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Psychosocial Factors and Treatment

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Overview

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Ten years ago, while epidemiologists were reporting that cocaine use was escalating in epidemic proportions and laboratory researchers were demonstrating the strong reinforcing power and addictive potential of the drug, treatment providers were wondering why they were not being inundated by patients seeking treatment for problems with cocaine. We, for example, despite being located in central Philadelphia, were seeing very few cocaine abusers in our inpatient, outpatient, or consultation services.

Admissions to our programs at that time were reported under only three categories: alcohol, drugs, or both. The greatest number involved alcohol. The numbers of patients using any of the other drugs were not sufficient to warrant separate recording categories, and they were all simply grouped together as drugs. It was not until the early 1980s that we began seeing more than occasional patients with cocaine problems. Thereafter, however, things changed rapidly and markedly with the increasing numbers of patients straining our resources, challenging us regarding appropriate treatment methods, and resulting in major changes in our programs.

By 1987 the number of admissions for cocaine to our inpatient program almost equaled that for alcohol, the number of beds doubled, and in effect, the program became a combined-disorders rather than an alcohol treatment unit. We prefer the term "combined" to "dual" because many of our patients have combinations of more than two substance-use and other psychiatric disorders. The number of cocaine admissions exceeded that for alcohol for the first time in 1988, and this trend has continued to the present. Of 138 patients admitted

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during the last 6 months, 49 involved cocaine, 20 alcohol, 39 cocaine and alcohol, and the remaining 30 included all others, some of whom were polydrug abusers who were also using alcohol and/or cocaine.

The increase in the number of cocaine abusers requesting outpatient treatment was no less dramatic. By 1989 the demand for services grew beyond what our established programs could accommodate, and we found it necessary to obtain additional support and open a new outpatient cocaine treatment program. Currently, our monthly outpatient admissions for cocaine are more than double those for alcohol and all other drugs combined.

Thus, in a short period of time, cocaine has emerged as the most common substance-use disorder being treated in our programs. Moreover, even when it is not the primary substance-use disorder, it is a common second disorder. In our methadone program, for example, about half the patients report using or abusing cocaine. Ten years ago, we were concerned about whether and how to treat alcohol and drug abusers in the *same program*. Today we are concerned about how to treat alcohol, cocaine, and other drug abuse in the *same person*. It has become difficult to try to understand or even think about the underlying biological mechanisms, social settings, developmental features, classification, or treatment of "pure," single, substance-abuse disorders or, indeed, to find examples for purposes of research.

Clearly these changes raise many issues for clinicians, researchers, and those charged with planning service delivery systems. We have observed the onset and spread of a substance-use epidemic. Why did this occur at this particular time and place and what did cocaine have, for example, that amphetamine did not? Amphetamine was available, its actions and effects are very similar, and it is of course much cheaper than cocaine. Are there some basic biological, behavioral, and/or sociocultural differences involved here that could help us understand the factors that go into the making of a substance use epidemic?

We were surprised that it took so long before the increased numbers of cocaine users in the 1970s became treatment admissions in the 1980s. Different drugs differ in the period of time elapsing between first use, heavy use, and problematic use. For cocaine this period is on average shorter than that for alcohol. What seems puzzling is that it is longer than that for heroin, even though in the laboratory cocaine has been shown to be a more powerful reinforcer than heroin. Drugs also differ in the proportion of users who progress from recreational use to problematic use and the proportion of problematic users who seek treatment. It is not clear whether these characteristics are related and to what extent these characteristics may be determined by the properties of the drugs (e.g., biochemical action, reinforcing potency, or the change from nasal to respiratory administration), the individual users (e.g., psychopathology, expectations, or a decrease in socioeconomic level), and/or the context (e.g., stage of epidemic, marketing and distribution system, availability and accessibility of treatment).

More and more of our patients appear to be using multiple drugs from

multiple classes concurrently, consecutively, or both. Downers are used with uppers or with other downers. Cocaine is used with alcohol and with heroin, although there seems to be a special affinity between alcohol and cocaine. What are the implications of this increasing trend toward polydrug abuse with respect to (1) self-medication and drug-of-choice hypotheses, (2) organizing principles for subclassifying the substance use disorders, (3) searching for general compared to more specific etiological mechanisms, and (4) treatment planning? In terms of treatment, a wide variety of newer and older psychosocial and pharmacological techniques are being attempted and studied. Some findings are beginning to emerge, but as yet there are no proven preferred methodologies.

The increasing curve of cocaine use did level off and has now even turned a bit downward. Could it be that as more and more individuals come to recognize that cocaine does not provide a harmless high, but is instead a dangerous drug, its use and abuse will decrease sharply? This occurred with LSD and with cocaine on previous occasions. Even if this does occur, it is unclear what the time frame might be and how many residual chronic cocaine abusers will remain requiring treatment services. By contrast, what is the likelihood that it might take its place in our society as another common recreational drug such as alcohol, nicotine, and marijuana? We have learned that, despite the laboratory findings with respect to its powerful reinforcing potential, some individuals can use the drug for considerable periods of time in a nonproblematic fashion. If this does occur, what proportion of users will progress to problematic use and of these, what proportion will be seeking treatment?

Some of the above issues and many others are explored in greater detail in the following five chapters comprising this section. In each, alcohol and cocaine are compared and contrasted as the authors from a variety of perspectives search for insights relevant to the etiology, development, prevention, or treatment of substance-use disorders.