The Research of Medical Science Review
ISSN: 3007-1208 & 3007-1216 Volume 3, Issue 3, 2025

BEHIND THE STRUGGLE: A PSYCHOLOGICAL CASE STUDY ON ADDICTION AND TRANSFORMATION

Shamsa Batool[1], Dr. Saima Majeed[2], Abraham Yousaf[3], Hephsibah Younis[4]

[1]*MSCP, Forman Christian College A Chartered University Lahore*
[2]*Associates Professor, Department of Psychology, Forman Christian College A Chartered University Lahore*
[3]*Manchester Metropolitan University*
[4]*MSCP, Forman Christian College (A Chartered University)*

[1]shamsabatool007@gmail.com, [3]abrahamyousaf36@gmail.com, [4]hephsibahyounis@gmail.com

DOI: https://doi.org/10.5281/zenodo.15067493

Keywords
Cognitive Behavior Therapy (CBT), MI, Assessment, Management, Drug Addiction, Alcohol, opium, withdrawal symptoms, disorders, relaxation exercise, sleep hygine

Article History
Received on 12 February 2025
Accepted on 12 March 2025
Published on 22 March 2025

Corresponding Author: *

Abstract

Globally, over 296 million people are reported to use multiple types of drugs, with the prevalence of drug addiction increasing steadily. The United Nations Office on Drugs and Crime (UNODC, 2023) reported a 45% rise in drug use disorders over recent decades, affecting more than 39.5 million individuals worldwide. In Pakistan, over 7.6 million people suffer from drug addiction, with 78% being male and 22% female (UNODC, 2018). Research indicates that drug addiction in Pakistan predominantly affects individuals under the age of 30, with contributing factors including illiteracy, peer pressure, and social modeling (Masood et al., 2022). This case study explores the underlying causes and management strategies for drug addiction through the example of a 32-year-old male patient presenting with symptoms such as trembling hands, disturbed sleep, body aches, aggression, and cravings. A combination of formal and informal assessments was conducted, including structured clinical interviews, behavioral observations, the Craving Identification Chart, the Mini-Mental State Examination (MMSE), and the Drug Abuse Screening Test (DAST-20). The patient underwent 13 sessions of therapeutic interventions, including relaxation exercises, motivational interviewing, activity scheduling, and cognitive behavioral therapy (CBT). Specific CBT techniques addressed high-risk situations, coping mechanisms, goal setting, and drug refusal skills. The interventions resulted in a 50% improvement in reported symptoms. The provisional diagnosis was Alcohol Withdrawal Disorder (DSM-5 Code 291.81).

INTRODUCTION

History of Illness

The client has a ten-year history of alcohol (whisky) use, which began as a coping mechanism following the emotional distress of his girlfriend marrying someone else. He reported no significant disruptions initially from alcohol use. Over the past ten months, the client developed a dependency on powdered drugs, consuming one gram daily via sniffing for nine months. He experienced significant physical pain, particularly in his legs, as well as irritability, restlessness, aggression, and sleep disturbances.

Two weeks prior to seeking treatment, the client's older brother passed away from drug-related causes. This loss motivated the client to pursue recovery to take care of his mother, as he is now her only remaining son.

Background Information

The client reported using alcohol regularly to escape memories of his breakup and ongoing family conflicts. He stated that alcohol helped him feel relaxed, alleviated negative thoughts, and provided temporary happiness by numbing his emotional distress. He began using powdered drugs ten months ago, consuming half a gram twice daily in the morning and evening.

In February 2019, the client was arrested for drug possession and spent six days in jail. He described the experience as traumatic but did not seek treatment at the time.

Family History

The client belongs to a lower-middle-class nuclear family. His father passed away five years ago at the age of 60, which marked the onset of the client's increased alcohol and drug use as a coping mechanism for the emotional loss. Professionally, the client is a driver, described as caring and friendly, but authoritative within his family.

The client's 54-year-old mother, a staff nurse, maintained a satisfactory yet authoritative relationship with him. The client has five siblings: his eldest brother (34 years old, married with two children) died two weeks ago due to excessive drug use. Their relationship was complicated, as the brother often scolded him for using alcohol and drugs. The third sibling, a 30-year-old sister and married nurse, shares a congenial relationship with the client. The fourth sibling, also a sister, was married and reported to have offered him powdered drugs free of charge through her husband. The youngest sibling is a 20-year-old housewife.

The client reported growing up in a household with parental conflicts, where his father was a habitual drinker and financially unproductive, leaving his mother to shoulder financial responsibilities. The family had a history of substance abuse, including the use of tobacco, huqqa, and powdered drugs by paternal forefathers.

Developmental and Educational History

The client was born through normal delivery, with no significant developmental delays. He was an active child but often preferred solitude. He was an average student, with no reported issues with peers, teachers, or family during his school years. However, he lost interest in academics and discontinued his education before completing matriculation.

Personal and Relationship History

The client had a long-term emotional and physical relationship with a maternal cousin for five years. After four years, the cousin became pregnant, leading to family conflicts and an abortion. The families opposed their marriage, and the cousin eventually married someone else. This emotional trauma marked the beginning of the client's substance use. He attempted engagement twice but ended the relationships after revealing his drug use. Client reported that he used to take different drugs before sex because it enhance his sexual power and make him satisfied.

Occupational History

The client began his career as an auto driver and later worked for a ride-hailing service, eventually saving enough money to purchase his own van. He used the van for a school and college transportation service, demonstrating a capacity for professional independence and responsibility.

Summary

This case underscores the complex interplay of familial substance abuse history, personal trauma, and socioeconomic factors in the development of the client's substance use disorder. It highlights the need for targeted interventions addressing emotional, familial, and behavioral factors to support recovery.

Psychological Assessment

Psychological assessment of the client was carried out on two levels including Informal and Formal assessment.

Formal Assessment

- DAS-20
- MMSE
- Craving identification chart
- Functional analysis assessment

Informal Assessment

- Clinical Interview
- Behavioral observation
- Subjective rating of presenting complaints

Informal Assessment

The client underwent an informal assessment using a clinical interview, Mini Mental Status Examination (MMSE), subjective rating of presenting complaints, and behavioral observation.

Clinical Interview

The clinical interview aimed to gather detailed information regarding the client's demographics, presenting complaints, and history, including childhood, personal, educational, occupational, family, sexual history, premorbid personality, and substance use history.

Behavioral Observation

The client was neatly dressed and reported taking regular baths, particularly when experiencing body pain. However, an unpleasant odor was noted during the assessment. In the initial sessions, the client struggled with eye contact, though this improved in later sessions. He also reported experiencing body aches, which he managed through home remedies and gym practices. His speech was clear and coherent. The client expressed a strong commitment to overcoming his addiction and supporting his mother. He also stated his intention to continue his driving work and maintain his business. Overall, the client demonstrated motivation and determination to quit substance use.

Subjective Ratings of Client's Problematic Symptoms

Subjective ratings for presenting complaints were taken from client and his mother. They were asked to rate between 0-10 on the intensity and frequency of particular undesirable.

They were told that 0 was not at all, 5 means moderate and 10 was high level.

Table No: 1

Table Showing Subjective Ratings of the Client's Symptoms on 1-10 Scale

Symptoms	Client's Ratings
Cravings	9
Irritate and anger	9
Restlessness	9
Body aches	7
Disturbed sleep	8

Formal Assessment

DAST-20 (Drug Abuse Screening test)

DAST-20 a known screening test in which 20 items were administered by therapist. Each question requires" yes or no" response statement and the test was completed in less than 5 minutes. These questions refer to the past 12 months. The score of the DAST (adult version) determines the degree of problem related to drug abuse.

Table No: 2

Showing client's Obtained Score, Range and Severity Level on DAST 20

Obtained Score	Level of Severity
14	16-20 Severe Intensive

The client obtained a total score of 14, which indicated that the client has moderate level of drug use. While filling the DAST-20 the client reported that he did not use any other medicines or other drugs which were prescribed or recommended by the doctors. He lost his friends and dear one due to the use of drug.

Qualitative Interpretation

The Drug Abuse Screening Test-20 (DAST-20) was administered to assess the severity of the client's substance use, placing him in the moderate category. Prior to treatment, the client reported never attempting to quit or seeking help to reduce his drug use. Additionally, he described having strained and conflicted relationships with his family and close

relatives. His daily routine was frequently disrupted due to his substance use.

Mini Mental Status Examination (MMSE)

The Mini Mental Status Examination (MMSE) is a widely used tool to assess cognitive functioning, including memory, attention, concentration, language, communication skills, and the ability to follow instructions. The MMSE consists of 30 questions, with a maximum score of 30. A score of 25 or higher is considered normal, while a score below 25 may indicate cognitive impairment. Impairment levels are categorized as mild (21-24), moderate (10-20), or severe (below 10) (David R. N., 2016).

Quantitative Analysis

The table following shows the scoring of client scored in MMSE which has been shown below:

Table No 3

MMSE scores and level of cognition	Client scores	Mini mental status exam
28	0-30	Level of cognition

Qualitative Analysis

The Mini Mental Status Examination (MMSE) results indicated that the client's cognition was intact, with scores falling within the normal range, suggesting that all cognitive domains were functioning properly.

Functional Analysis

Functional analysis was employed to identify the client's drug abuse determinants through a series of questions (what, who, when, where, and to whom). A Functional Analysis Assessment (FAA) worksheet was administered to explore the client's daily activities and the role of drug use. This tool helped identify the client's triggers and served as a therapeutic technique to manage daily functions. It provided both the client and therapist with clearer insight into the client's addictive behavior and strategies to manage triggering situations.

Craving Identification Chart (CIC)

The Craving Identification Chart (CIC) was used as a baseline tool to assess the client's cravings. It helped pinpoint situations where cravings arose, thoughts associated with cravings, emotional responses, and coping strategies. The client reported experiencing heightened cravings when exposed to drug-related discussions or witnessing drug use. The intensity, frequency, and duration of these cravings were significantly increased.

Diagnosis

Based on the client's history, presenting symptoms, and assessment tools, the client was diagnosed with Heroin Withdrawal Disorder (291.81) as per DSM-5 criteria.

Diagnosis and Case Conceptualization

The client's symptoms significantly impair his daily life, causing distress in social, occupational, and other important areas of functioning. These symptoms are not attributable to another medical condition or substance withdrawal. The client has been drinking alcohol for ten years and has been using powder through sniffing for the past nine months. However, his symptoms do not meet the criteria for Heroin or other disorders. Thus, the client was diagnosed with "Alcohol Withdrawal Disorder" (DSM-5 code 291.81; Nussbaum, 2022).

The client's drug abuse, including cigarette smoking, alcohol consumption, and powder sniffing, was accompanied by irritability, anger, cravings, restlessness, disturbed sleep, hand trembling, nausea, and body aches.

Predisposing Factors

The client has a family history of drug abuse, with multiple relatives, including his father, brother, and grandfather, also having a history of substance use. This familial pattern suggests genetic predisposition, with the client learning this behavior through social modeling from family members.

Perpetuating Factors

The availability of drugs and the influence of his sister-in-law, who was also involved in drug abuse, contributed to the client's continued substance use. The client began using drugs at the age of 14 following a breakup, a time of vulnerability. According to a recent survey, Pakistani youth, especially those from broken families or who have experienced abuse, are at high risk for addiction (Hussain, 2010). This early exposure to substance use was triggered by the client's emotional distress.

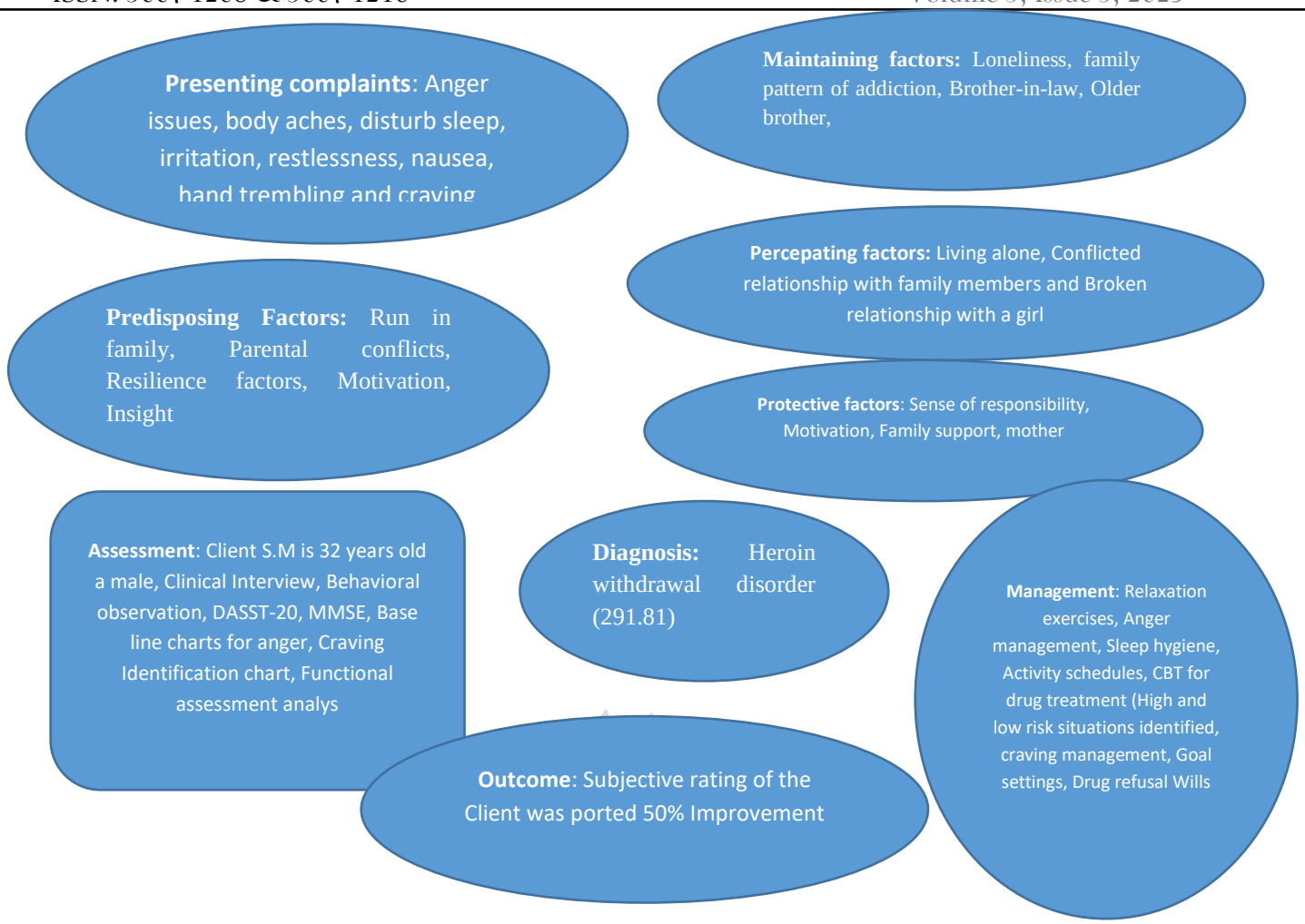
Protective Factors

The client's emotional attachment to his mother and his determination to quit drugs for her well-being serve as protective factors. Additionally, the recent death of his older brother due to drug use strengthened his resolve to quit and to contribute to his family financially and emotionally.

Theoretical Frameworks

The Social Learning Theory (Akers et al., 1989) posits that individuals learn behaviors from their social environment. The client learned to drink alcohol and use powder by observing and imitating his family members. Similarly, the Modeling Theory suggests that individuals replicate behaviors modeled by significant others, in this case, the client's father and grandfather.

The client's initial drug use was experimental, offering temporary relief and a sense of energy. Over time, this evolved into heavy, regular use, leading to physiological dependence (William, 2002). According to Cognitive Theory, the client turned to drugs to alleviate anxiety and sadness, reinforcing the belief that drugs could help him manage life's challenges (Peale, 1985; Beck et al., 1993). Research indicates that easy access to substances is a major contributing factor to addiction (Wells, 1997). In this case, the client had no difficulty obtaining drugs, as drug dealers were readily available to him.



Summary of Case Formulation: Figure 1: Showing Pictorial Summary of Case Formulation

Therapeutic Intervention

A comprehensive intervention plan with both short-term and long-term goals was designed to help the client address his addiction symptoms.

Rapport Building: Establishing rapport was essential to make the client feel accepted and comfortable. Addiction often leads to shame, making it difficult for clients to open up. Building trust through unconditional positive regard, acceptance, and encouragement helped the client become more open after initial resistance (Joseph & Strain, 2004).

Psycho-education: The client and his mother were educated on the development of addiction and strategies for managing it. The mother was advised to avoid taunting or giving excessive money, to spend quality time with the client, and to encourage positive behavior through praise (Adly Mohammed A & Said Sayed F., 2024).

Relaxation Techniques: The client was taught muscle relaxation techniques to address complaints of fatigue, irritability, and sleep disturbances. By focusing on specific muscle groups and relaxing them, the client increased his awareness of physical sensations (Stein et al., 2020).

Diversion Methods: To manage cravings, the client was taught various diversion methods, including engaging in leisure activities, completing daily tasks, and practicing relaxation techniques (Kitzinger Jr et al., 2023).

Sleep Hygiene: Given the client's disrupted sleep patterns, instructions on sleep hygiene were provided, which helped him regain normal sleep after following the suggested practices (Herscher et al., 2021).

Anger Management: The client was taught deep breathing and progressive muscle relaxation to manage anger. Techniques for delaying responses to anger-inducing situations, such as counting to 30 and walking away, were introduced (Zachariah, 2023).

Motivational Interviewing: Motivational interviewing was used to assess the client's readiness for change, identifying him at the "Action" stage of readiness (Prochaska & DiClemente, 2015). This intervention focused on increasing his self-confidence and commitment to quitting drugs.

Cognitive Behavioral Therapy (CBT) for Drug Treatment: CBT techniques were introduced to help the client cope with cravings, recognize high-risk situations, and learn how to refuse drug offers. Techniques such as goal setting and role-playing were used to strengthen the client's coping strategies (DeMarce et al., 2014).

Active and Reflective Listening: Active listening was essential in establishing a strong therapeutic relationship, helping the client feel heard and supported in discussing and resolving concerns related to addiction ("Assessment Techniques," 2016).

Decisional Analysis: A decisional analysis chart was used to enhance the client's motivation to refuse drugs. The client self-reported being in the "Action" stage of change, which guided the application of further interventions.

Functional Analysis Management: Functional analysis was used to identify the client's triggers for drug abuse. By examining the "5 Ws" (What, Who, When, Where, and To Whom), the client gained insight into his addictive behavior and learned how to manage triggers effectively.

Craving Identification Management (CIM): A craving identification chart was used as a baseline to help the client recognize situations that triggered cravings and how to cope with them. Attention-diverting methods, such as walking, taking a bath, or talking to someone, were taught to manage cravings effectively (Hung et al., 2023).

Coping Skills Training: The client learned healthy coping behaviors, such as engaging in work or spending time with supportive family members, to help manage cravings and avoid relapse (Magill et al., 2023).

High and Low-Risk Situation Analysis: The client was trained to identify high-risk situations for drug

abuse and recognize safe, low-risk situations. This awareness enabled the client to avoid triggers and seek support during vulnerable times.

Coping with Craving: Coping techniques focused on recognizing, avoiding, and managing cravings. The client learned to distract himself using strategies like engaging in physical activities, talking to supportive individuals, and recalling the negative consequences of drug use.

Refusal Skills/Assertiveness: The client was taught assertive refusal skills to decline drug offers effectively. Role-playing scenarios helped the client practice saying "No" and maintaining strong boundaries in high-risk situations (Nadkarni et al., 2023).

Post rating of the client's problematic areas

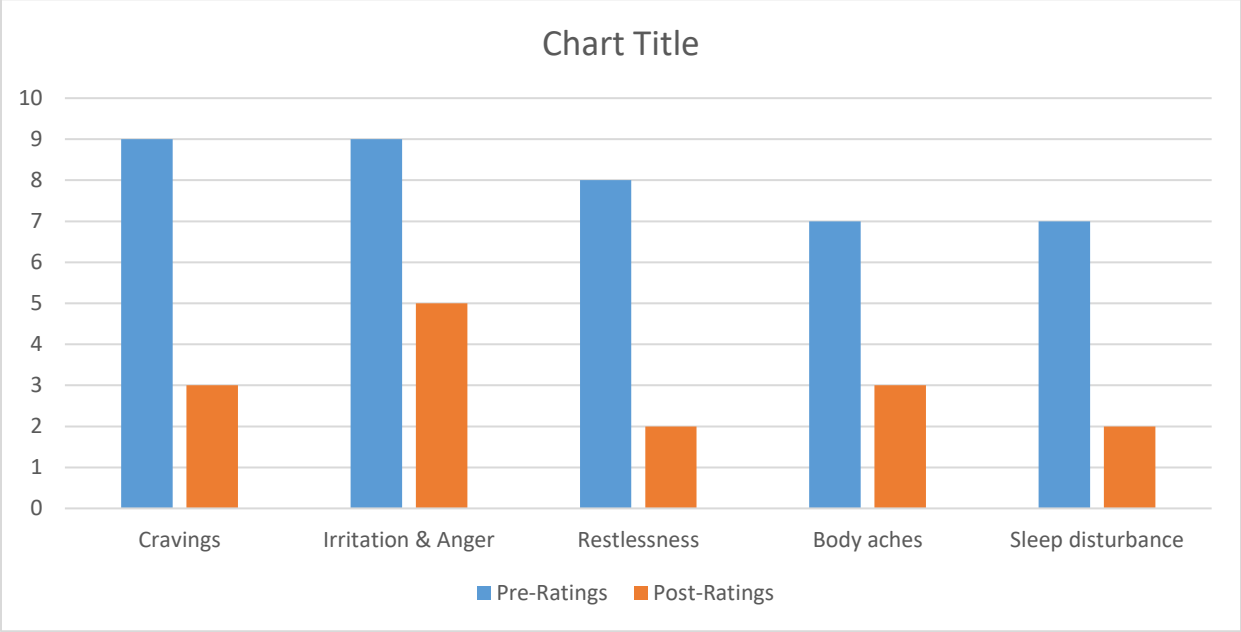
Table.2

Table Showing Subjective Ratings of the Client's Symptoms on 1-10 Scale

Symptoms	Pre-Ratings	Post-Ratings
Cravings	9	3
Irritation & Anger	9	5
Restlessness	8	2
Body aches	7	3
Sleep disturbance	7	2

Figure.2

Pre and post outcome of therapeutic sessions



Outcome of Therapy

The client participated in 13 weekly sessions with a clinical psychologist. Post-assessment indicated a 50% improvement in the issues reported by both the client and his mother. Problematic behaviors gradually improved following therapy.

Limitations: Therapy was limited by time constraints, and no co-therapist was available within the client's family. The client's brother-in-law, a drug dealer, posed additional challenges. Consistent follow-up sessions were difficult for the client to attend due to these factors.

Suggestions: For continued progress, it is crucial for the client to adhere to the therapist's instructions and practice the techniques learned during therapy.

Therapeutic Blueprint: The client was provided with a therapeutic blueprint, which included an overview of his problematic behaviors, the assessments used, and the therapeutic techniques implemented. The blueprint also highlighted early warning signs. The client expressed satisfaction with the therapy and felt more confident in managing his drug use and family-related issues.

REFERENCES

Akers RL, La Greca AJ, Cochran J, Sellers C. Social learning theory and alcohol behavior among the elderly. Sociological Quarterly. 1989 Dec;30(4):625-38.)

UNODC World Drug Report 2023 [en/ar/ru/zh] - world. ReliefWeb. (2023, June 25). https://reliefweb.int/report/world/unodc-world-drug-report-2023-enarruzh#:~:text=Globally%2C%20over%20296%20million%20people,cent%20increase%20over%2010%20years.

Drug abuse in Pakistan reaches an alarming level. (2018, February 10). The Nation. https://www.nation.com.pk/10-Feb-2018/drug-abuse-in-pakistan-reaches-alarming-level

Masood Afaq MY, Rehna T, Akhtar Z. The journey from drug addiction to drug recovery; a case report of an inpatient rehabilitation. *J Pak Med Assoc*. 2022 Jul;72(7):1435-1437. doi: 10.47391/JPMA.2419. PMID: 36156576.

DeMarce, J. M., Gnys, M., Raffa, S.D, & Karlin, B. E. (2014). Cognitive Behavioral Therapy for Substance Use Disorder Among Veterans: Therapist Manual. Washington, DC: U.S. Department of Veterans Affairs

Joseph, S., & Strain, M. (2004). *Humanistic psychology in practice: Building rapport and trust in therapy*. Journal of Humanistic Practice, 12(3), 245–258.

Pignataro, R. M., & Huddleston, J. (2015). The use of motivational interviewing in physical therapy education and practice: empowering patients through effective self-management. Journal of Physical Therapy Education, 29(2), 62-71.

Herscher, M., Mikhaylov, D., Barazani, S., Sastow, D., Yeo, I., Dunn, A. S., & Cho, H. J. (2021). A sleep hygiene intervention to improve sleep quality for hospitalized patients. The Joint Commission Journal on Quality and Patient Safety, 47(6), 343-346.

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders. (5th Ed.). Washington, DC: Author

Nussbaum, A. M. (2022). The Pocket Guide to the DSM-5-TR™ Diagnostic Exam. American Psychiatric Pub.

Comer, J. R. (2013).Abnormal Psychology. (8th Ed.). USA: Catherine Woods.

David R. N (2016, October 15). The Mental Status Examination. Retrieved from https://www.aafp.org/afp/2016/1015/p635.html

Rollnick. (1991). Chapter 3-Motivational Interviewing as a Counseling Style-Enhancing Motivation for Change in Substance Abuse Treatment - NCBI Bookshelf Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK64964/

Hussain, S. (2010). "Drug Addiction & The Youth" retrieved from http://www.minhaj.org/english/tid/11912/Drugs-addiction-and-the-youth.html

Adly Mohammed A, Said Sayed F. Effect of Psycho-Educational Program on the Quality of Life and Coping Patterns of Substance related disorders Patients. Journal of Nursing Science Benha University. 2024 Jan 1;5(1):736-50.

Zachariah RA. Cognitive Behavior Therapy for Anger and Aggression.

Nadkarni A, Massazza A, Guda R, Fernandes LT, Garg A, Jolly M, Andersen LS, Bhatia U, Bogdanov S, Roberts B, Tol WA. Common strategies in empirically supported psychological interventions for alcohol use disorders: A meta-review. Drug and alcohol review. 2023 Jan;42(1):94-104.

You CW, Hung MW, Hou CT, Ho CJ, Yuan CW, Bi N, Huang MC. Trigger or Treat: Using Technology to Facilitate the Perception of Cravings and Corresponding Cues for Achieving Clinical-friendly Drug Psychotherapy. Proceedings of the ACM on Human-Computer Interaction. 2023 Apr 16;7(CSCW1):1-26.

Kitzinger Jr RH, Gardner JA, Moran M, Celkos C, Fasano N, Linares E, Muthee J, Royzner G. Habits and routines of adults in early recovery from substance use disorder: clinical and research implications from a mixed methodology exploratory study. Substance Abuse: Research and Treatment. 2023 Feb;17:11782218231153843.

Magill M, Kiluk BD, Ray LA. Efficacy of cognitive behavioral therapy for alcohol and other drug use disorders: is a one-size-fits-all approach appropriate?. Substance Abuse and Rehabilitation. 2023 Dec 31:1-1.

Prochaska, J. O., & DiClemente, C. C. (2015). *The transtheoretical approach: Stages of change.* Oxford University Press.

Stein LA, Martin R, Clair-Michaud M, Lebeau R, Hurlbut W, Kahler CW, Monti PM, Rohsenow D. A randomized clinical trial of motivational interviewing plus skills training vs. Relaxation plus education and 12-Steps for substance using incarcerated youth: Effects on alcohol, marijuana and crimes of aggression. Drug and alcohol dependence. 2020 Feb 1;207:107774.

William, G. (2002). *Substance dependence: Developmental processes and patterns of use.* Journal of Addiction Research, 18(3), 245–258.

Wells, S. (1997). *The availability of substances and its impact on addiction: A global perspective.* Journal of Addiction Studies, 15(4), 321–330.

Beck, A. T., Wright, F. D., Newman, C. F., & Liese, B. S. (1993). *Cognitive therapy of substance abuse.* Guilford Press.

Peale, N. V. (1985). *The power of positive thinking.* Doubleday. (as cited in Beck et al., 1993)