

CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

WORKING WITH THE SUBSTANCE ABUSE POPULATION
A MFT TRAINEE'S RESOURCE GUIDE

A graduate project submitted in partial fulfillment of the requirements

For the degree of Master of Science in Counseling,

Marriage and Family Therapy

By

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PREFACE

For the past six years I have been earning an education that would allow me to obtain a career in the mental health field. During this time I have received a bachelor's degree in Psychology from California State University, Northridge, completed the majority of the required coursework for a certificate of completion from Los Angeles City College's Drug and Alcohol Counseling Program, and worked at Tarzana Treatment Centers.

Currently, I am a candidate to receive a Master's in Science in Marriage and Family Therapy from California State University, Northridge. For the past eighteen months I have been training at Valley Women's Center, a community-based mental health center that primarily focuses on treating victims of domestic violence and providing treatment for the substance abuse population. During my training at the center, I have facilitated substance abuse-related educational and support groups, and I have counseled and provided therapy for clients with substance abuse-related issues. I have been employed at Tarzana Treatment Centers' transitional housing program for the past six years. The majority of the clients who receive services from this program have an extensive history of substance-related disorders.

During my educational and training experiences I have come to realize that many of my fellow students and trainees have limited or no experience in working with the difficult and challenging substance abuse population. Consequently, I believe a resource guide tailored to the needs of the marriage and family therapist trainee would be beneficial to both new mental health professionals and their substance abusing clients.

The goal of this project is to develop a resource guide for marriage and family therapist trainees that offers an overview of the definition of substance abuse, describes the theories of addiction, and presents practical information about treatment models and treatment settings.

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TABLE OF CONTENTS

SIGNATURE PAGE	ii
PREFACE	iii
ACKNOWLEDGMENTS	v
ABSTRACT	viii
CHAPTER ONE: INTRODUCTION	1
Statement of the Problem	1
Purpose of the Project	2
Project's Use of Substance-related Terms.....	3
Project Overview	3
Limitations of the Study	4
CHAPTER TWO: REVIEW OF THE LITERATURE.....	5
Diagnostic and Statistical Manual of Mental Disorders Definition of Substance Abuse.....	5
Treatment Settings	7
Theoretical Models of Substance Abuse	9
Comorbidity/Dual Diagnosis	16
Psychopharmacology	18
Pain Management Issues Relating to Treatment	19
Best Practices/Evidence Based Treatment Modalities.....	21
Genogram Utilization.....	22
Twelve-step Program Conceptualization	23
Group Therapy in Treating Substance Abuse.....	25
Relapse Prevention.....	27
Conclusion.....	28
CHAPTER THREE: PROJECT AUDIENCE AND IMPLEMENTAION FACTORS....	29
Introduction	29
Development of Project.....	29
Intended Audience	30
Project Outline	31
CHAPTER FOUR: CONCLUSION	32

Summary 32
Discussion..... 32
Future Work..... 33

REFERENCES..... 34

APPENDIX

A. Working with the Substance Abuse Population: A MFT Trainees Resource
Guide 40
B. Commonly Abused Drugs..... 73

ABSTRACT

WORKING WITH THE SUBSTANCE ABUSE POPULATION

A MFT TRAINEE'S RESOURCE GUIDE

By

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Master of Science in Counseling

Marriage and Family Therapy

The prevalence of substance abuse-related disorders is alarmingly high among adolescents and adults in the United States. Some of these individuals seek alcohol and drug treatment voluntarily as a result of personal, family, and relational problems. Many others are referred to treatment through legal mandates and court referrals. In addition, substance abuse is a common co-morbidity among individuals with mental health issues. As a consequence, marriage and family therapist trainees are likely to encounter clients with substance abuse-related disorders during their training in settings such as schools and community mental health centers. This resource guide is a practical guide for the marriage and family therapy trainee who may lack experience in working with this challenging client population.

CHAPTER ONE

INTRODUCTION

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Survey on Drug Use and Health, there were 23.5 million people in the United States who were over the age of 12 who needed treatment for a substance abuse problem in 2009 ("National Institute," 2011). That is almost one in ten individuals in our nation's population. Most of those who need specialized treatment for a drug or alcohol problem in the United States do not receive it ("Substance Abuse," 2010).

Substance abuse is associated with numerous serious health conditions including cardiovascular disease, cancer, liver and kidney damage, and neurological and respiratory effects ("Medical consequences of," 2012). Chronic use of some drugs of abuse can cause changes in the brain leading to paranoia, depression, aggression, and hallucinations. Importantly, the dysfunctional behaviors associated with substance abuse can negatively impact a person's normal functioning in the family, the work place and the community (Rehm, 2009). Beyond the health and social consequences, the economic burden of alcohol and illicit drug use is substantial, costing the nation an estimated \$428 billion each year ("National Drug," 2010).

Statement of the Problem

Many individuals will eventually seek some form of treatment for their substance abuse and/or underlying substance-related issues either by choice, by family concerns, or by legal mandates. The most common methods for treatment are twelve-step programs,

inpatient treatment centers, outpatient substance abuse programs, and other alternative treatment models such as sober living communities.

In the United States there are over a hundred marriage and family therapy training programs. As a typical part of their curriculum, students are required to train at local community institutions such as schools, treatment centers, and mental health programs. During their training period, students will frequently experience their first face-to-face contact with clients. Many of these clients will either have current or past issues with substance abuse.

Marriage and family therapist trainees often have little or no experience working with the complex and often challenging substance-abusing population. Issues such as involuntary treatment, denial, physical dependence, co-morbidity, family dynamics, and cultural considerations can complicate a therapist's attempt to effectively treat an individual with substance abuse. Having a basic understanding of these issues and the ways they influence an individual's experience in recovery can enhance a trainee's ability to work effectively with this population.

Purpose of Project

The prevalence of alcohol abuse, illicit (i.e., illegal) drug use, and non-medical use of prescription drugs in the United States is high and associated with serious health, social and economic burdens. Importantly, substance abuse plays a significant role in the lives of the client population seen by marriage and family therapist trainees. Treating clients with substance-related issues is complex and challenging for the large number of marriage and family therapist trainees with little experience with individuals suffering from the effects of substance abuse. The purpose of this project is to provide trainees with

a resource to help them work more effectively with the substance-abusing population and to get more individuals the help they need.

Project's Use of Substance-Related Terms

As detailed in the literature review in Chapter Two, there are numerous terms and definitions for describing the use of harmful substances. In general, this project will describe substance abuse as the misuse of substances including alcohol, illicit drugs, and prescription medications. Importantly, substance abuse can lead to addiction. Addiction is defined a chronic condition that consists of compulsive substance seeking and use, despite negative consequences.

Project Overview

Chapter Two contains a focused literature review that describes the evolving definition of substance abuse and highlights the research describing the theories of addiction, treatment models, and treatment settings. Chapter Three describes the need for a resource guide to help marriage and family therapy trainees and the project outline. Chapter Four provides a summary and discussion of future work. Appendix A consists of the MFT trainee guide, and Appendix B is a list of commonly abused substances which may be used by potential clients of MFT trainees.

The resource guide was developed with the intention of providing an inexperienced marriage and family therapist trainee a practical overview for working with the substance-abuse population. This resource guide is designed to provide: a basic understanding of what substance abuse is, an overview of the most common approaches/models in treating substance abuse, a brief description of the various

substance related twelve-step programs, various resources for treating substance abuse, and a brief description of theoretical perspectives on treating clients with substance abuse-related problems.

Limitations of Study

This guide does not provide in depth and detailed information about the specifics of the following: treatment plans, diagnosis, the twelve-step process, rehabilitation, and recovery. This handbook is not to be considered to contain all-inclusive information. If a trainee is seeking further information on these topics, they are urged to seek additional literature and training to gain expertise.

CHAPTER TWO

REVIEW OF THE LITERATURE

Due to the depth and breadth of available literature relating to addiction and substance abuse treatment, and the potential complexities in treating substance abuse, the following literature review was undertaken to provide research in support of the development of a practical resource guide for marriage and family therapist trainees in working with the substance abuse population. The content of the resource guide focuses on providing a simplified basic understanding of the causes of substance abuse, effective treatment of substance abuse, and the recovery process from substance abuse.

Diagnostic and Statistical Manual of Mental Disorders Definition of Substance Abuse

According to the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000), there is a distinction between substance dependence and substance abuse. Substance dependence is defined as a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive drug taking behavior (*DSM IV-TR*, p.198).

Substance abuse is defined as

a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.” “There may be repeated failure to fulfill major role obligations, repeated use in situations where it is physically hazardous, multiple legal problems, and recurrent social and interpersonal problems (*DSM IV-TR*, p.198).

Unlike the criteria for substance dependence, the criteria for substance abuse do not include tolerance, withdrawal, or a pattern of compulsive use and instead include only the harmful consequences of repeated use (*DSM IV-TR*, p.198)

Recently, the American Psychiatric Association released the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (5th ed., *DSM V*; American Psychiatric Association, 2013). In the fifth edition there are changes in the definitions, classifications, and criteria relating to substance related disorders, and there is no longer a diagnostic criteria for either substance dependence or substance abuse. The DSM V revisions of the definitions associated with substance abuse are scheduled to go into effect in 2014. These changes will impact diagnosis, treatment planning, and documentation.

The DSM V has combined the DSM IV classifications of substance abuse and substance dependence into a single disorder. This single disorder is now referred to as a substance use disorder (*DSM-V*). According to the American Psychiatric Association's web page "Substance-Related and Addictive Disorders" (2013), substance use disorders are measured on a continuum from mild to severe. Diagnosis of substance use disorder and the severity of the disorder will be based on the number of symptoms (from a list of eleven) that the individual is presenting. Further, substance dependence was removed from DSM classification because of the need to eliminate the confusion derived from the common misconception that dependence always indicates addiction, when dependence can be the result of normal body responses to substances ("Substance," 2013).

Of note, similar to the DSM IV, the DSM V states "[T]he overall category of substance-induced disorders includes intoxication, withdrawal, and substance-related

mental disorders...” (DSM-V). The criteria for substance intoxication are substance specific and are listed in the DSM V’s chapter on substance-related disorders.

Treatment Settings

Outpatient Treatment Programs

Clients who are capable of consistent independent functioning, who are psychologically and physically stable, who possess a social support group, and who have the ability to refrain from the use of substance while establishing a new lifestyle are most suitable for outpatient treatment (Lewis et al., 1994). Outpatient substance abuse counseling is offered in a variety of environments that range from private practice offices to community-based mental health centers. Treatment techniques that are offered in outpatient treatment programs consist of services such as substance-related individual and group counseling, family-based intervention, and psychotherapy. A benefit of outpatient treatment is that it provides the opportunity for counselors/therapists to tailor their treatment planning to their clients’ individual needs as opposed to a highly structured inpatient environment where the freedom of individual treatment planning may be impractical. According to Lewis, Dasna, and Blevins (1994) it is widely accepted that outpatient treatment is the preferred method of treatment. However, outpatient treatment may not be suitable for all clients.

Sober Living Communities

Lack of a substance-free living environment can be a barrier for some individuals to develop a substance free lifestyle. Sober livings homes are drug and alcohol-free living

environments that provide a foundation of recovery based on support for clients who may not yet be ready to live on their own. Many sober living homes require their residents to attempt and maintain sobriety, attend a minimum number of twelve-step meetings, adhere to the house rules including curfews, and submit to random drug testing. Sober living homes are not governed or funded by county or state governments, and residents are required to pay their own rent. Sober living rents range from a few hundred dollars a month up to several thousand dollars a month (Polcin, Korcha, Bond & Galloway, 2010).

Additionally, there are also transitional housing programs often run by treatment centers. These programs are often subsidized by federal, state, county, and city funding. Often transitional programs are utilized as re-integration housing facilities following inpatient treatment or incarceration. Clients usually are required to participate in outpatient services during their stay in these programs ("Itp online the,").

Inpatient Treatment Programs

The purpose of inpatient residential treatment centers is to provide a substance-free environment, the opportunity to heal physically, emotionally, and psychologically from substance use, to allow clients the opportunity to develop their personal goals relating to their recovery, to develop relapse prevention methods, to practice living life free of substances in a safe environment, and to prepare for re-integration into society. Inpatient treatment programs exist in a variety of settings including hospitals, independent residential treatment centers, and social agencies. These programs can exist in either medical or non-medical settings. Medical settings may be more appropriate for individuals who possess health issues or severe addictions to substances such as opiates, alcohol, and some prescription medications. A limitation of many inpatient facilities is

that clients are forced to adhere to predetermined programs that may not have the ability to adapt to a client's individual needs. Unfortunately, this dynamic prevents many clients from being able to successfully complete these inpatient programs (Lewis et al., 1994)

Detoxification Centers

Detoxification treatment is designed to assist clients to safely withdraw from substances to which they have become addicted. During the initial withdrawal period (depending on the substance of addiction) clients may experience severe physical and psychological discomfort. Some clients may even experience a medical emergency during their withdrawal from drugs and/or alcohol. As a result, many clients choose medical detoxification programs that are housed in hospital settings. Clients in these types of programs are closely supervised by medically-trained staff members.

Furthermore, medications may be utilized to assist clients in increasing their comfort and safety.

There are also non-medical detoxification programs that focus more on counseling and psychological support rather than on pharmaceutically-assisted withdrawal. However, many of these non-medical detoxification programs do have procedures in place, and medical personnel on call, in the event of a medical emergency (Lewis et al., 1994).

Theoretical Models of Substance Abuse

There are many theories that have been proposed to explain the dynamic of substance abuse. These theories have focused on concepts such as genetic factors, psychological issues, learned behavior, morality, personal choice, and environmental and

social factors. Despite these theoretical explanations of the reasons an individual may develop an addiction to substances, no clear causation has been empirically identified.

Bio-Psycho-Social Model

The bio-psycho-social model integrates concepts from the various theories and allows a counselor/therapist the freedom to tailor their approach to fit an individual client's needs. (Sales, 1999). A basic definition of the bio-psycho-social model is the recognition of the various interactions of biological, psychological, and social factors that influence the development of addiction (Humphrey, 2007).

Biological Influences: A considerable amount of research indicates that the consumption of alcohol and/or drugs interferes with the chemical processes of the human brain. An important component of these processes is the brain's neurotransmitter balance which is interrupted by exposure to chemical substances. Furthermore, each individual substance has a different effect on the brain's chemistry. For example, when an individual ingests cocaine they usually feel an initial increase in alertness, arousal, euphoria, and levels of energy. This heightened state is likely induced by the cocaine increasing the production of neurochemicals such as dopamine, serotonin, and others. However, habitual and chronic use of cocaine causes a negative impact on the production levels of these important neurochemicals. As a result, after prolonged use the individual begins to experience adverse changes in energy levels, mood, cognition, and behavior (Rotgers, Morgenstern & Walters, 2006).

Alcohol influences the brain in an entirely different manner. Initial exposure to alcohol can interrupt the natural balance between the brain's inhibitory and excitatory processes by enhancing the functions of inhibitory neurochemicals such as glycine,

adenosine, and GABA, while decreasing the abilities of excitatory neurochemicals such as glutamate and aspartate. However, after long term exposure to alcohol, the brain begins to restore balance by decreasing its natural production of inhibitory neurochemicals while increasing its production of excitatory neurochemicals. Unfortunately, when an individual withdraws from alcohol this complex neurochemical balance is once again interrupted by the effects of the abundance of excitatory neurochemical that are no longer being opposed by the presence of alcohol. This state of increased excitation can cause hypertension, anxiety, and delirium (Valenzuela, 1997). There has been a considerable amount of research that suggests substance abuse may run in families. According to Tsuang et al (1996) much of this research has focused on studies that have sought genetic dispositions and traits that could indicate potential substance abuse among family members.

Psychological Influences: Many of the studies that have concentrated on the psychological influences on addiction have focused on the relationship between factors such as post-traumatic stress disorder, child and sexual abuse, and the susceptibility of addiction (Ouimette & Brown, 2003; Rosen, Ouimette, Sheikh, Gregg, & Moos, 2002). There has also been a significant amount of research on the presence of co-morbidity in the substance abuse population. Studies have shown there is a strong association with substance abuse and mood and anxiety disorders, conduct disorder, and anti-personality disorder (Merikangus, Mehta, Molnar, Walters, Swendsen, Aguilar-Gaziola & Kessler, 1998).

Social Influences: Additionally, the literature describes the social and environmental dynamics that increase the risk of substance abuse including the influences

of home, family and peer relationships (Saah, 2005). Much of the evidence for the impact of social influences on drug and/or alcohol abuse has been collected from studies among adolescents. In one such study (Simons-Morton, 2007) consisting of 2453 adolescent participants researchers found a positive association with an increase in substance abuse and the number of substance-abusing friends the participants had in their peer group. The study also reported that positive parenting practices had a direct protective effect on the prevention of substance abuse.

The Disease Model

The disease model of addiction is the preferred treatment modality used in the majority of substance abuse treatment programs in the United States. According to Washton and Zweban (2006), an essential component of the disease model theory is the concept that once an individual's substance use has progressed from controlled use to uncontrollable use, the individual loses the ability to successfully return to controlled use. Consequently, the preferred method of treatment is total abstinence from all mind and mood altering substances. Proponents of the disease model believe that abstinence is not a cure for addiction, rather abstinence from drugs and/or alcohol will facilitate remission of the disease (Washton & Zweban, 2006).

In this model, there are two primary reasons that contribute to the need for abstinence from substances. The first reason is the danger from substance substitution. Substance substitution occurs when an individual stops using a substance that has become harmful and then replaces the substance with a perceived less harmful substance. Often the consequences of the use of the perceived less harmful substance are underestimated leading ultimately to the need for additional treatment. The second reason is that it is

thought the use of any intoxicating substance can trigger the “craving” for and the eventual use of the individual’s initial substance of choice. The return to use of the initial substance of choice may be immediate or delayed for a significant period of time. Because of the potential delay in the return to the use of the substance of choice, it may become difficult to provide treatment to clients who have substituted substances (Washton & Zweben, 2006).

Another noteworthy aspect of the disease model is the comparison of alcoholism and/or drug addiction to other medical diseases. In Lewis’s article (as cited in Margolis & Zweban, 1998) describing the disease model and how it relates to alcoholism, he stated that alcoholism shares similar criteria for classification of disease with common conditions such as diabetes, cancer, syphilis, rheumatoid arthritis, etc. The common criteria that Lewis identified were: (a) a clear biological basis, (b) a set of unique identifiable signs and symptoms, (c) a predictable course and outcome, and (d) a lack of intentional causation.

Lewis concludes research indicates that alcoholism is a biologically-influenced disease that has genetic predispositions that are environmentally activated. He claims that there are unique and identifiable symptoms associated with alcoholism. He found that although there is variation in outcomes, it is possible to identify a predictable course and outcome of untreated alcoholism. Additionally, Lewis stated that because of the lack of control that is associated with alcoholism and/or other addictions, there is a lack of intentional causation (as cited in Margolis & Zweban, 1998).

Abstinence Model

Supporters of the Disease Model of addiction and the various substance-related twelve step programs emphasize the importance of abstinence when attempting to initiate and maintain recovery. The primary goal of the abstinence model is to eliminate all use of alcohol and other harmful substances. Members and proponents of the substance-related twelve-step programs stress the necessity of total abstinence from all substances because of two simple, yet important, reasons. The first reason is that it is known throughout the twelve-step fellowships that the majority of their members have tried and failed with attempts to successfully develop the ability to control their drinking of alcohol and/or use of substances. The second reason is that the members have little or no experience with individuals in their homes or in the community who have successfully developed the ability to control their drinking of alcohol and/or consumption of drugs. Twelve-step theorists and clinicians who work with the substance abuse treatment population report similar findings in both community and clinical settings. Clinicians working in the substance abuse treatment environment report virtually no long-term consistent controlled drinking of alcohol and/or use of drugs by individuals recovering from substance abuse (Rotgers, Morgenstern & Walters, 2006).

Abstinence is most commonly achieved by an ongoing progressive process that is usually obtained through will power and support (Yeh, Che, & Wu, 2009). There are many therapeutic techniques that can be applied in assisting clients who are seeking the ability to obtain abstinence from substances. Traditional substance treatment-based strategies can be used to increase client insight and skills, while facilitating the development of support. These approaches can be implemented in both individual and

group settings (Mueser, Noordsy, Drake & Fox, 2003). In individual sessions, clinicians can assist clients with cognitive-behavioral techniques that can enhance the client's ability to attain abstinence. Encouraging the client's involvement in the pursuit of stable employment can lead to the eventual increase in self-esteem, financial standing, and psychiatric stability, while decreasing free time and opportunities to use substances. Substance-related treatment groups can assist clients in creating the necessary skills to manage high risk situations and in the development of new ways to have their needs met without the use of substances (Mueser, Noordsy, Drake & Fox, 2003).

Harm Reduction Model

The harm reduction model places emphasis on reducing the negative consequences associated with the consumption of alcohol and drugs. Clients who can potentially benefit from harm reduction-focused treatment usually either do not have the ability or the desire to refrain completely from the use of drugs and/or alcohol (Lenton, 1998). Consequently, the harm reduction approach can be seen as an attempt to meet clients where they are, rather than where a clinician thinks they should be. Harm reduction treatment acknowledges that lifelong attainment of abstinence from harmful substances may not be possible for all clients, even though abstinence may be the ideal treatment goal for the client (Rotgers, Morgenstern & Walters, 2006).

When implementing a harm reduction approach, an incremental step-by-step process toward the eventual goal of abstinence is encouraged, even if the reality of the client's circumstances indicate the likelihood of success is minimal. The primary goal of the harm reduction model is to reduce substance-related consequences that negatively affect client health and well-being. As a result, this model promotes any change in

behavior or environment that reduces substance use (Rotgers, Morgenstern & Walters, 2006).

According to Denning, Little, and Glickman there are multiple potential harm reduction techniques. Examples of these methods include: (1) reducing the amount of the substance used, (2) reducing or eliminating poly-substance use, (3) reducing the frequency of the substance use, (4) altering the route of administration of the substance, (5) reducing exposure to environments where the use of substances is likely, (6) substitution of the substance of choice for a less harmful substance, (7) prevention of potential substance overdose, and (8) reducing use incrementally with the goal of attaining eventual abstinence (as cited in Washton & Zweben, 2006).

Comorbidity/Dual Diagnosis

The prevalence of clients seeking treatment for both a substance abuse-related disorder and mental health disorder is high. Consequently, many studies have been conducted examining the relationship between substance abuse and mental illness. According to Regier et al, the most extensive comprehensive diagnostic assessment of both mental health disorders and substance abuse disorders is the Epidemiologic Catchment Area study (as cited in Mueser, Noordsy, Drake & Fox, 2003).

Data was collected from 20,000 participants who consisted of randomly selected individuals in the United States. An oversampling of individuals residing in mental health settings such as psychiatric hospitals, medical settings, and/or jails or prisons was included to insure a sufficient number of participants with mental health diagnoses. The results of the study indicated that clients with psychiatric disorders were far more likely to have a substance abuse-related disorder than were clients who did not have a

psychiatric disorder. For example, the lifetime prevalence of drug use disorders for the general population was 6.1%, and the lifetime prevalence of alcohol use disorders for the general population was 13.5%. For individuals with schizophrenia the lifetime prevalence for drug use disorder was 27.5%, and for alcohol use disorders it was 33.7%. Also, for respondents with bi-polar disorder the rates were higher, with a 33.6% prevalence for a drug use disorder and a 43.6% prevalence for an alcohol use disorder. The prevalence of substance abuse among individuals with other mental health issues was also higher than rates for the general population (Mueser, Noordsy, Drake & Fox, 2003).

Research has established that the frequency of dual disorders in the substance abuse population is the norm, rather than the exception. Psychotherapists are usually proficient at treating the mental health component, however, often times they lack experience in identifying and addressing substance abuse-related disorders. Because substance use can influence mental health disorders by increasing and/or minimizing symptoms, activate the early onset of severe disorders, and affect treatment participation and progress, it is recommended that general psychotherapists become adept at identifying and treating substance abuse disorders (Washton & Zweben, 2006).

The relationship between substance abuse-related disorders and psychiatric disorders is complicated. Simplistic treatment models do not exist. Researchers such as Khantzian, support the theory that substance abusers consume drugs and/or alcohol as a method to self-medicate from pre-existing mental health conditions (as cited in Rotgers, Morgenstern, and Walters, 2006). Proponents of the disease model of addiction argue that mental health disorders are a result of the abuse of substances, and that symptoms will dissipate upon the attainment of abstinence and/or sobriety. However, there is no

empirical evidence to support either view, and further research is required to better understand the dynamics of the relationship between substance abuse and mental health disorders (Rotgers, Morgenstern, and Walters, 2006).

Psychopharmacology

As previously described in the above section in this literature review, there is a high prevalence of mental health issues among individuals who have substance abuse disorders. As a result, many of these individuals may be taking prescribed psychopharmacological medication. Because of the frequency of psychological services being provided by non-medical therapists, it is important for these therapists who are treating dually-diagnosed clients to obtain a basic understanding of the various psychotropic medications that are often used to treat common mental health disorders (Preston, O'neal & Talaga, 2013).

Additionally, therapists working with this population should become familiar with the differences in the types of psychiatric medications that are used in treating substance abuse disorders. These types of medications usually consists of: (1) medications to assist with detoxification and withdrawal, (2) medications to assist with relapse prevention, and (3) opioid agonist medications as maintenance and/or substitution therapy (Zweben & Washton, 2006).

Medications such as diazepam (valium), lorazepam (Ativan), chlordiazepoxide (Librium), clorazepate (Tranxene) and phenobarbital can be used to assist with the process of detoxification and withdrawal from alcohol. These types of are drugs are prescribed to prevent serious withdrawal complications such as seizures and delirium tremens. Withdrawal and detoxification from cocaine and other stimulants can cause

significant irritability, depression, and potential suicidal ideation. Medications that are used to reduce and potentially alleviate these symptoms are diazepam and for more severe symptoms desipramine (Norpramin). Medications to assist with the withdrawal of heroin and other opiates include clonidine (Catapres) and methadone (Miller & Gold, 1998).

Medications that are used to assist with relapse prevention are disulfiram, methadone, and naltrexone. Disulfiram (Antabuse) is prescribed to prevent the use of alcohol. Disulfiram is an inhibitor that influences acetaldehyde dehydrogenase, which is an enzyme that affects the degradation of acetaldehyde. An accumulation of acetaldehyde results in an adverse reaction when alcohol is ingested that is similar to a severe hangover. Methadone treatment is a form of harm reduction treatment that is used primarily as substitution therapy with clients who are addicted to powerful opiates such as heroin. Methadone is an opiate agonist that produces effects similar to those of heroin, however, these effects are not as severe. Thus, the methadone can relieve the addicted individual of opiate-related cravings, while not causing as much potential harm as heroin would. Additionally, Naltrexone is used to treat opiate and alcohol addiction. Naltrexone works as an opioid antagonist that inhibits the effects of the opiates. It also has been suggested by the results of double blind studies that naltrexone can decrease cravings for alcohol (Miller & Gold, 1998).

Pain Management Issues Relating to Treatment

Attempting to treat individuals for substance abuse issues who have concurrent medical issues that require the use of prescribed pain medications can be challenging. Opioids are considered the most effective medications to alleviate pain, however, they are

among the most addictive and commonly abused substances. Introducing prescribed opiates as pain medication to the recovering individual can elevate the risk of relapse. Not prescribing opioids to the recovering individual can contribute to severe discomfort and prolonged physical recovery time, which could also initiate relapse. Consequently, it is usually advised from a humane pain management perspective, for the client in recovery to use opiate pain medications (Margolis & Zweban, 1998)

In attempting to predict potential relapse or the development of additional issues with addiction as a result of the administration of prescribed opiates for pain management, it can be useful to identify pre-existing circumstances that could indicate potential susceptibility. Results from a study conducted by Mitchna et al. (2004) found that patients who had a history of substance abuse in their families, had past legal issues, and/or prior or current problems with substance abuse were considered high risk for possible complications with addictions and the prescription of opioid pain medications (p.250).

Once a clinician has identified that their client is at risk for potential complications resulting from prescribed pain medication, it is important to assist the client in developing safety and preventive interventions that can prevent relapse. The following precautions and strategies are recommended: (1) openly discuss with the client their history of abuse and potential for relapse, (2) use a team treatment approach that includes a mental health clinician and medical professional when possible, (3) create a contract with the client (i.e. limiting prescriptions to one week supply, agreeing to random drug testing to check for use of other substances, etc.), (4) assist the client in arranging for a trusted household member or other responsible individual to possess the

medication and monitor the clients use, (5) request that the client only receive medication from one provider (i.e. doctors, pharmacies, etc.), and (6) assist the client in creating a pain diary that tracks client levels of pain and use of medications (Newshan, G., 2000).

Best Practices/Evidence-Based Treatment Modalities

Evidence-based treatment is considered to be therapeutic techniques, methods, applications, and implementations that have been scientifically tested and clinically determined to be effective in treating a particular individual, population, or specific issue. Evidence for efficacy of treatment is evaluated by several different methods. These methods include randomized controlled trials, clinical trials, and scientific reviews of previously conducted studies of particular topics, and meta-analysis of multiple previously conducted studies (Miller, 2009).

A review of the research and literature associated with effective treatment practices found that a biopsychosocial theoretical perspective is currently recommended as the preferred focus of evidence-based substance abuse treatment. The biopsychosocial perspective includes supportive counseling services that attempt to assist clients in increasing levels of motivation for change and in improving coping skills. The goals of treatment include the establishment and maintenance of a substance free lifestyle, the development of problem solving skills, and the improvement of impulse control skills. This perspective combines cognitive-behavioral therapy, twelve-step facilitation therapy, and motivational/insight developmental techniques that are tailored to the client's individual needs ("Best practices in," 2008).

The following is a list of thirteen research-based principles that relate to effective substance abuse treatment that was developed by the National Institute on Drug Abuse:

(1) addiction is a complex but treatable disease that affects brain function and behavior, (2) no single treatment is appropriate for everyone, (3) treatment needs to be readily available, (4) effective treatment attends to multiple needs of the individual, not just his or her drug abuse, (5) remaining in treatment for an adequate period of time is critical, (6) behavioral therapies including individual, family, or group counseling are the most commonly used forms of drug abuse treatment, (7) medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies, (8) an individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs, (9) many drug-addicted individuals also have other mental health disorders, (10) medically-assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse, (11) treatment does not need to be voluntary to be effective, (12) drug use during treatment must be monitored continuously, as lapses during treatment do occur, and (13) treatment programs should test patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling, linking patients to treatment if necessary ("Principles," 2012).

Genogram Utilization

According to McGoldrick and Gerson, an effective method to assist therapists in understanding familial relationships is the genogram. A genogram is a pictorial chart that is similar to a family tree that tracks family relationships, characteristics, and events. The use of genograms is usually introduced in an early session and can be discussed and analyzed as the therapy progresses (as cited in "Substance," 2004).

Genograms are an intergenerational family therapy technique that can be useful in treating substance abuse. Intergenerational therapy views problems as being products of patterns of unresolved familial issues. In assisting a client in creating a genogram that tracks family relationships, issues, characteristics, etc., a therapist can help their client to recognize dysfunctional patterns. Ideally, this recognition will facilitate the development of client insight and will reduce feelings of guilt and self-blame (McCollum & Trepper, 2001).

Twelve-Step Conceptualization

Twelve step-programs have assisted millions of people throughout the world with issues associated with a variety of addictions. These programs were adopted from Alcoholics Anonymous which was founded in 1935. Alcoholics Anonymous describes itself as a program that is based on spiritual principles that can assist alcoholics abstain from drinking. The foundation of the program is the twelve steps. The twelve steps can be considered as a method for developing a new way of life. The twelve steps are a sequence of activities and thought-altering exercises that should be performed in sequence under the guidance of a sponsor. The twelve steps have been adapted and tailored to fit the needs of at least seventy-three different programs that assist with issues of compulsions and addictions such as gambling, sex, drugs, and eating (Seppala, 2001).

Twelve-step programs can be described as mutual support groups that focus on the attainment of abstinence from addictive behaviors. To become a member an individual simply has to attend a meeting and express an interest in eliminating the addictive behavior. There are many different types of meetings. There are open meetings that anyone can attend. There are also closed meetings that are held only for the self-

identified alcoholic or addict. Additionally, there are meetings that are held for men only, women only, young people, LGBT populations, new members, and many others. The two main meeting formats are speaker meetings and discussion/participation meetings.

Speaker meetings usually focus on a main speaker who shares their personal story of recovery with the group. Discussion/participation meetings usually start with a speaker sharing his/her experiences on a specific topic, followed by other group members taking turns sharing their thoughts, feelings, and emotions that relate to the topic (Seppala, 2001).

When attempting to assist a client in selecting a potential twelve-step recovery program several factors should be considered. Usually, it is recommended for clients who will attending their first meeting to choose a program that focuses on their specific issue with addiction. For example, a client who has been seeking treatment for substance abuse issues relating to their use of cocaine should perhaps begin the twelve-step process by attending a Cocaine Anonymous meeting. It can also be helpful to select a meeting that is located in a neighborhood that reflects the client's socio-economic status with the purpose of increasing the likelihood the client will feel "part of", "accepted", or hear members' stories they can identify with and relate to (Margolis & Zweben, 1998).

The selection of a sponsor is an important component of the twelve-step process. A sponsor is an experienced group member who initially educates the new member about the various aspects of the program, and eventually guides the new member through the twelve steps. Sponsors should be selected for their ability to model a desired way of life that is free of the use of substances. This relationship should focus on the sponsee's development in recovery. The relationship should be free of sexual attraction, or any

other component that would distract from the purpose of the relationship (Margolis & Zweben, 1998).

Group Therapy in Treating Substance Abuse

The ability to successfully recover from substance abuse can be greatly influenced by the individual's level of social skills and their ability to develop successful interpersonal relationships. Participation in group therapy can help clients in developing and/or enhancing these abilities. According to Dagley, Gazda, and Pistole the following list of characteristics of group counseling/therapy are conducive to the development of these attributes: (1) the group experience can provide the opportunity for the client to test their perceptions about reality, (2) during the group process, false perceptions and beliefs may become apparent and lose their importance, (3) the group can provide an environment of psychological safety that can support positive behavioral change, (4) groups provide a safe environment for clients to express new thoughts and behaviors, (5) interacting with other group members can assist in developing insight relating to the universality of common personal issues, (6) group members can develop the ability to self-disclose and offer feedback to other members, (7) the group process can increase client levels of empathy and social interest, (8) group interaction can provide reinforcement of positive personal change, (9) groups can assist members by providing understanding and acceptance of individual differences, and (10) consistent feedback from other group members can increase clients' accuracy of perception and communication. These group characteristics are important to the newly recovering client because individuals often enter treatment with dysfunctional and inaccurate views of

themselves and the world, usually as a result of many years of drug and/or alcohol abuse (Lewis, Dana, & Blevins, 1994).

The term recovery group is used to describe the various types of abstinence-related therapy groups that are formed in both private, institutional, and community-based clinical settings. Larger programs have the option to form “phase groups”. These programs allow clients to graduate from earlier phase groups to more advanced groups as they progress in treatment. Early-phase groups focus on the establishment of abstinence from substances. Later-phase groups focus on issues such as stress management, recovery from past traumas, repairing relationships and forming new ones, etc. (Margolis & Zweben, 1998).

Mixed-phase groups may be more suitable for smaller programs or private practice settings. The mixed-phase group model allows for flexibility in group focus, types of members, duration of treatment, treatment goals, etc. In mixed groups, newer members are exposed to group members who have gained success in recovery and who can be seen as positive role models. Group members who have developed a healthy lifestyle that is free of the use of substances benefit by the presence of newer members who are a reminder of what life was and could be like if they return to addiction (Margolis & Zweben, 1998).

Despite the advantages of group therapy provides, there are several limitations as well. Concerns about privacy and confidentiality can be a barrier for some clients in joining a group. Clients may not be comfortable disclosing details about their private lives at the group level. Another disadvantage of group therapy is that only a small amount of time can be dedicating to the needs of any one individual, and it may not be a

sufficient amount of time to address the individual needs of each of the group members. Also, the content of group therapy sessions is tailored to meet the needs of the group as a whole, not the needs of the individual. As a result, the group discussion may be out of sync with the needs of some of the members (Washton & Zweben, 2006).

Relapse Prevention

Relapse prevention can be described as a set of strategies, interventions, techniques, and behaviors that are designed to prevent the individual who has succeeded in the attainment of abstinence from drugs and alcohol from returning to the use of substances. According to Polich, Armor, and Braiker almost ninety percent of newly recovering individuals relapse within the first year following treatment for substance abuse issues (as cited in Lewis, Dana, & Blevins, 1994). This alarmingly high rate of relapse indicates the critical need for relapse prevention efforts to insure effective long term treatment (Lewis, Dana, & Blevins, 1994).

The ability to recognize and understand factors and warning signs that are associated with relapse can enhance a client's ability to avoid a return to the use of substances. Gorski stated that relapse begins with the presence of dysfunctional and/or unpleasant feelings, thoughts, and behaviors that precede the actual resumption of the use of substances. He identified both internal and behavioral warning signs that could indicate the potential for imminent relapse. Examples of internal warnings signs are: (1) difficulty thinking clearly, (2) difficulty managing emotions, (3) difficulties with memory, (4) poor stress management skills, (5) engaging in excessive wishful thinking and/or daydreaming, (6) hopeless feelings, and (7) irritability. Behavioral examples are: (1) poor eating habits, (2) irregular sleep patterns, (3) a lack of daily structure, (4)

irregular attendance at treatment-related and/or twelve-step program activities, (5) displays of anger, frustration, and resentment, and (6) being manipulative and/or engaging in lying (as cited in Margolis & Zweben, 1998).

Being able to identify situations and environments that can contribute to a relapse can also be an effective method for preventing a return to the use of substances. These situations include: (1) people, places, and things related to the prior use of substances, (2) being bored or having excess idle time, (3) certain days of the week such as Friday or Saturday nights, (4) access to large amounts of cash, (5) bars and nightclubs, and (6) holidays and other special events (Washton & Zweben, 2006).

Assisting clients to develop relapse prevention strategies can help ensure a positive long term treatment outcome. This can be accomplished by preparing clients who are in active treatment for the possibility of relapse, while helping them in developing methods to minimize the likelihood. Such methods include: (1) reviewing past experiences with relapse and/or near relapses, (2) identifying triggers for relapse, (3) identifying high-risk situations, (4) developing a support network, (5) developing healthy social skills, (6) developing emotional regulatory abilities, (7) twelve step program involvement, and (8) finding meaningful ways to spend time (Mueser, Noordsy, Drake, & Fox, 2003).

Conclusion

The above literature review was conducted to support the development of the substance abuse resource guide for the MFT trainee. Topics were selected to provide practical advice and an understanding of the fundamental concepts and terms associated with substance abuse theory and treatment.

CHAPTER THREE

PROJECT AUDIENCE AND IMPLEMENTATION FACTORS

Introduction

Most graduate programs for marriage and family therapy in the United States require training at a field site. Field sites consist of environments such as schools, community mental health centers, substance abuse treatment centers, etc. Given the high prevalence of substance abuse-related disorders among clients seeking mental health treatment, it is highly likely that trainees will encounter clients with substance-related disorders during the initial stages of their training experience. This project was developed in recognition of the need among inexperienced MFT trainees for guidance about substance-related issues and treatment. The intention was to provide a practical guide to improve MFT trainees' understanding of the definitions, concepts, and dynamics involved in working with the substance abusing population.

Development of Project

This project was developed through a combination of extensive review of the literature, professional experience, educational experience, and clinical training. The literature review focused on the substance abuse-related concepts that were included in the project's guide (Appendix A). The sources that were used for the literature review consisted of peer reviewed journal articles, textbooks written for students and/or entry level therapists and counselors, books written by professionals in the substance abuse therapy/counseling field, various twelve-step program literature, and government

publications. The professional experience that contributed to the development of this project consisted of almost six years of working closely with the substance abuse population while being employed at Tarzana Treatment Centers' transitional housing program. The educational experience that contributed to the development of this project was over two years of course work in fulfillment of the Los Angeles City College's, Drug and Alcohol Counseling Certification Program, numerous undergraduate and graduate-level psychology and counseling courses at Los Angeles City College, Los Angeles Valley College, and California State University Northridge. The clinical development that contributed to this project consisted of nearly two years of providing individual and group counseling services for the substance abuse population while training at Valley Women's Center. The cumulative influence of the research that was conducted and the professional, educational, clinical, and developmental experiences has enhanced the author's understanding and insight about the many potential challenges a MFT trainee may encounter during the early stages of their clinical training while attempting to treat a client with substance abuse issues.

Intended Audience

This project created an educational resource for the inexperienced Marriage and Family Therapist trainee who will be working with clients with substance abuse-related issues during their initial clinical training and development. This guide can also be used by interns and trainees from other helping professions such as social workers and professional counselors who may be working with the substance abuse population during their training and development. Additionally, college and university professors who are

teaching substance abuse therapy/counseling coursework may find it useful in sharing this guide with their students.

Project Outline

I. What is Substance Abuse?

DSM IV Definition and Criteria

DSM V Definition and Criteria

II. Traditional Substance Abuse Treatment Programs

Outpatient Settings

Sober Living Environments

Residential Treatment Centers

Detoxification

III. Bio-Psycho-Social Disorder

Biological Influences

Psychological Influences

Social Influences

IV. Treatment Models

Disease Model

Total Abstinence

Harm Reduction

V. Factors that Complicate Substance Abuse Treatment

Stages of Change

Comorbidity

Psychopharmacology

Pain Management Issues in Treatment

Best Practices/Evidence-Based Treatment Modalities

Genograms

VI. Twelve Step Program Conceptualization

Sponsorship

The Twelve Steps

VII. Group Counseling

VIII. Relapse Prevention

IX. Final Thoughts

CHAPTER FOUR

CONCLUSION

Summary

The purpose of this project is to create a guide for the inexperienced marriage and family therapist trainee who will be working with the substance abuse population. The guide focuses on the terms, definitions, and concepts that are frequently relevant to the treatment of the substance abusing client. Some of the topics include the definitions of substance abuse, the common substance abuse treatment settings, substance abuse treatment models, stages of change, best practices/evidence-based treatment, genogram utilization, twelve-step programs, group counseling, and relapse prevention. Further, this guide attempts to facilitate a basic understanding of additional factors such as co-morbidity/dual diagnosis, psychopharmacology, and medical issues/pain management that frequently complicate treatment of the substance abusing client. In summary, this guide was developed with the intention of providing help to the marriage and family therapy student/trainee during their initial exposures to substance abuse treatment.

Discussion

Due to the extent and depth of the substance abuse-related literature, it took considerable effort to decide which topics to address in the guide. After careful consideration, I chose topics that I believed would best provide a basic overview of substance abuse treatment for the MFT student/trainee. While it is common for MFT trainees to encounter clients who have substance abuse-related problems, many of these trainees lack personal experience, professional training, and education relating to the

substance abuse population. The guide attempts to enhance the MFT trainee's ability to provide effective care to clients with substance abuse-related issues.

Future Work

Once I complete the MFT program at California State University Northridge, I plan to continue my clinical training in preparation for licensing with the State of California Board of Behavioral Sciences. During this period of professional development I plan to gain a greater understanding of the various theoretical orientations that are commonly applied in the marriage and family therapy field. Furthermore, I plan to continue working with clients who are experiencing substance abuse-related issues. My future plans may include developing a guide tailored to diverse theoretical approaches for MFT interns or newly licensed therapists working with the substance abuse population. Examples of theoretical orientations that could may be included in the future project are Family Systems Therapy, Narrative Therapy, Gestalt Therapy, Client Centered Therapy, and Cognitive Behavioral Therapy.

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APPENDIX A

WORKING WITH THE SUBSTANCE ABUSE POPULATION

A MFT TRAINEE’S RESOURCE GUIDE

Training as a marriage and family therapist can be an intimidating and stressful experience. Most trainees receive a year of Master’s level education before they begin to see clients at their respective field sites. If you are conducting your training at a field site such as a school, community mental health center, or a treatment center you will likely be working with clients who are experiencing substance abuse-related issues. This resource guide was created with the intention of assisting the MFT trainee in being able to identify and understand the various dynamics that exist in working with this complex and challenging population. Furthermore, this guide will provide a basic understanding of the concepts and terms that are often associated with substance abuse, and the implications for treatment.

What is Substance Abuse?

According to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (*DSM IV-TR*) there is a distinction between substance abuse and substance dependence. Substance abuse is defined as “...a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.” “There may be repeated failure to fulfill major role obligations, repeated use in situations where it is physically hazardous, multiple legal problems, and recurrent social and interpersonal problems. Substance dependence is described in the DSM IV as “... a cluster of cognitive, behavioral, and physiological symptoms indicating that the

individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive drug taking behavior.”

Detailed information in the DSM IV that refers to the Substance-Related disorders can be found on pages 191 through 343 in the DSM IV-TR.

It is necessary to understand the DSM’s definitions of substance related disorders, especially when it comes to diagnosis and treatment planning. However, it is one thing to read and understand the DSM’s definitions and another to be able identify the criteria of these disorders in our clients. The following concepts hopefully will make this process a little easier. Substance abuse can be thought of as the behaviors that are associated with the period of time when it is apparent that the use of substances has become a major problem in an individual’s life. Substance abuse almost always precedes dependence. Examples of common issues that substance-abusing clients experience prior to and during initial treatment include:

- Relational- often times substance abusers have begun to lose the ability to develop and maintain healthy relationships. Issues with family, spouses/partners, peers, and with co-workers can become prevalent.
- Legal- driving under the influence, possession and/or sales of controlled substances, domestic disturbances, petty theft, and being under the influence in public are common legal issues that substance abusers experience.
- Health- sudden weight loss or gain, frequently hung over, deterioration of physical appearance, decreased levels of personal hygiene, disruptions in sleep patterns.

- Financial- unexplained sudden need for money, unexplained sudden loss of money, inability to meet basic financial responsibilities, unemployment.

Substance dependence can be thought of as the behaviors and conditions associated with an individual becoming physically, mentally, and/or psychologically addicted to one or more substances. Substance dependence usually develops after prolonged use of a substance, however, it can vary depending on the individual and the substances they are consuming. Furthermore, the effect that substance dependence has on an individual's level of functioning can vary. Examples of common issues that are associated with individuals who are experiencing substance dependence are:

- Dual Diagnoses- mental health issues are common with individuals who are substance dependent. It can be extremely difficult to determine whether an individual has developed a psychological disorder as a result of their substance use or if they have become dependent as a result of their attempts to self-medicate from a psychological disorder.
- Familial- long term dependence can result in familial discord and potential estrangement from family members.
- Legal- long term dependence can be associated with multiple encounters with law enforcement and incarceration.
- Financial- severe economic issues such as joblessness and homelessness are frequently associated with long term dependence.
- Health- severe health issues such as hepatitis, tuberculosis, sexually transmitted diseases, respiratory problems, liver problems, and neurological problems are common with long term dependence.

DSM V Definitions

Recently, the American Psychiatric Association has released the fifth edition of the DSM (DSM-V). At the time this guide was written, the mental health field was preparing to begin to transition from the DSM IV to the DSM V. It is thought that the DSM V will become fully implemented in the later part of 2014. Consequently, it is important for MFT trainees to be aware of the changes in the definitions, classifications, and criteria associated with substance-related disorders in the DSM V. Additionally, trainees need to know that the DSM V has combined the DSM IV classifications of substance abuse and substance dependence into a single disorder. This single disorder is now referred to as a substance use disorder (*DSM-V*). According to the American Psychiatric Association's web page "Substance-Related and Addictive Disorders" (2013), substance use disorders will be measured on a continuum from mild to severe. Diagnosis of substance use disorder and the severity of the disorder will be based on the number of symptoms (from a list of eleven) that the individual is presenting. Further, substance dependence was removed from DSM classification because of the need to eliminate the confusion derived from the common misconception that dependence always indicates addiction, when dependence can be the result of normal body responses to substances (Substance, 2013).

In addition, the DSM V describes substance-induced disorders as an overall category including intoxication, withdrawal, and other substance/medication-induced mental disorders. The criteria for substance intoxication are substance specific and are listed in the DSM V's chapter on substance-related disorders. Furthermore, the DSM V contains important substance-related information such as the neurological changes that

take place and which may persist beyond detoxification, and how these effects may influence relapse and induce craving when there is exposure to substance related stimuli.

It will be important for the MFT Trainee who is working with the substance abuse population to be familiar with the material in the DSM V that relates to the Substance-Related and Addictive Disorders. This information can be found on pages 481 thru 585 in the DSM V.

Traditional Substance Treatment Program Settings

There are several types of traditional substance-related treatment settings. Each of these settings offer different types of services based on a client's level of need. The most common treatment settings that a MFT trainee should be aware of are out-patient programs, sober living housing programs, inpatient/residential treatment programs, and detoxification centers.

Outpatient Settings

Outpatient substance-related treatment programs are often set in community mental health centers, drug and alcohol treatment centers, and in hospital or other medical care settings. Clients who seek services from outpatient treatment centers can either be seeking services voluntarily or they can be referred by the courts or other governmental entities such as the Department of Children and Family Services. Outpatient program services can include individual therapy sessions, individual substance-related counseling sessions, group therapy and/or counseling, mandated twelve-step program attendance, and drug and alcohol testing. Clients of outpatient programs are only required to be in attendance at the program's treatment center during

scheduled hours of service. Outpatient programs may be suitable for higher functioning clients who have access to resources such as stable housing, income, transportation, and social and family support.

Sober living environments

Sober living communities and environments are usually simply referred to as “sober livings.” It is possible that during your MFT fieldwork training you will encounter a client who either currently resides in a sober living or perhaps one who may require a referral or recommendation to a sober living. Sober living can offer clients who are new to recovery additional support and affordable structured housing. Sober livings can be independently-owned and operated, or they can be managed and operated as part of a treatment center’s transitional housing services. Some treatment centers own or rent homes and will house clients who have successfully completed residential treatment. Transitional housing programs allow their clients to integrate back into society while providing them with outpatient services during their time of adjustment. Independently-owned and operated sober livings range from expensive high end living situations that cost several thousand dollars a month to inexpensive shared living arrangements that charge a few hundred dollars a month. Typically, clients must agree to the sober living’s rules and regulations such as abiding by a curfew, submitting to requested drug testing, attending a minimum number of twelve-step meetings, and abiding by the housekeeping rules.

Residential Treatment Centers

Residential treatment centers are inpatient facilities that specialize in treating substance-related disorders. Clients of these types of programs are required to live at the treatment centers for a period of time usually ranging from thirty days up to as long as a year. Clients' length of stay is usually determined by the severity of client need and/or available funding for services. Inpatient services can include individual and group psychotherapy, individual and group substance-related counseling, drug testing, and medical care. Inpatient treatment may be appropriate for clients who have been unsuccessful in outpatient and/or substance-related twelve-step programs, have become substance dependent, or have substance-related psychological or medical issues. Residential inpatient treatment can be very expensive. Most residential treatment centers accept various forms of insurance, and some have contracts with the county or state that provide treatment for clients who meet specific criteria. A disadvantage of residential inpatient facilities is that they usually have a rigid one size fits all approach to treatment that does not allow for an individualized integrated approach which may be more effective with some clients.

Detoxification Centers

Detoxification centers are treatment facilities that assist clients with the withdrawal symptoms of addiction. Detoxification centers are commonly referred to as "Detox". Clients whom have become dependent on substances such as alcohol, opiates (Heroin, OxyContin, Vicodin, etc.) and benzodiazepines (Xanax, Valium, etc.) often require medical assistance and observation in order to be able to safely withdrawal from

these substances. The focus of detoxification with these clients is usually of a physical nature.

Additionally, clients who have become either dependent on or severely intoxicated from substances such as methamphetamine, cocaine, and some the newer designer drugs (MDMA, Bath Salts, Ketamine, etc.) may require medical detoxification and/or observation. However, due to the potential harmful effects on the brain from these types of drugs, the process of detoxification can have serious psychological complications.

Hopefully, at this point you now have a basic understanding of the following: (1) how substance-related disorders are defined in the DSM IV and DSM V, (2) the types of settings where many of our clients with substance-related issues may have received treatment in the past, and (3) the types of settings/programs to which our clients with substance-related issues can be referred too. The following section of this guide will focus on the biological, psychological and social components that contribute to the dynamic of substance addiction. It will introduce and define the disease, total abstinence, and harm reduction models/concepts of addiction.

Bio-Psycho-Social Disorder

The term bio-psycho-social is often associated with the substance-related disorders. The term represents the combined biological, psychological, and social components that are frequently present to varying degrees in individuals who possess substance-related disorders. The biological aspect includes factors such as genetic influences, neurochemical changes, and physiological process that are associated with

drug use. The psychological aspect consists of the entire spectrum of mental health conditions and disorders, emotional disruptions, and difficult personality characteristics associated with substance abuse. Furthermore, the effects of past traumatic experiences can also contribute to the psychological aspect. Social factors and dynamics include a reduction or loss of the ability to develop and maintain healthy relationships (marriages, families, children, close friends, etc.), the influence of the prevalence of substance use in one's peer group, cultural influences, the media, familial influences, substance-related influences in the environment where the client lives from both their residence and neighborhood, and, importantly, the social stigma attached to the substance abuse lifestyle.

It is important to note that not every substance-abusing client will experience or display all of these dynamics and characteristics. Every client should be treated with an individual approach that attempts to address their unique combination of issues and traits.

Treatment Models

The Disease Model

The disease model is a theory that attempts to define the dynamic of addiction as being a disease. The term "disease" is commonly applied to the description of addiction in many of the substance-related twelve-step programs. It is also used in some of the theoretical treatment orientations of many substance-related rehabilitation programs. The theory is based on the idea that there is a genetic predisposition to addiction or alcoholism. Once the predisposed individual starts to consume the substances they will either rapidly or eventually experience the inability to control their use of the substance.

This lack of control is accompanied by the phenomenon of craving for the substance. The feeling of craving can be described as being “intense and overpowering.” Additionally, this theory qualifies addiction/alcoholism as a disease because of the chronic and progressive nature of the disorder.

Total Abstinence

Total abstinence is a recovery concept that emphasizes the necessity for individuals who possess substance use disorders to refrain from using all mind or mood-altering substances (i.e. drugs and alcohol). From the point of view of the disease model of addiction, the total abstinence approach can be thought of as the preferred method of treatment. Addicts and alcoholics in early recovery can have a difficult time associating their use of substances with long term consequences, however, they usually can correlate their use with immediate consequences. For example, most addicts or alcoholics in early recovery can understand the immediate consequence of getting intoxicated at a party, and then subsequently getting arrested for drunk driving on the way home. However, more resistant clients will usually have a difficult time comprehending that the drinks they had two weeks before the night of the party (initial relapse) was the preceding event that led up to the drunk driving arrest (consequence). From the total abstinence perspective, it is thought that if a client is able to remain abstinent from substances, he or she will be able to prevent the initial activating influence and thus prevent the negative consequences.

Furthermore, the abstinence concept relates to the disease model and the phenomenon of “craving”. As previously mentioned, the phenomenon of “craving” can be a component of the disease aspect of addiction. It is thought that once a substance has

been consumed by an individual who has become addicted to the substance, the intense desire to use the substance becomes magnified. Additionally, if a client switches substances, the development of poly-substance addiction is likely for those who possess substance-related disorders. Thus, if a client is able to remain abstinent from all substances the levels of “craving” are reduced and ideally eventually eliminated. Total abstinence is the preferred treatment goal of the majority of addiction treatment centers and substance-related twelve-step programs.

Harm Reduction

Harm reduction is a concept that focuses on reducing as many harmful effects of a substance-related disorder as possible. This approach may be more effective in treating clients who may not have the ability and/or desire to become totally abstinent from all substances. The inability to obtain abstinence may be influenced by severe mental health issues or severe dependence on substances such as opiates. In treating these types of clients, the harm reduction approach would focus on assisting the client in reducing harmful behaviors and developing positive life skills rather than achieving total abstinence from substances. This shift of focus would ideally facilitate a feeling of accomplishment and success rather than feelings of failure that can be associated with failed attempts at abstinence which, in turn, can potentially influence the desire to use substances to medicate as a result of the emotional pain and discomfort associated with the failed attempts.

Examples of the harm reduction approach:

- Methadone programs- harm is minimized by the client replacing the use of heroin by using methadone (a less harmful substance that assists clients with craving and withdrawal).
- Needle exchange programs- harm is reduced by exchanging used needles for sterile unused hypodermic needles as a method to reduce risk of diseases such as HIV and Hepatitis that are associated with hypodermic drug use.
- Allowing clients to participate in outpatient treatment who continue to use less harmful substances that do not interfere with their ability to progress in treatment (such as a methamphetamine addict who has stopped using for six months, who has been able to obtain and maintain employment and housing, but who continues to smoke marijuana).

Factors that Complicate Substance Abuse Treatment

Before we begin treating clients who are experiencing a substance abuse disorder, there are a few more factors that a MFT trainee needs to be aware of. Being cognizant of a client's current level of insight and motivation to change their substance abuse behavior is essential for providing effective treatment. Furthermore, conditions such as the presence of comorbidity, the effects of psycho-pharmaceutical drugs, and client medical issues can have a tremendous influence on the efficacy of treatment. It is extremely important to be aware of the potential difficulties that may arise when treating clients who possess these types of issues. Working closely with a supervisor who is experienced in working with the substance use population and reading current research and literature that relates to your client's presenting issues is essential. Additionally, having a basic

awareness of the best practices and the commonly applied evidence-based treatment modalities for substance-related disorders can contribute to a trainee's effectiveness.

Stages of Change

The "Stages of Change" theoretical framework can provide the MFT trainee with an effective approach to assessing a client's interest and willingness to change substance abuse behavior. Following is a list of the stages of change that may reflect a client's level of insight and/or commitment regarding his or her substance abuse. The stages were proposed by James Prochaska and Carlo DiClemente based on their studies of nicotine addiction in the late 1970s and early 1980s and later applied to numerous health-related behaviors including alcohol and drug abuse:

- Pre-contemplation stage- the client has not yet decided to make any changes relating to their use of substances.
- Contemplating stage- the client is beginning to develop insight relating to their use of substances, and is considered making a change.
- Preparation stage- the client is deciding to make changes relating to their substance use, and is attempting to decide on the best method to do so.
- Action stage- the client is actively trying to make changes relating to their use of substances.
- Maintenance stage- the client has incorporated positive behavioral changes relating to their use of substances.

Comorbidity

Working with and attempting to treat clients who possess both a substance-related disorder and a mental health disorder can be challenging even for an experienced licensed therapists. However, with patience, empathy, dedication, education, and training an inexperienced trainee can help these types of clients. Three scenarios that a trainee will commonly experience when working with clients with substance use issues are: (1) the client is seeking substance abuse treatment and has been previously diagnosed with a mental health disorder, (2) the client seeking treatment for a mental health disorder, has undisclosed substance abuse issues, and (3) the client is seeking substance abuse treatment and either has not been previously diagnosed or does not report having been previously diagnosed with a mental health disorder, but who is reporting and/or displaying behaviors and/or characteristics that would initiate the consideration of a mental health diagnosis.

In treating clients who possess a pre-existing mental health diagnosis the following methods can be useful:

- Make an attempt to assess client's level of substance use severity.
- Make an attempt to learn as much as possible about the disorder.
- Attempt to identify the severity of the disorder.
- Find out what types of psycho-pharmaceuticals the client may be taking.
- Explore the possibility that the client is using substances to manage the difficult thoughts, feelings, and emotions that are associated with the disorder.

- Explore whether the severity of the disorder affects the client's ability to become substance free. Consider whether the client would benefit from a harm reduction approach?
- If possible, consult with other mental health professionals who may be servicing or have serviced the client such as a psychiatrist or clinical psychologist.
- Work closely with your supervisor and present your case in supervision to get feedback from your colleagues.

In working with clients who are seeking substance abuse treatment who may present criteria for a mental health diagnosis, it can be very difficult to differentiate whether the client is using substances to self-medicate from the uncomfortable thoughts, feelings, and emotions associated with the disorder, or if the client's substance use is influencing or causing the presence or appearance of the disorder. When working with clients who are initially presenting with issues of co-morbidity, treating the substance use disorder is usually primary. The rationale for this approach is that if the client succeeds in becoming abstinent from substances for a significant amount of time, the client's symptoms may dissipate. If they do, it is likely the symptoms were substance related. However, if the symptoms persist, it is likely the symptoms derived from a true mental health issue/disorder rather from substance toxicity or withdrawal. Factors such as individual differences, duration of use, intensity of use, and types of substances can affect the amount of time that it can take for a client to psychologically recover from substance abuse. In general, a conservative estimate is four to six weeks of abstinence before a client can achieve baseline functioning.

Psychopharmacology

MFT trainees working with the substance abuse population will likely encounter clients who have been prescribed psycho-pharmaceutical drugs. The types of medications commonly used in treating substance-related disorders fall into four categories:

1. Medications to assist with detoxification and withdrawal. For example, a client who is seeking treatment for alcohol withdrawal is given a prescription for the benzodiazepine Valium, which suppresses nerve-cell arousal in the brain. The administration of valium can alleviate withdrawal symptoms, prevent the advancement of delirium tremens, and decrease the potential for seizures.
2. Medications to treat co-existing psychological disorders. For example, a client who is newly recovering from long-term crystal methamphetamine addiction who has been previously diagnosed with bi-polar disorder, has been taking Seroquel XR prior, during, and after the period of active methamphetamine use.
3. Medications to assist in preventing relapse. For example, a client who is attempting to recover from heroin abuse is prescribed Naltrexone. Naltrexone works as an antagonist agent by blocking the opiate receptors, thus preventing the pleasurable effects of an administered dose of heroin.
4. Opiate agonist medication drugs used in maintenance/substitution treatment. For example, a client who is attempting to recover from heroin addiction begins outpatient treatment at a methadone clinic. Methadone treatment is usually utilized by clients who are addicted to opiates, and who have been unsuccessful at developing a drug-free lifestyle for a significant amount of time. Methadone maintenance is a corrective approach rather than a curative treatment. Methadone

is considered a less harmful substance that, if taken in proper doses, can prevent opiate withdrawal and replace the use of more harmful substances such as heroin.

Treating clients with substance use issues who are taking psycho-pharmaceutical drugs can be challenging. Nevertheless, there are several basic steps a trainee can take to increase their ability to provide sufficient care to this population. MFT trainees working with the substance use population should develop a fundamental understanding of the various psycho-pharmaceuticals that are used in treatment. Also, if possible, working in collaboration with the prescribing physician and/or an experienced supervisor will enhance the trainee's comprehension of the rationale, desired effects, and possible side effects of the prescribed medications. This information will enhance the trainee's ability to assist clients with their concerns, thoughts, and emotions that may arise as a result of taking medication. Additionally, due to the intimate therapeutic relation that develops between client and therapist, the trainee may have a greater opportunity to monitor and review a client's condition and progress than will the client's prescribing physician.

Pain Management Relating to Treatment

Attempting to treat substance-using clients who are taking pain management medications for a medical condition is another challenge for an inexperienced MFT trainee. The use of pain medications can add an additional barrier to the recovery process. In this scenario it may be beneficial for the initial focus of treatment to concentrate on the client's use of illicit substances rather than potential abuse of pain medications. Once the client has achieved abstinence from the illicit substances, the

clinician can then assess for and begin to assist the client with issues relating to the use of pain medications.

As listed below, there are several recommendations for enhancing a trainee's ability to assist clients recovering from substance use who concurrently use pain medication:

1. Openly discuss with client their history of substance addiction.
2. Be aware of signs of medication abuse and substance relapse.
3. If possible, work in collaboration with the client's prescribing physician and insure that the client has informed the physician of their history of addiction.
4. Request that the client entrust possession and administration of medication with another individual such as a responsible household member, a sponsor or other experienced member of client's twelve-step group (if the client is a member of a twelve-step recovery program), or a trusted friend or family member.
5. If possible, assist the client with arranging for all medications to be prescribed by one provider.
6. Develop and maintain a consistent non-judgmental therapeutic relationship with the client.
7. Assist the client in creating a "pain diary" that indicates why, when, and how much medication is being used.
8. Discuss whether the use of the medication is inducing illicit substance relapse ideation.
9. Always work closely with your supervisor and be prepared to present your case in supervision.

Best Practices/Evidence-Based Treatment Modalities

Every client's path to recovery from substances is unique. What may work for one client may not work for another. Treatment should be tailored considering a client's individual experiences, needs, strengths, and weaknesses. Nevertheless, a trainee should be aware of the accepted "best practices" and evidenced-based treatment modalities that are currently utilized in treating the substance abuse population. The term "best practices" refers to the most effective and accepted treatment methods that have consistently shown positive results. Evidence-based treatment modalities refers to providing care with treatment that has been proven effective by research studies.

The National Institute on Drug Abuse (NIDA) developed the following list of "best practices" treatment approaches and principles based on a review of scientific research that has been conducted over the past thirty years:

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available.
3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.
4. An individual's treatment and services plan must be assessed continually, and modified as necessary to ensure that the plan meets the person's changing needs.
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
6. Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.

7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated manner.
9. Medical detoxification is only the first stage of addiction treatment, and by itself does little to change long-term drug use.
10. Treatment does not need to be voluntary to be effective.
11. Possible drug use during treatment must be monitored continuously.
12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases. They should also provide counseling to help patients modify or change behaviors that place themselves or others at risk of infection.
13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

Evidence-based treatment modalities for substance-related disorders developed by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) include:

1. Cognitive behavioral interventions- this approach involves using awareness and skill-building activities with clients.
2. Community reinforcement- this approach involves connecting the client with agencies and services in the community.

3. Motivational enhancement therapy- this approach involves using motivational interviewing strategies and interventions that are based on a stages of change model.
4. Twelve-step facilitation- this is a structured, individualized approach for introducing clients to a Twelve-step program such as Alcoholic Anonymous. Facilitation often results in better attendance at group meetings for a longer period of time.
5. Contingency management- this approach includes behavioral contracting where clients have opportunities to earn rewards for specific desirable behaviors. There is considerable evidence demonstrating that stimulant users respond well to this approach. They stay in treatment longer, make measurable progress and have better treatment outcomes.
6. Pharmacological therapies- There is strong evidence that medications like antabuse, naltrexone, methadone and buprenorphine can help stabilize a person's life when their alcohol or drug use is out of control. The availability of these therapies continues to expand.
7. Systems treatment- this term refers to treating clients in their natural social environment. Couples therapy, family therapy and multi-systemic family therapy are all examples of systems treatment models. There is substantial evidence indicating that clients whose families are engaged in the treatment process show improved outcomes. Systems treatment appears to be especially effective with young people.

For additional information about best practices see: National Institute on Drug Abuse, (2012). Principles of drug addiction treatment (NIH 12-4180). Washington D.C.: National Institutes of Health.

Genograms

The genogram is a visual display of an individual's family relationships and medical history. In contrast to a traditional family tree, a genogram maps patterns in a patient's history that influence his or her current state of mind and behavior. The utilization of genograms can be an effective method in working with the substance-abuse population. The use of genograms give clients and therapists a visual presentation of the substance-related influences and dynamics that are often present in families of individuals with substance-related disorders. This graphic representation can facilitate the development of client insight into the depth and severity of their substance-related issues. Being able to see in black and white the various substance-related influences that have been and are still present in their families can be a powerful tool in breaking through a client's defense mechanisms (denial, minimization, etc.).

A hypothetical example of substance-related familial influences and dynamics that could be identified through the use of a genograms is described below:

A 50-year old resistant male client was referred to treatment for substance abuse after his second DUI offense. Through developing a genogram he identified substance abuse among his great grandfather, his grandmother, his father, and three of his uncles. Further, all of them except one of his uncles died prematurely due to substance-related health issues or accidents. Identifying the multi-generational pattern of substance abuse in

his genogram helped the client see the destructive influences of substance abuse in his family and provided insight into his own difficulties with alcohol.

The above example would identify the possibility that there is a genetic predisposition to substance abuse that runs in the client's family of origin. This information can be difficult to deny, and it can be utilized to facilitate client motivation in becoming substance free, especially if the client is a parent of young children. Additionally, the above example could indicate that there is an acceptance of substance use in the client's family. It is important to consider that familial and cultural influences can be powerful barriers to facilitating insight into a client's substance-related issues.

Information pertaining to the effective use of genograms can be found in the following books: Genograms: Assessment and intervention (3rd. edition) written by Monica McGoldrick, Randy Gerson, and Sueli Petry

Twelve-Step Program Conceptualization

Twelve-step programs are perhaps the most utilized and successful method to treat addiction. Substance-related twelve-step programs could be described as network of support groups that focus on assisting recovering alcoholics and addicts with successfully obtaining abstinence from drugs and/or alcohol. Twelve-step program meetings can range from very large speaker meetings with several hundred members in attendance to small intimate participation meetings that consist of just a few members.

The format of speaker meetings usually focuses on a main speaker who shares his or her personal story of recovery with the group. Individual group members usually do

not participate in speaker meetings beyond making announcements or participating in tradition/commitment duties such as sobriety date recognitions. Speaker meetings may be more appropriate for clients who are shy, skeptical, not very social, and/or new to the twelve-step philosophy of recovery.

The participation meeting format usually focuses on a discussion topic that is introduced to the group. The group members then take turns sharing their thoughts, feelings, and experiences relating to the topic. Participation meetings may be more suitable for clients who are comfortable speaking in groups, in need of an intimate supportive environment, and/or have been previously exposed to the twelve-step environment. Program formats vary from meeting to meeting and, consequently, they offer individuals in or contemplating recovery a wide choice of group styles and content.

Sponsorship

Recommended program participation usually consists of meeting attendance, sponsorship, and step-work. Sponsors are experienced members who could be thought of ideally as a “caretaker” who guides and nurtures another member through the process of recovery and eventual abstinence sustainment. The primary aspect of the sponsor/sponsee relationship is the actual twelve-step process. A sponsor should have an adequate amount of obtained sobriety, the ability to model a healthy and desirable drug and/or alcohol free lifestyle, are experienced, and have completed the twelve step process.

The Twelve Steps

The twelve-step process could be described as a series of actions that are designed to facilitate insight, personal growth, and development in the recovering individual. The twelve-step process is commonly referred to “step-work” by program members. The following description is based on the Twelve Steps of Alcoholics Anonymous which is considered the original substance-related twelve-step program:

1. “We admitted we were powerless over alcohol- that our lives had become unmanageable.” This step states admission of the existence of the problem. An honest admission of a substance-related issue can be a powerful tool in breaking through the denial aspect of addiction.
2. “Came to believe a power greater than ourselves could restore us to sanity.” This step reflects the beliefs of the founders of Alcoholics Anonymous that the solution to alcoholism (and/or addiction) is of a spiritual nature. Of note, this concept of a spiritual solution can become a barrier when working with clients who are not religious. Twelve-step programs such as Narcotics Anonymous have substituted the word “God” for the term “Higher Power” and encourages their members to freely apply the term to their own personal belief system. The word “sanity” that is used in this step can be interpreted by resistant clients as an imposed assumption of mental illness. To counter this resistance a clinician could offer the alternate phrase “a return to a healthier way of life.”
3. “Made a decision to turn our will and our lives over to the care of God as we understood Him.” This step is often described as the “turning it over” step and

also as the first “action” step. Ideally, the act of turning one’s will and life over to the care of “God” or a “Higher Power” is thought to reinforce the act of surrendering to the process of recovery, initiate the recognition of personal limitations, and influence the acceptance of a spiritual solution.

4. “Made a searching and fearless moral inventory of ourselves.” Step four can be an intimidating and fear-provoking experience for a recovering individual. This step can ask to create an honest written moral list/inventory of past experiences and behaviors related to the individual’s substance use. The act of identifying and surfacing these often unpleasant memories in a purposeful manner is thought to begin the process of reducing the guilt and shame that is associated with these past experiences.
5. “Admitted to God, to ourselves, and to another being, the exact nature of wrongs.” Usually the fifth step involves the revealing of the fourth step to the recovering individual’s sponsor. Ideally, at this point the sponsor/sponsee relationship has developed to the point where a significant amount of trust has been developed. Furthermore, it is extremely important for the sponsor to be experienced in this process before being entrusted with a newly recovering sponsee’s secrets and often deep emotional wounds. A MFT trainee who is treating a client who is going through the fifth step process can utilize her or his training and education to provide additional support and guidance during this often difficult and uncomfortable process.
6. “We are entirely ready to have God remove all these defects of character.” This step asks for the recovering individual to become ready to ask “God” or a

“Higher Power” to remove the defects of character or shortcomings that were identified in the previous steps. This step can further the idea of an admission of past errors and the need for a spiritual solution.

7. “Humbly asked Him to remove our shortcomings.” This step can be related to the idea that the recovering individual has accepted the concept of the need for assistance from “God” or a “Higher Power” to remove the undesirable character traits that were revealed in the previous steps. The request for spiritual assistance can be seen as a shift away from a desire to self-modify behavior.
8. “Made a list of all persons we had harmed, and became willing to make amends to them all.” This step is both an action step and awareness step. This step asks the recovering individual to create a thorough and detailed list of all persons they have harmed. The creation of this list can assist the individual to gain insight about their history of relationships. Becoming aware of their undesirable behaviors and behavioral patterns can assist individual in developing healthier relationships in the future.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.” This step should be taken under the guidance of an experienced sponsor and/or counselor/therapist. Deciding which people on the list from step eight to make amends to, should be done with careful consideration. Approaching people from one’s past and reopening old wounds can potentially cause unintended negative consequences. Once a sound approach is decided upon, the ideal outcome of this step is to relieve the

recovery individual from guilt and shame associated with these past unpleasant events.

10. “Continued to take personal inventory and when we were wrong promptly admitted it.” This step can identify and acknowledge both personal attributes and dysfunctional behaviors and characteristics. Identifying personal attributes can re-affirm growth and development. Having the ability to admit to being wrong can influence the ability to recognize issues and perhaps inspire further personal improvement.
11. “Sought through prayer and meditation to improve our conscious contact with God as *we understand Him*, praying only for knowledge of his will for us and the power to carry that out.” This step does not involve action, rather it involves a shift toward a spiritual way of life.
12. “Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics, and practice these principles in all our affairs.” This step reflects the acknowledgement of the obtainment of sobriety, the necessity to continue to live by the spiritual principles that were required as a result of working the twelve steps, and the responsibility to assist other alcoholics who are seeking help.

A major theme of the twelve-step process and program-relevant literature is the references to “God”, “Higher Power” and spirituality. Furthermore, many twelve-step program meetings take place in church settings. Consequently, clients may perceive twelve-step programs as being religious organizations. This perception can become a

barrier for clients who do not possess spiritual beliefs or who have had previous negative experiences associated with religion.

The following interpretation of the twelve steps may be utilized and potentially integrated into the treatment of clients who are resistant to the twelve-step process because of the religious implications:

An Agnostic's 12 Steps

“I include the following for Humanist, agnostic and atheist alcoholics who, like myself, find it intellectually impossible to subscribe to any program which relies so heavily on a belief in a god, "A Humanist Alternative to A.A.'s 12 Steps" by B. F. Skinner (Harvard University Scientist) from July/August 1987 Humanist Magazine (retrieved from <http://www.minnesotarecovery.info/literature/agnost12.htm>):

1. We accept the fact that all of our efforts to stop drinking have failed.
2. We believe that we must turn elsewhere for help.
3. We turn to our fellow men and women, particularly those who have struggled with the same problem.
4. We have made a list of the situations in which we are most likely to drink.
5. We ask our friends to help us avoid those situations.
6. We are ready to accept the help they give us.
7. We earnestly hope that they will help.
8. We have made a list of the persons we have harmed and to whom we hope to make amends.
9. We shall do all we can to make amends, in any way which will not cause further harm.

10. We will continue to make such lists and revise them as needed.
11. We appreciate what our friends have done and are doing to help us.
12. We, in turn, are ready to help others who may come to us in the same way.

Group Counseling

Although this guide is designed for the MFT trainee providing individual counseling to clients with substance abuse issues, it is important to understand the potential unique benefits that group counseling/therapy can offer. Quite often the group dynamic can create an environment of social support that is built on mutual identification, acceptance, and the pursuit of common goals. This environment of social support can be effective in alleviating uncomfortable feelings and emotions such as guilt, shame, and self-condemnation that is often associated with the substance-related disorders.

Typically, groups consist of 8-10 members, and the group sessions last about ninety minutes. There are several different types of substance-related groups that are tailored to address the various aspects of the recovery process and other characteristics of group members. Groups created for clients who may be in the pre-contemplation stage or contemplation stage focus on assisting clients in developing insight relating to their use of substances while attempting to increase levels of motivation to change. Groups that are formed for clients who are in the action stage of recovery usually focus on the obtainment of abstinence from substances. Additionally, clients who are in the maintenance stage of recovery can benefit from relapse prevention and advanced recovery related groups.

Relapse Prevention

Many individuals who experience issues with substance-related disorders have the ability to refrain from the use of drugs and/or alcohol for a limited period of time.

Unfortunately, the ability to sustain abstinence for the long term can be difficult and the likelihood of relapse is high especially in the early stages of recovery. When treating a newly recovering client, a MFT trainee's effectiveness can be enhanced by recognizing the warning signs that are commonly associated with relapse, and by tailoring a treatment plan to meet the client's needs and provide the tools and information that will decrease the potential for relapse.

The following list from the journal article "Cocaine addiction: Treatment, recovery, and relapse prevention" by Arnold Washton is a helpful description of the progression that often precedes relapse during recovery from substance abuse:

1. There is a buildup or onset of stress caused by negative events (e.g., relationship conflict, financial pressures, etc.).
2. The stress activates over-negative thoughts, moods, and feelings that lead the person to feel overwhelmed or emotionally numb.
3. Either overreaction or emotional numbing cause failure to take action, leading to the continuation and eventual escalation of the problem.
4. The person gradually withdraws from their established recovery support system and daily routine.
5. There is a resurfacing or exacerbation of denial, as evidenced by increasingly skeptical and cynical attitudes towards treatment, self-help, and other commitments.

6. Feelings of futility about the ability to manage life comfortably without using alcohol or drugs, coupled with an increasing belief that relapse is inevitable, begins to overshadow whatever progress that person has achieved.
7. Signs of impaired judgment and impulsiveness become evident as the individual makes poor decisions that result in even greater stress.
8. As the person's life becomes increasingly unmanageable, feelings of frustration, despair, and self-pity set in and trigger obsessive thoughts about using again.
9. Irresistible urges and cravings lead to drug-seeking and drug-using behavior.
The relapse chain is complete.

The following list of suggestions is based on Table 10.2 in the textbook "Integrated Treatment for Dual Disorders" by Kim Mueser, Douglas Noordsy, Robert Drake, and Lindy Fox that can potentially be incorporated into a relapse prevention plan:

- Review and discuss with client their past experiences with relapse and/or near relapse.
- Identify past situations that were associated with prior and/or near relapse.
- Identify triggers that may have influenced a prior and/or near relapse.
- Review and discuss past situations in which the client had been successful in avoiding past relapses.
- Review and discuss past situations in which the client had not been successful in avoiding relapse.
- Assist client in "identifying" high risk situations that could potentially influence a possible relapse.

- Assist client in developing a plan that will help them in avoiding high-risk situations.
- Assist client in developing a plan that will enhance their ability for dealing with unexpected and unavoidable high-risk situations.
- Identify specific triggers for possible relapse such as moods, images, self-statements, and environments.
- Develop a plan for how to respond to triggers for relapse.
- Assist client in considering what skills or alternative options they will need to avoid returning to substance use such as social skills, skills for dealing with anxiety, depression, and anger, developing interest in recreation and leisure activities, and developing the ability in discovering meaning in their lives.
- Assist client in identifying individuals they can contact if a potential relapse is imminent.
- Encourage the client to share their relapse prevention plan with a trusted member of their support network.

Final Thoughts

In addition to reading this guide I encourage MFT trainees who either are or will be treating clients for substance-related issues to: (1) work closely with an experienced supervisor, (2) present your substance-related cases in supervision (do not be afraid to show your inexperience and/or vulnerability in working with this population), (3) research and become familiar with the “best practices” and “evidenced- based” modalities that currently are being utilized in substance treatment, and (4) attend a variety

of substance-related twelve-step meetings and become familiar with the literature and the procedures that are associated with these programs.

My goal in writing this guide was to assist the inexperienced MFT trainee in working with the often challenging substance abuse population. This guide was created with the intention of providing a basic understanding of the terms, concepts, and dynamics that are common in substance abuse treatment. Although many individuals who possess substance abuse issues may never recover, it is my hope that you will have the opportunity to experience the reward of successfully assisting a client through his/her recovery process. Hopefully, you will find this guide helpful in your work and professional development.

APPENDIX B: COMMONLY ABUSED DRUGS*

Category & Name	Common Commercial & Street Names	Method of Administration
Alcohol (ethyl alcohol)	Found in beer, wine, liquor	Swallowed
<p><u>Acute effects:</u> <u>Low doses:</u> euphoria, mild stimulation, relaxation, lowered inhibitions <u>Higher doses:</u> drowsiness, slurred speech, nausea, emotional volatility, loss of coordination, visual distortions, impaired memory, sexual dysfunction, loss of consciousness</p> <p><u>Health risks:</u> increased injuries, violence, fetal damage, depression, neurologic deficits, hypertension, liver and heart disease, addiction, fatal overdose</p>		
Cannabinoids		
Marijuana	Blunt, dope, ganja, grass, herb, joint, bud, Mary Jane, pot, reefer, green, trees, smoke, sinsemilla, skunk, weed	Smoked, swallowed
Hashish	Boom, gangster, hash, hash oil, hemp	Smoked, swallowed
<p><u>Acute effects:</u> euphoria, relaxation, slowed reaction time, distorted sensory perception, impaired balance and coordination, increased heart rate and appetite, impaired learning, memory anxiety, panic attacks, psychosis</p> <p><u>Health risks:</u> cough, frequent respiratory infections, possible mental health decline, addiction</p>		
Opioids		
Heroin	Diacetylmorphine: smack, horse, brown sugar, dope, H, junk, skag, skunk, white horse, China white	Injected, smoked, snorted
Opium	Laudanum, paregoric: big O, black stuff, block, gum, hop	Swallowed, smoked
<p><u>Acute effects:</u> euphoria, drowsiness, impaired coordination, dizziness, confusion, nausea, sedation, feeling of heaviness in the body, slowed or arrested breathing</p> <p><u>Health risks:</u> constipation, endocarditis, hepatitis, HIV, addiction, fatal overdose</p>		

Stimulants		
Cocaine	Cocaine hydrochloride: blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	Snorted, smoked, injected
Amphetamine	Biphetamine, Dexedrine: bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	Swallowed, snorted, smoked, injected
Methamphetamine	Desoxyn: meth, ice, crank, chalk, crystal, fire, glass, go fast, speed	Swallowed, snorted, smoked, injected
<p><u>Acute effects:</u> increased heart rate, blood pressure, body temperature, metabolism; feelings of exhilaration; increased energy, mental awareness; tremors; reduced appetite; irritability; anxiety; panic, paranoia; violent behavior; psychosis</p> <p><u>Health risks:</u> weight loss, insomnia, cardiac or cardiovascular complications, stroke, seizures, addiction</p> <p><u>Also for cocaine:</u> nasal damage from snorting</p> <p><u>Also for methamphetamine:</u> severe dental problems</p>		
Club drugs		
MDMA (methylene-dioxy-methamphetamine)	Ecstasy, Adam, clarity, Eve, lover's speed, peace, uppers	Swallowed, snorted, injected
Flunitrazepam	Rohypnol: forget-me pill, Mexican Valium, R2, roach, Roche, roofies, roofinol, rope, rophies	Swallowed, snorted
GHB	Gamma-hydro-xybutyrate: G, Georgia home boy, grievous bodily harm, liquid ecstasy, soap, scoop, goop, liquid X	Swallowed
<p><u>Acute effects for MDMA:</u> mild hallucinogenic effects, increased tactile sensitivity, empathic feelings, lowered inhibition, anxiety, chills, sweating, teeth clenching, muscle cramping</p> <p><u>Also for Flunitrazepam:</u> sedation, muscle relaxation, confusion, memory loss, dizziness, impaired coordination</p> <p><u>Also for GHB:</u> drowsiness, nausea, headache, disorientation, loss of coordination, memory loss</p> <p><u>Health risks for MDMA:</u> sleep disturbances, depression, impaired memory, hyperthermia, impaired coordination</p> <p><u>Also for Flunitrazepam:</u> addiction</p>		

Also for GHB: unconsciousness, seizures, coma

Also for Flunitrazepam & GHB: associated with sexual assaults

Dissociative Drugs

Ketamine	Ketalar SV: cat Valium, Special K, vitamin K	Injected, snorted, smoked
PCP and analogs	Phencyclidine: angel dust, boat, hog, love boat, peace pill	Swallowed, smoked, injected
Salvia divinorum	Salvia, Sheperdess's Herb, Maria Pastora, magic mint, Sally-D	Chewed, swallowed, smoked
Dextrometh-orphan (DXM)	Found in some cough and cold medications: Robotripping, Robo, Triple C	Swallowed

Acute Effects: feelings of being separate from one's body and environment, impaired motor function

Also for ketamine: analgesia, impaired memory, delirium, respiratory depression and arrest, death

Also for PCP and analogs: analgesia, psychosis, aggression, violence, slurred speech, loss of coordination, hallucinations

Also for DXM: euphoria, slurred speech, confusion, dizziness, distorted visual perceptions

Health risks: anxiety, tremors, numbness, memory loss, nausea

Hallucinogens

LSD	Lysergic acid diethylamide: acid, blotter, cubes, microdot yellow sunshine, blue heaven	Swallowed, absorbed through mouth tissues
Mescaline	Buttons, cactus, mesc, peyote	Swallowed, smoked
Psilocybin	Magic mushrooms, purple passion, shrooms, little smoke	Swallowed

Acute effects: altered states of perception and feeling, hallucinations, nausea

Also for LSD and Mescaline: increased body temperature, heart rate, blood pressure; loss of appetite; sweating; sleeplessness; numbness, dizziness, weakness, tremors; impulsive behavior; rapid shifts in emotion

Also for Psilocybin: nervousness, paranoia, panic

Health risks for LSD: flashbacks, Hallucinogen Persisting Disorder		
Other Compounds		
Anabolic steroids	Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise: roids, juice, gym candy pumpers	Injected, swallowed, applied to skin
Inhalants	Solvents (paint thinners, gasoline, glues); gases (butane, propane, aerosol propellants, nitrous oxide); nitrites (isoamyl, isobutyl, cyclohexyl); laughing gas, poppers, snappers, whippets	Inhaled through nose or mouth
<p>Acute effects for anabolic steroids: no intoxication effects</p> <p>Also for Inhalants (varies by chemical): stimulation, loss of inhibition, headache, nausea or vomiting, slurred speech, loss of motor coordination, wheezing</p> <p>Health Risks for Anabolic steroids: hypertension, blood clotting and cholesterol changes, liver cysts, hostility and aggression, acne, in adolescents – premature stoppage of growth, in males – prostate cancer, reduced sperm production, shrunken testicles, breast enlargement, in females—menstrual irregularities, development of beard and other masculine characteristics</p> <p>Also for Inhalants: cramps, muscle weakness, depression, memory impairment, damage to cardiovascular and nervous systems, unconsciousness, sudden death</p>		
Prescription Medications		
CNS Depressants	See the National Institute on Drug Abuse’s website (www.drugabuse.gov) for the chart of Commonly Abused Prescription Drugs	
Stimulants		
Opioid Pain Relievers		

*From the Commonly Abused Drugs Chart, National Institute on Drug Abuse (<http://www.drugabuse.gov/drugs-abuse/commonly-abused-drugs/commonly-abused-drugs-chart>)