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Psychological Assessment of Drug Addictive Patient

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ABSTRACT

Psychological assessment is also known as psychological testing, is done to help a psychologist better understand an individual and provide valuable insights into the individual's behaviour, skills, thoughts and personality. Tests are samples of behaviour analysis. Efficient, organized assessment of substance use disorders is essential for clinical research, treatment planning, and referral to adjunctive services. In this article, we discuss the basic concepts of formalized assessment for substance abuse and addiction, as established by the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision, and describe six widely used structured assessment instruments. Our aim is to help researchers and clinical programs identify the instruments that best suit their particular situations and purposes. We used Beck Depression Inventory (BDI): To assess the severity level of depression. Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES): To assess the motivation level of the client. Temperament Character Inventory (TCI): To assess the complete personality profile of the patient. In overall tests finding indicative that patient have depressive symptom, she knew drug is cause of problematic behaviour and now she is on preparation stage of motivation.

Keywords: Drug Addiction, Psychological Assessment, Motivation, Depression Temperament Character Inventory, Stages of Change Readiness and Treatment Eagerness Scale.

INTRODUCTION

SOCIO-DEMOGRAPHIC DETAILS

Name : Mrs. X
Age/Sex : 26 years /female
Education : 10th
Occupation : house-wife
Marital status : married
Socioeconomic Status: middle
Background : Urban
Inform ant : Self and father
CRF NO : 239936,588/14
Information is adequate and reliable.

CHIEF COMPLAINTS

According to Client:

Cap. Spasmoproxyvono intake } X 11 years

Cap. Tramadol intake } X 2 months

Precipitating factor- not known

HISTORY OF PRESENT ILLNESS

Patient was free from any psychoactive substance till at the age of 14 years. At the age of 15 years when she felt abdomen pain during menstrual cycle she took capsules Spsmoproxyvon prescribed by a private practiener. Within one month when abdomen pain occurs she took 2-3 capsules per days. That time she laid down on bed whole day, not takes part in any house-hold work and not took food properly felt drowsy throughout day. At the age of 16 she got married, and kept on that pattern regular. At the age of 17 she was pregnant. During pregnancy time she did not use any substance. After the delivery when menstrual cycle regular again then she started capsules Spasmoproxyvono. Now she was taking 3-4 capsules per day as previously. But when pain increased, she increased the amount of capsules own self 5-10 capsules in a day. Once she got no relief in pain she increased the amount of the capsules 15-20 in a day to get the same desire effect. That time she used capsules in regular patterns. She felt drowsy throughout day. She did work but not properly. When she did not take capsules felt strong desire to take. She was not able to controlling capsules taking behaviour. She would not able to do house hold work without capsules. She laid down whole day on the bed, could not able to regular daily activities. She would felt vomiting and sneezing, yawning, sweating, watering in eyes and nose and felt joint pain. For this reason many times there would argument among patient and in-laws family and voice level is high. In-laws and husband physically abused her, she would left in- laws home and stay with maternal home. After 5-6 month she returned in laws home by herself due to her son was there. That kind behaviour happened 5-6 times after marriage. In- laws family not support her finically, but patient father and brother support her finically. She used 15-20 capsules per day till at the age of 22. At that time patient elder brother expired in a road accident. After that she increased the amount of cap. 20-25 per day to get the same desire effect. That time she developed symptoms like low mood, lose of interest, no interaction with others and live alone, did not participant in any work. Her sleep and appetite decreased also. That time she also tried to self harm to ate the blade and, hanged to the fan but failure to attempt because the rope broken. Once she took 30 tablet of the sleep. Before 4 years she used 20-25 capsules per day and that time sadness also maintained. Before 2 months she was on treatment capsules tramadol started. Client shift capsules spasmoproxyvon to capsules tramadol own self and increased dose 15 to 20 (50 mg) per days. She was not able to control the capsule taking behaviour by own self, sleep and appetite was also decreased from last two 2 months. When the symptoms became unmanagble at house the family member brought her in 'X' hospital at Hisar for treatment and admitted in DDC.

Current Patterns

Capsules Tramadol

Usual dose	15
Maximum dose	20
Last dose	18

Negative History

- No history suggestive of any head injury, seizure or high grade fever, fetes like episodes.
- No history suggestive of over familiarities, big talk, over religious, over grooming and elevated mood
- No h/o any repetitive or intrusive thoughts, images or impulses or repetitive behaviours / acts.
- No h/s/o any specific irrational fears of any specific objects, situations or open spaces.
- No history suggestive of panic attacks.
- No history of any other substance abuse.

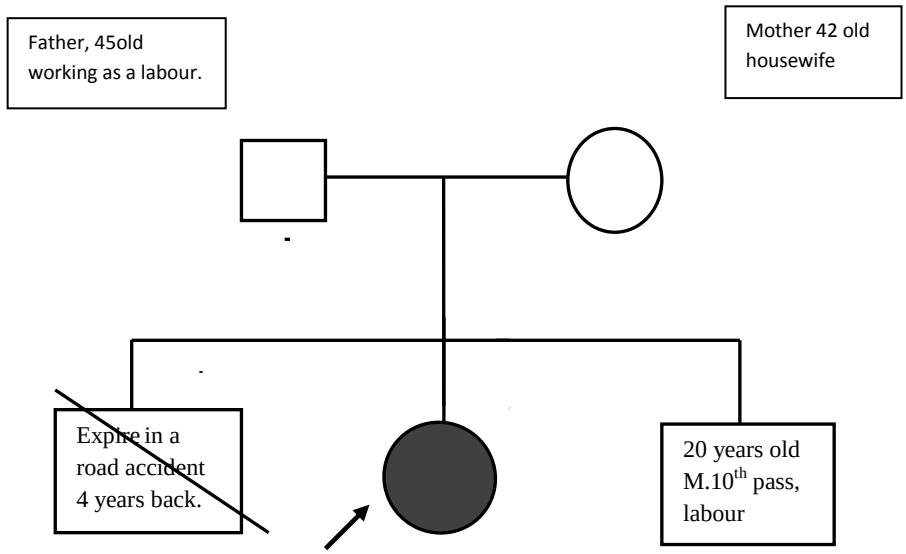
Consequences:

Psychological : Irritability, anger
Physical : patient suffered from abdomen pain, decreased sleep and appetites, diarries**.**
Social : patient has argument with husband and in laws family. No good relation with family member and decreased social relation.
Legal : Client denies for any legal issues**.**
Occupation : Client is house wife when not taking capsules then not able to do house hold work**.**
Finical : Client In -laws family not supports her to finical but maternal parents supports her to finical 3000-4000 per month. Not success to save the money due to substance use.

Past History

No past history of significant medical or surgical illness
No past history of psychiatric illness.

Family History



No history of psychiatric illness in patient family.
No history of any substance abuse in patient family.
No history of any suicide in patient family.

PERSONAL HISTORY

Birth History

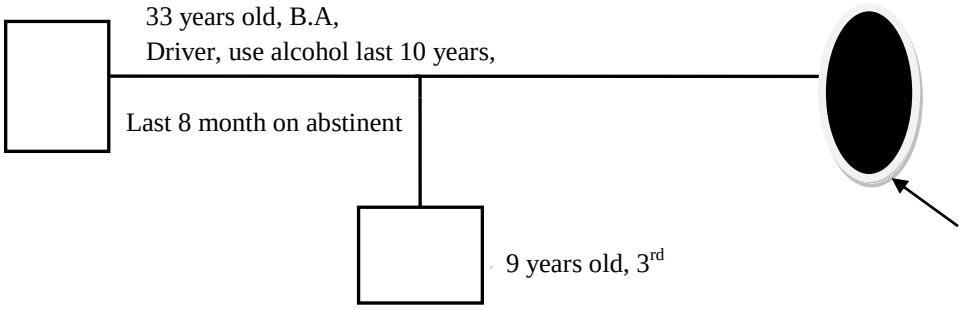
Full term normal delivery at home by a trained dyee
Birth cry – immediate birth cry present

Developmental history

Milestones achieved normally.

Educational history: She started schooling at the age of 5 years. She passed high school pass and was well adjusted in her school and respected her authorities in her school and had friends but very few with whom she would interact well. Her academic performance was good. She left school at the age of 16 years after that she married.

Martial History: she was married at the age of 16 years and not good relation with husband due to substance use.



Pre morbid Temperaments:

Interpersonal relationship: patient had satisfactory interpersonal relationship with family members, friends, and neighbours.

Use of leisure time; In leisure time play with friends and drawing.
Predominant mood: Euthymic.
Attitude toward self and others: cooperative.
Attitude to work and responsibility: She used to take her decision by herself. She has no difficulties in fulfilling the responsibilities which was given to her.
Religious beliefs: She believes in God.
Impression – Adjusted Pre- morbid Temperaments:

Mental Status Examination:

General Appearance and Behaviour:
An average thin built female appearing stated age, with appropriately dressed and well kempt, having normal gait when entered into the interview room, sat on offered chair, greeted to the examiner. During interview she was sitting relaxed, comfortable and response to the question. She was cooperative and appeared willing to talk to the interviewer. Eye to eye contact was maintained and rapport could be established. Her psychomotor activity was within normal limits.

Speech : Coherent and relevant. Pitch, tone and volume –decreased.
Affect : Subjective – Dhukhi hu
: Objective – depressed, restated, appropriate, and reactive

Thought
Flow : No Abnormality Detected.
Form : No formal thought disorder could be detected.
Content : Suicidal ideation, hopelessness and helplessness.
Perception: No Abnormality Detected.

Higher mental functions :

Orientation

Time
Place
Person
} oriented to time, place and person.

Attention and Concentration

Attention and concentration arouse and sustained.

Memory:

Immediate, Recent and remote memory: Intact
Patient has adequate general fund of knowledge, and verbal calculation or compression.

Personal judgement : Intact
Social judgement : Intact
Test judgement : Intact
Insight : motivation of preparation stages

DIAGNOSTIC FORMULATION

Patient x 26 year old married female house wife Hindu, unmarried, belonging to an urban domicile and low socioeconomic status, presented with the 11 years of opioid intake in dependent pattern which is characterised by craving, tolerance, withdrawal symptoms with no significant abstinent history, no history of substance and psychiatry illness in the family. With the history of harm self in past and low mood, loss of interest, decreased energy for two month.
On MSE reveals normal psychomotor activity, speech normal in rate/tone/volume, depressed affect with ideas of suicidal ideas, hopelessness and helplessness with adequate higher cognitive function and preparation stage of motivation.

PSYCHOLOGICAL ASSESSMENT

1. **Beck Depression Inventory (BDI):** To assess the severity level of depression.
2. **Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES):** To assess the motivation level of the client.
3. **Temperament Character Inventory (TCI):** To assess the complete personality profile of the patient.

Behavioural Observation:

During testing, she was cooperative. Assessment took two sessions for completion. She entered the room with abnormal gait and sat on the chair when offered. Her attention could be aroused and sustained. She was motivated for testing.

Test Finding;

Beck Depression Inventory;

On Beck Depression Inventory pt. got score 25 that indicate the moderate level of the depression.

Stage of Change Readiness and Treatment Eagerness Scale (SOCRATES);

Using the SOCRATES Profile sheet, patient got following raw scores:

	Recognition	Ambivalence	Taking Steps
Score	**24**	**12**	**37**
Performance	**Low**	**Low**	**High**

On Recognition high scores directly acknowledge that having problem related to her drug use, tending to express a desire for change. Low scores on Ambivalence indicate that she know drug abusing is causing problem. On Taking Steps pt. report score high that means she are already doing things to make a positive change in their drug use and may have experienced some success in this regard. Change is under way, and they may want help to persist. A high score on this scale has been found to be predictive of successful change. Overall pt. is on preparation stage.

Temperament and Character Inventory (TCI):

Using the TCI profile sheet and pt. Report following scores:

Personality Dimension	Score Range	Raw Score	Performance
Novelty Seeking	14.8-24.8	25	High
Harm Avoidance	13.2-19.9	11	Low
Reward Dependence	14.7-19.0	13	Low
Persistence Character	5.6-7.6	6	Average
Self Directness	26.6-34.1	29	Average
Cooperativeness	27.9- 35.0	26	Low
Transcendence	20.1-26.2	25	Average

On the bases of TCI manual pt. got score high on Novelty seeking that indicate patient is exploratory and curious, impulsive and extravagant.
Low Score on Harm Avoidance, Reward Dependence and Cooperativeness that suggestive relaxed and optimistic, bold and confident or outgoing. She is practical, cold and independent. She is socially intolerant, critical.

IMPRESSION:

Overall tests finding indicative that patient have depressive symptom, she knew drug is cause of problematic behaviour and now she is on preparation stage of motivation.