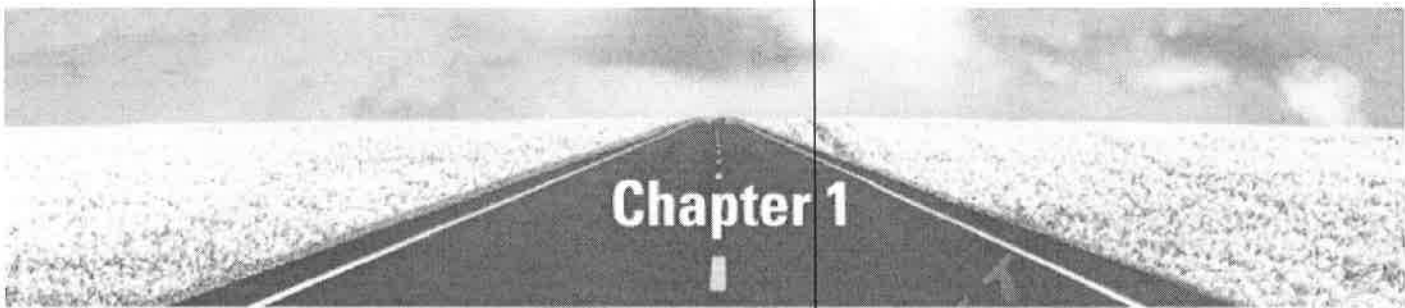




Chapter 1

Introduction to Assessment

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Key Terms: addiction, substance-related disorders, substance use disorders, substance abuse, substance dependence

Key Objectives: This chapter will provide students with an understanding of the history of drug and alcohol treatment, models of addiction, and current treatment practices for substance-related disorders.

Treatment for Alcohol and Drug Addictions

Although the “War on Drugs” has waged for several decades, drug use continues to rise in the United States. In 2015, 9.4% of individuals age 12 and over reported past month use of an illicit drug (National Institute on Drug Abuse [NIDA], 2015). Binge drinking of alcohol also remains high with 30.2% of males and 16% of females engaging in binge drinking (five or more drinks on the same occasion) during the past month (NIDA, 2015). According to national studies, there are over 22 million people in the United States in need of substance use treatment, yet only around 2.5 million actually receive it (NIDA, 2015). Substance abuse treatment as a profession has a long history and there is still much we have yet to learn. The purpose of this book is to provide counselors and counselors-in-training with a comprehensive guide for assessing substance-related and addictive disorders, but first here are some important terms for you to learn.

With the release of the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition; *DSM-5*) in 2013 came new terminology in the field of addictions. The previous version of the DSM described people with severe substance use disorders (SUDs) as having *substance dependence* and those with mild or moderate symptoms as having *substance abuse*. Dependence was synonymous with addiction, a term that has long been used to describe being either physiologically or psychologically enslaved to the use of drugs or alcohol. According to the *DSM-5*, a person with a pathological pattern of behaviors related to substance use is a person with a SUD. A substance-related disorder includes SUDs, substance intoxication, and substance withdrawal. For the purpose of this text, a *person with a substance use disorder* is a person who meets the *DSM-5* diagnostic criteria for a cluster of cognitive, behavioral, and physiological symptoms as a result of their continued use of drugs or alcohol. This chapter will review the history of substance use and treatment and will provide you with a foundation on which to build your assessment knowledge and skills.

History of Treatment

For thousands of years, human beings have been using substances for healing, health, happiness, and mental escape. Ancient Sumerian writings referring to opium poppies as “Joy Plant” have been found

disorders need the support of each other and a Higher Power in order to maintain sobriety. Still widely popular, AA has swept the globe and is one of the most recognizable recovery programs available. The first professional treatment programs were established in the 1940s (Holloway, 2010). Early treatment relied heavily on the use of group therapy, the disease model, and principles of AA (Holloway, 2010).

Addiction Models

Moral Model

Over the decades, people have tried to conceptualize addiction with various models. One of the earliest models of addiction is the moral model. According to this model, addiction results from a defect in character—a moral failing. This model implies that addiction is a personal choice, and, if afflicted individuals simply tried hard enough or used willpower, they could overcome their addiction. Advocates of this model believe that SUDs are symptoms of immorality and lawlessness and should be legislated away and punished like other criminal acts. Unfortunately, the moral model has been and continues to be prevalent in society. It seems the moral model is running the “war on drugs” and despite decades of research, society continues to attempt to rehabilitate persons with SUDs through punishment and incarceration.

Disease Model

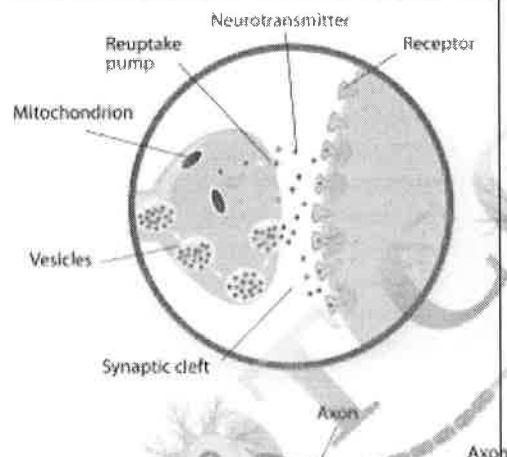
The disease model of SUDs is by no means new. Built on a research article published by E. M. Jellinek in 1947, the disease model asserts that addiction is a chronic and progressive disease influenced by biological factors which cause the user to have no control over his or her use. The disease model has been embraced by AA and numerous treatment programs for decades (Hanson et al., 2009). In 1956, the American Medical Association adopted the disease model, describing alcoholism as “a chronic illness characterized by preoccupation with alcohol and loss of control over its consumption” (Van Wormer & Davis, 2008, p. 10). Soon after, treatment agencies began to emerge all over the country and even insurance companies embraced this new model and began to cover the costs of treatment (Benshoff & Jankowski, 2000).

Biopsychosocial Model

Another popular model of addiction is the biopsychosocial model (Van Wormer & Davis, 2008). This model takes a holistic approach to the etiology and treatment of addiction by focusing on the interaction of biological, psychological, and social factors which contribute to the disorder. Over the past two decades, advances in neuroscience has allowed researchers greater understanding of the science of addiction. Newer technologies like fMRI and PET scans now enable scientists to “see” inside the brain and have allowed researchers to understand the neurological factors associated with SUDs like never before. For example, researchers have used fMRIs to see the brain exhibit craving states when exposed to certain drug cues or “relapse triggers” (Goldstein & Volkow, 2011).

In 2016, the Surgeon General released the Surgeon General's Report on Alcohol, Drugs, and Health. This was the first report of its kind and calls for nationwide prioritization of SUDs as a public health crisis. In fact, according to this report, the Surgeon General has determined that “alcohol and drug misuse, substance use disorders and addiction are the most pressing public health concerns facing America.” The Surgeon General's report calls for educators, treatment providers, healthcare practitioners, advocates, policy makers, community members, families, and individuals to come

STRUCTURE OF A TYPICAL CHEMICAL SYNAPSE



Nature has provided humans with a built-in reward system for engaging in activities necessary for survival, like eating food and having sex. For example, every time a human eats food, his or her brain releases dopamine which produces a pleasure feeling. That pleasurable feeling helps to ensure we want to keep eating food. It just so happens that our brains do not only reward us for doing healthy, necessary for survival activities. Our brains use the same reward system when humans use drugs or alcohol. The primary pleasure pathway in the brain lies deep within the brain in an area within the basal ganglia. The basal ganglia are also responsible for voluntary movements, cognition, emotions, and learning.

Alcohol and other drugs "hijack" this pleasure pathway in the brain and convince the brain that the substances are as important for survival as food and sex. This helps explain why individuals with SUD continue to use substances despite tragic and catastrophic consequences and why stopping is not just a matter of "willpower." The brain tells the user that they must continue to use just like our brains tell us that we must eat.

Another area of the brain at work in SUD is the extended amygdala. The amygdala is the part of the brain that controls reactions to strong emotion and the "fight or flight" response. When a person with a SUD attempts to stop taking their drug of choice, the amygdala is activated and produces a stress response, creating unpleasant feelings known as craving.

The prefrontal cortex is the area of the brain where decisions are made and consequences are weighed. In persons with SUD, the prefrontal cortex is unable to engage in adequate problem solving and impulse control, craving is allowed to take over, and the brain becomes a rogue system without guidance from the frontal lobe.

Recent research has been able to record the activity of the brain during cravings and has found that cravings occur in microseconds—faster than the brain can process images when exposed to drug cues

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attitude of "unconditional positive regard." Most importantly, this approach allows clients to explore their feelings and mental processes, gain insight into their behaviors, and work toward growth and change in a supportive atmosphere. The empathic counselor does not need to give advice, use anecdotes, self-disclose, or inundate the client with didactic material. The counselor needs only to focus fully on understanding the client in the here and now. Empathy is not a talent with which people are born; rather, it is a skill that is developed over time. Fortunately, for most counselors-in-training, empathy can be learned.

Introduction to Evidence-Based Practices

According to Miller et al. (2011), empathy is itself an *evidence-based practice*. Evidence-based practices are those approaches to treatment which have been proven effective. SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) is a valuable tool for clinicians who want to select approaches which have been rigorously tested. This online registry allows clinicians to choose an approach based on select demographics and settings. NREPP contains over 280 interventions, including motivational enhancement therapy, cognitive behavioral therapy (CBT), contingency management (CM), and community reinforcement approaches (CRAs; NREPP, 2013). It is important for counselors to choose from approaches which are evidence based. Chapter 8 of this book will describe more about the evidence-based practices mentioned in this chapter.

Client Readiness for Change

Change is an important element in addiction treatment. The *stages of change* as described by Prochaska and DiClemente's (1984) transtheoretical model, are used throughout treatment programs. The main premise of the stages of change is that individuals differ in their readiness to change and it is the clinician's responsibility to meet clients where they are rather than attempt to "force" them to change. The first of the five stages is *precontemplation*. At this stage, a client has not considered change—he or she does not recognize the need for it. Or perhaps, he or she has attempted to change in the past and failed and has given up the idea. The second stage is *contemplation*. Here, a client is considering change. He or she may be weighing the benefits vs. the cost, but has not yet made a decision. The third stage is *preparation*, where the client makes the decision to change but may not yet know how to go about it. Stage 4 is *action*. This is when the client has made a commitment to change and is taking the first steps toward it. For example, a client may throw out his or her stash of drugs and begins to actively implement a plan for change. In the fifth stage, *maintenance*, the client has made great progress toward change and is working on maintaining his or her new behaviors. Many clients refer to this as being in recovery.

It is important to note that clients may not progress through the stages of change in a linear fashion. Sometimes they will move back and forth between stages and may even cycle backward through stages (Miller et al., 2011). Moreover, there are no criteria dictating how long a client will stay in a given stage. Progression may be very fast, incredibly slow, or even nonexistent. Counselors need to recognize the stage in which their client is and be realistic in their expectations. Furthermore, counselors should celebrate any forward movement through the stages. If a client is at the precontemplation stage at the beginning of treatment and only begins preparation for change before dropping out, that client has moved two whole stages. Although this may not be the "miracle" the counselor was hoping to see, it is still change. Perhaps, the client will later return to treatment ready to begin the action stage.

Motivational interviewing is an evidence-based practice which increases a client's motivation for change and is particularly useful for clients in the contemplation and preparation stages (Emmelkamp & Vedel, 2006). When a client reaches the action stage, he or she is likely well motivated and ready for change. This is when a cognitive behavioral approach may be appropriate (Emmelkamp & Vedel, 2006). The focus of CBT is on changing irrational beliefs and unhealthy behaviors. It combines elements of

from these substances can be dangerous, leading to seizures or even death. For clients at risk of dangerous withdrawal, a medical setting is the safest place for detox. Social setting detox (nonmedical detox) is often available at community-based treatment agencies. This is a lower cost option for people with non-life-threatening withdrawal. Most detox programs last only a few days, and it is important for clients to enter a treatment program immediately after detox.

Brief Intervention

Brief intervention (BI) has become an increasingly popular treatment modality which is well suited for light to moderate users or those at risk of developing a drug or alcohol problem. The goal of BI is to investigate potential problems and increase motivation to change (Center for Substance Abuse Treatment, 1999). BIs are time limited and cost effective. BI can help clients to reduce or stop their use of substances on their own and change other specific behaviors. BI also works well as a precursor to treatment (Center for Substance Abuse Treatment, 1999).

Inpatient/Residential

There are several types of inpatient/residential treatment programs. Some of these are the 28-day programs while others are more time intensive, lasting from 3 to 6 months. Studies show that longer stays in substance abuse treatment are more effective. Specifically, according to the National Institute on Drug Abuse (2012), most clients need at least 3 months in treatment to significantly reduce or stop their drug use and many clients require multiple episodes of treatment. Inpatient/residential treatment programs often incorporate individual and group therapy, as well as family therapy. Many also encourage clients to attend 12-step groups like AA. Upon completion of inpatient/residential treatment, clients will often complete an aftercare program.

Aftercare, also known as continuing care, is an important follow-up to inpatient/residential treatment. It helps clients to maintain recovery while back in their communities. Newly learned skills can be practiced and reinforced in the "real world." Aftercare may last for varying lengths of time, based on client needs.

Outpatient

Outpatient treatment is a less costly and less restrictive alternative to inpatient/residential treatment. It is well suited for clients who can maintain sobriety and change behaviors while remaining in their own environment. There are several advantages to outpatient treatment, one of which is that it is less life intrusive—clients attend school or work and take care of their home responsibilities while in treatment. Also, clients are able to practice newly learned skills in their community. Outpatient treatment frequently consists of both individual and group therapies. Many outpatient agencies are using evidence-based practices like motivational interviewing, cognitive behavioral therapies, and pharmacological interventions. Clients are often encouraged to attend 12-step meetings, while in outpatient treatment. For clients whose environments do not support recovery efforts or for those who have been unsuccessful in outpatient treatment, inpatient/residential treatment may be more appropriate.

Mandated Treatment

Many clients who enter substance abuse treatment do not do so voluntarily. According to Farabee, Prendergast, and Anglin (1998), requiring individuals to complete treatment has been ongoing since the 1920s when morphine addicts were forced into treatment. Long before the 1920s, those with alcohol dependence were forced into asylums. Detaining individuals in these asylums was thought to be necessary in order to "cure" those with alcohol dependence, known as "inebriates" in the 19th century (Brown, 1985). Currently,

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