SCREENING AND ASSESSMENT OF SUBSTANCE USE DISORDERS:

Methods from researchers, addiction counselors, and clinical supervisors

Abstract

Funders and regulators of behavioral health services in the USA typically mandate the use of various and particular data collection tools for screening and assessment of substance use disorders. These mandates in policy and procedure prevent clinical flexibility. They do so by precluding both rapid clinical incorporation of the latest research findings, and organic development of nuanced clinical methods seated in the clinician's intuition - as honed over decades of clinical practice heritage. This work responds by introducing principles and methods related to SUD screening and assessment derived from formal logic, recent research findings, and developments over recent decades from the clinical portion of the SUD treatment field.

Disclaimers

Nothing in this document should be taken or held as clinical instruction, clinical supervision, or advisory concerning patient care. This document reflects my opinions and is not authoritative.

Preface

Earlier this year I was asked if I would consider giving a lecture to a SUD-specific course within an MSW program. I jumped at the chance, but asked for a list of topics to consider focusing on. When I got the list, "screening and assessment" jumped out at me. I prepared some rather extensive notes from which I would make my comments, and an accompanying slide deck that was sparse and minimalist by comparison. I gave that lecture as a CE event in-house at my workplace, then presented it to that class, and finally facilitated an in-house round-table workshop on the content for CEs. Having prepared and exercised the material in those ways, I thought it might be worthwhile to write out my main points in a full-text version and make it accessible to others.

The content in this work reflects my decades of personal clinical experience in addiction treatment specifically, and the SUD services arena generally. As such, both the development of this content and its manner of delivery within the work come from a clinical perspective.

Why have I undertaken the effort to assemble content on this topic particularly? And why on sub-topics related to logic, formal definitions, clinical and non-clinical contexts, taxonomy and nomenclature, associated features, qualitative and quantitative sources, the handling of diagnostic criteria, and so forth? I've done it for a few reasons.

One reason is the poor result often achieved by blending (1) the features of addiction illness that are present during the screening/pre-treatment phase with (2) the skills of the newer clinician. The common picture of that kind of matching is found in the all too common scenario where a relatively large preponderance of material sourced in the patient's *denial, delusion, and minimizing* secondary to shame or stigma, *is combined* with the average newer-in-career clinician's adherence to *person-centered methods plus nothing* – that serves as their nearly sole method of information gathering and understanding the patient.

Another reason is related to how the diagnostic criteria are often applied inside this matching. The cartoon image of the common difficulty that this kind of matching produces is something like the clinician using each of the criteria almost verbatim as a "yes/no" question (or starting point for the patient to otherwise elaborate their estimation of each criteria's level of relevance to their difficulties). The process part of the difficulty is the clinician giving the responsibility of the diagnostician to the patient, while the clinician in fact abandons the burden of that duty and accepts the patient's answers as *the answer*. As an aside I would like to note that in that way the clinician also transforms the patient into their clinical supervisor. Digging deeper, it might be true that the clinician's anxiety is thus reduced in the immediate term, and the therapeutic alliance might look positive to the untrained evaluator. But the naïve and perhaps accidental formation of collusion of this kind is not inherently sufficient for the task at hand.

Aside from that matching problem per se, our field faces its own sub-set of variances contributing to that same process problem among the much more qualified and experienced.

Those problems are those found in (1) quantified, industrialized, mechanized, check-listed, maximally efficient, AI-supported, short appointments; (2) our field's satisfaction with allowing the patient to take charge of the clinical process, (3) our field's satisfaction with "fail your way up to residential treatment" as a clinical care pathway, and (4) using best practices and related approaches last rather than first.

A condensation of these factors can be found in the following example:

> Clinician: "Do you have cravings?"
> Patient: "No."

Further, the material in this work will not only reflect my clinical focus and experience, but will largely consist of preliminary instruction or an introduction toward further study (a propaedeutic focus). In that way, for some readers the content may not seem advanced enough. But by it being focused on introductory matters, my hope is that it challenges *any reader* by dislodging unrecognized assumptions and providing starting places that are not commonly considered.

I have two main take-aways for the reader in mind and I'll share both of them right now.

One is called "The Big 5 SUD criteria".

- This refers to the pattern of positive DSM-5-TR SUD criteria based on their separate and differing relative weights, rather than merely adding up how many criteria are met.

The other is to use top-down (research-based) and bottom-up (phenomenologically-based) types of *information* and *reasoning*.

- This refers to a way of using a simple structured process in our screening and assessment method that can help improve our thoroughness and sufficiency, and therefore the precision and accuracy of our determinations.

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Logic about logic

When conducting a SUD screening or assessment,
use both inductive and deductive information and reasoning.

I want to begin this work with thinking about thinking. To me, that's a very important and over-looked topic related to the screening and assessment of SUDs. And it applies directly. (By the way, thinking about thinking is not the same as "over-thinking", which is different). What I have in mind is a simple and clear framework that can serve as a starting point for our method, before we begin anything related to a specific case. If we are clear in our method before we begin, we can hold that structure and lift the bottom of our effectiveness, sufficiency, and over time compare and contrast our results and slowly improve in a reliable and standardized context. I also think about the analogy of a pre-flight checklist used by pilots – not as it applies to safety but as it applies to the base of a sufficient method.

In short, the message I want to send related to logic about logic consists of what could be called "bottom-up" content and methods, and "top-down" content and methods. In this section of the work I'll discuss both related to our work.

Inductive reasoning is the development of generalizations or basic truth claims after gathering a bunch of individual examples. So inductive reasoning starts with **observations** made over time. And these observations naturally lead us to develop **inferences** or **general principles**. In that way this kind of mental activity is "bottom-up" (from examples to general principles), organic (happens rather naturally over time), and phenomenological (based on real experiences).

While the results of inductive reasoning are often helpful, they can be error-prone. How so? Mainly due to lack of specificity. For example, the information is not obtained from a tightly controlled research study, and the inferences or general principles being developed are not rigorous and tightly limited by their nature.

Some people, while considering the screening and assessment of substance use disorders, would teach us to not gather **data** in a relatively unplanned way, or in a phenomenologically oriented way, or **information** based in a source like a patient's story telling. They would rather we limit ourselves to strictly scientific methods of **data gathering**. Further, some people would limit us to not use inductive **reasoning,** or inference, or the drawing of general conclusions during our screening and assessment procedures. In general, I would suggest that we combine inductive reasoning, methods, and related data with a second method I will describe later.

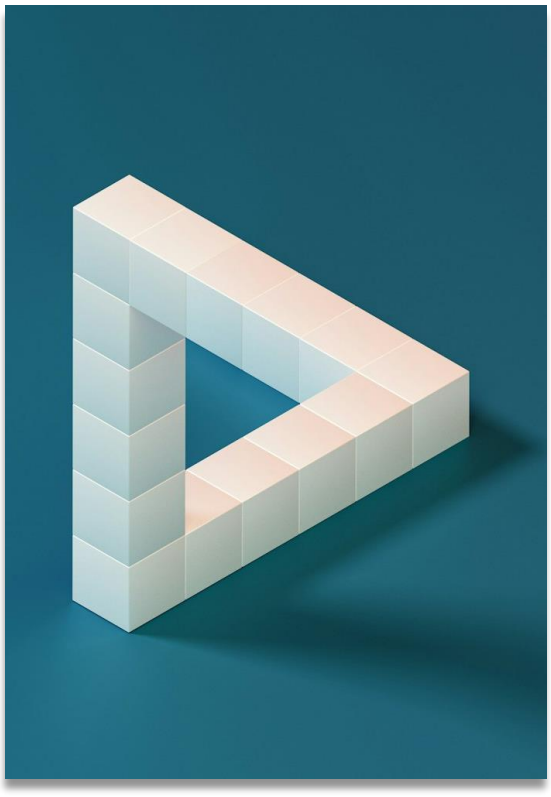
Terrance Gorski's methods of clinical observation (e.g. his gathering of relapse warning signs and identifiers of the early, middle, and late relapse dynamic) are an example of the inductive method in the SUD arena. ***Gorski's relapse prevention therapy*** (he as a person, his information, and his methods) have been rejected out-of-hand by some simply because they are seated in observation, rather than derived from tightly controlled scientific research. Similarly, ***inferred principles*** of psychology and ***psychodynamic psychotherapy*** developed by Sigmund Freud are rejected for similar reasons, as is Freud himself.

Interestingly, more recent work in the philosophy of science, critique of the evidence-based practice movement, research related to unconscious mental processes, identification of mental processes that underly disorders beneath and across diagnostic categories (e.g. Hofmann & Hayes, 2019), and newer third-wave CBT methods rooted in mindfulness, have “brought-in” inductive methods and also confirmed some claims from authors such as Gorski and Freud.

Challenges we can bring to those who continue to reject inductive methods in a wholesale fashion include the following:

- "Does the surgeon who has done 10,000 of the same procedure have something to say about the illness, its treatment, and recovery?"
- "The plural of anecdote is data.”
- "If your theory doesn't match the folklore, it's time to adjust your theory." (Hoffmann).

Are simple observations and the general principles inferred from them useless? Or are they “everything” and the only thing we should rely on? A better approach might be to appreciate that socio-biologists and evolutionary psychologists recognize that folklore is one way for a people group to advance their survival interests by capturing aggregated wisdom in an oral-tradition form that can be easily stored in memory and passed along orally across generations.



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Deductive reasoning. By contrast with inductive reasoning, deductive reasoning starts with a premise or experimental hypothesis, and puts that hypothesis to the test. An idea is put into the form of an experimental question; the results of the experiment may support or fail to support the hypothesis being tested. In either case the results are synthetic and objective. Like inductive

reasoning, deductive reasoning is prone to error, but error of a different kind. Mainly, deductive reasoning struggles (1) against the limits of generalizability and (2) from insufficient replication of experiments. For example, suppose one well-conducted and well-controlled study does find a certain result. In such an instance, although the results are objective and reliable, they still only constitute one observational opportunity. If we ran the exact same study again, would the same results be found?

Treatment methods that derive from deductive reasoning could include medications, or a CBT manualized protocol. Why are these examples of clinical care derived from deductive reasoning? Because these tools come from accumulated evidence found in the results of research studies – not from simple observations over time leading to general inferences.

When the clinician is doing a patient screening, which method should they use? Inductive or deductive? How about during a patient assessment? Which method should they use then?

The reader can consider incorporating both the information and the methods from inductive reasoning and from deductive reasoning. That is to say, we can and perhaps should use both methods appropriately. This can mean using them together, while not putting them in tension.

By contrast, some systems require one very particular screening or assessment tool, or method, and put such controls and time constraints on the clinician such that nothing else is possible.

Here's a simple example of each of the two methods: inductive and deductive.

Example 1 (inductive): When I see a person for the purpose of a screening, imagine they present with yellowed fingertips, a cough, wide gait, and an oddly bronze-colored skin. Based on knowledge of associated features of various substance classes, the notion might form that this is a person who smokes cigarettes and also drinks alcohol problematically. Should we form that inference, or are we better off to not form any inferences? If such an inference is formed, should we explore it using a variety of methods, or should we merely note the inference and move along to the next portion of the screening?

Example 2 (deductive): During my undergraduate practicum in 1987 I was assigned to spend time with a counselor who had a caseload in a half-way house for alcoholic adult males. The counselor also did screenings for those presenting with any and all possible MH or SUD needs for possible referral. One day, a middle-aged woman came in for her screening appointment. After getting some basic information the counselor calibrated a breathalyzer and instructed her to blow. I was incredulous at how silly this seemed. (The counselor had no college education at all, and this obviously sober and coherent woman did not need to blow for any reason. I felt very superior the this so-called "counselor"). I was amazed the result showed a 0.4 and she easily stated she had been a maintenance drinker for many years. I realized the counselor had stuck to an empirical method, regardless of how things looked. The use of deductive thinking (when doing a screening, use laboratory techniques x, y, and z no matter what), information (breath results), and reasoning (high tolerance) in that instance was amazing. I learned a lot that day.

Next in this work, let's compare how two different traditions define two key terms.

Definitions

When conducting a SUD screening or assessment, adhere in a structured way to both scientifically and humanistically-oriented methods.

Let's look at the definitions of "screening" and "assessment". And let's compare how the definition of each one differs when the definition is sourced from a medical dictionary, or from a drug and alcohol counselor credentialing body.

First, let's look at the term **"screening"**.

Mosby's medical dictionary states that screening is, "A preliminary procedure, such as a test or examination, to detect the most characteristic sign or signs of a disorder that may require further investigation."

By contrast, the *IC&RC* defines screening as, "The process by which the client is determined appropriate and eligible for admission to a particular program."

To me those are very different definitions. My background in psychology is very empirical, and rooted in the "scientist-practitioner" model of psychology. Thus, the definition from the medical dictionary really resonates with me. The IC&RC definition resonates in a totally different way – given my career length in clinical addiction treatment settings.

In hindsight, I've done lots and lots of both of those kinds of activities: (1) looking for characteristic signs that would indicate the need of further assessment, and also (2) checking case data for the person's "fit" or lack of fit for a specific program. And reading these different definitions, I would suggest that both of these two categories of method, targets and purpose are valuable. And I would go further and also suggest that a clinical screening method can encapsulate both of these purposes – and that they are in fact complementary.

Before we leave the term "screening" and move to "assessment" let's consider some simple real-life clinical examples.

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Example 1: Have you ever screened someone for admission to a residential addiction treatment program who eventually said they had no substance use history at all? And that they were simply looking for a place to live for the winter, knowing that the stigma was so bad that if they said "yes" to most things in the interview, they knew that they would be admitted?

Imagine screening (either definition or both) a person who reported being a 2-pack a day cigarette smoker for the most recent 20 years, having drank 12-24 beers per day that whole time, and smoking crack from a small metal pipe around the clock for 3-4 days at a time, with about a week between crack binges, for the most recent 8-9 years. And now imagine that during the interview you start to realize that the person has:

- perfectly intact facial skin
- no burns or burn marks or scars on or around their lips
- no yellowish stains on their fingernails or finger tips
- no burns or burn scars on their finger tips
- no abdominal swelling
- a normal gait
- a fully intact mental status
- no difficulties in short-term or long-term memory
- normal breathing without any shallowness, strain, or breath sounds
- no detectable sub-culture slang from any using community
- no shame or emotional discomfort discussing their history

And upon checking the chart, you see their blood work is unremarkable (with key biomarkers, including liver function tests, all within normal limits) and their toxicology testing is negative.

Conversely, have you ever screened someone with gross signs and symptoms of a chronic and severe substance use disorder who simply and easily stated they had no use history at all?

Example 2: Imagine screening (either definition or both) someone with: old burn marks on their face including around their lips, new burns on their lips, finger tips with some missing flesh and long ago scarred over, abdominal swelling on the right side, a wide gait, blunted affect, poor concentration, problems with short term and long term memory, shallow and strained breathing making some raspy breath sounds, using esoteric slang from a particular drug-using subculture, and they avoid eye contact and lower their eyes when directly asked about substance use. And when asked their lifetime and recent substance use history they simply say they "don't use" drugs or alcohol, and are not "on any drugs", and "don't take drugs at all." And when checking the chart, they have elevations in liver enzymes (ALT and AST), as well as GGT and MCV. And when looking at their toxicology screening their results are positive for nicotine, cocaine, and recent alcohol use (EtS and EtG).

Each example presents an incongruence of (1) self-report information; (2) observable signs and symptoms known to be associated features; and (3) laboratory findings (toxicology specific and primary health blood work). And each example seems to point to a different clinical hypothesis. You might have noticed that these scenarios both make use of inductive *and* deductive information *and* methods of reasoning. Do we know the associated features well enough that we can realize what we are seeing when they are in front of us (Coon, B., November 17, 2021)?

But what of the term **"assessment"**? Let's have a look at that next.

Mosby's medical dictionary states an assessment is, "An evaluation or appraisal of a condition. The process of making an evaluation. In a problem-oriented medical record an examiner's evaluation of the disease or condition based on the patient's subjective report of the symptoms and course of the illness or condition and the examiner's objective findings, including data obtained through laboratory tests, physical examination, and medical history."

Meanwhile, the *IC&RC* states assessment means, "The procedures by which a counselor/program identifies and evaluates an individual's strengths, weaknesses, problems and needs for the development of a treatment plan."

Once again, to me, these definitions are remarkably different. And they can also be held as complimentary rather than in tension.

It seems to me that the definition from Mosby's is in the medical-scientific camp, and reflects empiricism, scientific reductionism, and the top-down scientific method generally. That definition describes the more thorough assessment of a clinically-significant problem that was identified from a screening procedure. And the disorder is assessed in a comprehensive way via the clinician's adherence to specific and standardized assessment protocols. Yet in this approach, after all the various kinds of information are gathered, the method still relies upon the

technical judgment of a subject matter expert to understand the results in the aggregate (see Coon, 2022, "Comments on the Task of Interpreting").

Meanwhile, it seems to me that the IC&RC definition implies a different kind of method and target – one related to wholistic, humanistic, and phenomenological matters. For me it brings to mind such matters as one's adaptation to the presence of illness and one's capacities to receive help and partner in the change process. That's the domain of the psychology of chronic illness (e.g. Goodheart, & Lansing, 1997).

Are these domains at odds? Which one is the higher priority? Is one to be preferred while the other is to be excluded? Does one envelope and subsume the other entirely?

In my opinion the answer to all of these questions is, "No". And the aims and related activities of what we call an assessment is likely improved by attending to both.

With that in mind, I'd like to now turn our attention to the matter of *clinical tradition*.

It turns out each clinician is educated academically and has also had a level of mentoring with regard to matters of technique or skill. And it turns out that the educator and mentor alike both had educators and mentors of their own. Further, our clinical setting, service, and workplace have a current workforce – with each member having their own training and career lineage – and the workplace as a whole has a history or lineage as well. I think it's beneficial to be cognizant of one's own clinical heritage and contemporary clinical traditions while in the workplace context that surrounds them. That simple awareness might help us to more accurately employ or exit those influences as the clinical picture of a current case might demand.

But what can be acknowledged and gained with a look at clinical tradition? And how does the topic of clinical tradition apply to screening and assessment of substance use disorders?

In the next portion of this work I'll share the tradition I was brought up in clinically, as it specifically relates to the topic of screening and assessment of SUDs. In doing so I'll share and expound that method from my lineage. And the reader can draw their own comparisons with the information from my heritage and what has been presented in this work already, and come to their own conclusions.

Let's have a look.

Clinical tradition

When conducting a SUD screening or assessment, be consciously aware of your training and experience as context, and then match methods to the need.

The general topic of this work is "screening and assessment" of substance use disorders. Yet in the clinical tradition I'm from, we would add two additional terms. And the two additional terms would comprise two additional steps in a logical sequence that is thought of as one whole project.

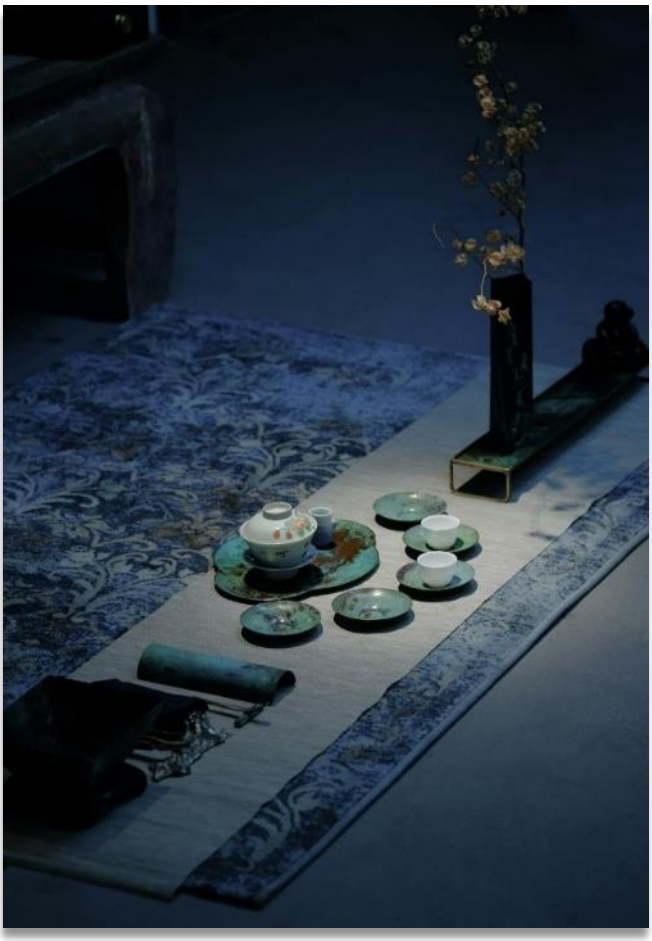
Here is the resulting list of four aims within that one project. These are found in my clinical tradition or lineage:

1. Screening
2. Assessment
3. Evaluation
4. Diagnosis

In the clinical tradition I'm from, "screening" is all about "detection". It's an efficient and very targeted survey of gross signs, soft signs, associated features. The data might be sourced in direct observation, self-report information, and perhaps some laboratory data. It helps to determine potential next steps, such as further assessment, or to help direct provision of care generally.

And in that tradition, "assessment" does concern itself with eligibility and appropriateness but its emphasis is an intermediate level of exploration of the person's problems and needs. And in the tradition I'm from, separating "screening" and "assessment" is understood, but is also considered somewhat artificial in terms of process/flow. That is to say, detection may seamlessly roll into an assessment as one essential activity – from the perspective of the experience of both the clinician and the patient. But when that shift happens, it's due to thresholds of detection being met, then the addition of an entirely formatted algorithm for further data collection begins.

Clinical heritage does provide a contextual container for, and ordering of, such activities. In general, we take our clinical heritage as context for granted and have difficulty apprehending it. Yet it provides us with a latently-instructive blend of knowledge, information, technique, approach, and tone. It benefits the patient for the clinician to be concretely aware of their heritage and its impact upon their impulses, methods, and understandings.



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Awareness can be a clear starting point for exercising or exiting its influence, as the situation might demand.

In the clinical tradition and lineage I'm from, we would add "evaluation" and "diagnosis" to the list of "screening and assessment". These would be thought of as logically-ordered and step-wise portions of one total effort to understand the patient from a clinical framework perspective.

In that tradition, "evaluation" is understood to be comprehensive in scope and also in detail. What are some ways that evaluation is more expansive, thorough, or detailed than "assessment"? In my upbringing, evaluation includes pursuit of disparate information from a variety of sources such as collateral information from family members, friends, current and former providers (physicians, therapists, etc.), their current or former sponsor and significant other, and so forth. It also includes medical records from current and former providers, including hospitalizations of various kinds. Another source of information is publicly available information or records easily found on-line. Current laboratory results can be added such as primary health blood chemistries, as can toxicology tests examining various drug classes with different kinds of laboratory samples. And a controlled substance query can be added as well (identifying who is prescribing what, and in what way, that has addiction potential). Patient interviewing is both broad and specific, and can include involvement of various clinical disciplines if necessary (clinical

psychology, psychiatry, primary health, spiritual care, etc.) before, during, and after any or all of the other data is collected. In short, so-called "controversy" or heterogeneity in the data itself is pursued until the case formulation resolves itself via clinical judgment given all available data.

That array of potential inputs may be burdensome, unnecessary, and even impossible to execute on every patient. But in the clinical tradition I'm from it behooves the clinician to know the options for what can be included in the space between "assessment" and forming a case conceptualization and diagnosis. And to take on the burden of consciously deciding and executing those that are in fact necessary and achievable is part of the standard process.

Ultimately then, "diagnosis" is a final result from the 3-stage process of screening, assessment, and evaluation. It's also important to note that the "diagnosis" at the end is an impression, and that a diagnostic suspicion or impression can and also does perhaps form after each of the 3 preceding portions of that process flow. So, in that tradition, "diagnosis" is both a final result at the end, and also a constantly evolving by-product resulting from each stage of the process along the way.

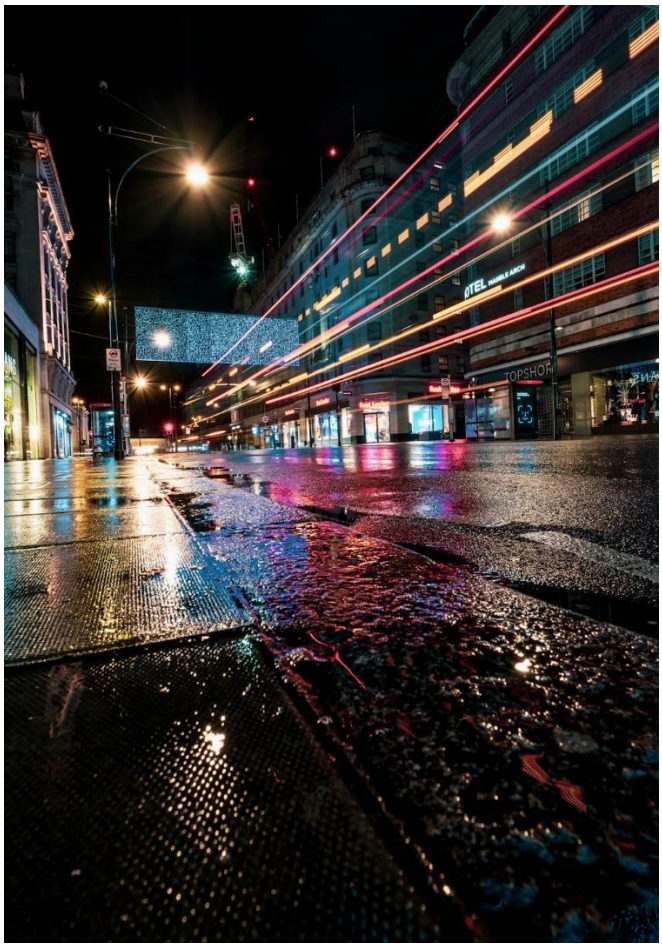
Of course, diagnosis is a hypothesis. And that hypothesis is held lightly during the entirety of the case. Data on the case are added over time, and the results of care are rolled back into the case. Thus, the diagnosis may be clarified and modified throughout the duration of the case. So in that sense, the task and result of "diagnosing" is not concluded per se, at least in a theoretical sense.

With that clinical sequence in mind, what can be said, then, pertaining to screening and assessment in non-clinical settings and services? We will start to consider that material next.

Non-clinical settings and services

When conducting a SUD screening or assessment,
apply epidemiologically-oriented information.

The activities of screening and assessment can be applied in non-clinical settings and services. My workplace from the time of my graduate internship in 87/88 through 2008 was rather vigorous about doing so. In this section I'll outline some principles and practices relevant to such aims. I'll also provide a few notes about the activity of raw observation in such settings and services, and how this can be clinically-relevant nonetheless.



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In clinical management parlance, "co-locator" is a term that refers to a clinician working in a non-clinical space. My former workplace staffed various examples of this. One was an SUD counselor inside the Public Aid/SSI office. The idea is if someone comes in to apply for public benefits, or a routine appointment of some kind, the staff of that service might notice some gross signs at the screening level of something like the possible presence of a significant substance use disorder. And that Public Aid/SSI worker could naturally have the person go to the desk of the next person (a co-locating SUD counselor) for some follow-up information gathering, if they are willing. This strategy heavily relies on training some of the regular staff of such an office.

Those non-clinical employees need very specific knowledge of associated features of clinically significant SUD problems that can manifest as gross or soft signs, and be detectable as symptoms when the person is not being asked about their symptoms. These are skills of observation and listening.

Over the decades, it has become clear to me that this kind of knowledge and skill is too specific to be expected to appear within the curriculum of our graduate training programs at the Master's level, especially in broad degree programs like clinical social work and mental health counseling. Our clinicians arrive in our clinical settings and services without this knowledge. And it's also become clear to me that professional addiction counselors do very well to learn such specific knowledge, and practice such skills of observation and listening – rather than merely rely on questioning as the main or only method to screen or assess an individual. (By the way, applying this exact same approach of gaining very specific knowledge, and thus applying vastly improved observation and listening to the matter of *improvement* – the *Stages of Healing* from substance use disorders, or *"recovery"* per se – is outside the scope of this work; Coon, 2019).

Other examples of co-locators from my former workplace were a SUD counselor located inside a school, and another located inside a county jail.

What signs and symptoms can the regular (non-clinical) staff of an office serving the public watch and listen for? And what are some tools such a person could use? Attempting to provide a comprehensive list of such is beyond the focus of this work. But I'll provide a few key examples related to both content and method. And of course, it behooves the SUD clinician to know these examples as well.

1. **Tobacco use**: Epidemiological data shows somewhere around 75% of regular smokers have either a mental health disorder or another substance use disorder. In that way, the mere presence of smoking is a screening tool.

2. **Critical life events:** Events such as dropping out of school are very often markers of the presence of a difficulty or combination of difficulties. A simple timeline of critical events can tell an even more significant story, or perhaps point toward one.

3. **First use before age 15:** Here's a SUD-specific example. At the population level, first use of addictive substances before age 15 marks membership in a significantly more at-risk sub-population. It may not be a hallmark of course of illness for the one particular person we are serving, but it nonetheless points toward a real potential difficulty.

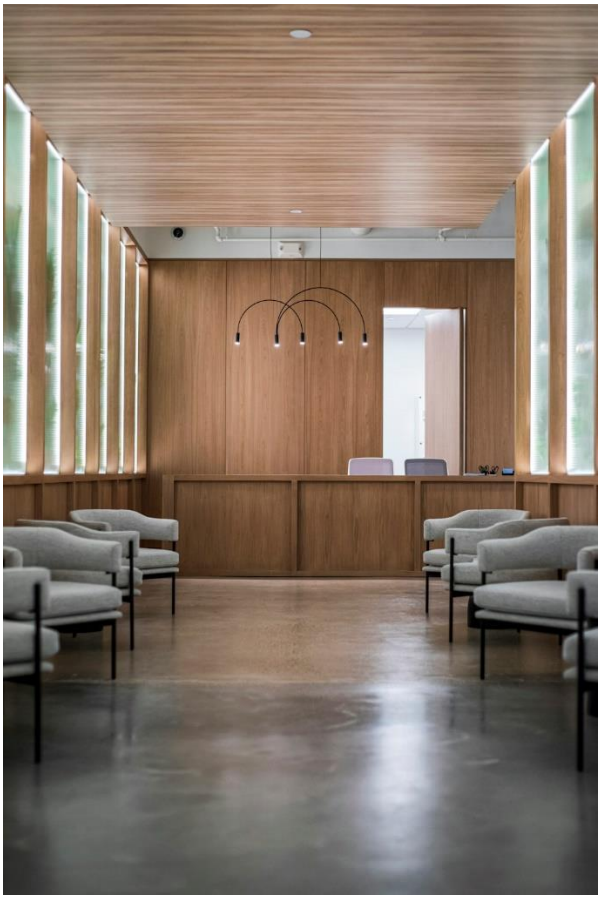
4. **Icebreaker topic:** In general, most people are almost totally willing to talk about tobacco use, caffeine, and nicotine. These can be icebreakers for getting to other topics and for getting rapport established before more difficult topics are raised. "Do you use heroin?" is not a great opening line, generally speaking.

With all of this being said about screening and assessment activities in non-clinical settings and services, what can be said about them *within* clinical settings and services? That topic is raised next.

Clinical settings and services

Scan your service area and target population for common clinical pictures, and memorize the relevant information.

For me, if the topic of "screening and assessment" of substance use disorders is applied to clinical settings and services, I can think of no approach that is more broad and at the same time more dense, than a list of things worth memorizing.



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Around 25 years ago the topic of a "list of things worth memorizing" was presented by a trainer who came to our agency. The trainer suggested ***a list of things worth memorizing*** could be helpful for clinicians, clinical supervisors, and program managers. The trainer said that each person should determine what should be on their own list.

The idea was that if a clinician ***actually memorized*** things, then those things would ***be available*** in real time. How simple. The idea struck all of us as attendees as basic, and helpful, and wonderful.

The trainer challenged us in this way: "What would be helpful to have memorized, rather than needing to look it up later?" The trainer told us that things we memorize could serve in any number of ways, including as a:

- Lens through which to listen (data);
- Resource to help understand the person served (assessment);
- Framework to consider while developing or providing clinical interventions (plan).

The trainer pointed out that something that's memorized can be useful, and brought up consciously in the mind of the clinician like a heads-up display. It can serve as a template for the situation to which it applies. We were told the only real trick is to ***actually memorize*** whatever you say is worth putting on your list, and then to later ***remember you have the list*** in the first place.

But during this training the major focus was on ***how to determine*** what to put on such a list. And that we should modify our lists over time.

The impact of this topic as a question to carry has been very significant for me, and I've been meditating on ***the idea*** of such a list for about 25 years.

- Pushing myself to try to recognize what is necessary and sufficient to memorize has been a helpful mental project causing me to pay attention.
- As I've learned new things over the years, I've considered, "Does this go on the list?"
- And I've taught the idea of such a list to generations of clinical supervisees of counseling, and of those I've trained and mentored in clinical supervision.

The trainer did suggest a few basic considerations for what we could include on our individual lists:

- The DSM diagnostic criteria for the most common one or two primary diagnoses in our particular setting or service area.
- The DSM diagnostic criteria, or similar standardized list of identifiers, of the few most common co-occurring disorders in our particular settings or service areas.
- Stuff that's helpful for developing clinical techniques during service delivery.

What's on my list? I'll give you my list, and then break down the members of each one. The last one on my list is so essential and important, I've decided to not share it here but rather to dedicate a whole section of this work to that topic. That section comes later in the work.

For now, here's my list with the exception of one additional item.

1. Medical mimics of mental disorders
2. 4 steps in pharmacokinetics
3. Depressive episode
4. Manic episode
5. 5 principles of motivational interviewing
6. MET/FRAMES
7. Assessment of strengths
8. Clusters of personality disorders
9. The 11 DSM-5-TR SUD criteria

And what follows is the break-down of each of those 9 items.

Medical mimics of mental disorders: THINCMED (Hedaya, 1996)

- Tumor
- Hormone dysregulation
- Infection/Immune suppression
- NutritionCentral nervous system integrity
- Miscellaneous
- Electrolyte imbalance/Environmental toxin exposure
- Drugs: over the counter, street drugs, prescription medications

I'll never forget a patient on my caseload back in the mid 1990's who had a ten-year history of unremitting depression – along with CBT for depression and ten years of world-class psychopharmacology interventions. All of that assistance was only marginally helpful. Then, not long after that patient was admitted to our long-term residential program, our program's medical director read that history and simply wrote an order for a certain lab test. When the result came back with abnormally low findings our physician then wrote an order for hormone replacement therapy. Her depression remitted in less than two weeks and never returned.

Later, when I read that list of medical mimics of mental disorders, I remembered that person's story and I knew I was adding this to my list of things worth memorizing. For me, that list of medical mimics has been super helpful.

Four steps in pharmacokinetics (Cozza, et. al.)

1. Absorption
2. Distribution
3. Metabolism
4. Excretion

I'll never forget when I undertook some focused learning in the early 2000's related to psychopharmacology and the basics of drug metabolism. This included drug-drug and drug-food interactions. From that point on I've used "Can you eat graham crackers? Should you eat graham crackers?" as my cartoon-like, easy-to-remember placeholder for appreciating this entire domain of knowledge. Afterall, to the body, food is a chemical. It's been helpful for me to know things can go wrong in various ways, differently, at each of these 4 stages in the process. The main way it's been helpful to me is to help me ***improve my "alert ignorance"*** – the clear realizing of what it is that I don't know – and then go ask or discuss with a nurse, PA, NP, or physician. Is something interfering with (slowing down or speeding up) absorption? Distribution? Metabolism? Excretion?

Depressive episode: SIGECAPSS

- Sadness (excessive)
- Interest (low)
- Guilt (excessive)
- Energy – low (atypical high)

- Concentration (poor)
- Anhedonia
- Psychomotor retardation (atypical agitation)
- Suicidality
- Sleep – increased (atypical decreased)

Clinical depression is so common in the severe and chronic SUD population that this list has been immensely useful for me on a regular basis. The wisdom of our trainer that the diagnostic criteria for the co-occurring disorder with the highest rate of frequency in your setting or service is probably worth memorizing turned out to be true. Experiencing that truth myself somehow made its validity more real. I learned this during the DSM-IV era.

Manic episode: DIGSHAFT

- Distractibility
- Irritability
- Grandiosity
- Sleep (reduced)
- High risk behavior
- Agitation
- Flight of ideas
- Talkative

Before we left the training that day, a couple of the clinical psychologists in our agency said that the criteria for a depressive episode and for a manic episode were worth putting on the list. They worked in the MH side of our agency. I liked their idea but I didn't know if it was a real fit and really worth it for me – someone who worked in a long-term residential SUD program, and a methadone maintenance outpatient program.

To help myself decide, I looked at the epidemiology literature and clinical depression was easily in first place among co-occurring MH conditions for people with severe, chronic, and complex SUDs. I went ahead and memorized the criteria for a manic episode too.

That list for a manic episode has been more useful more often than the list for a depressive episode. Why? By using these two lists of criteria I've learned over time that depression tends to be easier to identify, while mania on any level is harder to do the differential diagnosis with – given the range of substance classes with addiction potential we often encounter (especially stimulants). I also learned this one during the DSM-IV era.

5 principles of Motivational Interviewing: E, D, A, R, S

- Express empathy
- Develop discrepancy
- Avoid arguments
- Roll with resistance
- Support self-efficacy

I remember that in the mid to late 90's we were getting intentionally-provided training on MI. It was a whole different way to think and to provide therapy. I'll never forget a staff meeting we had in the late 90's when a patient about 2/3 of the way through the long-term residential program had been discussing the possibility of going home on pass. The patient was not present at the team meeting. Our team discussed the pros and cons of going, and of not going. It became a very drawn-out discussion leading to a certain kind of pointed impasse among the staff. I didn't like where the discussion was leading, as it seemed to be a topic with no natural resolution, and would produce division if the discussion kept on going. But regardless, the staff were getting stumped. Should we let the patient go on the pass or not? Feeling hopeless, I regressed into my own mind looking for answers. I remembered "The 5 Principles of Motivational Interviewing" from my ***list of things worth memorizing***.

"Express empathy", I said to myself. Not a fit. "Develop discrepancy". Not a fit. "Avoid arguments". We were arguing as a clinical staff and the patient wasn't even in the room. "Roll with resistance". That didn't fit, if only because the patient hadn't even submitted a pass request. "Support self-efficacy". BINGO!

I told the staff we should bring the patient in, mention the pass as an opportunity, and have them figure out if they wanted to request it or not, and we would support either decision. The staff was greatly relieved and the patient was boosted by this kind of validation of their autonomy. What a lesson for us. It seemed ***we*** needed the principle more than the patient did.

I'm old fashioned within various formats and portions of MI and personally prefer the EDARS format to anything newer from MI. It's beyond the point of this work, but if the reader is curious why I've preserved the use of the older set of MI principles, including the word and idea of "resistance", I would direct the reader to my monograph on that topic.

FRAMES (Motivational Enhancement Therapy)

- Feedback
- Responsibility
- Advice
- Menu of options
- Empathy
- Self-efficacy

During the BHRM project (1997-2007 or so) we chased fidelity to MI across our agency, with great gusto and sustained intent, using best-practice supervisory techniques for a number of years. We eventually made a formal decision to give up on MI as being too aspirational and not practical enough for the clinical staff, given our mainly very severely disturbed population of patients with profound symptoms of mental disorders, substance use disorders, and co-occurring disorders. As a leadership team we made the decision to replace our emphasis on MI with an emphasis on MET/FRAMES. It had more clinician-ready accessibility, and patient-ready relevance. But we did not abandon MI entirely.

By having both the 5 principles of MI and the FRAMES strategies from MET memorized, I have come to appreciate the ability to choose or oscillate between the two in-the-moment, as the current situation presents itself.

Assessment of strengths: ROPES (Graybeal, 2001)

- Resources
- Opportunities
- Possibilities
- Exceptions
- Solutions

During the BHRM project Thomas Murphy and I were made co-chairs of an ad-hoc working group tasked with finding the best practice literature on strengths. The strengths-model was already in our field and its literature; the question was not one of how to do strengths-based counseling but rather of assessment of strengths themselves in a simple form. We found the "ROPES" model. In short, having this format memorized has been super useful, as I'm sure you can imagine.

For the person not familiar with the ROPES model, I'll say one thing. "Exception" means something like "…when the problem doesn't happen." This points the clinician towards periods of wellbeing, effective self-care, or exploring what is happening when the problem is not happening or manifest. As a behaviorist, that made tons of sense to me and helped me not just chase down sources of variability but also get a specific picture of strengths related to those periods of time.

Personality Clusters: A, B, C (DSM)

- A (odd, eccentric): SPS
  - Schizoid
  - Paranoid
  - Schizotypal
- B (dramatic, emotional, erratic): BAHN
  - Borderline
  - Antisocial
  - Histrionic
  - Narcissistic
- C (fearful, avoidant): DOA
  - Dependent
  - Obsessive compulsive
  - Avoidant

As a working clinician, my main personal benefit of memorizing this list and framework has been two-fold. One is a concurrent awareness of the 3 clusters as described by the words in parentheses. That is to say, when considering personality, I often start by mentally scanning the 3 clusters. I do this by recalling the descriptive words for each cluster to see if a relevant place to land my thinking is present.

Beyond the simplicity of the 3 clusters, having the individual disorders memorized also means I can consider the disorders on the fly individually or concurrently.

Further, imagine laying the entire list of disorders sideways and considering them as individual features or factors – like channels on a sound board for concert mixing or a multi-band EQ for a stereo. This has allowed me to pick up traits, styles, and various nuances – at least as a starting place – from which to consider the giant domain of personality. That is, because of memorizing the disorders within the clusters, I can handle them as concurrent categories of function that might or might not be individually present.

I've added this list on the topic of personality within the most recent 15 years or so, and it's been super helpful for me.

The 11 DSM-5 criteria for SUD

When the DSM-5 came out we had a lot to do in terms of new memorizing. While memorizing this material, it helps to work with the list in any order numerically, and in both directions.

For example:

- "Criteria 6. Can you recite it?"

Or:

- "Use in physically hazardous situations. Which criteria number is that?"

If you have the list of the 11 DSM-5-TR criteria for SUD worked into your memory in such a way that you know the material in any order and in both directions (the number for each criteria, and the criteria for each number), it might improve your listening with patients and functioning with team members. And your screening and assessment activities while you're all alone – with a DSM within reach or not.

And in my experience, not having them memorized leads to reading them aloud to the patient and asking for a "yes" or a "no" or passively receiving their statement of evidence or no evidence.

But also in my experience, having them deeply memorized means you are holding them as latent raw material. And that enables you to activate a translational mechanism from which you can design or develop a much more effective comment or query for them to respond to.

With the 11 DSM-5-TR criteria for SUDs in mind, and the entire challenge of diagnosing as an activity and diagnosis as an entity in the first place, I want to next turn our attention to two related issues: categories and terms. Or, the topics of categorization and of the use of terminology. Or, in more formal terms, taxonomy and nomenclature.

Diagnostic taxonomy and nomenclature

Study categories and their limits of membership, in order to gain all their benefits and to know very well where and how those benefits end.

In this section of the work I'll present some challenges and get us in the weeds a bit. There's really no perfect solution or final answer to these difficulties. These are more like puzzles that we carry and also don't have perfect solutions for. Yet, considering them well in advance of facing them for the first time or during a moment of urgent and high-priority necessity can prove to be helpful.

I'll cover (1) diagnostic vs. non-diagnostic factors; (2) a way of considering co-occurring SUD and mental health problems; (3) and some difficulties related to individual differences vs diagnostic categories.

The first major sub-topic among these challenges is the entire issue of diagnostic factors vs. non-diagnostic factors. I'd like to handle this in two ways. One is to differentiate these two kinds of factors very clearly, and thus render the difference as eminently practical. The other is to make the difference between a diagnosis and a problem abundantly clear, and again render that difference as completely practical.

Here's a story. I once received a call from a family member of a patient we had treated a year prior. I was worried something had gone wrong. I was relieved during the call to hear the family member say things had gone so well that they were going to now send yet another family member in need of our services. They naturally and easily then began to recount this other family member's main difficulties needing our clinical attention.

After hearing the information, I inquired about this person's hobbies and main interests in life. I didn't do so abruptly or in an odd manner, but it did take more than a few attempts to clarify the reason for my asking. I shared how person-centered goals, or interests, can make all the difference in how someone lands in and benefits from (or not) a SUD treatment program. We discussed the first family member we saw a year previous, and how that person and our program were a "fit". I suggested that we might be a fit for the next family member, and given what I heard about the person's life goals and interests I also named a program of good quality designed around those matters. Sometimes retention follows from "fit". They called me a couple of weeks later and said they and their loved one looked at the information on our place and that other program, and they were delighted to choose the other program.

"Non-diagnostic" characteristics are those of the patient as a person. And from time to time these, when handled as targets within the processes of screening and of assessment, can make all the difference, it seems, in case conceptualization and planning provision of care. As opposed to the method of merely matching a pre-packaged and freeze-dried whole treatment to the diagnosis of the person seeking care, with no regard for the patient as a person – even among otherwise equivalent treatments.

Now to differentiate a diagnosis from a "problem". In short, we generally treat problems, not diagnoses. One could say the same thing this way: we treat problems, not disorders. What this means is that we treat the problems that are concretely real and right in front of us. We don't treat a disorder that is understood in an abstract or theoretical sense. We treat the actual problem; we don't treat the average meaning of a population-sized general description of what a diagnosis is defined to be in the aggregate. Yes, a very good understanding of the disorder or diagnosis as an entity can be very helpful (like informing us of where else to look) but we don't treat a hypothetical abstract diagnosis. We treat real problems as they actually are. A diagnosis is a general label while a problem is a concrete fact.

Sometimes a particular clinician might excel at understanding a diagnosis and remain poor at understanding the patient's problems. And thus, be very good at discussing a full range of possible problems, but poor at conceptualizing the clinical targets and methods to shift, modify, or alter those targets for a particular case.

The second major sub-topic concerns one particular way of thinking about co-occurring substance use and mental health disorders. This method is exemplified by its major exponent, Ken Minkoff (circa 2001). His approach in patient sorting is rather simple and helpful. One estimates, not by diagnosis only but by current functional status of presenting problems, a rough estimate of "high" vs. "low" for each category of their substance use and mental health. The *nature* of their illness *would* be considered (such as its historical severity in their individual case) but not the diagnostic label alone. At essence, it's a 2x2 quadrant as show below.

	MH low	**MH high**
SUD low		
SUD high		

Here are some hypothetical case examples and their placement within the grid.

- A mild alcohol use disorder in a patient with schizophrenia who has been stable for many years with no hospitalizations that whole time might be "SUD low/MH low", which is the top left quadrant.
- During a symptomatic phase of their MH condition that same patient might present as SUD low/MH high, which is the top right quadrant.
- A patient who has been smoking methamphetamine routinely for a few years and has a remote history of clinical depression and no active symptoms might be "SUD high/MH low", which is the bottom left quadrant.

- A patient with a 20-year history of drinking a case of beer daily until current, with active panic disorder, active generalized anxiety disorder, and active social phobia would be SUD high/MH high, which is the bottom right quadrant.

That basic formulation of SUD/MH x Low/High helps the clinician formulate the functional status of the case in a simple and practical sense.

Unsplash: Boston Public Library

At my former workplace, we went even further and for each residential and outpatient program separately drew a wiggly line through the quadrants, as applicable, to help to roughly designate the scope of practice for each program.

The third and final sub-topic related to taxonomy and nomenclature, as they pertain to the screening and assessment of SUDs, are the problems of some so-called diagnostic orphans.

In the DSM-5-TR, if a person meets 2-3 criteria for a substance class they are designated as "mild", and if 4-5 criteria met they are "moderate", and if 6 or more are met they are classified as "severe". This presents a bit of a puzzle. How so? Well, what are we to make of the person who meets only 1 criterion? In the current edition of the DSM we told to designate them as "unspecified". *But what are we to make of them?* And how?

Similarly, during the longstanding DSM-IV era (APA, 1994) we had a SUD diagnostic category called "Polysubstance Dependence". Personally, I liked the details of that formulation quite a bit. Here's how it worked.

In DSM-IV if someone met 3 or more criteria for a substance class they qualified as Dependent on that class. And a person could also be Dependent on more than one class. In other words, if they met the dependence criteria for more than one substance class, all of the dependencies would be listed for each substance class.

But if the person only met 1 or 2 criteria (falling short of the 3 required to be Dependent) for each of 3 or more substance classes total, and never met 3 or more for any one class (which would make them Dependent on that one class), then they were Polysubstance Dependent. The idea was they were dependent on substances in general, and not on any drug or drug class in particular. Just to be clear – if someone met Dependence criteria for any one substance class or more than one class, they were not allowed to be designated as Polysubstance Dependent.

In other words, such a person would only meet 1 or 2 criteria each for 3 separate classes or more. And then, when these criteria are all totaled, the Polysubstance Dependence comes into view because the total criteria met across all the classes *is* 3 or more total criteria across classes. In DSM-IV Polysubstance dependence is Dependence, but it's Dependence that's present *across classes*, and does not exist within any one particular class.

In my clinical experience, some patients are like that. But in DSM-5 the Polysubstance Dependence category was simply eliminated.

And remember, in DSM-5 if 2-3 criteria are present for a class that is "mild". Whereas in the DSM-IV, 3 criteria meant "Dependent". But regardless, with DSM-5 we could finally end up with:

- A patient meeting 1 criterion only for a certain class making an Unspecified use disorder, plus two Mild use disorders for 2 different and additional classes with 2-3 criteria being met for each.
- A patient only meeting 1 criterion for each of the 3 classes, and thus having 3 Unspecified use disorders.

For me, this aspect of the DSM-5 diagnostic system for SUDs breaks down and doesn't seem to hold together. Or convey meaning. Even though we can add the proper DSM-5-TR diagnostic labels, the formerly Polysubstance Dependent person *whose illness was like that* under DSM-5 *is an orphan at the level of meaning*, as their dependence fails to be recognized.

Another issue related to diagnostic orphans is attributable to clinical practice, and not an inherent aspect of the DSM. In the DSM one diagnoses by substance, not by class. Thus, one would record "Heroin use disorder", and not "Opioid use disorder". The axiom we learned in graduate school related to this is, "No one reads their DSM." From 1987 to present that's proved to be true, with the exception of fewer people than I can count on both hands. How such a large percentage of our field violates this instruction in recording SUD diagnoses is truly beyond me.

How does this lead to a problem of diagnostic orphans? When is the last time you saw a diagnosis listed that said “Speedball Use Disorder”?

Which does lead us to an inherent problem with the DSM. With the DSM one determines how a problem in a person’s life is attributed to a particular drug class. For someone injecting heroin and cocaine together, in a speedball, and for such a person who always and only uses in such a way, to which drug should the difficulties be attributed? And does such a person have two dependencies? Their phenomenology is of one dependency – upon speedballs.

It’s at this level of screening and assessment that we gain a real appreciation of the person as a person, and the data as the data, and the diagnosis as a diagnosis, and a case conceptualization as a case conceptualization. They are distinct, with space between each. Our systems are imperfect approximations.

As a well-known addiction medicine physician once told me during personal communication in 2014, "We would never say a person has co-occurring substance use disorders. Addiction illness is one illness."

With that, we will now turn to the topic of features associated with substance use disorders, and their value in SUD screening and assessment.

Associated features

At minimum, read the "associated features" portion of the DSM within each substance class.

So far throughout this work I have introduced the idea of what are commonly called "associated features" and incorporated that idea within various portions of the text. Thus, my handling of this topic here, in a separate section dedicated to it, will not need to be as long or detailed as it otherwise might.

Are all of the various use disorders of every chemical compound, across all drug classes, sufficiently describable by the same and only 11 diagnostic criteria for all? Of course not. As a physician might feel the shape, temperature, and texture of a tumor while having their gloved hand inside the abdomen of the patient, and perhaps even smell the offending tumor as well, so the addiction counselor can sense the nature of the patient's illness – far beyond the simple, dry description of the criteria that are met.

What shape does it take? What form? What features does it possess?

Unsplash: Pelayo Arbues

Examples might include yellow fingers tips, track marks, an unsteady wide gait, a distended liver, bronze-colored skin, and being jaundiced. In short, I encourage the reader to absorb the associated features of use disorders across various substance classes. The DSM is a good place to start. Also, I encourage the reader to develop a working understanding of the post-acute withdrawal syndrome (PAWS). Twenty-plus years ago some in our field derided that phenomena as being something like an urban legend promulgated by unreliable clinicians. But in recent years it's become the focus of highly credible academic research studies and its features are being normed (e.g. Haskell, 2022).

Perhaps two particular stories from my career will serve the reader better than lists of features than can be looked up elsewhere. These stories rest in the concept of associated features, and pertain directly to screening and assessment of SUDs.

Around ten years ago we were evaluating a person with a strong sense of quiet self-importance, and whose personal dignity did not allow them to disclose their use history. They finally stated

they didn't use drugs, and needed to be discharged. One of our physicians talked with me about this case prior to initiating the history and physical. I was directly asked how to go about doing the interview in the face of such overt resistance and such an emotional barrier to self-disclosure. My answer? I simply **gave a few light tugs to the left-hand sleeve** of my long-sleeved shirt. The physician gave a wry smile, understanding what I had just communicated. The next morning that physician recounted how when they got started doing the interview, and the first statement we knew to be overtly false based on credible collateral information was made, he tugged on his sleeve and asked the patient to roll up their left sleeve. The patient then softened, became authentic, and wept a bit while disclosing their IV use history.

During the first two weeks in my first full time job after internship, in a 9-12 month Therapeutic Community residential program (that also had an outpatient methadone maintenance program operating out of the first few rooms at the front of the facility), I got an intercom message from the nurse's station. The RN (who opened the methadone clinic in 1968 and still worked there at this time in 1989) asked me to come to her office, because she had something to show me for part of my training. When she asked, I calmly asked, "What is it you want to show me?" She balked and reiterated her request. We went back and forth a few times. She realized I was not going to relent and she finally described a wound on the back side of a patient's arm. The wound had developed due to a long history of IV administration. The wound being described was so severe I won't recount it here. I thanked her for her thoughtfulness in offering to help me with my training.

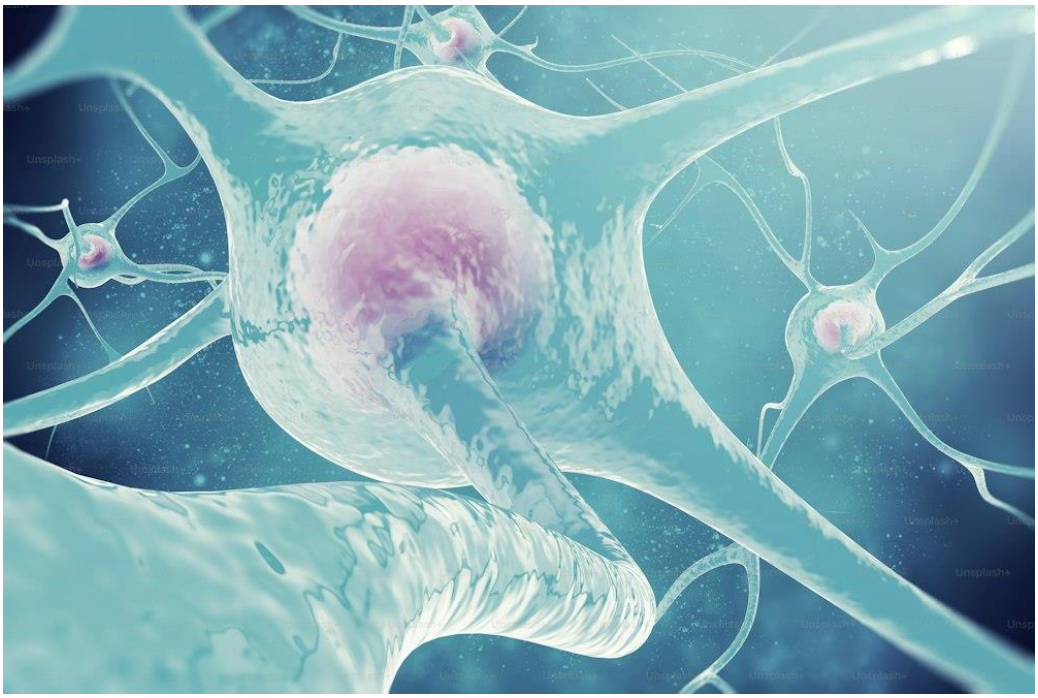
Back in 1987 when the non-degreed and certified counselor administered a breathalyzer to an apparently sober person, obtaining a result of a 0.4, I didn't imagine I would so soon see a gross sign of pathology that told me more than that one. But I did. All I could think of concerning the magnitude of that wound were topics like object relations, dissociation, defense mechanisms, illusion, the surreal, derealization, and depersonalization.

But next come hints from psychopharmacology itself.

Hints from psychopharmacology

When conducting a SUD screening or assessment, listen for attractions to and repulsions from effects and side effects of various street drugs, OTCs, and prescription compounds.

Here I'll share a few tips or techniques that add a whole content domain to our understanding of the patient via screening and assessment procedures. And it's related to lessons learned from psychopharmacology. The bottom-line message is to come to understand the patient's preferred pharmacological action, and to extend that understanding into their larger data set and resulting case conceptualization.



Unsplash: Getty

In 1996, after my clinical/administrative supervisor left to go on to full-time teaching, I was made responsible for the total operations of our 9-12 month residential program, as well as our outpatient methadone maintenance program. I started reading the methadone maintenance empirical literature with vigor, and sustained a rather large amount of reading on the topic for several years.

I eventually came across the fact that opioid receptors are not all one kind of receptor, and that they exist as sub-types. Each sub-receptor within the opioid class has its own properties and resulting action when activated. And each sub-receptor of course has its own distinct name. Frankly, given my life-long interest and reading in biology, this was exciting to me. But practical clinical utility hadn't occurred to me yet.

I shared this new learning with a counselor I had worked with since I started. This counselor had a decades-long heroin habit, had entered long-term residential treatment, found a path of

personal recovery, gotten a "civilian job" for several years as it used to be said, and later returned to the field as a certified drug and alcohol counselor.

As soon as I shared the part that broke down the different actions of different opioid sub-receptors, I could tell this was feeling like old news to this career-length counselor. I was surprised he was way ahead of me on this, but I tried not to let on that I was.

Once I was done with my exposition he told me that each person with an opioid addiction knows what they like.

"What do you mean?", I asked.

He started to slowly rattle off the names of different opioids and opiates. While doing so he emphasized that a relative difference in preference exists for each person between the available compounds. As I listened I connected hard facts about differing sub-receptor activity across the various chemicals to matters of personal preference. And I realized that the patients in the methadone program were a collection of individuals in a broad and loose group, whose illnesses also exist in sub-groups that could be sorted by preferred sub-receptor activity.

The specific sub-receptor activity is what each exact person precisely likes. And, given my upbringing in radical behaviorism, it struck me how important it is to know what a person finds rewarding.

I've thought since then about using that kind of information in at least two basic ways. One is to investigate the preferred receptor activity of any SUD moderate to severe patient, and see how those kinds of aims can be met in a healthy way in a recovery-orientation lifestyle, at least in the first year or two of their recovery. And the other is to be aware of drug-food and drug-drug interactions that can lead to pharmacokinetic or pharmacodynamic problems. And that one kind of interaction is phenomenological: cued cravings could be but one simple and common problem unintentionally resulting from the action of an otherwise well-meaning prescriber.

A main take-away from this sub-section of the work is as follows: during the screening and assessment interviews you conduct, consider listening from the pharmacological perspective. As you hear the person's drug and alcohol use history what do you notice about their:

- aesthetic preferences
- anesthetic preferences
- euphoric preferences
- unwanted side effects?

And what does that information suggest about them as a person – their phenomenological experience of what it's like to be them?

A person with an opioid use disorder might be seeking anesthesia. Another might be seeking somnolence. And another, pure euphoria. What does any such information lead us to wonder in any certain case? With that in mind, the next portion of the work turns to the matter of quantitative and qualitative data, and data sources.

Quantitative and qualitative data and sources

Years before he passed away, Lee Feldman spent many hours with me over a series of years. During our visits together, I usually ended up listening for 90% of the time. His background and knowledge base were most remarkable. As was his view of its application to our field.

One time in particular Lee introduced me to the word "qualia" and took me on a tour of its use. Qualia are the subjective aspects of human consciousness. Qualia could be thought of as related to the answer to the question, "What's it like to be you?"

One of Lee's main interests was development of decision-making models for complex heuristics. He told me some fascinating examples of that work he had done. One had to do with the role of the "master soup maker" in large soup factories. In short, he said that due to younger people no longer appearing at such places of employment with an interest in apprenticing as a master soup maker (responsible for making industrial-sized quantities of soup for canning) there was an interest in a computerized decision maker being developed. He took on the challenge and studied what the master soup makers do: recipes, step-wise sequences, etc. He also studied their behavior with planned behavioral observation.

The problem with making these soups, he explained, is that although the ingredients are controlled, the flavor profile of some ingredients are not. He gave the example of milk for cream of mushroom soup. He said that the milk differs in flavor based on the season it was obtained, because the flavor of grasses changes during the year. And thus, the flavor of the milk changes.

He explained how the master soup maker would taste (qualia) the soup, and make judgments in the moment about how to adapt or alter the recipe. This would be necessary in order to achieve the standard flavor that the customer in the grocery store knows to expect.

Lee explained that in all of his study of these processes, he was never able to write a complex decision-making algorithm that could succeed in doing the job of the master soup makers. His advice to that company was, "Continue to apprentice master soup makers".

While Lee was explaining "qualia" to me, he used the example of "eating a peach".

Unsplash: Michael Waddell

Lee emphasized how a person, if they have eaten a peach, can't quite transfer what that experience is like (texture, flavor, odor) to another person who has never eaten one. After we discussed that, he then drove the point home by pressing the fact that one also can't transfer what it's like to eat a peach *even to another person who has.* His point, as he explained it, was that people can't quite transfer their subjective aspects of consciousness to another person under any circumstances, period. Lee then explained how in our work those are qualitative data and data sources. And so, in our screening and assessment processes, can we have someone "Tell me what it's like to be you" and then listen for qualia? Or do we bypass that entire domain?

In a complimentary sense we should also use objective information. Many counselors often don't think about (1) looking at previous toxicology results, or (2) obtaining new ones, or (3) having someone review the primary care laboratory data and explain its relevance to SUD and MH matters, or (4) obtaining collateral information from family, friends, sponsor, significant other, etc., and (5) reading current and previous medical records from various providers over the years. Adding and then combining both subjective and objective data can be a big improvement.

In the next portion of the work, I'll cover a special way of examining the 11 SUD criteria from the DSM. It's from an interesting perspective that considers *the pattern* of positive criteria, not just the number.

The Big 5 SUD criteria

When conducting a screening or assessment for SUDs,
consider the pattern of positive SUD criteria.

Norman Hoffmann has both published, and presented at national conferences, his work concerning what he calls "The Big 5" substance use disorder (SUD) criteria from the DSM-5.

In short, Norm has examined ***the relative weight*** of each of the 11 DSM-5 SUD criteria, separately, as each is applied to the probability of having any one or more additional positive criteria for SUD (from data collected on thousands of consecutively incarcerated individuals).

The empirical questions and answers on The Big 5 as Norm has presented them are summarized here:

1. Question: Which of the 11 DSM criteria for SUD are commonly found among individuals with ***no SUD diagnosis***?
   - Answer: Tolerance, and Use in dangerous situations.
   - That is to say, in his sample, the presence of tolerance as a single factor did *not* make it more likely than not that any additional criteria were present – and the same was true of use in dangerous situations as a single factor.
2. Question: Which of the 11 DSM criteria for SUD are commonly found among those with ***mild to moderate*** SUD?
   - Answer: Unplanned use, Time spent, Interpersonal conflicts, and Use in spite of medical/psychological conditions.
3. Question: Which DSM criteria for SUD are found ***primarily in severe*** SUD's?
   - Answer: Efforts to control/cut down but unable (rule setting), Craving with compulsion to use, Failure to fulfill role obligations, Activities given up or reduced, Withdrawal.
   - That is to say, in his sample, the presence of any one of these 5 criteria, separately, *was* more likely than not to be present among 6 or more total positive SUD criteria for any one individual.

In presenting these results from his research, Norm has asked if perhaps the total constellation of The Big 5 is what is commonly called the disease of addiction.

Interestingly, Norm has also noted the individual may fit mild or severe characteristics (aside from DSM scaling), based on The Big 5, and as a result he has expressed the following questions:

- Are those with mild to moderate DSM ratings *without any* of the Big 5 able to moderate use with less intense and briefer services?
- What are the implications of The Big 5 for etiology and course of illness of the individual?
- Specifically, do those that are positive on 2 or more of Big 5 in fact require initial residential placement and/or more intense and longer care, and require abstinence – even when not numerically "Severe" according to DSM-5?

Overall, Norm encourages the clinician to consider *the pattern* of positive criteria, in addition to the mere total number of criteria present.

Unsplash: Sajad Nori

Similar to spending time with a person like Lee, I've spent even more time with Norm, over a series of even more years. I've benefitted tremendously from his inputs to me.

When he first explained these findings on what he called The Big 5, he was methodical and used examples.

He first told me that two criteria, each on their own, contribute no weight or probability that any more criteria would be met. And that these are tolerance, and use in dangerous situations. I asked Norm to explain this to me. He said, "Well, all the college kids have tolerance. It's the easiest criteria to get." It doesn't indicate there are any more criteria. And I go, "What about use in dangerous situations"? He said, "Well, they might be drinking and then jumping off the roof into the pool, but that doesn't mean there must be more criteria present." I got his point.

In explaining the criteria of unplanned use, time spent, and conflicts, he told a brief vignette about how a person has friends come by un-announced who want to go to the bar and shoot pool. In short, the spouse is upset, drinking was unplanned, and time is being spent. These weigh more than tolerance and use in dangerous situations as his results found, but they don't weigh nearly as much as The Big 5.

In describing the weight of The Big 5 in story form, Norm said,

"Brian, we're sending you a referral for treatment. They have some tolerance."

I started to laugh as he said it, because I got his point and in my clinical experience I know that doesn't say a lot.

Then he said, "Or how about this. Brian, we're sending you a referral for treatment. They are coming out of seven days in a hospital detox for alcohol, and we'll send them right to you."

Of course, by my clinical instincts, I could literally *feel the weight* of that withdrawal story, especially compared to "tolerance".

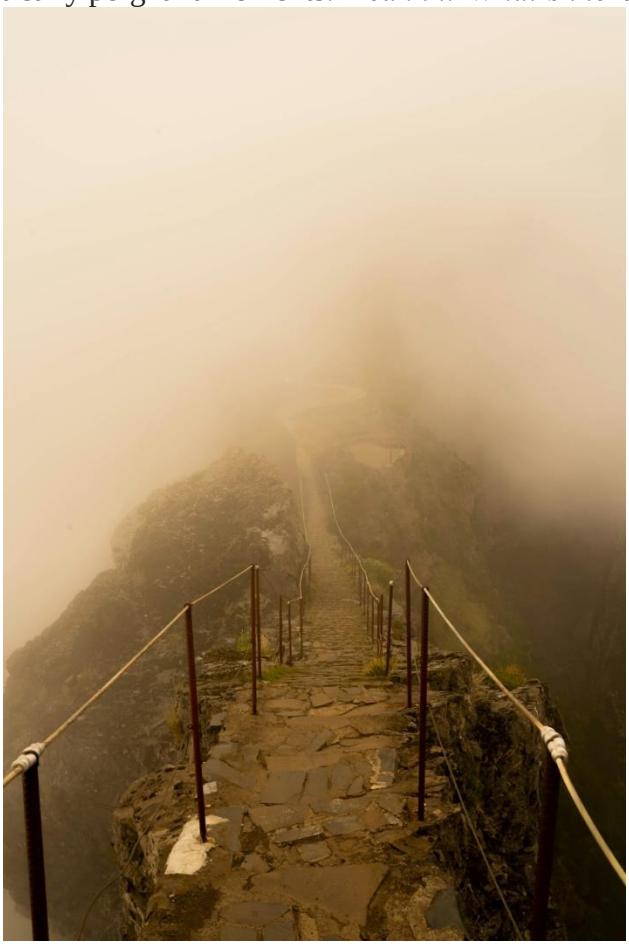
"Palpate the unknown"

Many in this work seem to not understand that the DSM criteria are "guides to judgment". And tend to use the list of the 11 SUD criteria as questions to ask the patient – which assesses the patient's judgment. And they often do so in a yes/no format, or something close to that.

Regardless, *what inputs* should we include *prior to making* our judgment?

Even if the patient says, "Yes" or otherwise endorses various criteria, does that mean the patient understands the meaning of the criteria? Well enough that our burden of clinical judgment is something we can and should relinquish, and hand over to the patient?

When educating, training, or supervising newer arrivals in our clinical work, I like to use the phrase "Palpate the unknown". I use it steadily at low frequency. I especially like to use it at critical or otherwise poetically poignant moments. *Lean in. What's there? What do you sense?*



Unsplash: Noah Grossenbacher

I conclude by asking the reader to consider what can we gain by suspending our over-attending to the exact words found in the criteria, and turning our entire conscious, unconscious, and undefended attention to the person? And to their illness? And what our interior (the sum of our education, training, supervision heritage, logic, and intuition) would tell us if we could, and did?

Afterward

Some time ago, I was asked a question by a person retired from career-length clinical work in our field. The question was, "What biases do you observe among many of the scientific and medical experts in the field?"

Below are portions excerpted from my reply.

1. The idea that knowing the list of diagnostic criteria is the same as *understanding the disorder*. Spotting something and understanding something are very different.

2. Ignoring signs and symptoms of the illness that come from non-research sources.

3. Transforming each of the diagnostic criteria into a simple yes/no question.
    - But people with addiction illness, those in recovery, and their family members – if they read over that diagnostic criteria list – would know that the simple list of diagnostic criteria falls far short of a sufficient quantitative and qualitative description of any one person's addiction illness.
    - Further, people who are maintaining recovery know all too well the signs and symptoms of their illness that are not found on the list of diagnostic criteria, and that tend to re-emerge at times over the years.

There *are* a variety of documented sources of that kind of information. My two favorite sources are older ones:

- The "Jellinek Chart" shows common ***signs of alcoholic disease progression***.
- Gorski lists ***relapse warning signs*** that show up before going to back to using (during the early, middle, and later stages of regression out of recovery).

Both of those sources describe what it's like to have or to witness the illness. Lists like these can help someone understand addiction illness in its various forms and stages.

To help make this point's relevance to the topic of screening and assessment clear, I'll share a story. Someone I know was present when a neurological bench scientist working in Parkinson's research met a person with Parkinson's for the first time. They were delighted to meet each other. But when the scientist explained what they were working on (movement problems) the person with Parkinson's asked if they ever worked on gut motility. The person with Parkinson's had to explain to the researcher that there are whole sets of problems not visible to others. The bench scientist was very grateful to hear of a whole new array of research targets – from a person who knew in a whole different way.

In the case of Parkinson's Disease, the patient's support people, clinical caregivers, and researchers easily observe the disordered motion the patient demonstrates. And the example above illuminates the existence of inwardly facing difficulties that research scientists, family members, or clinicians might not see, hear, consider, or understand.

I would like to leave the reader with a consideration about preserving both of two things: (1) *specificity across* data inputs and related ways of understanding on the one hand, and (2) *the totality of the whole* on the other hand.

I'll express what I have in mind in the form of a sequence of statements. To me, all of them are false. And seeing them as false can help us preserve something.

Consider the topic of screening and assessment of substance use disorders – the knowledge and skill required to perform those two functions – as you read them.

- If you want to understand philosophy, all you really need to understand is sociology.
- If you want to understand sociology, all you really need to understand is psychology.
- If you want to understand psychology, all you really need to understand is biology.
- If you want to understand biology, all you really need to understand is chemistry.
- If you want to understand chemistry, all you really need to understand is physics.
- If you want to understand physics, all you really need to understand is mathematics.

To me, that set of considerations provides fertile ground for clarifying questions.

- How far shall we reduce the person we serve?
- And how far shall we reduce our work?
- In what ways should we gather data at each level?
- When we gather specific information, shall we drill *down* to better understand?
- When we gather specific information, shall we turn *up* a level to better understand?
- And what can we do to gather data at the level of the whole, rather than component parts or levels?

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Suggested readings

These readings address the topic in a way that's not common. By engaging with any or all of these it might become evident how eager we are to dispense with the knowledge and wisdom of the past on the one hand, and how slow we are to adopt best practices on the other hand.

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Acknowledgements

I would like to thank Charlie Dennis, Tommy Lee, Yvette Szuster, and Kristin White for their comments and encouragement about this manuscript while it was in development.

About the author

Brian Coon has been working full time in addiction treatment programs from the time of his graduate internship in 1988 to the present. This includes serving in residential programs that entire time (a 9-12 month therapeutic community, a 30 day Minnesota Model, a 6-12 week interdisciplinary program) and outpatient programs almost that entire time (a methadone maintenance program, various IOPs, and aftercare programs). The target population of these services ranged from criminal justice, pregnant/post-partum parenting women, gender specific, those with severe enmeshment in cultures of addiction, emerging adults, and professionals with public safety sensitive roles.

Notably, the organizational workplace for his first 19 years was the community agency within which the Behavioral Health Recovery Management (BHRM) project was begun and operated. Brian served on the BHRM implementation steering committee for the entire 10-year lifespan of the BHRM project starting in 1998. The BHRM project was the living clinical laboratory where the principles and practices of recovery orientation for clinical services, such as recovery coaching, and approaches that later came to be known as "Recovery-Oriented Systems of Care" and "Recovery Management" were innovated and developed. During that time, Brian was in the original group of clinicians trained by Mike Dennis to use the first edition of the Global Appraisal of Individual Needs (GAIN). The GAIN was the tool used in that organization's central screening and intake service, designed by the BHRM steering committee, to assess and initially direct the care of thousands of patients annually with co-occurring disorders across dozens of programs and levels of care, including primary MH or primary SUD services.

Brian came to his current workplace in 2008 and served as Clinical Director for 10 years starting in 2011. He provided the admission approval vs. referral decision in the substance use and psychiatric domains for all prospective residential admissions, totaling more than 4,800 cases across 12 years. He has a strong life-long interest in biology and philosophy. His recent years have been marked by an interest in the analytic tradition/depth psychology, the mentoring of clinical supervision, and the impacts of each upon systems of care, individual clinicians, and clinical teams. Currently, his routine duties include the clinical supervision of clinical supervision, and of counseling.

He holds a BS in psychology and MA in community-clinical psychology. He is a licensed clinical addiction specialist (LCAS), certified clinical supervisor (CCS), and nationally credentialed as a master addiction counselor (MAC). His academic and clinical background is in the scientist-practitioner model, cognitive-behavioral psychology, and evidence-based treatment of co-occurring substance use and mental health disorders in adult populations. In his spare time, he has written beyond his published work as a Contributor at *recoveryreview.blog* and serves as an Affiliate at *addictionandbehavioralhealthalliance.com.*