

Substance Abuse and Suicide

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Suicide and AOD

- 90% of successful suicide attempts have depression or other mental disorders, substance abuse disorders, or a combination of the two present
- Between 40 & 60% are intoxicated at the time of death
- Adolescents who die by suicide are more likely to use a firearm than another method if they have alcohol in their blood at the time of death.
- Suicide rates among 18-20 year-olds were found to decrease among several states where the minimum legal drinking age was raised to 21.
- The seriousness of suicidal behavior is correlated with the level of cigarette smoking

Human Behavior

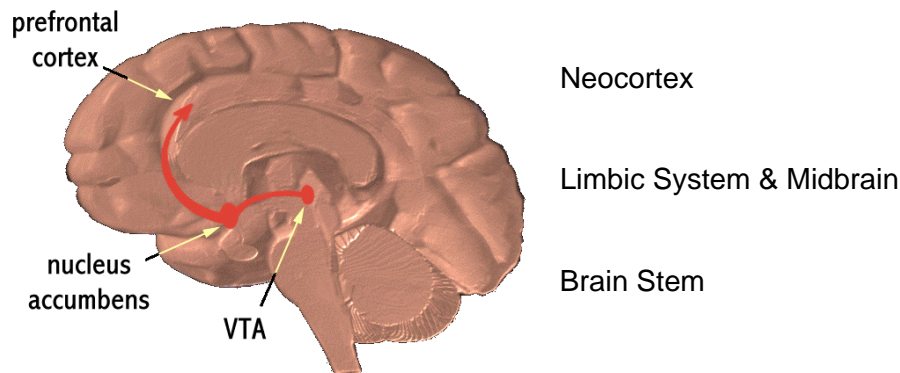
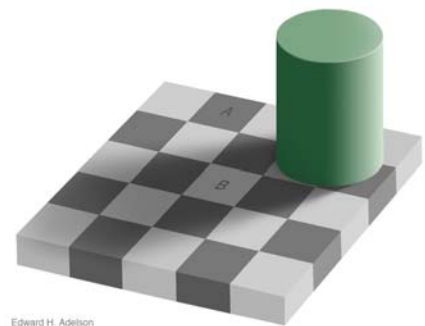
1 All behavior comes from the BRAIN

- Thoughts
- Emotions
- Senses
- Movement
- Memory

and 2 The brain works through chemical reactions

and 3 Chemistry follows the LAWS of physics and mathematics

Therefore: 4 ALL BEHAVIOR FOLLOWS THE LAWS OF MATHEMATICS

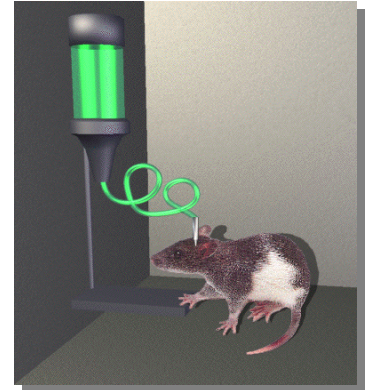


The reward pathways of the limbic system guide an animal's behavior to maximize its chance of survival. The brain is built to maximize pleasure and minimize discomfort.

"If it feels good it must be good for me."

Any chemical that stimulates our reward pathways automatically creates the desire (drive) to do it again.

Within 30 days, rats given the ability to stimulate their reward pathway at will do so continuously until they die from malnutrition, dehydration and exhaustion.

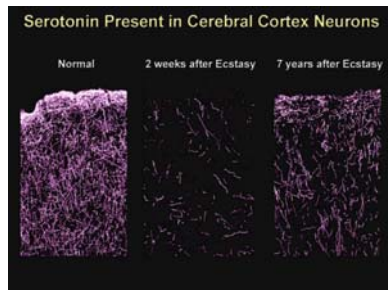


Alcohol & Drug Use

Alcohol and other drugs penetrate the blood-brain barrier to change the mathematical formulas that define our behavior - ALL of our behavior.

Drug penetrates blood-brain barrier

- ↳ Changes chemistry of the brain
 - ↳ Activates reward pathways with “drive” to repeat
 - ↳ Drugged behavior
 - ↳ Altered experience of events
 - ↳ Altered memory of events
 - ↳ Brain is depleted of neurotransmitters resulting in a hangover or “crash”



The changes in brain functioning from chemical use mirrors the conditions underlying major mental illnesses.

Unbalanced brain chemistry is prominent in all the major mental illnesses

Use of alcohol and most drugs of abuse (including nicotine) leads to chronically low serotonin levels

Low serotonin level is associated with depression and suicide behavior

Addiction

Over time neurons adapt to the consistent presence of a chemical by:

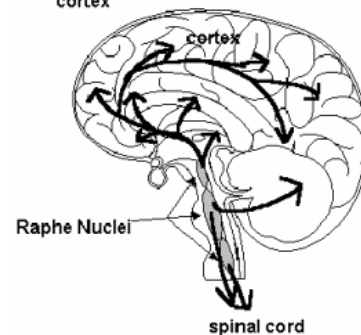
- Changing the amount of neurotransmitters available to the brain
- Increasing or decreasing receptor sites
- "Growing and pruning" neural connections to adjust activity to its set point

The reward pathway changes in response to the drugs

The drug takes on the properties of the activities that naturally create sensations of pleasure

Serotonin projections

Raphe Projects throughout the cortex





Definition of Addiction:

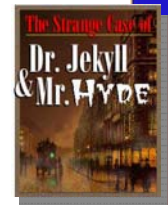
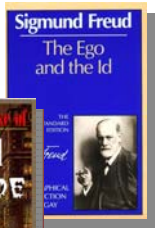
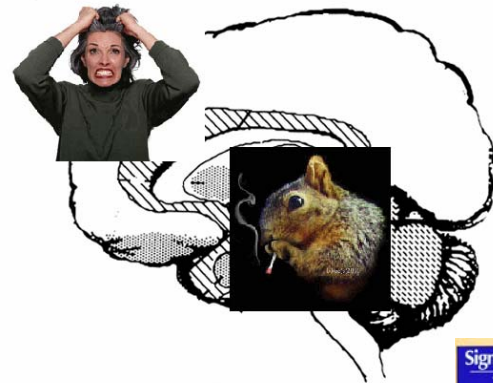
Addiction is the physical adaptation of the reward pathways of the brain to the consistent presence of a chemical. The chemical, then, takes on all the properties of the other primal drives, food, water and sex.

The Adolescent Brain

- Tremendous growth occurs in the prefrontal cortex (PFC) between ages 13 to 24
- If the adolescent is using alcohol/drugs, the addiction (adaptation) is highly accelerated
- Adolescents that use fail to allow the PFC to fully develop
- Addicts who start using as teenagers have immature PFC's

A New Motivation

- “Animal” motivation comes from the lower areas of the brain. It compels the animal to act in ways that ensures its survival
 - Eat
 - Drink
 - Procreate
 - (Drug)
- The duality of man. Man's existence is to be torn between animal impulses and rational choice.
- Addiction is rooted in the animal brain, not the PFC
- Deprivation leads to stress, and stress leads to arousal, preoccupation and hunting. Lower order deprivation takes priority over higher order motivations



A Weak Prefrontal Cortex is marked by:

- Short attention span
- Distractibility
- Lack of perspective
- Poor impulse control
- Hyperactivity
- Chronic lateness / poor time management
- Poor organization and planning

- Procrastination
- Poor emotion modulation
- Misperceptions
- Poor judgment
- Trouble learning from experience
- Short term memory problems
- Social anxiety
- Lying

Indicators of Addiction

Relief use
Guilt
Lying / excuses
Defensiveness
Hiding / sneaking drinks
Blackouts
Confrontation or requests to quit or cut back by others
Self imposed drinking / using rules
Gulping (urgency)



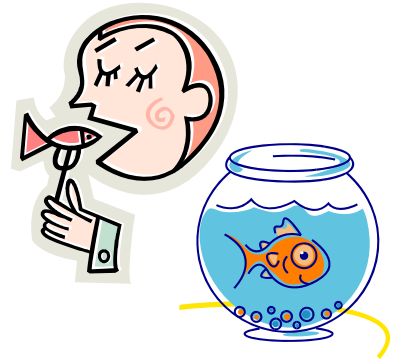
Erratic / inconsistent behavior
Mood swings
Missing Mondays and/or Fridays
More than one alcohol/drug offense
Use or intoxication at inappropriate times
Frequent short-term illnesses
Irritability that disappears after the first drink
Oddly constricted or dilated pupils

Enabling

- Enabling is any behavior that has a reinforcing effect on someone's drinking/using behavior.
- It is usually passive.
- Enabling is done for the benefit of the enabler, **NOT** the addict

Examples of Enabling

- Making excuses for someone's using behavior
- Calling in sick for them
- Allowing a using person to live with you
- Paying for his/her tuition
- Giving/lending them money
- Assuming household or work responsibilities
- Covering bills and other expenses
- Drinking or using with the alcoholic/addict
- Giving them "one more chance"... then another...then another...



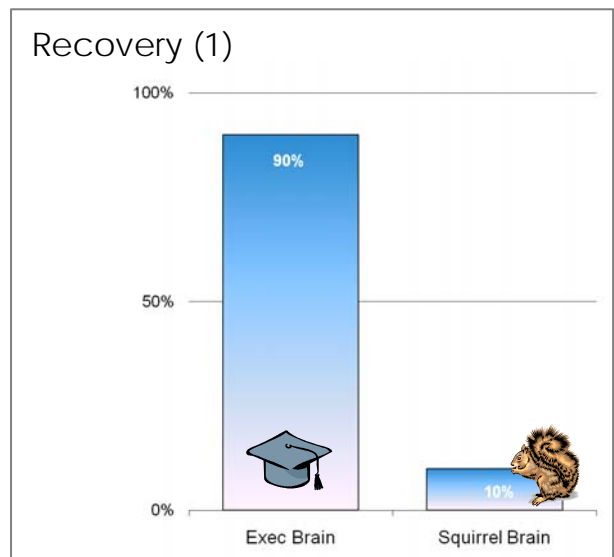
Treatment & Recovery

Brain Distress: In distress, the most intricate and sophisticated areas of the brain are affected first; the prefrontal cortex (PFC)

Since rational decision-making is needed to counter impulsive acting-out, energy in the PFC must stay higher than in the midbrain.

The PFC loses power through:

- Fatigue
- Unbalanced glucose levels
- Stress
- Pain



- Illness
- Alcohol / drug use

The Midbrain is empowered by:

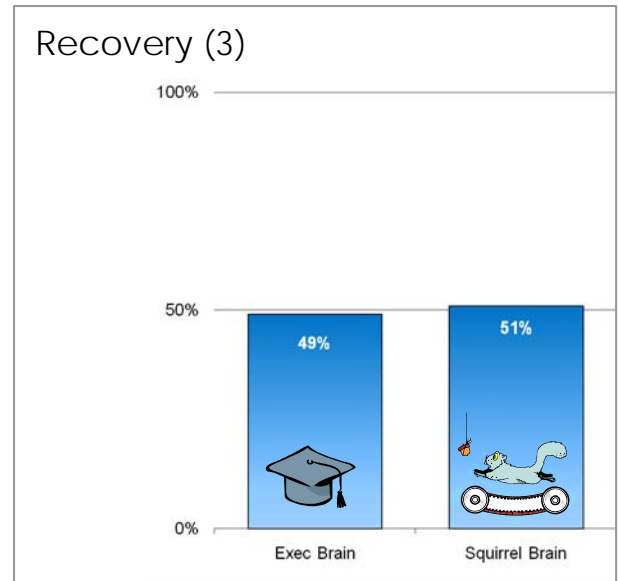
EXPOSURE to anything associated with use:

- People
- Places
- Things

Relapse occurs when the midbrain takes over

Primary goals of early treatment are:

1. To empower a person to be able to be steered by his or her prefrontal cortex
2. To develop and support life-style changes needed to support recovery



More specifically:

1. Abstinence from all mood altering drugs
2. Immersion into sober activities with sober people
3. Change association of substances from positive to negative
4. Learn recovery skills
 - Craving management
 - Problem solving
 - Refusal skills
 - Crisis management

Fundamentals

Sleep

- Prioritizing sleep
- Instruction on dealing with insomnia

Dietary considerations

- Goal of balancing glucose levels through diet instruction and monitoring
- Vitamin and supplement plan

Exercise

- Promotes rest and sleep, releases endorphins, and provides quick positive reinforcement
- Create and monitor safe and entertaining/rewarding exercise plan

Start on psychotropic medication if needed

Develop new neural pathways

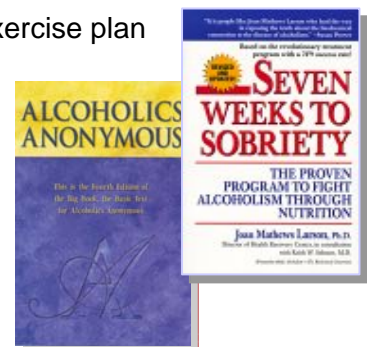
- New (active) activities
- Puzzles & brain teasers

12-step activity

- Meetings

Post Acute Withdrawal (PAWS)
 Withdrawal-like symptoms occur intermittently in the early stages of recovery. They are made worse by stress or other triggers but may arise at unexpected times and for no apparent reason. They may last for a short while or longer.
 Common symptoms of are:

- Inability to think clearly
- Memory problems
- Emotional overreactions or numbness
- Sleep disturbances
- Physical coordination problems
- Stress sensitivity
- Increased sensitivity to pain



- Sponsor (guide)
- “Extracurriculars” such as dances, pot lucks, conferences, etc.

Relaxation

- Slows thought process, promotes healing
- Structured techniques are preferred (guided imagery, progressive muscle, meditation, etc.)
- Explore use of physical methods (massage pad, yoga, whirlpool, etc.)

STOP NICOTINE USE

- Nicotine depletes serotonin
- The seriousness of suicidal behavior is directly correlated with amount of cigarette smoking
- Recovery rates for non-smokers is double that of smokers regardless of when the smoking stopped

General Guidelines for Working with AOD / Suicidal Patients

DO NOT ASSUME THEY ARE SANE!

Noncompliance with medications is very high with AOD patients

The existing research does not support the use of no-harm contracts as a method for preventing suicide, nor for protecting against malpractice litigation in the event of a client suicide.

Family / SO Support Considerations

“No Use” Contract with Family Members

Practical “What Do I Do If...” Situations

Setting Boundaries and Limits - Contracts

Family Support Groups (ex. Al-Anon)

Focus on positive (*what are they doing right*)

Work with patient’s strengths and assets

Use what has worked in the past

Reinforce small gains

Focus on what they have to look forward to

Not about “giving up”, but about substituting healthy activities to achieve desired effect

De-stigmatize addiction

Do not use insight therapies early on (*the patient is not cognitively stable*)

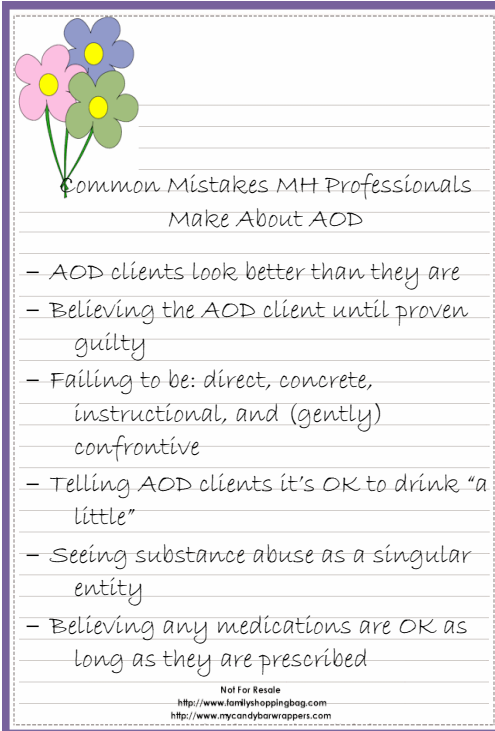
Behavioral, cognitive, and cognitive-behavioral techniques generally work best in early recovery

Avoid “feelings” work early in recovery

Emotional centers are easily overwhelmed

Catharsis is not therapeutic

BUT... always acknowledge and validate a patient’s feelings



Common Mistakes MH Professionals Make About AOD

- AOD clients look better than they are
- Believing the AOD client until proven guilty
- Failing to be: direct, concrete, instructional, and (gently) confrontive
- Telling AOD clients it's OK to drink "a little"
- Seeing substance abuse as a singular entity
- Believing any medications are OK as long as they are prescribed

Not For Resale
<http://www.familysupportgroup.com>
<http://www.nycandybarwrappers.com>

Put everything in writing (*easier to recognize than remember*)

Be clear, consistent, & concrete (*patients can't handle ambiguity*)

Emphasis of “doing” over “under-standing”

Know that there is nothing “wrong” with the patient (*They are acting true to where they are*)

Repetition, Repetition, Repetition

Have fun and laugh

The most important counselor attributes are

Acceptance of the patient where he/she is at this time

Empathy

Genuineness

Love and acceptance go a long way



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