

2021

## **Substance abuse relapse is not about willpower but is the culmination of psychological and socioeconomic stress**

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### **Recommended Citation**

STEFFES PA. Reflection on Clinical Decision Science: Substance abuse relapse is not about willpower but is the culmination of psychological and socioeconomic stress. Clin. Res. Prac. Oct 13 2021;7(2):eP2867. <https://doi.org/10.22237/crp/1633977018>

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## REFLECTION ON CLINICAL DECISION SCIENCE: Substance abuse relapse is not about willpower but is the culmination of psychological and socioeconomic stress

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I recently cared for a patient that changed the way I think about providing care to patients with substance abuse disorders. I learned how powerful non-judgmental listening can be.

Candace Parker (pseudonym) is a 32-year-old Caucasian woman with past medical history of polysubstance abuse, intravenous drug use, infective endocarditis, untreated Hepatitis C and seizure history who presented with a 5-day history of fever, abdominal and back pain, jaundice, dark urine, and right ear pain. She states she woke up one day and noticed her skin was yellow. She also noticed some right upper quadrant abdominal pain and vomited twice. She has never had these symptoms before and was worried because she felt like she was getting worse and did not know what was causing it. She was admitted for acute liver injury (ALT 1222; AST 1603; Total Bilirubin 7.47) and was worked up for possible underlying cause. She was positive for hepatitis C antibodies for which she was previously diagnosed but denied being offered treatment; autoimmune panel, serology, and urine drug screen were ordered.

Discussion on social history revealed polysubstance abuse: tobacco use ½ pack per day; alcohol use 5-6 drinks per day; intravenous heroin 2-3 times per week; crack cocaine 2-3 times per week; and marijuana 1-2 times per week. When further asked about her drug usage, she was very much aware of what she was doing was harmful to her body and had expressed a desire to quit, as she had done before. She completed a methadone program several years back and was drug free for a while. Though she still drank and smoked, she was quite proud of herself for quitting. However, in the last year or so, many internal and external stressors have piled up in her life and in her mind, causing her to relapse in order to feel some solace and escape. Her grandfather, whom she was quite close, had recently died; both she and her child witnessed a shooting and were the intended victims of gun violence. She hasn't worked since the COVID-19 pandemic started and has been relying on her father and her boyfriend for financial support. She has suffered from depression and anxiety before and had turned to drugs to cope. In the past she used them for different reasons – she shared only with me that she had tried to commit suicide by acetaminophen overdose twice when she was 15 and when she was 26. She was previously treated with N-acetylcysteine and did not require liver transplant. She denied any Tylenol ingestion preceding this recent event and trace acetaminophen was found in her blood. Further workup showed she was positive for Epstein-Barr Virus, and an ANA 1:160; blood toxicology was positive for many things, but one which was unexpected was quinidine/quinine and its metabolites. When asked about it, she stated that she had heard about heroin being laced with quinidine, and that her boyfriend has recently switched to a new dealer with a new supply. It was believed that this was the cause of her acute liver injury, which subsided in the typical fashion of ALT/AST peaking and dropping, followed by total/direct bilirubin peaking/dropping. She was discharged a day earlier than we would have liked – though subjectively/objectively she was improving – due to concerns with her family. She agreed to be placed in a rehabilitation program for her polysubstance abuse and agreed to avoid any more of her current supply of heroin. A discussion with her about her continued drug use and how it can further damage her liver was held, especially in

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<https://doi.org/10.22237/crp/1633977018>

combination with her hepatitis C infection, and she agreed to look for more beneficial ways to relieve her stress, including meeting with a therapist.

Why do we clinicians always think of relapse as an on and off switch and never as a process?<sup>1</sup>

When holding a discussion with Ms. Parker about her substance use, it was ensured that her social needs were addressed in order to better identify the root cause of her continued drug use. Ms. Parker's response during this conversation was, "I feel less judged and more understood." She specifically stated that she felt brushed aside by many of the other healthcare teams and felt more understood by our team. While it did not affect her acute care, it made her feel accepted and that made it easier to elicit information from her to better understand her medical and psychiatric conditions. Additionally, much of her information shared was documented, and will aid in her future treatment if rehabilitation fails again and she necessitates treatment and hospitalization. It turns out that non-judgmental listening can change clinical decisions.

1. Kabisa, E., Biracyaza, E., Habagusenga, J.d. et al. Determinants and prevalence of relapse among patients with substance use disorders: case of Icyizere Psychotherapeutic Centre. *Subst Abuse Treat Prev Policy.* 2021;16(13)  
<https://doi.org/10.1186/s13011-021-00347-0>