

CHAPTER 1

Assessment and Treatment of Clients with Substance Use Disorders

An Overview

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From the infant born to a woman addicted to narcotics to the elderly man with a history of alcohol use problems who needs nursing home care, the direct or indirect impact of substance use disorder is a major health and social problem affecting every segment of our society. It is encountered by social workers and other clinicians in all types of settings and requires every clinician to have some familiarity with the various psychoactive substances and the assessment and treatment needs of those who experience problems with them. The purpose of this chapter is to provide an overview of the impact of the excessive use of alcohol and other drugs on individuals and to discuss the issues related to clinical assessment and interventions with clients who have a drug or alcohol use disorder and their families.

Definition of Terms

Every day, millions of Americans use alcohol and other psychoactive substances; however, not everyone experiences a problem due to such use. It is therefore helpful to conceptualize alcohol and other drug (AOD) use as ranging on a continuum from nonproblematic experimental and social *use* to substance *misuse* (such as using pain medication to get high) to AOD *addiction* (which may require physical detoxification).

The earlier term of substance *abuse*, implying the excessive use of a substance that results in a negative impact on the life of the individual and those around him or her, has fallen out of favor among professionals since it was viewed as a stigmatized concept reflecting a moral judgment and, as discussed below, is no longer part of the official *Diagnostic and Statistical Manual of Mental Disorders* diagnostic criteria (National Institute on Drug Abuse [NIDA], 2021; Volkow et al., 2021). Nonetheless, this concept is often used as a catchall term for substance use–related problems.

One other change in terminology focuses on using *person-first language*, which emphasizes that individuals are more than their substance use and highlights their potential for recovery. Thus, a statement such as “a person with substance use disorder” indicates that the individual has a problem with substance use, rather than he or she “is” the problem (Volkow, 2020).

The potential for addiction of different substances varies greatly; for example, narcotics or crack cocaine have a much higher potential for addiction than alcohol or marijuana. Although alcohol is an addictive mood-altering drug, traditionally, due to a combination of political, historical, economic, and racial factors, *alcohol abuse* and *alcoholism* were viewed as distinct from, and more acceptable than, excessive use of or addiction to other drugs. Over time, despite the omission of alcohol from most “war on drugs” legislation and a historical separation of federal funding streams for alcohol and drug use research and programs, the line separating “alcoholism” from “drug abuse” programs had started to erode, and the treatment for people in both groups began to converge. According to the National Survey of Substance Abuse Treatment Services, by 2023 an estimated 7.5 million people receiving substance use treatment were in treatment for *both* drug and alcohol use disorders (Substance Abuse and Mental Health Services Administration, 2024a).

The change in client population led to a change in nomenclature as well as in the diagnostic criteria. The fourth edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published in 2000, used the term *substance-related disorders* (SRDs) to classify all disorders related to the problematic consequences of substance use. The SRD category was further divided into *substance use disorders* (SUDs), which included the criteria for diagnosing *substance abuse* and *substance dependence*, and *substance-induced disorders* (SIDs), which contained 10 disorders. As the term implies, SID included those disorders that are caused or *induced* by the use of a substance; these ranged from substance intoxication or withdrawal symptoms to substance-induced mood, anxiety, psychotic, or sleeping disorders. It was assumed that once a person stopped his or her use of or dependence on a substance, these SIDs would disappear within a relatively short time. Individuals whose psychiatric symptoms did not disappear over time were likely to receive additional diagnoses, variously referred to as coexisting, co-occurring, or comorbid—all of which referred to individuals who were

suffering from both major mental illness (including personality disorders) and had diagnosable problems due to their use of substances.

The Use of DSM-5 and DSM-5-TR Diagnostic Criteria

The previous terminology of *substance-related disorders* has been changed in DSM-5 and DSM-5-TR (American Psychiatric Association, 2013, 2022), to *substance use and addictive disorders* (SUADs) and includes an additional diagnosis of *gambling disorder*.¹ What is important to note, beyond the differences in numbering—moving from using Roman (*DSM-IV*) to Arabic numerals (*DSM-5*)—is the elimination of the diagnostic terms “substance abuse” and “substance dependence,” and the addition of a *severity index*, as discussed below.

The 10 substances included in DSM-5-TR are alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedative/hypnotics, stimulants, tobacco, and “other” (or “unknown”) substances. The DSM-5 also includes nine SIDs, which cover both physiological and psychiatric symptoms. They include substance-induced psychotic disorder; substance-induced bipolar and related disorder; substance-induced depressive disorder; substance-induced anxiety disorder; substance-induced obsessive–compulsive or related disorder; substance-induced sleep disorder; substance-induced sexual dysfunction; substance-induced delirium; and substance-induced neurocognitive disorder. Also included in this category are *substance-induced intoxication and withdrawal* symptoms that are specified for each substance class (e.g., alcohol intoxication, opiate withdrawal).

According to the current DSM, to diagnose an individual with SUD requires that he or she manifest two or more (out of 11) clinically significant impairments within the last 12 months. Such impairments reflect their loss of control over the use of a substance; impact on their social life, whether at home or work; reflect risky or dangerous use; and show pharmacological changes, such as an increase or decrease of tolerance and withdrawal symptoms. (For a full description of each of these criteria, see American Psychiatric Association, 2022.)

The DSM-IV criterion of recurrent substance-related legal problems, which was a part of the previous diagnosis of substance abuse, has been eliminated. What has been added is a *severity diagnosis* based on how many criteria the individual meets: no disorder (meeting 0–1 criteria), mild disorder (2–3), moderate disorder (4–5), or severe disorder (6 or more). The higher end of severity is equivalent to the previous DSM-IV “substance dependence” diagnosis.

The DSM-5 diagnosis of SUD uses one of six so-called course specifiers delineating the longer-term outcome of these disorders. These specifiers can only be

¹For a fuller discussion of the evolution of DSM terminology in relation to substance use disorders, see Straussner (2014).

given *after* the individual has completely stopped using a given substance for at least 3 *months* (a change from the DSM-IV requirement of 1 *month* of abstinence) and does not show any symptoms, with the exception of “craving.” The specifiers include *early full remission*, defined as being substance-free for more than 3 months but less than 12 months; *early partial remission*, whereby the individual resumes some use of a substance (colloquially referred to as having a “slip”) and subsequently exhibits some problematic symptoms within the first year of recovery; *sustained full remission*, defined as being totally substance-free for 12 months or more; and *sustained partial remission*, in which the individual resumes substance use after 12 months of not having any symptoms, and then meets at least one criterion related to SUAD. The two final specifiers are: *on maintenance therapy*, which refers to the use of agonist or antagonist medication to treat the substance of choice, such as using methadone as a replacement for the use of opiates; and *in a controlled environment*, indicating that the individual is not using a substance because he or she is living in a substance-free environment, such as a therapeutic community or a prison. Finally, each substance is diagnosed separately or has its own category of “disorder not elsewhere classified” (e.g., “opioid-induced disorder not elsewhere classified”). Since each substance has its own category, there is no diagnosis of “polysubstance” use disorder.

The most recent *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR), published in 2022, did not change any of the previous criteria for diagnosing SUDs. It does, however, include some minor changes related to documentation or billing language, recommended phrasing to use in diagnostic statements, and updated guidance on discussing social and cultural determinants of health, emphasizing how systemic inequities, discrimination, and differential access to care may play a role in the onset, recognition, and outcomes of substance-induced conditions (American Psychiatric Association, 2022).

The Scope of Problematic Substance Use

SUDs remain highly prevalent in the U.S. population. Due to changes in terminology, it is difficult to compare past and recent data regarding problematic use of substances. As indicated above, under DSM-5 and DSM-5-TR, the categories of *substance abuse* and *substance dependence* were combined into a single diagnosis: SUD classified by severity (mild, moderate, or severe). Most recent data indicate that approximately 17% of adults 18 years or older, totaling nearly 50 million people met the diagnostic criteria for a SUD in the past year (Substance Abuse and Mental Health Services Administration [SAMHSA], 2025a). As discussed below, the most common substance used is alcohol, with a similar number having a drug use disorder (around 28 million), which includes users of both licit (prescription) and illicit drugs, and about 1 in 6 people had *both* an alcohol and a drug use

disorder (16% or 7.7 million people). Outside of alcohol and nicotine, the most common substance use disorders were cannabis/marijuana (20.6 million), followed by opioid (4.8 million) and stimulant use disorder (4.3 million). Rates were disproportionately higher among younger adults, males, sexual minority groups, those with lower education or income, and among certain racial/ethnic groups, particularly among individuals from multiracial backgrounds (Ali et al., 2023).

It is estimated that more than 20 percent of all deaths in the United States are attributable to tobacco, alcohol, and other drug use (National Center for Drug Abuse Statistics, <https://drugabusestatistics.org>). In addition, the use of these substances contributes to more than 70 other conditions requiring medical care, including cancer, cardiovascular disease, HIV/AIDS, respiratory disease, cirrhosis, ulcers, pregnancy complications, and trauma (National Center on Addiction and Substance Abuse [CASA] at Columbia University, 2012). Other associated substance use-related social consequences include crime, accidents, suicide, child neglect and abuse, domestic violence, unplanned pregnancies, and lost productivity—all of which cost the U.S. government billions of dollars each year. Yet, despite the morbidity and disability associated with SUDs, treatment rates remain low, with fewer than 19% (around 10.2 million) of those so diagnosed receiving treatment (SAMHSA, 2025a). Less than half of the U.S. federal drug control budget is allocated for treatment of substance use disorders, whereas more than 50% is spent on the criminal justice system and interdiction (Office of National Drug Control Policy, 2025).

Alcohol use disorder (AUD) is the most prevalent SUD in the United States. Despite the government and media focus on users of opiates, clinically, it is important to note that there are approximately 28.9 *million* individuals manifesting an AUD, compared to an *estimated 5.7 million* individuals manifesting an opioid drug use disorder (SAMHSA, 2025a). Thus, it is much more likely that a clinician in a nonaddiction setting will encounter someone with an alcohol use-related problem, or their family member, than problematic users of any other substances.

Heavy alcohol use is associated with a wide variety of illnesses and social problems, including neurological problems (such as dementia), stroke, and neuropathy; cardiovascular problems; psychiatric problems, including depression and anxiety; liver diseases, including hepatitis and cirrhosis; and gastrointestinal problems, such as pancreatitis and gastritis. Other associated conditions include increased risk of cancer of the liver, breast, mouth, throat, esophagus, and colon, and research suggests that risky alcohol use may contribute to the physiological process that causes cancer cells to metastasize (CASA, 2012). Past studies indicated that nearly half of all violent deaths (accidents, suicides, and homicides), particularly of men below age 34, were alcohol use-related, and alcohol use has been found to be a consistent factor in reports of child physical and sexual abuse, including incest, and in cases of rape and domestic violence (Staton-Tindall et al., 2013). Up to 60% of sexual offenders were drinking at the time of the offense, and

more than 75% of female victims of nonfatal domestic violence reported that the assailant was drinking or using drugs (Kirk-Provencher et al., 2021).

Severe alcohol use varies according to age and gender, as well as ethnic and racial factors. Although men consume alcohol at higher rates than women, this gender gap has decreased due to women's earlier initiation of drinking in recent years. Compared with men, women experience significantly shorter time intervals between the initiation of alcohol use and the onset of significant alcohol-related problems and treatment entry—a phenomenon known as *telescoping*, which is attributed to a variety of biological, socioeconomic, psychological, and cultural factors that affect women (Zakiniiez & Potenza, 2018).

Regarding racial/ethnic differences, alcohol use is the most prevalent SUD among all racial/ethnic populations in the United States. It is most common among Whites, American Indian/Alaska Native, and those of multiracial backgrounds. The lower rates of alcohol use among the understudied Asian populations (a term encompassing a diverse group of ethnicities with vastly different substance use patterns) may reflect a genetic physiological sensitivity to the effects of alcohol, the so-called *flushing* response (Ali et al., 2023; Sue, 1987).

Theories of Addiction

Although addiction is increasingly seen as a “primary and often chronic disease of the brain” that affects the brain's reward, pleasure, memory, and motivation (American Society of Addiction Medicine, 2000), research and clinical data reveal no single etiological factor that accounts for why some people misuse and become addicted to a substance and others do not. Some of the factors frequently cited are discussed below.

Biochemical and Genetic Factors

Studies on twins, half-siblings, and adopted children of alcoholics (Edwards et al., 2009; Goodwin, 1984; Schuckit et al., 1972), as well as newer research on markers of inherited susceptibility, point to the presence of a genetic factor in the intergenerational transmission of AUD, especially in males, whereas neurochemical studies point to the importance of biochemical as well as genetic factors in narcotic and cocaine abuse (Hatoum et al., 2023). According to some authors, genetic factors appear to be stronger drivers than environmental factors in the initiation of substance use at an early age (Agrawal & Lynskey, 2008; CASA, 2012). The three important points regarding the genetic component of addiction agreed upon by studies to date are (1) a family history of addiction is a strong predictor of risk, regardless of socioeconomic status; (2) there is no single gene but rather an interaction of multiple genes with environmental factors that leads to increased

risk of addiction; and (3) factors that may trigger SUD differ among different individuals.

Familial Factors

According to CASA (2012), “The nature of the parent–child relationship is key; people who come from families with high levels of parent–child conflict, poor communication, weak family bonds and other indicators of an unhealthy parent–child relationship are at increased risk of substance use and addiction” (p. 24). Studies of the backgrounds of people with alcohol or opiate addictions in treatment indicate that they are more likely to have experienced early separation from one or both parents and tended to receive inadequate care during childhood (Kaufman, 1985). Findings from the adverse childhood experiences (ACEs) studies show a correlation between children who were physically, sexually, or otherwise abused during childhood and SUD in adulthood (Dube et al., 2003). Substance misuse has also been viewed as serving an important stabilizing force in dysfunctional families (Steinglass et al., 1971) and as a survival strategy to deal with childhood trauma.

Psychological Factors

Psychological explanations of substance abuse encompass various perspectives, including classical and modern psychoanalytic theory, developmental and personality theories, and behavioral, conditioning, and cognitive theories.

According to the classical psychoanalytic view, the individual uses a substance as a defense against unacceptable sexual and aggressive drives. In a letter to his friend Wilhelm Fleiss, Freud described addictions to “alcohol, morphine, tobacco, etc.” as a “substitute and replacement” for the “primal addiction,” masturbation (Freud, 1897/1954), and in his description of the case of Dr. Schreber, Freud (1911/1958) posited alcoholism as being a defense against homosexuality. Other early psychoanalysts viewed alcoholism as being the result of a fixation in and regression to the oral stage of development (Abraham, 1908/1979), as a response to underlying neurotic conflict between dependence and anger (Fenichel, 1945), and/or as a slow form of suicide (Menninger, 1938).

Modern psychoanalysts, focusing on attachment theories, object relations, ego, and self psychology theories, view the abuse of alcohol and other drugs as (1) resulting from insecure attachment due to interpersonal childhood adversities (Flores, 2004), (2) an attempt to deal with poor ego development (Khantzian, 1997), (3) regression to or fixation at the stage of pathological narcissism (Kernberg, 1975), or (4) an effort to overcome a deficiency in the sense of self (Kohut, 1971, 1977). According to this view, alcohol and other drugs provide a “sense of internal homeostasis which substitutes for the basic lack of a sense of integration of self” (Kaufman, 1985, p. 14).

Other psychological perspectives view the abuse of alcohol and other drugs as:

- Attempts to “medicate” preexisting emotional problems, such as mood, anxiety disorders, or schizophrenia, and behavioral disorders such as conduct disorder and attention-deficit/hyperactivity disorder—as well as to cope with borderline, narcissistic, or antisocial personality disorders (Brook et al., 2010; Khantzian, 1997).
- Ways of coping with situational stress and trauma, particularly for individuals who develop posttraumatic stress disorder (PTSD), which are common among veterans and individuals in active military duty (CASA, 2012).
- Efforts to diminish anxieties about self-assertion and to obliterate unacceptable feelings of anger and hostility (Kaufman, 1985).
- Ways of expressing unacceptable dependency needs (McCord et al., 1960).
- Efforts to compensate for feelings of inferiority or powerlessness (McClelland et al., 1972).
- Related to personality characteristics such as novelty seeking, field dependence, low frustration tolerance, high impulsivity, or inability to endure anxiety or tension (Leonard & Blane, 1999; Vaillant, 1995).

According to learning and behavioral theories, substance abuse is a conditioned behavioral response that results from positive reinforcement following initial alcohol or other drug use. Although drug use originally may have been motivated by a desire for the pleasurable effects, the aversive consequence of taking a substance or a fear of negative consequences may be equally as reinforcing under certain environmental conditions (Littrell, 2010). Moreover, withdrawal signs could be conditioned to specific environmental cues. Expectancy, modeling, imitation, and identification also may play a role in substance misuse (Marlatt et al., 1988).

Cognitive-behavioral theorists such as Albert Ellis (Ellis et al., 1988) and Aaron Beck (Beck et al., 1993) focus on the mental schemas or distorted cognitive beliefs about self and others. Such distorted or irrational beliefs make it difficult for the individual to respond appropriately to certain triggers; the absence of an ability to respond appropriately, in turn, leads to a chain of negative behaviors and consequences, including substance misuse (see Liese & Monley, Chapter 7, this volume).

Environmental and Sociocultural Factors

Numerous environmental, social, cultural, and economic factors have been linked to substance use and addiction, including the increasing availability of various substances; exposure opportunity, whereby young people who are using one substance, such as marijuana, are shown to be more likely to expose themselves to

more harmful drugs; a paucity of alternatives to a meaningful life or source of income, particularly among individuals in inner-city communities; the influence of peer groups and the mass media; and social acceptance, even cultural idealization, of various substances.

Studies of females with substance use disorders, particularly those in lower socioeconomic classes, show a high correlation between substance misuse by women *and* by their spouses or boyfriends, suggesting women's emotional as well as economic dependence on men as a factor in substance misuse (Straussner & Attia, 2002).

Multifactorial Perspective

Each theory of substance use problems has implications for both prevention and treatment; however, the etiology of alcohol and other drug misuse and addiction remains empirically unsubstantiated and debatable. Multifactorial views encompassing biological vulnerabilities, psychological traits, family environment, community norms, and larger cultural/social contexts, exposure to trauma or ACEs, lower socioeconomic status, and discrimination elevate the risks for SUD (Volkow, 2020). Most likely, SUD results from a combination of factors, including biochemical, genetic, epigenetic, familial, environmental, social, and cultural ones, as well as personality dynamics. Therefore, it may be best to view substance misuse as a dynamic, multivariate syndrome, in which multiple patterns of dysfunctional substance use occur in various types of people or within the same person at different times in his or her life, requiring a variety of appropriate interventions.

Psychopharmacology

Every individual who takes a mind-altering substance in sufficient quantity will experience a physiological reaction or a state of intoxication. Moreover, many substances, if taken in large doses over a long period of time, lead to addiction or physiological dependence, regardless of the individual's predisposing characteristics. Thus, it is important to understand the physiological impact of the various substances on the human brain and body. Of the different ways of categorizing the numerous substances available today, the most useful classification is based on their effect on the central nervous system (CNS).

CNS Depressants

This category includes alcoholic beverages, barbiturates, and nonbarbiturate sedative/hypnotics (anti-anxiety and sleeping medications) such as Amytal, Luminal,

Tuinal, Doriden, Quaalude, Placidyl, Noludar, Nembutal, and Seconal; benzodiazepines (minor tranquilizers) such as Valium, Xanax, Ativan, Restoril, Klonopin, Tranxene, Dalmane, and Serax; anesthetics such as chloroform, ether, and nitrous oxide; volatile solvents such as toluene, xylene, and benzene; and low doses of cannabinoids such as marijuana and hashish. These drugs slow down, or sedate, the excitable brain tissues. Such sedation affects the brain centers that control speech, vision, coordination, and social judgment. The individual also experiences increased agitation and excitability when coming off these drugs—a withdrawal effect commonly known as a “hangover.”

Individuals under the influence of alcohol or other CNS depressants are likely to exercise poor judgment, which is often manifested in inappropriate and even destructive behaviors. Whereas low doses of a CNS depressant, particularly alcohol, block the usual inhibitions, making the person appear to be relaxed or unreserved, high doses slow down the heart rate and respiration, produce lethargy and stupor, and may result in death. Numerous descriptions of deaths among young people resulting from the ingestion of massive amounts of alcohol in short periods of time have been reported in the popular press.

Another dangerous situation arises from the potentiating effect of combining two or more substances within this category. Thus, a combination of alcohol with Valium or any other sedative/hypnotic is a common cause of purposeful or accidental overdose, particularly among women.

Narcotics or Opiates

These drugs decrease pain by binding to specific receptors in the brain. The word *narcotic* simply means sleep- or numbness-inducing. This category includes opium and its derivatives, such as morphine, heroin, and codeine, as well as synthetic drugs such as methadone (Dolophine) and buprenorphine (marketed as Subutex or Suboxone, which is a combination of buprenorphine and naloxone), fentanyl, Demerol, Darvon, Prinadol, Lomotil, Talwin, Percodan, Percocet, OxyContin, and Vicodin—all of which tend to serve as narcotic analgesics.

The pharmacological action of opiates generally tends to have a sedative and tranquilizing effect. However, unlike the users of sedative substances, narcotic users do not usually experience poor motor coordination or loss of consciousness. The opiate-using individual is more likely to experience a state of stuporous inactivity and dwell in daydreaming fantasies. Due to the physical agitation caused by withdrawal and the psychological panic related to the anticipation of withdrawal symptoms, antisocial behaviors may occur during drug-seeking behavior or actual withdrawal. A person dependent on one particular opiate, whether it is medically prescribed or not, may find that switching to a different opiate helps prevent withdrawal symptoms. Thus, the opiate epidemic of recent years was often started by

people with physical pain who became dependent on prescription pain-relieving narcotic drugs, then switched to illicit opioids or heroin when their medically supplied narcotics ran out.

Impact of Opioid Use

Given the deadly impact of opioid use, it is important to have a clear understanding of it. The term *opioids* refers to substances that act on the body's opioid receptors. These can be natural, semisynthetic, and fully synthetic (made by humans). Natural opioids are those derived from the opium poppies and include opium, morphine, and codeine; semisynthetics include heroin, oxycodone, and hydrocodone; while those that are fully synthetic include fentanyl, methadone, nitazenes, and tramadol. The often confusing term *opiates* refers to the subset of opioids that are directly derived from the opium poppy. Sometimes, heroin is also included in the opiate group, because, although it is a semisynthetic, it is derived directly from morphine. In short, all opiates fit under the umbrella term of opioid drugs, and all are addictive and potentially deadly.

Opioids can be obtained via medical prescription or illicitly. For years, prescription opioids have been provided by doctors to manage moderate to severe pain, as was true for the initial use of OxyContin. Over time, however, as addiction to OxyContin exploded, the laws regulating its prescriptions tightened up, and many users turned to using illegal substitutes, which were often laced with deadly fentanyl. The unregulated fentanyl—a potent, cheaply made, synthetic opioid that was often made in China and smuggled mainly from Mexico—became the central driver of overdose deaths. While recent federal estimates indicate that drug overdose deaths in the U.S. dropped to their lowest level in 5 years, synthetic opioids still remain a significant factor in these fatalities.

Although the rates of transmission of HIV/AIDS through drug injections in the United States have decreased dramatically since the 1990s, when approximately 28–35% of all cases were linked to injection drug use and related sexual transmission, the current prevalence is still high, with about a 7% rate. This drug–AIDS connection is especially detrimental to communities of color, with African Americans having a rate twice that of Whites. While about 4–7% of new diagnoses among Hispanic/Latino males were linked directly to injection drug use (IDU), for Hispanic/Latina females, approximately 12% of new diagnoses were attributed to IDU (Burnett et al., 2018).

In addition to AIDS, the use of dirty, shared, and reused needles results in various systemic infections. Illnesses such as anemia, tuberculosis, heart disease, diabetes, pneumonia, and hepatitis are also common among heroin users. Prostitution, a frequent means of support for drug-dependent women, leads to a high incidence of sexually transmitted diseases (O'Connor et al., 2002).

One positive result of the opiate overdose epidemic was an expanding access to evidence-based treatment for opioid use disorder (OUD), which decreased overdose risk by over 50% (Santo et al., 2021). Methadone, buprenorphine, and extended-release naltrexone are three U.S. Food and Drug Administration (FDA)–approved medications for OUD that are consistently associated with improved health outcomes, including reduced opioid use, transmission of HIV and hepatitis C, and overdose risk (Leshner & Mancher, 2019). While methadone can only be dispensed by certified opioid treatment programs, buprenorphine can be prescribed by approved providers (Drug Addiction Treatment Act of 2000). Naltrexone (sold as Vivitrol) can be administered in several ways, including via a monthly injection by any provider so long as it falls within their scope of practice. It works by blocking the euphoric feelings from opioids and alcohol to reduce cravings, and is used primarily for AUD and less often for OUD treatment (Volkow & Blanco, 2020). Naloxone, which is often confused with naltrexone, is not a treatment medication, but a fast-acting emergency antidote for overdose, available over the counter in nasal spray form as Narcan.

Cannabis

In recent years, cannabis or marijuana has become the most commonly used substance, after alcohol and nicotine, with more than 60 million individuals reporting past-year use. However, a much smaller subset met the criteria for Cannabis Use Disorder, underscoring the distinction between use and a diagnosable disorder (SAMHSA, 2025a).

Cannabis does not fit neatly into the CNS classification since it has *mixed CNS effects* with a combination of CNS depressant sedation and mild stimulant effects, as well as some hallucinogenic aspects, depending on its potency. Clinically, cannabis potentiates CNS depression when combined with alcohol, opioids, or benzodiazepines.

Cannabis (also called “marijuana,” “weed,” “pot”) comes from the *Cannabis sativa* or *Cannabis indica* plant. Its main active ingredients are *THC* (tetrahydrocannabinol, which causes psychoactive “high” effects) and *CBD* (cannabidiol, nonpsychoactive). People use cannabis recreationally (for its mind-altering effects) and medically (to try to relieve symptoms of some conditions). Despite the fact that many states have decriminalized the medical use of cannabis, and some have allowed for its recreational use, it was only in December 2025 that President Donald J. Trump used an executive order to change this drug from being listed as a Schedule I drug, the same category as heroin and seen as not having any medical use, to a Schedule III drug, the same category as ketamine, buprenorphine, or anabolic steroids (Broadwater, 2025). While this change does not legalize the drug, as has been done by a growing number of states, and would not affect law enforcement’s approach to making arrests connected to marijuana, recategorizing

the drug is an acknowledgment by the federal government that cannabis has some medicinal value and a lower potential for abuse. It will also allow for greater federal funding for research.

Cannabis products can be consumed in different ways: smoking or vaping; as edibles (foods, drinks); as oils, tinctures, or capsules; and as topical creams or lotions. Effects vary by method, dose, THC concentration, and individual differences. While reliable research is lacking, cannabis has both potential medical uses and real risks. Conditions for which cannabinoids have approval from the FDA include HIV/AIDS-related anorexia, chemotherapy-induced nausea and vomiting, and certain pediatric seizure disorders (Hsu et al., 2026). When used recreationally, cannabis has been shown to impair cognition, coordination, and judgment and increase anxiety, panic, and paranoia in some users. It can also negatively affect cardiovascular health and can lead to dependence (Hsu et al., 2026).

It is important to note that the marijuana used today is much more potent than that used during the 1960s and 1970s. Frequent use of marijuana by adolescents and young adults has been correlated with the development of the so-called amotivational syndrome, a nonempirically based concept characterized by passivity and lack of ambition leading to poor school and work performance and personality deterioration (Pacheco-Colón et al., 2019).

CNS Stimulants

CNS stimulants include cocaine (powder, crack); amphetamine; and the more potent methamphetamine (known variously as “speed,” “ice,” “crystal meth,” “crank,” “fire,” “glass”); prescription drugs such as Dexedrine, Ritalin, Adderall, Vyvanse; and caffeine and nicotine. In varying degrees, these drugs increase or speed up the function of excitable brain tissues, resulting in energized muscles, increased heart rate and blood pressure, and decreased appetite and need for sleep. Low doses of amphetamines are commonly used by people wishing to stay awake, such as students and truck drivers; however, when coming off these drugs, users experience exhaustion and “crash” or fall asleep. Large doses of such stimulants as amphetamines and cocaine can produce acute delirium and psychosis. At times, the psychotic symptoms can be difficult to distinguish from schizophrenia and may include hallucinations, paranoia, and hypersexuality. With repeated use, these effects diminish, while compulsive use and harms increase. Suicidal and violent behavior under the influence of amphetamines and the more potent forms of cocaine, such as crack, has been noted by researchers and clinicians.

Cocaine and Crack

An estimated 4.3 million people in the U.S. use cocaine (SAMHSA, 2024a). Cocaine use affects the cardiovascular system, resulting in blockages in blood

circulation, abnormal heart rhythms, and strokes. It is often marked by binge-crash cycles and has a high relapse risk.

Crack cocaine is a form of cocaine that has been processed into small, smokable “rocks.” It is made by chemically converting powdered cocaine (usually cocaine hydrochloride) into a “free base” form using substances like baking soda or ammonia. The name *crack* comes from the crackling sound the rocks make when heated. Its smokable form delivers the drug to the brain very rapidly, producing a faster and more intense high than snorted cocaine. Because it reaches the brain quickly, the high from crack typically starts in seconds but lasts only 5–15 minutes, leading many users to take repeated doses in short “binges” (Rosário et al., 2020).

Psychedelics/Hallucinogens

Psychedelics, also known as hallucinogens, produce gross distortions of thinking and sensory processes, thereby inducing a psychosis-like state that often includes visual hallucinations. They have a long history of Indigenous and ceremonial use and were prominent in Western counterculture in the 1950s to the 1970s. Included in this category are the “alphabet drugs,” such as LSD, PCP, DOM, or STP, as well as ibogaine, ayahuasca, mescaline, psilocybin, and large or highly potent doses of cannabinoids or marijuana. Currently, we are experiencing a “psychedelic renaissance,” with renewed scientific interest in research and policy discussions, especially in relation to psychedelic-assisted psychotherapy for PTSD and treatment-resistant depression, as well as alcohol and tobacco use disorders (Rucker et al., 2018).

Psychedelics are not physiologically addictive; however, they have been reported to precipitate panic reactions and psychosis in some vulnerable individuals, especially those with bipolar disorders. They also result in feelings of extreme anxiety and misperception of reality, particularly for users of phencyclidine (PCP, also known as “angel dust”), who frequently experience distorted body image, depersonalization, depression, and hostility that may be expressed through violence (NIDA, 2023).

Novel Psychoactive Substances: Designer and Club Drugs

Also commonly used by young people are the more recently renamed *novel psychoactive substances* (NPS), previously known as designer or club drugs. These look-alike drugs are synthesized in clandestine laboratories and resemble highly potent doses of amphetamines or narcotics in their impact. Currently, one of the most widely used club drugs is MDMA or Ecstasy (also known as “XTC,” “X,” “Adam,” or “lover’s speed”). Other club drugs include GHB (“grievous bodily harm,” “G,” “liquid Ecstasy,” “Georgia home boy”); Rohypnol (“roofies,” “rophies,” “roche,”

“forget-me pill”); MPTP and China white; and ketamine (“Special K,” “K,” “vitamin K,” “cat valiums”). Novel psychoactive drugs are manufactured all the time, and their popularity ebbs and flows over time (see www.clubdrugs.org for more information).

The chemicals found in club drugs vary widely depending on manufacturing sources. Contaminants in these drugs have resulted in negative physical and psychological reactions among some young people. Moreover, since some of these substances tend to be colorless, tasteless, and odorless, there have been numerous reports of club drugs, particularly Rohypnol, being added unknowingly to beverages of individuals who then become victims of sexual assaults.

Combinations of Drugs

Various combinations of drugs—such as heroin and cocaine (commonly referred to as a *speedball*), cocaine and alcohol or marijuana, cocaine and PCP, methadone and alcohol or cocaine, tranquilizers and alcohol, and so forth—are frequently used to counteract the side effects of any one drug or to synergistically increase the impact of the drugs.

As can be seen from the above discussion, the various substances have a differential impact on a person’s mood and behavior, regardless of his or her premorbid personality. Thus, familiarity with the impact of the various substances on behavior and thinking processes is a crucial aspect of clinical assessment and treatment.

Scope of Substance Use Problems Related to Gender and Age

As in the past, national survey data indicate that men have a higher rate of illicit drug use than women. However, between the years of 2002 and 2013, women had a 100% increase in the use of heroin versus a 50% increase in men (Zakiniaez & Potenza, 2018). Today, what is most noteworthy is the disappearance of the gender gap among young people. According to recent studies, “Gen Z women [the demographic cohort born roughly between 1997 and 2012] are abusing stimulants and binge drinking more than their male counterparts—and any other age group” (Bardolf, 2025).

Women in the criminal justice system have a particularly high rate of substance use problems: Roughly 70% of women in jails or prisons meet the criteria for a substance use disorder (compared to 60% of men), and women are more likely than men to report using drugs, particularly methamphetamines, cocaine, and opioids, at the time of their offense (Bronson et al., 2017).

Another group with a growing substance use problem is older adults: Nearly 1 million adults age 65 and older live with a SUD, and between 2000 and 2012, the proportion of admissions to treatment of older adults increased from 3.4 to

7.0%. Although alcohol was the primary substance, there was a decreasing trend in its proportion among users (from 77 to 64%), while the following substances showed an increase: cocaine/crack, marijuana/hashish, heroin, nonprescription methadone, and other opiates and synthetics (Chhatre et al., 2017).

Prenatal Impact of Alcohol and Other Drugs

A unique issue among women who overuse alcohol and/or drugs is the prenatal impact of these substances on their children. Estimates suggest 8–11% of pregnant women used alcohol, tobacco, or illicit drugs in the past month (SAMHSA, 2022), and an unknown number take prescription medication during pregnancy, despite insufficient evidence of the risks of such use. The degree of impact on the fetus due to exposure to alcohol or other drugs is determined by many factors, including the type of substance, the gestation age of the fetus, the route and duration of exposure, the dosage and frequency of drug intake, other substances consumed simultaneously, and environmental factors. Substances used by the mother are transmitted to the fetus during pregnancy and may result in the birth of an addicted newborn or a baby with permanent physiological and brain damage, depending on the substance used and the timing of use during pregnancy (Straussner & Fewell, 2018). There's no safe trimester for use.

Heavy use of alcohol during pregnancy is associated with miscarriage and stillbirth. *Fetal alcohol spectrum disorder* is one of the primary causes of severe mental and developmental delays in infants and is the leading known cause of preventable mental retardation (Sokol et al., 2003). Opioid use disorder in pregnancy has risen sharply over the past decade and is associated with preterm birth, stillbirth, maternal mortality, and *neonatal abstinence syndrome*—a condition where the newborn experiences withdrawal symptoms (Centers for Disease Control and Prevention [CDC], 2024). While the use of cannabis during pregnancy has increased in recent years, partly due to perceptions of safety of this drug, heavy cannabis use has been linked to preterm birth, low birth weight, increased NICU admissions, and potential long-term neurodevelopmental issues (CDC, 2024).

Many pregnant people use more than one substance (e.g., alcohol + tobacco + cannabis), and the effects of polysubstance use are not well understood but may multiply risks. Additionally, 9 in 10 pregnant women take prescription medication during pregnancy, despite insufficient evidence of the risks of use during pregnancy for the vast majority of these prescribed medications (Martin et al., 2020).

Although the impact of *paternal* drug and alcohol use has not been widely researched, authorities have taken a harsh view of the damage caused to the fetus and the newborn due to maternal use of drugs and alcohol. In many states, children who are born addicted or who test positive to illicit substances are legally viewed as abused, and hospital workers are required to report such cases to local child welfare agencies (Staton-Tindall et al., 2013). Among the consequences are

imprisonment or mandatory treatment for the mother, foster care placement, and the possibility of permanently losing custody of the child.

While evidence-based treatment, including medications for opioid use disorder like methadone or buprenorphine, significantly improves outcomes for both mother and infant, many SUD facilities do not offer such treatment for pregnant women (CDC, 2024).

Substance Use by Young People

Unlike the relatively constant rate of alcohol and drug misuse by adults over the years, the use of substances by young people tends to fluctuate over time. Such fluctuation reflects the availability of particular substances, their popularity among certain subgroups, and the nature of governmental data collection (Johnston et al., 2011). Overall, the rate of substance use by young people went down during the COVID-19 pandemic and has not rebounded (Miech et al., 2025).

Based on recent public health data and surveys, the most popular substances used by young people—including teens (ages 12–17) and young adults—are alcohol, nicotine products (vaping and tobacco), cannabis, and prescription medications used to get high, including painkilling opioids and stimulants, such as Adderall and Ritalin. Among younger adolescents, inhalants such as glue, solvents, or nitrous oxide are sometimes used because they are easy to access, though overall prevalence is low (Miech et al., 2025).

In the past, the use of alcohol, marijuana, and tobacco or nicotine among young people has been viewed as a “gateway” to other drugs. Although such a view has been questioned recently, it is generally acknowledged that adolescence is a critical developmental period in which the brain’s reward systems and impulse control are still maturing. Studies show that the earlier the use of drugs begins, the more likely the users are to have substance use problems later in life. Such findings reinforce the need for prevention programs whose aim is to postpone the age of initiation into substance use (Ren & Lotfipour, 2019).

Clinical Interventions

Clinical interventions with individuals who use substances, as with all clients, begin with a comprehensive assessment followed by appropriate intervention approaches that include some or all of the following:

- Identifying the kinds of substances being misused and the degree of physical and psychological dependence
- Assessing the degree to which these substances interfere with daily life
- Motivating the individual to obtain appropriate treatment

- Helping the person achieve recovery
- Monitoring ongoing recovery
- Helping family members and significant others understand substance misuse and SUD and its impact on them

Screening and Assessment

Screening attempts to identify people whose substance use–related problems are not clearly evident, whereas *assessment* is undertaken once a problem is more apparent. Assessment is an ongoing, interactive process made up of several important tasks, including (1) determining a formal diagnosis, (2) ascertaining the severity and impact of the substance on the user and those around him or her, (3) establishing a baseline of the patient’s condition for future comparison, (4) providing a guide to treatment planning and the patient’s progress in treatment, and (5) evaluating the impact of environmental influences and appropriate preventive efforts. A comprehensive assessment may include a medical examination, clinical interviews, collateral information, and data obtained through a variety of formal instruments.

The first task in screening and assessing people who misuse drugs or alcohol is to avoid stereotyping them. As noted, there are tremendous variations in the background and characteristics of people with substance misuse and SUD, in the kinds of substances being misused, and in the impact of these chemicals on the users and their significant others. Nonetheless, there are certain characteristics and behavioral patterns that *are* common to many and provide basic assessment clues.

All clients whose behavior is highly volatile and unpredictable or whose history indicates interpersonal, occupational, financial, and/or legal problems should be questioned about possible SUD. Whereas some individuals may readily admit to their substance misuse, others may not. It is often helpful to obtain factual information from family members or other relevant sources and to conduct urine or other screenings, as well as to rely on behavioral clues, such as a runny nose, the wearing of long sleeves in the summer to cover up needle marks, or the smell of alcohol on the breath (especially early in the day).

Given that most people in this society drink, it is less threatening to start with questions about alcohol consumption before gathering data about illicit drugs. It is also important to obtain information about the onset of substance use and misuse. Clinically, it is helpful to conceptualize the person as developmentally arrested at the age at which the substance misuse (not just *use*) first began, regardless of current chronological age, because there are profound developmental differences between an individual who started misusing alcohol and/or heavily smoking marijuana at age 13 and one who did so at age 23.

A growing number of clinicians are also using standardized screening and assessment instruments. Among the most frequently used instruments are various versions of the *CAGE* for assessing alcohol use-related problems and the

CAGE-AID, which includes other drugs (Brown & Rounds, 1995; Mayfield et al., 1974). The recently developed TAPS tool, a brief, validated screening instrument from NIDA, is used to quickly assess past-year use of *Tobacco, Alcohol, Prescription medications, and other Substances* (TAPS), identifying at-risk patients for further intervention, ranging from brief counseling for those at lower-risk use, to treatment referrals for higher-risk patterns. It involves two parts: TAPS-1 (a four-item screen for frequency) and TAPS-2 (brief follow-up questions), generating risk scores for each substance type. (For a helpful guide to the different screening instruments, see <https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools>.)

During the past two decades, there has been a growing recognition of the need for universal screening for substance use in all health care settings. Consequently, the *Screening, Brief Intervention, and Referral to Treatment* model has been introduced throughout the United States, spurred by federal funding (Madras et al., 2009). It consists of three major components (SAMHSA, 2025b):

- *Screening*, which, as indicated above, calls for assessment of risky substance use behaviors using standardized screening tools.
- *Brief Intervention*, which consists of a brief discussion with a patient, pointing out his or her risky substance use behaviors and providing feedback and advice about it.
- *Referral to Treatment* for those patients whose screening indicates need for additional services.

Whatever format is being used, it is crucial that all assessment questions be asked in a nonjudgmental manner. The clinician needs to remember that once individuals start misusing substances such as alcohol, opiates, or cocaine, they often become addicted to them. They cannot just stop using a substance through willpower alone. They should not be condemned or made to feel guilty for their dependence on a chemical any more than a client would be condemned for having an uncontrolled medical condition. Also important in assessment is the differential biopsychosocial effects of various substances. The use of an illicit substance such as crack, with its 30-second high and immediately recurring craving, will have different emotional, legal, financial, and social sequelae than the drinking of a legally obtained bottle of Scotch (Straussner, 2012).

Finally, it is important to be cognizant of the fact that substance use is a “family disease”—that although a client may not be the one who misuses alcohol or other drugs, he or she might be the spouse or child of someone who does and thus a part of a substance-misusing family system (Straussner & Fewell, 2020). Assessing the impact of familial substance use on mental health and daily functioning is an important intervention with all clients, regardless of their presenting problems (see Kourgiantakis & Hamilton, Chapter 2, this volume). A very important assessment area is differentiating between SUD and other psychopathology. Individuals

with a diagnosis of SUD also may be diagnosed with a comorbid major psychiatric condition and/or have an underlying personality disorder, necessitating a comprehensive psychiatric assessment in addition to assessment of their substance use. (For further discussion of coexisting diagnoses, see Morgen & Brummer, Chapter 15, and Zmuda, Chapter 16, this volume.)

Motivation for Treatment

A comprehensive assessment must include an exploration of the client's motivation for treatment, as well as his or her readiness for change. What is helpful to many clinicians is the concept of *stages of change*. First conceptualized by Prochaska, DiClemente, and Norcross (1992) in dealing with smoking cessation, the stages of change model posits that, for most people, a change in behavior occurs gradually, with the patient moving from being unaware or unwilling to make a change (pre-contemplation), to considering a change (contemplation), to deciding and preparing to make a change. Determined action is then taken and, over time, attempts to maintain the new behavior occur. Relapses are viewed as almost inevitable; they can occur at any stage in the process and become part of the process of working toward lifelong change. This perspective helps to minimize unrealistic expectations of quick change and is more effective in keeping clients in treatment and supporting his or her efforts toward recovery (see Lessa, Chapter 5, this volume, for more details).

Miller and Rollnick's (1991) five principles of *motivational interviewing* provide a useful framework that helps motivate clients to move from one stage of change to another. The five general principles are (1) expressing empathy, (2) developing discrepancy, (3) avoiding argumentation, (4) rolling with resistance, and (5) supporting self-efficacy. The goal of motivational interviewing is to ignite motivation for change, even when a client enters treatment due to external pressures. It is the job of the clinician to provide feedback to the client that illustrates the discrepancy between his or her ability to achieve the desired goals and the client's continuing use of substances. To be effective, such feedback must be given within an empathetic environment that avoids argumentation or direct confrontation of resistance, and one that supports self-efficacy (i.e., the client's belief in his or her own ability to make changes; Straussner & Attia, 2002). Studies show that the more caring approaches of "motivational interviewing" are more effective than the traditional confrontational approaches (Rollnick et al., 2008).

Treatment Facilities and Approaches

A critical task for clinicians is to determine appropriate forms of treatment for clients with substance use problems. Workers need to be aware of the various

treatment options available for these clients in their community and, if at all possible, the quality of these services. Although fewer than one-fourth of those individuals who need help for their SUD ever get treatment, most of those who obtain treatment do get better, with outcomes that are similar to those of other chronic health conditions, such as diabetes (Volkow, 2020). The most important treatment approaches are discussed next.

Detoxification

Detoxification is a medical intervention for individuals who are physically addicted to opioids, alcohol, barbiturates, or other sedative/hypnotics, and amphetamines. It is not required for cocaine/crack abusers or for marijuana smokers. Physical dependence or addiction is defined primarily by signs of withdrawal: the presence of symptoms that appear when the intake of a given substance is terminated. The withdrawal symptoms from stimulants such as amphetamines include severe depression; symptoms of withdrawal from sedative/hypnotics such as alcohol, which occur 6–48 hours after cessation of alcohol consumption, may include sweating, anxiety, and agitation. Alcohol withdrawal abates after 2–5 days; however, it may be complicated by grand mal seizures and progress to delirium (known as delirium tremens, or DTs). Although withdrawal from opiates has been given much publicity, it is not life-threatening, as it can be from severe alcohol, Xanax, or barbiturate addiction. Opiate withdrawal has been compared to “a one-week bout with influenza” (Waldinger, 1986, p. 315).

Traditionally, detoxification has been conducted on medical or psychiatric inpatient units to allow for careful monitoring of physical status and to prevent potentially lethal withdrawal reactions. Detoxification can also be provided in outpatient settings or by physicians in private practice. Heroin/opioid users can be detoxified on an outpatient basis with the help of chemicals such as clonidine or decreasing doses of methadone or buprenorphine. Some drug users also detoxify themselves—“cold turkey”—in a range of ways.

Rehabilitation Treatment Programs

Detoxification is usually only the beginning of the recovery process. When people with substance use disorders cease use, they may experience a prolonged period of physiological and psychological withdrawal. Moreover, the lives of many individuals with SUD may revolve around the process of obtaining drugs or alcohol; this focus provides a daily routine as well as relationships with other substance users, both of which must be replaced if the individual is to maintain a substance-free existence. Furthermore, since substance users often medicate unpleasant feelings, such as anxiety or depression, these feelings are likely to surface or worsen when the substance is removed.

To address these challenges, short- and long-term inpatient and outpatient rehabilitation programs and drug-free residential therapeutic communities are invaluable. In these structured settings, substance misusers can examine the impact of alcohol and/or other drugs on their lives, their ability to relate to other people, and the necessary changes they must make if they want to recover. Although cocaine and crack users do not require detoxification, they do require ongoing outpatient counseling, and, at times, antidepressants or other medications. Currently, much of the treatment is provided via intensive outpatient rehabilitation programs, as well as online.

Also available in some communities are day-treatment programs and part-time residential facilities such as halfway and quarter-way houses, and substance-free housing.

Outpatient Individual Therapy or Counseling

Generally, outpatient psychodynamically oriented individual psychotherapy is not recommended until the person is secure in his or her abstinence from chemicals, because the anxiety aroused during treatment may lead to the resumption of alcohol or drug use. Moreover, conducting individual counseling or therapy with an active substance user is questionable due to the impact of the chemicals on the brain and the possibility of blackouts (i.e., memory loss while intoxicated). However, if a client has stopped using substances or is making serious efforts to diminish his or her drug and alcohol use, cognitive-behavioral, ego-supportive counseling, or a self-psychological approach (Levin, 1987) can be useful.

Because chronic substance users usually substitute a chemical for human contact, a crucial part of treatment is the establishment of a nonthreatening relationship with a caring and consistently reliable individual. The goal of individual treatment is to enhance patients' self-image and provide needed ego support so that they can begin to examine their use of chemicals and their current feelings and behavior.

The view of SUD as a disease is invaluable in helping drug and alcohol users to alleviate frequently extreme feelings of guilt without absolving them from responsibility for their future behavior. This perspective also diminishes the usually negative countertransference reactions of workers. Motivational interviewing (MI), mentioned earlier, is both an interviewing technique and a treatment approach (Miller & Rollnick, 1991). The client's motivation for change is assessed and encouraged, while the clinician builds a strong and trusting relationship.

Twelve-Step facilitation (TSF) therapy is a brief, structured approach to facilitating early recovery from alcohol and drug misuse. Implemented in 12–15 individual client sessions, the intervention is grounded in the behavioral, spiritual, and cognitive principles of the fellowships of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Accepting that addiction is a chronic, progressive disease

that one is powerless over and that life has become unmanageable, surrendering to a higher power, and active involvement in 12-Step fellowships are central principles in TSF (see Fewell, Chapter 10, this volume).

An alternative to the mainstream addictive/disease approach is solution-focused therapy. Specific techniques might involve (1) asking for exceptions to the problem (“When is the last period of time you were not drinking? What was different about that time?”); (2) use of scaling questions (“On a scale of 1–10, with 10 being the most motivated, where would you rate your motivation to change your marijuana use patterns?”); and (3) use of coping questions (“How did you manage to get your children dressed and get to school yesterday, after all you’ve told me about your difficulties?”). This approach focuses on the client’s strengths and past successes in dealing with problems and on the acceptance of the client’s definition of the problem and immediate goals (see <https://solutionfocused.net/what-is-solution-focused-therapy>; Žak & Pečala, 2024).

There are a great number of cognitive-behavioral therapies (CBT) currently utilized in the treatment of SUD. In general, CBT attempts to reduce self-defeating behavior by modifying cognitive distortions and maladaptive beliefs and teaching techniques of thought control. Based on the premise that negative thoughts and beliefs influence emotion and behavior, CBT is a collaborative, active, and highly structured approach that teaches the patient to pay attention to his or her thinking, to cravings and substance-seeking behaviors, to identify high-risk situations that can compromise one’s recovery, and to develop effective relapse prevention strategies (see Liese & Monley, Chapter 7, this volume). Cognitive-behavioral therapies with the strongest evidence for effectiveness include contingency management therapy (see Froais & Rash, Chapter 8, this volume), motivational enhancement therapy, and TSF therapy (SAMHSA, 2008).

Harm reduction is both a treatment philosophy and a treatment approach. Originating in Europe, it was initially adopted in the United States in the 1980s in order to minimize the transmission of HIV among injection drug users. It refers to a range of pragmatic and evidence-based public health policies designed to reduce the harmful consequences associated with drug use. In general, harm reduction in the United States includes needle exchange programs, opioid substitution therapy, and Housing First approaches. As a treatment approach, harm reduction has been applied to private clinical treatment where the focus is not on complete abstinence, but on engaging clients in a therapeutic relationship without getting into a power struggle over preordained goals set by the therapist (Tatarsky, 2002). In essence, this approach is in line with traditional social work values of “starting where the client is” and then figuring out mutually agreed-upon goals (see Collin & Halmo, Chapter 19, this volume).

Other additional approaches to helping individuals with SUD include trauma-focused approaches, such as adaptation of *Seeking Safety* by Lisa Najavits (2002; see Wiechelt, Chapter 4, this volume), and treatments focused on a range of

co-occurring disorders, such as borderline personality disorders (Linehan et al., 1993).

Group Interventions

Group counseling and group activities appear to be the treatment of choice for many people with substance use disorders (see Velasquez & Kennedy, Chapter 9, this volume). Group therapy with fellow recovering substance misusers provides helpful peer interaction and support as well as useful confrontations of substance-using patients with the consequences of their attitudes and behavior (Flores, 1996). The value of separate groups for substance-misusing women has been noted by many clinicians (Beyer & Carnabucci, 2002).

Activity groups focused around the arts, cooking, program planning, sports, and so forth, allow for social interaction, the development of a variety of essential life skills, and the sublimation of self- and other-destructive feelings. Psychodrama groups are particularly helpful for patients because they provide a forum in which repressed feelings can be concretized and expressed and “unfinished business” resolved (Dayton, 2011).

Self- or mutual-help “12-step” programs, such as AA, NA, Pills Anonymous (PA), and Cocaine Anonymous (CA), have proven to be particularly helpful and are free and available in almost every community. These groups provide continuously available support and help to replace drinking and drugging companions with a new group of peers with whom the substance user can identify. Self-help groups allow members not only to receive help but also to give help to others, thereby enhancing self-esteem (see Fewell, Chapter 10, this volume).

It is strongly recommended that all clinicians attend a few “open” meetings of the various self-help groups, especially AA. At times, it may be helpful to escort a patient to a meeting or to encourage the client to call, in the presence of the worker, the main number of the self-help group and ask for help. Clinicians can also request a 12-step group to arrange for an “institutional meeting” for clients at the worker’s agency.

In addition to 12-step groups, other self-help groups can be utilized when appropriate; these include Women for Sobriety, SMART Recovery (Self-Management and Recovery Training), Social Workers Helping Social Workers, Recovery Dharma, LifeRing Secular Recovery, Refuge Recovery, and Double Trouble/Recovery groups for those with dual diagnoses.

Psychoeducational Approaches

Didactic education is an effective strategy in the treatment of SUD. Lectures and discussion on such topics as the signs and symptoms of substance misuse and addiction, the addiction cycle for specific substances (such as cocaine, with its euphoric

binges and depressive crashes), relapse prevention, the impact of substance misuse on the family, effective communication skills, coping with stress and trauma, human sexuality, and assertiveness training provide cognitive, non-ego-threatening understanding of the dynamics of substance use and practical information about how the individual and the family can help themselves. Such a psychoeducational approach can be provided in settings that are not specifically connected to SUD treatment and can include individual, group, or family treatment modalities.

Use of Pharmacotherapy and Complementary and Alternative Treatment Approaches

Medications can help diminish the cravings for drugs and assist clients in reestablishing normal brain functioning. For opiate addiction, as mentioned previously, the most commonly used medications, or opiate-substitution therapies, are methadone and buprenorphine.

The utilization of methadone maintenance programs can lead to better prognosis for rehabilitation and allow those addicted to narcotics and other opiates to avail themselves of such services as individual or group counseling and educational or vocational training; it can also help them improve the overall quality of their lives once the daily concern about obtaining drugs is alleviated. Buprenorphine (also known as “bup,” or as the prescription drugs Subutex and Suboxone, a combination of buprenorphine with naloxone, making it less likely to be abused) is an important substitution medication for opiate addiction. As of 2025, new regulations allowed qualified physicians in private practice to prescribe buprenorphine for opioid treatment for as many patients as they can handle. This created a paradigm shift by bringing opioid addiction treatment into mainstream, office-based medicine (SAMHSA, 2025b).

A medication that is sometimes used to help people with alcohol use disorders is disulfiram, commonly known as Antabuse. It blocks the normal oxidation of alcohol so that acetaldehyde, a by-product of alcohol, accumulates in the bloodstream and causes unpleasant, and at times even life-threatening, symptoms, such as rapid pulse and vomiting. These distressing symptoms serve as a deterrent—an experienced negative reinforcement—to drinking while the person is using Antabuse.

A new, so far experimental, approach is the use of glucagon-like peptide-1 (GLP-1) receptor agonists, originally developed for type 2 diabetes and obesity, as potential treatment of SUDs. They modulate the neural reward pathways and appear to reduce cravings and substance-seeking behaviors, particularly for alcohol and nicotine. These medications appear to be opening up a previous unexplored approach to the treatment of addictions (Volkow & Xu, 2025).

A number of substance misuse treatment settings and clinicians have incorporated complementary and alternative treatment approaches, some of which have

been shown to be more effective than others. Among them are the use of acupuncture treatment during the withdrawal process and in the early phase of rehabilitation treatment, yoga, and the one with the most positive research outcomes, mindfulness meditation (Bowen et al., 2011).

Social Supports

Substance-misusing patients often experience various social problems. Thus, the provision of financial and social supports—including adequate housing, vocational rehabilitation programs, and legal assistance—is an essential aspect of helping this population.

The Recovery Model

The peer-focused recovery model has an interesting history, beginning with its origin in 12-step approaches (or even earlier in the various alcohol-recovery movements of the 19th century), moving into mental health, and now coming back into the field of addiction via the growing emphasis on co-occurring disorders. As defined by a panel of substance abuse experts, *recovery* is viewed as “a voluntarily maintained lifestyle comprised of sobriety, personal health and citizenship” (McLellan, 2010, p. 109). This definition reinforces the concept of sobriety, and not just abstinence or stopping the use of a substance, as well as citizenship, which is based on the British notion of “participating in the rights and responsibilities of social life” (McLellan, 2010, p. 112). It thus includes not only professional treatment but also client involvement and responsibilities, as well as the development of a new profession of *peer support specialists* who use their lived experiences to help others. The recovery notion provides a bridge between the traditional abstinence philosophy and the newer harm reduction approach (Straussner, 2012).

Treatment Issues for Specific Populations

Space limitations preclude a comprehensive discussion of the numerous treatment issues and the unique treatment needs of various substance-misusing populations. For example, clinicians need to take into account the life-cycle stages of clients, and to realize that both assessment and intervention with an alcohol-misusing 17-year-old young man will differ from those with a 67-year-old alcohol-misusing older man (see Freshman & Lefkowitz, Chapter 11, and Kuerbis, Chapter 12, this volume). The issue of gender also has to be addressed differentially (see Sarabia & Smith, Chapter 13, this volume), as does that of patients with co-occurring disorders.

Treatment of people from minoritized racial and ethnic groups, particularly African American clients, needs to take into account that they are more likely to enter treatment through the courts than through formal intervention processes or 12-step programs, and they are more likely to access treatment much later and thus may have a more difficult recovery process (O'Connell, 1991).

Ethnocultural norms and values need to be taken into account in treatment planning and relapse prevention with each client (see Straussner, 2001), as do issues of sexual identity and sexual behavior, including the need for safe sex. The special needs of substance-misusing gay, lesbian, and transgender clients need to be addressed (see Senreich, Chapter 14, this volume). Finally, we need to remember that SUD “is a chronic but treatable condition, that most people with SUDs need help from several sources, that recovery often takes multiple episodes of treatment, and that relapse is common” (Dennis & Scott, 2007, p. 53).

Impact of Substance Misuse on the Family

Life with a family member who is misusing substances is typically full of inconsistency and unpredictability, resulting in a chronic state of crisis. Legal and financial problems, serious illnesses, and various accidents are common occurrences that intrude on family life. When the substance user is a parent, dysfunctional cross-generational alliance and role reversal (i.e., children assume parental roles and responsibilities) are frequently seen (Straussner, 2012). Child neglect and, in more disturbed families, violence between parents, child abuse, and incest are some of the consequences and correlates of substance misuse; indeed, substance use is present in at least two-thirds of the families known to public child welfare agencies (Staton-Tindall et al., 2013).

The impact of substance misuse on the family has additional intergenerational repercussions: The sons of fathers with alcohol problems are four times more likely to become alcohol misusers, and the daughters are three times more likely to have alcohol problems themselves. Moreover, the daughters of such fathers are also more likely to marry alcohol-misusing men. Intergenerational repercussions also exist for families with parental opiate and other drug addiction (CASA, 2011); thus, the need for family intervention.

Intervention with Family Members

Couple and family therapies, including multifamily groups, are effective treatment modalities for families with members who have SUD and are already chemically free or are working on their recovery. A research-based, family-oriented treatment approach called *CRAFT* (*Community Reinforcement and Family Training*; Archer et al., 2020; Miller et al., 1999) involves the following eight basic components:

1. Increasing family members' motivation to change by establishing positive expectations
2. Teaching communications skills that allow significant others to provide effective feedback and encouragement to the substance misuser
3. Assessing for domestic violence and making plans for escaping potentially dangerous situations
4. Focusing on the nonreinforcement of substance use by learning to ignore the person when he or she is using
5. Initiating positive activities that interfere with or compete with substance use and using small rewards to reinforce sober behavior
6. Teaching how to allow for the natural consequences of using a substance and problem-solving strategies
7. Exploring significant others' dissatisfaction in life and planning how to increase their own quality of life regardless of whether the substance misuser enters treatment or not
8. Helping family members plan the best time for suggesting treatment to the substance misuser and providing information about different treatment options

It is also beneficial to refer family members to mutual-help groups such as Al-Anon, Pill-Anon, Co-Anon, or Nar-Anon. These groups help adult family members examine their own role in “enabling” or perpetuating the behavior of the addicted person and obtain support from others in the same circumstances. These groups are particularly useful for parents and spouses of substance misusers.

Adolescent children of alcohol- and narcotic-misusing parents may benefit from self-help groups such as Alateen and Narateen. Adult Children of Alcoholics groups are extremely helpful for mature adolescents and adult children of alcohol-misusing parents, as are the Codependency Anonymous groups that help people identify and work on their unmet dependency needs.

Intervention with latency-aged and adolescent children of substance abusers must focus not only on how to say “no” to their own substance use and misuse, but also on helping the children recognize and understand familial substance abuse and its impact on them and other family members. Extensive literature, written specifically for children and adolescents, can be obtained from Al-Anon and Nar-Anon, as well as from the National Association for Children of Alcoholics (see www.nacoa.org), and is extremely valuable in helping children begin to understand what has happened to them and, hopefully, preventing the pattern from repeating itself in the next generation.

Clinicians also must be aware of their own countertransferential reactions to families of substance misusers, particularly in view of the fact that many in the helping professions are themselves affected by familial substance use (Straussner et al., 2018).

Conclusion

Helping clients with substance use problems and their families is a challenging, yet a highly rewarding, task. It is a task that requires a variety of treatment modalities and intervention approaches and calls on the worker to be an astute diagnostician, therapist, educator, advocate, and educated consumer of never-ending research data. Most of all, it requires a clinician who is sensitive to the impact of substance use on these individuals and those close to them, who can appreciate the strengths and the courage that these clients present, and who can provide hope for a better tomorrow.

REFERENCES

- Abraham, K. (1979). The psychological relations between sexuality and alcoholism. In *Selected papers on psychoanalysis* (pp. 80–89). Brunner/Mazel. (Original work published 1908)
- Agrawal, A., & Lynskey, M. T. (2008). Are there genetic influences adoption and twin studies. *Addiction*, 103(7), 1069–1081.
- Ali, M., Creedon, T., Bagalman, E., Bui, J., Clemans-Cope, L., Winiski, E., . . . Allen, E. H. (2023, November 13). *Substance use and substance use disorders by race and ethnicity, 2015–2019*. Office of the Assistant Secretary for Planning and Evaluation.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Author.
- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). Author.
- Archer, M., Harwood, H. L., Stevelink, S. A. M., Rafferty, L. A., & Greenberg, N. (2020). Community reinforcement and family training and rates of treatment entry: A systematic review. *Addiction*, 115(6), 1024–1037.
- Bardolf, D. (2025, April 26). Gen Z women abuse stimulants, binge-drink more than any other group, studies find. *New York Post*. <https://nypost.com/2025/04/26/health/gen-z-women-binge-drink-abuse-stimulants-the-most-research>.
- Beck, A. T., Wright, F. D., Newman, C. F., & Liese, B. S. (1993). *Cognitive therapy of substance abuse*. Guilford Press.
- Beyer, E. P., & Carnabucci, K. (2002). Group treatment of substance-abusing women. In S. L. A. Straussner & S. Brown (Eds.), *The handbook of addiction treatment for women* (pp. 515–538). Jossey-Bass.
- Bowen, S., Chawla, N., & Marlatt, G. A. (2011). *Mindfulness-based relapse prevention for addictive behaviors*. Guilford Press.
- Broadwater, L. (2025, December 18). Trump signs executive order to reclassify marijuana, easing restrictions on the drug. *New York Times*. www.nytimes.com/2025/12/18/us/politics/trump-marijuana-reclassify-order.html.

- Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). *Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009* (NCJ 250546). Bureau of Justice Statistics. <https://bjs.ojp.gov/content/pub/pdf/dudasppi0709.pdf>.
- Brook, D. W., Brook, J. S., Zhang, C., & Koppel, J. (2010). Association between attention deficit/hyperactivity disorder in adolescence and substance use disorders in adulthood. *Archives of Pediatrics and Adolescent Medicine*, 164(10), 930–934.
- Brown, R. L., & Rounds, L. A. (1995). Conjoint screening questionnaires for alcohol and drug abuse. *Wisconsin Medical Journal*, 94, 135–140.
- Burnett, J. C., Broz, D., Spiller, M. W., Wejnert, C., & Paz-Bailey, G. (2018). HIV infection and HIV-associated behaviors among persons who inject drugs—20 cities, United States, 2015. *Morbidity & Mortality Weekly Report*, 67, 23–28.
- Centers for Disease Control and Prevention. (2024). *Substance use during pregnancy*. www.cdc.gov/maternal-infant-health/pregnancy-substance-abuse/index.html.
- Chhatre, S., Cook, R., Mallik, E., & Jayadevappa, R., (2017). Trends in substance use admissions among older adults. *BMC Health Service Research*, 17, 584.
- Dayton, T. (2011). Treatment issues and psychodrama interventions with adults who grew up with substance-abusing parents. In S. L. A. Straussner & C. H. Fewell (Eds), *Children of substance abusing parents: Dynamics and treatment* (pp. 153–170). Springer.
- Dennis, M., & Scott, C. K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, 4(1), 45–55.
- Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., & Anda, R. F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The Adverse Childhood Experiences study. *Pediatrics*, 111(3), 564–572.
- Edwards, A. C., Svikis, D. S., Pickens, R. W., & Dick, D. M. (2009) Genetic influences on addiction. *Primary Psychiatry*, 16(8), 40–46.
- Ellis, A., McInterney, J. F., DiGiuseppe, R., & Yeager, R. J. (1988). *Rational emotive therapy with alcoholics and substance abusers*. Pergamon Press.
- Fenichel, O. (1945). *The psychoanalytic theory of neurosis*. Norton.
- Flores, P. J. (1996). *Group psychotherapy with addicted population: An integration of 12 step and psychodynamic theory* (2nd ed.). Haworth Press.
- Flores, P. J. (2004). *Addiction as an attachment disorder*. Jason Aronson.
- Freud, S. (1954). Letter 79, December 22, 1897. In M. Bonaparte, A. Freud, & E. Kris (Eds.) and E. Mosbacher & J. Strachey (Trans.), *The origins of psycho-analysis: Letters to Wilhelm Fliess, drafts and notes: 1887–1902*. Imago. (Original work published 1897)
- Freud, S. (1958). Psycho-analytic notes on an autobiographical account of a case of paranoia. In K. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 1–82). Hogarth Press. (Original work published 1911)
- Goodwin, D. W. (1984). Studies of familial alcoholism: A review. *Journal of Clinical Psychiatry*, 45(2), 14–17.
- Hatoum, A. S., Colbert, S. M. C., Johnson, E. C., Huggett, S. B., Deak, J. D., Pathak, G., . . . Agrawal, A. (2023). *Nature Mental Health*, 1(3), 210–223.
- Hsu, M., Shah, A., Jordan, A., Gold, M. S., & Hill, K. P. (2026). Therapeutic use of can-

- nabis and cannabinoids: A review. *Journal of the American Medical Association*, 335(4), 345–359.
- Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2011). *Monitoring the future national results on adolescent drug use: Overview of key findings, 2010*. Institute for Social Research, University of Michigan.
- Kaufman, G. (1985). *Shame: The power of caring*. Schenkman Books.
- Kernberg, O. (1975). *Borderline conditions and pathological narcissism*. Jason Aronson.
- Khantzian, E. J. (1997). The self-medication hypothesis of drug use disorders: A reconsideration and recent applications. *Harvard Review of Psychiatry*, 4, 231–244.
- Kirk-Provencher, K. T., Jeglic, E. L., Calkins, C., Nichea, S., & Spillane, N. S. (2021). The use of substances in sexual offending in a United States sample. *Psychiatry, Psychology & Law*, 29(1), 53–67.
- Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders*. International Universities Press.
- Kohut, H. (1977). Preface. In *Psychodynamics of drug dependence* (NIDA Research Monograph No. 12). U.S. Government Printing Office.
- Leonard, K. E., & Blane, H. T. (Eds.). (1999). *Psychological theories of drinking and alcoholism* (2nd ed.). Guilford Press.
- Leshner, A. I., & Mancher, M. (Eds.). (2019). *Medications for opioid use disorder save lives*. National Academies of Sciences, Engineering, and Medicine.
- Levin, J. D. (1987). *Treatment of alcoholism and other addictions: A self-psychology approach*. Jason Aronson.
- Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. Guilford Press.
- Littrell, J. (2010). Perspectives emerging from neuroscience on how people become addicted and what to do about it. *Journal of Social Work Practice in the Addictions*, 10(3), 229–256.
- Madras, B. K., Compton, W. M., Avula, D., Stegbauer, T., Stein, J. B., & Clark, H. W. (2009). Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and 6 months later. *Drug and Alcohol Dependence*, 99(1–3), 280–295.
- Marlatt, G. A., Baer, J. S., Donovan, D. M., & Kivlahan, D. R. (1988). Addictive behaviors: Etiology and treatment. *Annual Review of Psychology*, 39, 223–252.
- Martin, C. E., Scialli, A., & Terplan, M. (2020). Unmet substance use disorder treatment need among reproductive age women. *Drug and Alcohol Dependence*, 206, 107679.
- Mayfield, D., McLeod, G. N., & Hall, P. (1974). The CAGE questionnaire: Validation of a new alcoholism screening instrument. *American Journal of Psychiatry*, 131(10), 1121–1123.
- McClelland, D. C., Davis, W. N., Kalin, R., & Wanner, E. (1972). *The drinking man: Alcohol and human motivation*. Free Press.
- McCord, W., McCord, J., & Gudeman, J. (1960). *Origins of alcoholism*. Stanford University Press.
- McLellan, A. T. (2010). What is recovery?: Revisiting the Betty Ford Institute consensus panel definition. *Journal of Social Work Practice in the Addictions*, 10(1), 109–113.

- Menninger, K. (1938). *Man against himself*. Harcourt Brace.
- Miech, R. A., Johnston, L. D., Patrick, M. E., & O'Malley, P. M. (2025). *Monitoring the Future national survey results on drug use, 1975–2024: Overview and detailed results for secondary school students*. Institute for Social Research, University of Michigan. <https://monitoringthefuture.org/results/annual-reports>.
- Miller, W. R., Meyers, R. J., & Tonigan, J. S. (1999). Engaging the unmotivated in treatment for alcohol problems: A comparison of three interventions through family members. *Journal of Consulting and Clinical Psychology*, 67(5), 688–697.
- Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. Guilford Press.
- Najavits, L. M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse*. Guilford Press.
- National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2011). *Adolescent substance use: America's #1 public health problem*. Author.
- National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2012). *Addiction medicine: Closing the gap between science and practice*. Author.
- National Institute on Drug Abuse. (2021). *Words matter—Terms to use and avoid when talking about addiction*. <https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction?utm>.
- National Institute on Drug Abuse. (2023). *Psychedelic and dissociative drugs*. <https://nida.nih.gov/research-topics/psychedelic-dissociative-drugs>.
- O'Connell, T. (1991). Treatment of minorities. *Drug and Alcohol Dependence*, 15(10), 13.
- O'Connor, L. E., Esherick, M., & Vieten, C. (2002). Drug- and alcohol-abusing women. In S. L. A. Straussner & S. Brown (Eds.), *The handbook of addictions treatment for women* (pp. 75–98). Jossey-Bass.
- Office of National Drug Control Policy. (2025). *National drug control strategy*. www.whitehouse.gov/wp-content/uploads/2024/06/National-Drug-Control-Strategy-FY-2025-Budget-Summary.pdf.
- Pacheco-Colón, I., Ramirez, A. R., & Gonzalez, R. (2019). Effects of adolescent cannabis use on motivation and depression: A systematic review. *Current Addiction Report*, 6(4), 532–546.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47(9), 1102–1114.
- Ren, M., & Lotfipour, S. (2019). Nicotine gateway effects on adolescent substance use. *West Journal of Emergency Medicine*, 20(5), 696–709.
- Rollnick, S., Miller, W. R., & Butler, C. C. (2008). *Motivational interviewing in health care: Helping patients change behavior*. Guilford Press.
- Rosário, B., de Nazaré, M., Estadella, D., Ribeiro, D., & Viana, M. (2020). Behavioral and neurobiological alterations induced by chronic use of crack cocaine. *Reviews in the Neurosciences*, 31(1), 59–75.
- Rucker, J. J. H., Iliff, J., & Nutt, D. J. (2018). Psychiatry and the psychedelic drugs. Past, present and future. *Neuropharmacology*, 142, 200–218.
- Santo, T. Jr, Clark, B., Hickman, M., Grebely, J., Campbell, G., Sordo, L., . . . Degenhardt,

- L. (2021). Association of opioid agonist treatment with all-cause mortality and specific causes of death among people with opioid dependence: A systematic review and meta-analysis. *JAMA Psychiatry*, 78(9), 979–993.
- Schuckit, M., Goodwin, D. W., & Winokur, G. (1972). A study of alcoholism in half-siblings. *American Journal of Psychiatry*, 128, 1132–1136.
- Sokol, R. J., Delaney-Black, V., & Nordstrom, B. (2003). Fetal alcohol spectrum disorder. *Journal of the American Medical Association*, 290(22), 2996–2999.
- Staton-Tindall, M., Sprang, G., Clark, J., Walker, R., & Craig, C. D. (2013). Caregiver substance use and child outcomes: A systematic review. *Journal of Social Work Practice in the Addictions*, 13(1), 6–31.
- Steinglass, P., Weiner, S., & Mendelson, J. H. (1971). A systems approach to alcoholism: A model and its clinical application. *Archive of General Psychiatry*, 24(5), 401–408.
- Straussner, S. L. A. (2012). Clinical treatment of substance abusers: Past, present and future. *Journal of Clinical Social Work*, 40(2), 127–133.
- Straussner, S. L. A. (2014). The DSM–5 diagnostic criteria: What’s new? *Journal of Social Work Practice in the Addictions*, 13(4), 448–453.
- Straussner, S. L. A., & Attia, P. R. (2002). Women’s addiction and treatment through a historical lens. In S. L. A. Straussner & S. Brown (Eds.), *The handbook of addiction treatment for women* (pp. 3–25). Jossey-Bass.
- Straussner, S. L. A., & Fewell, C. F. (2018). A review of recent literature on the impact of parental substance use disorders on children and the provision of effective services. *Current Opinion in Psychiatry*, 31(4), 363–367.
- Straussner, S. L. A., & Fewell, C. H. (2020). Working with children whose parents engage in substance misuse. In A. L. Begun & M. M. Murray (Eds.), *The Routledge handbook of social work and addictive behavior*. Routledge.
- Substance Abuse and Mental Health Services Administration. (2008). *National Registry of Evidence-Based Programs and Practices (NREPP)*. U.S. Department of Health and Human Services. <https://nrepp.samhsa.gov/>.
- Substance Abuse and Mental Health Services Administration (2022). *2020 National Survey on Drug Use and Health: Women*. Author.
- Substance Abuse and Mental Health Services Administration. (2024a). *Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health* (HHS Publication No. PEP24-07-021, NSDUH Series H-59). www.samhsa.gov/data/report/2023-nsduh-annual-national-report.
- Substance Abuse and Mental Health Services Administration. (2024b, November 7). *Screening, Brief Intervention, and Referral to Treatment (SBIRT)*. www.samhsa.gov/substance-use/treatment/sbirt.
- Substance Abuse and Mental Health Services Administration. (2025a, February 13). *2023 National Survey on Drug Use and Health (NSDUH) releases*. www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2023#annual-national-report.
- Substance Abuse and Mental Health Services Administration. (2025b, December 12). *What is Naltrexone?* www.samhsa.gov/substance-use/treatment/options/naltrexone?utm.
- Sue, D. (1987). Use and abuse of alcohol by Asian Americans. *Journal of Psychoactive Drugs*, 19(1), 57–66.

- Tatarsky, A. (Ed.). (2002). *Harm reduction psychotherapy: A new treatment for drug and alcohol problems*. Jason Aronson.
- Vaillant, G. E. (1995). *The natural history of alcoholism revisited*. Harvard University Press.
- Volkow, N. D. (2020). Personalizing the treatment of substance use disorders. *American Journal of Psychiatry*, 177(2), 113–116.
- Volkow, N. D., & Blanco, C. (2020). The changing opioid crisis: Development, challenges, and opportunities. *Molecular Psychiatry*, 26(1), 218–233.
- Volkow, N. D., Gordon, J. A., & Koob, G. F. (2021). Choosing appropriate language to reduce the stigma around mental illness and substance use disorders. *Neuropsychopharmacology*, 46(13), 2230–2232.
- Volkow, N. D., & Xu, R. (2025). GLP-1R agonist medications for addiction treatment. *Addiction*, 120(2), 198–200.
- Waldinger, R. J. (1986). *Fundamentals of psychiatry*. American Psychiatric Press.
- Żak, A. M., & Pękala, K. (2024). Effectiveness of solution-focused brief therapy: An umbrella review of systematic reviews and meta-analyses. *Psychotherapy Research*, 1–13.
- Zakiniæiz, Y., & Potenza, M. N. (2018). Gender-related differences in addiction: A review of human studies. *Current Opinion in Behavioral Sciences*, 23, 171–175.