Assessment and Diagnosis of the Substance Use Disorders (SUDs)

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The Diagnostic and Statistical Manual of Mental Disorders, *fourth edition* (DSM-IV; *American Psychiatric Association, 1994) provides counselors with an updated method for diagnosing Substance Use Disorders (SUDs). In this article, the author presents information that demonstrates the need for all counselors to be knowledgeable concerning the SUDs and examines the essential features of the SUDs and the use of the* DSM-IV *in their diagnosis. A review of select instruments and techniques for assessment of the SUDs is presented.*

It is estimated that approximately 30% of the population will have a diagnosable Substance Use Disorder (SUD) in their lifetime (Califano, 1992; Moore et al., 1989). The National Institute on Drug Abuse (1990) estimates that there are 5.3 million people with a diagnosable drug problem of abuse or dependence at any given point in time. The Institute also estimates that only 15% of the people in need of clinical intervention for SUD ever receive it.

The lifetime prevalence rates of other mental disorders among persons diagnosed with SUDs range from 75% to 85% (Ball & Kosten, 1994). Also, the symptoms of withdrawal and intoxication for many substances mimic the symptoms of other mental disorders. Therefore, it is important for the clinician to be able to distinguish between symptoms from SUDs and symptoms attributable to Substance-Related Disorders, to other mental disorders, or to a combination of both. Failure to make this distinction can result in misdiagnosis and poor treatment planning (Rounsaville & Kranzler, 1989).

Also, the far-reaching consequences of undiagnosed or misdiagnosed SUDs can be extrapolated from the following facts. There are approximately 6 million children from homes where SUD is diagnosable in one or both parents (Buwick, Martin, & Martin, 1988). Fifty-four percent of state prison inmates had a diagnosable Substance-related Disorder at the time of their crime (United States Department of Justice, 1991), and 89% of the supported reports of child abuse for children under 1 year of age involve families with substance abuse problems (Kowal, 1990). Deaths from SUDs in the United States include 350 per day from nicotine dependence and related complications, 150 per day from alcohol abuse and dependence, and 15 or more per day from all other drugs combined. The estimated cost to society of the substance-related disorders is $510 billion per year, which exceeds the entire U.S. deficit (Schwarz, 1993).

Finally, if over 30% of the general population suffers from a SUD, as indicated by Califano (1992) and Moore et al. (1989), and there is a high prevalence of concomitant mental disorders among these persons, as indicated by Ball and Kosten (1994), it follows that a high percentage of clients have some connection with a SUD. However, these clients often do not identify the SUD as the major presenting problem. It is obvious that counselors need to be knowledgeable about the assessment and diagnosis of the SUDs regardless of counselors' employment setting (Griffin, 1991).

A BRIEF HISTORY OF THE SUDS IN THE *DSMS*

The historical development of the *Diagnostic and Statistical Manual of Mental Disorders,* fourth edition *(DSM-IV;* APA, 1994*)* can be traced from the publication of the *DSM* (APA, 1952) to the publication of the *DSM-II* (APA, 1968), *DSM-III* (APA, 1980), and *DSM-III-R* (APA, 1987). The *DSM-I* includes criteria for two categories of SUDs: Alcoholism (addiction) and Drug Addiction. These categories were classified as types of "sociopathic personality disorders." The *DSM-II* provides subdivisions for specific substances, but does not differentiate between abuse and dependence and classified the disorders under the broad category of Personality Disorders. The *DSM-II* also states that alcoholism could be due to another mental disorder. Placing the SUDs in a personality disorder category and stating that they may be caused by other mental disorders are examples of how the diagnostic criteria for this group of disorders was sensitive to the generally accepted public and

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professional opinions concerning etiology. In a move to be more objective, subsequent *DSM*s do not advance theories concerning the etiology of the SUDs. This is most evident in the objectivity demonstrated in the *DSM-IV*.

The *DSM-III* and *DSM-III-R* continue the move toward more specific classes of substances and the effects of specific drugs within these classes. The use of more precise criteria for dependence and abuse, within a class of substance, is also introduced in the *DSM-III*. The addition of specifiers in 1980 and the increase in the number of specifiers in the *DSM-IV* has improved the accuracy of the multiaxial system for diagnosing the SUDs.

THE *DSM-IV* DIAGNOSIS OF THE SUDS

The *DSM-IV* divides the Substance-Related Disorders into two groups: SUDs and Substance-Induced Disorders. A change from *DSM-III* and *DSM-III-R* is that the *DSM-IV* includes the criteria for the Substance-Induced Disorders in the sections of the manual where disorders that share phenomenology appear (e.g., Substance-Induced Mood Disorder is included in the "Mood Disorders" section). The name and code for these diagnoses, along with a reference to the page where the description and criteria appear, can be found near the beginning of the information about each drug class.

The SUDs section provides the criteria sets for the various disorders that are common among all classes of substances, followed by sections covering the associated features; culture, age, and gender features; course; impairment and complications; familial pattern; differential diagnosis; and recording procedures. Finally, the specific aspects of dependence, abuse, intoxication, and withdrawal unique to each substance class are reviewed. Due to the prevalence of other mental disorders among persons diagnosed with SUDs, and to the similar symptomatologies of these disorders, counselors should review the differential diagnosis sections of *DSM-IV* for dependence and abuse for different substances. Counselors should also be familiar with the symptoms of the Substance-Induced Mental Disorders as well as the symptoms presented in the Psychoactive Substance-Induced Disorders decision trees (APA, 1994, Appendix A, pp. 692–693) to differentiate between these disorders and make appropriate diagnoses.

SUBSTANCE DEPENDENCE

The *DSM-IV* describes Substance Dependence in terms of the symptoms presented in three realms of functioning: cognitive, behavioral, and physiological. These symptoms are the result of the individual's continued use despite significant substance-related problems. There also must be a pattern of repeated self-administration usually resulting in tolerance, withdrawal, and compulsive drug-taking behavior, and the diagnosis requires that three or more of the symptoms occur concurrently at any time in the same 12-month period. Craving is defined as a strong subjective drive to use the substance and is present in most individuals suffering from Substance Dependence. Eleven classes of substances, as well as the classes Polysubstance Dependence and Other, or Unknown Substance-Related Disorder, are used to account for all substances for which diagnoses are available. Dependence can be applied to all of these substances except caffeine, and abuse can be applied to all except nicotine and caffeine (caffeine is only associated with Substance-Induced Disorders diagnoses). A chart has been included in the *DSM-IV* (APA, 1994, p. 177) to indicate which diagnoses are associated with each class of substance.

Counselors also must familiarize themselves with the criteria for Polysubstance Dependence because many clients who present for treatment are not "pure" alcoholics or faithful to a particular class of substance. Clients who use at least three substances, and whose use of those substances meets the criteria for dependence as a group but not for any particular substance, receive this diagnosis.

It is specifically noted in the *DSM-IV* that neither tolerance nor withdrawal is necessary or sufficient for a diagnosis of Substance Dependence. Understanding this concept is important because the pharmacology of different drugs, the physiology of different people, and the combination of pharmacology and physiology can cause dependence to manifest itself differently in different individuals (Inaba & Cohen, 1989).

DSM-IV uses two specifiers to indicate the presence or absence of tolerance or withdrawal. The presence of either tolerance or withdrawal may require medical intervention for the purpose of stabilizing the individual during detoxification. The specifiers "With Physiological Dependence" and "Without Physiological Dependence" are used with the diagnosis of Substance Dependence to communicate this vital information.

There are six course specifiers that can be used with the diagnosis of Substance Dependence. Four of these can be used to indicate a level of remission of the disorder and can only be used after no symptoms of dependence or abuse have been present for 1 month. These specifiers are "Early Full Remission," "Early Partial Remission," "Sustained Full Remission," and "Sustained Partial Remission."

Each of these specifiers requires different periods of symptom remission before they can be applied. The use of a period of symptom remission versus a period of abstinence as the criteria for the remission specifiers permits the client to use substances and still receive a diagnosis with a remission specifier. Clients presenting with a history of SUDs with remission specifiers attached will need to be questioned explicitly concerning the presence of substance use during the period of time a disorder was determined to be in remission.

The course specifier "On Agonist Therapy" is used in the *DSM-IV* to indicate that the client is receiving medication therapy using one of two different types of substances. The first of these is agonist therapy, which refers to a medication whose effects mimic the action of the substance the client

was using. The agonist also is often addictive, and symptoms of intoxication, tolerance, and withdrawal may be present. An example of agonist therapy is methadone treatment for opiate dependence. A partial agonist may sometimes be used in this type of treatment. The partial agonist is a substance that is incapable of producing the maximal effect of an agonist and therefore may produce less severe intoxication, withdrawal, and tolerance. The criteria for Substance Dependence or Substance Abuse for the medication must not have been met for the past month in order for this specifier to be used. This specifier ("On Agonist Therapy") is also used if the client is receiving a substance called an antagonist. An antagonist is a medication that blocks the effects of the substance the client is using. If the client uses the substance while the antagonist is present in the system, no effect will occur. An example of this is the use of naltrexone, which blocks the effects of opioids if the client uses them while the medication is in the system. Naltrexone is also used in the management of opioid overdose.

Sometimes a combination of agonist and antagonist substances are used as a component of the treatment of SUDs. Agonist/antagonist therapy uses a combination of these medications. The agonist is used first to control the quality and dosage of the drug. The rationale for this is that there is no way to control the quality of the drug a person is buying on the street or to control the dosage of a drug being self-administered. When the dosage and quality are stabilized, the second phase of this treatment can begin. The antagonist is introduced in hopes of allowing the client to remain drug-free long enough to begin making the life changes necessary for long-term recovery.

The remaining course specifier used in the *DSM-IV* is "In a Controlled Environment." This specifier is used when no criteria for Substance Abuse or Substance Dependence have been met for the last month and the client has been in an environment where alcohol and other drug access is restricted. Environments such as a prison, hospital, or residential drug treatment program are considered to have restricted access. To indicate that the client is improving, the "Early Remission" specifier can be used when a period of one month has elapsed after (a) discontinuation of agonist and/or antagonist medication, (b) after the individual is released from a controlled environment, or (c) both. The criteria for Substance Dependence or Substance Abuse must be absent during that month.

Substance Abuse

Substance Abuse is a less pervasive disorder than Substance Dependence and its diagnosis requires fewer, less severe criteria to be met. Viewed on a continuum, Substance Abuse precedes Substance Dependence, although it is not necessary for a person to have been diagnosed with Substance Abuse prior to receiving the diagnosis of Substance Dependence. Some individuals are prone to dependence and move rapidly from initial use to dependence. Certain drugs produce dependence more rapidly than others, which can cause the period of abuse to be short or nonexistent (*DSM-IV*).

The *DSM-IV* states that the Substance Abuse diagnosis is more likely to occur in individuals who have recently started using a substance. It also acknowledges that there are individuals who continue using at the level of Substance Abuse for long periods without developing Substance Dependence. The diagnosis of Substance Abuse does not apply to nicotine or caffeine.

Substance Abuse is defined as a maladaptive pattern of substance use that causes "impairment or distress" in one of the major realms of functioning and has occurred in the last 12 months. These realms include the social, the physical, the legal, and the vocational or educational realms. Also, recurrent use when it is physically hazardous is considered a part of the criteria. The criteria for Substance Abuse do not include tolerance, withdrawal, or the compulsive use associated with Substance Dependence. The clinician is required to gather information in a manner that distinguishes Substance Abuse from Substance Dependence.

Other areas of the *DSM-IV* with which counselors should be familiar to facilitate the identification of SUDs are the proper recording procedures (APA, 1994, p. 187); the decision trees in Appendix A; and the E-codes, which are used when a substance is taken for medicinal purposes, in Appendix G (APA, 1994, p. 813). Another important area of the *DSM-IV* counselors should know is the proper use of "Other (or Unknown) Substance-Related Disorders"—used for those not covered by the 11 classes but which have psychoactive effects (e.g., antibiotics, plant substances, unlabeled bottle of pills), and "Not Otherwise Specified"—used when there is incomplete data or uncertainty about etiology, when the presentation meets the criteria for a disorder under study listed in Appendix B (APA, 1994, p. 703), or when the presentation is of clinical significance but does not meet the general guidelines for diagnosis.

The Diagnostic Criteria Checklist shown in the Appendix of this article was developed to facilitate the gathering of the information needed to make a diagnosis of Substance Dependence or Substance Abuse. However, this checklist and many other assessment tools are not helpful unless the counselor has specific knowledge and skills that facilitate the assessment and diagnosis of the SUDs. Information about a select group of assessment instruments and techniques is presented in the next section.

ASSESSMENT OF THE SUDS

Assessment and diagnosis can best be described as processes that require participation from and interaction between the client and the counselor. The process begins with working together toward the goal of making a tentative diagnosis. The development of a working diagnosis is critical to the client's receiving appropriate treatment and a relevant treatment plan at the earliest possible point in the intervention (Seligman, 1993).

Fong (1993) used a two-stage model for teaching assessment and diagnosis. This model is generic and useful in con-

ceptualizing the skills needed to diagnose the SUDs. The first stage is Assessment and Data Gathering.

The skills needed for this stage are "behavioral observation, intake interviewing," and the ability to complete a "mental status exam" (Fong, 1993, p. 279). The counselor may also use several SUD-specific interview instruments in this stage.

Counselors are often responsible for taking the information gathered for an assessment and developing a treatment plan based on the individual client's needs. The information necessary for this individualized treatment plan can be gathered by clinical interviewing in conjunction with an assessment instrument that accounts for the setting in which the client is met. No single assessment instrument or interview should be used exclusively to make the diagnosis of SUD (Allen & Litten, 1994; Griffin, 1991).

There are numerous instruments available for the assessment of SUDs, although measures for Alcohol Dependence and Alcohol Abuse far outnumber the instruments available for other drugs. Studies have shown some concurrent validity between different measuring instruments and methods, but it is not sufficient to justify the use of any one method or technique (Allen & Litten, 1994). The validity and reliability of the instruments used in diagnosis of SUDs varies widely (Ross, Swinson, Larkin, & Doumani, 1994), and counselors should be aware of these properties in any of the instruments they use. Caetano (1992) found that the words used to ask a question about a client's use of substances, whether written or verbal, had a significant impact on the answers. Counselors therefore should carefully review the questions in any instrument they use.

A common factor among all SUD assessment instruments that rely on information from the client is that they are relying on information from a person under duress. The counselor must remember that clients with SUDs are not always truthful. Using information from all available sources, including family, employers, coworkers, legal representatives, police, and probation officers will yield a diagnostic snapshot of the individual that can be confirmed with the use of various instruments.

Pencil-and-paper questionnaires, computer assessment programs, and interactive assessment instruments can be used to facilitate the gathering of information (Ross et al., 1994). The instruments reviewed in this article are compared in Table 1, and range from brief questionnaires of only three or four questions that require only minutes to be administered by someone with be no specialized training, to lengthy questionnaires of more than 150 questions that require 2 to 3 hours to administer and extensive specialized training for the administrator. Examples of brief instruments are the FOY (Family, Others, and You; Woodruff, Clayton, Cloniger, & Guze, 1976) and the CAGE (Cut down, Annoy others, feel Guilt and Eye opener [morning drink]; Mayfield, McLeod, & Hall, 1974). Examples of the more comprehensive instruments are the Structured Clinical Interview for *DSM-IV* Axis I Disorders (SCID-I, the revised version of the SCID for the *DSM-III-R*; Spitzer, Williams, Gibbon, & First, 1992) and the Addiction Severity Index (ASI; McClellan, Lubrorsky, Woody, & O'Brien, 1980).

Assessment Instruments

The SCID (Spitzer et al., 1992) is a semistructured interview designed to obtain Axis I and II diagnoses based on the *DSM-III-R* criteria. The publication of the *DSM-IV* has been followed by the development of the Structured Clinical Interview for *DSM-IV* Axis I Disorders: Clinician Version (SCID-CV; First, Gibbon, Williams, & Spitzer, 1995b). I was unable to locate any published literature concerning the updated version at the time of this writing.

A computer-administered version of the SCID, the SCID Screen Patient Questionnaire Computer Program (SCID Screen PQ; First, Gibbon, Williams, & Spitzer, 1995a) also is available. It takes about 25 minutes for the client to complete, and generates a report that includes diagnoses for the SUDs.

These instruments are to be administered and interpreted by clinicians (usually master's or doctoral level) who have undergone extensive training. Because the SCID instruments use the criteria-based symptomatology model to diagnose SUDs, they should be used in conjunction with an instrument that measures severity if the results are to be used for comprehensive treatment planning (Gastfriend, Najavitas, & Reif, 1994). Readers are advised to review the information on the *DSM-III-R* version (Spitzer, Williams, Gibbon, & First, 1989, 1992; Williams et al., 1992) and to review the literature on the *DSM-IV* version.

The Addiction Severity Index (ASI; McClellan et al., 1980) is an example of an interactive instrument that combines interviewing with standardized measurement techniques. The ASI is designed to be administered by a trained clinician, and gathers information about the specific amounts of alcohol and other drugs clients have used in the past 30 days and in their lifetime. In addition, the ASI assesses the past and present functioning of the client in the following areas: medical, employment or school, legal, family history, family/social relationships, and psychiatric.

The ASI is successful in assessing dependence despite the multidimensional nature of severity. As discussed earlier, because dependence manifests itself differently among individuals, the ability to diagnose dependence in its varied presentations is quite important. An example is the binge cocaine addict versus the regular use cocaine addict. Both have symptoms that qualify them for the diagnosis of dependence, but only an instrument that includes assessment of the severity of the problems caused by the substance use (as opposed to only the amount or frequency of use) will render the appropriate diagnosis. The ASI includes this comprehensive assessment.

Assessment instruments for specific substances are available and can be used when the clinician has determined which substance is being used. These instruments can also combine data-gathering on other substances with an emphasis on the particular substance of interest, or they can assess severity of addiction exclusively on the particular substance. The Cocaine Addiction Severity Test (CAST;

TABLE 1

Substance Use Disorders Assessment Instruments

Instrument (with Citation)	Purpose	Format	Administration Time	Administrator	Number of Items
Family, Others, and You (FOY; Woodruff et al., 1976)	Diagnose alcohol dependence	Structured interview	Under 15 minutes	Clinician	3
Cut down, Annoy others, Feel guilt, and Eye opener [morning drink] (CAGE; Mayfield et al., 1974)	Diagnose alcohol dependence	Structured interview	Under 15 minutes	Clinician	4
Structured Clinical Interview for *DSM-IV* Screen Patient Questionnaire (SCID Screen-PQ; First et. al., 1995a)	Diagnose Axis I Disorders including the Substance Use Disorders	Computer-administered structured interview	25 minutes	Master's level or above clinician with relevant experience	76
Structured Clinical Interview for *DSM-IV* Axis I Disorders: Clinical Version (SCID-CV; First et al., 1995b)	Diagnose Axis I Disorders (separate modules for each of 6 disorder categories including the Substance Use Disorders)	Structured interview	45–90 minutes	Master's level or above clinician with relevant experience	Varies by client
Addiction Severity Index (ASI; McClellan et al., 1980)	Diagnose Substance Use Disorders and their severity	Structured interview	1–3 hours	Clinician trained in the ASI interview protocol	150
Cocaine Assessment Profile (CAP; Washton & Gold, 1987)	Diagnose cocaine abuse or cocaine dependence	Questionnaire or interview	30 minutes–1 hour	Clinician	28
The Cocaine Addiction Severity Test (CAST; Washton & Gold, 1987)	Assesses the severity of cocaine dependence	Questionnaire or interview	30 minutes–1 hour	Clinician	38
Michigan Alcoholism Screening Test (MAST; Selzer, 1971)	Diagnose alcohol dependence	Questionnaire or interview	15 minutes	Clinician	25
Short Michigan Alcoholism Screening Test (SMAST; Selzer et al., 1975)	Diagnose alcohol dependence	Questionnaire or interview	Under 15 minutes	Clinician	13
Brief Michigan Alcoholism Screening Test (BMAST; Porknoy et al., 1972)	Diagnose alcohol dependence	Questionnaire or interview	Under 15 minutes	Clinician	10

Watson and Gold, 1987) and the Cocaine Assessment Profile (CAP; Washton & Gold, 1987) are examples of these types of instruments.

The CAP (Washton & Gold, 1987) is a questionnaire that is designed to be completed by the client. It consists of three sections that assess the frequency, quantity, setting, and effects (physical, legal, financial, social, psychological, and vocational) of cocaine use. The CAP also assesses the client's current and past involvement with other substances and prescription medication. Finally, the questionnaire requests information on past treatment.

The CAST (Washton & Gold, 1987) is a questionnaire that does not assess dependence, but which can be used to determine severity of dependence after it has been diagnosed using other methods. It consists of 38 questions with yes or no answers. The higher the number of affirmative responses, the greater the severity of the addiction.

The Michigan Alcoholism Screening Test (MAST; Selzer, 1971) consists of 25 questions with *yes* or *no* answers. It was one of the first alcoholism assessment instruments to be developed and is still the most widely used (Brostoff, 1994). Shorter versions have been developed over the years and their validity and reliability have been demonstrated. Among these are the Short MAST (SMAST; Selzer, Vinokur, & van Rooijen, 1975), which consists of 13 questions from the original, and the Brief MAST (BMAST; Porknoy, Byron, & Kaplan, 1972), which uses 10 questions from the original.

The CAGE uses only four questions from the MAST. Three of the questions deal with the emotional reactions of the drinker and the other asks about drinking to relieve withdrawal (morning drinking). The CAGE is particularly useful with clients seeking counseling or medical or psychiatric services. Two affirmative responses indicate the presence of Alcohol Dependence in most cases when used with this population.

The FOY (Woodruff et al., 1976) uses three extremely sensitive questions from the MAST relating to concern about the client's drinking expressed by family, others, or you [self]. One or two positive responses indicate a high positive correlation with the presence of Alcohol Dependence. The FOY is particularly susceptible to the client's denial of the problem and, as with all instruments, is reliant upon the client's capacity to be honest. This further demonstrates the need to use more than one assessment instrument in conjunction with clinical interviewing to facilitate accurate diagnoses (Brostoff, 1994).

Some instruments do not generalize well to all settings or populations. The ASI (McClellan et al., 1980), for example, requires clients to discuss their most recent drug use. A client who is incarcerated where the admission of drug use might result in an extended sentence may be reluctant to give truthful answers to this type of question. The counselor needs to use assessment methods that will facilitate information gathering while being sensitive to the setting.

There are many instruments available to assist counselors in gathering the information needed to make the diagnosis of SUD. Reviews of these instruments can be found in the professional literature, and readers are directed to those sources for information. SUD assessment instruments are reviewed in *Buros Mental Measurement Yearbook* (Conoley & Impara, 1995). Other sources for information on SUDs assessment instruments include Benzer (1986), Miller (1991), Schuckit (1984), and the Substance Abuse and Mental Health Services Administration (1994).

Laboratory Tests

Allen and Litten (1994) stated that there are numerous medical, biochemical, and laboratory tests that can be performed to enhance the accuracy of diagnosing the SUDs. The most common of these are analyses of blood, urine, hair, and saliva for the presence of addictive substances. Some of these tests can determine the amount of substances present in the system, which can indicate severity, frequency of use, recency of use, and level of tolerance. Also, blood analysis can reveal damage to various systems that indicates the presence of SUDs. Results of laboratory tests can be recorded on Axis III of the *DSM-IV* multiaxial assessment.

As with the other assessment techniques, the administration and interpretation of these tests require varying degrees of training. These requirements range from minimal training for the use of a breathalyzer and some urine screening tests up to a medical degree for the interpretation of the results of certain blood tests and the identification of physical pathology (DuPont, 1994). Counselors should be aware of what tests are available, what the tests can show, and how to access these tests for their clients.

Counselors are often restricted in their use of instruments by work setting, data gathering requirements, funding source requirements, and licensure requirements. The use of instruments for information gathering does not relieve the counselor of the responsibility of interviewing the client and the client's significant others, if they are available. The interview is one of the most powerful assessment techniques for persons with SUDs (Griffin, 1991).

Assessment Interviewing Techniques

The need for accurate information to make a diagnosis of SUD requires that the counselor gather data from a client who is usually under duress and often not very trusting. To facilitate gathering the information, counselors will need to pay close attention to how they ask questions. Counselors should avoid the use of terms with negative connotations. Instead of asking "Have you ever had a blackout?" more information can often be gathered by using a less threatening reframe such as "Have you ever forgotten things you have done while drinking?" or "Have you had difficulty recalling what you did at a party?"

Counselors also should be aware that many persons who are "exclusively" alcoholics and those who are prescription drug addicts will not respond affirmatively to the question "Have you ever used drugs?" As part of their defense mechanism, these clients may believe that they do not use drugs. Alcoholics will often admit to using "nerve pills" to get through the day at work. Prescription drug addicts will often respond to questions about the type and amount of "medicine" they are taking.

While interviewing the client the counselor should be aware of behavioral characteristics, especially body language, and the client's level of agitation. Clients with SUDs have developed conditioned responses elicited by talking about substances, thinking about substances, seeing substances, and seeing paraphernalia for using substances. Involuntary behavioral manifestations that can help the counselor determine what line of questioning to pursue are often demonstrated in the interview. An example of this might occur with a client who uses substances intravenously (IV) but is not revealing this in the interview. The counselor can often elicit behavioral changes in the client that suggest IV use by discussing the act of IV drug use. These behavioral changes might include an increase in agitation, fidgeting, flushing of the face, and loss of eye contact while listening to the discussion.

If the counselor suspects involvement with a particular type of substance or route of administration but the client is not divulging this information, the following technique can be used. Have the client describe someone else's use and watch for the behavioral changes mentioned above. Encouraging the client to describe another person's use in explicit detail may produce the behavioral changes. Asking the client to notice the changes that have occurred and then discussing why these changes appeared could help the client be more honest.

SPECIAL KNOWLEDGE, SKILLS, AND CONSIDERATIONS

Counselors should have a basic understanding of the 11 classes of substances, what the effects of these substances are, and how they cause their effects. Included in this knowl-

edge is information about physical and behavioral tolerance, cross-tolerance, and synergism. As referred to previously, not all drugs have the same effect on all people. This complex concept is demonstrated by clients who have reported stimulant effects from their use of depressants. Another example is the commonly reported occurrence of two persons smoking the same amount of the same marijuana. One person experiences a stimulant effect, whereas the other experiences a depressant effect.

These differences are mostly due to the differences in biological makeup between individuals and the resulting differing susceptibility to a particular substance. Other factors include the pharmacological properties of the drug, the amount of the drug taken, frequency of use, how the substance is introduced into the system (route of administration), and what combination of substances are used. The final considerations are the user's past experiences with substances, the user's expectations concerning the use of the substance, and the set and setting in which the substance is used.

The qualities and skills of the counselor that are generic to any counseling relationship also must be present in the counselor working with persons diagnosed with SUDs. Included here are the abilities to be direct in questioning and confronting, to self-disclose appropriately, to clarify, to be aware of countertransference, and to be aware of the effects one's own beliefs may have on the counseling relationship. The qualities that are necessary for the counselor to possess include empathy, genuineness, warmth, and nonjudgmental acceptance (Lewis, Dana & Blevins, 1988; Powell, 1980, 1989).

Persons diagnosed with a SUD have developed various and complex coping mechanisms to continue to function despite the psychic pain their situation causes them. The most frequently occurring manifestations of these mechanisms are denial, rationalization, justification, and minimization. Although these coping mechanisms are healthy and serve a purpose in the nonafflicted individual, in the person with an SUD they are used repeatedly, in every situation, and to the exclusion of the other defense mechanisms (Griffin, 1991).

Counselors must be careful not to let the client's defenses cause frustration and anger, and must not mistake the client's inability to accept responsibility as purposeful resistance. The nature of SUDs and the associated stigma increase the likelihood that the client will not be truthful with the counselor. The client may also be argumentative and attack the counselor verbally in an attempt to divert attention. It is important that counselors receive appropriate clinical supervision when working with the SUD population. Studies have demonstrated that when working with this difficult population, counselors who receive adequate supervision are more satisfied with their jobs and less susceptible to burnout than counselors who do not (Evans & Hohenshil, 1997; Powell, 1989).

Benzer (1986) pointed out that all clients presenting for treatment of an SUD are presenting under duress. This duress may be caused by their inability to change their behavior, their deteriorating health, the courts, family, work or school, or any combination of these. Because of this and because of the defenses used by clients, they are often only available for intervention for a short period before they slip back into the comfort of active use. It is therefore imperative that intervention take place at the time the client presents, and that it is carried out to a conclusion before the client's defenses reemerge. Counselors should know what resources are available for clients with SUDs and the most expedient way to facilitate treatment.

The family history of the client may reveal a history of SUDs and concomitant mental disorders. A genetic factor for transmission of SUDs does exist, but it is only part of the complex puzzle that, when complete, gives the clinician a better picture of the client (U.S. Department of Health and Human Services, 1990). The clinician must look at the pharmacological and physiological properties that determine the substances' effects as well as environmental and sociocultural factors. Although information about these factors is not required for the diagnosis of SUDs, they are necessary for formulation of appropriate treatment planning.

The client's social and relationship history also will reveal information about the presence or progression of SUD. Employment history, military history, and any history of involvement with the criminal justice system are all important factors to consider when assessing the client's situation. The collaboration of any information from the client by family members, employers, legal authorities, or other concerned individuals should be taken into account (Griffin, 1991).

The counselor must also get a physical history from the client. This history may reveal general medical conditions relevant to the client's treatment and should be recorded on Axis III of the *DSM-IV* multiaxial assessment. The results of drug screens and toxicology reports can also be placed on Axis III. A detailed physical history does not relieve the counselor of the responsibility to have the client assessed by medical professionals. A full physical examination by qualified medical personnel is the best way for the client's current medical status to be determined.

Correctly diagnosing SUDs at the earliest possible point in the course of the disorder greatly improves the prognosis for the client. Problems that seem to be inextricably enmeshed with the SUD usually cannot be addressed alone. The fact that the symptoms of withdrawal and intoxication for many substances mimic the symptoms for other mental disorders underscores the need for treating the SUD first, or at least concurrently with other disorders (Ross et al., 1994; Schuckit, 1984). The use of medical toxicology reports, including analyses of blood, urine, hair, and breath concentrations of substances, will be useful in diagnosis and in indicating a tolerance level (DuPont, 1994).

Counselors need to be appropriately supervised as they develop the skills necessary for diagnostic interviewing. A counselor's bias, lack of knowledge, or misinformation can show in the interview process. Clients will often attempt either to educate the counselor concerning drugs or to mis-

inform the counselor. Persons with SUDs may also try to focus attention on counselors and their drug use in an attempt to escape an uncomfortable situation.

CONCLUSION

The assessment, diagnosis, and treatment of SUDs require counselors to possess not only general counseling skills and abilities, but specialized skills and abilities relative to this population. Knowledge of assessment instruments and techniques that facilitate the making of a *DSM-IV* (APA, 1994) diagnosis is necessary for the counselor to communicate with other professionals and make treatment recommendations. The proper use of supervision will greatly enhance the counselors' effectiveness and comfort when working with this population. Accurate diagnosis at the earliest possible point in the counseling relationship greatly improves the prognosis for the client.

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APPENDIX

DSM-1V Diagnostic Criteria Checklist

DSM-IV (1994) Diagnostic Criteria Checklist

Substance Dependence Three or more of the following in the same 12 month period	Alcohol	Amphetamine	Caffeine	Cannabis	Cocaine	Hallucinogens	Inhalants	Nicotine	Opioids	Phencyclidine	Sedative/Hypnotics	Polysubstance	Other
(1) tolerance													
(2) withdrawal													
(3) use of more or longer than intended													
(4) desire to control or unsuccessful efforts to control													
(5) excessive time involvement													
(6) lifestyle change due to use													
(7) use continues knowing it causes other problems													
Dependence criteria met:													

If "yes" to either (1) or (2) use the specifier "with physiological dependence," if "no"to both use specifier "without physiological dependence."

Course specifiers:

Substance Abuse A. One or more of the following occurring in the same 12 month period:													
(1) failure to meet major role obligations (work, home, school) - recurrent													
(2) use interferes with safety - recurrent													
(3) substance related legal problems - recurrent													
(4) continued use knowing it causes problems													
B. Never met the criteria for Substance Dependence for this class of substance													
Abuse criteria met:													

Note. Adapted from the *Diagnostic and Statistical Manual of Mental Disorders,* 1994.