

# Substance Abuse Course

By Lance J Parks, LCSW

7 CE Credits /Contact Hours

**[Author's Note:** Some sections of this course mention potential medication treatments for informational purposes only. Unless you are licensed to prescribe, recommending or prescribing medication is outside the scope of practice for mental health professionals, is unethical, and is against the law. If you believe medication may benefit a client, you should refer them to a qualified medical professional who is licensed to provide such consultation and care.]

**Important Note:** We recommend printing the test and completing it as you read to prepare for the online post-test. As you go through the course, hover over or click the yellow 'sticky notes' to reveal helpful study tips. Enjoy the course!

## Chapter 1: Introduction

### 1.1 Background and Significance

Alcohol and substance use disorders represent some of the most persistent and costly public health problems worldwide. Alcohol use disorder (AUD), or alcoholism, is defined as a chronic disease marked by compulsive use, loss of control, and negative emotional states when not drinking (American Society of Addiction Medicine, 2019). Substance use disorder (SUD) is a broader term for patterns of harmful use involving alcohol, prescription drugs, or illicit substances that lead to impairment or distress (American Psychiatric Association, 2022). “Dependence” can refer to either physical reliance—characterized by tolerance and withdrawal—or psychological dependence, where preoccupation and craving dominate thought processes (Medical News Today, 2023).

While the terms overlap, addiction usually describes severe SUD with compulsive substance-seeking despite negative consequences (NIDA, 2020).

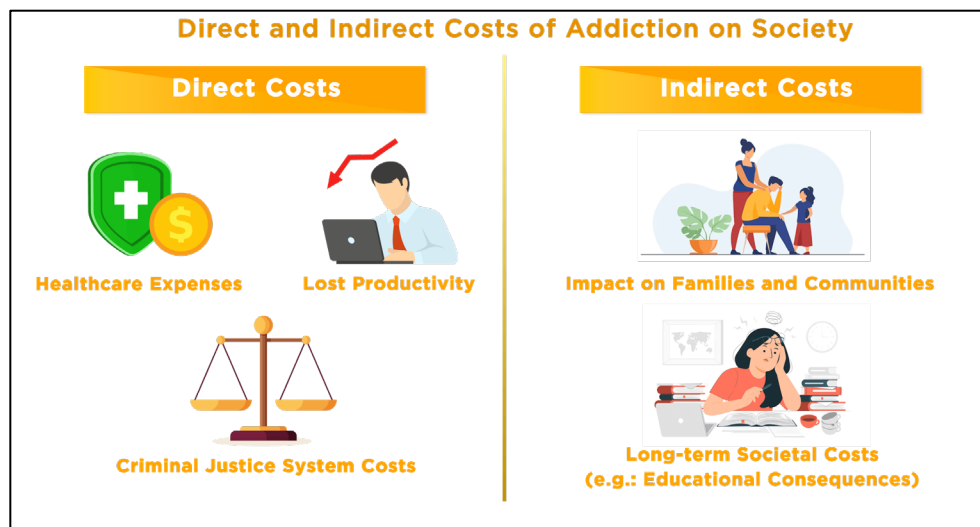
Globally, the scope of harm is staggering. Harmful alcohol consumption is linked to approximately three million deaths annually, representing about one in twenty of all deaths (WHO, 2018). Alcohol use is reported among more than 2.3 billion people worldwide, with an estimated 400 million meeting diagnostic criteria for AUD (WHO, 2024). Drug use is also pervasive, with roughly 296 million individuals aged 15–64 reporting drug use in 2021 and about 39.5 million suffering from drug use disorders (UNODC, 2023). Drug-related deaths exceed 600,000 annually, reflecting the lethal impact of opioids and synthetic drugs. These statistics demonstrate that substance misuse is not confined to any one nation but is instead a truly global concern.

In the United States, national surveys continue to highlight the high prevalence of SUDs. The 2021 National Survey on Drug Use and Health (NSDUH) reported that approximately 20 million Americans aged 12 or older had an illicit drug use disorder, with the number climbing to 24 million when prescription misuse was included (SAMHSA, 2022). Alcohol misuse remains even more widespread. In 2023, nearly 29 million Americans—about 10.2% of the population aged 12 and older—met the criteria for AUD (NIAAA, 2024). Men were more likely than women to experience AUD, but the impact was substantial across genders and ages, including nearly 760,000 adolescents.

The opioid crisis continues to dominate headlines and public health statistics. Since 2021, drug overdose deaths have consistently exceeded 100,000 annually, primarily driven by fentanyl and other synthetic opioids (CDC, 2023; NIDA, 2024). Overdoses now represent a leading cause of death for Americans under 50. Alcohol-related deaths, though less publicized, claim more than 140,000 lives per year, with rates increasing during and after the COVID-19 pandemic (White et al., 2022). Together, alcohol and drug use have contributed to declining life expectancy in the U.S.

The consequences extend beyond mortality. **Health impacts** include cardiovascular disease, liver cirrhosis, pancreatitis, neurological impairment, and heightened risk for cancers (Rehm et al., 2019). Co-occurring mental health disorders such as depression, anxiety, and psychosis further complicate treatment (Kelly & Daley, 2013). At the **family**

**level**, substance use can lead to conflict, intimate partner violence, neglect of children, and intergenerational cycles of trauma (NIDA, 2020). On the **community level**, substance misuse drives crime, incarceration, and accidents—particularly impaired driving fatalities—and contributes to homelessness and strained social services. **Economically**, the U.S. bears an estimated annual cost exceeding \$740 billion, including healthcare expenditures, lost productivity, law enforcement, and accidents (NIDA, 2020). Alcohol misuse alone costs about \$249 billion each year, and prescription opioid misuse adds more than \$78 billion. Globally, the WHO warns that harmful alcohol use hampers both health and economic development (WHO, 2018).



Taken together, alcohol and drug misuse represent an enormous burden measured in deaths, diseases,

fractured families, weakened communities, and economic losses. The scale of the problem underscores why professionals in mental health and healthcare must have a deep understanding of addiction's causes, impacts, and evidence-based treatments.

## 1.2 Purpose of the Course

Given the magnitude of alcohol- and drug-related harm, this course is designed to provide a comprehensive yet practical review of substance use disorders for professionals working in mental health, healthcare, and addiction treatment. The intended audience includes licensed clinicians, social workers, psychologists, counselors, psychiatric nurses, physicians, and certified drug and alcohol counselors. Students and trainees preparing for careers in these fields will also benefit from the material.

The overall aim is to **bridge scientific research with clinical practice**. While scholarly literature provides rich data, practitioners need accessible insights that can guide real-world assessments, treatment planning, and ethical decision-making. By translating current knowledge into a usable framework, this course equips professionals to better serve clients and advocate for effective policies.

---

## Scope and Objectives

The course is structured to address the **continuum of addiction**—from causes to consequences to solutions. Its scope includes:

### 1. Clarifying definitions and prevalence

- Establishing clear terminology (alcohol use disorder, substance use disorder, dependence, addiction).
- Presenting global and U.S. epidemiological data to highlight the scale of the issue.
- Explaining trends in alcohol, opioid, stimulant, and other drug use between 2015–2025.

### 2. Exploring development and risk factors

- Identifying biological, psychological, and social influences on addiction.
- Reviewing theories such as the brain disease model, reinforcement and learning theories, trauma-based models, and genetic predispositions.
- Understanding how risk factors interact to create pathways from experimentation to misuse to full dependence.

### 3. Reviewing evidence-based treatment approaches

- Highlighting the most effective interventions, including:
  - **Medications** (e.g., naltrexone, acamprosate, buprenorphine, methadone).

- **Psychotherapies** (e.g., cognitive-behavioral therapy, motivational interviewing, contingency management).
- **Peer and support programs** (e.g., Alcoholics Anonymous, SMART Recovery, digital therapeutic platforms).
- Emphasizing integrated, individualized treatment plans that combine approaches to maximize effectiveness.

#### 4. Addressing ethical and legal considerations

- Reviewing confidentiality laws (including 42 CFR Part 2 in the U.S.) and informed consent practices.
- Outlining mandatory reporting requirements for child abuse, endangerment, and client self-harm or threats.
- Discussing professional ethical codes that emphasize client dignity, non-discrimination, cultural humility, and competence.
- Preparing clinicians to navigate stigma, power dynamics, and professional boundaries responsibly.

---

### Practical Outcomes

By completing this course, participants will:

- Gain a working knowledge of how SUDs are defined, diagnosed, and measured across populations.
- Understand the interplay of biology, psychology, and social environment in the development of addiction.
- Become familiar with evidence-based treatments and their relative effectiveness.
- Learn to apply ethical and legal standards to complex clinical situations.
- Develop cultural and professional competence in treating diverse populations affected by substance misuse.

This combination of knowledge and application ensures that participants are better prepared not only to treat individuals but also to contribute to prevention, education, and community health efforts.

### 1.3 Research Questions

The course is organized around three central questions that reflect the core challenges faced by clinicians, policymakers, and researchers in addressing substance use disorders:

---

#### 1. How do alcohol and substance use disorders develop?

Understanding the **etiology** of addiction is essential for prevention and early intervention. Research highlights a complex interplay of:

- **Biological mechanisms** such as genetic vulnerability, alterations in brain reward circuitry, and neuroadaptations in dopamine pathways (Volkow & Koob, 2015).
- **Psychological influences** including trauma, stress, mental health disorders, and self-medication tendencies.
- **Social and environmental factors** such as family dynamics, peer influence, socioeconomic stress, and cultural norms.

Addiction develops gradually through stages—experimentation, regular use, risky use, dependence, and addiction—each influenced by unique risk factors. For example, an adolescent with a genetic predisposition who also experiences childhood trauma is at heightened risk of developing SUDs compared to peers without those vulnerabilities (Withe, 2023). Recognizing these pathways helps providers identify at-risk individuals and intervene before addiction becomes entrenched.

---

#### 2. What are evidence-based treatment approaches for alcohol and substance use disorders?

Effective recovery depends on **evidence-based interventions** that integrate behavioral, medical, and social supports. Research supports a wide range of approaches:

- **Behavioral therapies** such as cognitive-behavioral therapy, motivational interviewing, and contingency management.
- **Medication-Assisted Treatment (MAT)** including methadone and buprenorphine for opioid use disorder, or naltrexone and acamprosate for alcohol use disorder (Strang et al., 2020; Jonas et al., 2014).
- **Supportive interventions** such as Alcoholics Anonymous, SMART Recovery, and emerging digital recovery platforms.

Evidence suggests that combining psychosocial therapies with medication yields the best outcomes. Integrated care that addresses co-occurring disorders, provides adequate treatment duration, and tailors care to individual needs is especially effective (NIDA, 2020).

---

### **3. What ethical and legal considerations are essential in practice?**

Even the most effective treatments must be delivered within ethical and legal frameworks. Addiction practice is shaped by:

- **Confidentiality requirements** such as 42 CFR Part 2, which provides heightened protection for substance use treatment records (HHS, 2021).
- **Informed consent and patient autonomy**, particularly in mandated treatment or when working with minors.
- **Mandatory reporting laws** for child abuse, neglect, or imminent harm.
- **Professional ethics** including avoiding dual relationships, addressing counselor impairment, and respecting client dignity and cultural values (NAADAC, 2021).
- **Legal contexts** such as disability rights protections under the Americans with Disabilities Act (ADA).

Harm reduction approaches—such as syringe exchange or naloxone distribution—also raise ethical debates, particularly in balancing public health goals with societal stigma or political controversy. Clinicians must be equipped to navigate these complexities with knowledge and sensitivity.

---



Together, these three questions provide the blueprint for the course:

1. **Understanding** how SUDs develop.
2. **Identifying** what works in treatment.
3. **Ensuring** ethical, legal, and culturally competent practice.

By exploring these areas, the course prepares practitioners to deliver treatment that is not only scientifically sound but also ethically responsible and client-centered.

## 1.4 Methodology Overview

This course is based on a broad literature review conducted between 2015 and 2025, ensuring the material reflects the most up-to-date research and policy developments. Sources include peer-reviewed journals, systematic reviews, and authoritative reports from organizations such as the World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC), Centers for Disease Control and Prevention (CDC), National Institute on Drug Abuse (NIDA), Substance Abuse and Mental Health Services



Administration (SAMHSA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

**Search Strategy:** Key terms varied by research question, such as “etiology of alcohol use disorder,” “risk factors for addiction,” “evidence-based substance use treatment,” “motivational interviewing effectiveness,” and “42 CFR Part 2 confidentiality.” Broad searches were followed by more focused queries when themes emerged (e.g., digital therapeutics for SUD, contingency management outcomes, or opioid prescribing policy reforms). References from pivotal studies were snowballed to capture additional relevant work.

**Inclusion Criteria:** Only sources published between 2015 and 2025 were included unless a seminal pre-2015 study was essential for context (e.g., DSM-5 diagnostic criteria from 2013). Priority was given to meta-analyses, systematic reviews, and clinical guidelines, though high-quality empirical studies were also incorporated. Opinion pieces and commentaries were used sparingly, primarily to illustrate ethical debates or highlight emerging practices.

**Quality Considerations:** Reliability was assessed through study design, sample size, and peer-review status. Conflicting findings were acknowledged, and where possible, reconciled using consensus guidelines. Emphasis was placed on sources with broad professional acceptance, ensuring that conclusions rest on credible evidence.

**Data Synthesis:** Literature was organized thematically to align with the research questions. For Question 1 (development), findings on genetic, neurobiological, psychological, and social contributors were extracted. For Question 2 (treatment), data on effectiveness, treatment outcomes, and guideline recommendations were compiled. For Question 3 (ethical/legal), professional codes (e.g., NASW, NAADAC, NBCC) and laws (such as HIPAA and ADA) were reviewed. Thematic organization allowed integration across disciplines, presenting addiction as a multifaceted issue requiring equally multifaceted responses.

**Currency and Relevance:** Because substance use patterns and treatment landscapes evolve rapidly, emphasis was placed on studies reflecting contemporary challenges

such as the COVID-19 pandemic's effects on alcohol consumption, the surge in fentanyl-related deaths, and the expansion of harm-reduction policies. Recent regulatory changes—including revisions to 42 CFR Part 2 and shifts in marijuana legalization—were integrated to keep the course relevant to current practice.

**Limitations:** As a narrative review, this methodology does not include formal quality scoring of each study. The literature base also contains gaps—for example, limited long-term studies on digital therapies or underrepresentation of marginalized populations. Nonetheless, reliance on consensus guidelines and meta-analyses provides a reliable foundation for the course.

---

## **Summary of Chapter 1**

In sum, substance use disorders are among the most pressing global health challenges, with devastating personal, social, and economic impacts. This chapter introduced the scope of the problem, clarified terminology, and emphasized why an evidence-based, ethically grounded approach is essential. The purpose of the course is to prepare practitioners with the knowledge and tools necessary to address addiction effectively in diverse contexts. Guided by three core research questions and supported by a rigorous literature review, the following chapters will expand on etiology, treatment, and ethical/legal considerations in depth.

## **Chapter 2: Historical Perspectives**

### **2.1 Historical Overview of Alcoholism and Substance Abuse**

#### **Ancient Civilizations**

Humanity's relationship with psychoactive substances stretches back thousands of years, entwined with culture, medicine, and spirituality. Archaeological findings from Jiahu, China, indicate that people were fermenting mixtures of rice, honey, and fruit as early as 7000 BCE (McGovern et al., 2004). Alcohol was not simply consumed for



pleasure; it carried symbolic meaning in rituals and was believed to connect humans with divine forces.

(Chemical analyses recently confirmed that the earliest alcoholic beverage in the world was a mixed fermented drink of rice, honey, and hawthorn fruit and/or grape

(<https://benedante.blogspot.com/2013/09/neolithic-alcohol-in-china.html>)).

In Mesopotamia, beer was considered essential for survival and was offered as tribute to gods. The “Hymn to Ninkasi,” a Sumerian text, praised the goddess of brewing and recorded recipes for beer production, showing that alcohol had religious as well as nutritional significance (Dietler, 2022). Egyptian society also wove alcohol into daily life. Beer was consumed by peasants and laborers—including the builders of the pyramids—while wine was often reserved for elites and ceremonies. Medical papyri reveal both medicinal uses and warnings about excess, highlighting awareness of alcohol’s dual nature even in antiquity (Darby, 2021).

Greek culture developed the idea of moderation. At the *symposium*, men gathered for philosophical discussion, music, and poetry, and wine—always diluted with water—was served.



**Figure:** Athenian red-figure column krater (c. 450–425 BCE) attributed to the Naples Painter, depicting a symposium scene. Guests recline on couches as music, games, and conversation accompany wine consumption—illustrating how Greek symposia balanced intellectual multiple meanings with social moderation (University of Sydney).

Drunkenness was considered shameful, an imbalance that undermined reason and virtue. Hippocrates observed alcohol's effects on the body, linking heavy use with illness and confusion. In Rome, wine was ubiquitous, consumed across all classes. Yet Roman leaders feared the social disorder caused by unchecked excess; the Senate restricted the Bacchanalia in 186 BCE, signaling the first governmental attempt to regulate intoxicating practices (Paolucci, 2022).

Thus, in the ancient world, alcohol was at once medicine, food, and ritual object—but also a recognized source of potential harm. That paradox—between celebration and condemnation—remains central to the history of substance use.

---

## **The Middle Ages**

During the medieval era, alcohol's role intensified, especially in Europe. Water was often unsafe, making ale, beer, and wine the beverages of choice across all ages and social groups. Monasteries became centers of brewing and winemaking, pioneering new techniques that elevated alcohol from a household craft to a commercial enterprise (Hornsey, 2021). Religious life reinforced alcohol's central role: sacramental wine was used in Christian communion, while drunkenness was condemned in sermons as sinful and destructive.

Islamic societies offered a different model. Qur'anic prohibitions against alcohol led to formal bans across much of the Islamic world, making it one of the earliest cultures to legally codify abstinence. Enforcement varied by region, but the principle that intoxicants impaired moral and spiritual integrity became firmly rooted (Shafi, 2022). Meanwhile, cannabis, coffee, and other substances became culturally significant in certain Islamic communities, showing that patterns of prohibition and substitution existed side by side.

---

## **Early Modern Era (1500–1800)**



The early modern period was defined by the rise of distilled spirits. Brandy, rum, and later gin contained far higher alcohol content than beer or wine, producing new patterns of rapid intoxication and social concern. In London, the “Gin Craze” (1695–1751) became infamous. Gin was cheap, accessible, and heavily consumed by the urban poor. Reports described infants given gin to quiet them, widespread crime, and staggering neglect. William Hogarth’s *Gin Lane* (1751) captured the devastation: a mother, drunk and indifferent, drops her child while society

collapses around her. The image symbolized the corrosive effects of uncontrolled access to strong spirits (Warner, 2021).

Public backlash led Parliament to pass successive Gin Acts, regulating production, sales, and licensing. Though enforcement was inconsistent, these laws marked an early recognition that substance misuse required social and legislative responses.



In colonial America, alcohol held a complex role. Taverns served as social and political hubs where revolutionaries debated independence. Rum production fueled the triangular trade, connecting New England to the slave economies of the Caribbean and West Africa. Alcohol was

woven into commerce and community life, yet Puritan leaders decried drunkenness as

sinful, planting seeds of moral ambivalence that would shape American temperance movements centuries later (Breen, 2023).

---

## **Summary of Early Use**

By the end of the early modern era, alcohol had become both **essential and controversial**. It was a staple of daily diets, a commodity in trade, and a tool of social bonding. At the same time, its destructive potential was increasingly recognized, sparking some of the first public debates and policy responses. This historical foundation set the stage for the 19th-century reform movements that would radically reshape ideas about alcohol, addiction, and morality.

### **2.1.4 Nineteenth Century: Reform and Temperance**

The 19th century was a turning point in how society viewed alcohol and drug use. Industrialization, urbanization, and shifting family structures created new social pressures that amplified both the availability of alcohol and its harms. Against this backdrop, reformers began building movements that framed excessive drinking as not only a personal failing but also a social crisis demanding collective action.

#### **The Rise of Temperance Movements**

Early temperance reform was rooted in the belief that moderation could solve the problem. Organizations like the American Temperance Society, founded in 1826,

encouraged individuals to pledge to reduce drinking, particularly distilled spirits. Within a decade, the group had spread nationwide, attracting hundreds of thousands of members and shifting public opinion toward abstinence as the only solution (Levine, 2020).



The Washingtonian Movement, which began in 1840, added another layer to the reform tradition. Unlike moralizing groups, the Washingtonians emphasized peer support and mutual aid. Six working-class men in Baltimore pledged sobriety and began sharing their experiences in meetings, sparking a grassroots movement that resonated with thousands. Though the movement eventually faded, it laid groundwork for later mutual-help models, including Alcoholics Anonymous, nearly a century later (White, 2022).

## **Women and the Temperance Cause**



Women played a central role in temperance advocacy.

Alcohol misuse was not only a health issue but also a domestic crisis, often tied to poverty and violence.

Husbands' wages spent on drink left families destitute, and alcohol-fueled violence endangered wives and

children. The Women's Christian Temperance Union (WCTU), founded in 1874, became one of the most influential reform organizations of the era. Led by figures such as Frances Willard, the WCTU campaigned for prohibition, women's suffrage, and social reform, linking the fight against alcohol to broader struggles for equality and justice (Blocker, 2021).

## **Medicalization of Addiction**

During the same period, early medical approaches to addiction began to emerge. The founding of the New York State Inebriate Asylum in 1864 marked the first attempt in the U.S. to treat alcoholism as a disease requiring institutional care. Though the asylum faced challenges—including poor funding and high relapse rates—it signaled a shift away from purely moral interpretations. Physicians like Dr. Benjamin Rush, often considered the “father of American psychiatry,” had earlier argued that habitual drunkenness was a disease, not merely a vice (White, 2020). By the late 19th century,

this medical framing gained traction, influencing how professionals and reformers understood the problem.

Addiction to other substances was also recognized during this time. Morphine, widely prescribed during and after the Civil War, left thousands of veterans dependent on opioids. Medical journals began describing “morphinism,” paralleling alcoholism in both symptoms and social stigma. Cocaine, initially celebrated for its stimulant properties, was later observed to cause dependence and social harm, foreshadowing cycles of enthusiasm and backlash that would characterize later drug histories.

### **Social and Political Dimensions**

The temperance movement intersected with politics in profound ways. By the late 1800s, statewide prohibition laws were passed in several U.S. states, though enforcement varied. The debates over alcohol mirrored broader anxieties about immigration, poverty, and morality. Alcohol was often associated with immigrant communities, particularly Irish and German Catholics, and temperance became tied to nativist sentiment. In this sense, the movement was both progressive and exclusionary—advocating family stability while reinforcing cultural divisions.

### **Case Example**

Consider the story of Sarah, a fictionalized composite drawn from women’s diaries of the time. Married to a factory worker in Massachusetts, Sarah struggled to feed her children because her husband spent much of his wages on alcohol. Nights were punctuated by violence, and she turned to her church’s temperance circle for support. For Sarah and countless others, temperance was not an abstract moral crusade but a fight for survival. The WCTU’s advocacy gave women like her both a voice and a platform to demand change, illustrating how reform was deeply rooted in lived experience.

---

## **Summary of the 19th Century**



The 19th century laid the groundwork for modern understandings of addiction. On one hand, reformers promoted abstinence and prohibition as moral and social necessities. On the other, physicians began reframing addiction as a disease requiring medical attention. Women's leadership in the temperance movement highlighted the gendered dimensions of substance misuse and helped link alcohol reform to broader struggles for justice. Though contradictions abounded—between moralism and science, inclusion and exclusion—this era marked a decisive shift toward organized, systematic responses to addiction.

## **2.1.5 The Twentieth Century: Prohibition, AA, and Addiction Science**

### **The Era of Prohibition**

The early 20th century brought the culmination of decades of temperance activism. The passage of the 18th Amendment in 1919 and the Volstead Act in 1920 ushered in national Prohibition in the United States. Advocates believed banning alcohol would strengthen families, reduce crime, and restore public morality. Initially, alcohol consumption dropped, and some communities reported decreases in arrests for drunkenness and related offenses.



However, unintended consequences soon emerged.

Organized crime syndicates thrived on the black market, running speakeasies, smuggling liquor, and corrupting public officials.

Figures like Al Capone became infamous symbols of the era, demonstrating how prohibition

policies could fuel lawlessness rather than eliminate drinking. Public opinion shifted, and

by 1933 the 21st Amendment repealed Prohibition, illustrating the limits of legislating morality (Okrent, 2010).

Despite its failures, Prohibition left lasting legacies. It solidified the federal government's role in regulating substances, inspired continuing debates about the effectiveness of bans, and highlighted the tension between personal freedom and public health.

---

## The Founding of Alcoholics Anonymous

In 1935, in Akron, Ohio, Alcoholics Anonymous (AA) was founded by Bill Wilson and Dr. Bob Smith. Drawing inspiration from the Oxford Group, a Christian fellowship focused on personal transformation, AA introduced the 12-step model that has since become a cornerstone of addiction recovery worldwide.



The program emphasized admission of powerlessness, moral inventory, confession, restitution, and spiritual awakening. Mutual support among peers was central, providing a sense of belonging and accountability. By the mid-20th century, AA had spread internationally, with millions of members. Its success lay in its accessibility,

nonprofessional approach, and adaptability across cultures.

Critics have noted AA's limitations, including its spiritual emphasis, variable effectiveness, and limited appeal for some populations. Nevertheless, its historical influence is undeniable. AA popularized the concept of alcoholism as a disease and demonstrated the importance of peer support in recovery (White, 2020).

**Case Example :** Charles, a middle-aged businessman in the 1940s, struggled with repeated relapses despite medical treatment. After attending AA meetings, he found strength in sharing his story with others who understood his struggle. The meetings

gave him a framework of accountability and purpose, allowing him to maintain sobriety for the first time in years. Charles's story illustrates why AA resonated with millions: it combined community, structure, and hope.

---

## **Advances in Addiction Science**

The mid-to-late 20th century also saw major advances in the scientific understanding of addiction. In the 1960s and 1970s, research in neuroscience revealed how substances alter the brain's reward pathways, laying the foundation for the modern brain disease model of addiction (Koob & Volkow, 2016). Epidemiological studies documented the scale of alcohol and drug problems, spurring new treatment approaches.

Meanwhile, cultural shifts transformed patterns of substance use. The counterculture of the 1960s normalized marijuana, LSD, and other psychedelics. The 1970 Controlled Substances Act classified drugs into schedules, shaping law enforcement and medical policy for decades. In the 1980s, the crack cocaine epidemic devastated urban communities, leading to a surge in incarceration rates through punitive policies such as mandatory minimum sentencing. Critics argue these policies disproportionately targeted communities of color and framed addiction as a criminal issue rather than a health problem (Alexander, 2020).

At the same time, the medical community refined treatment approaches. Methadone maintenance was introduced for opioid dependence in the 1960s, providing a harm-reduction strategy that reduced overdose deaths and stabilized lives. Residential treatment centers and outpatient counseling expanded, though access remained uneven. By the late 20th century, addiction was increasingly seen as a **chronic relapsing disorder** requiring ongoing management rather than a one-time cure.

---

## **Case Example: "Marilyn"**

Marilyn, a nurse who became addicted to opioids following surgery in the 1970s, entered a methadone maintenance program. Initially resistant, she gradually stabilized,

regained custody of her children, and returned to nursing. Her story reflects the shift from punitive attitudes toward medicalized, harm-reduction approaches that prioritized recovery over punishment.

---

## **Summary of the 20th Century**

The 20th century illustrates the complexity of addiction history: Prohibition demonstrated the unintended harms of strict bans; Alcoholics Anonymous provided a revolutionary peer-based recovery model; and advances in neuroscience and treatment reframed addiction as a chronic disease. Yet punitive policies and the “War on Drugs” highlighted ongoing tensions between public health and criminal justice. These lessons continue to influence how societies grapple with alcohol and substance use today.

### **2.1.6 Late Twentieth Century to the Present**

#### **The “War on Drugs”**

In the 1970s, U.S. President Richard Nixon declared drug abuse “public enemy number one,” launching the **War on Drugs**. Federal funding for law enforcement increased dramatically, and punitive policies shaped substance use responses for decades. The 1980s, under President Ronald Reagan, expanded these efforts with mandatory minimum sentencing laws and “zero tolerance” campaigns. While intended to deter drug use, these policies disproportionately affected minority and low-income communities. Crack cocaine, in particular, became the focus of harsh sentences, often far exceeding penalties for powder cocaine despite chemical similarity (Alexander, 2020).

The result was mass incarceration. By the 1990s, the U.S. prison population had quadrupled, with a significant portion incarcerated for nonviolent drug offenses. Families were disrupted, community trust eroded, and generational trauma deepened. Critics argued that the War on Drugs criminalized poverty and racial inequality while doing little to reduce drug availability or demand.

#### **Shifts Toward Public Health Approaches**

By the late 20th century, evidence mounted that punitive models were ineffective and costly. The HIV/AIDS epidemic highlighted the need for harm reduction: sharing needles spread HIV among people who inject drugs, creating a dual crisis of infection and addiction. Syringe service programs, once controversial, began to gain legitimacy as research showed they reduced HIV transmission without increasing drug use (Des Jarlais, 2019).

Simultaneously, the medical framing of addiction gained traction. The National Institute on Drug Abuse (NIDA) advanced the **brain disease model of addiction**, emphasizing neurochemical changes and the chronic, relapsing nature of substance use disorders (Volkow & Koob, 2015). This perspective encouraged treatment over punishment, though debates about stigma and responsibility persist.

### **Harm Reduction in Practice**

Harm reduction strategies expanded in the 1990s and 2000s. **Methadone and buprenorphine maintenance** became standard treatments for opioid dependence. **Naloxone distribution** emerged as a life-saving intervention, allowing overdoses to be reversed in minutes. Supervised consumption sites—though still controversial in the U.S.—were piloted in Canada, Australia, and parts of Europe, reducing overdose deaths and connecting users to health services (Marshall et al., 2011).

Portugal's 2001 decision to decriminalize all drugs stands as one of the most cited examples of harm reduction at the national level. Instead of prison, individuals found with drugs are referred to treatment and social services. Evaluations show declines in overdose deaths, HIV infections, and incarceration, demonstrating the potential of public health over criminal justice models (Hughes & Stevens, 2022).

Switzerland also pioneered heroin-assisted treatment, allowing severely dependent individuals to receive pharmaceutical-grade heroin under medical supervision. Studies showed dramatic improvements in health, reduced crime, and social reintegration (Uchtenhagen, 2021). These global models highlight alternative paths beyond punishment, providing valuable lessons for policymakers worldwide.

### **The Opioid Crisis**

The 21st century brought new challenges, most notably the opioid epidemic in the U.S. Beginning with the overprescription of painkillers in the 1990s, opioid misuse escalated into widespread addiction. As regulations tightened, many users turned to heroin, and eventually to fentanyl, a synthetic opioid 50–100 times stronger than morphine. Since 2016, fentanyl has driven unprecedented spikes in overdose deaths, exceeding 100,000 annually in the U.S. alone (CDC, 2023).

The crisis prompted expansions in medication-assisted treatment, naloxone access, and harm reduction. Yet stigma, limited treatment availability, and inconsistent policies continue to hinder progress.

### **Emerging Trends and Global Shifts**

Recent decades have also seen profound cultural and policy changes:

- **Marijuana legalization** has expanded across many U.S. states and countries such as Canada and Uruguay, reframing cannabis from a criminal issue to a regulated substance.
- **Psychedelic research** is experiencing a renaissance, with studies on psilocybin, MDMA, and ketamine showing promise for treating depression, PTSD, and addiction itself (Carhart-Harris & Goodwin, 2017).
- **Digital health tools** now provide telehealth counseling, app-based recovery supports, and online peer groups, expanding access to care.

Internationally, countries continue to grapple with balancing prohibition, regulation, and harm reduction. While some embrace progressive policies, others maintain strict bans, reflecting cultural and political differences.

---

### **Case Example (Expanded): “Luis”**

Luis, a 34-year-old construction worker in Ohio, became addicted to prescription opioids after a back injury. When his prescriptions were cut off, he turned to heroin, and later to fentanyl-laced pills. After multiple overdoses, he survived thanks to naloxone

administered by emergency responders. Eventually, Luis enrolled in a buprenorphine program and joined a peer recovery group. Though his journey remains ongoing, his story illustrates the intersection of medical treatment, harm reduction, and community support in responding to the modern opioid crisis.

---

### **Summary of Late 20th Century to Present**

This era reveals a dramatic shift: from punitive “wars” on drugs that fueled mass incarceration, to harm reduction models that prioritize health, safety, and dignity. Advances in neuroscience, the rise of the opioid epidemic, and global innovations in drug policy underscore the need for multifaceted responses. The story of addiction in the modern era is one of both setbacks and progress, reflecting ongoing struggles to balance justice, compassion, and science.

## **Chapter 3 Theoretical Frameworks of Addiction**

### **3.1 Biological Theories of Addiction**

Biological theories focus on the ways **genetics, brain chemistry, and neurophysiology** contribute to the onset, progression, and persistence of substance use disorders (SUDs). These approaches do not claim that biology is destiny — instead, they highlight vulnerabilities and mechanisms that can be modified through treatment, environment, and behavior change (Volkow et al., 2023).

---

#### **A. Genetic Predisposition**

##### **Evidence from Family, Twin, and Adoption Studies**

Research over decades has consistently shown that substance use disorders run in families, with **heritability estimates ranging from 40% to 60%** for alcohol and many drugs (Verhulst et al., 2022). Twin studies have been especially illuminating:



- Identical twins (sharing nearly 100% of genes) have much higher concordance rates for alcoholism compared to fraternal twins (sharing ~50% of genes).
- Adoption studies find that children born to biological parents with alcoholism remain at elevated risk even when raised by non-drinking adoptive parents (Kendler & Prescott, 2021).

**Table 3. Selected Findings from Twin and Adoption Studies on Addiction**



| Study Type     | Substance | Concordance / Relative Risk                             | Key Finding                                        |
|----------------|-----------|---------------------------------------------------------|----------------------------------------------------|
| Twin study     | Alcohol   | Identical twins: ~50%                                   | Strong genetic influence                           |
| Twin study     | Nicotine  | Identical twins: ~70%                                   | Nicotine dependence highly heritable               |
| Adoption study | Alcohol   | 4x higher in adoptees with biological alcoholic parents | Genetic vulnerability persists despite environment |

---

### Identified Genetic Markers

Recent advances in **genome-wide association studies (GWAS)** have identified specific genetic variants associated with SUD risk. The **DRD2 gene** (dopamine D2 receptor) is one of the most studied — certain alleles are linked to lower receptor density, potentially leading individuals to seek substances to boost dopamine activity (Perry et al., 2023). Other implicated genes include those related to alcohol metabolism (**ADH1B, ALDH2**) and opioid receptors (**OPRM1**).

---

### Epigenetics: Genes in Context

One of the most exciting developments in addiction science is **epigenetics** — the study of how environmental factors influence gene expression without changing DNA sequences. Chronic stress, trauma, and drug exposure can turn certain genes “on” or “off,” affecting neural pathways involved in reward, stress response, and impulse control (Liu et al., 2024). This helps explain why two people with similar genetic profiles can have very different outcomes based on life experiences.

---

### Clinical Relevance Today

Understanding genetic predisposition can help clinicians:

- Avoid **stigmatizing language** (“addictive personality”) and instead explain risk in a non-blaming way.
  - Recognize that **family history** is a clinically important risk factor, warranting early intervention and monitoring.
  - Offer psychoeducation on how **lifestyle changes** and supportive environments can reduce the expression of genetic vulnerability.
- 

## B. Neurobiology of Addiction

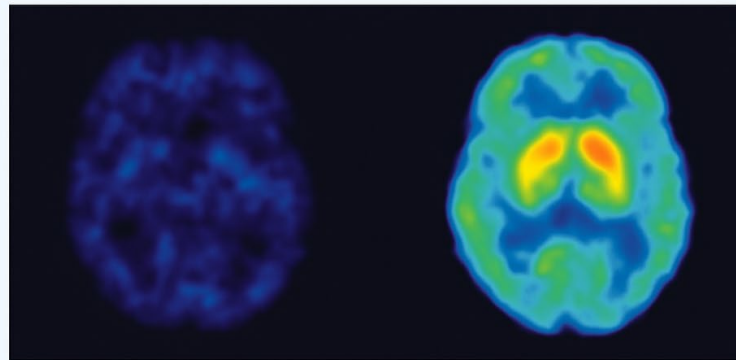
Biological theories remind us that substances don’t just affect behavior—they quite literally **re-wire the brain’s reward system**. At the center of this system lies the **mesolimbic dopamine pathway**, sometimes called the brain’s “pleasure highway.”

When someone takes a drink, inhales a hit, or injects a drug, the brain responds with a powerful surge of **dopamine** in the **nucleus accumbens**, the region deeply tied to feelings of reward and reinforcement. That’s why the first encounter with alcohol, opioids, or stimulants often feels so striking—like a sudden rush of warmth, calm, or energy. The brain interprets these substances as deeply rewarding, even more so than natural pleasures like food, laughter, or companionship.

But over time, with repeated use, the system begins to adapt. Dopamine receptors start to **downregulate**, as if the brain is pulling back the volume knob on its reward circuits (Volkow et al., 2023). The result? Everyday joys—sharing a meal, spending time with loved ones, enjoying a hobby—no longer feel as satisfying. The drug takes center stage, not because the person consciously chooses it over everything else, but because the brain has recalibrated what feels rewarding.

In this way, addiction is not just about poor choices or weak willpower—it is about a brain that has been biologically reshaped, nudging a person again and again toward the substance that once brought relief, even as it erodes the very capacity to enjoy life’s ordinary rewards.

# Dopamine Receptors in the Brain



**Addicted**

**Non-Addicted**

Low



High

Chronic substance use can lower dopamine receptor availability, reducing pleasure from everyday activities (Volkow et al., 2023).

## Case Vignette: “David and the Empty Evenings”

David was a 34-year-old father of two who had once been passionate about woodworking. His garage was filled with tools, half-finished tables, and carefully drawn plans for projects he never got around to completing. Before substances entered his life, he’d often lose track of time tinkering on furniture after work, proud of the craftsmanship that made his wife smile when she walked past his bench.

But after an injury left him with a prescription for oxycodone, things began to shift. At first, the pills were simply relief—a way to ease the pain so he could keep working and still play with his kids on weekends. Then he noticed that the pills didn’t just take away physical pain; they brought an emotional quiet he hadn’t felt in years. The constant churn of worry, the fatigue of long days, even the frustration of a tough job—it all seemed to melt away.

Months later, woodworking no longer gave him joy. He would walk into the garage, look at his tools, and feel nothing. Meals with his family, once a highlight of his week, felt like

chores. Even simple pleasures like watching a funny movie or sitting on the porch with his wife left him restless and unsatisfied. The only time he felt alive, he admitted later, was when he swallowed another pill.

“I don’t know what’s wrong with me,” David told his counselor, tears welling up. “I used to love my life. Now, unless I take something, everything feels gray. Even my kids’ laughter—it just doesn’t hit the same.”

The counselor explained what David was experiencing: his brain’s **reward system had been recalibrated**. The repeated surges of dopamine from opioids had **downregulated his natural receptors**, leaving everyday joys muted in comparison. David wasn’t broken or unloving; his biology had been reshaped by the very substance that once promised relief.

For David, understanding this was a turning point. He realized his emptiness wasn’t proof that he didn’t care about his family—it was proof of how deeply opioids had hijacked his brain. That knowledge helped reduce his shame and gave him the courage to commit to treatment.

## **Neuroadaptation and Tolerance**

At first, a substance may feel like magic. One pill, one drink, one line can transform a mood, easing pain or lighting up the brain with pleasure. But the brain is not a passive bystander — it adapts. With repeated exposure, the brain begins to **change its wiring**: producing fewer neurotransmitters, reducing the sensitivity of receptors, and gradually demanding **more of the substance just to feel the same effect**.

This is what we call **tolerance**. What once took a small dose now takes two, three, or more. And when the substance is taken away, the body protests. The nervous system, used to running on “borrowed chemistry,” falters. Anxiety spikes, the body aches, sleep is broken — the familiar signs of **withdrawal** (Koob, 2021).

For clients, this often feels like chasing something that is always one step ahead. They remember the relief the substance once brought, but they find themselves needing more, while enjoying it less.

---

## **Stress and the Extended Amygdala**

Addiction is not just about pleasure — it is also about **avoiding pain**. In the brain's emotional circuitry lies the **extended amygdala**, a hub that becomes overactive when withdrawal sets in. Instead of calm, the person feels restless. Instead of peace, they feel tension and despair.

This is why so many clients describe relapse not as chasing a high, but as trying to quiet an unbearable storm inside. The stress, irritability, and emotional dysregulation of withdrawal push people back toward the very substance they are trying to escape. Neuroscience shows that it isn't weakness or lack of willpower — it is the brain's stress systems firing on overdrive (Koob & Schulkin, 2023).

For counselors and therapists, this knowledge reshapes treatment. Stress is not just a side issue; it is a **core driver of relapse**. Teaching clients to manage stress — through therapy, mindfulness, healthy routines, and support networks — is as essential as addressing cravings. In many ways, recovery is less about chasing pleasure and more about learning to live peacefully without the constant weight of stress.

## **Case Vignette: “Maria and the Breaking Point”**

Maria was a 42-year-old mother of three who had worked steadily as a nursing assistant for nearly two decades. Her coworkers admired her compassion; she was the one who stayed late to comfort anxious patients, the one families sought out when they needed reassurance. But Maria carried her own silent burden: years of quiet reliance on prescription opioids after a back injury.



At first, she took the pills exactly as prescribed. Then, when her hours grew longer and her back ached more, she found herself doubling the dose. She noticed that the extra pills not only dulled her pain but softened the edge of stress after grueling shifts. Before long, she needed them not just for her back, but to get through the day.

The trouble came when her prescription was cut back. Maria tried to ration what she had, but withdrawal set in quickly. Her body

trembled at night; she felt drenched in sweat, restless, unable to sleep. At work, her patience grew thin. Small frustrations triggered outbursts she barely recognized as her own.

Then came the breaking point. One evening, after a brutal double shift and an argument with her teenage son, Maria sat in her car in the driveway, shaking. The **extended amygdala's stress circuitry was firing like an alarm**, flooding her with dread and irritability. She told herself she didn't want to relapse, but the pull to stop the pain—emotional and physical—was overwhelming. She drove to a friend who sold pills. “Just this once, just to calm down,” she thought.

Later, in counseling, Maria described the moment: *“I wasn't chasing a high. I just wanted the storm in my body to stop.”*

Her counselor explained how tolerance had changed her brain chemistry, and how withdrawal lit up her stress circuits, making relapse feel like the only escape. Together, they reframed her recovery plan: it wasn't just about avoiding opioids, but about building tools to manage stress—through therapy, mindfulness, support groups, and healthier routines.

**Clinical Relevance:** Maria's story shows why relapse prevention cannot focus only on craving and willpower. It must also address the **stress systems** that push people back to substances, teaching them new ways to quiet the storm without returning to the drug.

---

Neurobiology helps explain why clients often struggle with **loss of control** and **relapse**, even after long periods of abstinence. It supports using medication-assisted treatment (MAT) to stabilize brain chemistry while also addressing behavioral and psychosocial needs.

### 3.2 Psychological Theories of Addiction

[Author's Note: In some sections of this course, potential medication treatments are mentioned. This is provided for information purposes only. Unless licensed to do so, suggesting or prescribing medications is out of the scope of mental health professionals, unethical, and against the law. If a mental health professional determines medication might be of possible assistance, they should refer the client to a medical professional licensed to consult on such matters.]

While biological theories explore the “hardware” of addiction — the genes, brain chemistry, and neurocircuitry — **psychological theories** focus on the “software”: the learned patterns, thought processes, emotional needs, and coping strategies that shape substance use. These theories are essential for mental health professionals because they guide much of the **therapeutic intervention** in counseling and psychotherapy.

---

#### A. Cognitive-Behavioral Theories

Imagine someone at the end of a long day who whispers to themselves, *“I can't relax without a drink.”* Or a student before an exam thinking, *“I'll fail if I don't take something*

*to stay awake.*” These thoughts may feel small in the moment, but they reveal the heart of what **cognitive-behavioral theories** describe: how our patterns of thinking and behaving can trap us in cycles of substance use.

**Cognitive-behavioral** models suggest that substance use disorders are not just about the chemical pull of the drug itself, but also about the **beliefs we carry and the habits we build around them**. People may learn, often unconsciously, to link substances with relief from stress, escape from trauma, or simply a way to fill the emptiness of boredom. Over time, these associations grow stronger—“I need it” becomes a reflex thought, and reaching for the substance becomes the learned behavior that follows (Beck et al., 2022).

In this sense, addiction can be understood as a **reinforcement cycle**: distorted thoughts fuel use, and the short-term relief from using reinforces the distorted thought. Each repetition deepens the groove until it feels automatic. The good news is that these cycles can be unlearned. Through therapy, clients can begin to recognize the voice of those thoughts, challenge them, and practice new behaviors that bring relief without substances.

---

### Core Concepts in the CBT Model of Addiction

1. **Trigger** — An internal or external cue (stress, social event, emotional pain).
2. **Thought** — Often distorted, e.g., “**One drink won’t hurt**” or “I deserve this.”
3. **Craving** — Physiological and psychological urge to use.
4. **Behavior** — Substance use.
5. **Consequence** — Short-term relief, but long-term harm.

Over time, these cycles become **automatic**, making them harder to interrupt without deliberate restructuring.

---

### Case Vignette: “Lena and the Evening Glass of Wine”



Lena, 39, was a marketing manager who seemed to have it all together. She kept up with deadlines, raised two children, and hosted dinner parties with an effortless charm. Yet every night, as she walked through the door after work, one thought would flash through her mind: ***"I can't relax without a glass of wine."***



At first, it was one glass, paired with cooking dinner. But over time, one became two, then three. She told herself it was harmless—after all, plenty of people drink wine. Yet on nights when she tried to skip it, her restlessness grew. She snapped at her kids, tossed and turned in bed, and felt on edge the next morning. The thought loop reinforced itself: ***"See? I really do need the wine to calm down."***

In therapy, Lena's counselor invited her to slow down and notice that automatic thought. Together, they explored whether the wine was the only way she could relax—or whether that belief had simply become ingrained through repetition. Lena admitted she once enjoyed yoga, reading novels, and evening walks, but "none of it feels as good as wine anymore."

The counselor explained how substance use creates a **reinforcement cycle**: the thought ("I need wine to relax") leads to the behavior (drinking), which brings short-term relief, which in turn reinforces the original thought. Breaking the cycle would mean both **challenging the belief** and **experimenting with new behaviors**.

Lena began journaling her automatic thoughts, and practicing alternatives. On nights when stress spiked, she tried ten minutes of yoga or calling a friend. The first attempts felt awkward, but she noticed something: the restlessness lessened even when she skipped the wine. Over weeks, she discovered that her need wasn't for alcohol—it was for decompression, connection, and self-care.

In session, she smiled when she realized: *“I guess I don’t need wine. I just need a way to put the day down.”*

---

👉 This vignette ties theory directly to lived experience, showing how cognitive-behavioral work turns vague beliefs into concrete, modifiable patterns.

---

## Research Spotlight

Recent studies show CBT can significantly reduce relapse rates for alcohol and cocaine users when combined with motivational interviewing and contingency management (Carroll et al., 2023). Digital CBT programs are also gaining popularity, offering accessible tools for clients between sessions (Kiluk et al., 2024).

## Clinical Relevance Today

CBT is one of the most **widely available, insurance-covered, and evidence-based** approaches for SUDs. It’s particularly effective when:

- Clients can articulate thoughts and feelings.
  - There is a strong therapeutic alliance.
  - Homework (e.g., thought records) is consistently completed.
- 

## B. Psychodynamic Theories

From a psychodynamic lens, substance use is not simply a bad habit or a matter of poor choices. Instead, it is often seen as the outward expression of **inner conflicts and unmet needs**. Early relationships, the wounds we carry from childhood, and the unconscious struggles we may not even fully recognize can shape how we turn to substances later in life. In this view, addiction is less about “seeking pleasure” and more about trying to soothe **emotional pain that has never been fully healed** (Khantzian, 2021).

A client may drink not just to feel good, but to quiet the echo of loneliness. Another may rely on stimulants, not simply to stay awake, but to fight back against a buried sense of helplessness. Psychodynamic theories invite us to look beneath the surface: to ask not only *what* someone is using, but *why the substance feels necessary in the first place*.

---

## The Self-Medication Hypothesis

 Dr. Edward Khantzian's **Self-Medication Hypothesis** takes this one step further, offering a compassionate way to understand why people choose particular substances. According to this theory, substances become tools—clumsy but powerful tools—that people reach for in order to **manage unbearable feelings**.

- Someone who feels consumed by anger or aggression may find relief in the numbing calm of **opioids**.
- A person weighed down by constant **anxiety** may turn to alcohol, appreciating the temporary loosening of worry it brings.
- Someone caught in the flat emptiness of **depression** may reach for stimulants, chasing energy and drive they cannot otherwise summon (Khantzian, 2021).

The tragedy, of course, is that while these substances bring fleeting relief, they rarely heal the root wound. Over time, they deepen it. Yet the theory reminds us that addiction is not irrational—it is **a desperate attempt at self-care, using the only tools a person believes they have**.

For clinicians, this perspective shifts the tone of treatment. Instead of asking, “*Why are you doing this to yourself?*” the better question becomes, “*What pain are you trying to soothe, and how can we find safer, healthier ways to meet that need?*”

---

## Case Vignette: “Anthony and the Anxiety He Never Named”

Anthony was a 45-year-old accountant who seemed, on the surface, to have built a steady life. He was meticulous in his work, rarely missed deadlines, and was known by

colleagues as “the calm one” during tax season. But beneath his composed exterior, Anthony lived with a constant hum of **anxiety** that he never spoke of.

As a child, Anthony grew up in a home where mistakes weren’t tolerated. His father, a strict disciplinarian, often scolded him for small errors—spilled milk, a B on a test, shoes left by the door. Anthony learned to stay quiet, to keep his feelings hidden, and to strive for perfection. The lesson was clear: showing vulnerability wasn’t safe.

By the time he reached adulthood, Anthony was skilled at holding everything in. But the price was a relentless undercurrent of tension—tight shoulders, restless nights, a mind that spun through every possible mistake before it happened. Then, in his early twenties, a colleague offered him a drink after work. Anthony noticed something he had never felt before: the **buzz of alcohol softened the edges of his worry**. For the first time, he felt like he could breathe.

Over the years, the pattern deepened. One glass of wine after work became two, then three. At family gatherings, he drank just enough to quiet the nervous energy that made him feel out of place. When his wife gently asked if he thought he was drinking too much, Anthony deflected: “It’s just to take the edge off.”

In therapy, decades later, Anthony finally connected the dots. He wasn’t drinking because he loved alcohol. **He was drinking because it was the only tool he knew to calm the fear that had been wired into him as a child.** His counselor introduced Khantzian’s **Self-Medication Hypothesis**, explaining that alcohol was serving as his homemade prescription for anxiety (Khantzian, 2021). The insight struck him: *“So it’s not that I’m weak—it’s that I never learned any other way to deal with this.”*

That reframing changed everything. Together, Anthony and his counselor worked on healthier strategies for managing anxiety—deep breathing, mindfulness, exercise, and eventually, medication prescribed appropriately for his condition. For the first time in years, Anthony began to imagine evenings without wine, filled instead with genuine calm.

---

**Clinical Relevance:** Anthony's story captures the heart of the Self-Medication Hypothesis—addiction often grows out of **unmet psychological needs**, with substances serving as makeshift solutions. Understanding this allows clinicians to treat the person's pain, not just their drinking.

---

## Object Relations and Addiction

From the lens of object relations, addiction is not simply about chasing pleasure or numbing pain—it is about **longing for connection**. When children grow up with caregiving that is inconsistent, neglectful, or emotionally unavailable, they often carry an invisible ache into adulthood. The early bond that should have offered safety and stability instead leaves gaps, and those gaps can echo for years.

**For** many, substances step in as a kind of **surrogate attachment figure**. A drink, a pill, or a hit may feel like the dependable presence that was missing in childhood: always there, always soothing, always predictable. The bottle doesn't abandon. The pill doesn't criticize. The high, at least for a while, wraps around the person like the comfort they once longed to receive from a parent or caregiver (Flores, 2022).

Seen this way, addiction is not merely maladaptive behavior—it is an attempt to **repair old wounds of attachment** with the only tools the person believes they have. And for counselors, this perspective softens judgment and sharpens compassion: our clients are not simply choosing substances, they are often reaching for the closest substitute for love and security they ever knew.

---

## Case Vignette: “Samantha and the Bottle That Never Left”

Samantha grew up in a home where her mother cycled in and out of depression and her father often worked two jobs, rarely home except to sleep. As a child, she learned early that comfort wasn't reliable. Sometimes her mother would be warm and attentive, brushing Samantha's hair and asking about her day. Other times, she was withdrawn,

lost in her own sadness, leaving Samantha to make her own dinner and tuck herself into bed.



That inconsistency taught Samantha a painful lesson: she could never fully count on anyone. By the time she was in her late twenties, working as a paralegal, she carried an undercurrent of loneliness she couldn't name. On the outside, she was successful and organized. But every evening when she returned to her apartment, the silence felt crushing.

That was when she began pouring herself a glass of wine—first as a reward, then as a ritual, and eventually as a necessity. She confessed later to her counselor, *"The wine feels like a friend waiting for me at the end of the day. It's always there. It never forgets me. It doesn't leave."*

Through therapy, Samantha began to recognize how alcohol had become a **surrogate attachment figure**—a stand-in for the reliable presence she had longed for as a child. The bottle gave her the illusion of comfort and stability she never fully experienced in her early relationships.

**Clinical Relevance:** Samantha's story highlights how, from an object relations perspective, addiction is not simply about chemical dependence. It is about filling an **attachment void**, reaching for substances when early caregivers failed to provide the consistency and safety every child needs. For clinicians, recognizing this dynamic can transform treatment, shifting the conversation from *"Why can't you stop?"* to *"What is the bottle giving you that you never received elsewhere, and how can we meet that need in healthier ways?"*

### Clinical Relevance Today

While psychodynamic therapy is less common as a **stand-alone** SUD treatment in the

U.S., elements like exploring emotional meaning, building insight, and addressing attachment issues are invaluable when combined with structured methods like CBT or MAT.

---

## C. Learning Theories

Learning theories emphasize that addiction is a **conditioned behavior** reinforced over time. They draw heavily from **classical conditioning**, **operant conditioning**, and **social learning theory**.

---

### Classical Conditioning

Addiction often weaves itself into the rhythms and rituals of daily life. It's not only the substance that holds power, but the **surroundings, routines, and cues** tied to it. Just as Pavlov's dogs learned to salivate at the sound of a bell, people can find themselves craving a drink, a hit, or a smoke when certain familiar situations arise.

Think of someone who always cracked open a cold beer while watching football. Over time, the sound of a referee's whistle, the sight of a kickoff, or even the smell of game-day snacks can stir up a deep, automatic urge to drink—even if they haven't touched alcohol in months. The brain has learned: *football means beer*.

These associations can be surprisingly powerful, sparking cravings that feel as if they come out of nowhere. But what's really happening is that the brain has been **conditioned** to link specific cues with the expectation of substance use. Understanding this helps us see why relapse can feel so sudden, and why recovery work often includes identifying these "triggers" and building new responses to them.

### Case Vignette: "Mark and the Friday Night Cravings"

Mark was 29, a graphic designer who had recently completed a 30-day residential program for alcohol use disorder. He felt strong, motivated, and proud as he returned

home. He had new routines in place—morning runs, evening journaling—and he was determined to build a life that didn't revolve around drinking.

But on his first Friday night back in the city, something unexpected happened. Walking home from work, he passed the corner pub where he and his coworkers used to gather every week. The sound of laughter spilling from the doorway, the clink of glasses, and even the faint smell of fried food hit him like a wave. His chest tightened, and suddenly he was overwhelmed by an almost physical urge to step inside.

Mark was confused. *"I don't even want to drink,"* he told his sponsor later. *"But my body reacted like I needed to."*

His counselor explained that this was **classical conditioning in action**. For years, Mark's brain had paired the sights, sounds, and smells of Friday nights with the reward of alcohol. Now, even without a conscious desire, those cues triggered intense cravings.

Over the next few weeks, Mark worked with his counselor to anticipate these triggers. Instead of walking past the pub, he took a different route home. He created new Friday rituals—meeting a sober friend for coffee, or heading to the gym. Slowly, his brain began forming **new associations**, linking Friday nights with connection and accomplishment rather than alcohol.

### **Clinical Relevance:**

Mark's story illustrates how environmental cues can reignite cravings long after detox. For clients, knowing that these reactions are normal—and rooted in conditioned learning—can reduce shame and build confidence. For clinicians, it underscores the importance of helping clients both **identify triggers** and **create new, healthier associations** to replace them.

---

## **Operant Conditioning**

- **Positive reinforcement:** Substances produce pleasurable effects (e.g., euphoria from opioids).



- **Negative reinforcement:** Substances remove unpleasant states (e.g., alcohol reducing anxiety).

Addiction doesn't unfold in a vacuum. It is shaped by the way the brain learns from rewards and relief—what psychologists call **operant conditioning**. At first, substances pull people in through **positive reinforcement**. An opioid might flood the body with warmth and euphoria, or alcohol might spark a burst of social confidence at a party. Those initial moments feel good, and the brain remembers: *“This works—do it again.”*

But over time, something shifts. The high becomes less about pleasure and more about **escape**. Substances begin to serve as **negative reinforcement**—not so much creating joy as taking away discomfort. A drink eases the anxiety that's been gnawing all day. A hit of heroin stops the chills, the sweats, and the crawling skin of withdrawal.

Relief becomes the new reward. By the later stages of addiction, many people describe their use not as chasing a high, but as **avoiding misery**. What began as seeking pleasure has become a desperate attempt to quiet suffering, to feel “normal,” or simply to keep the body from unraveling (Koob, 2021).

Understanding this progression matters for clinicians. It reminds us that clients may not be coming back to substances for thrill-seeking or rebellion, but because their nervous system has learned—over countless repetitions—that the substance is the only reliable way to make the pain stop.

---

### **Case Vignette: “Kevin and the Morning Shot”**

Kevin was 28 when he first tried heroin. At the time, he was working construction and hanging out with a group of older friends who partied after long shifts. His first hit felt like a revelation—warmth spread through his body, his worries melted away, and for a few hours, he felt unstoppable. *“This is it,”* he thought. *“This is what I've been missing.”*

In those early months, Kevin used on weekends for the rush, for the glow that made him feel alive and connected. This was **positive reinforcement** in action: the drug brought pleasure, and the pleasure kept him coming back.

But as the months stretched into years, something shifted. The high wasn't as strong anymore. What once took one bag now took three. And worse, when Kevin didn't use, his body rebelled. His mornings began with shaking hands, cold sweats, and cramps that twisted his stomach into knots. The only way to make it stop was another shot.

By then, heroin was no longer about chasing euphoria. It was about **avoiding misery**. Kevin would tell his counselor later: *"I wasn't even getting high anymore. I just didn't want to feel sick."*

In therapy, this realization became a breakthrough. His counselor explained how the brain's learning systems had shifted—from seeking pleasure to seeking relief. Kevin wasn't weak or hopeless; his nervous system had been rewired to survive on heroin. That understanding gave him a language for his struggle—and a reason to hope that with treatment, his brain could learn new ways to feel balanced again.

### **Clinical Relevance:**

Kevin's story captures the essence of **operant conditioning in addiction**. At first, substances reward with pleasure. Later, they "reward" by removing unbearable withdrawal symptoms. Recognizing this shift helps clinicians explain why recovery often feels less about giving up a thrill, and more about finding freedom from a cycle of misery.

---

### **Social Learning Theory**

**Alb**ert Bandura's model reminds us that people don't just learn from trial and error—they learn by **watching the world around them**. For many clients, the first lessons about substances come not from a health class or a pamphlet, but from the people closest to them.

A teenager might watch an older sibling crack open a beer after school and notice how the stress of the day seems to melt away. A child might see a parent take a pill before bed and connect it with relief. When those behaviors appear to bring comfort, fun, or belonging, the message takes root: *“This is how people cope. This is what grown-ups do. This is how I can feel better too.”*

The same patterns play out in broader culture. Movies, music, and social media often paint drinking or drug use as glamorous, adventurous, or even romantic. A night of heavy drinking might be framed as comic relief; a character’s drug use might be linked to their creativity or confidence. These portrayals quietly **normalize risky behavior**, making it seem less like a danger and more like a rite of passage (Bandura, 2020).

For clinicians, Bandura’s insight is a reminder that substance use is not learned in isolation. It’s absorbed through **modeling**, through the examples people see in their families, peer groups, and culture. And it means that recovery, too, can be modeled—clients can learn healthier ways of coping by observing and imitating positive role models in therapy, peer groups, or supportive communities.

### **Case Vignette: “Jordan and the Friday Night Lessons”**

Jordan was 16 when he first started drinking. His parents didn’t allow alcohol in the house, but every Friday night, he hung out at his best friend’s place where older siblings kept the fridge stocked with beer. At first, Jordan wasn’t sure he wanted to join in. But as he watched his peers laughing, joking, and loosening up with each bottle, he felt the pull.



One night, a friend handed him a drink and said, “C’mon, everyone’s doing it—it’s just fun.” Jordan hesitated, then took a sip. The beer tasted bitter, but the laughter around him seemed sweeter. The connection, the sense of belonging—that was what stuck. Soon, Friday nights weren’t just about hanging out; they were about drinking, because that was what the group modeled as the way to relax and connect.

**Later, in counseling, Jordan reflected: “It wasn’t that I loved the taste. It was that I wanted to feel part of the group. Drinking was the ticket in.”**

His counselor helped him see how those early experiences shaped his beliefs—how **observing his peers’ behavior and the rewards they seemed to get** (fun, confidence, acceptance) had taught him to associate alcohol with belonging. It wasn’t about weakness; it was about learning by example.

**Clinical Relevance:** Jordan’s story illustrates Bandura’s insight that people often learn substance use by **watching others and imitating what seems rewarding**. For clinicians, this perspective reinforces the value of creating **new, positive role models** in recovery—peer groups, mentors, and communities where clients can observe and practice healthier ways of coping.

---

### Clinical Relevance Today

Learning theory principles are applied in relapse prevention, cue exposure therapy, and family interventions. They remind us that changing **environmental contingencies** is as important as changing thoughts or biology.

### 3.3 Sociocultural Theories of Addiction

Biological and psychological perspectives explain much about *individual vulnerability* to substance use disorders, but addiction does not occur in a vacuum. **Sociocultural theories** examine how *the environment, cultural norms, and social structures* influence the development and persistence of substance use problems. For mental health and addiction professionals, these theories are crucial because they reveal how **social context can either protect against or promote substance misuse** (Room et al., 2023).

---

#### A. Family Systems Perspectives

Family systems theory invites us to see addiction not as an isolated problem living inside one person, but as part of the larger **emotional ecosystem of the family**. In this model, families are like intricate webs—when one strand is pulled, the entire structure trembles.



When a son drinks heavily, his parents may react with worry, anger, or denial; siblings may feel overlooked or pressured to keep the peace. When a parent struggles with substance use, children often adapt in ways that ripple into their own adult lives—becoming caretakers too early, withdrawing emotionally,

or acting out to draw attention. In every case, the family shifts, sometimes subtly and sometimes dramatically, around the person's behavior.

This perspective reminds us that substance use is both **shaped by family dynamics and shapes them in return** (Bowen, 2020). Addiction can create distance, tension, or

rigid roles, but it can also be maintained by long-standing patterns of communication, conflict, and coping within the household.

For clinicians, the family systems lens is powerful because it encourages us to look not only at the individual who uses substances, but at the whole circle of relationships. Healing, then, becomes more than helping one person stop using—it's about helping families find new ways to connect, communicate, and support one another.

---

## Key Concepts

### 1. Roles in Addicted Families —

When addiction enters a family, it rarely affects just one person. Like ripples in a pond, its impact spreads through every relationship, often creating **recurring roles** that family members unconsciously step into in order to keep the system going. These roles don't make anyone "good" or "bad"—they are survival strategies, ways of coping in a household that feels unpredictable or unsafe.

- **The Enabler** is often the caretaker of the family. They smooth over consequences, cover up mistakes, and do whatever they can to maintain stability. To outsiders, they may look strong and supportive, but inside they often feel exhausted and resentful. Their efforts to protect the addicted person come from love, but can also unintentionally shield them from facing the truth.
- **The Hero** becomes the family's bright star. Through achievement and responsibility, they work tirelessly to distract from the chaos at home. Straight-A grades, overachievement at work, or relentless "success" can be their way of shouting to the world: *"We're okay."* Yet beneath the polished surface, heroes often carry anxiety and perfectionism, terrified of failure.
- **The Scapegoat** acts out, drawing negative attention to themselves. Their misbehavior—skipping school, breaking rules, getting into fights—redirects focus away from the addicted person. Seen as the "problem child," they often carry

unspoken pain and anger, expressing through rebellion what others feel but cannot say.

- **The Lost Child** retreats into the background. Quiet and withdrawn, they avoid conflict by disappearing emotionally or physically. They may escape into books, video games, or solitude. While their silence keeps them out of the family storm, it often comes at the cost of their own voice, leaving them feeling invisible.
- **The Mascot** lightens the tension with humor. They crack jokes, act silly, or play the clown, trying to bring relief to heavy moments. Their laughter can temporarily soothe the family's pain, but it can also mask their own deep fear and sadness.

These roles don't define a person forever, but they can shape how individuals grow, relate to others, and even carry patterns into adulthood. For clinicians, recognizing these dynamics offers a doorway to healing—helping families see not only the struggles behind each role, but also the strengths and resilience hidden within them.

### **Composite Family Vignette: The Martinez Family**

The Martinez household looked ordinary from the outside: a small suburban home, a dog in the yard, kids on bikes in the driveway. But inside, the family had been shaped for years by Mr. Martinez's struggle with alcohol use.

#### **The Enabler: Mrs. Martinez**

Mrs. Martinez worked tirelessly to hold everything together. She covered for her husband's missed workdays, made excuses to the kids, and smoothed things over with neighbors when arguments grew too loud. "He's just under a lot of stress," she'd say, even when her own exhaustion showed. Her caregiving came from love, but it also protected her husband from facing the full weight of his addiction.

#### **The Hero: Emily, 17**

Emily, the eldest, responded by striving for perfection. She threw herself into schoolwork, sports, and community volunteering. Her trophies lined the shelves in the

living room, silent evidence that “at least one of us is making the family look good.” On the outside, she was a model student; on the inside, she carried crushing pressure and a constant fear of failure.

### **The Scapegoat: Jake, 15**

Her younger brother Jake went the opposite direction. He skipped classes, picked fights at school, and earned a reputation as “the problem kid.” When teachers called home, the focus shifted away from Mr. Martinez’s drinking to Jake’s behavior. His rebellion was less about mischief and more about unspoken anger—anger at his dad’s absence, anger at the constant tension, anger that no one seemed to notice his pain.

### **The Lost Child: Lily, 10**

Then there was Lily, the quiet one. She spent most of her time in her room, drawing or reading. She never argued, never complained, never made demands. In many ways, she was the easiest child in the house—so easy, in fact, that she often faded into the background. Her withdrawal was her way of staying safe, but it also left her lonely and unseen.

### **The Mascot: Danny, 7**

Finally, little Danny had learned to make everyone laugh. At the dinner table, when the air grew heavy with silence, he would crack a joke or make a funny face. His humor lifted spirits, if only for a moment. But behind his clowning was a child who worried deeply, carrying more fear than he let on.

## **Clinical Relevance**

The Martinez family shows how addiction rearranges an entire household. Each member developed a role—Enabler, Hero, Scapegoat, Lost Child, Mascot—not because they chose it, but because the family system needed ways to cope with chaos and pain. These roles helped them survive, but they also shaped how each child saw themselves and related to the world.



For counselors, seeing these patterns can transform treatment. It reminds us that recovery is not just about helping Mr. Martinez stop drinking. It's also about helping Emily loosen her perfectionism, Jake find healthier ways to express anger, Lily learn to speak up, and Danny discover he doesn't have to be funny to be loved.

---

## **The Martinez Family: A Glimpse of Recovery**

When Mr. Martinez finally entered treatment and began working toward sobriety, the ripples through the family were just as profound as the ripples of his drinking had once been. Healing didn't happen overnight, but with counseling and support, each family member slowly stepped out of the rigid roles that addiction had carved for them.

### **Mrs. Martinez, the Enabler**

For years she carried the family on her back, covering up and smoothing over crises. In therapy, she began to learn that protecting her husband from consequences was not the same as supporting his recovery. Letting go was terrifying, but she discovered she could care without rescuing. As she put it in one session: *"I'm learning to stand beside him, not in front of him."*

### **Emily, the Hero**

Emily's perfectionism had been her shield. In family therapy, she admitted how exhausting it was to always be "the good one." With encouragement, she allowed herself to be a teenager again—going to the movies with friends, letting grades slip from perfect A's to healthy balance, and realizing that her worth wasn't tied to achievement.

### **Jake, the Scapegoat**

Jake's anger had long masked his hurt. When the family began talking openly about Mr. Martinez's drinking, he no longer needed to act out to be noticed. With his pain validated, Jake began to channel his energy into constructive outlets—joining a boxing gym where his strength was celebrated, not punished.

### **Lily, the Lost Child**

For Lily, simply being seen was healing. Family therapy gave her space to speak up and

share her drawings, which often expressed feelings she couldn't put into words. Her parents began making a conscious effort to invite her into conversations, and slowly she found her voice.

### **Danny, the Mascot**

Little Danny's humor was still a gift, but he learned he didn't have to carry the family's mood on his shoulders. When he cracked jokes now, it was because he wanted to—not because he felt responsible for keeping everyone smiling.

### **Clinical Relevance**

The Martinez family's journey shows that when recovery begins, **roles can loosen**. Each family member starts to reclaim parts of themselves that had been hidden or distorted by addiction. For clinicians, this highlights why family work is so important: true healing is not just about one person's sobriety, but about giving the entire family permission to grow, shift, and connect in new ways.

## **2. Intergenerational Transmission**

Addiction rarely begins in a vacuum. Families carry stories, wounds, and coping strategies across generations, sometimes without even realizing it. What one parent or grandparent couldn't resolve often echoes forward, shaping the lives of children and grandchildren.

In households where substance use was present, children grow up watching, absorbing, and learning—even when nothing is spoken out loud. A daughter who saw her father cope with stress by drinking may come to believe that alcohol is the natural way to ease tension. A son who watched his mother disappear into prescription pills may unconsciously carry that script into his own adulthood. These aren't simply bad choices; they are **learned behaviors woven into the family fabric**.

Unresolved trauma is another powerful thread. A grandmother who lived through violence or poverty may never speak of her pain, but the patterns of silence, fear, or

self-medication ripple into the next generation. Trauma that isn't healed often finds expression in the behaviors of children and grandchildren—sometimes through anger, sometimes through withdrawal, sometimes through turning to substances as a substitute for comfort.

This is the heart of **intergenerational transmission**: the way dysfunction, especially substance misuse, can travel down family lines. But the story doesn't have to end there. What is passed down can also be interrupted. When one person begins to heal—seeking therapy, breaking old patterns, naming what was once unspoken—they plant the seeds of a different legacy. Recovery, in this sense, is not only for the individual but for their children and generations yet to come.

---

When an adolescent struggles with substance use, it rarely affects only them. Parents, siblings, and even extended family often carry the weight—sometimes in silence, sometimes in conflict, always in pain. That's why approaches like **Multidimensional Family Therapy (MDFT)** have been so powerful: they don't just treat the young person, they invite the whole family into the healing process.

In MDFT, the focus isn't simply on stopping drug use. It's about **repairing relationships, opening communication, and creating a supportive environment** where recovery has a chance to grow. Parents learn new ways to set limits and show care without slipping into criticism or control. Teens are given space to voice their struggles and to see themselves not as “the problem” but as part of a family that can change together.

Research has shown that this kind of intervention makes a real difference. Adolescents who participate in MDFT are not only less likely to relapse, but families often report feeling closer, stronger, and better able to handle stress (Liddle et al., 2024). What begins as treatment for substance use becomes an opportunity for the entire family to find a healthier rhythm—one where connection replaces conflict, and where hope is no longer carried by one person alone, but shared by everyone at the table.

## Clinical Relevance Today

For counselors, understanding family dynamics can prevent treatment from focusing solely on the individual and overlooking powerful systemic influences that may undermine recovery.

---

## B. Peer Influence and Social Networks

Humans are wired for connection. From adolescence through adulthood, we look to our friends and peers to guide us, shape us, and reassure us about who we are. That sense of belonging can be life-giving—but it can also make us vulnerable. In the context of substance use, peers are often among the most powerful influences in both **starting** and **sustaining** patterns of drinking or drug use.

A teenager may take their first sip of alcohol not because they craved it, but because their friends were laughing around a bonfire and they didn't want to feel left out. A college student might experiment with stimulants during finals after watching classmates lean on them to study all night. Even adults, surrounded by colleagues or neighbors who normalize heavy drinking, may find themselves reaching for a glass more often than they ever planned.

In each case, the pull is less about the substance itself and more about the **desire to belong, to feel included, to share in what others seem to enjoy**. Understanding this truth helps clinicians see substance use not simply as a solitary act, but as part of the social fabric people are constantly navigating.

---

## Mechanisms of Peer Influence

The way peers shape substance use is rarely a single moment of pressure—it's a web of experiences that unfold quietly and powerfully in daily life.

**Modeling** often comes first. A young person sees their friends drinking at a party or smoking in the school parking lot and notices they seem relaxed, confident, or popular. Even if no one says a word, the message is clear: *“This is what people my age do.”* The simple act of watching peers use substances without obvious harm can make risky behaviors seem ordinary.

Then there is **direct pressure**, which can be as subtle as a teasing nudge or as blunt as, *“Don’t be lame, just try it.”* For someone craving acceptance, that moment can feel like a crossroads between belonging and rejection. Saying no may feel riskier than saying yes.

Perhaps most powerful of all are **perceived norms**. Even if only a few peers are drinking heavily or experimenting with drugs, it’s easy for someone to believe, *“Everyone is doing it.”* That belief alone can lower defenses and make trying substances feel not only acceptable but expected.

For many clients, their first steps into substance use weren’t about rebellion—they were about connection. Understanding these mechanisms helps us see that peer influence isn’t simply peer pressure; it’s the natural human pull to fit in, to feel safe in a group, and to not be left behind.

**Table 4. Peer Influence Pathways in Substance Use**

| Pathway         | Example                              | Possible Intervention                                                                                            |
|-----------------|--------------------------------------|------------------------------------------------------------------------------------------------------------------|
| Modeling        | Watching older siblings smoke        | Mentorship programs                                                                                              |
| Direct Pressure | Friends offering cocaine at parties  | Refusal skills training                                                                                          |
| Perceived Norms | Believing “all students binge drink” |  Social norms media campaigns |

---

## C. Societal and Cultural Pressures

The way we think about substances is never shaped in isolation. It's shaped by the culture we grow up in—the stories we hear at the dinner table, the rituals we see at weddings and holidays, the commercials on TV, the laws in our communities. Culture quietly teaches us what's "normal," what's acceptable, and what's off-limits.

In some cultures, drinking a glass of wine with dinner is a sign of refinement and celebration. In others, alcohol is seen as dangerous, forbidden, or taboo. Some societies celebrate cannabis as medicine or spiritual aid, while others criminalize it harshly. Even within the same country, norms can vary: a college campus where binge drinking is expected feels very different from a faith community where abstinence is the rule.

These cultural messages don't just set the stage—they shape the decisions people make every day. A young adult might drink not because they truly want to, but because they've grown up in a social circle where *not* drinking feels abnormal. Someone else might carry deep shame around substance use because their cultural background labels it as moral failure rather than illness.

For clinicians, understanding these pressures matters deeply. When a client sits across from us, they are not only bringing their personal story—they are bringing the weight of cultural expectations, family traditions, and societal judgments. Healing, then, is not only about changing behavior, but also about helping clients navigate the powerful voices of culture that tell them what their substance use means.

## 3.4 DSM-5-TR and ICD-11 Criteria for Substance Use Disorders

### A. Overview of Diagnostic Frameworks

When we talk about substance use disorders (SUDs), it's important to recognize that clinicians around the world use **shared frameworks** to guide diagnosis. These frameworks aren't just technical checklists—they are roadmaps that help providers speak the same language, ensure consistency in care, and give clients clarity about what they're facing.

In the United States, the most widely used system is the **DSM-5-TR (Diagnostic and Statistical Manual of Mental Disorders, Text Revision)**. Published by the American Psychiatric Association, the DSM provides the criteria that most U.S. clinicians use in practice. It shapes not only how providers assess and diagnose but also how treatment is documented for research, billing, and insurance purposes (APA, 2022).

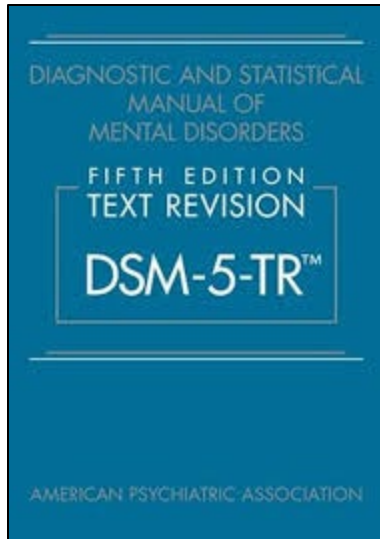
Internationally, the **ICD-11 (International Classification of Diseases, 11th Revision)** plays a similar but broader role. Developed by the World Health Organization, the ICD is used across many countries for clinical practice, public health surveillance, and epidemiology. It serves as a tool for coding and tracking diseases globally, making it essential for understanding larger trends and shaping policy (WHO, 2022).

While both systems aim for the same outcome—**better diagnostic reliability and clearer communication**—they are not identical. The DSM-5-TR provides a detailed, clinically focused picture of substance use disorders, often with more emphasis on mental health practice in the U.S. The ICD-11, meanwhile, emphasizes accessibility across cultures and health systems, with slightly different terminology and categories designed for use in international contexts.

For clinicians, the key takeaway is this: whichever framework is used, the goal remains the same—to provide clients with an accurate understanding of their condition and a pathway toward effective care. These tools remind us that while the details may differ, the global effort to recognize and treat substance use disorders is shared.

---

## B. DSM-5-TR Criteria



In earlier editions of the DSM, clinicians faced a split when diagnosing substance problems: was it “abuse” or was it “dependence”? For many providers, this division created confusion, and for many clients, it felt limiting. The reality of substance use didn’t always fit neatly into one category or the other.

With the **DSM-5-TR**, that separation was replaced by a more unified and flexible approach. Instead of dividing people into “abuse” versus “dependence,” the manual now describes a single diagnosis: **Substance Use Disorder**

(**SUD**). Each type of substance—alcohol, opioids, cannabis, stimulants, and others—has its own version, such as **Alcohol Use Disorder** or **Opioid Use Disorder**.

This change might sound technical, but in practice it reflects a shift toward greater compassion and accuracy. Rather than forcing a client into one box or another, the DSM-5-TR allows clinicians to assess a **spectrum of severity**, from mild to severe. It acknowledges that substance use exists on a continuum—that someone struggling with weekend binge drinking is not in the same place as someone experiencing daily withdrawal, but both deserve to have their challenges recognized and addressed.

For clients, this framework can feel validating. It moves the conversation away from rigid labels and toward a more nuanced understanding: *“This is where I am right now, and here’s how we can help.”*

---

## 1. The DSM Criteria

A diagnosis requires meeting **at least 2 criteria** within a **12-month period**:

### # DSM-5-TR Criterion

- 1 Taking the substance in larger amounts or for longer than intended.



## # DSM-5-TR Criterion

- 2 Persistent desire or unsuccessful efforts to cut down or control use.
  - 3 Spending a great deal of time obtaining, using, or recovering from the substance.
  - 4 Craving, or a strong desire/urge to use.
  - 5 Recurrent use resulting in failure to fulfill obligations at work, school, or home.
  - 6 Continued use despite persistent/recurrent social or interpersonal problems caused by use.
  - 7 Giving up or reducing important activities because of use.
  - 8 Recurrent use in physically hazardous situations.
  - 9 Continued use despite knowledge of having a physical or psychological problem likely caused/exacerbated by use.
  - 10 Tolerance — needing more to achieve the same effect or reduced effect with the same amount.
  - 11 Withdrawal — characteristic symptoms or use to avoid withdrawal.
- 

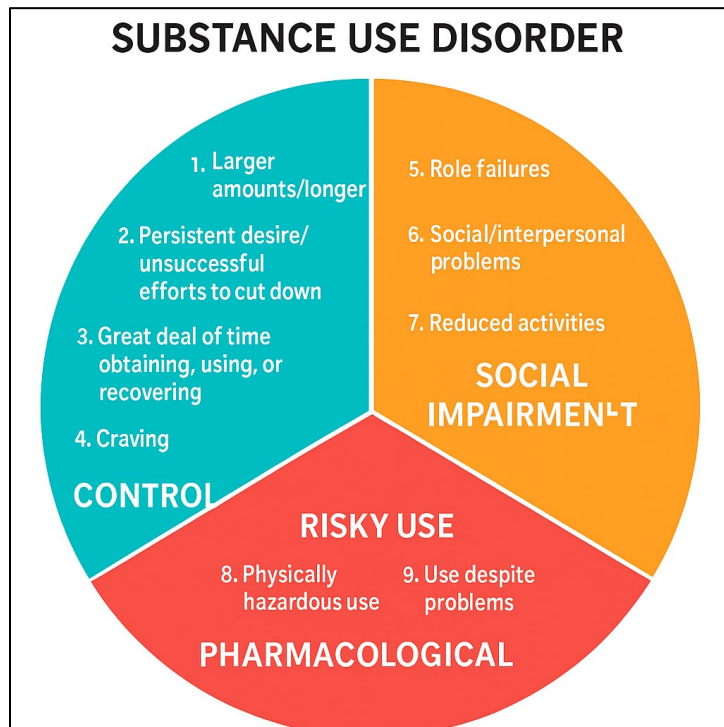
## 2. Severity Levels

- **Mild**: 2–3 symptoms
- **Moderate**: 4–5 symptoms
- **Severe**: 6+ symptoms

One of the most important shifts in the DSM-5-TR is that it recognizes substance use disorders on a **continuum of severity**. Instead of dividing people into rigid “abuse” versus “dependence” labels, it asks: *How many criteria are present, and how much do they affect a person’s life?*

- **Mild SUD**

Someone with a mild substance use disorder may meet just a couple of criteria—say, drinking more than intended and feeling unable to cut back. They might still be working, caring for their family, and keeping up with responsibilities, but their use is starting to take up more space than they want. Often, these clients feel conflicted: *“I’m not out of control, but I’m not happy with this, either.”*



- **Moderate SUD**

In the moderate range, the disorder is harder to ignore. The person may be missing work, arguing with loved ones, or spending more time and energy planning when and how they’ll use. They might have tried to stop several times, only to relapse. There’s still a sense of agency, but the substance is beginning to drive decisions rather than the other way around.

- 

- **Severe SUD**

At the severe end of the spectrum, the substance has become the center of life. Health is declining, relationships are fractured, finances may be unstable, and withdrawal symptoms are common. People in this stage often describe their use not as chasing pleasure, but as trying to stave off misery or keep from “falling apart.” Here, the criteria don’t just signal a diagnosis—they paint a picture of a life narrowed by the gravitational pull of addiction.

---

## Why This Matters

For clients, hearing “mild,” “moderate,” or “severe” can be a relief. It places their experience on a spectrum rather than stamping them with an all-or-nothing label. For clinicians, it offers a framework for tailoring treatment—recognizing that someone with mild SUD may benefit from brief interventions, while someone with severe SUD may need intensive, multi-layered care.

At its heart, this framework gives us a more **compassionate language**. It reminds us that substance use is not a single fixed identity, but a dynamic condition that can worsen—or improve—with time, support, and treatment.

---

### **Case Vignette: Moderate Substance Use Disorder — “Marcus and the Missing Mondays”**

Marcus, 42, worked in IT. His colleagues noticed he was often “sick” on Mondays. In truth, Marcus was recovering from weekend binges. His drinking had started as stress relief after work, but now it stretched into entire weekends. His wife complained that he was less present with the kids, and his work performance was slipping.

Marcus admitted he had tried to stop “more times than I can count,” but by midweek, the pull to drink was overwhelming. He wasn’t facing legal trouble yet, but he could see the toll: arguments at home, mounting absences at work, and a growing sense of shame.

**Clinical note:** Marcus met 5–6 criteria, including failed attempts to quit, neglecting responsibilities, and continued use despite problems—placing him in the **moderate SUD** range. Treatment included CBT, family therapy, and a relapse prevention plan.

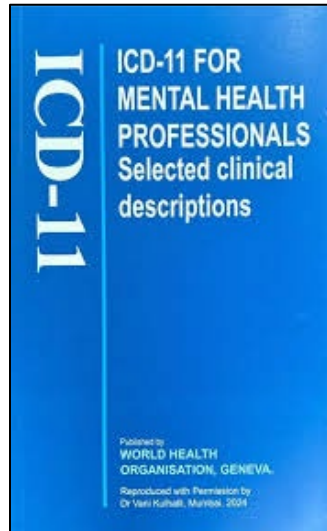
### **Clinical Relevance Today**

The DSM-5-TR is essential for **treatment planning, insurance reimbursement, and research** in the U.S. Mental health professionals must document **both the criteria met and severity level** to meet billing and reporting requirements.

---

## C. ICD-11 Criteria

While the DSM-5-TR is the tool most often used in U.S. clinical practice, the **ICD-11 (International Classification of Diseases, 11th Revision)** takes a broader, more



global view. Developed by the World Health Organization, the ICD was designed with cultural diversity in mind—meant to be useful not only in large academic hospitals but also in community clinics, rural health systems, and countries with very different resources and traditions of care.

In this framework, substance-related conditions are grouped under “**Disorders due to substance use or addictive behaviours.**” This inclusive category recognizes that addiction can take many forms, whether tied to alcohol, opioids, stimulants, or even non-substance behaviors like gambling (WHO, 2022). The language of the ICD is intentionally more flexible, giving space for cultural adaptability so clinicians across the world can diagnose and treat within the realities of their own health systems.

For clients, this global perspective matters. It signals that substance use disorders are not confined to one culture or nation—they are a shared human struggle, recognized and addressed across borders. For clinicians, it provides a common vocabulary that makes it possible to compare research, track global health trends, and understand how different societies respond to the challenge of addiction.

---

### 1. Core Diagnostic Features

The **ICD-11** describes substance use disorders in a way that feels both simple and profound: it asks us to look for the patterns that show when substance use has truly begun to take over a person’s life. A diagnosis of “**Disorder due to substance use**”

requires at least two of three key features to be present over the course of a year—or in some cases, over a much shorter time if the severity is clear.

The first is **impaired control**. This might look like someone who promises themselves they'll only have one drink, but again and again finds the evening ending with far more. Or it might be the person who swears off pills in the morning but finds themselves unable to resist by night. The heart of this feature is the feeling of being *pulled back in*, even when the intention to stop is genuine.

The second feature is when substance use begins to take **priority over other parts of life**. Hobbies fade. Responsibilities slip. Relationships strain. What once mattered deeply—family dinners, work deadlines, favorite pastimes—starts to feel secondary to the need for the next drink, pill, or hit.

The third is the presence of **physiological signs** such as tolerance and withdrawal. The body itself adapts, demanding more of the substance to achieve the same effect, and punishing its absence with symptoms ranging from irritability and anxiety to tremors and seizures. These physical changes often make the cycle of use even harder to break.

Together, these three features create a picture that is recognizable across cultures and health systems (WHO, 2022). They remind us that while the details of a client's story may differ, the **core markers of addiction are universal**: loss of control, shifting priorities, and the body's deep entanglement with the substance.

---

## 2. Harmful Pattern of Use

Not every person who struggles with substances meets the full criteria for a substance use disorder. The **ICD-11** makes space for this nuance with a diagnosis called **Harmful Pattern of Use**.

This category is used when substance use is clearly causing harm—whether to a person's **physical health** (like liver damage from heavy drinking) or their **mental health**

(like worsening anxiety from cannabis use)—but the pattern hasn’t yet reached the level of full dependence or loss of control.

Think of someone who drinks heavily on weekends and ends up in the emergency room with an injury, but doesn’t experience cravings or withdrawal during the week. Or a young professional who uses stimulants to power through long workdays, only to find their sleep and mood spiraling downward. In both cases, the use is **hurting them**, even if it doesn’t fit neatly into the picture of a substance use disorder.

This diagnosis matters because it allows clinicians to **name the harm early**, before the cycle of tolerance, withdrawal, and impaired control has fully taken hold. It offers an opening for conversation, education, and intervention—an opportunity to change course before the problem deepens. In this way, “Harmful Pattern of Use” acknowledges something many clients know in their gut: *“I may not be addicted, but this is hurting me.”*

**Table 5. DSM-5-TR vs. ICD-11: Key Differences**

| Feature               | DSM-5-TR                 | ICD-11                                       |
|-----------------------|--------------------------|----------------------------------------------|
| Terminology           | Substance Use Disorder   | Disorder due to Substance Use                |
| Severity Grading      | Mild, Moderate, Severe   | Not formalized; severity implied by features |
| Criteria Count        | 11 specific criteria     | 3 broad core features                        |
| Harmful Use           | Folded into SUD criteria | Separate diagnosis category                  |
| Cultural Adaptability | Primarily U.S.-oriented  | Global health focus                          |

**Clinical Relevance Today**

ICD-11 is now the **official standard for international health reporting**. For U.S.

practitioners, familiarity is crucial when working with global organizations, participating in WHO studies, or treating clients from diverse cultural backgrounds.

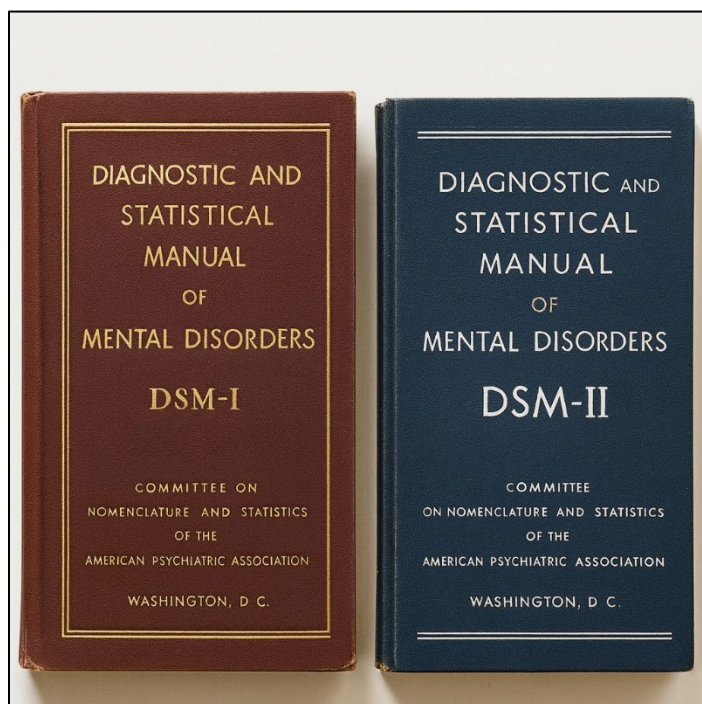
## D. Historical Evolution of Substance Use Diagnoses

Understanding how diagnostic criteria evolved helps professionals appreciate **why certain features are included or excluded** today.

---

### 1. Early DSM Versions

- **DSM-I (1952):** Substance-related disorders described vaguely as “addictions” or “habit disturbances,” without clear operational definitions.
- **DSM-II (1968):** Continued to use non-specific terms like “drug dependence,” reflecting limited research and strong stigma at the time.



When the DSM-I was first published in 1952, the way it described substance-related problems reflected the times. Addiction was spoken of vaguely, lumped into terms like “habit disturbances” or “addictions,” without the kind of clear definitions we rely on today. These early descriptions carried more judgment than clarity—rooted in moral overtones rather than science.

By the time the DSM-II arrived in 1968, the language had shifted slightly, but not by much. Terms like “drug dependence” appeared, yet the framework was still imprecise. The science of addiction was in its infancy, and stigma loomed large. People struggling with alcohol or drugs were often seen as weak-willed or morally

flawed rather than as individuals facing a health condition. The manual mirrored that limited understanding, providing clinicians with little guidance beyond labels that carried social weight but offered few practical insights.

Looking back, these early DSMs tell us as much about the cultural attitudes of their time as they do about psychiatry itself. Addiction wasn't yet seen as a medical disorder with clear diagnostic features—it was viewed through a hazier, judgmental lens. And for those living with substance struggles, this meant fewer paths to understanding, support, or treatment.

---

## 2. DSM-III (1980) Breakthrough

- Introduced **operationalized criteria** for substance abuse vs. substance dependence.
- Abuse = maladaptive pattern causing social/occupational/legal problems.
- Dependence = tolerance, withdrawal, compulsive use.

By 1980, the release of the DSM-III marked a sea change in how psychiatry approached substance use. The field was beginning to embrace science more fully, and the language started to shift from moral judgment to clinical description. Substance-related problems were no longer grouped under vague labels; instead, terms like “substance abuse” and “substance dependence” appeared as separate categories.

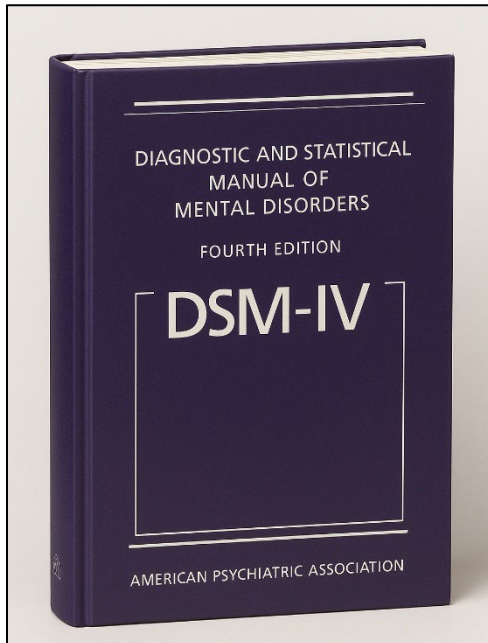
This distinction reflected a new seriousness. “Abuse” was used when people were experiencing harmful consequences from use—missed work, legal trouble, strained relationships—while “dependence” was tied more closely to physiological changes, like tolerance and withdrawal. For the first time, clinicians had more structured criteria, and treatment centers could point to language that carried medical weight. Still, even with these advances, the division between “abuse” and “dependence” sometimes left clients in confusing gray areas.

---



### 3. DSM-IV (1994)

- Retained abuse vs. dependence, but research revealed **low reliability** — many people with dependence also met abuse criteria.
- The division was criticized as **arbitrary and stigmatizing** (Hasin et al., 2013).



By 1994, when the DSM-IV was published, the science of addiction had moved further along. The categories of “substance abuse” and “substance dependence” were refined, with more precise diagnostic criteria. This era reflected growing recognition that addiction was not simply a failure of willpower but a complex medical condition involving biology, psychology, and environment.

For clients and families, this shift mattered. Substance use disorders were now being discussed more openly as health conditions rather than moral failings. Treatment approaches grew

more diverse, drawing from evidence-based therapies, medical support, and prevention strategies. Still, the split between “abuse” and “dependence” sometimes created challenges—especially for people who didn’t fit neatly into one category. Clinicians and researchers began to see the need for a more unified, spectrum-based model.

### Looking Ahead

These gradual shifts—from the vagueness of the DSM-I and II, through the structure of DSM-III, to the refinements of DSM-IV—tell a larger story: the field of addiction science was slowly breaking away from stigma and moving toward compassion, clarity, and evidence. Each edition was a step closer to seeing substance use disorders not as personal flaws, but as health conditions that deserved understanding and treatment.

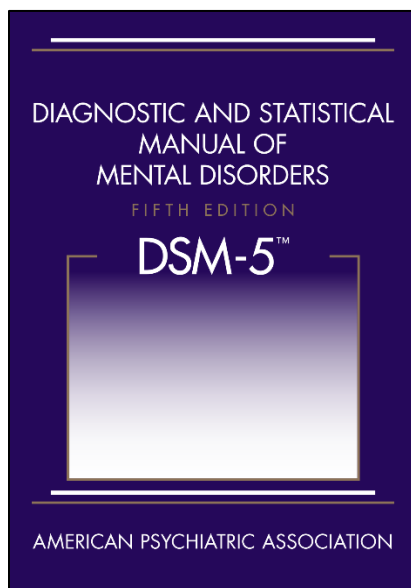
It was this trajectory that eventually led to the **DSM-5's unification** of abuse and dependence into one continuum of **substance use disorders**, a model that reflects both science and humanity more faithfully.

---

#### 4. DSM-5 (2013) & DSM-5-TR (2022)

- Merged abuse and dependence into a **single continuum**: Substance Use Disorder.
- Added “**craving**” as a criterion, reflecting neuroscience findings.
- Introduced **severity specifiers**.
- DSM-5-TR refined language for clarity and inclusivity but retained the 11 criteria.

#### DSM-5 (2013): Unifying the Diagnosis



By the time the DSM-5 was released in 2013, the field had learned from decades of clinical experience. Researchers and clinicians alike recognized that splitting substance problems into “abuse” and “dependence” categories wasn’t serving clients well. Too often, people slipped through the cracks—struggling but not “meeting criteria,” or bouncing between labels that didn’t fully capture their experience.

The DSM-5 introduced a unified diagnosis: Substance Use Disorder (SUD). Instead of separating abuse and dependence, all substance-related problems were now

seen along a continuum of severity: mild, moderate, or severe. This was a compassionate and practical shift. It meant that a young adult binge drinking on

weekends and a middle-aged person experiencing daily withdrawal were understood as being on the same spectrum—different points, same condition.

This change also reflected advances in science. By then, decades of research had shown that substance use disorders share common features across substances and across cultures: impaired control, prioritization of use, and physiological changes. The DSM-5 captured these realities with clearer, evidence-based criteria.

### DSM-5-TR (2022): Refining the Language



The DSM-5-TR (Text Revision), published in 2022, didn't overhaul the structure but refined it with updated language, research, and cultural considerations. It acknowledged new findings on the neurobiology of addiction, clarified diagnostic thresholds, and worked to reduce stigma through more precise terminology.

For example, the TR version took care to use language that better reflects lived experience and avoids moralizing overtones. This evolution in tone matters: when clinicians use respectful, non-stigmatizing language, clients are more likely to feel understood rather than judged.

### The Larger Story

From the vague “habit disturbances” of the DSM-I to the refined spectrum of the DSM-5-TR, this journey tells a larger story of progress. Each edition reflects not only advances in science but also shifts in cultural attitudes—from stigma and blame toward compassion and recognition of addiction as a legitimate health condition.

For today's clinicians, the DSM-5-TR is more than a diagnostic manual. It's the culmination of decades of learning, reminding us that substance use disorders are

complex, human conditions that deserve clear understanding, respectful language, and evidence-based care.

---

## E. Practical Assessment Tips

Assessing substance use disorders can feel complex, but it becomes more manageable when we lean on structured, thoughtful practices. These tips aren't just technical steps—they're ways to make sure we're seeing the whole person in front of us, not just their symptoms.

### Use Structured Interviews

When sitting down with a client, it helps to have a reliable map. Tools like the **Structured Clinical Interview for DSM-5 (SCID-5)** provide that structure, ensuring important details aren't overlooked and that assessments are consistent across clients. For many clinicians, it brings clarity to conversations that might otherwise feel scattered.

### Screen for All Substances

Clients often underreport use—not always out of dishonesty, but sometimes out of shame, fear, or simple forgetfulness. That's why using validated screeners like the **AUDIT** for alcohol or the **DAST-10** for drugs is so valuable. These tools open the door to patterns that might not emerge in casual conversation, allowing clinicians to see the fuller picture.

### Cross-Map DSM and ICD

In today's interconnected world, records often travel across borders. Many electronic health records now support **dual coding** in DSM and ICD formats. Taking advantage of this isn't just about paperwork—it ensures that if a client's care extends internationally, their diagnosis remains clear and consistent wherever they go.

### Document Functional Impact

Both DSM and ICD frameworks remind us that what matters most is not simply *how often* someone uses, but **how that use affects their life**. Is the client missing work?

Are relationships strained? Is health suffering? Documenting these impacts turns abstract criteria into a human story, one that both client and clinician can work with.

### **Assess Comorbidities Simultaneously**

Finally, it's essential to look at the whole person. Depression, anxiety, PTSD, or other mental health challenges can shape—and complicate—substance use. Addressing these **co-occurring disorders** alongside the SUD not only sharpens the accuracy of diagnosis but also strengthens treatment planning.

---

✦ **Takeaway:** Good assessment is less about checking boxes and more about creating a clear, compassionate map of a client's experience. Structured tools, attention to function, and awareness of co-occurring issues help us understand not just *what* someone is using, but *how it is shaping their life*—and how best to support their path forward.

---

### **Teaching Vignette: Intake with Carlos**

Carlos, a 36-year-old restaurant manager, came in for his first appointment reluctantly. He admitted right away that he was “probably drinking too much,” but quickly added, *“It’s not like I can’t handle it. I’ve got work, family... I’m fine.”*

The counselor knew this was a chance to build trust while also gathering reliable information. She began with a **structured interview**, using parts of the SCID-5. Instead of sounding like a checklist, she wove the questions into conversation: *“Tell me about times when you’ve tried to cut back. What was that like?”* This structure helped ensure that no critical details slipped through.

Next, she invited Carlos to complete the **AUDIT** screening tool. He hesitated, but agreed. When his score suggested hazardous drinking, she gently shared: *“These numbers don’t label you—they just help us see how your drinking compares to patterns that tend to cause harm.”* This shifted the focus from judgment to curiosity.

Because Carlos occasionally used stimulants at parties, she also screened with the **DAST-10**. He minimized his use at first, but when asked about *how often* it interfered with sleep and work, he admitted more than he'd first let on. This showed how important it was to **screen for all substances**, not just the one he volunteered.

As she documented, she was careful to note the **functional impact**—how his absences from work and rising tension at home mattered as much as the quantity of alcohol he consumed. She also entered his diagnosis into the clinic's electronic health record with **dual coding** for DSM-5 and ICD-11, explaining: *"This way, no matter where your records go, your care will make sense to other providers."*

Finally, she asked about his mental health. Carlos revealed that anxiety often spiked on nights he drank the most. The counselor explained how **co-occurring conditions** can complicate treatment, and together they agreed to explore anxiety management alongside his recovery plan.

---

## Clinical Relevance

This vignette shows how a few intentional practices—structured interviews, validated screeners, dual coding, functional documentation, and comorbidity assessment—can turn a first session into a foundation for meaningful treatment. More importantly, it demonstrates how a **warm, collaborative tone** helps clients feel supported rather than judged, increasing the likelihood they'll return for care.



## 3.5 Comorbidity

Big picture: when you meet someone with a substance use disorder (SUD), expect another diagnosable mental health condition to be nearby. Co-occurrence is the rule,

not the exception—and treating both together usually works best (SAMHSA, 2023; APA, 2022; NIDA, 2024).

### 3.5.1 Comorbidity: When Struggles Overlap

In real life, clients rarely walk into the room with tidy, one-label problems. More often, their struggles overlap in complicated ways. Someone comes in with anxiety so severe they can't sleep, so they start using stimulants to stay awake at work. The stimulants worsen their paranoia, which fuels more anxiety... and the cycle tightens. This is the reality of **comorbidity**, sometimes called **co-occurring disorders** or **dual diagnosis**: when a person meets criteria for both a substance use disorder and at least one other psychiatric condition—like major depression, PTSD, or bipolar disorder.

For many addiction specialists, this isn't the exception; it's the norm (Volkow et al., 2022). In fact, recent U.S. data show just how common it is: in 2022, **21.5 million adults experienced both a mental illness and a substance use disorder** (SAMHSA, 2023). And in treatment settings, the numbers climb even higher—between **50% and 75% of people in addiction programs** also carry another psychiatric diagnosis (Kelly & Daley, 2023).

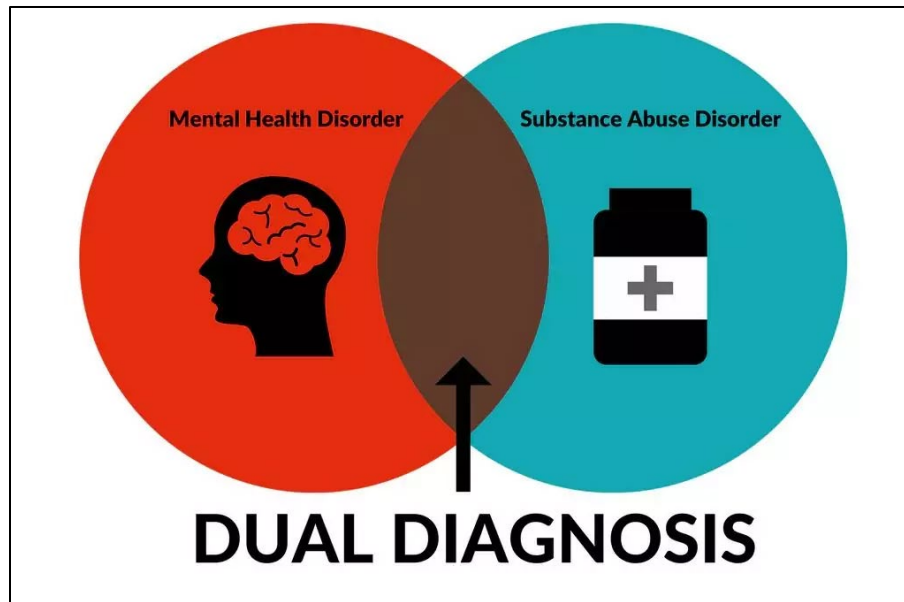
The consequences of comorbidity are profound:

- **Higher severity and complexity.** Clients with both SUD and another psychiatric condition are more likely to end up in the ER, face higher overdose risk, and struggle with greater functional impairment (NIDA, 2024).
- **Lower engagement and retention.** Depression's fatigue, panic's paralysis, or psychosis's distortions can make it incredibly difficult to attend sessions consistently or stay the course in treatment (SAMHSA, 2023).
- **Different treatment needs.** A single-focus plan—treating just the substance use or just the mental health condition—often falls flat. **Integrated care**, where both conditions are addressed together, leads to far better outcomes (APA, 2022).

For clinicians, comorbidity requires a mindset shift. It's not about "fixing the addiction first" or "treating the depression first"—it's about understanding that the two are woven

together, each influencing the other. Helping clients means holding both realities at once, and building treatment plans that reflect the full complexity of their lives.

---



The overlap between substance use disorders and mental illness is substantial, reflecting shared biological, psychological, and social risk factors (SAMHSA, 2023).

---

### **Clinical Relevance Today**

A client presenting with *only* substance-related symptoms is the exception. In most treatment contexts, assessing for co-occurring mental health conditions should be standard — not optional.

### **3.5.2 Common co-occurring conditions**

#### **How to Read the Following Sub-Sections**

In the pages ahead, each subsection invites you to step into the *lived reality* of co-occurring disorders. To make these complex patterns approachable, we'll move through

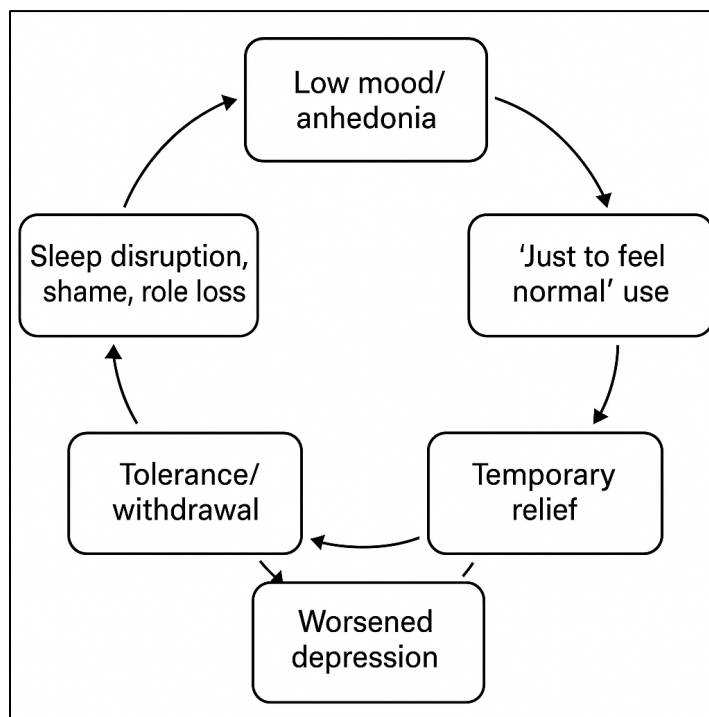


them in a simple, structured way. First, we'll explore **how and why the pair of conditions often show up together**, weaving in both science and story. Next, you'll see a **clinical pathway diagram** that visually traces how symptoms feed into one another. From there, we'll highlight a few **practical assessment pearls**—the small but powerful tips that can make your evaluations sharper and more compassionate. We'll also cover the **treatment keys** clinicians have found most helpful when supporting clients facing this dual challenge. Finally, to bring it all to life, each section closes with a **mini-case narrative**, so you can picture what these dynamics look like in real practice.

---

### 3.5.2.1 Depressive disorders (MDD, persistent depressive disorder)

**Why it's common:** Depression and SUD share risk factors (genetic vulnerability, chronic stress, ACEs), and they reinforce each other. Alcohol and sedatives blunt painful affect in the short run, but worsen sleep architecture, energy, and mood cycles—setting up negative reinforcement (Koob, 2021; NIDA, 2024). This is illustrated in the following image:



When clients present with both substance use and depression, it can feel like untangling a knot. Which came first—the drinking and drug use, or the sadness and low energy? Often the answer isn't simple, but careful listening and time help us trace the threads.

### **Assessment: Looking at the Timeline and Safety**

One of the most important clues is the **time course** of symptoms.  If a client's depressive symptoms—persistent sadness, loss of interest, hopelessness—*began long before* their heavy drinking or opioid use, and continue even after **4–6 weeks of sobriety**, then we are likely looking at a **primary depressive disorder**. But if those symptoms **lift during abstinence**, it points instead to a **substance-induced depression** (APA, 2022).

Because depression and substance use together raise risk for suicide, we cannot shy away from asking **direct, compassionate questions**. Exploring both passive thoughts (“I wish I wouldn’t wake up”) and active ones (“I’ve thought about how I might end my life”) gives us a clearer picture of risk. Just as importantly, we revisit these questions often, since risk can rise or fall as sobriety deepens.

### **Treatment: Weaving Both Threads Together**

The most effective care treats **both conditions at once**. An **integrated plan** might combine alcohol or opioid medications—like naltrexone, acamprosate, buprenorphine, or methadone—with **cognitive behavioral therapy (CBT)** and **behavioral activation** for depression (NIDA, 2024; APA, 2022). These parallel supports help clients not only reduce substance use but also rebuild meaning and routine in daily life.

For those with persistent depression, **antidepressants** can play an important role. SSRIs and SNRIs are often safe first-line choices. Still, we stay alert in the early weeks of recovery, when shifts in energy can increase suicide risk before mood lifts. And we remain cautious about combinations—especially avoiding alcohol or sedatives alongside medications that can deepen central nervous system depression.

### **The Heart of the Matter**

Clients with both depression and substance use often arrive feeling as if they are

fighting two battles at once. But with careful assessment, integrated treatment, and ongoing safety checks, we can help them see these are not two separate wars—they are part of the same story. When treated together, clients often discover that healing in one area fuels progress in the other.

### Mini-Case: “David and the Empty Evenings”

David, a 46-year-old accountant, came to treatment at the urging of his sister. On the surface, he seemed “functional”—he still held a job, paid his bills, and lived alone in a tidy apartment. But in session, he admitted that his evenings had become increasingly dark.



He described finishing work, feeling an overwhelming wave of emptiness, and reaching for alcohol almost automatically. “It’s the only thing that quiets my mind,” he said. What began as two beers had become a nightly bottle of wine. Weekends blurred into long stretches of drinking, with Monday mornings marked by fog and guilt.

When asked about his mood, David’s eyes welled up. He shared that sadness and hopelessness had been part of his

life for years, long before alcohol became a nightly ritual. Even during short stretches of sobriety, the heaviness lingered. He often thought, “*What’s the point of all this?*” and admitted that, while he didn’t have a plan, he sometimes wished he wouldn’t wake up.

The assessment suggested **primary major depressive disorder with comorbid alcohol use disorder**. His depression had preceded his heavy drinking, and persisted even during brief abstinence periods. The alcohol, while numbing, deepened his fatigue and hopelessness, trapping him in a cycle that was both comforting and destructive.

Treatment began with an **integrated plan**: naltrexone to reduce alcohol cravings, CBT with behavioral activation to gently reintroduce meaningful activities, and an SSRI to support mood stabilization. Safety planning was woven into every session, with his sister included as part of his support system. Over time, David reported small but hopeful changes: more energy in the mornings, reconnecting with his niece, and even starting a weekend photography class.

---

## Clinical Relevance

David's case illustrates the **messy overlap of depression and alcohol use**—where one feeds the other in a loop. Without an integrated approach, treating just the depression or just the drinking might have left him vulnerable to relapse. But by holding both threads together, the team could help him begin to stitch together a life that felt more worth living.

## Clinical Relevance Today

Depression treatment often **unlocks motivation** for SUD work. When energy and sleep improve, craving intensity frequently drops (APA, 2022; NIDA, 2024).

---

### 3.5.2.2 Anxiety Disorders (GAD, Panic, Social Anxiety) and Substance Use

For many clients, **anxiety is the spark** that first lights the path toward substance use. The racing heart, the restless nights, the constant hum of worry—these sensations are so uncomfortable that people will try almost anything for relief. And substances like alcohol or benzodiazepines deliver that relief quickly. A drink can quiet the buzzing mind; a pill can soften the edges of panic. It's no wonder so many people with anxiety disorders find themselves reaching for substances, even when they know the risks.

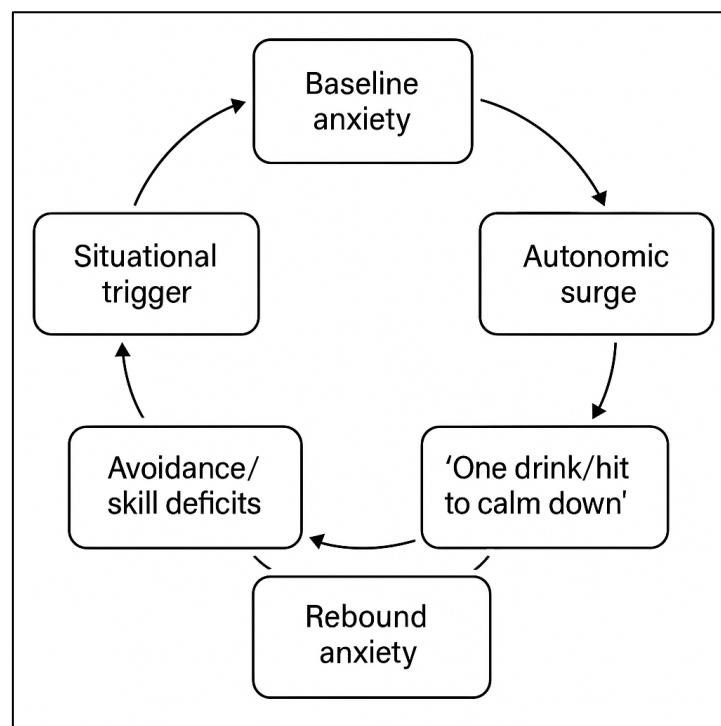
This pattern is a textbook example of **negative reinforcement**: using not to feel good, but to make the bad feelings stop. Each time the substance provides fast relief, the brain learns: *"This works."* Over time, that powerful conditioning makes the substance feel less like a choice and more like a necessity (Koob, 2021).

A client with **generalized anxiety disorder (GAD)** might say, “*I just can’t turn my mind off at night, and a couple of drinks are the only thing that helps me sleep.*” Another with **social anxiety** might notice that alcohol feels like a ticket into parties or work events, making them appear relaxed when inside they’re trembling. And someone with **panic disorder** might discover that benzodiazepines stop the terrifying spiral of a panic attack within minutes.

The challenge, of course, is that while these substances *work in the moment*, they often make anxiety worse in the long run. Hangovers heighten restlessness. Withdrawal can mimic panic symptoms. The more someone relies on substances to cope, the less confident they feel in their own ability to manage anxiety without them.

For clinicians, the key is recognizing how **anxiety and substance use reinforce each other** in a cycle of relief and rebound. Treatment means not only addressing the substance use but also giving clients healthier tools for calming their nervous systems—tools that can bring peace without pulling them deeper into dependency.

### Clinical pathway



## Assessment: Untangling Anxiety from Substance Effects

When clients present with anxiety, it's important to pause and carefully **sort out what we're really seeing**. A racing heart, sweating, and jitteriness could be signs of a panic attack—or they could just as easily be the aftereffects of stimulant use, like cocaine or amphetamines. Mislabeling one as the other can lead to the wrong plan. Similarly, withdrawal from benzodiazepines often looks like primary generalized anxiety disorder: insomnia, tremors, and restlessness. Asking clear, gentle questions about timing—*“When do the symptoms appear in relation to use or withdrawal?”*—can be the key to telling these apart.

---

## Treatment: Addressing Both Sides Together

Once the picture is clearer, treatment works best when it supports **both the anxiety and the substance use at the same time**.

- **Therapy first.** Cognitive-behavioral therapy (CBT) has a strong evidence base for anxiety. Techniques like interoceptive exposure—teaching clients to sit with the physical sensations of panic—can reduce fear over time. When paired with motivational interviewing (MI) and CBT for substance use, clients gain tools for both sides of the struggle.
- **Safer medications.** For clients with substance use disorders, long-term benzodiazepine prescriptions usually bring more risk than relief. Instead, doctors often lean on **non-addictive anxiolytics** such as SSRIs, SNRIs, buspirone, or even hydroxyzine for short-term relief. In cases where benzodiazepines are truly indicated, careful tapering and close monitoring are essential (APA, 2022).
- **Reinforcing progress.** Practical supports matter, too. Programs that use **contingency management**—rewarding clients for attending sessions and providing negative urine screens—can increase consistency and build momentum in recovery (SAMHSA, 2023).

---

## The Heart of the Work

Clients with both anxiety and substance use often describe feeling trapped in a vicious loop: using substances to calm their anxiety, only to have those same substances worsen the problem over time. Assessment helps us name the loop, and treatment—when compassionate, structured, and integrated—offers clients a way out. By pairing safer medications with therapy and reinforcement strategies, we give people both the skills and the hope they need to rebuild calmer, substance-free lives.

---

### 3.5.2.3 PTSD and Trauma-Related Disorders

For many clients, trauma feels like a wound that never fully heals. Memories intrude when least expected, sleep is shattered by nightmares, and the body itself remains on edge—always scanning for danger. Living in that state of constant **hyperarousal** is exhausting. To cope, many turn to substances that seem, at least at first, to bring relief.

Alcohol might soften the edges of intrusive memories. Cannabis may offer temporary calm, dulling the spikes of hypervigilance.  Opioids can wrap a person in numbness, blunting both physical and emotional pain. In the short term, these strategies seem to “work.” But over time, they almost always make things worse (NIDA, 2024).

Alcohol fragments sleep, deepening exhaustion and making nightmares harder to escape. Cannabis disrupts natural REM cycles, leaving clients foggy but still haunted. Opioids, while numbing, create a cycle of tolerance and withdrawal that compounds the very stress the person is trying to avoid. Instead of soothing trauma, substances end up **magnifying its reach**, pulling clients further into distress.

Clinicians often hear this in clients’ own words:

- *“I drink so I can fall asleep, but then I wake up shaking at 3 a.m.”*
- *“Weed helps me stop thinking... until the paranoia kicks in.”*



- *“Oxy was the only thing that ever gave me peace—but now I feel worse when I’m not on it.”*

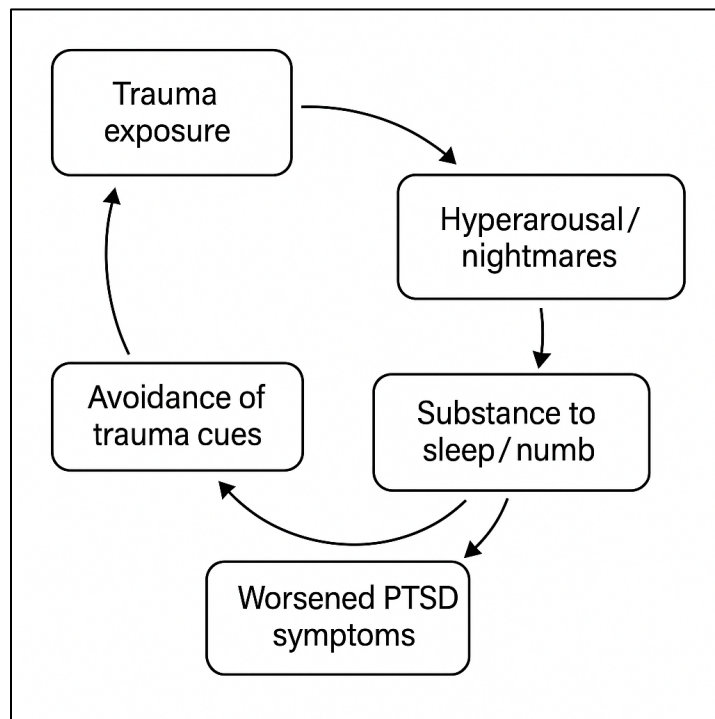
This is why **PTSD and substance use so often walk hand in hand**. The trauma creates unbearable symptoms; the substance offers quick relief; the side effects and withdrawal amplify the trauma symptoms again. It’s a heartbreaking cycle—but one that, when named and understood, can be disrupted.

For clients, the most healing moment can be realizing: *“I wasn’t weak for using—I was trying to survive.”* For clinicians,

that insight shifts the focus from blame to compassion, opening the door to trauma-informed, integrated care.

### **Assessment: Listening for the Pairing**

When working with clients who have trauma histories, it’s essential to ask about both PTSD symptoms and substance use—and, importantly, how the two fit together. Tools like the **PCL-5** can



help track PTSD severity, but the richest insight often comes from simple, direct questions:

*“When do you find yourself drinking or using—before nightmares? After flashbacks? On anniversaries of the trauma?”*

This temporal mapping often reveals patterns the client may not have noticed. For example, one veteran realized he only reached for alcohol after being startled awake from combat nightmares. Another survivor found she smoked cannabis most heavily around the anniversary of her assault, especially when she drove past the neighborhood where it happened. By connecting the dots between triggers and use,



assessment becomes not just about labeling symptoms—it becomes a way to help clients see how they’ve been using substances to manage unbearable feelings.

---

## **Treatment: Safety First, Then Healing**

Because trauma and substance use feed off one another, **trauma-informed care** begins at the very first contact. Clients need to know they are safe—that their story will be received without judgment and with sensitivity to the pain that drives both their symptoms and their use. Early priorities often include **stabilizing safety, sleep, and withdrawal**, since these are the foundations upon which deeper trauma work must rest.

Once stability is achieved, integrated protocols shine. **Seeking Safety** is one such approach, offering practical coping skills that strengthen resilience without requiring immediate deep-dive into trauma memories. Later, as clients gain stability, they may benefit from **trauma-focused therapies**—such as Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), or Eye Movement Desensitization and Reprocessing (EMDR)—combined with ongoing substance use disorder supports.

On the medication side, options like **prazosin** can reduce trauma-related nightmares, improving rest and resilience. Clinicians are generally cautious with benzodiazepines in this population; while they may provide momentary relief, they carry high risks of dependence and can worsen the cycle of avoidance (APA, 2022). For alcohol or opioid use disorders, medications such as **naltrexone, acamprosate, buprenorphine, or methadone** can help reduce reactivity to cues and blunt the withdrawal-driven urgency to use.

---

## **The Heart of the Work**

Clients with both PTSD and substance use are often caught in a heartbreaking loop: trauma drives substance use for relief, and the substances worsen trauma symptoms. Assessment that maps those connections and treatment that integrates safety, coping, and stabilization can break the cycle. Most importantly, when clients realize *“I wasn’t*

*broken for using—I was surviving the only way I knew how,”* the shift toward healing becomes possible.

### Case Vignette: “Malik and the Battle After the Battle”



Malik was a 34-year-old Army veteran who had returned from deployment more than a decade ago, but in many ways, the war still lived inside him. Nights were the worst. He often jolted awake drenched in sweat, heart pounding, the sound of gunfire echoing in his dreams. Sleep became so unpredictable that he dreaded going to bed at all.

At first, Malik turned to alcohol “just to take the edge off.” A few beers made it easier to fall asleep, but soon the beers weren’t enough. Within a year, he was drinking half a bottle of whiskey most nights. On nights without alcohol, the nightmares came roaring back, along with an anxious vigilance that

kept him pacing the house at 3 a.m. His partner began to worry—about his health, his temper, and the way alcohol seemed to have become his only refuge.

When Malik finally came to treatment, he described himself as “fighting two battles—the one in my head and the one in the bottle.” His assessment showed classic **PTSD symptoms**—hyperarousal, flashbacks, nightmares—and an **alcohol use disorder** that had developed in tandem. Careful questioning revealed the pattern: trauma symptoms triggered drinking, drinking disrupted his sleep further, and the resulting exhaustion worsened his PTSD.

---

### Treatment Plan and Recovery Steps

The first step was **stabilization**. Malik's clinician focused on safety planning, managing withdrawal risk, and helping him re-establish a basic sleep rhythm. Medications like **prazosin** were introduced to reduce nightmares, while **naltrexone** was offered to help curb alcohol cravings. His partner was invited to a family session, so both of them could better understand the cycle he was trapped in.

In therapy, Malik began with **Seeking Safety**, where he learned coping skills to manage both trauma symptoms and cravings without diving into painful memories too soon. As his stability grew, he transitioned into **Cognitive Processing Therapy (CPT)**, gradually working through the guilt and distorted beliefs he had carried since combat. The integration of trauma therapy and SUD supports helped him address both struggles at once, rather than treating them as separate battles.

---

## Outcome

After several months, Malik reported that while the nightmares hadn't vanished, they were less frequent and less terrifying. More importantly, he was no longer relying on alcohol to cope. His sleep improved, his energy returned, and his partner noticed he was more present with their children. Malik still described himself as "a work in progress," but for the first time in years, he felt hope that the cycle could be broken.

---

## Clinical Relevance

Malik's story shows how **PTSD and substance use often become tightly linked**, with one feeding the other. It underscores the need for **trauma-informed, integrated care**—stabilizing safety and withdrawal first, then layering in skills-based approaches before moving into deeper trauma processing. His journey illustrates that recovery is not about erasing trauma, but about building new ways to live with it—without relying on substances to survive.

## Clinical Relevance Today

You don't need to postpone **all** trauma therapy until long-term abstinence. With **careful staging**, trauma-focused work can proceed alongside SUD treatment (APA, 2022).

---

### 3.5.2.4 Bipolar disorder

**Why It's Tricky:** Bipolar disorder brings its own cycles of intensity—soaring highs and crushing lows—that can easily intertwine with substance use. During **manic or hypomanic episodes**, clients often feel unstoppable: energy is high, sleep is low, and judgment can be clouded. In that state, alcohol or stimulants may feel like natural companions, fueling the rush or blunting the agitation. The impulsivity of mania makes risky use almost effortless, with consequences that can unfold just as quickly.

Then come the **depressive episodes**. The same person who, weeks earlier, was electrified with energy now feels heavy, empty, and defeated. In these lows, substances take on a different role—no longer about chasing excitement, but about chasing relief. A drink to quiet despair. A pill to numb the ache. Self-medication feels like survival, even as it deepens the very pain it's meant to soothe.

 Adding to the challenge, the **effects of substances can mimic mood episodes**. Cocaine intoxication may look like mania. Alcohol withdrawal can look like anxiety or irritability. Even cannabis can blur the line between mood swings and substance effects. For clinicians, this overlap creates real diagnostic puzzles: *Is this a mood episode, a substance effect, or both?* (APA, 2022).

This is why co-occurring bipolar disorder and substance use requires patience, careful assessment, and integrated care. What may appear as “just another binge” might actually be part of a manic surge. What looks like “just another crash” could be depression compounded by withdrawal. Understanding these overlaps is not about splitting hairs—it's about meeting clients where they are, with clarity and compassion, in the middle of very complex storms.

## Differentiation snapshot

| Feature  | Substance-Induced Mania                      | Primary Bipolar Mania                    |
|----------|----------------------------------------------|------------------------------------------|
| Onset    | Temporal to intoxication/withdrawal          | Spontaneous/cyclical                     |
| Duration | Hours–days (substance window)                | ≥1 week (mania) or ≥4 days (hypomania)   |
| History  | Lacks distinct prior episodes off substances | Prior episodes without substance trigger |

### Treatment:

- **Mood stabilization first** (lithium, valproate, atypical antipsychotics); then tackle SUD drivers.
- Avoid antidepressant monotherapy; combine with mood stabilizer if needed.
- Build **sleep protection** and routine; use MI for medication adherence.

When bipolar disorder and substance use collide, treatment often begins not with the substances themselves, but with the mood storms underneath. Stabilizing the swings of mania and depression is the first priority. Medications such as lithium, valproate, or atypical antipsychotics can help steady the extremes, creating the foundation on which recovery from substance use can stand. For this reason, a referral to an appropriate medical professional would be critical.

Why start here? Because without stability, the pull of substances often remains irresistible—whether it's the rush of stimulants during manic surges or the numbing escape of alcohol during depressive lows. Once mood stabilization begins, clients are better able to recognize and address the drivers of their substance use.

Clinicians are also cautious with antidepressants. On their own, these medications can trigger mania in people with bipolar disorder. If needed, they're paired with a mood stabilizer, ensuring that the pendulum doesn't swing too far in the other direction.

Equally important are the daily rhythms of life. Sleep is often fragile in bipolar disorder, and when disrupted, it can trigger both mood episodes and cravings. Helping clients build routines around rest, meals, and activity creates anchors in the chaos.

Finally, Motivational Interviewing (MI) can be a powerful ally in supporting medication adherence. Rather than lecturing, MI invites clients into a conversation about their own goals and values, exploring how mood stability and sobriety connect to the life they want to reclaim.

### 💡 The Heart of the Work

Treatment for bipolar disorder with substance use is less about “fixing two problems” and more about weaving both strands of struggle into one integrated plan. By grounding clients in stability, protecting their sleep, and helping them find motivation for ongoing care, clinicians create the conditions for real, sustainable healing.

### **Case Vignette: “Rafael and the Pendulum Swings”**

Rafael was 32, an aspiring musician with bursts of brilliance followed by long stretches of silence. Friends described him as someone who could “light up a room” one month and disappear into it the next.

During his **manic phases**, Rafael felt unstoppable. He stayed up for nights on end, writing music and spending money he didn't have. In those highs, stimulants like cocaine seemed to amplify his energy—*“It makes me feel like I can fly,”* he told his clinician. Alcohol often flowed freely too, feeding the buzz. But the crash always came.

In his **depressive episodes**, the world went dark. He stopped returning calls, skipped rehearsals, and drank alone to quiet the emptiness. Sometimes he admitted he wasn't sure if he wanted to live through another cycle.

When Rafael entered treatment after a near-overdose, he felt torn: *“I don't know where the drugs end and where my moods begin.”* His clinician explained gently that this

overlap was common—substances could mimic mood episodes, and mood swings could drive risky use. The first step wasn't to strip everything away at once, but to **build stability**.

He started a **mood stabilizer**, and within weeks, the wildest swings softened. For the first time in years, Rafael began sleeping regularly. Therapy sessions focused on **sleep hygiene and daily structure**, as well as **motivational interviewing** to explore his ambivalence about staying on medications. Slowly, he began to see that the substances weren't fueling his creativity—they were stealing it.

With his mood steadier, he could now confront his **substance use head-on**. Cocaine use tapered with the help of CBT strategies for cravings, while contingency management reinforced his attendance at group therapy. Over months, Rafael began to describe feeling “more myself”—not the dizzy highs or crushing lows, but something steadier, more sustainable. He was writing music again, this time with clearer focus and without substances driving the rhythm.

---

## Clinical Relevance

Rafael's story captures the **complex dance between bipolar disorder and substance use**. His mania fueled risky stimulant and alcohol use, while his depressions pushed him toward numbing self-medication. Only when his treatment plan **prioritized mood stabilization first** could he begin to address his substance use in a meaningful way.

For learners, Rafael's case underscores a critical principle: in dual diagnosis work, healing is not about separating conditions, but about treating them as **intertwined threads**—stabilizing mood, reducing reliance on substances, and helping clients build lives steady enough to hold their recovery.

Stabilizing **sleep** is often the fastest lever to reduce both manic risk and craving cycles.

---

### 3.5.2.5 Psychotic disorders (schizophrenia spectrum) and substance-induced psychosis

When psychosis and substance use meet, the overlap can be both confusing and heartbreaking. For some individuals, the substance itself becomes the trigger. Cannabis, especially today's high-potency strains, has been shown to precipitate psychotic episodes in vulnerable people—sometimes bringing on a first break that might otherwise have remained dormant for years. Stimulants like cocaine or methamphetamine can do the same, flooding the brain with dopamine and tipping fragile systems into hallucinations or paranoia (NIDA, 2024).

On the other side of the equation, people already living with schizophrenia or other psychotic disorders may turn to substances in an effort to cope. The heavy weight of dysphoria, social withdrawal, or the numbing fog of negative symptoms can drive someone toward cannabis, alcohol, or stimulants in search of relief. In the short term, a joint might feel like it softens the flatness of affect, or a drink might ease the loneliness of being cut off from peers. But in the long run, these substances almost always worsen symptoms—deepening paranoia, amplifying disorganization, or accelerating relapses.

Clinicians often encounter clients who describe this dynamic in their own words:

- *“Weed makes me feel normal for a little while, but then the voices come back louder.”*
- *“When I’m on meth, I feel like I can finally connect with people, but afterwards I can’t tell what’s real anymore.”*

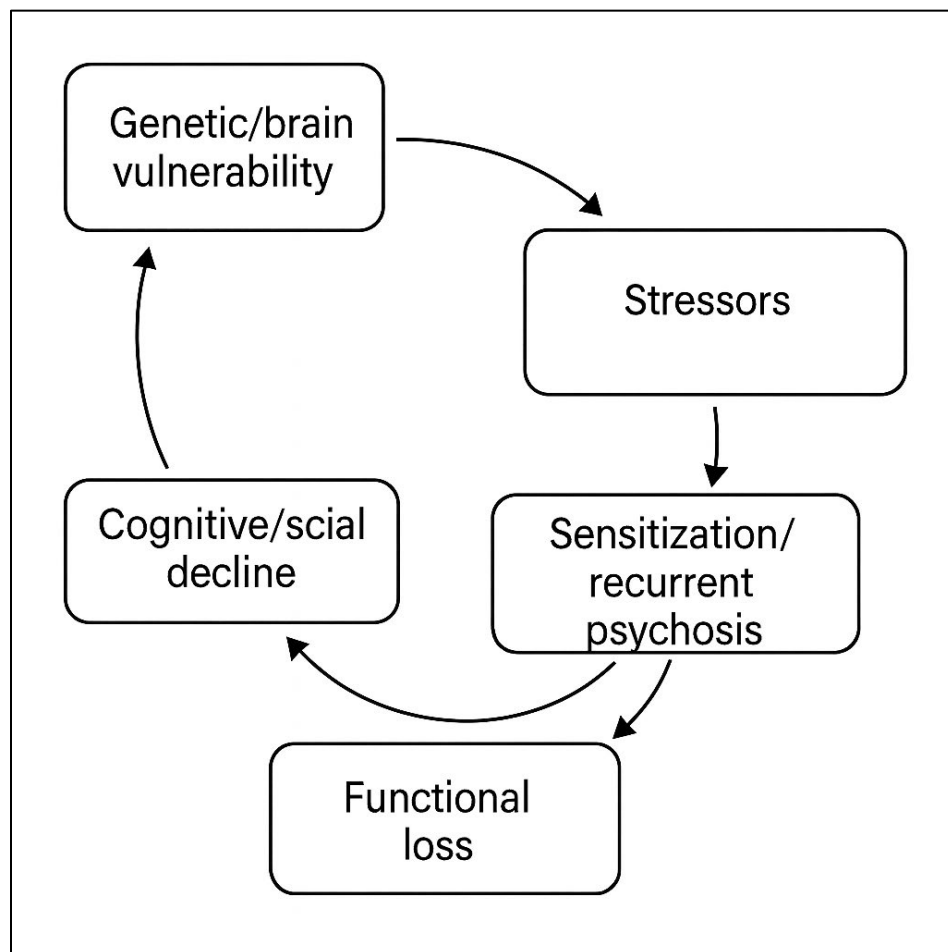
The clinical challenge is untangling what's substance-induced and what's part of an underlying psychotic disorder. Substance-induced psychosis may clear when the drug leaves the system, while schizophrenia-spectrum symptoms tend to persist even in sobriety. But in practice, the lines are rarely clean, especially when use and illness reinforce each other over years.

What matters most in the room with clients is remembering that this overlap is not rare. It is, in fact, common. And it is not a sign of failure—it is often a reflection of people



doing their best to cope with unbearable internal experiences, even if the strategy backfires. Approaching these cases with warmth and compassion can mean the difference between a client feeling dismissed as “drug-seeking” versus feeling truly understood as someone who is suffering.

### Clinical pathway



### Assessment: Mapping the Timeline

When psychosis and substance use overlap, the first step is to carefully trace the **timeline of symptoms**. Did hallucinations or paranoia appear only when the person was actively using cannabis or stimulants? Did they persist during stretches of abstinence? These questions help us tease apart **substance-induced psychosis** from an underlying schizophrenia-spectrum condition.

It's also essential to ask about **potency and frequency**. Today's high-THC cannabis concentrates, for example, can be far more destabilizing than the lower-potency marijuana of past decades. A young person experimenting with occasional use may present very differently than someone consuming strong cannabis daily. By gently but directly asking about these details, we can better understand the risks and tailor our recommendations.

---

### **Treatment: Supporting Both Sides of the Struggle**

Effective care requires addressing **both the psychosis and the substance use**, often at the same time.

- **Antipsychotic treatment** remains a cornerstone, helping reduce hallucinations, delusions, and paranoia. But medications alone are rarely enough.
- On the substance use side, approaches like **CBT for psychosis (CBT-p)**, **motivational interviewing (MI)**, and **contingency management (CM)** provide clients with practical tools, support motivation to change, and reinforce progress.
- One of the strongest recommendations for clients with psychosis is **cannabis abstinence**. While this can be difficult, especially when cannabis is normalized among peers, even partial reductions can lead to significant improvements in symptoms and functioning.

Beyond therapy and medications, recovery is often strengthened by **wraparound supports**: case management to help with housing or benefits, supported employment programs that build confidence and stability, and family education to reduce stigma and increase support at home.

---

### **The Heart of the Work**

Clients experiencing both psychosis and substance use often feel misunderstood or written off. But with careful assessment, an integrated treatment plan, and strong

support systems, recovery is possible. Each piece—mapping the timeline, clarifying substance effects, providing therapy and medication, and surrounding the person with practical supports—helps move them from crisis toward stability.

At its core, this work is about restoring dignity and hope. By treating the **whole person**, not just the diagnosis, we give clients a real chance to reconnect with their lives and communities.

### **Case Vignette: “Jared and the Green Line”**

Jared was 22, a college student who loved graphic design and spent long hours sketching in his dorm. He had started using cannabis in high school, mostly to “chill out” after stressful days. But by the time he reached university, his use had escalated. Not just smoking flower—he was using **high-THC concentrates** almost daily, convinced they helped his creativity.

At first, Jared’s friends didn’t notice much beyond his bloodshot eyes and occasional forgetfulness. But slowly, things changed. He began talking about seeing shadows moving in his room, even when no one else was there. He became convinced the people on the subway’s Green Line were whispering about him, laughing under their breath. His roommates worried when Jared stopped going to class and started locking his bedroom door, claiming someone was watching him through the vents.

When he was brought to the university counseling center, Jared insisted he wasn’t “crazy”—he just needed better weed. But the clinician gently mapped out the **timeline**: the voices and paranoia had only begun after his cannabis use spiked, and symptoms worsened the more he used. During a brief week of abstinence, his paranoia dulled, though it didn’t disappear completely.

---

### **Treatment Journey**

Jared’s care began with **antipsychotic medication**, which eased the intensity of his paranoia and helped him re-engage with daily routines. At the same time, his counselor worked with him on **motivational interviewing (MI)**—not lecturing him about cannabis,

but exploring how his use was affecting his goals, like graduating and getting a design internship.

In **CBT for psychosis (CBT-p)**, Jared learned to reality-test his thoughts: writing down what he believed, comparing it to evidence, and finding less frightening explanations for his experiences. Through **contingency management (CM)**, he was rewarded for negative cannabis screens and session attendance, which helped him stay consistent.

Perhaps most importantly, Jared was connected with **wraparound supports**: case management to help with academics, a supported employment program to prepare him for internships, and family psychoeducation so his parents understood that both cannabis and psychosis were part of his struggle—not just “bad behavior.”

---

## Outcome

Over months, Jared reduced his cannabis use dramatically and began to notice fewer whispers on the subway. The paranoia didn’t vanish entirely, but it no longer controlled him. He returned to his design courses, cautiously hopeful about his future. When asked what had changed, he said simply: *“I realized the weed wasn’t helping me anymore—it was stealing the things I cared about.”*

---

### 3.5.2.6 ADHD and Substance Use: Why They So Often Travel Together

For many clients, living with **ADHD** means navigating a brain that is wired for action, novelty, and stimulation. Impulsivity and thrill-seeking can make experimenting with substances more tempting, and sticking to limits more difficult. A teenager with ADHD might grab a beer at a party without pausing to think through consequences, or try stimulants offered by a friend simply because the moment feels exciting. That same impulsivity, combined with struggles around self-regulation, can open the door to early and risky substance use.

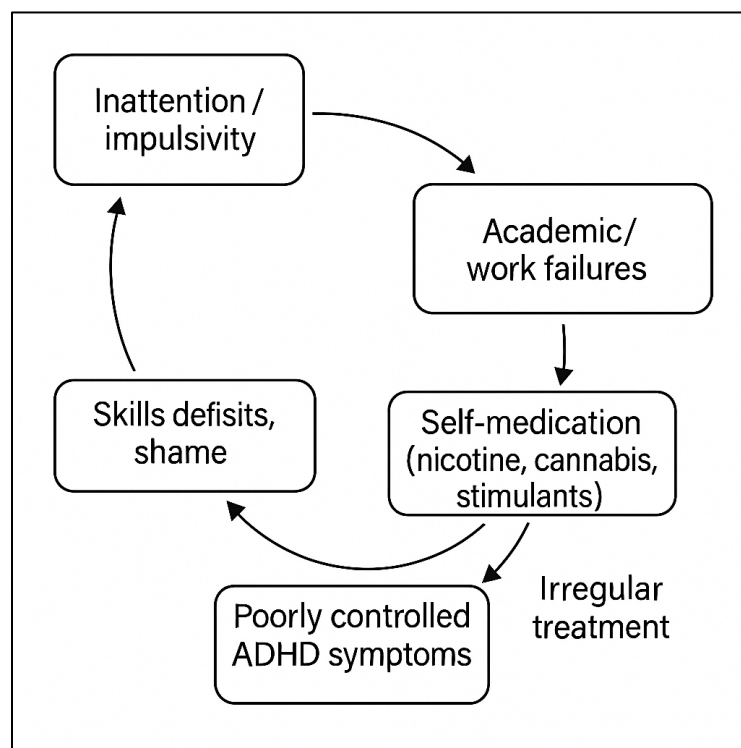
Research also shows that when **ADHD goes untreated**, the risk for developing a substance use disorder rises sharply. Unmanaged distractibility, frustration, and low self-

esteem can lead individuals to self-medicate—using cannabis to slow their thoughts, alcohol to soften social awkwardness, or stimulants outside of prescription to boost focus (Kaye et al., 2021). Over time, what began as coping can morph into dependency.

But the reverse is just as important to highlight: when ADHD is **appropriately treated**, especially with evidence-based strategies like behavioral therapy, coaching, and sometimes carefully monitored medications, the risk of later substance misuse can actually go down. Clients learn healthier ways to channel their energy, manage stress, and build confidence. This turns ADHD treatment not just into symptom management, but also into a powerful tool of **prevention** against future addiction.

For clinicians, this overlap is a reminder that ADHD isn't just about attention—it's about the ripple effects on decision-making, self-regulation, and risk. Addressing ADHD early and well may be one of the most protective steps we can take in reducing substance use problems later in life.

### Clinical pathway



## Treatment Keys for ADHD in the Context of Substance Use

Supporting clients who live with both ADHD and substance use challenges requires a balance of caution and creativity. Medications can be life-changing, but they need to be chosen and managed thoughtfully. Since medications are potentially a help, a referral to a qualified physician should be issued. Therapists should be aware of potential prescriptions and side-effects.

### Non-Stimulant Options

For some clients, non-stimulants such as **atomoxetine, bupropion, or guanfacine** provide a safer path forward. These medications can help reduce impulsivity, improve focus, and calm restlessness—without carrying the same risks of misuse. They're especially valuable when substance use history raises concerns about prescribing stimulants.

### If Stimulants Are Indicated

Sometimes, stimulants remain the best option for managing ADHD. When that's the case, it's important to build safety right into the plan. **Long-acting formulations** are preferred because they're harder to misuse and provide steadier coverage. Clinicians often establish **clear treatment agreements** (sometimes called contracts) that outline responsibilities and expectations. Simple practices like **pill counts, checking prescription drug monitoring programs (PDMPs), and periodic urine drug screens (UDS)** add another layer of accountability. None of these steps are about mistrust—they're about protecting clients and helping the medication do its intended work (APA, 2022).

### Skills Coaching: Beyond the Pill

Medication is only one part of the picture. For many clients, pairing treatment with **skills coaching** makes the difference between temporary relief and lasting progress. Sessions focused on organization, time management, planning ahead, and stress reduction equip clients with tools they can rely on in daily life. Over time, these skills help reduce reliance on substances as a “quick fix” for frustration or distraction.

---

## ✦ The Heart of the Work

When ADHD treatment is woven carefully into recovery, it doesn't just quiet symptoms—it can restore confidence, structure, and hope. The goal is not just prescribing safely, but helping clients see that their brains are capable of focus and balance without leaning on substances. With the right mix of medication, structure, and coaching, ADHD becomes less of a vulnerability and more of a manageable part of life.

### Case Vignette: “Jordan Finds His Focus”

Jordan was 24 when he entered treatment for stimulant misuse. He had dropped out of college a year earlier, overwhelmed by his inability to stay organized and complete assignments. A friend had offered him Adderall during finals week, and Jordan discovered it gave him laser focus. What began as a “study aid” quickly spiraled into daily use, and soon he was buying pills illegally just to feel functional.

When he sat across from his clinician for the first time, Jordan was nervous. “I don't want to feel like a failure,” he said. “But without the pills, my brain just won't work.” As they dug deeper, his history revealed something important: **ADHD symptoms had been there since childhood.** Teachers had described him as bright but distractible. His parents remembered constant battles over homework. What he thought was just weakness or laziness was, in fact, untreated ADHD.

### Integrated Treatment Plan

Jordan's clinician knew that both his ADHD and his substance misuse had to be addressed together. The first step was education: *“Your brain isn't broken—it's wired differently. The stimulants gave you a glimpse of what focus can feel like, but they pulled you into a dangerous cycle. Our goal is to find safe, sustainable ways to help you function at your best.”*

They decided to start with a **non-stimulant medication, atomoxetine**, to provide symptom relief without the risks of misuse. Jordan also joined a skills-coaching program

where he learned practical strategies for **organization, time management, and planning**.

Over time, when it became clear that his ADHD was only partially managed, the team cautiously introduced a **long-acting stimulant**—but with careful guardrails. A treatment contract was signed, **pill counts** were performed at each visit, the **prescription drug monitoring program (PDMP)** was checked regularly, and **urine drug screens** provided accountability. Jordan described these steps not as punishment but as “safety nets that keep me honest.”

## **Outcome**

Six months later, Jordan was re-enrolled in classes and holding down a part-time job. He proudly showed his clinician the color-coded planner he used to track assignments and shifts. “For the first time in my life,” he said, “I feel like I’m in the driver’s seat.” The combination of safe medication management, practical coaching, and accountability gave him tools not only to stay sober but to thrive.

## **Clinical Relevance**

Jordan’s story highlights how **untreated ADHD can fuel substance misuse**, but also how **thoughtful, integrated treatment** can transform vulnerability into resilience. By combining non-stimulant options, cautious stimulant prescribing when needed, and skills training, clinicians can help clients rebuild confidence and reduce the risk of relapse.

Treating ADHD often **reduces the “need”** clients feel to self-medicate.

### **3.5.2.7 Personality disorders (especially borderline personality disorder)**

#### **Personality Disorders and Substance Use**

When working with clients who live with borderline personality disorder (BPD), it becomes clear why substance use is so often part of the picture. Life feels like a storm:



emotions rise and crash quickly, rejection cuts deeply, and impulsivity drives decisions in the heat of the moment. For many, substances become a temporary anchor in that storm—a way to numb overwhelming feelings, blur the sting of rejection, or escape chaotic relationships.

But just as quickly as substances soothe, they add more chaos. Episodic heavy drinking, spur-of-the-moment binges with drugs, or erratic patterns of use often mirror the emotional turbulence of BPD itself. The very traits that make clients vulnerable to intense suffering—sensitivity, impulsivity, intensity—also make them vulnerable to substance misuse.

---

### Treatment Keys: Meeting Chaos with Structure and Compassion

The evidence shows that approaches tailored for both disorders work best. One of the most effective is Dialectical Behavior Therapy for Substance Use Disorders (DBT-S).

This adaptation of DBT focuses on teaching practical skills in:

- Distress tolerance: ways to ride out overwhelming urges without reaching for substances.
- Emotion regulation: strategies to reduce the rollercoaster swings of mood.
- Interpersonal effectiveness: tools for navigating the relationships that often trigger use.

DBT-S also integrates contingency management—reinforcing abstinence goals with small, tangible rewards to keep motivation alive.

Given the high risk of self-harm among clients with BPD, safety planning and clear crisis protocols are essential. Clients need to know that support will be consistent and reliable, especially when they feel most out of control.

---

### Case Vignette: “Sofia and the Friday Night Spiral”



Sofia was a 27-year-old barista with a magnetic personality. Friends adored her energy, but they also described her as “all or nothing.” Relationships burned bright and ended abruptly, often leaving her feeling devastated. On Friday nights, after arguments with her

boyfriend or long shifts at work, Sofia turned to alcohol.

At first, a few drinks felt like relief—like the world’s sharp edges softened. But as the night went on, her impulsivity grew. Sometimes she called ex-partners in tears, other times she found herself drinking far past her limit, waking up sick and ashamed.

Her clinician gently helped Sofia see the pattern: overwhelming rejection sensitivity and emotional pain led to heavy drinking, which in turn worsened her mood crashes and relationship volatility. It wasn’t that alcohol was the root of all her struggles—it was that alcohol had become her way of coping with storms she didn’t yet have tools to manage.

Treatment began with DBT-S, where Sofia learned to pause in moments of distress and reach for skills—cold water on her face, paced breathing, calling a supportive friend—rather than another drink. A contingency management program rewarded her for alcohol-free weekends, and regular safety planning gave her a map for moments when self-harm urges felt overwhelming.

Over time, Sofia began to describe herself differently: *“I still feel everything so strongly—but I don’t have to destroy myself to survive it.”*

---

## Clinical Relevance

Sofia’s story captures the core challenge of treating co-occurring BPD and substance use: the very traits that make life painful can also make recovery deeply meaningful. With structure, skills, and compassionate support, clients like Sofia can learn that survival doesn’t have to come from substances—it can come from themselves.

---

### 3.5.2.8 Eating disorders

#### Eating Disorders and Substance Use: Why They Often Overlap

The connection between **eating disorders (EDs)** and substance use disorders (SUDs) is strikingly common, and it’s not hard to see why. Both conditions often spring from shared traits: a tendency toward **perfectionism**, a deep undercurrent of **negative affect**, and a struggle to find control in an unpredictable world. For some, disruptions in appetite and satiety systems add to the mix, making substances feel like a way to “manage” food, weight, or emotional discomfort.

Among young adults especially, patterns like “**drunkorexia**”—restricting food intake to offset calories from alcohol—have become a troubling trend. Others may use stimulants to suppress appetite, or alcohol to numb shame after binge episodes. What begins as a coping strategy quickly weaves into the fabric of both disorders, often worsening the medical and psychological toll.

---

## Treatment Keys: Integrating Two Complex Needs

Working with clients who carry both EDs and SUDs requires coordination and care:

- **Collaboration is critical.** Coordination with eating disorder specialists ensures that both conditions are addressed without compromising safety.
- **Medical monitoring**—tracking electrolytes, EKGs, and vital signs—is essential, as malnutrition and substance use together pose significant risks.
- **Medication choices** must be careful: for instance, avoiding agents like **bupropion in bulimia**, given its increased seizure risk.
- **Structured meals** and therapeutic principles from **CBT-E (enhanced cognitive behavioral therapy)** can support healthier eating, while SUD-specific therapies provide tools to manage cravings and relapse triggers.

### Case Vignette: “Leila and the Balancing Act”

Leila was 21, a college junior majoring in communications. To her peers, she seemed energetic, ambitious, and “fun at parties.” But in private, she struggled with a painful cycle: binge eating episodes that left her ashamed, followed by purging to try to regain control. On top of this, weekends often meant heavy drinking.

When asked why she drank so much, Leila explained, *“It makes me forget the guilt from eating. And if I drink enough, I don’t feel hungry the next day.”* She also admitted to skipping meals before nights out—a pattern she half-jokingly called “saving calories for alcohol.”

Her health began to deteriorate: fainting spells, dizzy spells in class, and one frightening night when she collapsed after a party. That crisis brought her into treatment, where clinicians uncovered the **dual struggle of bulimia and alcohol misuse**.

Treatment began with stabilization. A medical team monitored her electrolytes and heart rhythm, while her therapist built a plan that integrated **structured meal support** with SUD care. Leila joined a DBT-informed group where she learned **distress tolerance** skills for moments when shame surged. Over time, CBT-E strategies helped her reframe rigid food rules, while motivational interviewing supported her decision to cut back on alcohol.

Six months later, Leila was not “cured”—but she was healthier, steadier, and proud of small victories: attending class without fainting, eating balanced meals, and enjoying a social night without binge drinking. She told her therapist, *“I finally feel like I don’t have to hurt myself in two ways at once.”*

---

## Clinical Relevance

Leila’s story underscores the **intertwined vulnerabilities** of EDs and SUDs. Both thrive on secrecy, shame, and the illusion of control. Effective treatment requires a **collaborative, integrated approach**—addressing medical risks, reshaping behaviors, and providing emotional tools—so that clients can move toward recovery in both domains at once.

---

### 3.5.2.9 Chronic pain and sleep disorders



Chronic Pain and Sleep Disorders: A Double Burden

Few things wear people down more than the combination of **chronic pain and poor sleep**. Day after day of aching joints, throbbing

backs, or neuropathic pain can feel unrelenting. Add to that nights of staring at the ceiling, restless and exhausted, and it’s no wonder that both pain and insomnia are some of the most powerful drivers of substance use.

For many, the entry point into opioids or benzodiazepines begins innocently—through a doctor’s prescription after surgery, an injury, or a period of grief-induced sleeplessness. The medications often work quickly, taking the edge off pain or quieting the mind enough for rest. But over time, doses creep higher, dependence grows, and what began as relief can become a new, more complicated burden: **substance use disorder layered onto chronic illness**.

---

### **Treatment Keys: A Whole-Person Approach**

Healing here means caring for the body, the brain, and the habits together:

- **Multimodal pain care** is the foundation. Combining physical therapy, mindfulness-based approaches, and CBT for pain (CBT-p) can shift the experience of pain from something overwhelming to something manageable. Non-opioid medications often play a role too. For those who already have opioid use disorder but still live with significant pain, **buprenorphine** offers a unique path—it can provide both analgesia and stabilization.
- **Sleep care is just as critical.** Chronic insomnia cannot be ignored. **Cognitive Behavioral Therapy for Insomnia (CBT-I)** is the gold standard, helping clients rebuild healthy sleep routines and break the cycle of lying awake dreading the night. Clinicians are generally cautious with sedative-hypnotics, as long-term use in the context of substance use disorder can do more harm than good.

Together, these approaches reinforce each other: when pain lessens, sleep improves; when sleep improves, pain feels more bearable.

---

### **Case Vignette: “Maria and the Long Nights”**

Maria, a 55-year-old former nurse, lived with chronic lower back pain after years of heavy lifting on hospital floors. Surgery had provided some relief, but the pain never fully went away. At first, her doctor prescribed opioids, which helped her move more

freely and sleep through the night. Over the years, however, the pills became less effective, and she found herself needing more just to function.

When insomnia worsened, she was prescribed a benzodiazepine. For a time, it felt like she had her life back—days less burdened by pain, nights softened by medication. But slowly, Maria noticed she couldn't get through the day without the pills. On nights she forgot her dose, she felt wired, restless, and anxious.

By the time she sought help, Maria described herself as “living in fragments”—pain, exhaustion, and reliance on pills. Her clinician offered her a different way forward: a **multimodal pain program** with physical therapy, mindfulness, and CBT-p. She transitioned from high-dose opioids to **buprenorphine**, which gave her both pain relief and stability. For sleep, she began **CBT-I**, learning how to build a bedtime routine that didn't rely on medication.

It wasn't an overnight fix—progress came in fits and starts—but Maria gradually began to notice differences. Her mornings felt clearer. She described fewer nights of “racing mind insomnia,” and the pills no longer dictated her days. Most importantly, she began to feel hopeful again, saying, *“For the first time in years, I feel like I'm not just surviving pain—I'm living around it.”*

---

## Clinical Relevance

Maria's story reflects a pattern many clinicians will recognize: pain and insomnia creating a pathway to opioid and benzodiazepine dependence. The key takeaway is that **integrated, multimodal care**—addressing both pain and sleep while supporting recovery—offers not just symptom relief but restoration of dignity and quality of life.

---

### 3.5.2.10 Suicidality and self-harm risk

#### Why It's Critical

Substance use and suicidality often intersect in ways that heighten risk dramatically. During **acute intoxication**, the brain's brakes come off—impulsivity rises, judgment slips, and the chance of acting on lethal thoughts increases. On the other end, **withdrawal** can fuel despair, anxiety, and agitation, leaving people vulnerable to hopelessness and self-harm. Add in the weight of **comorbid conditions like depression or PTSD**, and the baseline risk rises even higher.

This is why suicide assessment and safety planning are not optional in addiction care—they are essential, lifesaving practices woven into every clinical encounter.

---

### Immediate Actions for Clinicians

- **Suicide Screening:** Using tools like the **Columbia Suicide Severity Rating Scale (C-SSRS)** at intake and as needed helps clinicians ask the hard questions directly and compassionately.
  - **Lethal Means Counseling:** Gentle but clear conversations about access to firearms, large medication supplies, or other means of harm can reduce immediate danger.
  - **Collaborative Safety Planning:** Creating a plan together with the client—identifying warning signs, coping strategies, supportive contacts, and crisis numbers—gives them a roadmap for surviving intense urges.
  - **Warm Handoffs:** When higher levels of care are indicated, arranging a smooth, human-to-human transition rather than a cold referral increases trust and follow-through.
- 

### Case Vignette: “Andre and the Bridge”

Andre, a 39-year-old Army veteran, came into the ED after being found intoxicated near a city bridge. He had been drinking heavily for weeks, trying to quiet the flashbacks of



combat and the gnawing guilt he carried. On that night, overwhelmed and drunk, he had wandered to the bridge with the thought that jumping would end it all.

When sober, Andre admitted, *“I don’t even know if I really wanted to die, or if I just wanted the pain to stop.”* His story reflected the dual risks: alcohol had stripped away his inhibitions, and untreated PTSD had left him drowning in despair.

In the ED, the team didn’t just patch him up and send him home. A clinician sat with him, asking about his thoughts using the **C-SSRS**. They talked about his access to firearms at home, and Andre agreed to store them safely with a trusted friend. Together, they built a **safety plan**, listing his triggers (flashbacks, drinking alone at night), his internal coping tools (breathing techniques learned in service), and people he could call when urges rose. Finally, instead of being discharged with a paper referral, he was connected directly to a VA clinician through a **warm handoff** before leaving the hospital.

---

## Clinical Relevance

Andre’s story reminds us why suicide prevention must be integrated into substance use care. Clients often walk into treatment carrying more than addiction—they carry trauma, hopelessness, and impulses that substances can intensify. By asking direct questions, addressing lethal means, creating collaborative safety plans, and ensuring continuity of care, clinicians do more than reduce risk—they affirm life and restore hope.

### 3.5.3 Why Substance Use and Mental Illness Are So Intertwined

It’s easy to see the *what* of co-occurring disorders—people struggling with both substance use and mental illness. But the deeper question is **why these two often walk together**. Science offers several answers, each shedding light on the tangled relationship between the brain, the body, and the environment.

## Shared Genetics and Neurobiology

Part of the overlap comes from our biology. Research shows that the same genes that increase vulnerability to mood or anxiety disorders can also increase risk for substance use disorders. It's as if the wiring of the **reward, stress, and executive control systems** sets the stage for both. The mesolimbic dopamine pathway, the amygdala's alarm system, and the prefrontal cortex's decision-making hub are all players in this shared story (Koob, 2021; NIDA, 2024).

For clients, this helps shift the narrative away from blame: it's not weakness—it's biology interacting with experience.

### **Allostatic Load: The Cost of Chronic Stress**

Another piece of the puzzle is the concept of **allostatic load**—the wear and tear the body experiences when it's constantly adapting to stress. Chronic substance use doesn't just soothe stress in the short term—it **resets the body's stress system**. Over time, the brain's baseline shifts, leaving people feeling more anxious, more dysphoric, and more driven to use again just to feel “normal.” It's why withdrawal can feel like pure anguish: the brain's stress thermostat has been turned up, and the only quick relief seems to come from using again (Koob, 2021).

### **Inflammation and Sleep Disruption**

We also now understand that substances wreak havoc on **inflammation and sleep**—two systems that directly feed into mental health. Alcohol, stimulants, and opioids can all increase inflammatory processes in the body, which in turn worsen depression and anxiety. And few things destabilize mood more than chronic sleep disruption. Many clients describe this vicious cycle: *“I drink to fall asleep, then I wake up more anxious, so I drink again.”* It's not just bad habits—it's biology at war with itself.

### **Learning and Context**

Finally, there's the power of **learning and environment**. Our brains are built to connect cues with experiences, and substances are potent teachers. A person who always used heroin in a particular neighborhood may feel powerful cravings just walking down that street, years later. This kind of **conditioning** cements the cycle.

On top of that, **social determinants**—housing instability, exposure to violence, discrimination, or poverty—pile on risk. These contexts don’t just make life harder; they create environments where both substance use and mental illness are more likely to take root and persist.

**The Heart of It**

When we put these pieces together—genetics, brain changes, stress overload, inflammation, sleep, learned patterns, and social environments—it becomes clear why substance use and mental illness so often travel hand in hand. It isn’t one thing; it’s **many small forces converging**. And for clients, understanding these “whys” can be a turning point: they begin to see that their struggles are not moral failings but human responses to complex biological and social realities.

---

**Helpful table: distinguishing features**

| Symptom cluster    | Substance-induced clues                                               | Primary disorder clues                           |
|--------------------|-----------------------------------------------------------------------|--------------------------------------------------|
| Depression/anxiety | Onset with use; resolves in 4–6 weeks sobriety                        | Pre-use onset; persists through sobriety         |
| Mania              | Closely time-linked to stimulants; brief                              | Week-long episodes; family history               |
| Psychosis          | Emerges with high-potency cannabis/stimulants; clears with abstinence | Chronic course; negative symptoms off substances |

**Best practices**

- Use **measurement-based care** (PHQ-9, GAD-7, PCL-5) every 2–4 weeks.
- Gather **collateral** (family, prior records).
- Normalize uncertainty: “We’ll treat what we see now and keep watching the pattern.”

---

### 3.5.4 Assessment tools you'll actually use

The following chart lays out Key Assessment Tools for Substance Use and Co-occurring Disorders:

| Tool                                                                             | Purpose                                                                | Administration Time | Clinical Use                                                                                     |
|----------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------|
| <b>AUDIT</b> (Alcohol Use Disorders Identification Test)                         | Screens for hazardous or harmful alcohol use and related consequences. | 2–3 minutes         | Identifies risky drinking patterns; guides brief interventions or referral (Babor et al., 2023). |
| <b>DAST-10</b> (Drug Abuse Screening Test – 10 item)                             | Screens for non-alcohol drug use and related problems.                 | 2–3 minutes         | Detects likelihood of drug use disorders; informs further assessment (Skinner, 2022).            |
| <b>TAPS</b> (Tobacco, Alcohol, Prescription medication, and other Substance use) | Identifies lifetime and recent substance use across categories.        | 2–5 minutes         | Integrates into SBIRT protocols for primary care and behavioral health (McNeely et al., 2023).   |
| <b>ASSIST</b> (Alcohol, Smoking and Substance Involvement Screening Test)        | Assesses risk levels for various substances.                           | 5–10 minutes        | Provides substance-specific risk scores; guides targeted interventions (WHO, 2023).              |

| Tool                                          | Purpose                                                          | Administration Time | Clinical Use                                                                                 |
|-----------------------------------------------|------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------|
| <b>ASI</b> (Addiction Severity Index)         | Multidimensional assessment of life areas affected by addiction. | 45–60 minutes       | Establishes baseline and tracks changes in treatment across domains (McLellan et al., 2022). |
| <b>PHQ-9</b> (Patient Health Questionnaire-9) | Measures depression severity over the past two weeks.            | 2–3 minutes         | Screens for major depressive disorder; monitors treatment progress (Kroenke et al., 2022).   |
| <b>GAD-7</b> (Generalized Anxiety Disorder-7) | Measures severity of generalized anxiety symptoms.               | 2–3 minutes         | Identifies and tracks anxiety symptoms; informs therapy planning (Spitzer et al., 2022).     |
| <b>PDSS</b> (Panic Disorder Severity Scale)   | Measures frequency, intensity, and impact of panic attacks.      | 5–7 minutes         | Monitors treatment response in panic disorder (Shear et al., 2021).                          |
| <b>PCL-5</b> (PTSD Checklist for DSM-5)       | Assesses PTSD symptom severity according to DSM-5 criteria.      | 5–10 minutes        | Screens, provides provisional diagnosis, and tracks PTSD symptoms (Weathers et al., 2023).   |

| Tool                                                                 | Purpose                                                                     | Administration Time | Clinical Use                                                                                             |
|----------------------------------------------------------------------|-----------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------------|
| <b>MDQ</b> (Mood Disorder Questionnaire)                             | Screens for lifetime history of manic/hypomanic symptoms.                   | 5 minutes           | Identifies possible bipolar disorder; follow-up diagnostic interview required (Hirschfeld et al., 2021). |
| <b>Brief Psychosis Screens + Clinician Interview</b>                 | Screens for hallucinations, delusions, disorganization; confirms diagnosis. | 5–15 minutes        | Detects possible psychotic disorders; differentiates from substance-induced states (Kline et al., 2023). |
| <b>C-SSRS</b> (Columbia-Suicide Severity Rating Scale) + Safety Plan | Assesses suicidal ideation, behaviors, and risk.                            | 5–10 minutes        | Guides immediate safety planning; reduces imminent suicide risk (Posner et al., 2023).                   |

Tip: Pick **one** tool per domain and use it **consistently**; trending over time beats one-off snapshots.

## 2.4.7 Three Case Vignettes (Assessment → Plan → Follow-through)

---

### Case A – “Fentanyl, Nightmares, and the Night Shift”

D. was 32 years old and had the exhausted, taut look of someone who had seen too much, too often. As an emergency department medic, his nights were filled with flashing lights, metallic smells, and the sound of human suffering. Sleep was elusive—when it came, it brought combat-like nightmares that jolted him awake in a cold sweat.

He had found a grim solution: smoking fentanyl before bed. It slowed his mind and softened the images long enough to drift off. But this routine had nearly cost him his life; six months earlier, he'd overdosed in his own apartment, revived only because a colleague had stopped by unannounced.

When D. walked into the clinic, his PCL-5 score—a PTSD screening tool—was 48, signaling severe symptoms. His urine test confirmed opioid use disorder (severe), but there were no signs of psychosis or mania. His risk for another overdose was high, and his job meant he was constantly surrounded by trauma triggers.

#### **The Plan:**

The team acted quickly. D. began a same-day **buprenorphine micro-induction** to ease withdrawal without precipitating a crash. **Prazosin** was titrated to target the nightmares, and he left with a **naloxone kit** in his backpack. His therapy included **Seeking Safety** groups for trauma/substance recovery, with an eventual transition to **Cognitive Processing Therapy (CPT)**. **Contingency management** rewarded attendance, while sleep hygiene coaching and **CBT-I** techniques tackled insomnia head-on.

#### **The Follow-through:**

Twelve weeks later, D. returned with clearer eyes and steadier posture. His PCL-5 score had dropped 16 points. His urine drug screens were consistently negative—except for prescribed buprenorphine. He had resumed per-diem medic shifts and joined a peer support group for first responders. “The nightmares aren’t gone,” he said, “but they’re not running my life anymore.”

---

### **Case B – “Cannabis Wax and Campus Paranoia”**

P. was 20 and, like many college sophomores, balancing academic ambition with the temptations of campus life. But unlike most, he spent hours each day inhaling high-potency THC concentrates—“wax” that hit fast and hard. Over the past month, something had shifted. Whispers in the library felt directed at him; shadows seemed to move in his peripheral vision. His grades were slipping, and his professors had noticed.

At intake, the picture pointed to **cannabis use disorder (severe)**. But the clinical team was cautious—were these symptoms part of a **substance-induced psychosis** or the first signs of a primary psychotic disorder?

### **The Plan:**

P. began with **psychoeducation** about the link between high-potency cannabis and psychosis risk, a conversation that made him visibly uncomfortable. **Motivational enhancement therapy** helped explore his ambivalence about quitting. He started **CBT for psychosis (CBT-p)** to challenge distorted beliefs, combined with contingency management rewards for THC-negative urine tests. His parents joined **family sessions** to reinforce support at home. As a safeguard, the team considered a **low-dose antipsychotic** if paranoia lingered past abstinence.

### **The Follow-through:**

Eight weeks later, P. had been abstinent for nearly two months. The paranoia had fully resolved without medication. Academic support services helped him recover his GPA. His relapse prevention plan focused heavily on managing exam stress and keeping a regular sleep routine. “I didn’t realize how loud my brain had gotten,” he admitted. “Now it’s quiet again.”

---

## **Case C – “Wine, Worry, and the Boardroom”**

R. was a 46-year-old corporate executive whose confidence in boardrooms masked an unsteady truth: she avoided elevators. Even the thought of being enclosed sent her heart racing and palms sweating. To keep the edge off, she drank—half a bottle of wine most nights—and occasionally took a lorazepam prescribed years ago “as needed” for panic.



Her presenting issues were **alcohol use disorder (moderate)** and **panic disorder**. The conversation about benzodiazepines was frank—continuing them risked dependence, especially alongside alcohol.

### **The Plan:**

R. began **extended-release naltrexone** injections monthly to curb alcohol cravings. She committed to **CBT for Panic** with interoceptive exposure—recreating the sensations of panic in a safe setting to break the fear loop. Motivational interviewing targeted her belief that “stress equals success.” Together, they mapped a **lorazepam taper** and set **contingency management** rewards for completing therapy sessions.

### **The Follow-through:**

Ten weeks in, R. hadn’t touched her PRN benzodiazepines. She had ridden elevators three times without panic—two at work, one at a hotel conference. Her wine intake was down to less than twice a week, with no loss of control. Her relapse prevention plan included strategies for business travel, when both stress and alcohol availability were high. “I didn’t know I could do success without the glass in my hand,” she said, smiling as she left her session.

---

### **Pull-it-together checklist (for everyday practice)**

- ☐ Screen **both** sides (SUD + MH) every intake and at intervals.
- ☐ Map **time course** (what came first; what persists in sobriety).
- ☐ Start **evidence-based meds** early (MOUD, AUD meds; disorder-specific agents).
- ☐ Add **skills-based therapy** (CBT/DBT/trauma-focused).
- ☐ Use **contingency management** to boost engagement.
- ☐ Build **safety plans** (overdose + suicide).
- ☐ Address **sleep** early; it’s a leverage point.
- ☐ Track **scores** (PHQ-9, GAD-7, PCL-5) to guide step-ups.

- Involve **family/peers** when appropriate.
- Tackle **social determinants** (housing, food, transport, employment).

### Clinical Relevance Today

The most “high-yield” tweaks are usually **operational**, not exotic: same-day starts, warm handoffs, reminders, transportation help, and small incentives keep people in care long enough for the therapies to work.

## Chapter 4: Substance Abuse

### 4.1 Opioids: Numbness and Risk

#### The Lure of Relief



Opioids hold a paradoxical place in modern life. For centuries, humans have reached for opium and its derivatives to quiet pain and suffering. In today’s hospitals, opioids like morphine and hydromorphone still represent compassion in medicine—a way to help people endure surgeries, injuries, or the final stages of life with dignity. Patients often describe their first dose as if the body had been wrapped in a warm blanket, pain dissolving into stillness, breath easing for

the first time in hours. In those moments, opioids are not a threat but a gift.

Yet the same chemical properties that grant such relief also open the door to extraordinary danger. Misuse of opioids—whether prescription painkillers, illicit heroin, or synthetic fentanyl—has driven one of the most lethal public health crises of our time. Each surge of dopamine in the brain’s reward pathways conditions the mind to crave more. What begins as comfort can spiral into captivity (Volkow, 2023).

---

## Neurobiology of Comfort and Dependence

Opioids act by binding to mu-opioid receptors in the brain and spinal cord, blocking pain signals while releasing dopamine in the mesolimbic system. This dual action—pain relief and euphoria—explains their irresistible appeal (Reed et al., 2024).

But the same process fuels dependence. The brain adapts quickly, reducing receptor sensitivity. Within weeks, the same dose produces less effect—a phenomenon known as tolerance. When opioids are absent, withdrawal symptoms emerge: agitation, nausea, muscle pain, and sleeplessness. People no longer take opioids to feel pleasure but to avoid misery (Koob & Volkow, 2023).

Synthetic opioids like fentanyl accelerate this process. With potency 50–100 times that of morphine, fentanyl collapses the distance between use, dependence, and overdose. The margin for error narrows so dramatically that even a counterfeit pill can end a life.

---

## The Hidden Dangers

For many, opioid misuse does not begin with thrill-seeking but with pain, whether physical or emotional. A college student may experiment with leftover pills after dental surgery. A laborer with a chronic back injury may extend a prescription longer than needed. A survivor of trauma may discover that opioids numb not only pain but also memories.

In the short term, opioids bring drowsiness, slowed breathing, constipation, and dulled reflexes. But their most dangerous acute effect is respiratory depression. When combined with alcohol or benzodiazepines, even small doses can prove fatal (CDC, 2024).

---

## Case Narrative: Anna's Story

Anna, a 42-year-old teacher, first experienced opioids after spinal surgery. Morphine allowed her body to rest through the worst of her recovery. Months later, as life resumed, Anna found herself reaching for oxycodone not just when her back hurt, but when she felt anxious after long days in the classroom.

At first, it seemed harmless—just one pill on stressful nights. But tolerance crept in, and soon she needed two. When her prescription ran out, she panicked, describing herself as “restless, almost desperate.” What had begun as a compassionate tool for healing had quietly become a source of craving and dependence.

Anna’s story illustrates the dual nature of opioids: medicine in one season, menace in the next.

---

### **Case Narrative: Danielle’s Story**



Danielle, a 32-year-old emergency department nurse, lived daily at the crossroads of life and death. She carried images of trauma home with her—children she couldn’t save, the echo of sirens, the weight of families’ grief. A colleague introduced her to fentanyl patches. For Danielle, it was not about getting high but about finally sleeping.

“The first night,” she recalled, “it was like my body could breathe again.” But relief soon became necessity. Within weeks, she was distracted at work, consumed by cravings. Six months later, she admitted, “I don’t measure my days by patients anymore, but by how long

I can hold off the sickness.”

Danielle’s story underscores the vulnerability of even the most resilient professionals. For healthcare workers especially, unaddressed trauma and access to powerful substances can create a perfect storm (Peterson et al., 2024).

---

## The Crisis Today

In 2025, opioids remain the central driver of overdose deaths. Fentanyl is implicated in more than 70% of cases, often hidden in counterfeit pills or mixed with stimulants (CDC, 2025). Families describe the losses as sudden and incomprehensible: a loved one who seemed stable one day, gone the next.

Treatment requires more than abstinence. Medication-assisted treatment (MAT)—buprenorphine, methadone, or naltrexone—provides physiological stability, while counseling and peer support address trauma, identity, and hope. As Luis, a young father in MAT care, described: *“It’s like someone finally turned the volume down on the cravings.”*

Recovery is possible, but only when the dual nature of opioids is respected: both healer and destroyer, comfort and captivity.

## 4.2 Stimulants: The Drive That Consumes

### The Allure of Energy and Focus

Where opioids offer quiet relief, stimulants seduce with energy, clarity, and confidence. Cocaine, methamphetamine, and prescription amphetamines such as Adderall or Vyvanse promise sharper focus, longer hours, and the thrill of productivity. Many users describe their first experience as electrifying—thoughts race, fatigue disappears, and self-doubt evaporates.

The cultural narrative around stimulants often celebrates productivity. A pill to finish finals, a line of cocaine before a late-night shift, a “study drug” that feels like a secret edge. But what begins as a tool can rapidly become a trap. The same substances that spark drive and sociability can spiral into paranoia, aggression, and collapse (Hernandez et al., 2024).

---

## Neurobiology of Stimulants

Stimulants primarily affect the brain's dopamine and norepinephrine systems.

- **Dopamine** floods reward circuits, creating intense pleasure and compulsive seeking.
- **Norepinephrine** raises alertness and energy, but also blood pressure and heart rate.

Over time, the brain adapts. Dopamine transporters diminish, leaving motivation and pleasure blunted without the drug. Users describe everyday life as “flat” or “joyless,” fueling cycles of repeated use (Koob & Volkow, 2023).

Chronic methamphetamine use, for example, has been shown to cause long-term reductions in dopamine transporter availability, making recovery of normal mood regulation especially difficult (Velasquez et al., 2025).

---

### Case Narrative: Jared – The Student Who Couldn't Stop

Jared was a 21-year-old business student. He prided himself on ambition but struggled to keep pace with long nights of study and extracurricular commitments. When a classmate offered him an Adderall pill, she framed it as harmless: “It’s like rocket fuel for your brain.”

That first night, Jared powered through chapters with laser focus. At first, he restricted use to exams. But soon, every paper, every work shift, every presentation seemed to demand it. He began buying pills weekly, then daily. His appetite waned, his weight dropped, and paranoia set in.

By senior year, Jared was awake for 48-hour stretches, convinced his professors disliked him and his girlfriend was unfaithful. He collapsed during a class presentation, blood pressure spiking dangerously high. A drug screen revealed stimulant misuse.

Jared’s story mirrors a growing reality: 10–15% of college students report nonmedical stimulant use, often underestimating risks until health crises emerge (SAMHSA, 2023).

---

## Case Narrative: Tanya – The Meth Spiral

Tanya, 34, was a single mother working two jobs. A coworker introduced her to methamphetamine with the promise, “It’ll keep you going.” The first time, she felt unstoppable—energized, social, and strong.

But daily use soon replaced sleep. Her skin grew pale, her body thin. She developed sores from scratching imaginary “bugs.” Her daughter whispered, “Mom, you don’t smile the same anymore.”

Paranoia followed. Tanya was convinced her boss was plotting against her and strangers were following her. After staying awake three days straight, she collapsed in her hallway. At the ER, she presented with arrhythmia, dehydration, and stimulant-induced psychosis.

Methamphetamine’s grip, once a lifeline for fatigue, became a force unraveling her health and family. Neuroimaging studies confirm what Tanya lived: meth damages frontal-limbic circuits, fueling paranoia and emotional dysregulation (Velasquez et al., 2025).

---

## Broader Risks of Stimulants

Stimulants appear first as helpers—study aids, performance enhancers, mood boosters. But their costs accumulate quickly.

- **Short-term effects:** insomnia, irritability, dehydration, aggression, risky decision-making.
- **Long-term effects:** paranoia, hallucinations, cognitive decline, stroke, and dependence.
- **Social impact:** strained relationships, job loss, financial instability, criminal charges.

Physiologically, stimulants strain the heart while destabilizing the brain's reward system. Psychologically, they create cycles of craving, euphoria, and devastating crash.

---

## **Summary**

Stimulants are often framed as shortcuts to control—energy for students, endurance for workers, euphoria for partygoers. Yet for many, the very sense of control they chase dissolves into chaos. The worker who once relied on meth to endure long shifts ends up unable to sleep or trust her own mind. The student who took Adderall for focus finds himself unable to think without it.

The paradox is striking: stimulants promise vitality but leave behind exhaustion, isolation, and fragility. Families watch once-driven loved ones unravel into suspicion and frailty. Counselors encounter clients torn between longing for the surge and dread of the crash.

---

## **Closing Note**

Stimulants, like opioids, reveal addiction's central truth: substances often begin as solutions—relief, energy, escape—but morph into problems greater than the ones they were meant to solve. The drive they ignite can consume body, mind, and life. For clinicians, this means listening beyond the surface story of “study help” or “extra energy,” and recognizing the profound human cost behind stimulant misuse.

## **4.3 Cannabis: Between Medicine and Misuse**

### **A Substance of Paradox**

Cannabis occupies a complicated place in the landscape of substance use. For some, it represents liberation from pain, stigma, or sleepless nights. For others, it is the quiet thief of memory, motivation, or mental health. Once vilified as a “gateway drug,”



cannabis is now legal in many states, reshaping how people view both its risks and potential.

What complicates matters further is that cannabis today is far stronger than that of earlier decades. In the 1970s, THC levels averaged around 2–3%. By the 2020s, most retail strains exceeded 20% THC, and concentrates such as wax, shatter, and oils could reach up to 90%. These products are not merely stronger—they can fundamentally change the brain's response, increasing risks of dependence, paranoia, or psychosis in vulnerable individuals (Patel et al., 2024).

---

## Neurobiology and Effects

Cannabis primarily acts on the **endocannabinoid system**, a widespread network of CB1 and CB2 receptors throughout the brain and body. This system influences appetite, memory, coordination, and emotional regulation. THC, the main psychoactive compound, binds to CB1 receptors, altering perception and mood.

- **Short-term effects:** euphoria, laughter, relaxation, altered sense of time, increased appetite.
- **Risks:** slowed reaction times, impaired concentration, accidents, panic attacks.
- **Long-term effects:** reduced memory and concentration, dependence, worsening of depression or anxiety, and in some cases, increased risk of psychosis in genetically vulnerable individuals (Nguyen & Flores, 2025).

Daily use of high-potency products doubles the likelihood of developing a psychotic disorder among young adults with family histories of schizophrenia or bipolar disorder (Patel et al., 2024).

Another lesser-known risk is **cannabis hyperemesis syndrome (CHS)**, a condition where heavy users develop cycles of uncontrollable nausea and vomiting. Many patients find temporary relief only in hot showers, leaving them confused as to why a substance that once eased symptoms now causes them (Jones et al., 2024).

---

### **Case Narrative 1: Priya's Wax and Worry**

Priya, 20, began using cannabis wax during her sophomore year at a large university. She was high-achieving but socially anxious, and her friends assured her cannabis was “natural and safe.” At first, it gave her relief—her thoughts slowed, and she felt more connected to her peers.

Over time, however, her experiences shifted. She became suspicious of her professors, withdrew from classes, and locked herself in her dorm room. Her roommates grew alarmed after she accused them of spying. When she finally sought help, clinicians diagnosed her with cannabis-induced psychosis.

With abstinence, her paranoia subsided, but Priya was shaken. *“I never thought weed could do this,”* she admitted. Her case is increasingly common in clinical settings, where high-potency concentrates fuel psychiatric symptoms in young adults.

---

### **Case Narrative 2: Eleanor's Evening Ritual**

Eleanor, 67, was a retired nurse living with arthritis pain. After her opioid prescriptions were reduced, she turned to cannabis edibles, encouraged by a local dispensary clerk. Paired with wine, the gummies seemed to provide perfect sleep.

But tolerance grew. She needed more gummies, and her mornings became foggy. Twice she fell at home, once breaking her wrist. Her daughter noticed she was more forgetful and withdrawn. Eleanor confessed she could not sleep without cannabis, saying, *“It's the only thing that makes me feel okay.”*

Her story underscores the often-overlooked risks for older adults: combining cannabis with alcohol or other medications can magnify sedation, impair cognition, and increase fall risk (Johnson & Lee, 2024).

---

### **Case Narrative 3: Marcus and the “Creative Spark”**

Marcus, 45, was a graphic designer who prided himself on originality. A colleague suggested cannabis might help him “loosen up” creatively. At first, occasional use seemed beneficial—colors felt brighter, ideas flowed, and brainstorming sessions felt exhilarating.

But over time, Marcus relied on cannabis for every project. Without it, he felt uninspired and blocked. Deadlines slipped, and his work quality declined. At home, his wife noticed he was more irritable and disengaged. Marcus realized that what began as a creative spark had become a dependency that dulled both his art and his relationships.

---

## Adolescents and the Developing Brain

Adolescence is a particularly vulnerable period. The prefrontal cortex, responsible for judgment and impulse control, continues developing into the mid-20s. Cannabis use during this stage is linked to impaired memory, reduced academic achievement, and heightened risk of psychiatric illness later in life (Volkow et al., 2023).

Teens often dismiss these risks, pointing to legalization or peers’ casual use. Yet clinicians report that heavy adolescent users often describe feeling “stuck”—less motivated, more anxious, and unable to imagine futures beyond their immediate circles. This phenomenon, sometimes called “amotivational syndrome,” remains debated scientifically but resonates strongly in clinical narratives.

---

## Cultural and Legal Shifts

The legalization of cannabis has reshaped its cultural meaning. Dispensaries with sleek packaging and wellness branding frame cannabis as a lifestyle product, closer to herbal tea than to heroin. Campaigns emphasize words like *natural*, *organic*, and *healing*.

While legalization reduces some harms—such as criminal penalties and contaminated supplies—it also risks normalizing daily use. Surveys show that perceptions of cannabis as “low-risk” are at historic highs among young adults, even as potency and associated risks rise (NIDA, 2024).

---

## Summary

Cannabis is a mirror of human longing. For some, it brings relief from pain, quiet from anxiety, or connection in loneliness. For others, it creates disconnection—from studies, from family, from reality itself.

Eleanor found comfort in her evening gummies, only to discover dependency stealing her balance and clarity. Priya sought calm in wax but slipped into paranoia. Marcus turned to cannabis for creativity, only to find his spark fading.

The paradox is stark: cannabis can soothe and destabilize, connect and isolate, open doors and close them. The challenge for clinicians is not to cast judgment but to listen deeply—asking not just *“Do you use?”* but *“What does cannabis give you, and what does it take away?”*

## 4.4 Hallucinogens: Doors of Perception

### Introduction: The Allure of Altered States

Hallucinogens occupy a unique space in human history. For centuries, cultures around the world have turned to mushrooms, peyote, ayahuasca, and other plant-based psychedelics for spiritual insight, healing, and rituals of connection. In the modern West, they also carry the legacy of the counterculture of the 1960s and the cautious optimism of current clinical trials.

Today, hallucinogens are both feared and celebrated. To some, they are dangerous—capable of triggering panic, accidents, or lingering psychological harm. To others, they are promising tools, with psilocybin and MDMA showing therapeutic potential for depression, PTSD, and end-of-life anxiety (Johnson et al., 2023; Nguyen & Patel, 2025). The tension between risk and hope makes hallucinogens both fascinating and clinically important.

---

## Neurobiology and Effects

Hallucinogens are not a single class of drugs but a diverse group that includes psychedelics, empathogens, and dissociatives.

- **Classic psychedelics** (LSD, psilocybin, mescaline) act primarily on serotonin 5-HT2A receptors, altering sensory perception and cognition.
- **MDMA (ecstasy, molly)** increases serotonin, dopamine, and norepinephrine, creating euphoria, emotional openness, and empathy.
- **Ketamine** works differently, blocking NMDA receptors, producing dissociation and—in clinical settings—rapid antidepressant effects.

**Short-term effects:** visual distortions, intensified emotions, synesthesia, altered time perception, feelings of unity or transcendence.

**Risks:** panic reactions, overheating (particularly with MDMA), impaired judgment, and risk-taking behaviors.

**Long-term risks:** hallucinogen persisting perception disorder (HPPD), flashbacks, persistent anxiety, and in rare cases, psychosis in vulnerable individuals (Nguyen & Patel, 2025).

The unpredictability of hallucinogens—how one dose may bring awe in one person and terror in another—makes context (“set and setting”) critical (Griffiths et al., 2023).

---

### **Case Narrative 1: Diego’s Festival Gone Wrong**

Diego, 26, loved music festivals. At one summer event, a friend handed him what was advertised as MDMA. Within an hour, he felt euphoric—music pulsed through his body, and he hugged strangers with joy.

But as the night wore on, Diego’s body grew dangerously hot. He danced nonstop, forgetting to hydrate. Soon he collapsed, his muscles cramping. Medics rushed him to the tent, where his core temperature was critically high—a sign of MDMA-induced hyperthermia.

Diego survived, but weeks later, he still struggled with memory lapses and low mood. He admitted later, *“I thought it was just fun. I didn’t realize it could kill me.”*

His story reflects both the risks of MDMA itself and the dangers of adulteration: many “ecstasy” pills sold today contain methamphetamine or synthetic cathinones, making effects unpredictable (SAMHSA, 2024).

---

### **Case Narrative 2: Anna’s Unfinished Journey**

Anna, 39, had lived with depression for most of her adult life. After reading about psilocybin-assisted therapy, she decided to try mushrooms on her own.

Her first trip was awe-inspiring. She described colors breathing, trees whispering, and a profound sense of connection: *“For the first time in years, I felt hopeful.”* Encouraged, she began using mushrooms monthly, then weekly.

But the experiences grew darker. One night, she was gripped by terrifying visions, convinced she was dying. In the weeks that followed, she developed lingering anxiety and flashbacks. *“I was looking for healing,”* she later said, *“but without guidance, I got lost.”*

Anna’s story illustrates the difference between structured clinical trials, which involve screening, guidance, and integration therapy, and recreational use, which can destabilize mental health (Nguyen & Patel, 2025).

---

### **Case Narrative 3: Nathan’s Search for Meaning**

Nathan, 52, was a software engineer who described himself as “burned out and empty.” He had read online forums about ayahuasca retreats and traveled to South America seeking renewal.

The ceremony was intense. Guided by shamans, Nathan drank the bitter brew and experienced vivid visions, alternating between awe and terror. He vomited repeatedly, a

common effect. Yet by morning, he felt profoundly changed—more connected to his values and less burdened by work stress.

Back home, however, the glow faded. Without ongoing integration or support, he found himself chasing the same feelings by returning to retreats and experimenting with psychedelics alone. His wife grew concerned as he withdrew from family life. Nathan admitted he was “addicted to the search for meaning.”

His case highlights a growing trend: the rise of psychedelic tourism and the risk of using profound experiences without proper support or integration (Carhart-Harris & Goodwin, 2023).

---

## The Broader Risks of Hallucinogens

Hallucinogens are often misunderstood as “safe” because they do not typically cause physical dependence. Yet the risks are real:

- **Accidents:** distorted perception can lead to falls, burns, or drowning.
- **Overheating and dehydration:** especially with MDMA at festivals.
- **Lingering psychological symptoms:** panic, paranoia, or flashbacks.
- **Psychiatric destabilization:** triggering psychosis in vulnerable individuals.

At the same time, clinical trials suggest that under careful guidance, hallucinogens may reduce symptoms of PTSD, depression, and end-of-life anxiety (Johnson et al., 2023). The contrast between these two realities makes hallucinogens especially complex for counselors.

---

## Summary

Hallucinogens are often described as doors—sometimes opening into wonder, other times into chaos. Diego’s MDMA experience brought temporary joy but nearly cost him

his life. Anna sought healing but found herself lost in panic. Nathan experienced transcendence but struggled to integrate it into everyday living.

For clinicians, the task is to hold both sides of this paradox. Hallucinogens can be healing or harmful, liberating or destabilizing. They are not inherently safe or dangerous; their impact depends on dose, mindset, context, and vulnerability.

The modern moment is one of tension: clinical studies raise hope for therapeutic breakthroughs, while recreational markets fuel risks of contamination, overuse, and psychological fallout. As with all substances, the work lies in careful listening—understanding not only what was taken, but why, and how it has shaped the person’s journey.

## 4.5 Prescription Drugs: Hidden in Plain Sight

### Introduction: The Mask of Legitimacy

Prescription drugs differ from many other substances in one critical way: they often enter a person’s life through a place of trust—a physician’s office, a pharmacy counter, a hospital bedside. This origin grants them legitimacy, a veneer of safety. Clients may reason, *“If my doctor gave it to me, it can’t be dangerous.”*

Yet the reality is more complicated. Benzodiazepines, stimulants, and opioids—all essential medicines in the right context—can lead to dependence and devastating consequences when misused. Unlike illicit drugs, which carry obvious red flags, prescription misuse often unfolds quietly, behind closed doors, with denial and minimization cloaked in the language of “treatment” (SAMHSA, 2024).

---

### Neurobiology of Prescription Misuse

Prescription drugs act on some of the brain’s most powerful circuits:

- **Benzodiazepines** enhance GABA at GABA-A receptors, dampening anxiety and inducing sedation. Over time, the brain downregulates its natural calming



mechanisms, leaving clients vulnerable to rebound anxiety, seizures, and even death if the medication is stopped abruptly (Reynolds & Kim, 2024).

- **Prescription stimulants** increase dopamine and norepinephrine, enhancing alertness and productivity. But with chronic misuse, the brain's reward circuits dull, leading to fatigue, depression, and compulsive drug seeking (Nguyen & Flores, 2025).
- **Prescription opioids** activate mu-opioid receptors, reducing pain but also driving tolerance and hyperalgesia—where pain sensitivity paradoxically increases with long-term use (Reed et al., 2024).

Withdrawal from these substances can be especially dangerous. Benzodiazepine withdrawal can trigger seizures; stimulant crashes can lead to severe depression and suicidality; opioid withdrawal produces relentless physical and emotional distress. For many clients, the fear of withdrawal sustains continued misuse.

---

### **Case Narrative 1: Rebecca's Wine and Xanax**

Rebecca, 50, had always managed life's challenges with composure—until her divorce. Sleepless nights and anxiety spiraled until her doctor prescribed Xanax. At first, the pills brought relief. But soon, paired with her evening wine, they dulled not only her stress but her clarity. Her children noticed slurred words and morning confusion.

When she tried to stop, her body rebelled—tremors, racing heart, panic so severe she thought she was dying. Rebecca's story highlights how easily prescribed relief can entangle someone in physiological dependence, especially when combined with alcohol.

---

### **Case Narrative 2: Marcus and the ADHD Shortcut**

Marcus, 28, entered finance with ambition but soon felt crushed under the workload. Remembering the Adderall that boosted him in college, he persuaded his physician to

prescribe it again. At first, it sharpened his edge. But tolerance grew, and soon extra doses left him sleepless, paranoid, and depressed.

Marcus's trajectory reflects a growing reality: misuse of prescription stimulants in high-pressure industries, where performance demands outweigh concerns about long-term health.

---

### **Case Narrative 3: Harold's Quiet Dependence**

Harold, 72, never considered himself someone at risk of addiction. But after hip surgery, hydrocodone became his lifeline. At first, it let him walk and garden again. Over time, he found himself taking more, earlier, until he felt unable to function without it.

His daughter discovered the truth when Harold grew confused and drowsy, surrounded by empty bottles. Older adults, often overlooked in discussions of substance misuse, are particularly vulnerable due to slower metabolism, multiple prescriptions, and isolation (Reed et al., 2024).

---

### **Case Narrative 4: Tasha's Teen Pills**

Tasha, 17, struggled with test anxiety. A classmate offered her a few Adderall tablets before finals. The results were intoxicating—hours of focus, a rush of confidence, and grades that improved almost overnight. What began as “study help” turned into regular weekend use.

By senior year, she was skipping meals, jittery, and unable to sleep. She snapped at her parents, convinced they were “against her.” A health class drug screening revealed her stimulant misuse. Tasha's case mirrors a common adolescent entry point: academic pressure turning a prescribed medicine into a risky crutch (NIDA, 2024).

---

### **Case Narrative 5: Miguel the Veteran**

Miguel, 35, returned from deployment with PTSD and chronic knee pain. Doctors prescribed a combination of hydrocodone and Ativan. At first, the medications dulled both physical pain and nightmares. But as doses escalated, Miguel found himself detached from his wife and children, falling asleep at the dinner table, sometimes blacking out.

When he tried to stop, flashbacks and pain roared back. “The pills made me feel like a soldier again—steady, unshaken. Now without them, I feel like I’m falling apart,” he told his counselor. Miguel’s story shows how prescription misuse often overlaps with trauma, requiring integrated care for both body and mind.

---

### **Case Narrative 6: Alana’s Postpartum Struggle**

Alana, 32, gave birth to her second child and struggled with postpartum depression. Sleep was elusive, and her doctor prescribed Ativan “as needed.” At first, it felt like a lifeline. But soon, every restless night ended with a pill. Her anxiety about motherhood deepened, and she found herself hiding bottles around the house.

Her husband noticed she grew foggy and withdrawn. At intake, Alana admitted through tears, *“I thought I was just being a bad mom. I didn’t realize the medicine had taken over.”* Her case underscores how women’s health contexts—pregnancy, postpartum, menopause—often intersect with prescription misuse in ways that are underrecognized (Carroll et al., 2024).

---

### **Cultural Context: Why Prescription Drugs Feel “Safer”**

Unlike street drugs, prescription medications carry the authority of healthcare. Bottles are labeled, doses are explained, and pharmacies are familiar, respectable institutions. This legitimacy can lull clients into overlooking risks.

Families may ignore warning signs, assuming that “doctor’s orders” guarantee safety. Adolescents often see prescription stimulants as less risky than cocaine or meth, even

when the chemical actions overlap. Older adults may view benzodiazepines as harmless “sleeping pills” without realizing the dangers of dependence or falls.

This cultural framing creates a barrier to honest disclosure. Clients are often more willing to admit to cannabis or alcohol use than to doubling their Xanax dose or borrowing Adderall. For clinicians, it means asking precise, nonjudgmental questions is critical.

---

### The Broader Dangers of Prescription Misuse

- **Benzodiazepines** amplify sedation, impair cognition, and, when mixed with alcohol, sharply increase overdose risk (CDC, 2023).
  - **Prescription stimulants** can cause heart attacks, paranoia, and psychiatric destabilization.
  - **Prescription opioids** carry overdose risks identical to heroin and are often a gateway to illicit opioid use when prescriptions run out (Reed et al., 2024).
- 

### Summary

Prescription misuse is rarely about thrill-seeking. More often, it begins in moments of real need: Rebecca’s sleepless nights, Marcus’s crushing workload, Harold’s pain, Miguel’s trauma, Alana’s postpartum anxiety, Tasha’s academic pressure. These are not caricatures of “addicts” but ordinary people searching for relief, control, or peace.

The tragedy is not only that dependence can form, but that it often forms quietly, cloaked in medical legitimacy. A pill for sleep becomes a crutch. A stimulant for attention becomes a necessity. An opioid for recovery becomes a nightly ritual.

For clinicians, the task is not to demonize prescriptions—they remain vital tools—but to help clients recognize when healing has tipped into harm. That recognition requires compassion, careful inquiry, and an understanding of the cultural power that prescription bottles carry.

## **4.6 The Long Arc of Substance Use Trends: A Historical Context**

### **Introduction: Patterns Across Generations**

Substance use in the United States has never been static. Each decade carries its own story, shaped by medicine, markets, culture, and policy. The substances themselves change—morphine in the Civil War, cocaine in the Jazz Age, LSD in the 1960s, crack in the 1980s, OxyContin in the 1990s, fentanyl today. Yet the human themes remain constant: pain and relief, escape and connection, profit and policy.

Looking at the broader arc, we see how decisions in medicine and industry, combined with cultural currents, ripple for generations. Understanding this history matters—not just for perspective but because many clients walk into counseling rooms carrying the consequences of these historical waves in their own families.

---

### **The Prescription Era: From Relief to Risk**

In the late 1990s, pharmaceutical companies introduced new opioid formulations, most famously OxyContin. Backed by aggressive marketing, companies reassured doctors that these medications carried little risk of addiction when prescribed for pain (Van Zee, 2009; Kolodny et al., 2015). Pain became known as the “fifth vital sign,” and physicians were encouraged to treat it liberally.

For many patients, these medications were transformative. A construction worker with chronic back pain could return to the job site; a grandmother with arthritis could garden again. Prescriptions skyrocketed. But beneath the relief, dependence was growing quietly.

By the early 2000s, communities across rural Appalachia and small-town America were flooded with pills. Families that had never seen themselves as connected to “drug abuse” suddenly watched their children and neighbors slide into opioid misuse. For many counselors, the faces of clients began to shift: no longer just urban heroin users,

but teachers, factory workers, and grandparents dependent on pills from the family doctor (Quinones, 2015).

---

### **Case Vignette: Sarah's First Prescription**

Sarah was 29 when she injured her knee in a car accident. Her doctor prescribed OxyContin, reassuring her it was “non-addictive if used correctly.” At first, it was a blessing—she could walk without agony. But when the prescription ran out, she noticed her body trembling, her mood crashing. She returned for refills, and within months, she needed higher doses to feel the same relief.

By the time her doctor hesitated to continue prescribing, Sarah was desperate. A coworker offered her pills from another source. When those grew too expensive, she tried heroin, a decision she swore she'd never make. Sarah's story mirrors thousands from the 2000s: individuals who began with legitimate prescriptions and crossed into illicit opioids when the system pulled the safety net away.

---

### **The Shift to Heroin**

By 2010, the scale of prescription misuse was undeniable. States and regulators cracked down, monitoring prescribing more tightly. In 2010, Purdue Pharma reformulated OxyContin to make it harder to crush and snort. Prescriptions fell sharply. But the demand remained.

Cut off from pills, many dependent patients turned to heroin, which was cheaper and widely available. Heroin-related deaths tripled between 2010 and 2015 (CDC, 2015). Families described children who once took their mother's pain pills now shooting heroin in the bathroom. The “face of addiction” shifted again, revealing the unintended consequences of policy swings.

---

### **Case Vignette: Jake's Descent**

Jake, 22, had been prescribed Vicodin after wisdom tooth surgery. The leftover pills became his go-to escape during stressful college semesters. By senior year, he was buying them from friends. When his dealer switched to heroin, Jake resisted at first—until he saw the price.

Heroin was cheaper, stronger, and soon irresistible. Jake’s parents were stunned: “We thought he was just partying. We didn’t realize it started with a prescription.” His decline illustrates the bridge from prescription misuse to heroin—a pattern documented widely in the 2010s (Cicero et al., 2014).

---

## The Fentanyl Flood



Around 2013–2014, fentanyl appeared in the U.S. drug market. Unlike heroin, which required cultivating poppies, fentanyl could be synthesized cheaply in clandestine labs and shipped in small packages. By 2016,

fentanyl had saturated heroin supplies and even appeared in counterfeit pills sold as Xanax, Percocet, or Adderall (DEA, 2016).

The consequences were immediate and devastating. Overdoses skyrocketed because users often did not know fentanyl was in their supply. Families described sudden losses: a son who seemed stable one week, gone the next from a single counterfeit pill. By 2021, fentanyl was implicated in over 70% of U.S. overdose deaths (CDC, 2022).

---

## Case Vignette: Daniel’s Counterfeit Pill

Daniel, 19, was not a regular drug user. A friend gave him what he believed was a Percocet to “take the edge off” after finals. Hours later, his parents found him

unconscious. The pill had been laced with fentanyl. Despite immediate naloxone, Daniel did not survive.

His story reflects a chilling reality: even experimental use became deadly in the fentanyl era. For clinicians, it underscored that overdose prevention was not only for “addicts” but for anyone experimenting with pills or powders in a landscape flooded with synthetic opioids.

---

### **The Pandemic Years: Isolation and Escalation**

When COVID-19 struck in 2020, substance use collided with unprecedented isolation, job loss, and stress. Treatment centers closed or reduced capacity. Harm reduction programs struggled to stay open. Many people used more frequently, and often alone, raising the risk of fatal overdoses (NIDA, 2021).

Supply chains shifted as well, sometimes introducing unexpected adulterants. Stimulant-involved deaths rose, with methamphetamine increasingly contaminated with fentanyl. By 2021–2022, U.S. overdose deaths surpassed 100,000 annually—the highest in history (CDC, 2022).

---

### **Signs of Change: 2023–2025**

By 2024, provisional data brought a glimmer of hope. U.S. overdose deaths dropped nearly 27%, from about 110,000 in 2022 to around 80,000 in 2024 (CDC, 2025; Anderer, 2025). Expanded naloxone availability, including over-the-counter sales, played a major role (FDA, 2023). Telemedicine for buprenorphine and other medication-assisted treatments expanded care, especially in rural areas (SAMHSA, 2025).

Imagine a small-town clinic in 2020: overbooked, unable to initiate MAT quickly. Now, by 2024, that same clinic can start buprenorphine via video consultation and send patients home with naloxone. These changes, multiplied across the country, saved lives.



Still, threats remain. New synthetic opioids, such as nitazenes, have emerged, sometimes stronger than fentanyl (UNODC, 2024). Xylazine (“tranq”), a veterinary sedative, has increasingly contaminated supplies, causing wounds and complicating overdoses that do not respond to naloxone. The arc continues to shift, demanding vigilance.

---

### **Warm Narrative Reflection**

The long arc of substance use in America is a story of shifting landscapes. Each era has its own drug of choice, its own promises, its own devastation. Sarah’s OxyContin prescription, Jake’s slide to heroin, Daniel’s counterfeit pill, and countless others represent how history lives in individual lives.

The broader lesson is clear: substances do not exist in isolation. They are shaped by medicine, policy, economics, and culture. For clinicians, awareness of this history deepens empathy. When a client says, *“It started with my back injury,”* or *“I thought it was just one pill,”* those words carry echoes of decades of prescribing practices, pharmaceutical marketing, and policy shifts.

History is not just background—it walks into the room with every client. Recognizing that helps clinicians meet people not with judgment but with understanding: addiction is not simply an individual choice but part of a much larger human story.

## **4.8 The Polysubstance Era: New Adulterants and Market Shifts**

### **Introduction: The End of the “Single-Drug” Story**

In earlier decades, clinicians often spoke of people as “heroin users,” “cocaine users,” or “methamphetamine users.” Today, that neat categorization rarely applies. Most individuals who come into treatment test positive for more than one substance. The **polysubstance era** has arrived, reshaping risk, treatment, and even the meaning of overdose.

It is not only that people *choose* multiple drugs—though some do, seeking the “speedball” effect of stimulants with opioids. Increasingly, it is that the **supply itself is unpredictable**. Counterfeit pills, fentanyl-laced cocaine, benzodiazepines mixed into opioid tablets—what clients think they are taking is often not what their bodies are metabolizing (DEA, 2024).

---

## The Xylazine Shadow

Among the most striking shifts has been the rise of **xylazine**, a veterinary tranquilizer nicknamed “*tranq*.” First appearing in Puerto Rico in the early 2000s, it has now spread through U.S. fentanyl supplies, especially in the Northeast and Midwest (CDC, 2024).

Xylazine does not respond to naloxone, making overdoses harder to reverse. Its most visible effect is the development of severe skin ulcers, sometimes far from the injection site. For many users, these wounds are stigmatizing, frightening, and sometimes disabling.

## Case Vignette: Marissa’s Hidden Wounds

Marissa, 31, was living in Philadelphia when she noticed painful sores on her forearms. At first, she thought they were infections from bad injection technique. Over time, they worsened, spreading up her arms. Ashamed, she wore long sleeves even in summer.

When she finally sought help, doctors explained her fentanyl supply was contaminated with xylazine. The ulcers were not a sign of “dirty” behavior but of a toxic additive in the supply chain. “*I didn’t even know I was taking it,*” she said. For Marissa, the wounds were both a medical crisis and a turning point that brought her into treatment.

---

## Nitazenes: Potency Beyond Fentanyl

As if fentanyl were not potent enough, **nitazenes**, a new class of synthetic opioids, began appearing in the U.S. around 2022. Some are dozens of times stronger than morphine, rivaling or surpassing fentanyl (UNODC, 2024).

The danger lies in invisibility: nitazenes are often pressed into counterfeit pills sold as Xanax, Oxycodone, or even Adderall. Users may believe they are taking a “milder” medication, only to ingest something exponentially stronger.

### **Case Vignette: Tyler’s Counterfeit Xanax**

Tyler, 20, purchased what he thought were Xanax bars from a friend before a stressful exam. Within hours, he collapsed, requiring three doses of naloxone and intensive hospital care. Lab testing revealed nitazenes. Tyler later reflected, *“I thought I was taking something to calm down. I almost died instead.”*

His story shows why clinicians must warn clients that even “legit-looking” pills can conceal deadly synthetics.

---

### **The Stimulant Crossroads**

Cocaine and methamphetamine remain deeply woven into the polysubstance landscape. Some individuals intentionally mix them with opioids—seeking balance between sedation and stimulation. Others encounter contamination unknowingly. The result is a dangerous tug-of-war: stimulants accelerate the heart, while opioids suppress breathing. The combination makes overdoses unpredictable and difficult to manage (NIDA, 2024).

### **Case Vignette: Jamal’s Warehouse Collapse**

Jamal, 42, worked long hours at a distribution center. After years of pain and stress, he began using pills he believed were pressed Xanax. One day, he collapsed at work. Paramedics administered naloxone, which revived him only partially. Toxicology revealed fentanyl, xylazine, and traces of cocaine. Jamal had no idea he had taken any of these substances. *“I thought it was just for stress,”* he said.

His case underscores the clinical imperative to **assume polysubstance exposure until proven otherwise**.

---

## Why This Matters in Counseling

The polysubstance era challenges traditional clinical questions. Instead of asking, “*What drug do you use?*” professionals now ask:

- “*Tell me what you took yesterday.*”
- “*What did you expect it to be?*”
- “*Did it feel different than you thought?*”

These open-ended questions help reveal hidden risks—xylazine in fentanyl, nitazenes in pills, or methamphetamine mixed with opioids.

For clients, the new normal is unpredictability. What they think of as a pill for sleep or a bump of cocaine for energy may carry a mix of substances they never chose. For clinicians, this means overdose education must shift from single-substance warnings to layered conversations about contaminated supply, carrying multiple naloxone doses, and using test strips when available (SAMHSA, 2025).

---

## Warm Narrative Reflection

The polysubstance era is defined less by people chasing multiple highs and more by a **toxic supply chain** reshaping risk. Marissa’s ulcers, Tyler’s counterfeit pill, and Jamal’s collapse each reflect a deeper truth: in 2025, no drug supply can be assumed “pure.”

For professionals, this reality demands humility and vigilance. Clients are not simply “choosing” risk—they are often blindsided by it. Treatment and harm-reduction strategies must adapt, not by shaming use but by equipping clients with practical tools: naloxone, test kits, honest information, and compassionate dialogue.

The single-drug archetypes of the past have given way to something more complex. In today’s counseling rooms, clinicians meet people shaped not just by their choices but by an unpredictable and increasingly dangerous market.

## 4.9 Beyond the U.S.: Canada, Europe, and Australia

### Introduction: A Global Story with Local Accents

Though much of the public focus falls on the U.S. opioid crisis, substance use is not an American story alone. Across Canada, Europe, and Australia, the same threads emerge—potent opioids, stimulants, cannabis, and hallucinogens reshaping lives and communities. Yet each region has its own distinctive patterns, reflecting policy choices, cultural narratives, and market dynamics.

For professionals, understanding these global contexts is not an academic exercise. Patients move, travel, immigrate, and carry experiences across borders. A clinician in Ohio may sit with a client who used cocaine in London, MDMA in Berlin, or methamphetamine in Sydney. These global fingerprints appear in local counseling rooms, reminding us that substance use is a worldwide phenomenon, braided with culture and context.

---

### Canada: Polysubstance Toxicity as the Defining Crisis

In Canada, fentanyl dominates the drug landscape, but rarely travels alone. By 2024, **74% of opioid toxicity deaths involved fentanyl, and 70% also involved a stimulant** (Public Health Agency of Canada, 2025). In provinces like British Columbia, Alberta, and Ontario, paramedics report a new normal: patients whose bodies carry the signatures of both opioids and stimulants simultaneously.

Naloxone still saves lives, but families often describe confusion: *“We gave them Narcan—why didn’t it work right away?”* The answer often lies in polysubstance toxicity. Opioids can be reversed; stimulants, sedatives, and adulterants cannot.

### Case Vignette: Kyle in Vancouver

Kyle, 27, lived in Vancouver’s Downtown Eastside. He cycled between fentanyl, methamphetamine, and alcohol. On a rainy evening, he overdosed in a shelter bathroom. Staff rushed with naloxone, reviving him partially, but his heart still raced

erratically. At the hospital, toxicology confirmed fentanyl, methamphetamine, and benzodiazepines.

Kyle later reflected, *“I never set out to take three drugs. I just thought I was buying fentanyl.”* His story illustrates how the Canadian crisis is not defined by one drug but by dangerous cocktails hidden in the supply.

---

## **Europe: High Availability and Emerging Synthetic Threats**

Across Europe, the picture looks different yet familiar. Cocaine has reached record availability, especially through ports like Antwerp and Rotterdam, flooding local markets (EMCDDA, 2025). Cannabis remains the most widely used illicit drug, but synthetic stimulants such as amphetamine, methamphetamine, and cathinones dominate in certain regions.

A growing concern is the appearance of **nitazenes**, synthetic opioids many times more potent than morphine. Though still rare compared to fentanyl in North America, nitazenes have triggered alerts through Europe’s Early Warning System.

### **Case Vignette: Lena at a Berlin Club**

Lena, 23, attended a music festival in Berlin. She purchased what she thought was MDMA but quickly spiraled into panic, overheating, and confusion. At the hospital, bloodwork revealed nitazenes in the pill. *“I thought it was ecstasy,”* she told doctors, *“but it was something I’d never even heard of.”*

Her experience highlights Europe’s shifting risks. While harm reduction is often stronger—drug-checking services and supervised consumption sites are more available—new synthetics still slip into supplies, surprising even seasoned users.

---

## **Australia: Wastewater Windows into Behavior**

In Australia, one of the most striking tools for monitoring use is **wastewater testing**, which provides near real-time insight into national consumption patterns. Between 2023

and 2024, wastewater analysis showed Australians consumed over **22 metric tonnes of methamphetamine, cocaine, heroin, and MDMA combined** (Australian Criminal Intelligence Commission, 2024).

Methamphetamine—known locally as “ice”—remains especially entrenched. It shapes not just health but also crime, family stability, and community safety. Counselors in Sydney, Melbourne, and rural towns alike report meth-related paranoia, psychosis, and sleep deprivation as routine parts of their caseloads.

### **Case Vignette: Naomi in Melbourne**

Naomi, 34, was a single mother balancing childcare and part-time work. A friend offered her “ice” to help her keep up. At first, it felt like a miracle—energy, confidence, and productivity soared. But within a year, Naomi was using daily, paranoid about neighbors, and struggling to sleep for more than a few hours at a time.

When she sought help, she admitted, *“I thought it was just a helper. Now I don’t know who I am without it.”* Her story echoes across Australia, where methamphetamine has become one of the most socially disruptive substances in the national landscape.

---

### **Threads Across Borders**

Despite regional differences, clear threads emerge:

- **Polysubstance use is the new norm.** Few people use just one drug.
- **Potency keeps rising.** Fentanyl in North America, nitazenes in Europe, and high-purity methamphetamine in Australia all magnify risks.
- **Markets are globalized.** What emerges in one region often appears elsewhere within years.
- **Harm reduction matters.** Naloxone in the U.S., drug-checking in Europe, and wastewater surveillance in Australia show that practical, evidence-based measures save lives.

## Summary

Looking globally, we see different settings but familiar human struggles. Kyle in Vancouver, Lena in Berlin, Naomi in Melbourne—each is living in a context shaped by geography and policy, yet each story echoes universal themes: the search for relief, the risks of potency, the chaos of hidden mixtures.

For clinicians, these international trends are not distant. Clients bring these experiences back with them—immigrants, travelers, or even those who encounter imported substances locally. Recognizing that addiction is global broadens empathy and deepens awareness: what we face in one city is part of a larger human story, unfolding across continents.

---

## 4.10 What It Means for Clinicians on the Ground

### Introduction: Complexity Is the New Normal

The landscape of substance use in 2025 is not defined by one drug or one population. Instead, clinicians now face a **new normal of complexity**—where clients rarely present with a single substance problem, and where the risks involve not only overdose but also infectious disease, psychiatric instability, and deep social disruption (CDC, 2025; SAMHSA, 2025).

For professionals, this complexity is not a barrier but a call to adapt. To sit with clients today means holding multiple truths at once: a client may be both patient and defendant, both caregiver and user, both survivor and struggler. It requires flexibility, humility, and deep compassion.

---

### The Decline in Overdose Deaths: A False Finish Line



The decline in U.S. overdose deaths in 2024—from 110,000 to 80,400—was a historic milestone (Anderer, 2025). But for those on the ground, this does not mean the crisis is “over.”

In counseling rooms and ERs, clients still arrive daily with fentanyl in their bloodstream, wounds from xylazine, or paranoia from methamphetamine. The data may bend downward, but the work remains relentless. Clinicians must resist the temptation to treat progress as completion. The decline is an opening—a chance to build stronger systems of care—not a finish line.

---

### Case Vignette: Kevin's Collapse in the Warehouse

Kevin, 42, was working a long shift at a warehouse when he suddenly collapsed. Paramedics administered naloxone, reviving him only partially. In the ER, toxicology revealed fentanyl, cocaine, and xylazine in his system.

Kevin had thought he was taking a “pressed Xanax” for stress. He had no idea it contained multiple substances. His case highlights a new reality: **patients often do not know what they are ingesting**. For clinicians, this means screening and assessment must move beyond single-substance questions to open-ended prompts like:

- *“Tell me everything you’ve used this week, including anything you thought was a prescription.”*
- *“Did it feel different than you expected?”*

---

### The Global Ripples in Local Rooms

Substance use patterns in the U.S. no longer exist in isolation. Nitazenes in Europe, methamphetamine in Australia, and fentanyl in Canada all eventually influence American markets (UNODC, 2024; EMCDDA, 2025). Immigrants, travelers, and imported supplies bring these fingerprints into U.S. counseling rooms.

### Case Vignette: Marisol's Quiet Reliance

Marisol, 56, was a grandmother raising her grandsons. She had sworn she would never touch drugs, but chronic pain and stress wore her down. A neighbor gave her “pain pills,” which she took nightly. One evening, her grandson found her unconscious. In the ER, tests revealed fentanyl and nitazenes.

Marisol’s case reminds clinicians that **substance exposure now cuts across demographics** once thought “low risk.” Older adults, caregivers, and even those outside traditional “drug-using populations” may unknowingly ingest lethal synthetics.

---

### Practical Lessons for the Counseling Room

The new substance landscape requires updated instincts:

- **Always ask about combinations.** Clients may not realize multiple drugs are involved.
- **Assume fentanyl unless proven otherwise.** Whether a pill, powder, or heroin, fentanyl contamination is pervasive (CDC, 2025).
- **Prepare for naloxone complexity.** Educate clients and families that more than one dose may be needed—and that naloxone may not address all sedatives (e.g., xylazine).
- **Normalize harm-reduction tools.** Drug-checking kits, naloxone carry, and buddy systems are not signs of “failure” but strategies that save lives (SAMHSA, 2025).
- **Screen beyond opioids.** With cannabis and hallucinogen use at historic highs, and stimulants deeply embedded in polysubstance patterns, clinicians must broaden the lens.
- **Leverage telehealth and access innovations.** Post-pandemic flexibilities—like buprenorphine initiation via telemedicine—remain lifelines for rural and underserved areas (SAMHSA, 2025).

## Summary

For professionals, the most important shift is perspective. No longer can we assume simplicity. No longer can we rely on narrow categories or stereotypes. Today's clients carry complexity in their bloodstreams, in their histories, and in their daily lives.

Kevin's collapse at the warehouse, Marisol's hidden dependence, Jamal's counterfeit pill, Naomi's meth spiral—these are not isolated stories. They are the new face of substance use. They remind us that addiction is not only about chemicals but also about context, trauma, and survival.

Clinicians, then, must be both scientists and storytellers—grounding care in data while honoring the human narratives that bring meaning to recovery. In the polysubstance era, what it means to be a professional is to stand steady in the chaos, offering clarity, compassion, and hope.

---

## 4.11 Screening and Assessment

### Introduction: Finding Clarity in Complexity

When a client sits across from a clinician and begins to talk, the story is rarely straightforward. Some minimize their use: *"I only take a little when I'm stressed."* Others exaggerate or conceal details out of shame, fear, or mistrust. Still others do not actually know what they are taking—counterfeit pills, adulterated powders, or mixtures they never intended.

In such moments, screening and assessment tools become essential. They are not rigid checklists, but **structured windows** into the client's lived reality (Smith & Alvarez, 2023). These tools help clinicians move beyond impressions, anchoring treatment in shared language, measurable data, and a broader picture of functioning.

Three tools stand out as especially valuable in 2025:

|                                                                                   |                                                                                                                                                                             |                                                                                                                                                               |
|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <b>The Addiction Severity Index (ASI)</b><br>provides a broad, multidimensional picture of a person's functioning across medical, psychological, social, and legal domains. | 1. <b>The Addiction Severity Index (ASI)</b> – a multidimensional interview that maps substance use within medical, legal, psychiatric, and social domains.   |
|  | <b>The Drug Abuse Screening Test (DAST),</b><br>a brief but powerful screening tool for drug-related problems.                                                              | 2. <b>The Drug Abuse Screening Test (DAST)</b> – a brief, efficient screen that flags potential problems and invites deeper assessment.                       |
|  | <b>Urine and blood toxicology tests</b><br>which offer biological confirmation of substance use and play a critical role in both treatment planning and harm reduction.     | 3. <b>Urine and blood toxicology</b> – biological markers that confirm or challenge self-report, revealing hidden risks in today's unpredictable drug market. |

Used together, these tools can bridge the gap between what clients say, what their bodies reveal, and what clinicians need to know to shape care.

---

#### 4.11.1 The Addiction Severity Index (ASI)

The **Addiction Severity Index** has been in use since the 1980s and remains one of the most respected instruments for understanding substance use disorders holistically. Unlike narrow questionnaires, the ASI does not stop at “how much” or “how often.” Instead, it explores **seven key domains**:

1. Medical status
2. Employment/support
3. Alcohol use
4. Drug use

5. Legal status
6. Family/social relationships
7. Psychiatric status

This multidimensional view ensures that substance use is not treated in isolation. For example, a person's fentanyl use may be severe, but if unemployment, chronic pain, and family estrangement also define their daily life, a treatment plan must integrate all of those realities.

### **Case Vignette: Marcus and the ASI Interview**

Marcus, 38, sought treatment after a near-fatal overdose. He thought he was there “just for fentanyl.” But the ASI interview revealed much more:

- **Medical:** chronic back pain from a construction accident.
- **Employment:** out of work for six months.
- **Alcohol/Drugs:** daily fentanyl, occasional meth.
- **Legal:** pending DUI case.
- **Family/Social:** separated from his wife, estranged from his children.
- **Psychiatric:** high depression and anxiety scores.

At the end, Marcus admitted, *“I thought I just needed to stop the fentanyl. But I see now everything is connected.”* The ASI gave him and his counselor a roadmap: medication-assisted treatment, physical therapy, legal support, and family counseling.

This is the ASI's gift: it contextualizes substance use within the full web of life.

---

### **4.11.2 The Drug Abuse Screening Test (DAST)**

The **DAST** is the opposite of the ASI in length and scope—but no less valuable. Developed as a quick screen, the DAST (10 or 20 items) identifies drug-related risks in just a few minutes. Questions such as *“Have you engaged in illegal activities to obtain*

*drugs?” or “Do you abuse more than one drug at a time?”* turn vague habits into measurable risk (Reynolds et al., 2024).

Scores are categorized from *no problem (0)* to *severe problem (9–10)*, guiding whether further assessment is needed.

### **Case Vignette: Tyler’s Surprise Score**

Tyler, 23, insisted he wasn’t “into drugs,” admitting only to occasional Adderall and cocaine at parties. A DAST-10 screen scored him at 6—*substantial problem*. Seeing the number jolted him. *“I didn’t think it was serious. Everyone does it.”*

For his counselor, the DAST was not just a diagnostic tool but a **mirror**—helping Tyler confront the gap between his self-perception and reality.

---

### **4.11.3 Urine and Blood Toxicology**

Even with strong interviewing skills, clinicians cannot rely solely on self-report. Some clients underplay use, while others simply do not know what is in their supply.

**Toxicology tests**—especially urine screens—offer biological confirmation.

- **Urine screens** detect substances over hours to days.
- **Blood tests** provide a snapshot of intoxication in the moment.
- **Rapid fentanyl test strips** and expanded panels now detect emerging synthetics like nitazenes (Patel et al., 2024).

These tools are not punitive when used well. They can reveal hidden risks, restore trust, or even motivate change.

### **Case Vignette: Carlos and the Hidden Benzodiazepine**

Carlos, 29, proudly reported two weeks without heroin. A urine screen revealed buprenorphine (as prescribed)—but also benzodiazepines. Shocked, Carlos swore he hadn’t used Xanax. Later, he realized his “relaxation pills” from the street contained

benzos mixed with fentanyl. Without the test, he might have unknowingly risked fatal overdose.

### **Case Vignette: Linda's Restored Trust**

Linda, 47, told her counselor she had been clean from meth for six weeks. Her teenage son didn't believe her. A urine screen confirmed her report, allowing her to show her family tangible proof of honesty. Tears flowed. *"I didn't believe you,"* her son said. *"Now I can."* For Linda, the test wasn't about suspicion—it was about healing relationships.

### **Summary**

Each tool—the ASI, DAST, toxicology—serves as more than a checklist. They are **bridges**. They connect self-report with evidence, denial with insight, mistrust with verification. They remind both client and counselor that substance use is not an isolated behavior but a thread woven into health, relationships, and identity.

For professionals, the task is not simply to administer these tools, but to use them with **empathy**. A DAST score should not be a judgment; it should be an invitation. A toxicology result should not be a "gotcha"; it should be an opening to safety and trust. Used this way, assessment is not about labeling people but about helping them see their own story with new clarity—and beginning to write a different one.

---

## **4.12 Health and Social Consequences**

### **Introduction: Ripples Beyond the Substance**

Substance use is never just about the chemical. Every pill, injection, or inhalation sends ripples outward—into the body, family systems, workplaces, and communities. Some

consequences strike suddenly, like overdose. Others unfold slowly, like hepatitis C, endocarditis, or family estrangement. And while statistics can be staggering—tens of thousands of overdose deaths, millions living with viral infections—the human stories make the consequences most vivid.

For clinicians, understanding these consequences is not optional. It shapes assessment, informs treatment planning, and grounds interventions in the lived realities of clients.

---

#### 4.12.1 Overdose: The Acute Crisis

Overdose is the most immediate and terrifying consequence of substance use. Unlike gradual health decline, an overdose can steal life in minutes. With fentanyl saturating supplies, the margin for error is razor-thin—sometimes as small as a single pill (CDC, 2025).

##### The Physiology

- **Opioids** suppress breathing until oxygen deprivation causes brain damage or death.
- **Stimulants** overstimulate the cardiovascular system, leading to heart attack, stroke, or seizures.
- **Polysubstance use** complicates everything—opioids slow the lungs while stimulants speed the heart, creating chaos inside the body.

In 2024, U.S. overdose deaths declined by 27% compared to 2022 (Anderer, 2025). Yet the absolute toll—80,000 lives lost—remains devastating. Most involved opioids, often mixed with stimulants or xylazine.

##### Case Vignette: Jamal's Near-Miss

Jamal, 27, was a musician whose life looked bright. After a breakup and job loss, he began taking what he thought were oxycodone pills. One night, he overdosed. His roommate found him barely breathing, lips turning blue. Naloxone revived him, but



toxicology later revealed fentanyl and xylazine. *“I thought I was taking painkillers,”* Jamal said.

For Jamal, survival became a turning point. Counselors used the overdose as a motivational anchor: *“You almost lost your music. What do you want life to look like now?”*

### Case Vignette: Eleanor’s Silent Collapse



Eleanor, 63, was a retired schoolteacher, known in her community for volunteering at the library and leading a quilting circle. On the surface, she was steady and reliable. But quietly, Eleanor had been living with unrelenting back pain after a car accident years earlier. Her doctor prescribed opioids for a time, then tapered her off. When her prescriptions ran out, Eleanor turned to a combination of leftover pills, occasional “extras” from friends, and nightly glasses of wine to cope.

For years, she believed her use was under control. “I’m not like those people you see on TV,” she reassured her daughter. But over time, her tolerance grew. What began as one glass of wine and a pill on bad nights became two or three drinks most evenings, always paired with a few tablets.

One winter night, her daughter stopped by unexpectedly and found Eleanor slumped in her recliner. Her breathing was shallow, her skin pale and clammy. Terrified, her daughter called 911. Paramedics rushed in, quickly recognizing an **opioid overdose complicated by alcohol**. They administered naloxone. Eleanor gasped, then vomited, her body jerking as she struggled back toward consciousness.

Hospital tests revealed dangerously high blood pressure, aspiration pneumonia from fluid entering her lungs, and a blood alcohol level well above the legal limit. Eleanor spent a week in the hospital, much of it groggy and confused. For her family, the incident shattered the illusion of safety. “We thought Mom’s medicine was safe because it came from a bottle with her name on it,” her daughter said tearfully.

Discharge planning was sobering. Doctors emphasized the risks of mixing alcohol and opioids at her age: falls, brain injury, and the very real risk of another fatal overdose. Counselors introduced Eleanor to a support group for older adults with substance use issues, reassuring her that she was not alone. Slowly, Eleanor began to share her story with peers, realizing that her struggle wasn’t about moral failure but about unacknowledged pain, loss, and coping gone wrong.

---

#### 4.12.2 Infectious Disease Risk

Substance use also increases vulnerability to infections—viral, bacterial, and fungal.

- **HIV and Hepatitis C** spread through shared needles and injection equipment.
- **Endocarditis and osteomyelitis** follow repeated injection with non-sterile supplies.
- **Xylazine ulcers** leave slow-healing, sometimes disfiguring wounds.

A 2023 CDC report noted “flashpoint outbreaks” of hepatitis C linked to fentanyl injection practices (CDC, 2023). Despite prevention programs, hepatitis C remains widespread.

#### Case Vignette: Daniel’s Hidden Burden

Daniel, 41, a mechanic, injected heroin daily but hid it well. Fatigue sent him to the ER, where tests revealed **infective endocarditis**—a bacterial infection of his heart valve. He was stunned: *“I thought the worst that could happen was overdose. I never thought about my heart.”* Six weeks of IV antibiotics and surgery later, he entered treatment motivated not by overdose fear, but by the shock of nearly losing his life to infection.

### **Case Vignette: Tasha's Wounds**

Tasha, 29, smoked fentanyl daily. She noticed sores on her legs, which spread into deep ulcers. ER doctors recognized xylazine-induced necrosis. *"You're telling me the thing I used to feel better is literally rotting me?"* she wept. The wounds became both a physical and emotional turning point—visible proof of harm that helped anchor her recovery.

---

### **4.12.3 Social and Legal Consequences**

Addiction reshapes identities and relationships. Jobs are lost, families fracture, and legal entanglements follow desperate acts. For many, the legal system becomes the entry point into treatment.

### **Case Vignette: Robert's Kitchen Table and Courtroom**

Robert, 36, a chef, used cocaine to power through long shifts. Arrested for possession, he was mandated to counseling. At a family session, his nine-year-old daughter whispered, *"Daddy, I don't want you in jail. I just want you home at dinner."* Tears broke his defensive shell, reframing recovery not as punishment but as reconnection.

### **Case Vignette: Monique's Struggle for Stability**

Monique, 52, lost her job during the pandemic and turned to prescription opioids, then fentanyl. Petty theft arrests followed when she couldn't afford groceries. Ashamed, she entered treatment mandated by probation. Group counseling and family support helped her rebuild dignity. Her son's words—*"Mom, I just want you safe"*—helped shift her focus from shame to healing.

---

### **Summary**

The consequences of substance use ripple far beyond intoxication. Overdose steals life in minutes; infections erode it silently; social and legal consequences chip away at

identity and dignity. Yet within these crises lie openings—moments where fear, pain, or family voices create space for change.

For clinicians, the lesson is clear: we are not only treating the chemical but also the fallout—medical, relational, and social. Every overdose reversed, every infection treated, every relationship repaired is a reminder that recovery is not just about abstinence but about **rebuilding lives**.

#### 4.13 Conclusion

Substance abuse is never a story of just one drug. It is a **tapestry of substances, circumstances, and human needs**—woven together by biology, culture, trauma, and resilience. In this chapter, we have walked through opioids, stimulants, cannabis, hallucinogens, and prescription medications. Each carried its own pharmacology and dangers, but all shared one thread: the human longing for relief, escape, or connection.

##### The Complexity of Today's Landscape

The mid-2020s mark an era of **polysubstance use**, where clients rarely encounter one drug in isolation (CDC, 2025). Pills may contain fentanyl and nitazenes; methamphetamine may be laced with opioids; even cannabis can be contaminated or hyper-potent. Clinicians must assume complexity, ask broader questions, and prepare for hidden risks.

Overdose remains the most immediate danger. Yet, as Jamal's and Eleanor's stories showed, surviving an overdose can be an inflection point—an opportunity for reflection and engagement. Infectious diseases, whether Daniel's endocarditis or Tasha's xylazine ulcers, remind us that addiction is not only neurological but profoundly medical, with consequences that ripple into families and health systems (Johnson & Lee, 2024; CDC, 2023).

Beyond the body, the consequences strike at identity and community. Robert's daughter's plea in a family session—*"Daddy, I just want you home at dinner"*—and Monique's struggle to maintain dignity after shoplifting charges illustrate how addiction

touches the most intimate aspects of life. It is never only about the substance; it is about broken trust, lost roles, and the slow erosion of self-worth.

---

## Tools That Anchor Us

Amid this complexity, **screening and assessment tools**—the ASI, the DAST, toxicology—remain vital anchors. They are not perfect, but they give clinicians and clients a common map: one that transforms vague narratives into measurable realities and guides treatment toward multidimensional care (Smith & Alvarez, 2023; Reynolds et al., 2024). When used with empathy, they become not checklists, but bridges—helping clients like Marcus and Denise see the bigger picture of their struggles.

---

## Hope and Possibility

Even within grim statistics, there is hope. The 27% decline in overdose deaths in 2024 was not only a number but a signal that interventions—wider naloxone access, telehealth MAT, community harm reduction—can work (Anderer, 2025; SAMHSA, 2025). Luis's recovery through buprenorphine, counseling, and renewed fatherhood reminds us that treatment is not about abstinence alone but about reclaiming dignity, relationships, and life.

The stories of Anna, Tanya, Priya, Diego, and countless others illustrate both the vulnerability of being human and the possibility of renewal. Substances may alter brains and lives, but people remain capable of change. Recovery is not linear, and relapse does not erase progress. What matters is persistence, support, and compassion.

## Summary

For clinicians, the call is clear: we must meet clients not only with scientific knowledge but with **human presence**. To treat substance abuse is to treat the overdose survivor

gasping for meaning, the parent ashamed in court, the grandmother shocked by counterfeit pills, the student sliding from “study help” into paranoia.

Substance use disorders are **medical, psychological, and social conditions**. But they are also human stories—of pain, of searching, and of resilience. And for every client, the task is not only to end misuse but to restore connection: to family, to community, to purpose, and to self.

Chapter 4 leaves us with this truth: while the substances may evolve—from heroin to fentanyl, from MDMA to nitazenes—the clinician’s role remains steady. We are guides in the storm, helping clients move from the chaos of misuse toward recovery, dignity, and hope.

---

## **Chapter 5: Evidence-Based Treatment Approaches**

### **A Human Starting Point**

Recovery from substance use is rarely a straight line. Behind every treatment plan is a person—someone carrying both pain and resilience, someone stepping tentatively toward change. What makes treatment effective is not only the research that supports it, but the way it fits into real human lives. A therapy that empowers one client may leave another unmoved; a medication that quiets cravings for one person may not work for someone else.

This chapter explores the tools that research has shown to work—**evidence-based approaches**—but always with the reminder that science meets its true power when it is wrapped in compassion, flexibility, and trust.

---

### **5.1 Behavioral Interventions**

## Cognitive-Behavioral Therapy (CBT)

CBT has become a cornerstone of addiction treatment, not because it promises quick fixes, but because it gives people something precious: **clarity**. For many, life in addiction feels like chaos, an endless loop of triggers and regrets. CBT slows the loop down. It teaches clients to notice how thoughts, feelings, and behaviors connect—and how that chain can be broken and reshaped.

Instead of simply asking clients to “resist cravings,” CBT helps them see the thoughts that make cravings louder: *“I can’t handle this without drinking,”* or *“I’ve already failed, so why bother?”* In session, clients learn to pause, to question those thoughts, and to practice different responses. Over time, that pause becomes power—the power to choose a new script.

### Vignette: Mark Finds the Pattern

Mark, 29, came to CBT frustrated. “It’s always the same,” he sighed. “Stress at work builds up, I fight with my boss, and by Friday I’m drinking.” Together, he and his counselor mapped out the week. The triggers weren’t just the fights—they were the thoughts that followed: *“I can’t handle this without a drink.”*

Seeing it on paper, Mark realized it wasn’t weakness—it was a pattern. With guidance, he began replacing the old script with new ones: calling a friend after work, heading to the gym, journaling the loneliness instead of numbing it. “It’s like I finally found the roadmap,” he said later. The stress didn’t vanish, but he no longer felt doomed to crash every Friday. CBT gave him back a sense of agency.

---

## Motivational Interviewing (MI)

While CBT offers skills, MI offers something just as important: **a conversation that feels safe**. Many people come to treatment ambivalent—they want change, but they also cling to what substances give them. MI doesn’t argue with that ambivalence; it listens to it.

In MI, the therapist's job is not to push but to reflect—so the client hears their own reasons for change out loud. A small reflection—*“Part of you enjoys the release, and part of you dreads the Monday crash”*—can open space for the client to explore both sides of their struggle. When clients voice their own hopes and values, motivation grows naturally.

### **Vignette: Tanya's Turning Point**

Tanya, 31, walked into her first session braced for judgment. After a DUI, she expected lectures. Instead, her counselor said: *“You're not sure alcohol is the problem—and you're worried about your job and license.”* Tanya felt her shoulders loosen. She wasn't being scolded; she was being understood.

Over the next sessions, she admitted she wanted to be reliable for her sister, to keep her job, to break her family's cycle of addiction. By the end, Tanya wasn't being told why to change—she was telling herself. MI had shifted her from resistance to momentum, not through pressure but through empathy.

---

### **Contingency Management (CM)**

If MI draws out reasons for change, CM offers **immediate rewards for living it out**. Addiction thrives on quick reinforcement—the instant rush of dopamine. CM uses that same principle but turns it toward recovery: clean screens, medication adherence, or group attendance are met with tangible rewards—gift cards, prizes, or digital credits.

The idea is simple: healthy behaviors should feel rewarding *now*, not just “someday.” And for many, those small wins build momentum that lectures alone cannot.

### **Vignette: Devon's Small Wins**

Devon, 38, had tried to quit cocaine before. Each time, shame after relapse made him give up. When his counselor introduced CM, he scoffed: “You think a grocery card is gonna stop me from using?” But he agreed to try.

Each clean test earned him vouchers that grew in value with consistency. At first, it felt silly. Then one day, holding a bag of fresh fruit he bought with his rewards, Devon said,



“This feels better than blowing all my cash on a high.” The groceries weren’t the point—it was the sense of accomplishment, the proof that he *could* string together clean days. CM gave him a ladder of small victories that eventually added up to real change.

---

## 5.2 Pharmacological Interventions

Sometimes cravings roar louder than willpower. Medications can quiet that roar, giving clients space to heal.

- **For alcohol use:** Naltrexone dulls the reward of drinking, acamprosate stabilizes brain chemistry, and disulfiram creates a strong deterrent.
- **For opioids:** Methadone steadies the body, buprenorphine eases withdrawal, and naltrexone blocks opioid effects entirely.
- **For other substances:** Few medications exist for stimulants, though nicotine treatments are well studied.

For therapists, the role isn’t prescribing—it’s **normalizing**. Clients often fear that medication means “not really sober.” Gentle reassurance reframes it: medication isn’t weakness, it’s a bridge back to stability.

### Vignette: James and Naltrexone

James, 42, called alcohol cravings “the voice that never shuts up.” On naltrexone, he noticed the noise fading to background hum. With cravings less overwhelming, he could finally focus in therapy and spend weekends with his children instead of fighting relapse.

### Vignette: Angela and Buprenorphine

Angela, 36, had used opioids for nearly a decade. Her mornings were defined by sickness and panic. Buprenorphine changed that. “I can make my kids breakfast without shaking,” she told her therapist. Medication gave her body rest, and therapy gave her hope. Together, they helped her rebuild her life.

---

## 5.3 Detoxification and Medical Management

The first step of recovery can be the most dangerous. Withdrawal is not just uncomfortable—it can be life-threatening, especially with alcohol and benzodiazepines.

- **Inpatient detox** is safest for severe withdrawal, with 24-hour monitoring.
- **Outpatient detox** works for lower-risk clients with strong support, often paired with buprenorphine for opioids.

Therapists help clients see detox not as failure but as **safety and courage**—the doorway to recovery, not its end.

### **Vignette: Maria's First Step**

Maria, 47, had hidden her nightly drinking for years. When she tried to quit, she shook, sweated, and panicked. Her therapist reframed it: *"This isn't weakness—it's your body telling you it needs medical help."* With inpatient detox, Maria finally felt safe enough to move forward.

### **Vignette: Andre's New Morning**

Andre, 33, dreaded opioid withdrawal more than relapse. With outpatient buprenorphine, he experienced his first calm mornings in years. "I used to wake up thinking about how to get well. Now I wake up thinking about my day." Detox wasn't the end—it was the beginning.

---

## **5.4 Residential, Outpatient, and Community Programs**

Recovery doesn't happen alone. People heal in communities—whether residential programs, outpatient therapy, or peer-led groups.

For some, **12-Step programs** like AA offer structure, accountability, and spiritual grounding. For others, secular options like SMART Recovery or Refuge Recovery resonate more. **Harm reduction programs** meet people where they are, offering dignity and safety even if abstinence isn't the immediate goal.

### **Vignette: Calvin and the Circle of Chairs**

Calvin, 46, scoffed at AA until he walked into a room of laughter and acceptance. "It's

really about not doing this alone,” he realized. The circle of chairs gave him belonging, and with it, the strength to stay sober.

### **Vignette: Rosa and the Naloxone Kit**

Rosa, 28, wasn’t ready to quit heroin, but she carried naloxone after her therapist suggested it. When a friend overdosed, she used it and saved his life. That act sparked a shift: “If I can save him, maybe I can save myself.” Harm reduction had kept her alive long enough for hope to take root.

---

## **5.5 Telehealth and Digital Interventions**

Since 2020, telehealth has transformed care. Today, clients expect the option to log in from home, balancing therapy with childcare, jobs, or rural life. Mobile apps extend therapy into daily routines, tracking cravings or offering mindfulness practices.

Digital recovery groups give connection at any hour. Yet therapists must guard against digital pitfalls—protecting confidentiality, maintaining engagement, and encouraging balance between online and in-person support.

### **Vignette: Leah’s Return to Care**

Leah, 34, relapsed after nearly a year sober. Ashamed, she avoided in-person therapy—until she discovered online meetings. With her camera off, she listened, realizing she wasn’t alone. Soon, she reconnected with her therapist via telehealth. “I wouldn’t have come back if I had to walk through the office door,” she admitted. Online care gave her the doorway back.

---

## **Conclusion to Chapter 5**

Recovery is a mosaic. Some pieces are clinical—CBT, MI, CM, or medication. Some are medical—detox, stabilization, relapse prevention. Others are relational—support groups, harm reduction, or digital communities. Woven together, they create a tapestry of healing.

For therapists, the unifying thread is this: **treatment works best when it is human-centered**. We don't force clients down one road—we walk beside them, listening for what matters, offering tools that fit, and celebrating even the smallest steps forward.

Evidence-based approaches are not only about preventing relapse or reducing symptoms. They are about restoring agency, rebuilding connection, and helping clients believe in their own possibility again. When science is joined with compassion, recovery is not just possible—it becomes real.

---

## **Chapter 6: Counseling Strategies and Therapeutic Techniques**

### **From “What” to “How”**

If the last chapter explored *what* treatments work—CBT, MI, medications, detox—this chapter turns to *how* we bring those treatments to life. How does a therapist transform research into human connection? How do we structure conversations so that hope can take root?

Counseling is both science and art. It involves theory, but also timing, presence, and humility. Individual counseling builds trust one session at a time. Group therapy draws strength from shared stories. Family counseling helps repair bonds stretched thin by addiction. Cultural responsiveness ensures care feels safe and relevant. And through it all, ethics and law create guardrails—protecting both clients and clinicians as they navigate difficult terrain.

The work is never one-size-fits-all. It is an unfolding process of listening, adjusting, and responding. At its heart, counseling is less about fixing people and more about walking beside them as they rediscover their strength.

---

## 6.1 Individual Counseling



For many clients, individual counseling is the first space where they can remove the mask—where honesty no longer feels dangerous. The private, one-on-one setting provides focus, safety, and the foundation of a therapeutic alliance. Research consistently shows that this bond

between therapist and client is the strongest predictor of positive outcomes (Norcross & Lambert, 2019).

### Approaches

Therapists draw from multiple approaches, blending what works best for each person. CBT helps clients trace the links between thoughts, feelings, and behaviors (Carroll & Kiluk, 2017). MI invites ambivalent clients to voice their own reasons for change (Miller & Rollnick, 2023). Trauma-informed care acknowledges the wounds many clients carry, keeping sessions safe and empowering (SAMHSA, 2020).

### Session Flow

Most sessions follow a rhythm: early meetings focus on trust, middle ones dive into coping skills and triggers, and endings bring review, practice, and intention-setting (Beck et al., 2021). For clients used to chaos, this structure provides grounding—a reminder that progress builds step by step.

### Treatment Planning

Plans are more than paperwork; they are roadmaps co-written with clients. Goals are specific and attainable, whether that means two sober weeks, better communication

with a partner, or showing up for work. Plans evolve with progress, adjusting for setbacks and celebrating wins (APA, 2021).

### **Vignette: Jordan Finds His Voice**

Jordan, 35, came to therapy only because his partner threatened to leave. Defensive at first, he minimized his drinking. Using MI, his therapist gently reflected: *“On one hand, drinking feels like a release. On the other, it’s hurting your relationship.”* That crack opened the door.

Over time, CBT helped Jordan map his patterns: stress at work → “I deserve this” → drinking. For the first time, he realized his behavior wasn’t weakness—it was a script. Together, they practiced new responses. Instead of heading to the bar, he tried a walk, journaling, or calling a friend. Slowly, ambivalence gave way to motivation. “I thought alcohol was the only road,” he admitted months later. “Now I see there are others—and I get to choose.”

---

## **6.2 Group Therapy and Peer Support**

If individual counseling is about safety, group therapy is about solidarity. Groups help clients realize they are not alone. Addiction isolates; groups reconnect. Listening to another person voice what you’ve silently lived dismantles shame and builds belonging (Yalom & Leszcz, 2020).

Groups can be messy—voices compete, emotions surge—but with clear structure and boundaries, they become fertile ground for healing. Research shows they are as effective as individual therapy for many substance use disorders (Weiss et al., 2019).

Peer support beyond therapy—AA, NA, SMART Recovery—adds another layer, providing community and accountability long after formal treatment ends.

### **Vignette: The Power of Universality**

Darius, a truck driver, sat in his first group with arms crossed, skeptical. But as others shared, he heard his own story—payday binges, lonely nights, the promise of “just one

more time.” For the first time, he whispered, “I thought I was the only one.” Nods around the circle told him he wasn’t.

Weeks later, it was his peers—not just the therapist—who challenged him: “*You want to be there for your kids. How does using help with that?*” The words stung, but they stuck. Group therapy gave Darius both accountability and hope—a circle where his shame turned into belonging.

---

### 6.3 Family Therapy and Systemic Approaches

Addiction ripples through families—through silence, anger, enabling, and broken trust. Family therapy recognizes that healing is rarely an individual act; it is often relational (O’Farrell & Clements, 2012).

Sessions often begin with education, reframing addiction as a chronic illness rather than a moral failing. From there, families practice new ways of communicating—expressing needs without blame, setting boundaries with compassion, rebuilding trust step by step (Rowe, 2012).

Systemic models like Behavioral Couples Therapy (BCT) and CRAFT shift patterns that fuel relapse and teach families to reinforce recovery (Meyers et al., 2011). Therapists must also assess carefully—sometimes family involvement supports recovery, other times it harms.

#### **Vignette: Rebuilding Trust at the Dinner Table**

Elena, 27, dreaded involving her parents in treatment. “They’ll just yell or cry,” she said. But in their first session, the therapist explained addiction as a medical condition. Her father, for the first time, leaned forward: “*So it’s not just her choosing this?*”

In later sessions, her family practiced new communication tools. Instead of accusations, her mother tried: “*I worry when you don’t come home.*” Slowly, meals became less tense. Trust didn’t return overnight, but the family began shifting from blame to teamwork. Elena’s father summed it up: “We’re learning to be on the same side again.”

---

## 6.4 Cultural Competency in Counseling

Healing is shaped by culture. Clients bring identities, traditions, languages, and histories that influence both their substance use and their recovery. Cultural competence doesn't mean knowing every culture; it means practicing humility—listening, learning, and honoring what matters most to each client (Sue et al., 2019).

### Vignette: Meeting Recovery Through Faith

Amina, 32, feared therapy would not understand her cultural and religious world.

“Admitting this brings shame on my whole family,” she whispered. Instead of prescribing, her therapist asked: *“How does your faith shape your idea of healing?”*

Amina lit up. She shared how prayer, fasting, and service had once helped her.

Together, they built those practices into her recovery plan. She joined a faith-based recovery group where she felt at home. “For the first time,” she said, “I don’t have to leave part of myself at the door to get better.”

---

## 6.5 Ethical and Legal Considerations

Compassion must always be balanced with clear ethics. Confidentiality, informed consent, and mandated reporting are not red tape—they are the guardrails that keep therapy safe and just.

Clients must know their privacy is protected, except when safety is at risk (SAMHSA, 2020). Informed consent should be an ongoing conversation, not a single signature. And when safety demands reporting—child abuse, elder abuse, or imminent harm—therapists must be transparent, involving clients whenever possible.

### Vignette: When Safety Meets Confidentiality

Marcus, 19, admitted he sometimes drove after drinking. His therapist felt the weight of confidentiality versus safety. She reminded him: *“Remember when we talked about limits? If I believe someone could be seriously harmed, I need to act. Let’s think it through together.”*



Rather than panicking, Marcus appreciated her honesty. Together, they built a safety plan—rideshares, trusted friends, weekly check-ins. He later admitted: “I thought you’d just turn me in. Instead, you treated me like a partner.”

## **Conclusion to Chapter 6**

Counseling is where research meets relationship. Individual sessions give clients space to be seen. Groups remind them they are not alone. Families learn to heal together. Cultural humility ensures care feels safe and authentic. Ethics protect the fragile trust that makes it all possible.

The strategies in this chapter are not scripts but tools—adaptable, flexible, and deeply human. At their best, they remind us that therapy is not about doing something *to* clients but walking *with* them, step by step, as they rediscover possibility, dignity, and hope.

---

## **Conclusion**

At every stage of this journey—whether we have been examining the science of medications, the structure of counseling sessions, the power of groups, or the importance of cultural humility—the message has been the same: recovery is profoundly human. Research gives us the map, but it is people—their hopes, struggles, and resilience—who walk the road.

Clients do not come to therapy as blank slates. They bring stories of loss and longing, of shame and strength. Therapists do not simply apply techniques; they enter into those stories with care, offering guidance, safety, and encouragement. Together, they co-create pathways where change feels possible, one step at a time.

Evidence-based tools like CBT, MI, or contingency management matter because they work—but they work best when woven with empathy. Medications save lives by quieting

cravings and easing withdrawal, but their real gift is the breathing space they provide for families to reconnect and for clients to dream again. Groups remind us that no one heals alone. Families remind us that addiction ripples outward—and so can recovery. Cultural humility reminds us that every person's healing story is unique. And ethics remind us that this sacred work must always be safe, just, and trustworthy.

Recovery, then, is not about perfection or quick fixes. It is about persistence, connection, and small steps that grow into transformation. It is about turning moments of despair into openings for hope, and about remembering that even in the darkest seasons, people can and do reclaim their lives.

As professionals, our task is simple but never easy: to show up with skill and compassion, to hold hope when clients cannot, and to believe in the possibility of change even when the evidence feels thin. When we do this, we honor both the science and the humanity of our work.

Because in the end, the story of recovery is not only about substances or symptoms—it is about people finding their way back to themselves, and about the communities and clinicians who walk beside them on the journey home.

**End of the Course!**