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Vocational rehab concerns for clients who have exhibited meth induced psychosis

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Vocational rehab concerns for clients who have exhibited meth induced psychosis

I. Introduction

Meth induced psychosis is a condition that tends to occur in chronic users. According to McKetin, R., McLaren, J., Lubman, D. & Hides, L. methamphetamine can induce a transient psychotic state in users of the drug, which can be accompanied by unpredictable violent behavior including homicide (2008, p. 235). This can include delusions, hallucinations and thought disorder which are thought to be primarily due to the increase in dopamine and serotonin activity, although other factors such as chronic sleep deprivation may also play a part (Wikipedia, 2009).

Tweaking is a stage of meth use which is associated with meth induced psychosis. StopMethAddiction.com says this stage occurs at the end of the binge when no amount of methamphetamine can bring back the initial high feelings and the user generally experiences mental symptoms of emptiness, depression, and paranoia; they also often suffer a form of methamphetamine-induced schizophrenia including visual or auditory hallucinations as well as the feelings of bugs crawling underneath their skin (Meth mental effects, 2009, p. 1). During this phase the tweaker may employ a depressant such as alcohol to help them come down and crash. This can be a particularly dangerous combination when alcohol dis-inhibits behavior leading to crime.

Dr. William Mains, a San Francisco addiction psychiatrist says that meth induced psychosis responds well to anti-psychotic medications, and often only a few months of

treatment is needed (personal communication, May, 12, 2009). No matter what, the person who has experienced meth induced psychosis must be determined not to further abuse methamphetamine if s/he is to experience successful placement in a vocational rehabilitation setting, and success will depend upon their ability to follow through on this determination.

II. Methamphetamine manufacturing

Methamphetamine is a highly addictive stimulant made from many ordinary over the counter ingredients. It is commonly manufactured in California or Mexico. It can be smoked, snorted, injected or inserted anally. Its street names include ice, crystal, meth, chalk, and glass among others. Meth is cooked in home labs which produce dangerous, potentially explosive toxic gases. Sites of meth labs are notoriously expensive for law enforcement and environmental agencies to clean.

III. Methamphetamine cost

Compared with cocaine, meth produces a high that lasts much longer and is cheaper to use. The cost is about a fourth that of cocaine and a meth high can last 8-12 hours, while a cocaine high is only 20-30 minutes. StopMethAddiction.com says that “methamphetamine's street value is approximately \$3,000 per pound (about the size of a brick), while the price of cocaine is roughly \$11,000 per pound” (Meth statistics, 2009, p.1).

IV. Methamphetamine high

PBS' Frontline reports that in lab experiments done on animals, sex causes dopamine levels to jump from 100 to 200 units, and cocaine causes them to spike to 350 units (2006, p. 1). Dr. Richard Rawson says that with "methamphetamine you get a release from the base level to about 1,250 units, something that's about 12 times as much of a release of dopamine as you get from food and sex and other pleasurable activities. This really doesn't occur from any normally rewarding activity. That's one of the reasons why people, when they take methamphetamine, report having this euphoric [feeling] that's unlike anything they've ever experienced" (Frontline, 2006, p. 1). As the drug wears off, users experience profound depression and feel the need to keep taking the drug to avoid the crash (Frontline, 2006, p. 1).

V. Methamphetamine research

Research is limited on this topic, but one research study examined 1016 participants in eight out-patient treatment centers from 1999-2001. Zweben, J., Cohen, J., Christian, D., Galloway, G., Salinardi, M., Parent, D. and Iguchi, M. found that meth users "reported psychotic-like symptoms and scored high on the BSI [Brief Symptom Inventory] subscales for Paranoid Ideation and Psychoticism. Anxiety was another subscale that was elevated and women were significantly higher than men on all subscales. However, there were few age or racial differences in responses to the BSI, except that Caucasians were more likely than Latinos to score high on the Depression subscale" (2004, p. 184). Twenty-seven percent of the cohort had attempted suicide at

least once, with females being twice as high as males (Zweben et al., 2004, p. 184). They also found that injecting meth was associated with a significantly higher proportion of assault and weapons charges and higher frequency with difficulty controlling their violent behavior (Zweben et al., 2004, p. 185). The authors of this study concluded that meth use results in depression which can last for many months, and possibly be permanent due to the damage to the dopamine receptors; this presents a problem when many community based treatment programs are “addiction only” and do not treat co-occurring disorders (Zweben et al., 2004, p. 188).

Another study in Seattle, Washington compared emergency room charts of clients who reported to Psychiatric Emergency Services and found that the meth users tended to be male, referred by the police, and more often presented with tachycardia and hypertension along with dysphoria and psychosis while the control group presented with suicidal ideation (Pasic, J., Russo, J., Ries, R. & Roy-Byrne, P. 2007, p. 682). They found that most meth users presented to the emergency room while they were tweaking which was described as “a state of high arousal, agitation and bizarre uncontrollable movements, with prominent dysphoria, hallucinations and paranoia that are uncontrollable and distressing” (Pasic et al., 2007, p. 684). As a result of this distress, meth users were more likely to be given oral medications to ease the symptoms and Olanzapine was most often prescribed (Pasic et al., 2007, p. 684).

VI. Complications to the brain from meth use

Frontline cites a study by Dr. Nora Volkow, the director of the National Institute on Drug Abuse (2006, p. 1). She examined brain scans of several meth abusers who, after fourteen months of abstinence from the drug, had re-grown most of their damaged dopamine receptors; however, they showed no improvement in the cognitive abilities damaged by the drug (Frontline, 2006, p. 1). Each had more than a year's sobriety but still showed severe impairment in memory, judgment and motor coordination, with symptoms similar to those seen in individuals suffering from Parkinson's Disease (Frontline, 2006, p. 1).

Barr, A., Panenka, W., MacEwan, G., Thornton, A., Lang, D., Honer, W. and Lecomte, T. state that long term meth use can result in “substantial cognitive deficits, especially to memory, attention and executive function, possibly from neurotoxicity” and that “studies of neurochemistry and structural morphology of the brain... reveal numerous alterations, some of which show a direct relation to functional changes in behavior and cognition” (2006, p. 309). The authors also mention studies which showed that dopamine levels were reduced by 50 – 61% in long term meth users, many of whom died in drug overdoses (Barr et al., 2006, p. 304).

VII. Meth recovery

This drug is insidious. The initial rush in which the user experiences dopamine levels higher than anything humanly possible, leads the user to want to recreate this initial euphoria. Unfortunately, they will never again experience this type of pleasure, as

the drug damages and depletes receptors for dopamine, serotonin, and norepinephrine, sometimes permanently. Long term meth use leads to the inability to feel pleasure (Frontline, 2006, p. 1).

David Sheff, author of *Beautiful boy: A father's journey through his son's addiction*, states, "...meth addicts may be unable, not unwilling, to participate in many common treatments, at least in the early stages of withdrawal. Rather than a moral failure or a lack of willpower, dropping out and relapsing may be a result of a damaged brain" after he interviewed Dr. Edythe London (2008, p. 135). She told him that "patients with extremely high levels of depression and anxiety, and who are suffering a type of 'chronic agony,' as London describes it, are at a major disadvantage when taking part in cognitive and behavioral treatments" (Sheff, 2008, p. 135).

Recovery from meth addiction will require patience and an understanding that many relapses are likely to occur. Most programs include a 12 step model of recovery along with components of family therapy.

VIII. Considerations for vocational rehabilitation counselors

Bearing in mind this drug causes brain damage that can mimic Parkinson's Disease, and is often permanent, counselors should be alert to cognitive deficits when working with this population. A client with attention deficit hyperactivity disorder (ADHD) will experience a worsening of their symptoms once they cease meth use. Some clients will experience schizophrenia type delusions and hallucinations on going, and will be helped with medications. Recovery from this drug goes hand in hand with depression.

Most clients will likely have some type of psycho-pharmaceutical intervention.

The rehab counselor needs to consider all aspects of the recovering addict's life. Explore their social network, and living situation to assess its stability. Does the living situation seem relatively stable for the long term, or is it a short term one associated with a recovery program? This may force the client to move once they find stable employment creating additional stress.

Also the length of recovery time needs to be discussed. If the client has only a few weeks in recovery, they are likely to relapse – several times. The counselor can ask the client what their relapse prevention plan is. How will the client deal with stresses that make them want to use again? Hopefully the client has a support system in place with a recovery group. If not, these safety nets will need to be created.

The counselor should consider having the client's cognitive functioning evaluated to determine if there are deficits and where they lie. It may not be realistic for the client to do clerical work that requires a great deal of math until the brain has had substantial time to heal. After two years of sobriety, the testing should give a fairly accurate picture of the client's abilities, assuming they do not relapse and damage their brain further.

An evaluation of the client's skills and a history about where they used meth are important. Some industries, such as hotels and restaurants, are notorious for drug use. It is important not to place a client into a work environment with a high potential for relapse, while still considering their wishes and previous job experiences.

IX. Conclusion

Meth abuse is becoming an epidemic in America and certainly in California. This drug is one that can cause addiction in as little as one dose. A client in recovery from meth addiction is one who will be struggling with depression. This is a client who requires an extra smile and the empathetic therapeutic stance that might be on hold in a busy vocational rehabilitation office. In addition to remembering their counseling skills, rehab counselors need to make every effort to have good solid resources for clients keeping in mind all the client's needs – shelter, food, social networks, and certainly their livelihood.

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