Both of those cases illustrate the need for a general psychiatrist to have specific training in caring for the addicted patient. I hope that today’s residents fulfill the requirement to learn about addiction psychiatry. It should be something every practicing psychiatrist should learn and know how to do. The most important question to be asked is whether the use of drugs and alcohol is primary with anxiety and/or depression superimposed on the addiction because of the failure, dissipation, and uncontrollable craving. Or are the anxiety and/or depression primary, and is the patient using drugs and/or alcohol as self-medication?

Many patients whom I have evaluated start drinking early in adolescence because of the posttraumatic stress disorder (PTSD) suffered as a result of serious physical or emotional, or sexual abuse as a child. I believe the first patient’s problems were at least partly a result of his serious abuse as a child. But there is also the genetic element that cannot be discounted.

It is important that the clinician try to make the distinction as possible. The patient’s own denial, as well as the doctor’s, knows what direction to take in the treatment. Regardless of the answer, the initial care must be directed to the cessation of substance use.

For the nonaddict, the most difficult thing to understand is the depth and extent of the craving. Because brain changes clearly take place in the addict that make this craving a biologically driven reality, it is very difficult for the patient to “just say no.” Withpower is an insignificant force, compared with the attraction of the patient’s urge to obtain. Withall knows former smokers who, even though they have not smoked for 20 years, still desire a cigarette—especially when they are in the company of someone who is smoking. Similarly, the drug and alcohol addict cannot really control this desire. That’s why Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) are so important and would be part of every treatment regime. The key to AA/NA, in my opinion, is the sponsor. The sponsor is someone who is a mentor, guide, and coach who is available 24/7 to call and talk to the patient and help them through the attack of desire and not succumb to it.

There are many elements to AA/NA, but the secret is in the meetings—for beginners, daily—which brings the addict out of seclusion and into the presence of many others who are suffering from the same disorder and share their experiences and support group. At least the sponsor and the addict knows that he is not alone, and while shame and humiliation might initially stop him from “sharing,” he listens to the other’s emotions and as he hears the pain suffered by others.

Finding a sponsor is critical, and for some, the sooner the better. The psychiatrist or psychologist cannot do what the sponsor can do. Some psychiatrists try to give the drug and alcohol addict constant supervision 24 hours a day, but this method has not been successful. I believe the first patient’s problem was the result of severe social isolation, and the sponsor can do. Some psychiatrists try to give the drug and alcohol addict constant supervision 24 hours a day, but this method has not been successful. I believe the first patient’s problem was the result of severe social isolation, and the sponsor can do.

We often contribute to patients’ addiction by continuously prescribing opiates at their request without carefully scrutinizing the problem.

The prescription of opiates for undermine the patient’s own self-esteem and self-confidence, and it is the same situation to have a general practitioner or internist write the prescription. The prescription of opiates for undermine the patient’s own self-esteem and self-confidence, and it is the same situation to have a general practitioner or internist write the prescription.

The study mentioned in the question above demonstrated that patients with a psychiatric history are at risk for aberrant drug-related behavior if they have chronic pain (Clin. J. Pain 2007;23:307-15). The investigators found that patients who were classified in the high psychiatric group used more drugs and higher doses. The bottom line? A consistent association was seen between psychiatric morbidity and prescription opioid misuse in chronic pain patients.

We as psychiatrists must be acutely aware that factors such as a history of mood disorders, other psychiatric problems, and psychosocial stressors might place patients at risk for misuse of prescription opioids. We often contribute to patients’ addiction by continuously prescribing opiates at patients’ request without carefully scrutinizing the problem or even thinking twice about the deleterious effects of what we are doing.

Finding a sponsor is critical, and for some, the sooner the better. The psychiatrist or psychologist cannot do what the sponsor can do. Some psychiatrists try to give the drug and alcohol addict constant supervision 24 hours a day, but this method has not been successful. I believe the first patient’s problem was the result of severe social isolation, and the sponsor can do.

We often contribute to patients’ addiction by continuously prescribing opiates at their request without carefully scrutinizing the problem.

The prescription of opiates for undermine the patient’s own self-esteem and self-confidence, and it is the same situation to have a general practitioner or internist write the prescription. The prescription of opiates for undermine the patient’s own self-esteem and self-confidence, and it is the same situation to have a general practitioner or internist write the prescription.

The study mentioned in the question above demonstrated that patients with a psychiatric history are at risk for aberrant drug-related behavior if they have chronic pain (Clin. J. Pain 2007;23:307-15). The investigators found that patients who were classified in the high psychiatric group used more drugs and higher doses. The bottom line? A consistent association was seen between psychiatric morbidity and prescription opioid misuse in chronic pain patients.

We as psychiatrists must be acutely aware that factors such as a history of mood disorders, other psychiatric problems, and psychosocial stressors might place patients at risk for misuse of prescription opioids. We often contribute to patients’ addiction by continuously prescribing opiates at patients’ request without carefully scrutinizing the problem or even thinking twice about the deleterious effects of what we are doing.

Finding a sponsor is critical, and for some, the sooner the better. The psychiatrist or psychologist cannot do what the sponsor can do. Some psychiatrists try to give the drug and alcohol addict constant supervision 24 hours a day, but this method has not been successful. I believe the first patient’s problem was the result of severe social isolation, and the sponsor can do.