Clinical Diagnosis and Assessment

1. Introduction

The purpose of assessment is to ascertain the severity of the problem, as well as the patient’s biological, psychological, and social resources. Identification of both problems and resources is needed in order to determine need for and type of treatment.

Diagnosis is not an end itself. Mere labeling of drug dependence can do more harm than good. Instead, diagnosis should enable the physician and patient to achieve the following:

1. Become aware of the problem and its prognosis.
2. Choose treatment alternatives likely to be successful.
3. Facilitate communication among family members and professionals.

2. Background Factors

Patients with drug dependence present to clinical settings much as do other patients, but with certain additional and special characteristics. They often feel (and are) stigmatized because of being drug dependent and thus may fear the physician’s response to them. At times they want help for their medical complications from drug dependence, but are ambivalent about giving up their dependence on drugs. They may seek medical help at the insistence of others, rather than on their own. These background factors must be known and understood in undertaking thorough clinical assessment.
2.1. Interaction between the Physician, Patient, and Community

Complete assessment requires collaboration from the patient as well as other significant persons (e.g., family, employer, or teacher). Information will be available to the extent that the informant feels safe, is taken seriously, understands the purpose of the assessment, and trusts the clinician. Emphasis, sequence, wording, and the information provided by the clinician all influence this collaboration to a considerable extent.

The clinician must be prepared to deal with divergent information, needs, opinions, and definitions of the problem. Patient or family may use the physician not only as a health resource, but as a partisan, a control agent, a pressure valve, or a means of avoiding responsibility. In such circumstances the physician’s role and prestige can be either an asset or a liability, depending on how they are used. Awareness of these potential dilemmas is a major step in dealing with them.

Some patients initially test the clinician by presenting a part of the problem, or a different problem, before coming to the real issue. Their ambivalence about being helped, shame about being weak or a failure, and guilt feelings or fear of giving up drugs can interfere with the interview process. Feeling accepted and understood by the clinician is an important factor in establishing physician–patient rapport.

Helpful approaches on the part of the physician include the following:

- Empathy with and acceptance of the patient as a person do not imply acceptance of drug habits.
- Readiness to listen and understand before coming to premature conclusions.
- Being clear and firm regarding one’s own role, functions, abilities, powers, limits, and boundaries.
- Avoiding ambiguous messages.
- Awareness of one’s own feelings toward the patient (e.g., distrust, sympathy, repulsion, interest, identification, fear).
- Appreciating the patient’s ethical concerns while avoiding moral judgments.
- Inquiry should be guided by the intent to help the patient in coping with the situation, and not simply by the intent to find the patient guilty of drug dependence.

There are special circumstances in which the physician serves two masters: the patient and a social institution (e.g., army, school, prison, corporation). It is helpful at the outset to make clear the doctor’s role and potential authority. If this is done from the beginning, unrealistic fears and expectations can be avoided.

Even outside of social institutions, the physician may still be caught between the patient and other persons, such as the family. Differences should not