014). Opioids produce a rapid sensation of euphoria (i.e., the user typically feels an intense high immediately following the use of the substance) and tolerance to opioids develops rapidly (O'Neill, 2014). Opioids usually are purchased illegally; however, some users may obtain prescription opioids from physicians by falsifying medical problems or by receiving simultaneous prescriptions from several physicians (APA, 2013). Discontinuing use of opioids often brings about a withdrawal syndrome, which can include symptoms such as nausea, vomiting, chills, and body aches (O'Neill, 2014).

Opium use represents a significant and pervasive health concern. In 2011, there were nearly 17,000 deaths related to the overdose of opium analgesics (Chen, Hedegaard, & Warner, 2014). From 1999 through 2011, the rate for opium-analgesic poisoning deaths almost quadrupled from 1.4 per 100,000 in 1999 to 5.4 per 100,000 in 2011 (Chen et al., 2014). Opium use is associated with other related-risk factors (e.g., prostitution and criminal behavior; Öhlund & Grönbladh, 2009). Due to their intravenous substance use, those who inject heroin are also at an increased risk for contracting HIV/AIDS or hepatitis C (O'Neill, 2014). Researchers (e.g., Dinwiddie, Shicker, & Newman, 2003; Hagan, Pouget, Des Jarais, & Lelutiu-Weinberger, 2008; Loftis, Matthews, & Hauser, 2006 ) estimate that as many as 90% of all intravenous drug users test positive for acute or chronic hepatitis C infection. Opium use disorder is most commonly first observed in the late teens or early 20s. Once opium use disorder develops, it usually continues over a period of many years, even though brief periods of abstinence are frequent (APA, 2013).

Relapse following abstinence is common (APA, 2013). Relapse can be a potentially dangerous event, as many opium users will return to their pre-abstinence level of use. In other words, the opium user, although abstinent from heroin for a period of time, may return to using the same quantity of the drug that he or she used before detoxification. Put simply, after a period of sobriety, an individual's tolerance to the substance decreases; however, his or her craving to the drug remains the same.

## IDENTIFICATION/ASSESSMENT STRATEGIES

Over the past twenty years, significant advances have been made in the assessment of opium use, which have resulted in greater emphasis on individualized treatment (Westphal, Wasserman, Masson, & Sorensen, 2005). Opium use disorder is conceptualized by compulsive, prolonged self-administration of opium substances that are used for no legitimate medical purpose or, if another medical condition is present that requires opium treatment, that are used in doses greatly in excess of the amount needed for that medical condition (APA, 2013).

Opioid use disorder is often associated with the commission of drug-related crimes (e.g., possession or distribution of drugs, forgery, burglary, robbery, larceny, receiving stolen goods; APA, 2013). Interpersonal difficulties, relationship difficulties, and unemployment are also often associated with opioid use disorder at all socioeconomic levels (APA, 2013). These factors are often important when assessing the appropriate level of care for treatment of the client. For example, a client who is engaging in intravenous heroin use, has had legal uses, and does not have a strong support system will likely need an intensive level of care (e.g., intensive outpatient, inpatient treatment).

Appropriate assessment of opioid use is important. Counselors must determine the severity level of the opioid use disorder and select the appropriate level of care (e.g., outpatient, intensive outpatient, inpatient). Documentation of physical signs of opioid use (e.g., needle puncture marks, skin ulcers, ulcerations of nasal septum) is often an important assessment consideration.

Individuals from ethnic minority populations living in economically deprived areas have been historically overrepresented among individuals with opioid use disorder; however, opioid use disorder is seen more often among white middle-class individuals, especially females, suggesting that differences in use reflect the availability of opioid drugs and that other social factors may impact prevalence (APA, 2013).

Similar to the risk generally observed for all substance use disorders, opioid use disorder is associated with a heightened risk for suicide attempts and completed suicides (APA, 2013). In addition, repeated opioid intoxication or withdrawal may be associated with severe depression that, although temporary, can be intense enough to lead to suicide attempts and completed suicides (APA, 2013).

### **Clinical Opiate Withdrawal Scale (COWS; Wesson & Ling, 2003)**

The COWS is an 11-item clinician-administered scale. The COWS is designed to be used in both inpatient and outpatient settings to rate common signs and symptoms of opiate withdrawal (e.g., nausea, restlessness, sweating, irritability). This instrument can provide a useful baseline for clients who are presenting for an initial assessment. It can also provide helpful information about the client's ongoing withdrawal symptoms.

### **This Culture of Addiction Enmeshment Scale (White, 1996)**

White (1996) developed a scale to measure the degree of client involvement in a drug-related culture. This scale measures the amount of time a client spends actively involved with other addicts (e.g., securing drugs/alcohol, participating in events with drugs/alcohol present). Understanding the client's enmeshment in the culture of addiction is an important consideration because disrupting this culture of addiction is often an important component of addictions treatment.

The scale is accessible at the link below: <http://www.williamwhitepapers.com/pr/Culture%20of%20Addiction%20Enmeshment%20Scale.pdf>

### **Obsessive-Compulsive Drug Use Scale (OCDUS; Franken, Hendriks, & van den Brink, 2002)**

The OCDUS measures the obsessive-compulsive aspects of drug use and the client's general desire to use the drug of choice during the previous one-week period. The 13-item scale consists of three subscales: *Thought about Heroin and Interference*, *Desires and Control*, and *Resistance to Thoughts and Intentions*. This instrument can be helpful to measure craving, a serious obstacle in the client's attempts to maintain sobriety (Westphal et al., 2005).

### **Biological Testing**

Biological testing (i.e., drug testing) is an important indicator of ongoing client sobriety. Drug testing most often involves routine urinalyses of clients; however, in some cases, blood tests or a hair test may also be used. Drug testing is an important indicator of client sobriety as it provides evidence of clients' abstinence from substances beyond simply using clients' self-reports. The purpose of drug testing is to provide objective data about a client's continued sobriety.

Biological testing is also an important assessment component as it helps the counselor determine the appropriate level-of-care for client treatment. For example, clients who are using intravenous heroin may need a higher level of care (e.g., inpatient) and may require medical detoxification and/or medication-assisted treatments (e.g., buprenorphine, methadone) compared to those who are intermittently using intranasal heroin.

## **INTERVENTION STRATEGIES**

Individuals with opioid use disorders often present with co-occurring disorders (Mason et al., 1998) and counselors must be prepared to assess and treat comorbid conditions. The diagnostic criterion for opioid use disorders illustrates the chronic, progressive nature of this condition. People with opioid use disorder may experience difficulty controlling their use of the substance, they may have had unsuccessful past attempts to cut down or abstain from use, and they may experience cravings (i.e., an intense desire for the substance; APA, 2013). Effective treatment strategies help the client manage withdrawal symptoms, address cravings, enhance client motivation for sobriety, and encourage the development of ongoing relapse prevention strategies.

### **Cognitive-Behavioral Therapy (CBT)**

The cognitive-behavioral therapy approaches are well established in the counseling literature as an evidence-based approach in the treatment of all substance-related disorders (O'Neill, 2014). CBT approaches typically incorporate elements of social skills training, self-control training, community reinforcement, challenging irrational thoughts, contingency management, and stress-management training (Finney, Wilbourne, & Moos, 2007). Cognitive-Behavioral Therapy approaches are goal-oriented and structured, and they typically focus on helping clients match their abilities and skills with the demands of their environment.

Cognitive-Behavioral Therapy approaches of opioid use disorder might assist clients in cognitive restructuring of their irrational thoughts and beliefs, as well as increasing their drug refusal skills (e.g., social, coping, self-control, stress toleration, emotion regulation). Treatment often involves challenging irrational thoughts and beliefs, skill development, role-playing, emotion regulation, and relapse prevention. Encouraging the client to develop effective sober activities can be helpful as the client begins developing an alternative to his/her previous opioid using lifestyle.

### **Motivational-Interviewing (MI)**

Motivational Interviewing (MI) is an effective approach to working with resistant clients, court-mandated clients, or any client who may experience lack of motivation for sobriety. Motivational interviewing is an active, directive, and client-centered approach to facilitating client change by exploring and resolving ambivalence toward change (Miller & Rollnick, 2012). An overarching goal of MI is to alter how the client sees, feels, and responds to problematic behaviors, with the counselor amplifying any discrepancy between the client's present behavior and goals that he or she verbalizes to be important (Britt, Blampied, & Hudson, 2004).

Motivational interviewing creates a supportive, nonjudgmental therapeutic environment that enables the client to facilitate the exploration of motivations, readiness, and confidence levels for change (Miller & Rollnick, 2012). Motivational interviewing works by assessing the client's stage of change (i.e., pre-contemplation, contemplation, preparation, action, maintenance) and then developing interventions designed to fit the client's stage of change.

Resource:

Overview of motivational interviewing: <http://motivationalinterviewing.org/>

### **Medication-Assisted Treatment (MAT)**

Medication-Assisted Treatment (MAT) is generally considered the standard of practice in the treatment of chronic, severe opioid use disorders (O'Neill, 2014). MATs are designed to serve as an adjunct to other forms of treatment, including individual and group counseling (Kelch & Piazza, 2011). There are three main types of MATs: full opioid agonists (e.g., Methadone), partial opioid agonists (i.e., buprenorphine), and opioid antagonists (e.g., naltrexone).

Methadone is used as a replacement therapy for clients with severe opioid use disorders. Methadone works by binding to the opioid receptor, thereby decreasing an individual's withdrawal symptoms associated with heroin and preventing cravings associated with use (O'Neill, 2014). Methadone typically suppresses opioid withdrawal and drug craving for 24 to 36 hours in most people with opioid use disorders (Center for Substance Abuse Treatment, 2005).

Buprenorphine works similar to methadone; however, it does not fully bind to the opioid receptor. Buprenorphine can be prescribed on an outpatient basis and does not require daily dosing. Naltrexone, an opiate antagonist, blocks and reverses the physical effects of opioids (i.e., one cannot get "high" on an opioid while on naltrexone; O'Neill, 2014). Naltrexone can be helpful in conjunction with outpatient counseling treatments.

Medication Assisted Treatment Resources:

Centers for Disease Control (CDC) overview of methadone maintenance treatment: <http://www.cdc.gov/idu/facts/MethadoneFin.pdf>

Information regarding accreditation of methadone maintenance programs: <http://dpt.samhsa.gov/pdf/001218accred.pdf>

SAMHSA Methadone and Pregnancy handout:  
<http://store.samhsa.gov/shin/content//SMA14-4124/SMA14-4124.pdf>

SAMHSA overview of buprenorphine treatment:  
<http://buprenorphine.samhsa.gov/about.html>

SAMHSA treatment with buprenorphine handout:  
<http://store.samhsa.gov/shin/content//SMA14-4442/SMA14-4442.pdf>

SAMHSA handout for opioid use treatment with naltrexone:  
<http://store.samhsa.gov/shin/content/SMA12-4444/SMA12-4444.pdf>

SAMHSA Hepatitis and Medication Assisted Treatment information:  
<http://www.dpt.samhsa.gov/comor/hepatitis.aspx>

SAMHSA handout for Hepatitis:  
<http://store.samhsa.gov/product/Take-Action-Against-Hepatitis-C/SMA14-4853>

Resource for overdose prevention:  
Substance Abuse and Mental Health Services Administration's (SAMHSA) Opioid Overdose Toolkit:  
[http://store.samhsa.gov/shin/content/SMA14-4742/Overdose\\_Toolkit.pdf](http://store.samhsa.gov/shin/content/SMA14-4742/Overdose_Toolkit.pdf)

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