Supporting AOD clients with cognitive impairment: what clinicians need to know

Webinar attendee questions with answers from Dr. James Gooden and Dr. Vanessa Petersen (Turning Point)

Question: Can I ask about for lack of better wording 'memory insertion'? A person may think something will be happening - such as moving house - and then insists this is going to happen and prepares for such, packs up their belongings and is waiting to move. They create this narrative and then believe it to be true. This is related to long term alcohol use in this circumstance.

There are many possible reasons for this to occur and so it is difficult to comment on a specific example without conducting a full assessment. Having said that, it is possible that the 'memory insertion' represents confabulation, which is a feature of Korsakoff's syndrome that occurs in association with thiamine deficiency often observed in people who are alcohol dependent. I would highly recommend referral to neuropsychology, neurology or a cognitive memory clinic for a workup and review.

Question: Is there a frequent relationship between DV and cognitive impairments - more specifically such traumas as strangulation?

Great question. This is a very challenging space to comment on as the evidence is quite limited for many reasons. In short, there are no studies available that explore long term neuropsychological outcomes after strangulation in these settings to guide our assessments & formulation. The added concern is the ongoing effects of psychological trauma that can occur following these incidents which can in turn also impact cognitive functioning. So all these factors (particularly when combined with substance use or pre-existing difficulties or concerns for instance) can make it very difficult to determine the root cause of any cognitive impairment in clients presenting to services. I found a great paper on this topic (*The neuropsychological outcomes of non-fatal strangulation in domestic and sexual violence: A systematic review*). They highlight that outcomes can be similar to hypoxic-ischemic injuries which include a range of neurological consequences which highlights the severity of this issue and need for further research.

Question: I find that AOD use is more related to a direction or cue from someone else and not necessarily related to a high experienced by an individual. Do some clients see it as an association?

Certainly over time individuals can experience these strong associations between certain cues and substance use. Altering these associations can be very challenging as they can be very persistent. One new area of research on this front is cognitive bias modification, which aims to help breakdown

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these associations. For a better write up see our newly published guidelines (*Managing Cognitive Impairment in AOD*, page 82).

Question: How long would you recommend a study session with rest breaks as a compensatory strategy in a classroom (TAFE) environment?

This would need to be judged based on an individual's fatigue, attentional limits and general strengths and weaknesses. So you may need to workshop with the client about how long they feel they can concentrate for, whether certain topics or settings are more exhausting than others, how quickly they feel rested after a break and what other strategies they feel are helpful.

Question: Do external strategies make the brain 'lazy', or would they enable the brain to develop its own internal strategies?

I don't think using external strategies makes the brain lazy! Rather they can help reduce the cognitive load, allowing individuals manage everyday demands better. They won't serve to improve internal strategy use as these need to be practiced heavily by the individual to become habit.

Question: Bearing neuropsychology in mind, are there any preferred treatments for AOD clients (i.e., CBT, MI, DBT, etc)? Thank you.

The choice of therapy in these cases would really depend on the individual's cognitive strengths and weaknesses. For example individuals with weaknesses in verbal reasoning and comprehension skills might struggle with talking based therapies that rely heavily on verbal tracking and abstract concepts such as metaphors. Both MI and CBT have been used in cognitively impaired groups (e.g., TBI) with adaptions though and yielded good outcomes. So similar adaption could be applied in AOD settings for clients with cognitive impairment.

Question: Do you find epileptic seizures have an impact on peoples' consolidation of information?

Yes. Epilepsy is well documented to have an impact on cognitive functioning including memory. This is one of the many reasons why it is important for individuals with uncontrolled seizures to be referred to a neurologist or seizure clinic.

Question: Any recommended clinics in WA would be great - thanks team!

These might be some options: https://www.uwa.edu.au/Facilities/Robin-Winkler-Clinic and https://www.fsh.health.wa.gov.au/Our-services/Service-Directory/Clinical-Psychology-and-Clinical-Neuropsychology. Otherwise you can use the APS "Find a psychologist" tool on their webpage to search for a neuropsychologist in the area.

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Question: Any comments on whether self-regulation is linked to improved executive functioning, or strategies to improve self-regulation?

We do present some more ideas for managing self-regulation and impulsivity in our Guidelines. One good strategy is the stop, think, act strategy as we presented. Self-regulation is also closely related to one's insight and self-awareness and so individuals with difficulties in these areas may need more support to monitor their performance, errors and set more realistic goals (or have smaller achievable steps created within a larger goal) for instance.

General comment from attendee: We haven't even a rudimentary foundation yet for addressing psychotic disorders which overlap with a history of chronic substance use. Take, for example, someone in paranoid psychosis with a history of drug overdoses, pervasive anxiety and traumatic life events. Approaching their misplaced interpretations, distorted perceptions and memory confabulations as if they have an intellectual disability is not going to work, although cognitive deficits will play a role. Too often I encounter a schism between neuro-psychologists and psychiatrists in the attitude that "fixing the psychosis" is a medical (i.e. medication) issue - even though anti-psychotics often fail to address the paranoia and may exacerbate it - before counselling can provide rehabilitation. We cannot separate them: a thorough investigation of what is going on in the biochemistry/metabolism/neurology of that particular client is invariably missing.

Feedback from presenters: Great point and agree entirely. This is why we are very concerned with the overuse and at times simplistic use of labels such as ABI and ID when the clinical picture is far more nuanced as in that example. We absolutely need to be advocating for holistic approaches to care that include thorough investigations of medical, psychiatric, traumatic and other contributors to an individual's presentation and providing integrated care to address these concerns.

General feedback from James and Vanessa:

Thank you all for the feedback. We find it very valuable to gauge our content and plan further talks. We realise there was a lot to cover so apologies to those who wished it could be longer and contain more in-depth detail! We do regularly run workshops where we have the time to cover these topics further so keep an eye out for these.

We also didn't get a chance to mention our new *Guidelines for Managing Cognitive Impairment in AOD*, which have recently been published and are available online (https://www.turningpoint.org.au/treatment/clinicians/Managing-Cognitive-Impairment-in-AOD-Treatment-Guidelines). This resource covers all these topics including the specific cognitive concerns for individual substances in much more detail. We hope this is a helpful resource for anyone in the sector.

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