Chapter 4—Mental and Substance-Related Disorders: Diagnostic and Cross-Cutting Topics

KEY MESSAGES

- The co-occurrence of mental disorders with substance use disorders (SUDs) is the rule, not the exception. Addiction counselors should expect and prepare to see clients with these disorders in their settings.
- Addiction counselors generally do not diagnose mental disorders. But to engage in accurate treatment planning and to offer comprehensive, efficacious, and responsive services (or referral for such), clinicians must be able to recognize the disorders most likely to be seen in populations who misuse substances.
- It is not always readily apparent whether a co-occurring mental disorder is directly caused by substance misuse or is an independent disorder merely appearing alongside an SUD. This differentiation can be difficult to make but is critically important, as it informs treatment decision making.
- Suicide and trauma are sadly common across most combinations of co-occurring disorders (CODs) and require special attention. Addiction counselors have an ethical and professional responsibility to keep clients safe and to provide services that are supportive, empathic, and person-centered, and that reduce suffering.

Disentangling symptoms of SUDs from those of co-occurring mental disorders is a complex but necessary step in correctly assessing, diagnosing, determining level of service, selecting appropriate and effective treatments, and planning follow-up care. This chapter is designed to facilitate those processes by ensuring addiction counselors and other providers have a clear understanding of mental disorder symptoms and diagnostic criteria, their relationships with SUDs, and pertinent management strategies.

This chapter provides an overview for working with SUD treatment clients who also have mental disorders. The audiences for this chapter are counselors, other treatment/service providers, Supervisors, and Administrators. It is presented in concise form so that user can refer to this one chapter to obtain basic information. The material included is not a complete review of all mental disorders and is not intended to be a primer on diagnosis. Rather, it offers a summary of mental disorders with special relevance to co-occurring SUDs (see the section "Scope of the Chapter").

Since the original publication of this Treatment Improvement Protocol (TIP), updated mental disorder criteria have been published in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2013). This chapter contains these latest criteria and, where available, data from prevalence studies and randomized controlled trials in reflection of DSM-5.

Organization of the Chapter

The chapter begins with a brief description of selected mental disorders and their DSM-5 diagnostic criteria. For each disorder, material highlights some of the descriptive and diagnostic features, prevalence statistics, and relationship to SUDs. In general, the mental disorders in this chapter are presented in the following descending order by how commonly they co-occur with SUDs, although this is not applied rigidly: Depressive disorders, bipolar I disorder, posttraumatic stress disorder (PTSD), personality disorders (PDs),

anxiety disorders, schizophrenia and psychosis, attention deficit hyperactivity disorder (ADHD), and feeding and eating disorders.

Because of the greater availability of case histories from the mental health literature, the illustrative material has more emphasis on the mental disorders. Although not intended to offer extensive guidance on treatment, this chapter's coverage of specific mental disorders does include brief information about interventions for and clinical approaches to managing CODs involving each. (Chapter 7 focuses on treatment models for people with CODs.) Case histories illustrate the interaction between mental disorders and SUDs. Each diagnostic topic contains an Advice to the Counselor box containing key considerations related to diagnosis, treatment, or both.

The next main section of this chapter addresses substance-related disorders, including SUDs and substance-induced mental disorders. (DSM-5 uses the term "substance/medication-induced disorders"; this TIP focuses on nonmedication substances and thus will exclude the term "medication.") Because the primary audience for this chapter is addiction counselors, readers are assumed to be highly familiar with SUDs and their diagnostic criteria. Thus, the SUD section is briefer than the mental disorders section. The overall focus remains on substance-induced mental disorders, their relationship to independent co-occurring mental disorders, and what counselors need to know in terms of assessment and treatment.

> Licit and illicit drugs of misuse can cause symptoms that are identical to the symptoms of mental illness. Mental disorder diagnoses should be provisional and reevaluated constantly. **Some mental disorders are really substance-induced mental disorders, meaning they are caused by substance use.** Treatment of the SUD and an abstinent period of weeks or months may be required for a definitive diagnosis of an independent, co-occurring mental disorder. A fuller discussion of substance-induced disorders is provided later in this chapter.

The chapter ends with an overview of two concerns that appear across nearly all COD populations: suicidality and trauma. Although suicidality is not strictly speaking a DSM-5-diagnosed mental disorder, it is a high-risk behavior requiring serious attention by providers. The discussion of suicidality highlights key information addiction counselors should know about risk of self-harm in combination with substance misuse, mental disorders, or both. The section offers factual information (e.g., prevalence data), commonly agreed-on clinical practices, and other general information that may be best characterized as "working formulations." Like suicide, trauma itself is not a mental disorder but is extremely common in many psychiatric conditions, frequently coincides with addiction, and increases the odds of negative outcomes, including suicide. Having at least a basic understanding of suicide and trauma is a core competency for addiction counselors working with clients who have CODs and will help improve their ability to not only offer effective services but keep clients safe.

Scope of the Chapter

The mental disorder section of this chapter does not include all DSM-5 mental disorders. The consensus panel acknowledges that people with CODs may have multiple combinations of the various mental disorders presented in this chapter (e.g., a person could have an SUD, bipolar I disorder, and borderline PD [BPD]). However, for purposes of clarity and brevity, the panel chose to focus the discussion on the main disorders primarily seen in people with CODs and not explore the multitude of possible combinations. **This does not mean that other mental disorders excluded from this chapter cannot and do not co-occur with substance misuse.** But the scope of this chapter is such that it focuses only on mental disorders most likely to be seen by SUD treatment professionals.

The consensus panel recognizes that although this chapter covers a broad range of mental disorders and diagnostic material, it cannot and should not replace the comprehensive training necessary for diagnosing and treating clients with specific mental disorders cooccurring with SUDs. Readers of this TIP are assumed to already have working knowledge of mental disorders and their

symptoms. The "Advice to the Counselor" boxes cannot fully address the complexity involved in treating clients with CODs. These boxes distill for counselors the main actions and approaches they can take in working with clients in SUD treatment who have the specific mental disorder being discussed.

The consensus panel recognizes that this chapter cannot cover each mental disorder exhaustively and that **addiction counselors are not expected to diagnose mental disorders.** The panel's limited goals for this chapter are to increase SUD treatment counselors' familiarity with mental disorder terminology and criteria and to guide them on how to proceed with clients who have these disorders. The chapter also is meant to stimulate further work in this area and to make this research accessible to the addiction field.

Depressive Disorders

The depressive disorders category in DSM-5 comprises numerous conditions; addiction counselors are most likely to encounter major depressive disorder (MDD) and persistent depressive disorder (PDD; also called dysthymia) among their clients. Common features of all depressive disorders are excessively sad, empty, or irritable mood and somatic and cognitive changes that significantly affect ability to function.

Major Depressive Disorder

MDD is not merely extreme sadness, although sad mood is a defining characteristic. MDD is marked by **either** depressed mood **or** loss of interest in nearly all previously enjoyed activities. At least one of those symptoms must be present and must persist most of the day, almost every day over a 2-week period (Exhibit 4.1). Other core physical, cognitive, and psychosocial features of MDD also must be present nearly every day, with the exception of weight change and suicidal ideation.

MDD is highly associated with suicide risk. A study reported 39 percent of people with a lifetime MDD diagnosis contemplated suicide; nearly 14 percent had a lifetime history of suicide attempt (Hasin et al., 2018). Yet suicide is not isolated to those with depressed mood. **Counselors always should ask clients whether they have been thinking of suicide, whether or not they have, or mention, symptoms of depression.**

Severe depressive episodes can include psychotic features, such as an auditory hallucination of a voice saying that the person is "horrible," a visual hallucination of a lost relative mocking the person, or a delusion that one's internal body parts have rotted away. However, most people who have an MDE do not exhibit psychotic symptoms even when the depression is severe (for more information on psychosis, see the section "Schizophrenia and Other Psychotic Disorders").

WARNING TO COUNSELORS: KNOW YOUR LIMITS OF PRACTICE

This TIP is for addiction counselors in direct clinical contact with clients who have SUDs. Legal titles, levels, types of licenses, certifications, and scopes of practice for addiction counselors differ across all states and the District of Columbia (University of Michigan Behavioral Health Workforce Research Center, 2018). For instance, in certain states, addiction counselors can only conduct assessments and offer treatments for SUDs, limiting their ability to reach clients with CODs. Certification requirements and authorized services also vary by state.

This TIP is intended to benefit all licensed or certified addiction counselors, regardless of their titles. **However, the diagnostic and counseling activities described in this TIP are not necessarily appropriate for all addiction counselors to undertake, especially given that addiction counselors do not normally possess the required training and clinical experience to diagnose mental disorders.** Different SUD treatment settings will have different policies and rules about what addiction counselors can and cannot do. Whether certified/licensed or not, **addiction counselors should use these methods only under the supervision of an appropriately trained and certified or licensed SUD treatment provider or other mental health clinician.** Maintaining collaborative relationships with mental health service providers for consultation and referral is recommended, either directly or through clinical supervision.

EXHIBIT 4.1. Diagnostic Criteria for MDD

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gain.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A–C represent a major depressive episode (MDE).

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of an MDE in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.*

D. The occurrence of the MDE is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

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Specify:

- With anxious distress
- With mixed features
- With melancholic features
- With atypical features
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia
- With peripartum onset
- With seasonal pattern (recurrent episode only)

Specify current severity/course:

- Mild
- Moderate
- Severe
- With psychotic features
- In partial remission
- In full remission
- Unspecified

* In distinguishing grief from an MDE, it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in MDE. In grief, self-esteem is generally preserved, whereas in MDE feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about "joining" the deceased, whereas in MDE such thoughts are focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

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MDE must be distinguished from grief or bereavement, which are not mental disorders but rather normal human responses to loss. However, grief and MDD can be experienced at the same time; that is, the presence of grief does not rule out the presence of MDD. DSM-5 provides detailed guidance on diagnosing MDD in people who are bereaved.

Persistent Depressive Disorder

PDD presents as excessively sad or depressed mood that lasts most of the day, more days than not, for at least 2 years. PDD is somewhat of an "umbrella" diagnosis in that it covers two different types of people with depression: people with chronic MDD (i.e., depression lasting at least 2 years) and people who do not meet criteria for an MDD (see Criteria A through C in Exhibit 4.1) but otherwise have had depressive symptoms for at least 2 years. Thus, the criteria for PDD (Exhibit 4.2) are similar to, but less severe than, those of MDD.

Prevalence

Data from a national epidemiological survey indicate the 12-month and lifetime prevalence rates of DSM-5 MDD are 10 percent and 21 percent, respectively (Hasin et al., 2018). Prevalence of MDD in emerging adults (ages 18 to 29 years) is 3 times higher than the prevalence in older adults (ages 60 years and older). Women are 1.5 times as likely to report depression as men (Hasin et al., 2018).

Twelve-month and lifetime prevalence rates for DSM-5 PDD in U.S. samples have not been reported at the time of this publication. Using DSM-IV criteria, 12-month and lifetime prevalence of PDD in U.S. adults are estimated at 1.5 percent and 3 percent, respectively; DSM-IV dysthymia has an estimated 12-month and lifetime prevalence of 0.5 percent and 1 percent, respectively (Blanco et al., 2010).

EXHIBIT 4.2. Diagnostic Criteria for PDD

This disorder represents a consolidation of DSM-IV-defined chronic MDD and dysthymic disorder.

A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years. **Note:** In children and adolescents, mood can be irritable, and duration must be at least 1 year.

B. Presence, while depressed, of two (or more) of the following:

1. Poor appetite or overeating
2. Insomnia or hypersomnia
3. Low energy or fatigue
4. Low self-esteem
5. Poor concentration or difficulty making decisions
6. Feelings of hopelessness

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. Criteria for an MDD may be continuously present for 2 years.

E. There has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder.

F. The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of misuse, a medication) or another medical condition (e.g., hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: Because the criteria for an MDE include four symptoms that are absent from the symptom list for persistent depressive disorder (dysthymia), a very limited number of individuals will have depressive symptoms that have persisted longer than 2 years but will not meet criteria for PDD. If full criteria for an MDE have been met at some point during the current episode of illness, they should be given a diagnosis of MDD. Otherwise, a diagnosis of other specified depressive disorder or unspecified depressive disorder is warranted.

Specify if:

- With anxious distress
- With mixed features
- With melancholic features
- With atypical features
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With peripartum onset

Specify if:

- In partial remission
- In full remission

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Specify if:

- Early onset: If onset is before age 21 years
- Late onset: If onset is at age 21 years or older

Specify if (for most recent 2 years of persistent depressive disorder):

- With pure dysthymic syndrome: Full criteria for MDE have not been met in at least the preceding 2 years
- With persistent MDE: Full criteria for an MDE have not been met throughout the preceding 2-year period
- With intermittent MDEs, with current episode: Full criteria for MDE are currently met, but there have been periods of at least 8 weeks in at least the preceding 2 years with symptoms below the threshold for a full MDE
- With intermittent MDEs, without current episode: Full criteria for an MDE are not currently met, but there has been one or more MDEs in at least the preceding 2 years

Specify current severity:

- Mild
- Moderate
- Major

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Depressive Disorders and SUDs

Depressive disorders are highly comorbid with SUDs. For instance:

- Presence of a 12-month or lifetime DSM-5 drug use disorder (i.e., a nonalcohol SUD) is associated with a 1.5 to 1.9 increased odds of having any mood disorder, a 1.3 to 1.5 increased odds of having dysthymia, and a 1.2 to 1.3 increased odds of having MDD (Grant et al., 2016).
- Twelve-month alcohol use disorder (AUD) is also associated with an increased risk of MDD and lifetime AUD with persistent depression (Grant et al., 2015).
- A lifetime diagnosis of DSM-5 MDD is more likely to occur in individuals with a history of SUDs (58 percent; for AUD, 41 percent) than in people with a history of any anxiety disorder (37 percent) or PD (32 percent) (Hasin et al., 2018).

People with depression and co-occurring SUDs tend to have more severe mood symptoms (e.g., sleep disturbance, feelings of worthlessness), higher risk of suicidal ideation and suicide attempts, worse functioning, more psychiatric comorbidities, and greater disease burden (including increased mortality) than people with MDD alone (Blanco et al., 2012; Gadermann, Alonso, Vilagut, Zaslavsky, & Kessler, 2012). They are less likely than people with MDD alone to receive antidepressants—despite strong evidence supporting the efficacy of antidepressant medication in alleviating mood and even some SUD symptoms (Blanco et al., 2012).

Addiction counselors may represent a way to reduce lags in adequate depression care in people with depressive disorders and SUDs. Among 3.3 million people who reported both MDEs and SUDs between 2008 to 2014, only 55 percent received services for depression in the previous year (Han, Olfson, & Mojtabai, 2017). However, people who had received SUD treatment in the past year were 1.5 times more likely to have received depression care than people who had not engaged in SUD treatment (80 percent vs. 50 percent, respectively) and were 1.6 times more likely to perceive their depressive care as being helpful (48 percent vs. 32 percent) than people who did not access SUD treatment in the previous 12 months (Han, Olfson, & Mojtabai, 2017).

Other facts about depression and SUDs that addiction counselors should know include the following:

- Both substance use and discontinuance can be associated with depressive symptoms.
- During the first months of sobriety, many people with SUDs can exhibit symptoms of depression that fade over time and that are related to acute and protracted withdrawal.
- People with co-occurring depressive disorders and SUDs typically use a variety of drugs.
- Recent evidence suggests there is increasing cannabis use with depression, although cannabinoids have not been shown to be effective in self-management of depression. In fact, cannabis may actually worsen the course of MDD and reduce chances of treatment seeking (Bahorik et al., 2018).

Treatment of MDD and SUD

Psychotherapy (e.g., integrated cognitive–behavioral therapy [CBT], group CBT), with or without adjunct antidepressant use, can effectively reduce frequency of substance use and depressive symptoms and improve functioning briefly and over the long term (Paddock, Hunter, & Leininger, 2014; Vujanovic et al., 2017). In a review examining MDD and AUD specifically (Riper et al., 2014), treatment as usual supplemented with CBT and motivational interviewing had small but significant effects in improving depression and decreasing alcohol use versus treatment as usual alone or other brief psychosocial interventions.

For more extensive guidance about counseling clients with addiction and depression, see TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery (Center for Substance Abuse Treatment* [CSAT], 2008).

Bipolar I Disorder

Bipolar I disorder, also sometimes termed **manic-depression**, refers to a mental state wherein a person's mood fluctuates wildly between depressive and manic episodes (Exhibit 4.3). During depressive episodes, a person experiences symptoms of MDD (e.g., excessive sadness, loss of interest in normally pleasurably activities, physical and cognitive symptoms). During manic episodes, a person experiences the opposite—extreme euphoria, energy, and activity. Manic episodes vary with intensity and can be manifest in a variety of ways, such as having little or no need for sleep, very fast or "pressured" speech, impulsivity and erratic decision making (especially decisions of major consequence, like spending a large amount of money), and racing thoughts. Some manic episodes are milder in nature; these are known as hypomanic episodes. People with bipolar I disorder can experience both manic and hypomanic episodes. Bipolar II disorder is a related disorder in which the person only experiences hypomania and not full-blown mania. For the purposes of this chapter, only bipolar I disorder, which has ample research strongly linking it to SUDs, will be discussed.

Sometimes, manic episodes can produce symptoms that conflict with reality and are delusional in nature (e.g., a man believing he is going to marry the Queen of England). Because of these delusional and bizarre beliefs, bipolar disorder can sometimes appear similar to schizophrenia and other psychotic disorders (see the section "Schizophrenia and Other Psychotic Disorders"). In fact, increasing research supports a shared genetic risk between the bipolar and psychotic disorders (Cardno & Owen, 2014).

Suicidal thoughts and behaviors are common among people with bipolar disorder (APA, 2013), with **some believing it could have the highest suicide risk of all mental disorders** (Schaffer et

ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH A DEPRESSIVE DISORDER

- Possibly as many as half of the clients an addiction counselor sees will have an MDE (Center for Behavioral Health Statistics and Quality [CBHSQ], 2019). Counselors should expect to encounter depressive symptoms and disorders in their work and proactively familiarize themselves with diagnostic criteria and general treatment approaches.
- Differentiate among commonplace expressions of depression and depression associated with more serious mental illness (SMI), medical conditions and medication side effects, and substance-induced changes. Understand that it is possible to have depressive symptoms without meeting full criteria for MDD or another depressive disorder. Distinguishing MDD from normal moods and depressive symptoms is also important.
- Symptoms of depression can persist for 3 to 6 months following abstinence and need to be treated in counseling. Educate clients about the relationship of depression to substance misuse so that they know what to expect from treatment and the course of recovery.
- Sometimes substance use can mask depressive symptoms, and it may not become apparent that a client has depression until after he or she has stopped using substances. Monitor symptoms continually and respond immediately to any intensification of symptoms.
- Clients with depression often feel hopeless and unmotivated, which can hinder their participation and retention in treatment. If clients seem reluctant to engage in SUD treatment, do not interpret that as a sign of resistance or noncompliance. Alleviating their depressive symptoms could help with this to an extent. But also work with clients on enhancing motivation and self-efficacy so they can develop confidence and internalize the belief that recovery is possible.
- Gradually introduce and teach skills for participation in mutual-support programs.
- Consider CBT and motivational interviewing in place of or in addition to usual psychosocial treatment.
- Combine addiction counseling with medication and mental health services.
- Because antidepressants have such strong efficacy in reducing depressive symptoms, keep on hand the names of local mental health professionals (if one isn't available in the treatment setting) to refer clients for complete assessment and medication review.
- Given that depressive symptoms can result from SUDs and not an underlying mental disorder, careful and continual assessment is essential.
- Because of the increased risk of suicidality with MDD, continually assess and be vigilant for signs of suicidal ideation, gestures/behaviors, and attempts. Use risk mitigation strategies (e.g., safety plans) to protect clients from self-harm. (See the section "Cross-Cutting Topics: Suicide and Trauma" for more guidance.)

al., 2015). An estimated 20 percent of people with bipolar disorder try to commit suicide (Carra, Bartoli, Crocamo, Brady, & Clerici, 2014), leading to a standardized mortality ratio of suicide deaths that is 10 to 30 times greater than that of the general population (Schaffer et al., 2015). People with bipolar disorder and SUD are significantly more likely to try to commit suicide than people without both conditions (Carra et al., 2014; Schaffer et al., 2015). Interestingly, current or lifetime SUD is a significant risk factor for suicide attempt in bipolar disorder but not suicide death (Schaffer et al., 2015).

EXHIBIT 4.3. Diagnostic Criteria for Bipolar I Disorder

For a diagnosis of bipolar I disorder, it is necessary to meet the following criteria for a manic episode. The manic episode may have been preceded by and may be followed by hypomanic or MDEs.

Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:

1. Inflated self-esteem or grandiosity
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
3. More talkative than usual or pressure to keep talking
4. Flight of ideas or subjective experience that thoughts are racing
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli) as reported or observed
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity)
7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition.

Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I disorder.

Note: Criteria A–D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder.

Hypomanic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree:

1. Inflated self-esteem or grandiosity
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
3. More talkative than usual or pressure to keep talking
4. Flight of ideas or subjective experience that thoughts are racing
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli) as reported or observed.

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6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment).

Note: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

Note: Criteria A–F constitute a hypomanic episode. Hypomanic episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

MDE

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gain.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

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B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A–C constitute an MDE. MDEs are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of an MDE in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.*

Bipolar I Disorder

A. Criteria have been met for at least one manic episode (Criteria A—D under Manic Episode, above).

B. The occurrence of the manic episode and MDE is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

Specify current severity:

- Mild
- Moderate
- Severe

Specify:

- With psychotic features
- In partial remission
- In full remission
- Unspecified

Specify:

- With anxious distress
- With mixed features
- With rapid cycling
- With melancholic features
- With atypical features
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia
- With peripartum onset
- With seasonal pattern

* In distinguishing grief from an MDE, it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of MDE is

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more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in MDE. In grief, self-esteem is generally preserved, whereas in MDE feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about "joining" the deceased, whereas in MDE such thoughts are focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

Prevalence

The 12-month and lifetime prevalence rates of DSM-5 bipolar I disorder are 1.5 percent and 2 percent, respectively (Blanco et al., 2017). Rates are nearly equivalent between men and women for both 12-month and lifetime prevalence (Blanco et al., 2017).

Bipolar I Disorder and SUDs

Individuals with bipolar I have high prevalence rates (65 percent) of lifetime SUD, AUD (54 percent), and drug use disorder (32 percent) (McDermid et al., 2015). Presence of a 12-month or lifetime DSM-5 drug use disorder (i.e., an SUD excluding alcohol) is associated with a 1.4 to 1.5 increased odds in having bipolar I disorder (Grant et al., 2016). Similarly, presence of past-year or lifetime bipolar I disorder carries a 2 to 5.8 times greater risk of also having any 12-month or lifetime SUD (Blanco et al., 2017). A systematic review and meta-analysis found strong associations between co-occurring SUDs and bipolar illness in individuals in clinical settings, with the highest prevalence (average: 30 percent) for alcohol use, 20 percent (mean) for cannabis, and 17 percent (mean) for any drug use disorder (Hunt, Malhi, Cleary, Lai, & Sitharthan, 2016b).

Co-occurring bipolar illness and substance misuse are associated with numerous adverse clinical, social, and economic consequences, including increased symptom severity, poorer treatment outcomes, and greater suicide risk (Ma, Coles, & George, 2018). Presence of a co-occurring SUD with bipolar disorder has been linked to lower SUD treatment adherence and retention, protracted mood episodes, poorer recovery of functional abilities (even after abstaining from substances), increased utilization of emergency services, greater hospitalizations, more variable disease course, greater affective instability, more impulsivity, and poor response to lithium (the standard pharmacotherapy of choice) (Swann, 2010; Tolliver & Anton, 2015).

Treatment of Bipolar I Disorder and SUDs

Substance misuse by people with bipolar disorder complicates diagnosis and treatment. Evidence exists of a bidirectional relationship between bipolar disorder and SUDs, yet the ways in which these conditions influence one another is still unclear (Tolliver & Anton, 2015). Little research has examined nonpharmacological approaches to managing comorbid bipolar I disorder and SUDs. Group CBT, integrated therapy, and relapse prevention techniques may help reduce hospitalizations, increase abstinence, improve medication adherence, reduce addiction severity, and (to a lesser extent) improve mood symptoms (Gold et al., 2018). However, results are inconsistent across studies, underscoring the need for more research.

ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH BIPOLAR I DISORDER

- Although true for most counseling situations, maintaining a calm demeanor and a reassuring presence is especially important with these clients.
- Start low and go slow (that is, start "low" with general and nonprovocative topics and proceed gradually as clients become more comfortable talking about problems).
- Monitor symptoms and respond immediately to any intensification.
- At every session, strongly emphasize and monitor medication compliance and promote medication adherence. The cyclical nature of bipolar disorder is frequently punctuated by bouts of medication noncompliance, and it is crucial to cultivate and convey an understanding of the allure of the manic episode.
- Pay attention to signs of depression or mania, as medication might be able to ward off the worsening of the client's condition. For developing mania, which is virtually nonresponsive to psychosocial interventions, a variety of mood stabilizers have demonstrated remarkable efficacy. Their timely use can avert potentially life-altering, negative events. (See "Pharmacotherapy" in Chapter 7.)
- Although evidence on psychosocial treatments for bipolar I disorder and SUD is inconsistent, the strongest support seems to come from the use of integrated group-based interventions that use multiple treatment components to address both mood and substance-related symptoms. Techniques include counseling, relapse prevention, psychoeducation, medication management, and regular phone or in-person "check-in" sessions to monitor symptoms and treatment progress.
- Gradually introduce and teach skills for participation in mutual-support programs.
- Combine addiction counseling with medication and mental health services.
- Suicide and suicidal behaviors are major ongoing concerns for this client population, and the addiction counselor should have a thorough understanding of her or his role in preventing suicide.

Case Study: Counseling an SUD treatment Client With Bipolar I Disorder

John W. is a 30-year-old man with bipolar I disorder and AUD. He has a history of hospitalizations, both psychiatric and substance related; after the most recent extended psychiatric hospitalization, he was referred for SUD treatment. He told the counselor he used alcohol to facilitate social contact, as well as deal with boredom, because he had not been able to work for some time. The counselor learned that during his early 20s, John W. achieved full-time employment and established an intimate relationship with a nondrinking woman; however, his drinking led to the loss of both.

During one of his AUD treatments, he developed florid manic symptoms, believing himself to be a prophet with the power to heal others. He was transferred to a closed psychiatric unit, where he eventually stabilized on a combination of antipsychotic medications (risperidone) and lithium. Since that time, he has had two episodes of worsening psychiatric symptoms leading to hospitalization; each of these began with drinking, which then led to stopping his medications, then florid mania and psychiatric commitment. However, when he is taking his medications and is sober, John W. has a normal mental status and relates normally to others. Recently, following a series of stressors, John W. left his girlfriend, quit his job, and began using alcohol heavily again. He rapidly relapsed to active mania, did not adhere to a medication regimen, and was rehospitalized.

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At the point John W. is introduced to the SUD treatment counselor, his mental status is fairly normal; however, he warns the counselor that after manic episodes he tends to get somewhat depressed, even when he is taking medications. The counselor takes an addiction history and finds that John W. has had several periods of a year or two during which he was abstinent from alcohol and drugs of misuse, but he has never had ongoing AUD treatment or attended Alcoholics Anonymous (AA) meetings. John W. replies to the counselor's questions about this with, "Well, if I just take my meds and don't drink, I'm fine. So why do I need those meetings?"

Using a motivational approach, the counselor helps John W. analyze what has worked best for him in dealing with both addiction and mental problems, as well as what has not worked well for him. John W. is tired of the merry-go-round of his life; he certainly acknowledges that he has a major mental disorder, but thinks his drinking is only secondary to the mania. When the counselor gently points out that each of the episodes in which his mental disorder led to hospitalization began with an alcohol relapse, John W. begins to listen. In a group for clients with CODs at the SUD treatment agency, John W. is introduced to another client in recovery with a bipolar disorder, who tells his personal story and how he discovered that both of his problems need primary attention. This client agrees to be John W.'s temporary sponsor and calls John W.'s case manager, who works at the mental health center where John W. gets his medication, and describes the treatment plan. She then makes arrangements for a monthly meeting involving the counselor, case manager, and John W.

Discussion: The SUD treatment counselor has taken the wise step of taking a detailed history and attempting to establish the linkage between CODs. The counselor tries to appreciate the client's own understanding of the relationship between the two. She uses motivational approaches to analyze what John W. did in his previous partially successful attempts to deal with the problem and helps develop connections with other recovering clients to increase motivation. Lastly, she is working closely with the case manager to ensure a coordinated approach to management of each disorder.

Posttraumatic Stress Disorder

PTSD is an exaggerated fear response that occurs following exposure to one or more extremely upsetting events. Such events can include, but are not limited to, war, terrorist attacks, threatened or actual physical or sexual violence, being kidnapped, natural and man-made disasters, and serious motor vehicle accidents. Events may be experienced firsthand, witnessed, experienced through repeated exposure as a part of one's job (e.g., police officers repeatedly hearing details about child abuse, murder, and other violent and upsetting crimes), or by learning about such events occurring to a close loved one (e.g., learning of the murder of one's child). People with PTSD report the most distressing trauma to be sexual abuse before age 18 years (Goldstein et al., 2016).

Symptoms of PTSD are grouped into four categories:

- **Intrusive, persistent re-experiences of the trauma,** including recurrent dreams or nightmares, flashbacks, and distressing memories
- **Persistent avoidance** of people, places, objects, and events that remind the person of the trauma or otherwise trigger distressing memories, thoughts, feelings, and physiological reactions
- **Negative alterations in cognitions and mood**, such as memory loss (particularly regarding details surrounding the event), self-blame, guilt, hopelessness, social withdrawal, and an inability to experience positive emotions
- **Marked alterations in arousal and reactivity,** such as experiencing sleeplessness or feeling "jumpy," "on edge," easily started, irritable, angry, or unable to concentrate

Exhibit 4.4 lists the DSM-5 criteria for PTSD in adults and children older than age 6; separate criteria are available for children ages 6 years and younger and can be found in DSM-5.

EXHIBIT 4.4. Diagnostic Criteria for PTSD

Note: The following criteria apply to adults, adolescents, and children older than 6 years.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of these ways:

1. Directly experiencing the traumatic event(s)
2. Witnessing, in person, the event(s) as it occurred to others
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse)

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic events(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)

Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s)

Note: In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

Note: In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s)
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s)

D. Negative alterations in cognitions and mood associated with the traumatic events(s), beginning or worsening after the traumatic events(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic events(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs)

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2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined")
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame)
5. Markedly diminished interest or participation in significant activities
6. Feelings of detachment or estrangement from others
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings)

E. Marked alterations in arousal and reactivity associated with the traumatic events(s), beginning or worsening after the traumatic events(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects
2. Reckless or self-destructive behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems with concentration
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep)

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

- With dissociative symptoms: The individual's symptoms meet the criteria for PTSD, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly)
2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted)

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizure).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate)

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Prevalence

Twelve-month and lifetime prevalence rates of DSM-5 PTSD are 4.7 percent and 6.1 percent, respectively (Goldstein et al., 2016). Rates are markedly higher among women than men, about 6 percent and 8 percent for past-year and lifetime PTSD, respectively (Goldstein et al., 2016). Lifetime prevalence is even higher for female veterans (13.9 percent) and younger adults (ages 18 to 29 years, 15.3 percent) (Smith, Goldstein, & Grant, 2016). A 2016 study of veterans using DSM-5 criteria found the lifetime prevalence of PTSD to be 6.9 percent, with significantly higher prevalence rates noted for women and younger age groups (Smith et al., 2016).

Individuals in occupations at risk of exposure to traumatic events (e.g., police, firefighters, emergency medical personnel) have higher rates of PTSD. Among high-risk individuals (those who have survived rape, military combat, and captivity or ethnically or politically motivated internment and genocide), the proportion of those with PTSD ranges from one-third to one-half (APA, 2013).

PTSD and SUDs

A strong association exists between PTSD and substance misuse, including lifetime SUDs (Hasin & Kilcoyne, 2012), lifetime drug use disorders (Grant et al., 2016), and lifetime AUD (Grant et al., 2015). Among people with SUDs, lifetime prevalence of PTSD is thought to range between 26 percent and 52 percent and rates of current PTSD between 15 percent and 42 percent (Vujanovic, Bonn-Miller, & Petry, 2016). Among people with PTSD, lifetime rates of SUD are likely between 36 percent and 52 percent (Vujanovic et al., 2016). Presence of a 12-month or lifetime DSM-5 drug use disorder (i.e., an SUD excluding alcohol) is associated with a 1.5 to 1.6 increased odds of having PTSD (Grant et al., 2016). Similarly, presence of 12-month or lifetime PTSD is associated with a 1.3 to 1.5 increased odds of having a past-year or lifetime SUD (Goldstein et al., 2016).

Comorbid PTSD and addiction are highly complex and associated with worse treatment outcomes (including lower rates of remission and faster relapse), poorer treatment response, more cognitive difficulties, worse social functioning, greater risk of suicide attempt, and heightened mortality (Flanagan, Korte, Killeen, & Back, 2016; Schumm & Gore, 2016). Compared with people with PTSD or alcohol dependence alone, those with both report more traumatic childhoods, more psychiatric comorbidities, an increased risk of suicide, more severe symptoms, and greater disability (Blanco et al., 2013).

People with PTSD tend to misuse the most serious substances (cocaine and opioids); however, misuse of prescription medications, cannabis, and alcohol also are common.

WARNING TO COUNSELORS: PTSD OR DEPRESSION?

Many people with PTSD are mistakenly diagnosed with depression, particularly in SUD treatment settings where screening for trauma is low. The two conditions are highly comorbid. Symptoms can overlap to an extent, and when occurring together, the combination results in greater symptom severity than either disorder alone (Post, Feeny, Zoellner, & Connell, 2016). Subclinical traumatic stress reactions are commonly expressed as depressive symptoms. However, PTSD has unique treatment needs and a different disease course and treatment response than depression. When working with someone with a depressive disorder diagnosis who also has a history of trauma, consider screening for PTSD to gauge whether a referral for diagnostic assessment might be warranted.

Treatment of PTSD and SUDs

Historically, there has been debate about whether to treat PTSD and addiction concurrently or sequentially, with most providers falling on the side of treating the SUD separately and first (Schumm & Gore, 2016). Some believe that substance misuse among people with PTSD is a means of self-medicating to help manage distressing mood and anxiety symptoms, thus making PTSD the priority target for treatment. Alternatively, others have feared that treating PTSD first could exacerbate SUD symptoms or cause clients to use substances

as a means of coping with the hyperarousal and negative mood that can occur while progressing through PTSD treatment. However, integrated, concurrent treatment that addresses both conditions simultaneously has generated strong empirical support, appears to be preferable to clients, and is increasingly considered the current standard of care, particularly when combining psychosocial and pharmacologic approaches (Flanagan et al., 2016; Schumm & Gore, 2016; Simpson, Lehavot, & Petrakis, 2017).

Despite the evidence that concurrent treatment can be effective, people with PTSD and SUD are frequently only treated for addiction; further, **clients in SUD treatment settings are often not even assessed for PTSD** (Vujanovic et al., 2016). Whereas treating SUD alone rarely leads to improvement in PTSD symptoms, reducing PTSD symptoms can significantly decrease the odds of heavy substance (Hien et al., 2010).

Exposure therapy can be safe and effective at reducing trauma and SUD symptoms—although more evidence is needed (Flanagan et al., 2016). Nonexposure-based treatments have been studied more widely for co-occurring PTSD and SUD and may be moderately effective at improving both PTSD and substance symptoms, but the evidence is still premature (Flanagan et al., 2016). A Cochrane Review found individual trauma-focused psychotherapy with adjunctive SUD treatment to be effective at reducing posttreatment PTSD severity and substance use at 5 to 7 months following treatment; however, the authors deemed the current evidence base on psychological treatments for PTSD-SUD to be weak in terms of quality and methodology, underscoring the need for more rigorous research in this area (Roberts, Roberts, Jones, & Bisson, 2016). Studies of pharmacologic treatments for SUD with PTSD, and for AUD specifically, appear encouraging but, again, are understudied, often inconclusive, and require more data (Flanagan et al., 2016; Petrakis & Simpson, 2017).

See the section "Cross-Cutting Topics: Suicide and Trauma" at the end of this chapter for more information about trauma-informed care for people with CODs.

ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH PTSD

- As a counselor, it is important to recognize, and help clients understand, that becoming abstinent from substances does not resolve PTSD; both disorders must be addressed in treatment.
- Treatment of PTSD with cooccurring SUDs requires careful planning and supervision.
  - As the client faces painful trauma memories, the desire for intoxication can be overwhelming. By exploring trauma memories, well-intentioned counselors inadvertently may drive a client back to the substance by urging her to "tell her story" or "let out the abuse." Even if a client wants to discuss trauma and seems safe during the session, aftereffects may well ensue, including a flood of memories the client is unprepared to handle, increased suicidality, and "retraumatization" (feeling like one is reliving the event).
  - Such treatment approaches should be undertaken only with adequate formal training in both PTSD and substance misuse and only under careful clinical supervision.
- These clients need stability in their primary therapeutic relationship; hence, this work should not be undertaken in settings with high staff turnover and never without training and supervision.

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- Do not try to provide trauma exploration treatment in view of the potential for highly destabilizing effects (including worsening of substance misuse).
- Provide present-focused psychoeducation about PSTD, such as teaching the client to recognize symptoms of the disorder and how to cope with them.
- Clinicians are advised not to overlook the possibility of PTSD in men.
- People with PTSD and substance misuse are more likely to experience further trauma than people with substance misuse alone.
- Repeated trauma is common in domestic violence, child abuse, and some substance-using lifestyles (e.g., the drug trade), so helping the client protect against future trauma may be an important part of treatment.
- Anticipate proceeding slowly with a client who is diagnosed with or has symptoms of PTSD. Consider the effect of a trauma history on the client's current emotional state, such as an increased level of fear, depressed mood, or irritability.
- Trauma begets more trauma, as people with PTSD are at an increased risk of revictimization. Discuss with clients this increased risk, how to recognize and avoid threatening situations, and how substance use plays a role in increasing their vulnerability to revictimization.
- Develop a plan for increased safety if warranted.
- Respond more to the client's behavior than his or her words.
- Limit questioning about details of trauma.
- Recognize that trauma injures an individual's capacity for attachment. The establishment of a trusting treatment relationship will be a goal of treatment, not a starting point.
- Recognize the importance of one's own trauma history and countertransference.
- Help the client learn to deescalate intense emotions.
- Help the client understand the link between PTSD and substance use by providing psychoeducation.
- Teach coping skills to control PTSD symptoms.
- Recognize that PTSD/SUD treatment clients may have a more difficult time in treatment and that treatment for PTSD may be long term, especially for those who have a history of serious trauma.
- Help the client access long-term PTSD treatment and refer to trauma experts for trauma exploratory work.
- Given the high prevalence of self-harm in this population, counselors should screen for suicide risk early on in treatment and throughout the course of care. Risk of suicide in people with PTSD is correlated with a history of childhood maltreatment and more severe PTSD symptoms—especially ones concerning negative mood and cognitions (Criterion D in DSM-5 diagnostic criteria).

CASE STUDY: COUNSELING AN SUD TREATMENT CLIENT WHO BINGE DRINKS AND HAS PTSD

Caitlin P. is a 17-year-old Native American woman admitted to an inpatient SUD treatment program after she tried to kill herself during a drunken episode. She has been binge drinking since age 12 and also has tried a wide variety of pills without caring what she is taking. She has a history of depression and burning her arms with cigarettes. She was the victim of a date rape at age 15 and did not tell anyone but a close friend. She did not tell her family for fear that they would think less of her for not preventing or fighting off the attack.

In treatment, she worked with staff to try to gain control over her repeated self-destructive behavior. Together they worked on developing compassion for herself, created a safety plan to encourage her to reach out for help when in distress, and began a log to help her identify her PTSD symptoms so that she could recognize them more clearly. When she had the urge to drink, use drugs, or burn herself, she was guided to try to "bring down" the feelings through grounding, rethink the situation, and reassure herself that she could get through it. She began to see that her substance use had been a way to numb the pain.

Discussion: Counselors can help clients gain control over PTSD symptoms and self-destructive behavior associated with trauma. Providing specific coping strategies and lots of encouragement typically appeals to PTSD/SUD treatment clients, who may want to learn how to overcome the emotional rollercoaster of their disorders. Notice that in such early-phase treatment, detailed exploration of the past is not generally advised.

For more information about working with American Indian and Alaska Native clients who have SUDs or CODs, see TIP 61, *Behavioral Health Services for American Indians and Alaska Natives* (SAMHSA, 2018a).

Personality Disorders

A PD refers to a person's lifelong inability to form healthy, functional relationships with others and a failure to develop an adaptive sense of self. These are manifest as (a) destructive or otherwise problematic patterns of thinking and feeling about oneself, one's place in the world, and others and (b) negative ways of behaving toward others. People with PDs often lack insight into their dysfunctional cognitive, emotional, and behavioral patterns and often blame others or the world in general for their difficulties. Many people with PDs struggle to develop strong, positive relationships, because they view reality from the perspective of their own needs and therefore have a difficult time understanding, empathizing with, and connecting with others. PDs are lifelong conditions that develop in adolescence or early adulthood. They are frequently resistant to change and result in significant impairments in interpersonal functioning, work/school performance, and self-concept.

There are several types of PDs, and the precise symptoms someone exhibits will depend on which type of PD he or she has. For instance, depending on the PD type, an individual might think of himself/herself in overly negative ways or in grandiose ways, might be overly attached to others or completely indifferent to others, might constantly try to be the center of attention or might be socially reclusive. People with PDs must first meet the diagnostic criteria for a general PD (Exhibit 4.5) and then must meet additional diagnostic criteria for whatever PD type is most appropriate given their symptoms. Many individuals with PDs have features of, or meet full criteria for, other PDs.

This TIP provides details about the two PD types that are commonly comorbid with addiction—BPD and antisocial PD (ASPD). Before exploring BPD and ASPD in detail, an overview of PDs in general follows. Readers should be aware that the diagnostic approach to PDs continues to undergo refinement, as researchers in psychopathology have expressed many concerns about the meaningfulness, gender bias, accuracy, and utility of the current categorical diagnostic system for PDs (see Section III of DSM-5 for more information on alternative PD classification and diagnostic criteria).

PD Clusters

Once a person meets criteria for a general PD, his or her diagnosis is further categorized based on several specific PD types, including paranoid PD, schizoid PD, schizotypal PD, histrionic PD, narcissistic PD, ASPD, BPD, avoidant PD, dependent PD, and obsessive-compulsive PD. If the symptoms do not meet any of the types, he or she can be diagnosed with either unspecified PD or other specified PD. Detailed descriptions and criteria for all 10 PD types can be found in DSM-5. BPD and ASPD most frequently co-occur with substance misuse (Köck & Walter, 2018). Thus, they are included in this chapter and discussed in respective subsections.

In DSM5, PD types are categorized into three distinct clusters based on their common features:

- **Cluster A PDs** describe people who may be seen as odd or eccentric. This eccentricity can express itself in many ways (e.g., paranoia and suspicion, extreme social withdrawal/lack of

EXHIBIT 4.5. Diagnostic Criteria for General PD

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:

1. Cognition (i.e., ways of perceiving and interpreting self, other people, and events)
2. Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response)
3. Interpersonal functioning
4. Impulse control

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

E. The enduring pattern is not better explained as a manifestation or consequence of another mental disorder.

F. The enduring pattern is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., head trauma).

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WARNING TO COUNSELORS: PDS AND PROVIDER STIGMA

PDs are among the most stigmatized of all mental disorders (Sheehan, Nieweglowski, & Corrigan, 2016). Primary care, mental health, and SUD treatment professionals sometimes have contemptuous attitudes toward PDs and the people who live with them. They may think or say things such as:

- "These people cannot be treated, so why bother?"
- "I see PDs all the time, especially in women."
- "Most people with addiction also have a PD."
- "It is not worth the time to try to diagnose or treat someone with a PD because nothing can be done for them anyway."
- "I don't accept referrals for clients like that because they're too much work and can't be helped."
- "Most antisocial people are criminals and are just going to end up in prison."
- "People with ASPD are 'psychopaths' (or 'sociopaths')."
- "These people are just manipulative liars; they don't really want to get better or want my help."
- "That wasn't a real suicide attempt. She's borderline—she's just seeking attention."

It is true that PDs are lifelong disorders, can be challenging to work with, and may be more resistant to change than other mental disorders or SUDs. But that does not mean that counselors cannot offer people with these conditions any relief, and it does not mean that people with PDs cannot improve their symptoms. Addiction professionals can help clients with PDs reduce substance misuse, which in turn can indirectly help improve functioning and quality of life by reducing risky behavior and enhancing health.

Counselors can combat stigma and prejudice by:

- Becoming familiar with the latest evidence in support of PD treatment. The notion that these disorders are completely intractable is untrue. Even in the absence of validated treatments for the PD itself, interventions can still help reduce disabling symptoms and CODs, including co-occurring addiction.
- Engaging in honest self-reflection about their own views of and attitudes about PDs. Talking to a clinical supervisor, or even engaging in brief counseling themselves, can foster self-awareness and behavior change.
- Remembering that stereotypes can be dangerous and affect how counselors serve (or do not serve) the clients who need them. All people, regardless of symptoms or diagnoses, deserve health and happiness.

interest in interpersonal relationships, unusual beliefs or behaviors). PD types included in this cluster are:

  - Paranoid PD.
  - Schizoid PD.
  - Schizotypal PD.

- **Cluster B PDs** are characterized by dramatic, overly emotional, and erratic and unpredictable behavior. PD types included in this cluster are:
  - Histrionic PD.
  - Narcissistic PD.
  - ASPD.
  - BPD.
- **Cluster C PDs** are marked by anxious and fearful behaviors. PD types included in this cluster are:
  - Obsessive-compulsive PD.
  - Avoidant PD.
  - Dependent PD.

Prevalence

Prevalence estimates for PDs among the general population are difficult to ascertain, given lack of research examining large samples from the community (as opposed to clinical samples, in which PDs are far more common and frequently studied). Estimates are 9.1 percent for any PD, 5.7 percent for any Cluster A PD, 1.5 percent for any Cluster B, and 6 percent for Cluster C (APA, 2013). In one analysis of the National Epidemiologic Survey on Alcohol

and Related Conditions (NESARC), the prevalence of lifetime DSM-IV PDs varied from 0.5 percent to 7.9 percent, depending on the PD type (Hasin & Grant, 2015). Prevalence rates for BPD and ASPD are discussed in separate sections.

Diagnostic criteria for PDs have long been debated among psychopathology researchers and clinicians, given multiple problems with the way PDs are classified and diagnosed (Paris, 2014; Sarkar & Duggan, 2010). Problems include a lack of empirical evidence supporting PDs; the extensive overlap between diagnostic criteria among the specific types of PDs as well as overlap with other mental disorders; the fact that PD criteria are insufficiently discriminant, which has resulted in many individuals who exhibit PD pathology receiving a DSM-IV "personality disorder not otherwise specified" diagnosis after failing to "fit in" to any of the specified PD types; and the difficulty mental health professionals have in distinguishing PD traits from variants of normal personality, which means that deciding whether a person meets PD criteria is often a subjective judgment. **Thus, it is hard to know exactly how many people have a PD, including how many people with addiction have co-occurring PDs** (Paris, 2014).

PDs and SUDs

SUD counselors frequently see people with PD diagnoses in their treatment settings. A review found the prevalence of PDs among people with SUDs to be wide ranging but nonetheless extremely high, varying from about 35 percent to 65 percent; rates of ASPD ranged from about 14 percent to almost 35 percent (Köck & Walter, 2018). Similarly, among people undergoing detoxification for AUD, rates of co-occurring PDs vary widely from 5 percent to 87 percent (Newton-Howes & Foulds, 2018). PDs may be present in as much as 24 percent of people with AUD in the general population (Newton-Howes & Foulds, 2018).

> For most people with SUDs, drugs eventually become more important than jobs, friends, and family. These changes in priorities often appear similar to a PD, but diagnostic clarity for PDs in general is difficult. For clients with substance-related disorders, the true diagnostic picture might not emerge for weeks or months. It is not unusual for PD symptoms to clear with abstinence, sometimes even fairly early in recovery.

People with PDs and SUDs differ from those with PDs only or SUDs only in important ways (Köck & Walter, 2018), including more severe mental and substance-related symptoms, longer persisting substance use, a greater likelihood of other co-occurring mental disorders (e.g., anxiety, depressive, and eating disorders), increased mortality, and higher SUD treatment dropout.

Treatment for PDs and SUDs

No evidence-based treatments exist for PDs themselves (Bateman, Gunderson, & Mulder, 2015), but effective treatments are available to address a variety of PD symptoms, including risk of suicide and self-harm, affective dysregulation, maladaptive thought patterns, and poor interpersonal functioning. Psychotherapy is the primary form of intervention, as no medications have been approved for the treatment of PDs. Pharmacotherapy may be useful as an adjunctive treatment for certain symptoms like affective lability, impulsivity, and psychosis, but it is not useful as a primary intervention. (See the section "Pharmacotherapy" in Chapter 7 for more information.) Dialectical behavioral therapy, dynamic deconstructive psychotherapy, and dual-focused schema therapy appear promising, particularly for BPD, and have shown to positively affect psychiatric and addiction-related outcomes, although, in general, the research literature on effective treatments for PDs, with or without co-occurring SUD, is sparse and requires further evidence (Bateman et al., 2015; Köck & Walter, 2018).

BPD

The essential feature of BPD is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, along with marked impulsivity, that begins by early adulthood and is present in a variety of contexts (Exhibit 4.6). Relationships with others are likely to be unstable—for instance, people with BPD might remark how wonderful an

ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH A PD

- Clients with PDs tend to be limited in their ability to receive, accept, or benefit from corrective feedback.
- A further difficulty is the strong countertransference providers can have in working with these clients, who may be adept at igniting reactions in a variety of ways. Specific concerns will, however, vary according to the specific PD and other individual circumstances.
- PDs may cause difficulty forming genuinely positive therapeutic alliances. Some clients tend to frame reality in terms of their own needs and perceptions and not to understand the perspectives of others.
- The course and severity of PDs can be worsened by the presence of other mental disorders, such as depressive, anxiety, and psychotic disorders. Be sure to offer empirical treatments for co-occurring conditions as well as the primary PD and SUD.
- To get the best outcomes possible for clients with PDs and co-occurring SUDs, treatment should address both conditions to the extent possible and should not neglect one disorder over the other.

EXHIBIT 4.6. Diagnostic Criteria for BPD

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in various contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. Identity disturbance: markedly and persistently unstable self-image or sense of self
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating) (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoid ideation or severe dissociative symptoms

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individual is one day but express intense anger, disapproval, condemnation, and even hate toward that same individual a week later. The severe instability people with BPD experience includes fluctuating views and feelings about themselves. Those with BPD often feel good about themselves and their progress and optimistic about their future for a few days or weeks, only to have a seemingly minor experience turn their world upside down, with concomitant plunging self-esteem and depressing hopelessness. This instability often extends to work and school.

When experiencing emotional states they cannot handle, clients with BPD can be at high risk of suicidal, self-mutilating, or brief psychotic states.

About three-fourths of people with BPD have a history of self-harm, and the disorder carries a 10-percent lifetime risk of completed suicide (Antai-Otong, 2016).

Prevalence

BPD has a prevalence of 1.6 percent to 5.9 percent in the general population but is more common in mental health settings (about a 10-percent prevalence rate for outpatient mental health clinics, about 20 percent among psychiatric inpatients, and 6 percent in primary care settings) (APA, 2013). Lifetime prevalence of DSM-IV BPD is 5.9 percent (Hasin & Grant, 2015).

Women are much more likely to be diagnosed with BPD, generally at 3 times the rate of men (i.e., about 75 percent of cases are women) (APA, 2013). However, the accuracy of this pattern is dubious as epidemiologic surveys of the U.S. general population have found the lifetime prevalence of BPD does not actually differ significantly between men and women (Hasin & Grant, 2015).

BPD and SUDs

BPD is highly prevalent in SUD treatment settings (and especially inpatient and residential treatment), with rates averaging about 22 percent across multiple studies but as high as 53 percent in some research (Trull et al., 2018). Presence of a 12-month or lifetime DSM-5 drug use disorder (i.e., an SUD excluding alcohol) is associated with a 1.7 to 1.8 increased odds of having BPD (Grant et al., 2016). Approximately 45 percent of individuals with BPD also have a current SUD, and about 75 percent have a lifetime SUD (Trull et al., 2018). Opioids, cocaine, and alcohol are the substances with the strongest associations with BPD (Trull et al., 2018).

Treatment of BPD and SUDs

People with BPD typically seek behavioral health services based on their current life conditions and emotional state. Those who seek mental health services tend to be acutely emotionally distraught, needing some relief from how they feel. Similarly, those who choose (or are directed to choose) a program are likely experiencing the SUD as the immediate target for treatment. Consequently, the average admission of a person with BPD to a mental health program may be considerably different from the average admission of a person with BPD to an SUD treatment program.

In inpatient mental health service settings, dialectical behavior therapy for BPD is recommended to help reduce suicide risk, stabilize behavior, and help clients regulate emotions (Ritter & Platt, 2016). SUD treatment for people with BPD can be complicated, and progress may be slow, but effective interventions are available to help reduce symptoms and improve functioning. A systematic review of 10 studies on treatments for BPD and co-occurring SUDs found good support for dialectical behavior therapy, dynamic deconstructive therapy, and dual-focused schema therapy in improving outcomes of substance use, suicidal gestures and self-harm, global and social functioning, treatment utilization, and treatment retention (Lee, Cameron, & Jenner, 2015).

WARNING TO COUNSELORS: THE MISDIAGNOSIS OF BPD

PDs can be difficult to diagnose. BPD is especially prone to misdiagnosis, particularly among women. Reasons for incorrect diagnosis (or, alternatively, failure to diagnose) are numerous and include (Fruzzetti, 2017):

- Stigma surrounding the disorder may lead providers to refuse to diagnose it or to be overzealous in diagnosing it (the latter, especially in women who are "emotional," unstable, argumentative, or in crisis).
- Symptoms of BPD—including emotional lability, suicidality, and impulsive behaviors—that are also present in full or in part in many other disorders, including MDD, bipolar disorder, PTSD, SUDs, and more. This makes it difficult to disentangle BPD from other illnesses.
- The incorrect belief that BPD is not treatable, which may make clinicians less likely to give the diagnosis, especially when they believe that symptoms reflect a different disorder, like depression or PTSD.
- Women being significantly more likely to receive a BPD diagnosis because of gender bias.

ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH BPD

- Anticipate that client progress will be slow and uneven.
- Assess the risk of self-harm by asking about what is wrong, why now, whether the client has specific plans for suicide, past attempts, current feelings, and protective factors. (See the discussion of suicidality at the end of this chapter.)
- Maintain a positive but neutral professional relationship, avoid overinvolvement in the client's perceptions, and monitor the counseling process frequently with supervisors and colleagues.
- Set clear boundaries and expectations regarding limits and requirements in roles and behavior.
- Understand that clients with BPD may be inconsistent in their attendance to sessions; anticipate and discuss these interruptions with the client.
- Assist the client in developing skills (e.g., deep breathing, meditation, cognitive restructuring) to manage negative memories and emotions.
- Help the client understand the connections between their feelings and their behaviors.
- Monitor newly abstinent individuals with BPD for compulsive sexual behavior, compulsive gambling, compulsive spending/shopping, or other behaviors that result in negative or even dangerous consequences.
- Medication management and monitoring should be included in the treatment plan. Individuals with BPD often are skilled in seeking multiple sources of medication that they favor, such as benzodiazepines. Once they are prescribed this medication in a mental health system, they may demand to be continued on the medication to avoid dangerous withdrawal.
- Help clients manage their daily lives and responsibilities by focusing on work, family, and social functioning.
- At the beginning of a crisis episode, a client with BPD may take a drink or use a different substance in an attempt to quell the growing sense of tension or loss of control. The client must learn that at this point, substance use increases harm and real loss of control. The client needs to develop positive coping strategies to put into play immediately upon experiencing a desire to use substances.
- Educate clients about their SUDs and mental disorders. Clients should learn that treatment for and recovery from their SUD may progress at a different rate than their treatment for and recovery from BPD. In addition, although many clients appear to fully recover from their SUDs, the degree of long-term recovery from BPD is less understood and characterized.
- Written and oral contracts that are simple, clear, direct, and time limited can be a useful part of the treatment plan. Contracts can help clients create structure and safe environments for themselves, prevent relapse, or promote appropriate behavior in therapy sessions and in mutual-support meetings.
- To treat people with BPD, pay attention to several areas, such as violence to self or others, transference and countertransference, boundaries, treatment resistance, symptom substitution, and somatic complaints.
- Therapists should be realistic in their expectations and know that clients might try to test them. To respond to such tests, therapists should maintain a matter-of-fact, businesslike attitude, and remember that people with PDs often display maladaptive behaviors that have helped them to survive in difficult situations, sometimes called "survivor behaviors." (See TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* [CSAT, 2000c]).

CASE STUDY: COUNSELING AN SUD TREATMENT CLIENT WITH BPD

Ming L., an Asian woman, was 32 years old when she was taken by ambulance to the local hospital's emergency department (ED). Ming L. had taken 80 Tylenol capsules and an unknown amount of Ativan in a suicide attempt. Once medically stable, Ming L. was evaluated by the hospital's social worker to determine her clinical needs.

The social worker asked Ming L. about her family of origin. Ming L. gave a cold stare and said, "I don't talk about that." Asked if she had ever been sexually abused, Ming L. replied, "I don't remember." Ming L. acknowledged previous suicide attempts as well as a history of cutting her arm with a razor blade during stressful episodes. She reported that the cutting "helps the pain."

Ming L. denied having "a problem" with substances but admitted taking "medication" and "drinking socially." A review of Ming L.'s medications revealed the use of Ativan "when I need it." It soon became clear that Ming L. was using a variety of benzodiazepines (antianxiety medications) prescribed by several doctors and probably was taking a daily dose indicative of severe SUD. She reported using alcohol "on weekends with friends" but was vague about the amount. Ming L. did acknowledge that before her suicide attempts, she drank alone in her apartment. This last suicide attempt was a response to a breakup with her boyfriend.

The counselor reads through notes from an evaluating psychiatrist and reviews the social worker's report of his interview with Ming. She notes that the psychiatrist describes the client as having a severe BPD, major recurrent depression, and SUDs involving both benzodiazepines and alcohol.

Discussion: Knowing the limits of what an SUD treatment counselor or agency can and cannot realistically do is important. A client with problems this serious is unlikely to do well in standard SUD treatment unless she is also enrolled in a program qualified to provide treatment to clients with BPD, and preferably in a program that offers treatment designed especially for this disorder, such as dialectical behavior therapy (Linehan et al. 1999) (although SUD treatment programs are increasingly developing their capacities to address specialized mental disorders). She is likely to need detoxification either on an inpatient basis or in a long-term outpatient program that knows how to address clients with PDs.

ASPD

The core features of ASPD are a pervasive disregard for the rights, feelings, and needs of others and a failure to form long-term, fulfilling, adaptive relationships (Exhibit 4.7). Individuals with ASPD often display a host of challenging traits: deceitfulness, remorselessness, aggression, disregard for rules and laws, low conscientiousness, impulsivity, failure to adhere to social norms, delinquency, and recklessness. As a result, these individuals often lead unstable lives and are at high risk of increased mortality, violence/aggression, suicide and suicidal behavior, accidents, criminality, incarceration, and chronic illnesses (e.g., cancer, HIV) (Black, 2015; Black, 2017; Dykstra, Schumacher, Mota & Coffey, 2015; Krasnova, Eaton, & Samuels, 2018; McCloskey & Ammerman, 2018). Many people with ASPD have experienced traumatic or disruptive childhoods (Sher et al., 2015).

EXHIBIT 4.7. Diagnostic Criteria for ASPD

A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:

1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest
2. Deceitfulness, indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
3. Impulsivity or failure to plan ahead
4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults
5. Reckless disregard for safety of self or others
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
7. Lack of remorse, indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

B. The individual is at least age 18 years.

C. There is evidence of conduct disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.

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A particularly stigmatizing aspect of ASPD is its history of being equated with derisive terms like "sociopath" and "psychopath." ASPD thus carries extremely negative connotations that might well be accurate in only a small percentage of those people with the disorder. Psychopathy and sociopathy are personality traits, not mental disorders. They are related to ASPD but are usually manifest in more extreme ways than ASPD (e.g., criminal behavior). In short, **psychopathy and sociopathy are not the same as ASPD.** (See the TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* [CSAT, 2005b] for a full discussion of psychopathy and its relationship to ASPD.)

Prevalence

Twelve-month prevalence rates for DSM-IV ASPD fall between 0.2 percent and 3.3 percent (APA, 2013). Lifetime DSM-IV ASPD is estimated at 3.6 percent (Hasin & Grant, 2015). Much higher prevalence rates (up to 70 percent) have been found in studies of men in treatment for AUD and SUD treatment clinics, prisons, and other forensic settings (APA, 2013).

Men are 2 to 8 times more likely to have an ASPD diagnosis than women (Black, 2017). Lifetime prevalence of DSM-IV ASPD is estimated at 1.9 percent in women and 5.5 percent in men (Hasin & Grant, 2015).

ASPD and SUDs

Presence of a 12-month or lifetime DSM-5 drug use disorder (i.e., an SUD excluding alcohol) is linked with 1.4 to 2 increased odds of having ASPD (Grant et al., 2016). Prevalence of ASPD is 7 percent to 40 percent in men with existing SUDs. ASPD is significantly associated with persistent SUDs (Grant et al., 2015; Grant et al., 2016).

An analysis of NESARC data (using DSM-IV diagnoses) revealed gender differences in comorbidities with ASPD (Alegria et al., 2013). Men with ASPD were more likely to have AUD, any drug use disorder, and narcissistic PD. Women with ASPD were more likely to have any mood disorder, MDD, dysthymia, any anxiety disorder, panic disorder, specific phobia, PTSD, and generalized anxiety disorder (GAD). Women were also more likely to report childhood adverse events, such as sexual abuse.

Another study of treatment-seeking individuals assessing gender differences in individuals with an ASPD diagnosis similarly found that women with ASPD tended to be younger, had fewer episodes of antisocial behavior and higher scores on measures of trauma, including emotional and sexual abuse, than men with an ASPD (Sher et al., 2015). Both women and men with ASPD had comorbid alcohol (43.6 percent for women and 50 percent for men) and cannabis use disorders (21.8 percent and 29.7

percent, respectively), and men had higher rates of comorbid cocaine use disorder (22 percent) than women (7.3 percent). Many people with ASPD use substances in a polydrug pattern involving alcohol, marijuana, heroin, cocaine, and methamphetamine.

People with ASPD and SUDs have higher rates of aggression, impulsivity, and psychopathy than people with SUDs alone (Alcorn et al., 2013).

Disregard for others' rights is a key diagnostic feature of ASPD. Yet most clients who are actively using substances display behaviors at some point that show such disregard, so perceiving the distinction between SUD and ASPD can be difficult for the mental health and the SUD treatment fields.

Treatment of ASPD and SUDs

As with most PDs, no empirically supported treatments exist for ASPD, much less ASPD combined with SUDs (Bateman et al., 2015). Various therapies for ASPD with addiction (e.g., CBT, contingency management) may help ameliorate substance-related outcomes, like substance misuse and number of urine-negative specimens over time, but studies are few and sample sizes are small (Brazil, van Dongen, Maes, Mars, & Baskin-Sommers, 2018).

Anxiety Disorders

The distinguishing feature of anxiety disorders is excessive fear and worry along with behavioral disturbances, usually out of attempts to avoid or manage the anxiety. Anxiety disorders are highly

ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH ASPD

- As with CODs in general, clients with ASPD and those with both an SUD and ASPD may be seen as particularly hard to treat, having poor prognoses, and warranting exclusion from treatment programs or group counseling. Counselors should maintain a realistic but hopeful, optimistic attitude toward helping clients improve symptoms and functioning.
- Be aware of the stigma that surrounds ASPD. Many mental health professionals have strongly negative feelings about working with clients who have ASPD, or any PD. Some may even refuse to accept ASPD referrals. Treating ASPD can be challenging, but people with ASPD have the same rights to quality, ethical treatment as anyone else with any other mental disorder.
- Empirical support for interventions to effectively manage ASPD itself is lacking, but effective treatments exist to address certain symptoms (e.g., risk of suicide or self-harm, affective instability), especially those of co-occurring depression, anxiety, and SUDs. For instance, CBT can be useful in restructuring negative thought patterns and reducing impulsivity, improving interpersonal functioning, and providing general support.
- Heed the warning signs of countertransference and transference. Because many mental health professionals have negative attitudes or misperceptions about ASPD, countertransference can occur and prevent counselors from forming an empathic and effective therapeutic alliance with the client.
- Use a positive and empathetic attitude but remain firm in enforcing the structure, rules, and boundaries of psychotherapy and therapeutic relationship.
- Differentiate true ASPD from substance-related antisocial behavior. This can best be done by looking at how the person relates to others throughout the course of his or her life. People with this disorder will have evidence of antisocial behavior preceding substance use and even during periods of enforced abstinence.
- It also is important to recognize that people with substance-related antisocial behavior may be more likely to have MDD than other typical PDs. However, the type and character of depression that may be experienced by those with true ASPD have been less well characterized, and their treatment is unclear.

comorbid with each other but differ in the types of situations that arouse fear and the content of the anxiety-provoking thoughts and beliefs. Panic attacks are a common fear response in anxiety disorders but are not limited to these disorders.

Three of the more prevalent anxiety disorders in the adult population that are likely to co-occur with addiction are GAD, panic disorder, and social anxiety disorder (SAD).

GAD

GAD is marked by excessive anxiety and worry (apprehensive expectation) about a range of topics or events, like everyday living, finances, relationships, or work/school performance (Exhibit 4.8). Anxiety is intense, frequent, chronic (i.e., lasting at least 6 months), and disproportionate to the actual threat posed by the subject of worry. The worry is accompanied by additional cognitive/physical symptoms.

Panic Disorder

Panic disorder is diagnosed in people who experience repeated panic attacks that are distressing and disabling (Exhibit 4.9). A **panic attack** is an abrupt but very intense occurrence of extreme fear. It often only lasts for a few minutes but the symptoms can be extremely uncomfortable and upsetting, such as hyperventilation, palpitations, trembling, sweating, dizziness, hot flashes or chills, numbness or tingling, and the sensation or fear of nausea or choking. People experiencing panic attacks also can experience psychological symptoms, like feeling as though they are going to die, as though they are "losing their mind," as though things are not real (derealization), or as if they have left their body

EXHIBIT 4.8. Diagnostic Criteria for GAD

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):

Note: Only one item is required in children.

1. Restlessness or feeling keyed up or on edge
2. Being easily fatigued
3. Difficulty concentrating or mind going blank
4. Irritability
5. Muscle tension
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in SAD [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in PTSD, gaining weight in anorexia nervosa [AN], physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

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(depersonalization). Because of the distressing nature of panic attacks, people with panic disorder may constantly worry about having subsequent attacks or engage in behaviors in an attempt to control the attacks (like avoiding places where they have previously had a panic attack or fear they might have one).

Panic disorder often is underdiagnosed at the beginning of treatment or else is seen as secondary to the more significant disorders, which are the primary focus of treatment. However, panic disorder can significantly impede a person's ability to take certain steps toward recovery, such as getting on a bus to go to a meeting or sitting in a 12-Step meeting. **Sometimes counselors can erroneously identify these behaviors as manipulative or treatment-resistant behaviors.**

EXHIBIT 4.9. Diagnostic Criteria for Panic Disorder

A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:

Note: The abrupt surge can occur from a calm state or an anxious state.

1. Palpitations, pounding heart, or accelerated heart rate
2. Sweating
3. Trembling or shaking
4. Sensations of shortness of breath or smothering
5. Feelings of choking
6. Chest pain or discomfort
7. Nausea or abdominal distress
8. Feeling dizzy, unsteady, light-headed, or faint
9. Chills or heat sensations
10. Paresthesias (numbness or tingling sensations)
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself)
12. Fear of losing control or "going crazy"
13. Fear of dying

Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.

B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:

1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, "going crazy").
2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

C. The disturbance is not attributable to the physiological effects of a substance (e.g. a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders).

D. The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in SAD; in response to circumscribed phobic objects or situations, as in specific phobia; in response to obsessions, as in obsessive-compulsive disorder; in response to reminders of traumatic events, as in PTSD; or in response to separation from attachment figures, as in separation anxiety disorder).

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Agoraphobia

One of the changes in DSM-5 concerns the separation of agoraphobia from panic disorder. Although now two distinct conditions, they are closely related and many of their symptoms overlap. In agoraphobia, people exhibit a strong fear of being in certain places or situations where escape could be difficult should the person experience panic-like symptoms or otherwise feel anxious or a loss of control. Situations typically include being in crowds, on public transportation, in open spaces (like bridges), in closed spaces (such as the movie theater), or away from home. People with agoraphobia avoid these situations for fear of having panic attacks or similar incapacitating or embarrassing symptoms (e.g., vomiting, incontinence), or they tolerate them but with great distress and discomfort.

Agoraphobia often occurs without panic disorder in community settings but frequently occurs with panic disorder in clinical settings; the two conditions are distinct yet intertwined (APA, 2013; Asmundson, Taylor, & Smits, 2014). SUDs can and do co-occur with agoraphobia (Goodwin & Stein, 2013; Marmorstein, 2012), but literature on this co-occurrence is relatively small compared with other anxiety disorders or has been examined as occurring with panic disorder (Cougle, Hakes, Macatee, Chavarria, & Zvolensky, 2015) rather than occurring alone. Furthermore, research is more focused on its co-occurrence with nicotine than other substances.

The linkage of agoraphobia with addiction may be explained by its relationship with panic disorder and not with SUD. Thus, agoraphobia is not a subject of focus for this chapter but is mentioned here because of its interrelationship with panic disorder, which addiction counselors are likely to see in their clients.

SAD

Social phobia describes the persistent and recognizably irrational fear of embarrassment and humiliation in social situations (Exhibit 4.10). The social phobia may be quite specific (e.g., public speaking) or may become generalized to all social situations. SAD, also called social phobia in DSM-5, involves intense anxiety or fear in social or performance situations. Individuals may fear being judged by others (e.g., being perceived as stupid, awkward, or boring); being embarrassed or humiliated; accidentally offending someone; or being the center of attention. As a result, the individual will often avoid social or performance situations; when a situation cannot be avoided, they experience significant anxiety and distress. Many people with SAD have strong physical symptoms (e.g., rapid heart rate, nausea, sweating) and may experience full-blown attacks when confronting a feared situation. They recognize that their fear is excessive and unreasonable, but people with SAD often feel powerless against their anxiety.

EXHIBIT 4.10. Diagnostic Criteria for SAD

A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).

Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.

B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others).

C. The social situations almost always provoke fear or anxiety.

Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.

D. The social situations are avoided or endured with intense fear or anxiety.

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E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.

F. The fear, anxiety or avoidance is persistent, typically lasting for 6 months or more.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.

J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

Specify if:

- Performance only: If the fear is restricted to speaking or performing in public

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Prevalence

The lifetime prevalence of any anxiety disorder is estimated at over 30 percent; 12-month prevalence estimates are approximately 19 percent (Harvard Medical School, 2005). A recent World Health Organization (WHO) survey and analysis using DSM-5 diagnostic criteria found the community lifetime prevalence of GAD in the U.S. is 7.8 percent, and 12-month prevalence is 4 percent (Ruscio et al., 2017). Women are twice as likely as men to experience the disorder (APA, 2013). Lifetime prevalence of panic attacks (ascertained as part of an analysis of data collected worldwide and defined per DSM-5 criteria) with or without panic disorder is almost 28 percent (de Jonge et al., 2016). The 12-month prevalence in the general population for panic disorder is about 2.4 percent; lifetime prevalence is 6.8 percent (Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012). The 12-month prevalence for SAD is approximately 7 percent; rates in the community trend higher in women (1.5 times) than men, especially in young adults (APA, 2013).

Anxiety Disorders and SUDs

The relationship between substance use and anxiety disorders is complex and multifaceted, and the two disorders commonly co-occur. Presence of a 12-month or lifetime DSM-5 drug use disorder (i.e., an SUD excluding alcohol) is associated with a 1.2 to 1.3 increased odds of having any anxiety disorder, a 1.0 to 1.3 increased odds of having panic disorder, a 1.2 to 1.3 increased odds of having GAD, and a 1.1 to 1.3 increased odds of having SAD (Grant et al., 2016). Recent analyses indicate lifetime (but not 12-month) diagnosis of drug and alcohol use disorders is associated with GAD (Grant et al., 2015; Grant et al., 2016). Twelve-month prevalence of panic disorder with co-occurring SUD is 11 percent, and lifetime co-occurrence is 28 percent (de Jonge et al., 2016).

When anxiety and SUDs co-occur, the disorders affect development and maintenance of comorbidity, and each disorder modifies the presentation and treatment outcomes for the other (Brady, Haynes, Hartwell, & Killeen, 2013). Consequently, people with anxiety disorders and co-occurring SUDs experience worse outcomes than those with either disorder alone, including greater disability, more hospitalizations and healthcare utilization, poorer functioning, more difficulties in interpersonal relationships, more severe symptoms, worse health-related quality of life, and poorer treatment response (Buckner, Heimberg, Ecker, & Vinci, 2013; Magidson, Liu, Lejuez, & Blanco, 2012). GAD and addiction are

ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH AN ANXIETY DISORDER

- Treating only one disorder is usually insufficient, as is treating disorders in isolation (e.g., sequentially). Clients with both anxiety and addictions need concurrent treatment that equally targets both conditions.
- Pharmacotherapies can effectively reduce anxiety symptoms (especially if combined with psychotherapy) and may need to be a part of clients' treatment plans. But prescribing psychotropic medication in someone with an SUD can be tricky. As needed, refer the client to a mental health professional for a full assessment to determine whether medication is warranted and how to safely integrate it into the treatment plan.
- People in recovery from SUDs may have conflicting feelings about taking medication. Not all clients with anxiety disorders will need pharmacotherapy, but in many cases it can help and, when combined with psychotherapy, is frequently more effective at reducing anxiety symptoms and improving functioning than either medication or psychotherapy alone. That said, do not "push" medications on clients; instead, invite them to explore their feelings about taking medications and discuss advantages and disadvantages of such.
- Selective serotonin reuptake inhibitors are commonly used to help manage GAD, panic disorder, and SAD but should not be taken with alcohol. Addiction counselors must educate clients taking anxiolytics (especially benzodiazepines) about the indications, contraindications, adverse effects, and dangers of medication–alcohol interactions. For clients with anxiety and AUD specifically, referral to a mental health professional to discuss medication management may be needed.
- Be mindful of the increased risk of dependence and abuse liability with benzodiazepines. This risk might be heightened in people who misuse substances to self-medicate their anxiety symptoms or in people with SUDs in general. Use CBT known to effectively treat anxiety disorders to minimize or augment the use of medications.
- Educate clients on the dangers of using substances to self-medicate and control anxiety symptoms, and make distress tolerance, self-regulation, and adaptive coping skills major focuses of treatment.
- Assess for (and advise against) over-the-counter substances that can cause or exacerbate anxiety symptoms, like caffeine pills and weight loss supplements.
- Understand the special sensitivities of clients with SAD to social situations. Although group CBT can help people with SAD learn to become more comfortable in social environments, individual CBT can be equally effective and should be an option for clients who decline group treatment.
- When clients do not improve as expected, the cause is not necessarily treatment failure or client noncompliance. Clients may be compliant and plans may be adequate, but disease processes remain resistant.
- Expect a longer treatment duration compared with treatment for either anxiety or addiction alone.
- Clients with severe and persistent SUDs and anxiety disorders should not be seen as resistant, manipulative, or unmotivated but in need of intensive support.
- Symptoms may result from SUDs, not underlying mental disorders; careful, continual assessment is key.
- Anxiety symptoms and disorders are risk factors for suicidal ideation and suicide attempt. Use suicide risk mitigation (e.g., routine assessment, thorough documentation) and collaborate with clients to implement safety plans.

CASE STUDY: GAD AND PROTRACTED WITHDRAWAL

Ray Y., a 50-year-old husband and father of teenagers, is going through protracted alcohol withdrawal. He appears "edgy" and irritable, sometimes sad, and complains to his SUD treatment counselor of insomnia, headaches, and an upset stomach. He tells the counselor he can barely stand not to drink: "I'm jumping out of my skin." Although these symptoms are common during protracted withdrawal, because they have persisted for over a month the counselor begins a more detailed exploration.

The counselor asks Ray Y. whether he had these symptoms before he used alcohol, and Ray Y. says he's "always been this way." He worries about everything, even events that are weeks away. His family vacations are nightmares because every aspect of vacation planning troubles him and keeps him awake. During family therapy, it becomes apparent that his daughter deeply resents his controlling and distrustful behavior, as well as his overprotective stance toward all her social commitments. The counselor refers Ray Y. to a psychiatrist, who diagnoses GAD, begins a course of medication, and initiates mental health counseling. The family receives help coping with Ray Y.'s disorder, and his daughter is referred for short-term counseling to help her address the mental problems she is beginning to develop as a result of her father's excessive control.

Discussion: Anxiety symptoms are quite common during protracted withdrawal, but counselors should consider the possibility that an anxiety disorder is indicated. Symptoms should be tracked to see whether they persist beyond the normal time that might be expected for protracted withdrawal. Protracted withdrawal can occur up to a few months to a year, particularly with antianxiety medication. It varies according to severity, duration, and type of medication. Most protracted withdrawal is between 1 and 3 months. Counselors should also be aware of the effect of such disorders on close family members. Children and adolescents may not understand that a parent has a mental disorder and may be relieved to have a way of understanding and coping with difficult behavior.

associated with higher rates of heavy alcohol use, hospitalizations, relapse, and leaving treatment against medical advice compared with people with SUDs but no GAD (Domenico, Lewis, Hazarika, & Nixon, 2018).

Anxiety symptoms and anxiety disorders are predictors of suicidal ideation and suicide attempt (Bentley et al., 2016); given that SUDs also elevate risk of suicide (Yuodelis-Flores & Ries, 2015), the combination of the two suggests efforts to mitigate suicide risk mitigation are warranted with these clients.

Treatment of Anxiety Disorders and SUDs

SUD treatment for people with anxiety should include interventions that address the anxiety as well as the addiction. Clients may report a reduction in some anxiety symptoms during detoxification or early in recovery (McHugh, 2015). **That said, SUD treatment alone is not sufficient to address the co-occurring anxiety.** Further, the presence of an anxiety disorder complicates SUD treatment and can make achieving and sustaining abstinence and preventing relapse more problematic (McHugh, 2015).

Concurrent, integrated treatments that include CBT or exposure therapy can safely, effectively reduce psychiatric and SUD symptoms but in some studies are no more effective than placebo (McHugh, 2015).

Schizophrenia and Other Psychotic Disorders

Psychotic Disorders

Psychotic disorders are characterized by a severely incapacitated mental and emotional state involving a person's thinking, perception, and emotional control. Key features include distorted thoughts in which an individual has false beliefs, sensations, or perceptions that are imagined, are very extreme, or both; and unusual emotional and behavioral states with deterioration in thinking, judgment,

self-control, or understanding. Psychotic disorders are usually expressed clinically as a combination of:

- **Delusions:** Beliefs that are fixed, resistant to change, and are directly contradicted by evidence or otherwise not grounded in reality (e.g., the belief that one is being followed by people from Mars, or that one is a very important person to whom the President wants to speak right away).
- **Hallucinations:** Hearing, seeing, tasting, or feeling things that are not there and being unable to recognize that what is being experienced is not real (such as hearing voices that say self-condemning or other disturbing things, or seeing a person who isn't really there).
- **Disorganized thinking:** This is reflected in speech that is incoherent ("word salad"), illogical, uses unconventional or made-up words (neologisms and word approximations), fluctuates from topic to topic (loose associations), or is completely unrelated to subject matter at hand (tangential speech).
- **Grossly disorganized or abnormal motor behavior:** This includes a wide range of odd behaviors, such as laughing or smiling inappropriately, grimacing, staring, talking to oneself, purposeless or peculiar movements and mannerisms, mimicking others' speech or movements (echolalia and echopraxia), and random agitation. A specific psychomotor disturbance called **catatonia**—which includes immobility, stupor, and holding rigid body positions against gravity over extended periods of time (catalepsy)—can occur in schizophrenia but is also present in other mental disorders (like bipolar disorder) and some medical conditions.
- **Negative symptoms:** A constellation of symptoms reflecting diminished emotional expression and self-motivated purposeful activities (avolition). Negative symptoms also may include diminished speech output (alogia) or poverty of speech (e.g., one-word answers), motivation, ability to experience pleasure (anhedonia), or interest in social activities (asociality).

Although schizophrenia is perhaps the most well known psychotic disorder, people with bipolar disorders may experience psychotic states during periods of mania—the heightened state of excitement, little or no sleep, impulsiveness, and poor judgment (see the section "Bipolar I Disorder"). Other conditions also can be accompanied by a psychotic state, including toxic poisoning, other metabolic difficulties (infections [e.g., latestage AIDS]), and other mental disorders (MDD, dementia, PTSD, alcohol withdrawal states, brief reactive psychoses, and others).

SUD treatment counselors typically do not see clients in the throes of an acute psychotic episode, as such psychotic patients more likely present, or are referred to, EDs and mental health services facilities. Counselors are more likely to encounter such clients in a "residual" or later and less active phase of the illness, the time at which these individuals may receive treatment for their SUDs in an SUD treatment agency. Even if the SUD treatment counselor never sees a client during an actively psychotic period, knowing what the client experiences as a psychotic episode will enable the counselor to understand and assist the client more effectively. On the other hand, counselors are increasingly treating clients with methamphetamine dependence who often have residual paranoid and psychotic symptoms and may need antipsychotic medications.

Schizophrenia

No single symptom specifically indicates or characterizes schizophrenia. Symptoms include a range of cognitive, behavioral, and emotional dysfunctions (Exhibit 4.11). Thus, schizophrenia is a heterogeneous clinical syndrome. Symptoms of schizophrenia include delusions, hallucinations, disorganized speech (e.g., frequent derailment or incoherence), grossly disorganized or catatonic behavior, and deficits in certain areas of functioning—for example, the inability to initiate and persist in goal-directed activities. These symptoms regularly develop before the first episode of a schizophrenic breakdown, sometimes stretching back years and often intensifying prior to reactivations of an active, acutely psychotic state. Clinicians generally divide schizophrenia symptoms into positive and negative symptoms. Acute course schizophrenia is characterized by positive symptoms like hallucinations, delusions, excitement, motor manifestations (such as agitated

EXHIBIT 4.11. Diagnostic Criteria for Schizophrenia

A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be 1, 2, or 3:

1. Delusions
2. Hallucinations
3. Disorganized speech (e.g., frequent derailment or incoherence)
4. Grossly disorganized or catatonic behavior
5. Negative symptoms, (i.e., diminished emotional expression or avolition)

B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).

C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. Schizoaffective disorder and depressive or bipolar with psychotic features have been ruled out because either (1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or (2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, also are present for at least 1 month (or less if successfully treated).

Specify if:

The following course specifiers are only to be used after a 1-year duration of the disorder and if they are not in contradiction to the diagnostic course criteria.

- First episode, currently in acute episode: First manifestation of the disorder meeting the defining diagnostic symptom and time criteria. An acute episode is a time period in which the symptom criteria are fulfilled.
- First episode, currently in partial remission: Partial remission is a period of time during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled.
- First episode, currently in full remission: Full remission is a period of time after a previous episode during which no disorder-specific symptoms are present.
- Multiple episodes, currently in acute episode: Multiple episodes may be determined after a minimum of two episodes (i.e., after a first episode, a remission and a minimum of one relapse).
- Multiple episodes, currently in partial remission
- Multiple episodes, currently in full remission
- Continuous: Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with subthreshold symptom periods being very brief relative to the overall course.

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- Unspecified

Specify if:

- With catatonia

Specify current severity:

- Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe).

Note: Diagnosis of schizophrenia can be made without using this severity specifier.

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behavior or catatonia), disorganized speech, relatively minor thought disturbances, and positive response to neuroleptic medication. Chronic course schizophrenia is characterized by negative symptoms, such as lack of enjoyment (anhedonia), apathy, lack of emotional expressiveness (flat affect), and social isolation. Some clients will live their entire lives exhibiting only a single psychotic episode; others may have repeated episodes separated by varying durations of time.

Prevalence

Community prevalence rates for schizophrenia using DSM-5 criteria are not available at the time of this publication. The lifetime prevalence rate for adults with DSM-IV schizophrenia is between 0.3 percent and 0.7 percent (APA, 2013). The National Institute of Mental Health (NIMH; 2018) reports similar but slightly lower numbers, ranging between 0.25 percent and 0.64 percent. Although its prevalence is very low, schizophrenia is very burdensome and considered one of the top 15 leading causes of global disability (GBD 2016 Disease and Injury Incidence and Prevalence Collaborators, 2017).

Schizophrenia/Other Psychotic Disorders and SUDs

Substance misuse often occurs in people with schizophrenia and other psychotic disorders. In a study of more than 1,200 people with schizophrenia (Kerner, 2015), lifetime SUD prevalence was 55 percent, including alcohol abuse at 17 percent, alcohol dependence at 26 percent, illicit drug abuse at 13 percent, and illicit drug dependence at 14 percent. The most commonly used substances were alcohol (43 percent), cannabis (35 percent), and other illegal substances (27 percent). Compared with the general population, people with severe psychotic disorders have 4 times greater risk of heavy alcohol use, 3.5 times the risk of heavy cannabis use, and 4.6 times the risk of recreational drug use (Hartz et al., 2014).

Individuals with SMI (including schizophrenia, schizoaffective disorder, and bipolar disorder with psychotic features) die approximately 10 to 25 years earlier than the general population, mostly because of the effects of physical illnesses caused at least in part by SUDs (e.g., heart disease, lung disease, infectious disease) (Hartz et al., 2014; WHO, n.d.).

The combination of substance misuse in people with schizophrenia or other psychotic disorders contributes to shortened mortality and an increased likelihood of deleterious health and functional outcomes, including a higher risk for self-destructive and violent behaviors, victimization, suicide, housing instability, poor physical health, cognitive impairment, employment problems, legal difficulties, and unstable social relationships (Bennett, Bradshaw, & Catalano, 2017; Trudeau et al., 2018). Further, substance misuse in schizophrenia can worsen disease course and may reduce adherence to antipsychotic medication (Werner & Covenas, 2017).

CASE STUDY: COUNSELING AN SUD TREATMENT CLIENT WITH SCHIZOPHRENIA

Adolfo M. is a 40-year-old Latino man who began using cannabis and alcohol at 15. He was diagnosed as having schizophrenia when he was 18 and began using cocaine at 19. Sometimes, he lives with his sister or with temporary girlfriends; sometimes, on the street. He has never had a sustained relationship, and he has never held a steady job. He has few close friends. He has had periods of abstinence and freedom from hallucinations and major delusions, but he generally has unusual views of the world that emerge quickly in conversation.

Adolfo M. has been referred to an SUD treatment counselor, who was hired by the mental health center to do most of the group and individual drug/alcohol work with clients. The first step the counselor takes is to meet with Adolfo M. and his case manager together. This provides a clinical linkage and allows them to get the best history. The clinical history reveals that Adolfo M. does best when he is sober and on medications, but there are times when he will be sober and not adhere to a medical regimen, or when he is both taking medications and drinking (although these periods are becoming shorter in duration and less frequent). His case manager often is able to redirect him toward renewed sobriety and adherence to medications, but Adolfo M. and the case manager agree that the cycle of relapse and the work of pulling things back together is wearing them both out. After the meeting, the case manager, counselor, and Adolfo M. agree to meet weekly for a while to see what they can do together to increase the stable periods and decrease the relapse periods. After a month of these planning meetings, the following plan emerges. Adolfo M. will attend SUD treatment groups for people with CODs (run by the counselor three times a week at the clinic), see the team psychiatrist, and attend local dual disorder AA meetings. The SUD treatment group he will be joining is one that addresses not only addiction problems but also difficulties with treatment follow-through, life problems, ways of dealing with stress, and the need for social support for clients trying to get sober. When and if relapse happens, Adolfo M. will be accepted back without prejudice and supported in recovery and treatment of both his substance misuse and mental disorders; however, part of the plan is to analyze relapses with the group. His goal is to have as many sober days as possible with as many days adhering to a medical regimen as possible. Another aspect of the group is that monthly, 90-day, 6-month, and yearly sobriety birthdays are celebrated. Part of the employment program at the center is that clients need to have a minimum of 3 months of sobriety before they will be placed in a supported work situation, so this becomes an incentive for sobriety as well.

Discussion: SUD treatment counselors working within mental health centers should be aware of the need not only to work with the client but also to form solid working relationships with case managers, the psychiatrist, and other personnel. Seeing clients with case managers and other team members is a good way to establish important linkages and a united view of the treatment plan. In Adolfo M.'s case, the counselor used his ties with the case manager to good effect and also is using relapse prevention and contingency management strategies appropriately (see Chapter 5 for a discussion of relapse prevention).

ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH SCHIZOPHRENIA OR ANOTHER PSYCHOTIC DISORDER

- Understand that what looks like resistance or denial may in reality be a manifestation of negative symptoms of schizophrenia.
- Use a recovery perspective and a compassionate attitude toward the client. This can convey hope and allow the clients to envision significant recovery and improvement in his or her life.
- Obtain a working knowledge of the signs and symptoms of the disorder.

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- Be aware that an accurate understanding of the role of SUDs in the client's psychotic disorder requires a multiple-contact, longitudinal assessment.
- Work closely with a psychiatrist or mental health professional.
- Expect crises associated with the mental disorder and have available resources (e.g., crisis intervention, psychiatric consultation) to facilitate stabilization.
- As appropriate, assist the client to obtain Medicare, Medicaid, Temporary Assistance to Needy Families, disability payments, and other social services.
- Make available psychoeducation on the psychiatric condition and use of medication. The psychoeducational component of treatment should include information about mental disorders and SUDs, from causes and the natural histories of the disorders to the recovery process and how the illnesses can interact.
- Understand that medication adherence is critical to control positive symptoms and maintain stability/functionality. Yet nonadherence is common. Make medication monitoring and adherence a part of treatment by:
  - Providing psychoeducation about its importance.
  - Checking in with clients about the status of their symptoms (given that nonresponsiveness to medication may be a reason for nonadherence).
  - Discussing with clients their reasons for not taking the medication (e.g., unpleasant side effects, high cost, failing to remember to take them).
  - Using motivational interviewing techniques to explore clients' expectations and beliefs about taking (and not taking) medication, which can help identify barriers to behavior change.
  - Working with clients to develop helpful reminders, alerts, or other solutions to practical obstacles. If cost is an issue, connect the client to a prescription assistance program (offered by numerous nonprofit organizations, state/county/federal agencies, and pharmaceutical companies) or consult with the client's prescriber about the possibility of switching the client to a lower cost medication.
  - Enlisting, when appropriate, the help of family or loved ones to aid in giving positive reinforcement and supporting clients in adhering to their medication.
- Ensure that the treatment program philosophy is based on a multidisciplinary team approach. Ideally, team members should be cross-trained, and there should be representatives from the medical, mental health service, and addiction systems. The overall goals of long-term management should include:
  - Providing comprehensive and integrated services for both the mental disorders and SUDs.
  - Taking a long-term focus that addresses biopsychosocial matters in accord with a treatment plan with goals specific to a client's situation.
- Provide frequent breaks and shorter sessions or meetings.
- Use structure and support.
- Present material in simple, concrete terms with examples and use multimedia methods.
- Encourage participation in social clubs with recreational activities.
- Teach the client skills for detecting early signs of relapse for both mental illness and substance use.
- Consider including family members and community supports, when appropriate, in overall treatment.

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- Involve family in psychoeducational groups that specifically focus on education about SUDs and psychotic disorders; establish support groups of families and significant others.
- Understand that psychotic disorders and SUDs tend to be chronic disorders with multiple relapses and remissions, requiring long-term treatment. For clients with CODs involving psychotic disorders, a long-term approach is imperative.
- Monitor clients for signs of substance misuse relapse and a return of psychotic symptoms.
- Remember that suicide is a significant risk in schizophrenia, more so when co-occurring with SUDs. Ongoing monitoring/ assessment of suicidal ideation, gestures, plans, and attempts throughout treatment is imperative. Work with clients to form safety plans/contracts; make positive coping skills part of interventions.

Treatment of Schizophrenia/Other Psychotic Disorders and SUDs

Antipsychotic medication is the standard of care for reducing positive symptoms (e.g., delusions, hallucinations) whereas various psychosocial interventions and approaches can help address addiction recovery. Specifically, integrated CBT, group behavioral therapy, contingency management, 12-Step facilitation, motivational enhancement, motivational interviewing, assertive community treatment, or (preferably) a combination thereof may all help reduce substance use (quantity, frequency, and severity), increase abstinence, reduce number of drinking days, lower relapse rates, reduce the number of positive urine samples, and decrease negative consequences of substance use in people with SUDs and schizophrenia or other SMI (including psychotic disorders) (Bennett et al., 2017; De Witte, Crunelle, Sabbe, Moggi, & Dom, 2014). These approaches have also been associated with improvements in psychiatric symptoms (including negative symptoms), scores of global functioning, hospitalizations, and achieving stable housing (De Witte et al., 2014). Integrated treatments appear to yield more positive results than single interventions and are the recommended approach (De Witte et al., 2014).

Attention Deficit Hyperactivity Disorder

ADHD is marked by a chronic inability to direct, control, or sustain attention; hyperactivity; or both (Exhibit 4.12). People with ADHD often have difficulty concentrating for even short periods of time. They may be disorganized and restless or seem always "on the go," constantly moving and fidgeting. Some people with ADHD behave impulsively.

Although ADHD is frequently associated with children, the disorder can persist into adulthood and for some individuals can begin in adulthood. In adults, symptoms can include having a short temper, difficulty being productive at work, and an inability to sustain relationships.

The three types of ADHD are combined type (person has difficulty paying attention and hyperactivity); predominantly inattentive; and predominantly hyperactiveimpulsive.

Prevalence

At the time of this publication, 12-month and lifetime ADHD prevalence rates among all age groups in the general population using DSM-5 criteria are not readily available. However, data from the National Survey of Children's Health show that 6.1 million children and adolescents ages 2 to 17 years had ever been diagnosed with ADHD (Danielson et al., 2018).

The prevalence of ADHD in adults is less studied than in children. The overall current prevalence of adult ADHD (using DSM-IV criteria) is around 2.5 percent (APA, 2013; Simon, Czobor, Balint, Meszaros, & Bitter, 2009). Epidemiological population-based survey data on U.S. adults with ADHD (Kessler et al., 2005) suggest the estimated

EXHIBIT 4.12. Diagnostic Criteria for ADHD

A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):

1. Inattention: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities. **Note:** The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

- **a.** Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate)
- **b.** Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading)
- **c.** Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction)
- **d.** Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked)
- **e.** Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet demands)
- **f.** Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers)
- **g.** Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile phones)
- **h.** Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts)
- **i.** Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments)

2. Hyperactivity and impulsivity: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities. **Note:** The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (ages 17 and older), at least five symptoms are required.

- **a.** Often fidgets with or taps hands or feet or squirms in seat
- **b.** Often leaves seat in situations in which remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place)
- **c.** Often runs about or climbs in situations in which it is inappropriate. (**Note:** In adolescents or adults, may be limited to feeling restless.)
- **d.** Often unable to play or engage in leisure activities quietly
- **e.** Is often "on the go," acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with)
- **f.** Often talks excessively
- **g.** Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation)

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h. Often has difficulty awaiting his or her turn (e.g., while waiting in line)

i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing)

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.

C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).

D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, PD, substance intoxication or withdrawal).

Specify whether:

- Combined presentation: If both Criterion A1 (inattention) and Criterion A2 (hyperactivity-impulsivity) are met for the past 6 months
- Predominantly inattentive presentation: If Criterion A1 (inattention) is met but Criterion A2 (hyperactivity-impulsivity) is not met for the past 6 months
- Predominantly hyperactive/impulsive presentation: If Criterion A2 (hyperactivity-impulsivity) is met and Criterion A1 (inattention) is not met for the past 6 months

Specify if:

- In partial remission: When full criteria were previously met, fewer than the full criteria have been met for the past 6 months, and the symptoms still result in impairment in social, academic, or occupational functioning.

Specify current severity:

- Mild: Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairments in social or occupational functioning.
- Moderate: Symptoms or functional impairment between "mild" and "severe" are present.
- Severe: Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

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lifetime prevalence of DSM-IV ADHD in people ages 18 to 44 years is 8.1 percent.

ADHD and SUDs

SUDs are among the most common comorbidities of ADHD (Katzman, Bilkey, Chokka, Fallu, & Klassen, 2017), and data from clinical and epidemiological studies support this linkage (Martinez-Raga, Szerman, Knecht, & de Alvaro, 2013). Among adults with substance misuse, the prevalence of ADHD is approximately 23 percent, although this estimate is dependent on substance of misuse and assessment instrument used (van Emmerik-van Oortmerssen et al., 2012). Among a sample of more than 500 children with and without ADHD who were followed throughout adolescence and early adulthood (Molina et al., 2018), early substance use in adolescence was greater and escalated more quickly in the children with ADHD. Further, weekly and daily cannabis use and daily smoking in adulthood were significantly more prevalent in the ADHD group than the non-ADHD

group. Adults with ADHD have been found primarily to use alcohol, nicotine, cannabis, and cocaine (Lee, Humphreys, Flory, Liu, & Glass, 2011; Luo & Levin, 2017).

People with addiction who have co-occurring ADHD have a heightened risk for suicide attempts, hospitalizations, earlier onset of addiction, impulsivity, more severe disease course (for both ADHD and the SUD) and polysubstance use as well as lower rates of abstinence and treatment adherence (Egan, Dawson, & Wymbs, 2017; Katzman et al., 2017). ADHD and SUDs carry an enhanced risk of comorbidity with depression, conduct disorder, bipolar disorders, anxiety disorders, and PDs (Luo & Levin, 2017; Martinez-Raga et al., 2013; Regnart, Truter, & Meyer, 2017; Young & Sedgwick, 2015; Zulauf, Sprich, Safren, & Wilens, 2014). Symptoms of ADHD hyperactivity and impulsivity are more strongly seen with substance misuse and SUDs than ADHD symptoms of inattention (De Alwis, Lynskey, Reiersen, & Agrawal, 2014).

Although it is important to rule out other causes of inattention or hyperactivity, including substance misuse, **misattribution of ADHD symptoms to SUDs increases the likelihood of underdiagnosis** (Crunelle et al., 2018). People with SUDs who are newly abstinent or those in active or protracted withdrawal may experience some impairments similar to ADHD. Many of the behavioral symptoms of ADHD also appear during substance intoxication and withdrawal, and functional consequences of ADHD, such as poor job performance or job loss, are also evident in people with addiction. Both alcohol and cannabis can produce symptoms that mimic ADHD. This underscores the importance of conducting a thorough assessment (see Chapter 3) to fully investigate symptoms in childhood, family history of addiction and psychiatric illness, and other biopsychosocial factors that can inform whether a diagnosis of ADHD, SUD, or both are warranted.

Treatment of ADHD and SUDs

ADHD complicates SUD treatment because clients with these CODs may have more difficulty engaging in treatment and learning abstinence skills, be at greater risk for relapse, and have poorer substance use outcomes. The most common attention problems in SUD treatment populations are secondary to short-term toxic effects of substances, and these should be substantially better with each month of sobriety.

Only a limited number of studies explore treatment of ADHD with comorbid SUDs (De Crescenzo, Cortese, Adamo, & Janiri, 2017). Treatment of adults with ADHD often involves use of stimulant or nonstimulant medication; although efficacious in reducing psychiatric symptoms, these medications generally do not alleviate SUD symptoms (Cunill, Castells, Tobias, & Capella, 2015; De Crescenzo et al., 2017; Luo & Levin, 2017). Thus, ADHD medication alone is an insufficient treatment approach for clients with these CODs (Crunelle et

A consensus statement by an international panel of ADHD and addiction experts (including from the U.S.) on the treatment of ADHD and SUDs recommends (Crunelle et al., 2018):

- Using a combined treatment approach comprising psychoeducation, pharmacotherapy, individual or group CBT, and peer support.
- Integrating ADHD treatment into SUD treatment; integrating SUD treatment into mental health services.
- Treating both disorders, but addressing the SUD first and then the ADHD shortly afterwards.
- Considering residential treatment for cases of severe addiction.
- Providing pharmacotherapy for ADHD (particularly with psychotherapy), but clinicians should be aware that medication alone is usually not sufficient to treat the SUD.
- Prescribing ADHD medication as needed but understand that this is a controversial topic because of the misuse liability of stimulants. Clinicians should consider all risks and weigh them against potential benefits when deciding whether to prescribe stimulant medications for people with ADHD-SUD.

al., 2018; Zulauf et al., 2014). Stimulant medications have misuse potential, and counselors should be vigilant for signs of diversion. Use of long-acting or extended-release medication or use of antidepressants instead of stimulants can attenuate diversion and misuse liability. The advised approach to treatment involves a combination of psychoeducation, behavioral coaching, CBT, and nonstimulant or extended-release stimulant medication (De Crescenzo et al., 2017).

Little research supports concurrent treatment of these conditions. Some researchers recommend first addressing whichever condition is most debilitating to the client (Katzman et al., 2017; Klassen, Bilkey, Katzman, & Chokka, 2012). Others suggest that, to stabilize the client, treating the SUD should be prioritized (Crunelle et al., 2018). A systematic literature review and meta-analysis of pharmacotherapy for ADHD and SUD (Cunill et al., 2015) found no effect of timing of initiation of treatment but warns that treatment of ADHD symptoms may need to be delayed until after abstinence is achieved, given possible harmful interactions that can occur between ADHD medications and substances of misuse.

Feeding and Eating Disorders

Feeding and eating disorders have as their common core a persistent disturbance of eating or eating-related behavior, resulting in changes in consumption or absorption of food that significantly impair physical health or psychosocial functioning. The primary eating disorders linked to SUD and discussed in this section are AN, bulimia nervosa (BN), and binge eating disorder (BED).

Anorexia Nervosa

AN, the most visible eating disorder, is marked by a refusal to maintain body weight above the minimally normal weight for age and height because of an intense fear of weight gain (Exhibit 4.13). The term **anorexia nervosa** means "nervous loss of appetite," a misnomer; only in extreme stages of inanition (i.e., exhaustion as a result of lack of nutrients in the blood) is appetite actually lost.

Individuals with AN have a dogged determination to lose weight and can achieve this in several ways. Individuals with the restricting subtype of AN severely limit their food intake, engage in excessive exercise, and fast. Those with the binge-eating/purging subtype engage in episodes of binge eating or purging with self-induced vomiting,

CASE STUDY: COUNSELING AN SUD TREATMENT CLIENT WITH ADHD

John R., a 29-year-old White man, is seeking treatment. He has been in several treatment programs but always dropped out after the first 4 weeks. He tells the counselor he dropped out because he would get cravings and that he just could not concentrate in the treatment sessions. He mentions the difficulty of staying focused during 3-hour intensive group sessions. A contributing factor in his quitting treatment was that group leaders always seemed to scold him for talking to others. The clinician evaluating him asks how John R. did in school and finds that he had difficulty in his classwork years before he started using alcohol and drugs; he was restless and easily distracted. He had been evaluated for a learning disability and ADHD and took Ritalin for about 2 years (in the 5th and 6th grades), then stopped. He was not sure why, but he did terribly in school, eventually dropping out about the time he started using drugs regularly in the 8th grade.

Discussion: The SUD treatment provider reviewed John R.'s learning history and asked about anxiety or depressive disorders. The provider referred him to the team's psychiatrist, who uncovered more history about the ADHD and also contacted John R.'s mother. When the provider reviewed a list of features commonly associated with ADHD, she agreed that John R. had many of these features and that she had noticed them in childhood. John R. was started on bupropion and moved to a less intensive level of care (1 hour of group therapy, 30 minutes of individual counseling, and AA meetings 3 times weekly). Over the next 2 months, John R.'s ability to tolerate a more intensive treatment improved. Although he was still somewhat intrusive to others, he was able to benefit from more intensive group treatment.

EXHIBIT 4.13. Diagnostic Criteria for AN

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. **Significantly low weight** is defined as a weight that is less than minimally normal or, for children and adolescents, less than minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Specify whether:

- Restricting type: During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.
- Binge-eating/purging type: During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Specify if:

- In partial remission: After full criteria for AN were previously met, Criterion A (low body weight) has not been met for a sustained period, but either Criterion B (intense fear of gaining weight or becoming fat or behavior that interferes with weight gain) or Criterion C (disturbances in self-perception of weight and shape) is still met.
- In full remission: After full criteria for AN were previously met, none of the criteria have been met for a sustained period of time.

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Specify current severity:

The minimum level of severity is based, for adults, on current body mass index (BMI) (see below) or, for children and adolescents, BMI percentile. The ranges below are derived from WHO categories for thinness in adults; for children and adolescents, corresponding BMI percentiles should be used. The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.

- Mild: BMI ≥ 17 kg/m^2
- Moderate: BMI 16–16.99 kg/m^2
- Severe: BMI 15–15.99 kg/m^2
- Extreme: BMI < 15 kg/m^2

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laxatives, diuretics, or enemas. They engage in these behaviors out of a marked fear of weight gain, which is reinforced by distorted perceptions of their body shape (e.g., believing oneself to be "fat" even though bodyweight is extremely low).

Bulimia Nervosa

The core symptoms of BN are bingeing and purging (Exhibit 4.14). A binge is a rapid consumption of an unusually large amount of food, by comparison with social norms, in a discrete period of time (e.g., over 2 hours). Integral to the notion of a binge is feeling out of control; thus, a binge is not merely overeating. An individual with BN may state that he or she is unable to postpone the binge or stop eating willfully once the binge has begun. The binge may only end when the individual is interrupted, out of food, exhausted, or physically unable to consume more.

The second feature of BN is purging. Individuals with BN compensate in many different ways for overeating. Ninety percent of people with BN self-induce vomiting or misuse laxatives as their form of purging (Westmoreland, Krantz, & Mehler, 2016). Other methods of purgation include the

EXHIBIT 4.14. Diagnostic Criteria for BN

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances
2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain includes self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of AN.

Specify if:

- In partial remission: After full criteria for BN were previously met, some, but not all, of the criteria have been met for a sustained period of time.
- In full remission: After full criteria for BN were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based on the frequency of inappropriate compensatory behaviors (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

- Mild: An average of 1–3 episodes of inappropriate compensatory behaviors per week
- Moderate: An average of 4–7 episodes of inappropriate compensatory behaviors per week
- Severe: An average of 8–13 episodes of inappropriate compensatory behaviors per week
- Extreme: An average of 14 or more episodes of inappropriate compensatory behaviors per week

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misuse of diuretics and emetics; saunas; excessive exercise; fasting; and other idiosyncratic methods that people believe will lead to weight loss (such as "mono" dieting, in which a person eats only a single food for extended periods of time and nothing else, like apples or eggs). Many of these auxiliary methods are dangerous and ineffective because they promote loss of water and valuable electrolytes. As with AN, individuals with BN place an undue emphasis on shape and weight in their sense of identity. To meet criteria, bingeing and purging must occur, on average, at least once per week for 3 months.

Binge Eating Disorder

BED involves recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances, with episodes marked by feelings of lack of control (Exhibit 4.15). Someone with BED may eat too quickly, even when he or she is not hungry. The person may feel guilt, embarrassment, or disgust and may binge eat alone to hide the behavior. This disorder is linked with marked distress and occurs, on average, at least once a week over 3 months. Unlike in BN, the binge is not followed by compensatory behaviors to rid the body of food.

EXHIBIT 4.15. Diagnostic Criteria for BED

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances
2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. The binge-eating episodes are associated with three (or more) of the following:

1. Eating much more rapidly than normal
2. Eating until feeling uncomfortably full
3. Eating large amounts of food when not feeling physically hungry
4. Eating alone because of feeling embarrassed by how much one is eating
5. Feeling disgusted with oneself, depressed, or very guilty afterward

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for 3 months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in BN and does not occur exclusively during the course of BN or AN.

Specify if:

- In partial remission: After full criteria for binge-eating disorder were previously met, binge eating occurs at an average frequency of less than one episode per week for a sustained period of time.
- In full remission: After full criteria for binge-eating disorder were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based on the frequency of episodes of binge eating (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

- Mild: 1–3 binge-eating episodes per week
- Moderate: 4–7 binge-eating episodes per week
- Severe: 8–13 binge-eating episodes per week
- Extreme: 14 or more binge-eating episodes per week

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Prevalence

Feeding and eating disorders in the general population are rare. Twelve-month estimates of DSM-5 AN, BN, and BED are 0.05 percent, 0.14 percent, and 0.44 percent, respectively; lifetime prevalence rates are 0.80 percent, 0.28 percent, and 0.85 percent, respectively (Udo & Grilo, 2018). These rates are generally lower than previously reported estimates using DSM-IV criteria (APA, 2013) but were drawn from a sample roughly 12 times larger than the samples used in other survey studies (Udo & Grilo, 2018).

Eating disorders are far more prevalent in women than men. Women have 12 times the odds of having AN, 5.8 times the odds of having BN, and about 3 times the odds of having BED (Udo & Grilo, 2018).

Feeding and Eating Disorders and SUDs

Feeding and eating disorders are highly coincident with substance misuse (SAMHSA, 2011a), likely because the conditions share numerous physical, mental, and social risk factors (Brewerton, 2014). Most studies observe comorbidity rates that

exceed the general population of women of similar age. A meta-analysis (Bahji et al., 2019) found lifetime prevalence of any SUD among people with eating disorders to be 25 percent, including 20 percent for AUD, about 20 percent for any illicit drug use disorder, almost 14 percent for cocaine and cannabis use disorder (each), and 6 percent for opioid use disorder (OUD). **Even if not rising to the level of addiction, licit and illicit substance use is elevated in people with eating disorders, especially individuals with bulimic features.** In a sample of almost 3,000 people, 80 percent of those with BN reported using alcohol, and 50 percent used other substances; 65 percent of those with BED used alcohol, and nearly 24 percent used other substances; and 60 percent of those with AN (binge/purge subtype) used alcohol, and 44 percent used other substances (Fouladi et al., 2015).

SUD treatment-seeking women have higher rates of BN than any other feeding and eating disorder, and SUDs are more common alongside BN or AN with bulimic features than they are comorbid with restrictive AN (APA, 2013; CSAT, 2009; Fouladi et al., 2015). Some have suggested that the most common comorbidity among feeding and eating disorders and SUDs is BN (or AN with bulimic features) and AUD (Gregorowski, Seedat, & Jordaan, 2013; Munn-Chernoff et al., 2015).

Treatment outcomes of people with eating disorders and SUDs are worse than those of people without both conditions. They have higher odds of early mortality, co-occurring physical and mental illness, and delayed recovery (Root et al., 2010). People in SUD treatment with feeding/eating disorder symptoms have higher risk of treatment dropout and discharge against medical advice (Elmquist, Shorey, Anderson, & Stuart, 2015). Alcohol misuse more than doubles mortality risk in AN (Franko et al., 2013).

Treatment of Feeding and Eating Disorders and SUDs

Feeding or eating disorders can make SUD assessment and treatment more complex—such as by raising risk of stopping SUD treatment against medical advice (Elmquist et al., 2015). Heightened mortality with feeding and eating disorders means that multidisciplinary care should include primary care providers and dietary/nutritional rehabilitation professionals in addition to SUD treatment professionals, mental health professionals (e.g., psychiatric and mental health nurses), and social workers (SAMHSA, 2011a).

The literature does not currently describe randomized controlled trials for treatment of these CODs. In general, concurrent treatment is recommended; sequential interventions can increase likelihood of relapse or otherwise hinder recovery from the untreated CODs (Gregorowski et al., 2013). If integrated care is not possible, SUD treatment should proceed first to halt active substance use and allow the client to fully participate in further care (SAMHSA, 2011a).

"DRUNKOREXIA": A NEW AND DANGEROUS COMBINATION OF EATING DISORDERS AND ALCOHOL MISUSE

Researchers are noticing a disturbing trend of college students (particularly women) engaging in inappropriate compensatory behaviors prior to consuming alcohol in order to avoid or mitigate weight gain from drinking. For instance, a woman might fast all day or drastically reduce her caloric intake prior to going out to a party where she knows she will be drinking. This trend has been colloquially termed "drunkorexia" (Barry & Piazza-Gardner, 2012; Bryant, Darkes, & Rahal, 2012; Burke, Cremeens, Vail-Smith, & Woolsey, 2010; Hunt & Forbush, 2016; Wilkerson, Hackman, Rush, Usdan, & Smith, 2017) and is very serious given that excess consumption of alcohol on an empty stomach raises the risk of alcohol poisoning and damage to the brain and other organs. In light of high rates of binge and hazardous drinking in college-aged populations, this makes the combination of disordered eating and alcohol misuse potentially very dangerous.

ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH AN EATING DISORDER

- When possible, work closely with a professional who specializes in eating disorders. Programs that specialize in eating disorders and SUDs are rare, so parallel treatment by different providers may be necessary.
- Screen for eating disorders both at intake and intermittently throughout SUD treatment (e.g., during medical history, as a part of SUD assessment, as a part of daily or weekly meetings).
- Many symptoms and features of eating disorders overlap with those of SUDs as well as other mental disorders, such as reduced food intake, low energy, depressed affect, difficulty concentrating, and sleep disturbance. This underscores the importance of early screening and a thorough differential diagnosis.
- Addiction counselors may have a hard time detecting feeding and eating disorders because clients are often adept at concealing their symptoms. Contrary to popular belief, many people with feeding and eating disorders are not exceedingly thin. In fact, most people with BN are of normal weight or even overweight. Learn the symptoms of AN, BN, and BED, and have screening tools and referral information on hand for mental health professionals who can thoroughly assess clients for possible eating disorders and symptoms. Do not merely look for clients who "look like" they have an eating disorder.
- The stereotypical picture of someone with an eating disorder is a young, heterosexual, White woman, but these conditions occur in both genders, among diverse ethnic/racial groups, across cultures, throughout the lifespan, and in people of all sexual orientations and gender identities.
- Co-occurring depression and anxiety are common in people with eating disorders and SUDs. Assess for these (or their symptoms) and treat accordingly, because failure to do so can reduce overall treatment success.
- Some clients may be hesitant to address their SUD out of fear that doing so will cause them to gain weight.
- Medical stabilization is critical, as people with feeding and eating disorders are at high risk for serious health complications, including electrolyte imbalances, cardiovascular dysfunction (e.g., low blood pressure, arrhythmias), withdrawal from laxative use, and dehydration. Treatment should include continual collaboration with healthcare providers to ensure client safety and stability.
- People actively using substances need to be treated for their addiction before treatment for their eating disorder can proceed. Ideally, both conditions would be managed concurrently using an integrated, continuous care approach. But given that integrated programs for these CODs are uncommon, SUD treatment may need to be the primary focus, assuming the client is already medically stable.
- Family dynamics often play a prominent role in the lives of people with eating disorders. As appropriate, include family in the treatment process, including referral to a marriage and family therapist if needed.
- Document through a comprehensive assessment the individual's full repertoire of weight loss behaviors, as people with eating disorders will often go to dangerous extremes to lose weight.
- Conduct a behavioral analysis of foods and substances of choice; high-risk times and situations for engaging in disordered eating and substance misuse; and the nature, pattern, and interrelationship of disordered eating and substance use. Develop a treatment plan for both the eating disorder and the SUD.
- Use psychoeducation and CBT techniques.

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- Use adjunctive strategies such as nutritional consultation, the setting of a weight range goal, and observations at and between mealtimes for disordered eating behaviors.
- Incorporate relapse prevention strategies for a long course of treatment and several treatment episodes.
- In addition to "traditional" drugs of misuse and alcohol, women with eating disorders are unique in their misuse of pharmacological agents ingested for the purpose of weight loss, appetite suppression, and purging. Among these drugs are prescription and over-the-counter diet pills, laxatives, diuretics, and emetics. Nicotine and caffeine also must be considered when assessing substance use in women with eating disorders.
- Drugs related to purging (e.g., diuretics, laxatives, emetics), are ineffective and potentially dangerous methods of accomplishing weight loss or maintenance. The literature suggests that, like more common drugs of misuse, tolerance and withdrawal occur with laxatives, diuretics, and possibly diet pills and emetics.
- Alcohol and substances such as cannabis can disinhibit appetite (i.e., remove normal restraints on eating) and increase the risk of binge eating as well as relapse in individuals with BN.
- Clients with feeding and eating disorders have craving, tolerance, and withdrawal from drugs linked with purging (e.g., laxatives, diuretics) and urges (or cravings) for binge foods similar to urges for substances.
- Feeding and eating disorders are quite serious and can be fatal. Treat them accordingly.
- Suicide risk in this population is perilously high. Regularly assess for suicidal thoughts, gestures, and attempts and develop methods for safety monitoring and harm prevention (e.g., safety plans).

Only 51 percent of SUD treatment programs report screening clients for feeding and eating disorders (Kanbur & Harrison, 2016).

Regardless of treatment modality, providers must first ensure medical and weight stabilization so clients are healthy and able to physically and cognitively participate in and benefit from therapy (Harrop & Marlatt, 2010). Some clients with AN or BN may require inpatient treatment or partial hospitalization to stabilize weight. Depending on the facility, staff may not be equipped to address any co-occurring substance misuse simultaneously.

The primary treatment for these disorders is psychosocial intervention, including individual, group, family therapy, or a combination thereof. CBT can be effective for feeding and eating disorders but has not been researched thoroughly in populations with co-occurring addiction (Gregorowski et al., 2013). Dialectical behavior therapy also can be useful in promoting mindfulness, improving management of negative emotions, and teaching affective and behavioral self-regulation skills in feeding and eating disorders and in SUDs separately (Ritschel, Lim, & Stewart, 2015) but, again, has not been studied extensively in both concurrently. Pharmacotherapy may be warranted for BN and BED (SAMHSA, 2011a) but is not a first-line treatment. Further studies are needed to clarify how the presence of a feeding or eating disorder affects SUD treatment and how best to integrate treatment for both conditions.

Substance-Related Disorders

The primary aim of this section of the chapter is to describe substance-induced mental disorders and to clarify how to differentiate them from mental disorders that co-occur with SUDs.

Substance-related disorders include two subcategories: SUDs and substance-induced disorders. SUDs identify the cluster of cognitive, behavioral, and physical symptoms that occur as a result of continued and frequent use of substances. These consequences are not immediate. Rather, they occur over time as addiction progresses. Substance-induced mental disorders refer to the immediate effects of substance use (intoxication), the immediate effects of discontinuing a substance (substance withdrawal), and other substance-induced mental disorders (APA, 2013).

SUDs

The essential feature of an SUD is a cluster of cognitive, behavioral, and physical symptoms indicating that the individual continues using the substance despite significant substance-related problems. All DSM-5 SUDs have their own diagnostic criteria, but criteria are largely the same across substances. Addiction counselors should be familiar with SUD diagnostic criteria and refer to DSM-5 as needed.

Prevalence

Lifetime and 12-month prevalence rates of DSM-5 drug use disorders (i.e., non-alcohol-related SUDs) are nearly 10 percent and 4 percent, respectively (Grant et al., 2016). Lifetime and 12-month prevalence rates of AUD are about 29 percent and 14 percent, respectively (Grant et al., 2015). Past-month prevalence rates of misuse of other substances by adults ages 26 and older include (CBHSQ, 2019):

- 8.6 percent for cannabis.
- 0.7 percent for cocaine.
- 1.0 percent for pain relievers.
- 0.5 for tranquilizers.
- 0.4 percent for stimulants.
- 0.1 percent for prescription sedatives.
- 0.4 percent for hallucinogens.
- 0.2 percent for heroin.
- 0.1 percent for inhalants.

Substance-Induced Mental Disorders

The toxic effects of substances can mimic mental disorders in ways that can be difficult to distinguish from mental illness. This section focuses on a general description of symptoms of mental illness that are the result of substances or medications—a condition called **substance-induced mental disorders.**

DSM-5 substance-induced mental disorders include:

- Substance-induced depressive disorders.
- Substance-induced bipolar and related disorders.
- Substance-induced anxiety disorders.
- Substance-induced psychotic disorders.
- Substance-induced obsessive-compulsive and related disorders.
- Substance-induced sleep disorders.
- Substance-induced sexual dysfunctions.
- Substance-induced delirium.
- Substance-induced neurocognitive disorder.

The first four of the listed substance-induced mental disorders are the most common in addiction, discussed further in the section, "Specific Substance-Induced Mental Disorders." Exhibit 4.16 summarizes substances and the substance-induced mental disorders associated with each.

EXHIBIT 4.16. Substances and Corresponding Substance-Induced Mental Disorders

SUBSTANCE	SUBSTANCE-INDUCED MENTAL DISORDER	
Alcohol	• Psychotic disorders • Bipolar disorders • Depressive disorders	• Anxiety disorders • Sleep disorders
Caffeine	• Anxiety disorders	• Sleep disorders
Cannabis	• Psychotic disorders	• Anxiety disorders
Hallucinogens	• Psychotic disorders • Bipolar disorders	• Depressive disorders • Anxiety disorders
Inhalants	• Psychotic disorders • Depressive disorders	• Anxiety disorders
Opioids	• Depressive disorders • Anxiety disorders	• Sleep disorders
Sedatives	• Psychotic disorders • Bipolar disorders • Depressive disorders	• Anxiety disorders • Sleep disorders
Stimulants (e.g., cocaine, amphetamines)	• Psychotic disorders • Bipolar disorders • Depressive disorders	• Anxiety disorders • Sleep disorders

WARNING TO COUNSELORS: INDEPENDENT VERSUS SUBSTANCE-INDUCED MENTAL DISORDERS

The symptoms of substance-induced mental disorders may be identical to those of independent but co-occurring mental disorders. Accurate assessment of a mental disorder cannot occur while an individual is actively using substances. Knowing the difference between the two is key because they may (or may not) need to be treated differently and will have different prognoses. Mental disorder symptoms resulting from intoxication or withdrawal often need no formal treatment and will resolve on their own and quickly.

Also keep in mind the bidirectional and unstable temporal relationship between mental disorders and SUDs. Whether a substance is causing psychiatric symptoms or vice versa is often unclear, and the answer can change over time. Each disorder can affect the other reciprocally. **Even when a substance clearly is responsible for the emergence of a mental disorder/psychiatric symptoms, that does not preclude the possibility of an independent mental disorder developing in the future. In fact, an individual can have both a substance-induced and an independent mental disorder.** For example, a client may present with well-established independent and controlled bipolar I disorder and AUD in remission, but the same client could be experiencing amphetamine-induced auditory hallucinations and paranoia from an amphetamine misuse relapse over the last 3 weeks.

Even when the psychiatric diagnosis has not been established, the client's co-occurring symptoms should still be treated (with nonmedication). **Counselors should not withhold treatment simply because a determination about the origin of the mental disorder has not yet been made.**

General Considerations

Substance-induced mental disorders are distinct from independent co-occurring mental disorders in that all or most of the psychiatric symptoms are the direct result of substance use. This does not mean that substance-induced disorders preclude co-occurring mental disorders, only that the specific symptom cluster at a specific point in time is more likely the result of substance use, misuse, intoxication, or withdrawal than of underlying mental illness.

> Even when the psychiatric diagnosis has not been established, the client's co-occurring symptoms should still be treated (with nonmedication). Counselors should not withhold treatment simply because a determination about the origin of the mental disorder has not yet been made.

Symptoms of substance-induced mental disorders run the gamut from mild anxiety and depression (these are the most common across all substances) to full-blown manic and other psychotic reactions (much less common). For example, acute withdrawal symptoms from physiological depressants such as alcohol and benzodiazepines are hyperactivity, elevated blood pressure, agitation, and anxiety (i.e., "the shakes"). On the other hand, those who "crash" from stimulants are tired, withdrawn, and depressed.

Because clients vary greatly in how they respond to both intoxication and withdrawal given the same exposure to the same substance, and also because different substances may be taken at the same time, prediction of any particular substance-related syndrome has its limits. **What is most important is to continue to evaluate psychiatric symptoms and their relationship to abstinence or ongoing substance misuse over time.** Most substance-induced symptoms begin to improve within hours or days after substance use has stopped. Notable exceptions to this are psychotic symptoms caused by heavy and longterm amphetamine misuse and dementia (e.g., problems with memory, concentration, problem solving) caused by using substances directly toxic to the brain, which most commonly include alcohol, inhalants like gasoline, and amphetamines.

Exhibit 4.17 offers an overview of the most common classes of misused substances and the accompanying psychiatric symptoms seen in intoxication and withdrawal.

EXHIBIT 4.17. Substance-Induced Mental Disorder Symptoms (by Substance)

ALCOHOL
Intoxication. In most people, moderate to heavy consumption is associated with euphoria, mood lability, decreased impulse control, and increased social confidence (i.e., getting high). Symptoms may appear hypomanic but are often followed by next-day mild fatigue, nausea, and dysphoria.
Withdrawal. Following acute withdrawal (a few days), some people will experience continued mood instability, fatigue, insomnia, reduced sexual interest, and hostility for weeks or months, so-called "protracted withdrawal." Symptoms of alcohol withdrawal include agitation, anxiety, tremor, malaise, hyperreflexia (exaggeration of reflexes), mild tachycardia (rapid heartbeat), increasing blood pressure, sweating, insomnia, nausea or vomiting, and perceptual distortions. More severe withdrawal is characterized by severe instability in vital signs, agitation, hallucinations, delusions, and often seizures. Alcohol-induced deliriums after high-dose drinking are characterized by fluctuating mental status, confusion, and disorientation and are reversible once both alcohol and its withdrawal symptoms are gone.
CANNABIS
Intoxication. Consumption typically results in a "high" feeling followed by symptoms including euphoria, sedation, lethargy, impairment in short-term memory, difficulty carrying out complex mental processes, impaired judgement, distorted sensory perceptions, impaired motor performance, and the sensation that time is passing slowly. Occasionally, the individual experiences anxiety (which may be severe), dysphoria, or social withdrawal.

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Withdrawal. Cessation or substantial reduction in heavy or prolonged cannabis use may result in fatigue, yawning, difficulty concentrating, and rebound periods of increased appetite and hypersomnia that follow initial periods of loss of appetite and insomnia.

HALLUCINOGENS

Intoxication. Hallucinogens produce visual distortions and frank hallucinations. Some people who use hallucinogens experience a marked distortion of their sense of time and feelings of depersonalization. Hallucinogens may also be associated with drug-induced panic, paranoia, and even delusional states in addition to the hallucinations. Hallucinogen hallucinations usually are more visual (e.g., enhanced colors and shapes) as compared with schizophrenic-type hallucinations, which tend to be more auditory (e.g., voices). Phencyclidine (PCP) causes dissociative and delusional symptoms and may lead to violent behavior and amnesia of the intoxication.

OPIOIDS

Intoxication. Opioid intoxication is characterized by intense euphoria and feelings of well-being.

Withdrawal. Withdrawal can result in agitation, severe body aches, gastrointestinal symptoms, dysphoria, and craving to use more opioids. Symptoms during withdrawal vary—some will become acutely anxious and agitated, whereas others will experience depression and anhedonia. Even with abstinence, anxiety, depression, and sleep disturbance can persist as a protracted withdrawal syndrome.

SEDATIVES

Intoxication. Acute intoxication with sedatives like diazepam is similar to what is experienced with alcohol.

Withdrawal. Withdrawal symptoms are also similar to alcohol and include mood instability with anxiety or depression, sleep disturbance, autonomic hyperactivity, tremor, nausea or vomiting, and, in more severe cases, transient hallucinations or illusions and grand mal seizures. There are reports of a protracted withdrawal syndrome characterized by anxiety, depression, paresthesias, perceptual distortions, muscle pain and twitching, tinnitus, dizziness, headache, derealization and depersonalization, and impaired concentration. Most symptoms resolve in weeks, but some symptoms, such as anxiety, depression, tinnitus, and paresthesias (sensations such as prickling, burning, etc.), have been reported to last a year or more after withdrawal for some.

STIMULANTS (INCLUDES COCAINE AND AMPHETAMINES)

Intoxication. Mild to moderate intoxication from cocaine, methamphetamine, or other stimulants is associated with euphoria, and a sense of internal well-being, and perceived increased powers of thought, strength, and accomplishment. In fact, low to moderate doses of amphetamines may actually increase certain test-taking skills temporarily in those with ADHD and even in people who do not have ADHD. However, as more substance is used and intoxication increases, attention, ability to concentrate, and function decrease.

With cocaine and methamphetamines, dosing is almost always beyond the functional window. As dosage increases, the chances of impulsive dangerous behaviors, which may involve violence, promiscuous sexual activity, and others, also increases.

Withdrawal. After intoxication comes a crash in which the person is desperately fatigued, depressed, and often craves more stimulant to relieve these withdrawal symptoms. This dynamic is why it is thought that people who misuse stimulants often go on week- or month-long binges and have a hard time stopping.

Even with several weeks of abstinence, many people who are addicted to stimulants report a dysphoric state that is marked by anhedonia (absence of pleasure) or anxiety. Heavy, long-term amphetamine use appears to cause long-term changes in the functional structure of the brain, and this is accompanied by long-term problems with concentration, memory, and, at times, psychotic symptoms.

INDUCED VERSUS INDEPENDENT MENTAL DISORDERS: THE IMPORTANCE OF TREATMENT

It will not always be clear whether a client's mental disorder or symptoms are independent or caused by long-term substance use or withdrawal. But withholding treatment until this determination is made is inhumane and unethical. **Individuals should be engaged in treatment that addresses their co-occurring psychiatric symptoms, even if the origin of the co-occurring mental disorder is unclear.**

If counselors struggle to differentiate an independent from a substance-induced mental disorder, they should:

- Observe the client and watch for changes in symptoms (e.g., do symptoms abate once the person is abstinent from the substance for a length of time?).
- Reevaluate the client to help discern whether the symptoms/disorder is caused by withdrawal, protracted withdrawal, or the neurological effects of chronic substance use.
- Offer nonmedication treatment (e.g., SUD interventions or mental health services) for all symptoms, regardless of whether a formal diagnosis has been established.

Diagnoses of substance-induced mental disorders will typically be provisional and will require reevaluation—sometimes repeatedly. Many apparent acute mental disorders may really be substance-induced disorders, such as in those clients who use substances and who are acutely suicidal.

Some people who appear to have substance-induced mental disorders turn out to have a substance-induced mental disorder and independent mental disorder. Consider preexisting mood state, personal expectations, drug dosage, and environmental surroundings in understanding of how a particular client might experience a substance-induced disorder. Treatment of the SUD and an abstinent period of weeks or months may be required for a definitive diagnosis of an independent, co-occurring mental disorder. As described in Chapter 3, SUD treatment programs and clinical staff can concentrate on screening for mental disorders and determining the severity and acuity of symptoms, along with an understanding of the client's support network and overall life situation.

Specific Substance-Induced Mental Disorders

This section briefly discusses the most common substance-induced mental disorders in clinical populations: substance-induced depressive, anxiety, bipolar, and psychotic disorders. Diagnostic criteria for all substance-induced mental disorders, including the four mentioned, are nearly identical and comprise five general characteristics (Exhibit 4.18).

EXHIBIT 4.18. Features of DSM-5 Substance-Induced Mental Disorders

A. The disorder represents a clinically significant symptomatic presentation of a relevant mental disorder.

B. There is evidence from the history, physical examination, or laboratory findings of both of the following:

1. The disorder developed during or within 1 month of a substance intoxication or withdrawal or taking a medication; and
2. The involved substance/medication is capable of producing the mental disorder.

C. The disorder is not better explained by an independent mental disorder (i.e., one that is not substance- or medication-induced). Such evidence of an independent mental disorder could include the following:

1. The disorder preceded the onset of severe intoxication or withdrawal or exposure to the medication; or

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2. The full mental disorder persisted for a substantial period of time (e.g., at least 1 month) after the cessation of acute withdrawal or severe intoxication or taking the medication. This criterion does not apply to substance-induced neurocognitive disorders or hallucinogen persisting perception disorder, which persist beyond the cessation of acute intoxication or withdrawal.

D. The disorder does not occur exclusively during the course of a delirium.

E. The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Source: APA (2013, p. 488). Reprinted with permission from the DSM-5 (Copyright © 2013). APA. All Rights Reserved.

EXHIBIT 4.19. Substances That Precipitate or Mimic Common Mental Disorders

MENTAL DISORDER	SUBSTANCES THAT MIMIC MENTAL DISORDERS DURING USE (INTOXICATION)	SUBSTANCES THAT MIMIC MENTAL DISORDERS AFTER USE (WITHDRAWAL)
Depression and dysthymia	Alcohol, benzodiazepines, opioids, barbiturates, cannabis, steroids (chronic), stimulants (chronic)	Alcohol, benzodiazepines, barbiturates, opioids, steroids (chronic), stimulants (chronic)
Anxiety disorders	Alcohol, amphetamine and its derivatives, cannabis, cocaine, hallucinogens, intoxicants and PCP, inhalants, stimulants	Alcohol, cocaine, opioids, sedatives, hypnotics, anxiolytics, stimulants
Bipolar disorders and mania	Stimulants, alcohol, hallucinogens, inhalants (organic solvents), steroids (chronic, acute)	Alcohol, benzodiazepines, barbiturates, opioids, steroids (chronic)
Psychosis	Alcohol, anxiolytics, cannabis, hallucinogens (e.g., PCP), inhalants, sedatives, hypnotics, stimulants	Alcohol, sedatives, hypnotics, anxiolytics

Exhibit 4.19 lists substances most likely to induce/mimic depressive, anxiety, bipolar, and psychotic disorders.

Substance-induced depressive disorders

The lifetime prevalence of substance-induced depressive disorders in the general community is 0.26 percent (Blanco et al., 2012). Observed rates among clinical populations are much higher. For instance, in a study of people seeking treatment for co-occurring depressive disorders and SUDs, 24 percent had substance-induced depression; rates varied by substance. Among those with 12-month alcohol dependence, prevalence of

substance-induced MDD was 22 percent; for past-year cocaine dependence, 22 percent; and for past-year heroin dependence, nearly 37 percent (Samet et al., 2013). In another study of people with SUDs, 60 percent of people with depression had a substance-induced rather than independent depressive disorder (Conner et al., 2014). DSM-5 notes that although about 40 percent of people with AUD develop MDD, only about one-third to one-half are cases of independent depression, meaning **as much as 75 percent of occurrences of depressive disorders in the context of AUD could be because of intoxication or withdrawal** (APA, 2013). Depressive disorders or their symptoms could also be because of the long-term effects of substance use.

Diagnosis of a substance-induced versus independent depressive disorder can be difficult given that many people with SUDs do have mood symptoms, like depressed affect, and **intoxication and withdrawal from substances can mirror symptoms of depression.** During the first months of abstinence, many people with SUDs may exhibit symptoms of depression that fade over time and are related to acute withdrawal. Because depressive symptoms during withdrawal and early recovery may result from SUDs and not an underlying depression, a period of time should elapse before depression is diagnosed. This does not preclude the importance of addressing depressive symptoms during the early stage of recovery, before diagnosis. Further, even if an episode of depression is substance induced, that does not mean that it should not be treated. Overall, the process of addiction can result in biopsychosocial disintegration, leading to PDD or depression often lasting from months to years.

Substance-induced mood alterations can result from acute and chronic drug use as well as from drug withdrawal. Substance-induced depressive disorders, most notably acute depression lasting from hours to days, can result from sedative–hypnotic intoxication. Similarly, prolonged or subacute withdrawal, lasting from weeks to months, can cause episodes of depression, and sometimes is accompanied by suicidal ideation or attempts.

Stimulant withdrawal may provoke episodes of depression lasting from hours to days, especially following high-dose, chronic use. Acute stimulant withdrawal generally lasts from several hours to 1 week and is characterized by depressed mood, agitation, fatigue, voracious appetite, and insomnia or hypersomnia (oversleeping). Depression resulting from stimulant withdrawal may be severe and can be worsened by the individual's awareness of substance use–related adverse consequences. Symptoms of craving for stimulants are likely and suicide is possible. Protracted stimulant withdrawal often includes sustained episodes of anhedonia (absence of pleasure) and lethargy with frequent ruminations and dreams about stimulant use.

Stimulant cessation may be followed for several months by bursts of dysphoria, intense depression, insomnia, and agitation. These symptoms may be either worsened or lessened depending on the provider's treatment attitudes, beliefs, and approaches. It is a delicate balance—between allowing time to observe the direction of symptoms to treating the client's presenting symptoms regardless of origin.

Substance-Induced Anxiety Disorders

The prevalence of substance-induced anxiety disorders in the community is unreported and thought to be quite low (less than 0.1 percent), although likely higher in clinical samples (APA, 2013).

Licit and illicit substances can cause symptoms that are identical to those in anxiety. In addition, many medications, toxins, and medical procedures can cause or are associated with an eruption of anxiety. Moreover, these reactions vary greatly from mild manifestations of shortlived symptoms to full-blown manic and other psychotic reactions, which are not necessarily short lived.

Symptoms that look like anxiety may appear either during use or withdrawal. Alcohol, amphetamine and its derivatives, cannabis, cocaine, hallucinogens, intoxicants and phencyclidine and its relatives have been reported to cause the symptoms of anxiety during intoxication. Withdrawal from alcohol, cocaine, illicit opioids, and also caffeine and nicotine can also cause manifestations of anxiety. Similarly, withdrawal from depressants, opioids, and stimulants invariably includes potent anxiety symptoms.

Substance-Induced Bipolar Disorders

Epidemiologic data on substance-induced mania or bipolar disorders in the U.S. general population are not readily available.

A number of substances of misuse (as well as prescribed medications and several medical conditions) are also associated with manic-like phenomena. Acute manic symptoms may be induced or mimicked by intoxication with stimulants, steroids, hallucinogens, or polydrug combinations. They may also be caused by withdrawal from depressants such as alcohol. Individuals experiencing acute mania with its accompanying hyperactivity, psychosis, and often aggressive and impulsive behavior should be referred to emergency mental health professionals.

Stimulant-induced episodes of mania may include symptoms of paranoia lasting from hours to days. Stimulants such as cocaine and amphetamines cause potent psychomotor stimulation. Stimulant intoxication generally includes increased mental and physical energy, feelings of well-being and grandiosity, and rapid, pressured speech. Chronic, high-dose stimulant intoxication, especially with sleep deprivation, may prompt a manic episode. Symptoms may include euphoric, expansive, or irritable mood, often with flight of ideas, severe social functioning impairment, and insomnia.

Substance-Induced Psychosis

This condition is very rare; exact prevalence rates are unknown (APA, 2013). In first-episode psychosis, 7 percent to 25 percent of cases are substance induced (APA, 2013).

CASE STUDIES: IDENTIFYING DISORDERS

George M. is a 37-year-old divorced man who was brought to the ED intoxicated. His blood alcohol level was 0.27, and the toxicology screen was positive for cocaine. He was also suicidal ("I'm going to do it right this time!"). He has a history of three psychiatric hospitalizations and two inpatient SUD treatments. Each psychiatric admission was preceded by substance use.

George M. never followed through with mental health services. He sometimes attended AA, but not recently.

Teresa G. is a 37-year-old divorced woman who was brought into a detoxification unit 4 days ago with a blood alcohol level of 0.21. She is observed to be depressed, withdrawn, with little energy, fleeting suicidal thoughts, and poor concentration, but states she is just fine, not depressed, and life was good last week before her relapse. She has never used substances (other than alcohol) and began drinking alcohol only 3 years ago. However, she has had several alcohol-related problems since then. She has a history of three psychiatric hospitalizations for depression, at ages 19, 23, and 32. She reports a positive response to antidepressants. She is currently not receiving mental health services or SUD treatment. She is diagnosed with AUD (relapse) and substance-induced depressive disorder, with a likely history of, but not active, major depression.

Discussion: Many factors must be examined when making initial diagnostic and treatment decisions. For example, if George M.'s psychiatric admissions were 2 or 3 days long, usually with discharges related to leaving against medical advice, decisions about diagnosis and treatment would be different (i.e., this is likely a substance-induced suicidal state and referral at discharge should be to an SUD treatment agency rather than a mental health center) than if two of his psychiatric admissions were 2 or 3 weeks long with clearly defined manic and psychotic symptoms continuing throughout the course, despite aggressive use of mental health services and medication (this is more likely a person with both bipolar disorder and AUD who requires integrated treatment for both his severe AUD and bipolar disorder).

Similarly, if Teresa G. became increasingly depressed/withdrawn in the past 3 months, and had for a month experienced disordered sleep, poor concentration, and suicidal thoughts, she would be best diagnosed with MDD with acute alcohol relapse, not substance-induced depressive disorder secondary to alcohol relapse.

Heavy users of psychoactive substances, like cannabis, amphetamines, and cocaine, are vulnerable to substance-induced psychosis, especially clients with cooccurring schizophrenia and bipolar disorders. Antidepressants can also precipitate psychotic episodes, as can medications like prescribed steroids and nonsteroidal anti-inflammatory drugs, antiviral agents, antibiotics, anticholinergics, antihistamines, muscle relaxants, and opioids. Any number of physical illnesses or medication reactions, from brain tumors to steroid side effects, can cause a psychotic episode or psychotic behavior. **Virtually any substance taken in very large quantities over a long enough period can lead to a psychotic state.**

Differential diagnosis among psychotic disorders can be challenging, even for experienced clinicians and diagnosticians, especially when substances are involved. When a client presents in a psychotic state, any immediate or recent substance use is difficult to determine, and it may be impossible to discern whether the hallucinations or delusions are caused by substance use. If the hallucinations or delusions can be attributed to substance use but are prominent and beyond what one might expect from intoxication alone, the episode would be described as a substance-induced psychotic disorder. Hallucinations that the person knows are solely the result of substance use are not considered indicative of a psychotic episode; instead, they are diagnosed as substance intoxication or substance withdrawal with the specifier "with perceptual disturbances" (APA, 2013).

Cross-Cutting Topics: Suicide and Trauma

Suicide risk and trauma status are relevant to care planning, client safety, and treatment outcomes across many CODs. This section briefly addresses each issue and offers guidance to help addiction counselors understand why both need to be actively considered as part of assessment and treatment.

Ample literature discusses suicide, mental disorders, and addiction. This section is not intended to thoroughly review all aspects of suicide-related assessment, management, and prevention techniques for COD populations; readers instead are directed to TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009) for more information. The aim of this text is to ensure that readers have a broad and general understanding of the high risk of suicidal thoughts and behaviors in clients with CODs and feel confident in knowing how to prevent and respond to such events.

Similarly, trauma has been a significant topic of research in the behavioral health literature. What follows is an abbreviated summary of the link between trauma and mental disorders and SUDs and how addiction counselors can offer trauma-informed services. Readers should consult TIP 57, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA, 2014b) for more guidance in this area.

For both suicide and trauma, readers are reminded to review Chapter 3 for assessment techniques and tools, Appendix B for links to suicide prevention materials and other resources, and Appendix C for counselor tools like trauma screeners.

Suicide

Suicide is a common risk factor that pertains to nearly all CODs and particularly those involving addiction and MDD, bipolar disorder, schizophrenia, PTSD, or PDs (Yuodelis-Flores & Ries, 2015). Suicidality itself is not a mental disorder, but it is considered a high-risk behavior of significant public health concern (Hogan & Grumet, 2016). Substance-induced or exacerbated suicidal ideations, intentions, and behaviors are possible complications of SUDs, especially for clients with co-occurring mental disorders.

The topic of suicidality is critical for SUD treatment counselors working with clients who have CODs. SUDs alone increase suicidality (Yuodelis-Flores & Ries, 2015), whereas the added presence of some mental disorders doubles the already heightened risk (O'Connor & Pirkis, 2016). The risk of suicide is greatest when relapse occurs after a substantial

These populations (Department of Health and Human Services, 2012) are vulnerable to suicide risk; many are susceptible to addiction or CODs as well:

- American Indians/Alaska Natives
- Individuals who have lost a loved one to suicide
- Clients involved in criminal justice/child welfare systems
- Clients who engage in nonsuicidal self-injury
- Individuals with a history of previous suicide attempt
- Individuals with debilitating physical conditions
- Clients with mental disorders, SUDs, or both
- Individuals in the LGBTQ community
- Members of the armed forces and veterans
- Middle-aged and older men

period of abstinence—especially if there is concurrent financial or psychosocial loss. **Every agency that offers SUD counseling must also have a clear protocol in place that addresses the recognition and treatment (or referral) of people who may be suicidal.**

Prevalence

Suicide is the 10th leading cause of death in the United States among people ages 10 and older (Stone et al., 2019). Suicide is the second leading cause of death for people ages 10 to 34 and the fourth leading cause of death for those ages 35 and 54 (NIMH, 2019). Per the Centers for Disease Control and Prevention (CDC), from 1999 to 2018, suicide rates in the United States increased 41 percent, from 10.5 to 14.8 per 100,000 people (CDC, 2019). Suicide rates among men remain more than 3 times higher (23.4 per 100,000 in 2018) than among women (6.4 per 100,000 in 2018) (CDC, 2020).

Almost half (46 percent) of all individuals in the United States who died by suicide between 2014 and 2016 had a known mental health condition, and 54 percent were in treatment at the time of death (Stone et al., 2019). Depression was the most common mental disorder diagnosis among those who completed suicide (75 percent); other major mental disorder diagnoses included anxiety (17 percent), bipolar disorders (15 percent), schizophrenia (5 percent), and PTSD (4 percent) (Stone et al., 2019).

According to NSDUH data (CBHSQ, 2019), in 2018:

- About 10.7 million U.S. adults ages 18 or older thought seriously of dying by suicide (4.3 percent of adults).
- 3.3 million U.S. adults made suicide plans (1.3 percent).
- 1.4 million U.S. adults made nonfatal suicide attempts (0.6 percent).

Suicide and SUDs

Substance misuse makes people susceptible to self-harm; indeed, **suicide is the leading cause of death among people with addiction** (CSAT, 2009). From 2014 to 2016, 28 percent of people who died by suicide had problematic substance use, including 32 percent of people with a known mental health disorder (Stone et al., 2019). Of these individuals with known psychiatric problems, 39 percent tested positive for alcohol, 39 percent for benzodiazepines, 29 percent for opioids, 23 percent for cannabis, 10 percent for amphetamines, and 6 percent for cocaine (Stone et al., 2019).

Alcohol factors prominently into suicide (Darvishi, Farhadi, Haghtalab, & Poorolajal, 2015). **Acute alcohol intoxication increases the risk of suicide attempt by nearly 7 times and in some studies, if use is heavy, by as much as 37 times** (Borges et al., 2017). This risk appears to increase with corresponding increases in consumption; as such, populations with AUD have higher rates of suicide than people without problematic alcohol use (Yuodelis-Flores & Ries, 2015).

Other substances also carry an increased risk of self-harm, as suicidal behavior is prominent in OUD, cocaine use disorder, and polysubstance use (Yuodelis-Flores & Ries, 2015). Among

individuals with a history of substance misuse who died by suicide in 2014 (Fowler, Jack, Lyons, Betz, & Petrosky, 2018), the most commonly involved nonmedication substances were alcohol (51 percent), opioids (23 percent), and cannabis (almost 14 percent). Furthermore, among all suicide cases that year, opioids were the direct cause of death in 27 percent of people and alcohol in 13 percent (Fowler et al., 2018). The overall suicide rate of U.S. veterans with an SUD is estimated at 75.6 per 100,000 people and is highest among those who misuse sedatives, followed by amphetamines, opioids, cannabis, alcohol, and cocaine (Bohnert, Ilgen, Louzon, McCarthy, & Katz, 2017). People who report misusing prescription medication, and in particular pain relievers, also appear to be vulnerable to suicidal ideation (Ford & Perna, 2015).

The link between substance misuse and suicide may relate to the capacity of substances, especially alcohol, to quell inhibition, leading to poor judgment, mood instability, and impulsiveness. Depression, comorbid with suicide risk and substance misuse, may moderate this relationship. A population-based sample of people currently using alcohol and with a history of depressed mood (Sung et al., 2016) found that those with a positive history of suicide attempt were significantly more likely than those without such a history to have problematic substance use, including 21 percent with alcohol abuse or dependence and nearly 40 percent with illicit drug abuse or dependence. Yet alcohol dependence in this sample significantly increased the odds of suicidal ideation and suicide attempt even among people without a history of depressed mood. This suggests that depressed mood alone cannot account for the relationship between alcohol misuse and risk of suicide, although it undoubtedly increases the odds.

Many psychiatric illnesses have a heightened risk of suicidal thoughts and behaviors further exacerbated in the presence of co-occurring addiction. Risk factors for suicide that have been identified in the general population, such as a family history of suicide attempt or completion and access to firearms, also apply to people with CODs and make self-harm more likely. Additionally, **certain individuals with CODs may be at even further risk based on the presence of contributing factors that frequently appear in populations with mental disorders and SUDs.** For instance, having a chronic physical health condition (such as traumatic brain injury or infectious disease), experiencing homelessness, being a military veteran, and past involvement in the criminal justice system are all associated with suicide-related ideation, gestures, attempts, or deaths (Ahmedani et al., 2017; Cook, 2013; Jahn et al., 2018; Kang et al., 2015; Tsai & Cao, 2019) and may further compromise the safety of people with CODs. A history of adverse life experiences, like childhood maltreatment or intimate partner violence, also significantly increases risk of self-harm (especially in people with CODs) and is addressed in the section "Trauma."

Prevention and Management of Suicidal Behaviors

Although a rare event, suicide is often—but not always—preventable. **All SUD treatment clients should receive at least a basic screening for suicidality, and all SUD treatment professionals should know how to conduct at least basic screening and triage.** (To learn more about suicide screening, see Chapter 3 of this TIP.) SAMHSA's Five-Step Evaluation and Triage (SAMHSA, 2009b) recommends using the following process for identifying and responding to threat of self-harm:

1. **Identify risk factors.**
2. **Identify protective factors.**
3. **Conduct a suicidal inquiry** into the client's thoughts, plans, behaviors, and intents.
4. **Determine the level of risk** and appropriate interventions.
5. **Document** risk, rationale, intervention, and follow-up procedures.

Addiction counselors should regularly assess and monitor all clients with CODs for suicidal ideation, gestures, plans, and attempts and especially clients with depressive disorders, bipolar disorders, PTSD, schizophrenia, or PDs. Routine assessment should be an integral part of treatment but is especially critical during times of high stress or increased substance use (including relapse) as well as at intake, following any suicidal behavior, following reports of suicidal ideation,

and just before discharge. Information should be collected on the client's:

- Personal and family history of suicidal thoughts and behaviors.
- Plan for suicide.
- Reasons for not following through with past plans for suicide.
- Reasons for not following through with the current plan for suicide.
- Current support system.
- Means and access to lethal methods (e.g., firearms).
- History and current symptoms of impulsivity.
- Depressed mood, feelings of hopelessness, or both.
- Protective factors (e.g., coping skills, spiritual/religious beliefs).

Asking a client directly about his or her desire to die by suicide does not make self-harm more likely and in fact can yield helpful information.

Note that people may deny such thoughts or plans despite having them. Thus, **direct questioning alone is an insufficient risk mitigation strategy.** Suicide risk assessment scales might be useful in this regard (see Chapter 3 and Appendix C for suicide risk and self-harm screening tools) but often lack the specificity and sensitivity to adequately detect impending suicidal behaviors (Bolton, Gunnell, & Turecki, 2015). **Providers also should not rely solely on suicide measures.** Instead, suicide screening should include thorough investigation of all major signs, symptoms, and risk factors associated with self-harm in mental health, addiction, or COD populations.

Safety planning is critical in suicide risk mitigation. Suicide "contracts" are written statements in which the person who is suicidal states that he or she will not kill himself but rather call for help, go to an ED, or other seek other assistance if he or she becomes suicidal. These contracts are not effective alone for a client who is suicidal. Such contracts often help make clients and therapists less anxious

RESOURCE ALERT: SUICIDE PREVENTION RESOURCES FOR COUNSELORS

- American Counseling Association (ACA):
  - Suicide Prevention Tip Sheet (https://www.counseling.org/docs/default-source/Communications-/suicide-prevention-final.pdf?sfvrsn=2)
  - Counselor Training in Suicide Assessment, Prevention, and Management (www.counseling.org/docs/default-source/vistas/article_65d15528f16116603abcacff0000bee5e7.pdf?sfvrsn=4f43482c_6)
  - Developing Clinical Skills in Suicide Assessment, Prevention, and Treatment (www.counseling.org/publications/frontmatter/72861-fm.pdf)
- International Association for Suicide Prevention's Guidelines for Suicide Prevention (www.iasp.info/suicide_guidelines.php)
- SAMHSA:
  - Suicide Prevention Resource Center (www.sprc.org/)
  - Suicide Assessment Five-Step Evaluation and Triage for Mental Health Professionals (https://store.samhsa.gov/system/files/sma09-4432.pdf)
  - TIP 50, Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment (https://store.samhsa.gov/product/TIP-50-Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/SMA15-4381)
  - Video companion to TIP 50, Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment (www.youtube.com/watch?v=1n2Qzlheuzc&feature=youtu.be)

about a suicidal condition, but studies have never shown these contracts to be effective at preventing suicide. Rather, safety contracts help focus on the key elements that are most likely to keep clients safe, such as agreeing to remove the means a client is most likely to use to commit suicide.

Counselors and other providers should know their own skills and limitations in engaging, screening, assessing, and intervening with suicidal clients and work out these problems with a supervisor before an emergency. Providers also should know what immediate onsite and offsite resources are available to help with someone identified as suicidal. To learn more about suicide prevention, see "Resource Alert: Suicide Prevention Resources for Counselors."

No empirical treatments for suicide exist. However, **interventions that reduce symptoms of SUDs and mental illness can help mitigate suicide risk and decrease self-harm behaviors by improving mood and enhancing support and coping skills.** Some research supports the use of psychotherapies such as CBT and dialectical behavior therapy in reducing parasuicidal behavior and suicide attempts, but the overall evidence base is small (Bolton et al., 2015). Pharmacotherapy—particularly antidepressants—can reduce suicidal behavior in people ages 25 years and older. Yet paradoxically, some studies show that it actually increases suicide in people ages 25 and younger (Bolton et al., 2015). Certain mood stabilizers and antipsychotic medications also may reduce self-harm in people with bipolar disorder, schizophrenia, and other psychotic disorders (Bolton et al., 2015).

The first steps in suicide intervention, and thus crisis stabilization, are contained in the process of a good engagement and evaluation. **Asking suicide-related questions, exploring the context**

CASE STUDY: COUNSELING AN SUD TREATMENT CLIENT WHO IS SUICIDAL

Beth, a 44-year-old woman, comes to the SUD treatment center complaining that drinking too much causes problems for her. She has tried to stop drinking before but always relapses. The counselor finds that she has been sleeping and eating poorly and calling in sick to work. She spends much of the day crying and thinking of how alcohol, which destroyed her latest significant relationship, has ruined her life. She takes pain medication for a chronic back problem, which complicates her situation. The counselor tells her of a therapy group that is a good fit, tells her how to register, and arranges some individual counseling to set her on the right path. The counselor tells her she has done the right thing by coming in for help and offers encouragement about her ability to stop drinking.

Beth misses her next appointment. The counselor calls her home and learns from her roommate that Beth tried to commit suicide after leaving the SUD treatment center. She took an overdose of opioids and is recovering in the hospital. The ED staff had found Beth under the influence of alcohol upon admission.

Discussion: Although Beth provided information that showed she was depressed, the counselor did not explore the possibility of suicidal thinking. **Counselors always should ask if the client has been thinking of suicide, whether or not the client mentions depression.** Clients, in general, may not answer a very direct question or may hint at something darker without mentioning it directly. Interpreting the client's response requires sensitivity on the part of the counselor. It is important to realize that such questions do not increase the likelihood of suicide. Clients who, in fact, are contemplating suicide are more likely to feel relieved that the subject has now been brought into the light and can be addressed with help from someone who cares.

The client reports taking alcohol and pain medications. Alcohol impairs judgment and, like pain medications, depresses brain and body functions. The combination of substances increases the risk of suicide or accidental overdose. Readers are encouraged to think through this case and apply the risk assessment strategy included in Chapter 3 and use the tools in Appendix C, imagining what kind of answers the counselor might have received. Readers could consider interventions and referrals that would have been possible in their treatment settings.

of those impulses, evaluating support systems, considering the lethality of means, and assessing the client's motivation to seek help are in themselves an intervention. Such an interview will often elicit the client's own insight and problem solving and may result in a decrease in suicidal impulses.

If, however, the client experiences little or no relief after this process, psychiatric intervention is required, especially if the client has a cooccurring mental disorder or medical disorder in which the risk of suicide is elevated or if the client has a history of suicide attempts. If either or both is true, **arrangements should be made for transfer to a facility that can provide more intensive psychiatric evaluation and treatment. Emergency**

ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WHO IS SUICIDAL

- All SUD treatment clients should receive at least a brief screening for suicide, such as: "In the past, have you ever been suicidal or made a suicide attempt? Do you have any of those feelings now?"
- All SUD treatment staff should be able to screen for suicidality and basic mental disorders (e.g., depression, anxiety disorders, PTSD).
- Screen for suicidal thoughts or plans with anyone who makes suicidal references, appears seriously depressed, or who has a history of suicide attempts. Treat all suicide threats with seriousness.
- Inquire directly about a client's depressed mood or agitation. For example:
  - "You know, you seem to be pretty down. How depressed are you?"
  - The issue may arise via general questions. For example, a client may state, "I don't use crack much anymore. I get really down when I'm coming off it." The counselor may then ask, "How down have you gotten? Were you ever suicidal? How are you doing now?"
- The suicidal client is more likely to engage with the counselor and reveal suicidality if the counselor responds to clues given by the client and inquires sensitively about them. Saying, "You seem pretty uncomfortable and nervous—is there something I can do to help?" to an agitated client opens a door to further assessment.
- If the client screens positive, use the risk assessment strategy described in Chapter 3 to more thoroughly investigate suicide intent. Further screening/assessment should be documented to protect both the client and the counselor. This means writing information on evaluation forms or making additional notes, even if suicide-related items are not included on the form used.
- Assess the client's risk of self-harm by asking about what is wrong, why now, whether specific plans have been made to commit suicide, past attempts, current feelings, and protective factors. (See Chapter 3 and Appendix C for a risk assessment protocol and screening measures.)
- Develop a safety and risk management process with the client that involves a commitment on the client's part to follow advice, remove the means to commit suicide (e.g., a gun), and agree to seek help and treatment. Avoid sole reliance on "no suicide contracts."
- Assess the client's risk of harm to others.
- Clients who are actively suicidal should be evaluated by a psychiatrist onsite immediately, or a case manager or counselor should escort the client to emergency psychiatric services. Where available, mobile crisis service, including a psychiatrist, is a quick-response resource for management of the client who is suicidal.

Continued on next page

Continued

- Be caring and supportive. The seriously suicidal client should have someone to contact 24 hours a day, and frequent telephone contact between the client and the contact person usually is indicated.
- Provide availability of contact 24 hours per day until psychiatric referral is realized. Refer clients with serious plans, previous attempts, or SMI for psychiatric intervention or obtain the assistance of a psychiatric consultant for the management of these clients.
- Monitor and develop strategies to ensure medication adherence.
- Interventions should seek to increase support available to the client from family and community, and should provide immediate interventions, including medication to stabilize the client's mental state, if needed.
- Families and individuals often benefit from education about depression and suicidality, including warning signs, resources for help, and the importance of addressing this problem. Education often provides individuals with a sense of hope and realistic expectations.
- Develop long-term recovery plans to treat substance misuse. Longer term treatment concerns for a client who has been suicidal focus on long-term treatment strategies for CODs or on other risk factors that have culminated in a suicidal event. In this case, treatment becomes long-term prevention.
- In people with serious and persistent mental disorders (e.g., bipolar disorder), long-term medication compliance is key in preventing suicide. Just as essential as medication and medication compliance, however, is the need to rebuild hope in the future and engender the belief that recovery from co-occurring disorders is possible and that one has a sense of purpose, value, empowerment, and role in one's own recovery.
- Review all such situations with the supervisor or treatment team members.
- Document thoroughly all client reports and counselor suggestions.

procedures should be in place so the counselor can accomplish this transfer even when a psychiatrist or clinical supervisor/director is not available. Once the client is stabilized and is safe to return to a less restrictive setting, he or she should return to the program.

Trauma

DSM-5 defines trauma as "as exposure to actual or threatened death, serious injury, or sexual violence in one or more of the following ways: (a) directly experiencing the traumatic event; (b) witnessing, in person, an event as it occurred to others; (c) learning that the traumatic event occurred to a close family member or close friend; and (d) experiencing repeated or extreme exposure to aversive details of the traumatic event(s)" (APA, 2013, p. 271).

For many people with mental disorders, SUDs, or both, past or current trauma is a prominent driver of negative outcomes such as psychiatric hospitalizations; suicide attempts; self-harm behaviors; arrest; aggression; and substance use initiation, escalation (from occasional use, to regular use, to misuse/heavy use/addiction), treatment dropout, and relapse (Kumar, Stowe Han, & Mancino, 2016; Lijffijt, Hu, & Swann, 2014; Stinson, Quinn, & Levenson, 2016). Data from the National Longitudinal Study of Adolescent to Adult Health (Quinn et al., 2016) confirm that exposure to childhood trauma (e.g., sexual/emotional/physical abuse, neglect, witnessing violence) significantly increases the risk of adulthood prescription pain reliever misuse (PPRM) and injection drug use. This risk only grows as the number of traumas experienced increases; in the study, exposure to one trauma increased the risk of PPRM by

WARNING TO COUNSELORS: RETHINKING TRAUMA

When providers hear the term "trauma," they probably get a specific picture in their mind of what a client with trauma looks like—a woman who has been physically abused by her husband, a man who faced combat as a Marine, a woman who was date raped while in college. These are indeed common examples of trauma, but addiction counselors who only think of trauma in prototypical terms will overlook clients who have faced adversities and are in need of help. When thinking about clients with trauma:

Do not think only of women. Men experience trauma, and although at lower rates than women, their adversities are just as serious and potentially damaging.

Do not think only of military veterans or of people who served in combat. Rates of trauma and PTSD are certainly high in military populations, but trauma happens to people from all walks of life. Among active duty military personnel and veterans, people can experience trauma even if they were not directly involved in combat. (See the section "Special Considerations: Trauma and Military Personnel.")

Do not think only of physical violence. Emotional abuse and neglect are damaging and can have just as serious an impact as physical or sexual abuse (Norman et al., 2012).

Do not think only of young people. PTSD is less prevalent in older adults, but up to 52 percent of people ages 50 and older have had at least one traumatic event in their lives (Choi, DiNitto, Marti, & Choi, 2017).

Remember that someone may not have a PTSD diagnosis but still have PTSD symptoms, a history of trauma, or both. These people may be just as much in need of treatment as someone with a full-blown diagnosis. Also, PTSD and its symptoms are easily mistaken for other disorders, such as BPD and depressive disorders (especially MDD). Although the person may not meet sufficient criteria for PTSD, he or she may have traumatic stress reactions that need to be addressed. Subclinical traumatic stress reactions are more commonly expressed through depressive symptoms. **Do not assume that just because someone does not have a PTSD diagnosis that he or she is not in need of trauma-informed care.**

34 percent; two traumas, by 50 percent; three traumas, by 70 percent; and four traumas, by 217 percent. Emotional and physical abuse nearly doubled the risk of injection drug use.

Prevalence

Traumatic events are common in people with CODs in part because they are so widely prevalent in the general population. Almost 90 percent of people in the United States have a lifetime history of exposure to at least one traumatizing event, typically the death of family/close friend because of violence/accident/disaster; physical or sexual assault; disaster; or accident/fire (Kilpatrick et al., 2013).

Trauma and CODs

As noted in the section "PTSD," **trauma in people with addiction, mental illness, or both is the norm rather than the exception** (SAMHSA, 2014b). In more than 600 people receiving SUD treatment, 49 percent reported a lifetime history of physical or sexual abuse, and women were 5 times more likely than men to report lifetime trauma (Keyser-Marcus et al., 2015). In people with SMI, trauma exposure is common, with prevalence rates ranging from 25 percent to 72 percent for physical abuse, 24 percent to 49 percent for sexual abuse, and 20 percent to 47 percent for PTSD (Mauritz, Goossens, Draijer, & van Achterberg, 2013). Twelve-month or lifetime rates of DSM-5 drug use disorder (i.e., an SUD excluding alcohol) carries increased odds of having PTSD (Grant et al., 2016), and 12-month or lifetime PTSD increases the odds of having a past-year or lifetime SUD (Goldstein et al., 2016).

Adverse life experiences are highly coincident with SUDs and mental disorders, and vice versa:

- Current PTSD prevalence in addiction populations is likely 15 percent to 42 percent (Vujanovic et al., 2016).
- In active duty military personnel, prevalence rates of various comorbid mental disorders and SUDs in people with PTSD have been estimated at 49 percent for depressive disorders, 36

percent for GAD, and almost 27 percent for AUD (Walter, Levine, Highfill-McRoy, Navarro, & Thomsen, 2018).

- Among a sample of U.S. adults with any lifetime trauma, 47 percent screened positive for PTSD, almost 47 percent for GAD, and 42 percent for depression (Ghafoori, Barragan, & Palinkas, 2014).
- Between 28 percent and 43 percent of people with PTSD have an SMI (Lu et al., 2013).
- People with past-year or lifetime PTSD are at significant risk of developing any number of comorbid mental disorders, including any mood disorder (2.4 to 3 times the odds), bipolar I disorder (2.1 to 2.2 times), any anxiety disorder (2.6 to 2.8 times), GAD (2 to 2.2 times), panic disorder (2.1 times), and BPD (2.8 to 3.3 times) (Goldstein et al., 2016).
- People with adverse childhood events (e.g., abuse, neglect) are more likely to report lifetime drug use, past-year moderate-to-heavy alcohol use, lifetime suicide attempt, and past-year depressed mood than people without such a history (Merrick et al., 2017). Emotional abuse in childhood is linked with 6 times the odds for a lifetime suicide attempt (Merrick et al., 2017).

Trauma-Informed Treatment of CODs

Historically, trauma has not been adequately addressed in SUD treatment, given provider fear that doing so would worsen mental and addiction problems. However, research indicates the opposite—that **failing to address trauma in people with SUDs leads to worse outcomes** (Brown, Harris, & Fallot, 2013).

Trauma-informed care means attending to trauma-related symptoms and also creating a treatment environment that is responsive to the unique needs of individuals with histories of trauma. Treatment is focused on reducing specific symptoms and restoring functioning but also broader goals like building resiliency, reestablishing trust, preventing retraumatization, and offering hope for the future. Creating a supportive, safe treatment environment is crucial. Counselors must realize how the setting and their interactions with clients who have trauma can affect treatment adherence, retention, and outcomes.

Trauma-informed care for people with mental disorders, SUDs, or both often includes (SAMHSA, 2014b):

- Psychoeducation, especially about the relationship between trauma, mental health, and addiction. Psychoeducation is also needed to help normalize symptoms and reassure clients that their experiences are not unusual, "wrong," or "bad."
- Teaching coping and problem-solving skills to foster effective stress management.
- Discussing retraumatization and developing strategies to prevent further victimization.
- Helping clients feel empowered and in control of their lives.
- Establishing a sense of safety in clients' daily lives and in treatment.
- Promoting resilience and offering hope for change and improvement.
- Identifying and responding adaptatively to triggers, like intrusive thoughts, feelings, and sensations.
- Building a therapeutic alliance, which fosters trust, confidence, and self-worth—all keys to healing.
- Using trauma-specific interventions, like:
  - CBT.
  - Cognitive processing therapy.
  - Exposure therapy.
  - Eye movement desensitization/reprocessing.
  - Affective regulation.
  - Distress tolerance and stress inoculation.
  - Peer support services from other people who have a trauma history and are thriving.

TIP 57, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA, 2014b) and SAMHSA's "Concept of Trauma and Guidance for a Trauma-Informed Approach" (SAMHSA, 2014c) will help addiction and mental health professionals tailor their services in a way that is respectful of and sensitive to clients' trauma-related needs. Chapter 6 discusses adapting treatments for CODs to female clients with trauma.

ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH TRAUMA

- Clients need not only to feel safe in the treatment environment, but also to feel safe from their trauma symptoms, many of which are intrusive, overwhelming, and distressing.
- Ensure interventions/interactions do not distress or traumatize clients. Avoid:
  - Being overly confrontational or argumentative with clients.
  - Discounting and dismissing clients' experiences and feelings.
  - Minimizing or ignoring clients' responses and needs.
  - Pushing clients to talk in greater detail about their trauma.
  - Violating clients' physical boundaries.
- Educate clients about the link between trauma and mental disorders, SUDs, or both.
- Normalize clients' reactions and feelings; this helps validate their experiences and offers a sense of relief.
- Help clients identify triggers and learn more adaptive ways to cope and respond to them. This reduces maladaptive distress management strategies like substance use, self-injurious behaviors, and avoidance.
- Although trauma is an important focus of treatment, it does not need to be the sole focus. In fact, constantly focusing on the trauma can be overwhelming and emotionally draining for clients.
- Include specific SUD treatment approaches and techniques to address addiction symptoms.
- Use an integrated trauma and SUD recovery model that fully addresses mental and substance-related needs.
- Explore with clients their readiness for change using the Stages of Change Model. This aids treatment matching, fosters better adherence/completion rates, and increases clients' chances for long-term recovery.

Special Considerations: Trauma and Military Personnel

Active duty and veteran members of the military are highly susceptible to trauma and all of its deleterious aftereffects. PTSD prevalence is significantly higher than that of the general population and civilian clinical samples, including 9 percent among a sample of more than 4 million veterans in primary care settings (Trivedi et al., 2015), 23 percent among Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) veterans (Fulton et al., 2015), 21 percent in Gulf War veterans (Dursa, Barth, Schneiderman, & Bossarte, 2016), and 8.5 percent to 12.2 percent of Vietnam War veterans (Marmar et al., 2015).

About 20 percent of veterans have CODs (Trivedi et al., 2015); 16 percent have PTSD and SUDs specifically (Mansfield, Greenbaum, Schaper, Banducci, & Rosen, 2017). In a sample of (OEF/OIF) veterans, 63 percent of people with SUD also had PTSD (Seal et al., 2011). Other common mental disorders in this population include SMI, depression, and anxiety; all tend to co-occur often (Exhibit 4.20). These illnesses are linked with increased hospitalizations, ED use, and mortality, with SMI and SUDs being particularly damaging (Trivedi et al., 2015).

Many veterans seek treatment outside of the Veterans Health Administration, so community addiction counselors should prepare to work with them. **Counseling veteran or active duty military populations requires a slightly different knowledge base, clinical approach, and skillset than civilian populations.** SUD counselors should note that (Briggs & Reneson, 2010; Teeters, Lancaster, Brown, & Back, 2017):

- War zone stress reactions often require specialized care and an understanding of the experiences faced by soldiers in combat.

EXHIBIT 4.20. Veterans and CODs

COMORBID MENTAL ILLNESSES	**SUD**	21.9 percent	23.2 percent	22.1 percent	29.0 percent	—
	SMI	8.8 percent	8.0 percent	10.2 percent	—	12.8 percent
	Anxiety	13.9 percent	19.4 percent	—	13.3 percent	12.7 percent
	Depression	48.1 percent	—	55.0 percent	29.5 percent	37.8 percent
	PTSD	—	33.2 percent	27.1 percent	22.4 percent	24.6 percent
	Specific Disorder	**PTSD**	**Depression**	**Anxiety**	**SMI**	**SUD**
	PRIMARY MENTAL ILLNESS					

Source: Trivedi et al. (2015).

- Military-related trauma exposure does not include only direct combat. For instance, people working in intelligence gathering and medical personnel are often deployed to war zones where they witness horrific acts of violence and are potential targets of violence themselves.
- Female veterans often have specific service needs, such as those to address military sexual trauma (e.g., sexual assault, harassment), intimate partner violence, and child care. (Note that men also can be victims of military sexual trauma, albeit at far lower rates than reported by women. Do not assume that military sexual trauma is solely a women's issue.)
- Many veterans are hesitant to seek SUD treatment or mental health services because of fear that doing so could negatively affect their career advancement. Concerns about confidentiality are thus understandably very high in these clients.
- Shame, embarrassment, and stigma over mental health and addiction are prominent. Military culture fosters some behaviors and mindsets that can be adaptive in combat—like independence, being "masculine," and not showing "weakness"—but make seeking treatment much harder.
- Suicide risk is high in veterans. It requires active monitoring and management throughout treatment, particularly for military personnel with childhood trauma, PTSD, military sexual trauma, or depression (Carroll, Currier, McCormick, & Drescher, 2017; Cunningham et al., 2017; Kimerling, Makin-Byrd, Louzon, Ignacio, & McCarthy, 2016; McKinney, Hirsch, & Britton, 2017; Pompili et al., 2013).

Indepth discussions about prevention programming and treatment for military populations with trauma, suicide risk, SUDs, mental disorders, or a combination thereof is beyond the scope of this TIP. However, ample information is available elsewhere. The following resources offer helpful guidance about working with military professionals who engage in substance misuse or have mental illness, including trauma, suicidality, and CODs:

- ACA:
  - *Suicide Among Veterans and the Implications for Counselors* (www.counseling.org/docs/default-source/vistas/suicide-among-veterans-and-the-implications-for-counselors.pdf?sfvrsn=3803a659_11)
  - *Comparison of Civilian Trauma and Combat Trauma* (https://pdfs.semanticscholar.org/eff2/8af43d3feaac7bac3cc5bb789bd4d5f100ec.pdf)
  - *Counseling Addicted Veterans: What to Know and How to Help* (https://pdfs.semanticscholar.org/9742/967aac815ca02c4f599b36be996d0b10d3d9.pdf)
- The Department of Veterans Affairs' National Center for PTSD (www.ptsd.va.gov/):
  - *Practice Recommendations for Treatment of Veterans with Comorbid Substance Use Disorder and Posttraumatic Stress Disorder* (www.mentalhealth.va.gov/providers/sud/docs/SUD_PTSD_Practice_Recommendations.pdf)

  - Veteran Outreach Toolkit: Preventing Veteran Suicide Is Everyone's Business (www.va.gov/ve/docs/outreachToolkitPreventingVeteranSuicideIsEveryonesBusiness.pdf)
  - *National Strategy for Preventing Veteran Suicide, 2018–2028* (www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf)

- SAMHSA's *Addressing the Substance Use Disorder Service Needs of Returning Veterans and Their Families* (www.samhsa.gov/sites/default/files/veterans_report.pdf)
- Community Anti-Drug Coalitions of America's Strategies for *Addressing Substance Abuse in Veteran Populations* (www.cadca.org/sites/default/files/mckesson_toolkit_1.pdf)

Conclusion

The material in this chapter is intended to increase SUD treatment counselors' and other providers' familiarity with mental disorders terminology and criteria, as well as to provide advice on how to proceed with clients who demonstrate these disorders. The consensus panel encourages counselors to continue to increase their understanding of mental disorders by using the resource material referenced in each section (and in Appendix C), attending courses and conferences in these areas, and engaging in dialog with mental health professionals who are involved in treatment. At the same time, the panel urges continued work to develop improved treatment approaches that address substance use in combination with specific mental disorders, as well as better translation of that work to make it more accessible to the SUD treatment field.

Substance Use Disorder Treatment for People With Co-Occurring Disorders

UPDATED 2020

TREATMENT IMPROVEMENT PROTOCOL

TIP 42

SAMHSA
Substance Abuse and Mental Health Services Administration

SAMHSA Publication No. PEP20-02-01-004
Published 2020

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