

2

INTERVIEW, SCREENING, AND ASSESSMENT

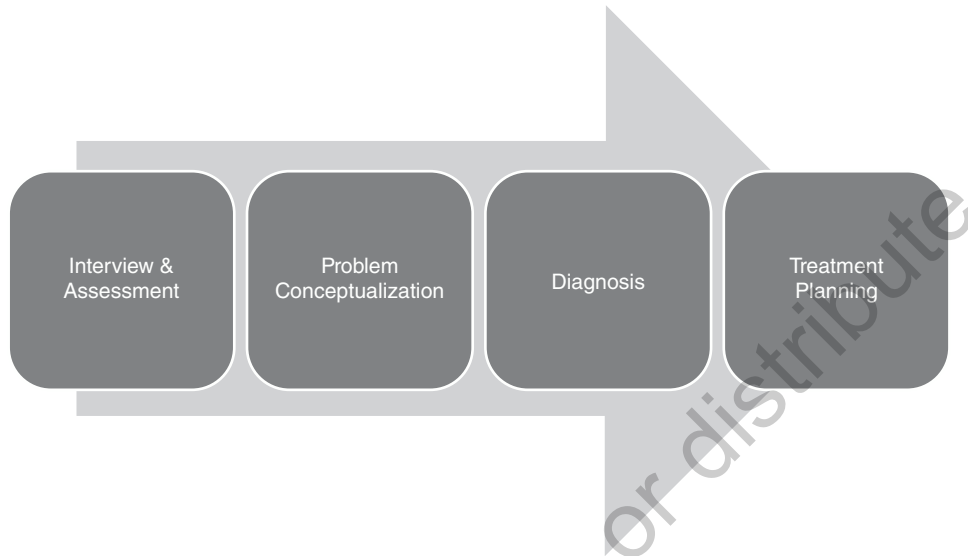
LEARNING OBJECTIVES

- LO 2.A** Reader can explain the components of a comprehensive interview
- LO 2.B** Reader can identify the role of assessment in the interview process

PURPOSE OF INTERVIEWING, SCREENING, AND ASSESSMENT

Initial interview, screening, and assessment are integrated tools. First, the initial interview serves as a data gathering dialogue where the counselor can also begin to craft the narrative regarding the need for treatment and what strengths the client brings to the treatment process. Second, the interview also informs the need for any screening applications. Screening is not just testing but rather a purposeful and applied clinical measurement to determine the existence of various problems. Third, assessment is a more comprehensive application where the pervasiveness or severity of various problems (including substance use disorder) may be further determined. In brief, the initial interview, screening, and assessment serve such functions as conceptualizing the problem(s), clarifying the severity of these problems, and informing/motivating the client for the need for treatment. Consequently, the interview, screening, and assessment phases of the initial session(s) eventually inform the diagnostic and treatment plan development process (see Figure 2.1). Furthermore, these critical tasks are conducted not only within substance use disorder (SUD) treatment facilities but also in other settings. Beginning with the Institute of Medicine's (1990) call to expand substance use screening efforts beyond the SUD treatment arena up to the most recent screening recommendations by the U.S. Preventive Services Task Force Recommendation Statement (Krist et al., 2020), the substance use interview, screening, and assessment processes have expanded to such populations/settings as emergency room (ER) patients (e.g., Elder et al., 2020; Hawk & D'Onofrio, 2018), primary health care practices (e.g., McNeely et al., 2018), K–12 schools by school counselors (e.g., Foss-Kelly et al., 2021), and college/university counseling centers (e.g., Denering & Spear, 2012) in an attempt to target not only those with diagnosable SUDs but also those individuals who present with unhealthy use that does not yet rise to a diagnostic level.

FIGURE 2.1 ■ The Process From Interview and Assessment to Treatment Planning



COMPONENTS OF THE INTERVIEW

Substance Use History

Table 2.1 covers all of the substances for evaluation in addition to alcohol. It is critical to inquire regarding all substances and not just the primary substance. Furthermore, it is imperative to understand how substances interact with alcohol due to the high prevalence rates of individuals using other substances in conjunction with alcohol (regardless if the alcohol use rises to the level of an alcohol use disorder). The information derived from this inquiry will guide treatment recommendations as well as further screening or assessment.

Best practices dictate the following areas be addressed. One, age at first use. Early first use of substances (before 15 years old) is typically associated with the development of future substance-related disorders (Piehler et al., 2012). Consequently, age at first use may have diagnostic or prognostic implications (see Table 2.2).

Two, the frequency and amount of the substance use, as well as the route(s) of administration for each substance assist the interviewer in gauging the trajectory of substance use increase over time. For instance, a drinker who went from a six-pack per night to over 20 beers per night reflects key diagnostic information regarding drinking progression. Similarly, the client who reports one bag of heroin use (snorted) last year but now reports injecting approximately multiple bags per day also demonstrates a dramatic increase in substance use and reduced client capacity to reign in the addictive behavior (see Tables 2.3, 2.4, and 2.5).

Three, questions regarding consequences of use help the clinician pinpoint areas of dysfunction caused by the addiction, such as deficits at school (e.g., Hollar & Moore, 2004), work

TABLE 2.1 ■ Commonly Abused Substances for Assessment in Addition to Alcohol

Substance	Form	Administration	Street Names	Short-Term Effects	Long-Term Effects	Combined With Alcohol	Withdrawal Symptoms
Cocaine	White powder, white crystal	Snorted, smoked, injected	blow, bump, candy, crack, rock, snow	Narrowed blood vessels; enlarged pupils; increased body temperature, heart rate, and blood pressure; headache; abdominal pain and nausea; euphoria; increased energy, alertness; insomnia, restlessness; anxiety; erratic and violent behavior, panic attacks, paranoia, psychosis; heart rhythm problems, heart attack; stroke, seizure, coma	Loss of sense of smell, nosebleeds, nasal damage and trouble swallowing from snorting; infection and death of bowel tissue from decreased blood flow; poor nutrition and weight loss from decreased appetite	Greater risk of overdose and more sudden death than from either drug alone	Depression, tiredness, increased appetite, insomnia, vivid unpleasant dreams, slowed thinking and movement, restlessness
Heroin	White or brown powder	Injected, smoked, snorted	brown sugar, dope, junk, smack	Euphoria; warm flushing of skin; dry mouth; heavy feeling in the hands and feet; clouded thinking; alternate wakeful and drowsy states; itching; nausea; vomiting; slowed breathing and heart rate	Collapsed veins; abscesses (swollen tissue with pus); infection of the lining and valves in the heart; constipation and stomach cramps; liver or kidney disease; pneumonia	Dangerous slowdown of heart rate and breathing, coma, death	Restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes with goose bumps ("cold turkey"), leg movements

(Continued)

TABLE 2.1 ■ Commonly Abused Substances for Assessment in Addition to Alcohol (Continued)

Substance	Form	Administration	Street Names	Short-Term Effects	Long-Term Effects	Combined With Alcohol	Withdrawal Symptoms
Inhalants	Paint thinners or removers, degreasers, dry-cleaning fluids, gasoline, lighter fluids, correction fluids, permanent markers, electronics cleaners and freeze sprays, glue, spray paint, hair or deodorant sprays, fabric protector sprays, aerosol computer cleaning products, vegetable oil sprays, butane lighters, propane tanks, whipped cream aerosol containers	Inhaled	N/A	Confusion; nausea; slurred speech; lack of coordination; euphoria; dizziness; drowsiness; disinhibition, lightheadedness, hallucinations/delusions; headaches; sudden sniffing death due to heart failure (from butane, propane, and other chemicals in aerosols); death from asphyxiation, suffocation, convulsions or seizures, coma, or choking	Liver and kidney damage; bone marrow damage; limb spasms due to nerve damage; brain damage from lack of oxygen that can cause problems with thinking, movement, vision, and hearing	Dangerously low blood pressure potential	Nausea, loss of appetite, sweating, tics, problems sleeping, and mood changes

TABLE 2.1 ■ Commonly Abused Substances for Assessment in Addition to Alcohol (Continued)

Substance	Form	Administration	Street Names	Short-Term Effects	Long-Term Effects	Combined With Alcohol	Withdrawal Symptoms
LSD	Tablet; capsule; clear liquid; small, decorated squares of absorbent paper that liquid has been added to	Swallowed or absorbed through mouth	acid, blotter, blue heaven	Rapid emotional swings; distortion of a person's ability to recognize reality, think rationally, or communicate with others; raised blood pressure, heart rate, body temperature; dizziness and insomnia; loss of appetite; dry mouth; sweating; numbness; weakness; tremors; enlarged pupils	Frightening flashbacks (called hallucinogen persisting perception disorder [HPPD]); ongoing visual disturbances, disorganized thinking, paranoia, and mood swings	May decrease the perceived effects of alcohol	Unknown
Marijuana	Greenish-gray mixture of dried, shredded leaves, stems, seeds, and/or flowers; resin (hashish) or sticky, black liquid (hash oil)	Smoked, eaten (mixed in food or brewed as tea)	blunt, bud, dope, ganja, grass, green, herb, joint, Mary Jane, pot, reefer, skunk, smoke, trees, weed Hashish: boom, hash, hemp	Enhanced sensory perception and euphoria followed by drowsiness/relaxation; slowed reaction time; problems with balance and coordination; increased heart rate and appetite; problems with learning and memory; hallucinations; anxiety; panic attacks; psychosis	Mental health problems, chronic cough, frequent respiratory infections	Increased heart rate, blood pressure; further slowing of mental processing and reaction time	Irritability, trouble sleeping, decreased appetite, anxiety
MDMA	Colorful tablets with imprinted logos, capsules, powder, liquid	Swallowed, snorted	Adam, clarity, ecstasy, Eve, lover's speed, molly, peace, uppers	Lowered inhibition; enhanced sensory perception; confusion; depression; sleep problems; anxiety; increased heart rate and blood pressure; muscle tension; teeth clenching; nausea; blurred vision; faintness; chills or sweating; sharp rise in body temperature leading to liver, kidney, or heart failure and death	Long-lasting confusion, depression, problems with attention, memory, and sleep; increased anxiety, impulsiveness, aggression; loss of appetite; less interest in sex	May increase the risk of cell and organ damage	Fatigue, loss of appetite, depression, trouble concentrating

(Continued)

TABLE 2.1 ■ Commonly Abused Substances for Assessment in Addition to Alcohol (Continued)

Substance	Form	Administration	Street Names	Short-Term Effects	Long-Term Effects	Combined With Alcohol	Withdrawal Symptoms
Methamphetamine	White powder or pill; crystal meth looks like pieces of glass or shiny blue-white "rocks" of different sizes	Swallowed, snorted, smoked, injected	crank, chalk, crystal, fire, glass, go fast, ice, meth, speed	Increased wakefulness and physical activity; decreased appetite; increased breathing, heart rate, blood pressure, temperature; irregular heartbeat	Anxiety, confusion, insomnia, mood problems, violent behavior, paranoia, hallucinations, delusions, weight loss, severe dental problems ("meth mouth"), intense itching leading to skin sores from scratching	Masks the depressant effect of alcohol, increasing risk of alcohol overdose; may increase blood pressure and jitters	Depression, anxiety, tiredness
Dextromethorphan	Syrup, capsule	Swallowed	Robo, Triple C, cough medicine brands typically have name including "DM"	Euphoria; slurred speech; increased heart rate, blood pressure, temperature; numbness; dizziness; nausea, vomiting; confusion; paranoia; altered visual perceptions; problems with movement; buildup of excess acid in body fluids	Unknown	Increased risk of adverse effects	Unknown
PCP	White or colored powder, tablet, or capsule; clear liquid	Injected, snorted, swallowed, smoked	angel dust, boat, hog, love boat, peace pill	Delusions, hallucinations, paranoia, problems thinking, a sense of distance from one's environment, anxiety	Memory loss, problems with speech and thinking, depression, weight loss, anxiety	Increased risk of coma	Headaches, sweating

TABLE 2.1 ■ Commonly Abused Substances for Assessment in Addition to Alcohol (Continued)

Substance	Form	Administration	Street Names	Short-Term Effects	Long-Term Effects	Combined With Alcohol	Withdrawal Symptoms
Prescription Opioids	Tablet, capsule, liquid, suppository	Injected, swallowed, smoked, snorted, inserted rectally	codeine: Captain Cody, Cody, lean, sizzurp, purple drank hydrocodone or dihydrocodeine (Vicodin, Lortab, Lorcet): vike, Watson-387 hydromorphone (Dilaudid): D, dillies, footballs, juice, smack meperidine (Demerol): demmies, pain killer methadone (Dolophine, Methadose) oxycodone (OxyContin, Percodan, Percocet): O.C., oxycet, oxycotton, oxy, hillbilly heroin, percs oxymorphone (Opanal): biscuits, blue heaven, blues, Mrs. O, O bomb, octagons	Pain relief, drowsiness, nausea, constipation, euphoria, confusion, slowed breathing, death	Miscarriage, low birth weight, neonatal abstinence syndrome. In older adults a higher risk of accidental misuse or abuse as many older adults have multiple prescriptions, increasing the risk of drug-drug interactions	Dangerous slowing of heart rate and breathing leading to coma or death	Restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes with goose bumps ("cold turkey"), leg movements

(Continued)

TABLE 2.1 ■ **Commonly Abused Substances for Assessment in Addition to Alcohol** *(Continued)*

Substance	Form	Administration	Street Names	Short-Term Effects	Long-Term Effects	Combined With Alcohol	Withdrawal Symptoms
Prescription Sedatives	Pill, capsule, liquid	Swallowed, injected, snorted	Barbiturates: pentobarbital (Nembutal), phenobarbital (Luminal): barbs, phennies, red birds, reds, tooies, yellow jackets Benzodiazepines: alprazolam (Xanax), chlordiazepoxide (Limbitol), diazepam (Valium), lorazepam (Ativan), triazolam (Halcion): candy, downers, sleeping pills, tranks	Drowsiness, slurred speech, poor concentration, confusion, dizziness, problems with movement and memory, lowered blood pressure, slowed breathing	Unknown	Further slows heart rate and breathing, which can lead to death	Must be discussed with a health care provider; barbiturate withdrawal can cause a serious abstinence syndrome that may include seizures
			Sleep Medications: eszopiclone (Lunesta), zaleplon (Sonata), zolpidem (Ambien): forget-me pill, Mexican valium, R2, roche, roofies, roofinol, rope, rophies		Unknown	Further slows heart rate and breathing, which can lead to death	Must be discussed with a health care provider; barbiturate withdrawal can cause a serious abstinence syndrome that may include seizures

TABLE 2.1 ■ Commonly Abused Substances for Assessment in Addition to Alcohol (Continued)

Substance	Form	Administration	Street Names	Short-Term Effects	Long-Term Effects	Combined With Alcohol	Withdrawal Symptoms
Prescription Stimulants	Liquid, tablet, chewable tablet, capsule	Swallowed, snorted, smoked, injected, chewed	amphetamine (Adderall, Benzedrine): bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers methylphenidate (Concerta, Ritalin): JIF, MPH, R-ball, skippy, the smart drug, vitamin R	Increased alertness, attention, energy; increased blood pressure and heart rate; narrowed blood vessels; increased blood sugar	Heart problems, psychosis, anger, paranoia	Masks the depressant action of alcohol, increasing risk of alcohol overdose; may increase blood pressure and jitters	Depression, tiredness, sleep problems
Steroids	Tablet, capsule, liquid drops, gel, cream, patch, injectable solution	Injected, swallowed, applied to skin	nandrolone (Oxandrin), oxandrolone (Anadrol), oxymetholone (Winströl), stanozolol (Durabolin), testosterone cypionate (Depo-testosterone): juice, gym candy, pumpers, roids	Headache, acne, fluid retention (especially in the hands and feet), oily skin, yellowing of the skin and whites of the eyes, infection at the injection site	Kidney damage or failure; liver damage; high blood pressure, enlarged heart, or changes in cholesterol leading to increased risk of stroke or heart attack, even in young people; aggression; extreme mood swings; anger ("roid rage"); paranoid jealousy; extreme irritability; delusions; impaired judgment	Increased risk of violent behavior	Mood swings; tiredness; restlessness; loss of appetite; insomnia; lowered sex drive; depression, sometimes leading to suicide attempts

(Continued)

TABLE 2.1 ■ Commonly Abused Substances for Assessment in Addition to Alcohol (Continued)

Substance	Form	Administration	Street Names	Short-Term Effects	Long-Term Effects	Combined With Alcohol	Withdrawal Symptoms
Bath Salts	White or brown crystalline powder sold in small plastic or foil packages labeled “not for human consumption” and sometimes sold as jewelry cleaner; tablet, capsule, liquid	Swallowed, snorted, injected	bloom, cloud nine, cosmic blast, flakka, ivory wave, lunar wave, scarface, vanilla sky, white lightning	Increased heart rate and blood pressure; euphoria; increased sociability and sex drive; paranoia, agitation, and hallucinations; psychotic and violent behavior; nosebleeds; sweating; nausea, vomiting; insomnia; irritability; dizziness; depression; suicidal thoughts; panic attacks; reduced motor control; cloudy thinking	Breakdown of skeletal muscle tissue; kidney failure; death	Unknown	Depression, anxiety, problems sleeping, tremors, paranoia

Source: National Institute on Drug Abuse (2016).

TABLE 2.2 ■ Age of Primary Substance First Use: Treatment Episode Data Set (2021) Results

Age (Years)	N	%
11 and younger	59,675	4.0%
12–14	205,819	13.9%
15–17	302,513	20.4%
18–20	225,656	15.2%
21–24	145,560	9.8%
25–29	106,942	7.2%
30 and older	150,858	10.2%
TOTAL	1,482,543	100.0%

Source: Substance Abuse and Mental Health Services Administration (2023f).

TABLE 2.3 ■ Primary Substance Reported at Admission: Treatment Episode Data Set (2021) Results (Minimum 5% Reporting)

Substance	N	%
Alcohol	439,755	29.7%
Heroin	255,401	17.2%
Methamphetamine	170,220	11.5%
Marijuana	129,343	8.7%
Other Opiates	113,764	7.7%

Source: Substance Abuse and Mental Health Services Administration (2023f).

TABLE 2.4 ■ Substances Used and Reported at Admission (Minimum 5%): Treatment Episode Data Set (2021) Results

Substance	N	%
Alcohol	580,402	39.1%
Marijuana	374,671	25.3%
Heroin	315,750	21.3%
Methamphetamine	281,602	19.0%
Cocaine/Crack	231,890	15.6%
Other Opiates	171,235	11.6%

Source: Substance Abuse and Mental Health Services Administration (2023f).
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TABLE 2.5 ■ Route of Administration for Primary Substance: Treatment Episode Data Set (2021) Results

Route of Administration	<i>N</i>	%
Oral	520,317	35.1%
Smoked	309,385	20.9%
IV or IM	209,227	14.1%
Inhaled	158,853	10.7%
Other	12,390	0.8%

Source: Substance Abuse and Mental Health Services Administration (2023f).

(e.g., Frone, 2009), home (e.g., Dunne et al., 2015), and in the family (e.g., Juhnke & Hagedorn, 2006) as well as financial, legal, or medical problems (e.g., G. Miller, 2015).

Four, an examination of any prolonged (30 days or longer) abstinence period is also critical. Reasons for the abstinence from, as well as the return to, substance use help the clinician create a timeline for the waxing and waning of substance use common in an addiction history. Specifically, what were the psychosocial constructs that contributed to the abstinence from, as well as the return to, substance use? The Timeline Followback (TLFB; S. M. Robinson et al., 2014) is a clinical tool that helps the clinician see the schedule of substance use and abstinence over a prolonged period of time. The TLFB can be administered by an interviewer (or the client) and asks clients to retrospectively estimate their substance use anywhere between 7 days and 2 years prior to the interview date. In clinical settings, the TLFB serves as a motivational tool to contribute to efforts designed to increase client motivation and readiness for treatment.

Psychiatric History

As we will discuss in Chapter 3, there is a clearly established relationship between substance use and psychiatric disorders. Recent admissions data in the Treatment Episode Data Set Admissions (TEDS-A) reflect that 34.9% ($n = 517,950$) of admitted clients ($N = 1,482,543$) come to SUD treatment with a co-occurring psychiatric disorder (Substance Abuse and Mental Health Services Administration, 2023 f). However, this is likely an underestimation due to clients first being diagnosed in a treatment episode or the client experiences sub-syndromal symptoms not rising to a diagnostic level. Consequently, the interview focused on psychiatric history should be mindful that most clients will have a current experience and/or past experiences of outright diagnosable *DSM 5-TR* psychiatric disorders or the presence/history of sub-syndromal experiences that, though not rising to a diagnosable level, still cause distress.

This interview is complicated. For example, the clinician must address the following matters:

- Is there a history of an independent *DSM 5-TR* diagnosed psychiatric disorder?
- Regardless of history, is the client demonstrating any current symptoms that may reflect a psychiatric disorder?

- What is the history of the client's psychiatric symptom experiences in conjunction with substance intoxication, withdrawal, or prolonged abstinence?
- Are there any instances of distressful emotional experiences that may resemble diagnosable disorders but fail to adhere to any nosology?

A few challenges are inherent within this process. First, as we will review in the following chapters, there is tremendous overlap between substance use and psychiatric symptoms. For example, experiences of anxiety, depressed mood, or paranoia are symptoms of numerous psychiatric disorders but also occur in various instances of substance intoxication or withdrawal. Considering that many clients enter treatment or an emergency room setting while still actively using or in the early withdrawal phase, it can become very difficult to tease out the temporal and causal relationship (if any) between substance use and psychiatric symptoms. Second, recall that as a clinician you are asking about this complicated and typically unclear relationship from an individual who (due to substance use past and present) is not the best equipped to provide a lucid and organized recollection of all symptoms and experiences. The deficit in memory may be due to limited memory capacity when having been intoxicated or due to the current memory and other cognitive deficits, as discussed in Chapter 1.

Due to these issues, the interview may not result in a definitive answer. But, the interview (for any clinical area) is not designed to produce a definitive outcome. As emphasized by Ivey and colleagues (2012), the clinical interview is designed to start the framework of the client narrative. Out of this interview, the narrative may produce additional questions in need of clarification. Thus, the interview provides the basis for deciding what additional screening and assessment measures may be needed to crystallize the client's psychiatric experiences.

Chronic Pain

Chronic pain and addiction frequently co-occur (e.g., Schaffer et al., 2023), and they impact all age ranges, including adolescents (e.g., Pielech et al., 2020) and older adults (e.g., Staton et al., 2022). In addition, chronic pain and addiction fluctuate in intensity over time and under different circumstances and have similar physical, social, and emotional impacts on health and well-being (Green et al., 2003). Assessment of pain should include onset of pain condition(s), medications, history of misuse of medication(s), history of illicit substance use other than prescribed pain medication (e.g., heroin use for those prescribed an opioid pain medication), severity and frequency of pain, whether pain symptoms exacerbate any psychiatric symptoms, and client self-assessment of how well pain is managed in a non-substance manner (e.g., resiliency for managing pain and not having symptoms impede day-to-day tasks).

Medical History

In addition to a pain history, a complete medical history (present and past medical problems, surgeries, and medications) is crucial for clients presenting with a substance use disorder. Many substance users neglect their health and thus come to treatment with numerous medical ailments (e.g., Lima et al., 2009; Morgen et al., 2007). For each of the medical conditions, the

clinician must determine if the symptoms are related to or independent of substance use. This is primarily accomplished by making inquiries regarding the temporal or causal relationships between medical issues and substance use. Furthermore, there are medical conditions that are associated with a class of substances. Myriad medical ailments are linked with various substances (see Table 2.6).

Especially considering the neuropsychological impact of substance use discussed in the prior chapter, a brief examination of basic mental status functioning is warranted. The mental status

TABLE 2.6 ■ Medical Ailments Associated With Various Substances of Abuse

HIV, Hepatitis
Heroin
Cocaine
Methamphetamine
Cardiovascular
Cocaine
Heroin
Inhalants
Marijuana
MDMA (Ecstasy)
Methamphetamine
PCP
Stimulants
Respiratory
Cocaine
Heroin
Inhalants
Marijuana
PCP
Prescription Opiates
Nicotine
Gastrointestinal
Cocaine
Heroin
Prescription Opiates
MDMA (Ecstasy)
Musculoskeletal
Inhalants
MDMA (Ecstasy)
Steroids
Kidneys
Heroin
Inhalants
MDMA (Ecstasy)
Liver
Heroin
Inhalants
Steroids

Source: National Institute on Drug Abuse (2012).

examination is a useful component of a SUD intake interview (Anderson & Parker, 1997). If (or when) the client is capable of being examined (i.e., not intoxicated), the mental status examination should cover all of the following areas:

- Appearance
 - General appearance
 - Motor status
 - Activity
 - Facial expression
- Characteristics of Talk
 - Blocking
 - Preservation
 - Flight of ideas
- Emotional State
 - Mood (e.g., depressed, manic)
 - Affect (e.g., anxious, labile)
- Content of Thought
 - Hallucinations
 - Delusions
 - Compulsions
 - Obsessions
 - Ritualistic behaviors
 - Depersonalization
- Orientation
 - Person
 - Place
 - Time
 - General confusion
- Memory
 - Remote past experiences
 - Recall of long ago and recent past experiences

Family History

Family history provides several meaningful elements. First, a reported family history of substance use disorder may indicate a client's genetic predisposition for the disorder (Agrawal & Lynskey, 2008). Second, family history also provides a thorough overview of how substance use has entered the family system and the resulting consequences (Lander et al., 2013). The Center for Substance Abuse Treatment (SAMHSA, 2020a) recommends the following content be included in any family history inquiry as part of the interview:

- Client family of origin history, including substance use by member(s) and any instances of family dysfunction (e.g., abuse, neglect)
- Romantic relationship status and history, including whether substance use has ever caused dysfunction or the ending of a relationship (e.g., marital tension due to substance use, past relationships ending due to substance use)
- Any children?
- Substance use by other member(s) of family? If yes, the substance(s) used, frequency, and for how long the use has occurred
- Whether substance use has caused client or other family member(s) to be alienated from rest of the family
- Current or past instances of domestic abuse or other abuses (physical, sexual, verbal, emotional)
- Overall quality of current family unit

Social History

A thorough psychosocial history reviews the overall landscape of a client's life and how the client's substance use (and any psychiatric issues) possibly impacts these key areas. First, the interview should examine the client's career history because addiction issues commonly influence workplace performance (Frone, 2009). Specifically, the interview should cover current employment status, employment history, satisfaction with current employment, and whether substance use has ever impacted their work performance.

Second, educational history is examined. Educational attainment informs the clinician of the client's potential employment options post-treatment as well as whether substance use derailed the client's schooling. For example, when working in a therapeutic community, I typically encountered clients who had failed to obtain a high school diploma because their substance use caused them to drop out of school. Thus, the clinician should inquire about the highest educational level obtained as well as any substance-related reasons for any aborted schooling. For example, if the client discusses that they started community college but never finished their last 20 credits, the clinician should investigate if substance use played any role (direct or indirect) in why the client stopped their education and never returned to finish.

Third, many SUD clients come to treatment with an extensive criminal justice history as well as current legal issues (e.g., CSAT, 2005; Morgen et al., 2013). Clients may be referred from drug court, a parole/re-entry system, or enter treatment with current charges such as drug possession or a DWI/DUI. The interview will determine such factors as any stresses on the client due to pending legal matters, the potential for the client to have treatment disrupted due to a prison sentencing, as well as any other offices/individuals you will need to engage with (e.g., parole officer, attorney) during the client's treatment.

Fourth, client financial health should also be investigated. In my experiences, client financial health may play one of two roles in the client's case. In some scenarios, the client is

experiencing money issues and may turn to selling substances or engaging in prostitution to augment their income. In this scenario, the financials are integrated into the other dysfunctional addictive behavior(s). However, in some other situations, the client experiences stress regarding an uncertain financial standing, and this pressure can serve as a stressor for returning to substance use.

Fifth, though not an area of the interview, all critical information should be corroborated by a collateral informant (typically a spouse, parent, significant other, or other family member). Not only does the clinician obtain verification and clarification of interview information, the corroboration seeking initiates the process of incorporating the key members of the client's life in their treatment. As per ethical and legal practices, corroboration with collateral informants can only occur following signed written authorization by the client.

Drug Testing

Verebey and Meenan (2011) note that drug testing is important for the selection of appropriate treatment planning as well as identifying those currently in treatment as a mechanism to catch some of the earliest signs of a relapse. According to the Substance Abuse and Mental Health Administration (SAMHSA; 2012), drug testing in SUD treatment serves one or more of these functions:

- A component of the initial assessment for the SUD evaluation
- A screening tool to prevent any adverse pharmacotherapy effects (e.g., opioid screen to verify opiate levels prior to naltrexone treatment)
- A mechanism to evaluate and reevaluate the appropriate level of care
- A way to monitor the client's use of substances and/or adherence to pharmacotherapy regimen

Considering the prevalence of dishonesty about substance use and/or continued substance use despite known and experienced consequences, drug testing is a critical screening tool to manage substance use disorder (DuPont & Selavka, 2015).

Federal mandatory guidelines include procedures, regulations, and certification requirements for drug testing laboratories, specific substances tested, and set cutoff concentrations for detecting these substances. The federal mandatory guidelines recommend that the initial screening test identify the presence of the following commonly abused drugs or their metabolites (SAMHSA, 2012): amphetamines (amphetamine, methamphetamine), cocaine metabolites, marijuana metabolites, opiate metabolites (codeine, morphine), and phencyclidine (PCP). Most drug testing retrospectively identifies recent substance use in settings where that information is of diagnostic significance (e.g., ER) or where the information has value in reinforcing an abstinence mandate (e.g., SUD treatment, workplace, schools).

Drug testing technology includes sweat, oral fluid, and hair in addition to urine. Regardless of testing procedure, each form uses highly reliable science. Sweat, oral fluid, and hair specimen

testing are performed at a limited number of specialized laboratories, whereas urine testing is performed at most clinical laboratories (DuPont & Selavka, 2015). The level of a drug or drug metabolite in the urine is influenced by recent fluid consumption and does not correspond with blood levels. Urine test results are either positive or negative at specific cutoff levels. A cutoff strategy is also used for sweat patches and hair tests. Whereas urinalysis is subject to dilution related to fluid consumption, hair biomarker tests can be used to distinguish between light, moderate, and heavy use of drugs and alcohol. However, this procedure is more expensive than the simple positive or negative result from drug urinalyses. Consequently, hair testing may not be a cost-feasible option for many SUD treatment clinics.

Blood has the briefest window of detection because most drugs are cleared at measurable levels from the blood within 12 hours. Urine is quite different, with a detection window of about 1 to 3 days (SAMHSA, 2012). Head hair grows at the average rate of about 0.5 inch per month. Newly created hair cells incorporate substances used from the blood on that day, creating a day-by-day registry of substance use. Hair-test reporting cutoffs report positive results only when a person has used a drug at least 4 to 6 times (at typical nonmedical doses) per month. Thus, positive hair testing results are considered reliable indicators of chronic substance use. Table 2.7 reviews some basic information for the various types of testing.

Recovery Capital

Recovery depends on many intrapersonal, interpersonal, and larger community/societal components. The presence or absence of these components plays a pivotal role in a successful or unsuccessful recovery. These components are organized in a theory called recovery capital (RC; reviewed in Chapter 10). Granfield and Cloud (1999) proposed a three-domain RC model consisting of social, human, and physical capital constructs that contribute to recovery. A few years

TABLE 2.7 ■ Cutoff Concentrations for Initial and Confirmatory Drug Tests in Urine

Initial Test Analyte	Federal Cutoff Concentrations (ng/ml)
Marijuana metabolites	50
Cocaine metabolites	150
Opiate metabolites (Codeine/morphine)	2,000
Hydrocodone/Hydromorphone	300
Oxycodone/Oxymorphone	100
6-Acetylmorphine (6-AM)	10
Amphetamines (Amphetamine/methamphetamine)	500
Phencyclidine (PCP)	25
Methylenedioxymethamphetamine (MDMA)	500

TABLE 2.7 ■ Cutoff Concentrations for Initial and Confirmatory Drug Tests in Urine (Continued)

Confirmatory Test Analyte	Federal Cutoff Concentrations (ng/ml)
Marijuana metabolites	15
Cocaine metabolites	100
Opiate metabolites (Codeine/morphine)	2,000
Hydrocodone/Hydromorphone	100
Oxycodone/Oxymorphone	100
6-Acetylmorphine (6-AM)	10
Amphetamines (Amphetamine/methamphetamine)	250
Phencyclidine (PCP)	25
Methylenedioxymethamphetamine (MDMA)	250

Source: U.S. Department of Transportation (2023).

later, Cloud and Granfield (2008) expanded to a four-domain RC model via the addition of cultural capital. In addition, in this revised model Cloud and Granfield also proposed RC as on a continuum where any of these four RC constructs may either bolster (i.e., positive RC) or impede (i.e., negative RC) recovery. The White and Cloud (2008) RC model differed via conceptualizing RC across the three domains of personal, family/social, and community and argued that cultural capital is a component of the community domain. Regardless of RC model, it is important to recognize that research reflects recovery capital as not accrued in a linear manner (Cano et al., 2017).

RC covers areas that, if present, enhance recovery potential whereas, if lacking, deficits in these areas likely impede or outright block recovery potential. For example, Laudet et al. (2006) found that social supports, spirituality, religiousness, life meaning, and 12-step affiliation buffer stress effects on enhanced life satisfaction with the “buffer” constructs accounting for 22% of the variance in life satisfaction. Though this study was focused on individuals already well into the treatment and recovery process, the buffer constructs are perfect examples of strengths to assess. Each of these key strengths-based concepts is an RC area.

Social Support

Empirical evidence has linked social support to increased health, happiness, and longevity (N. Lin, 1986). Among substance users, lower levels of social support have shown to be a reliable predictor of relapse (Havassy et al., 1993), whereas higher levels of social support predicted a diminished rate of substance use (Humphreys & Noko 1997; Noone et al., 1999; Rumpf et al., 2002). Moreover, social support is a significant concept in the perceived well-being of those

with co-occurring substance use and psychiatric disorders (Laudet et al., 2000). This social support can come from friends, family, support group/community, and nonsecular organizations (e.g., church, synagogue, mosque).

Spirituality and Religion

Religious and spiritual beliefs function as protective factors between life stressors and overall perceived quality of life (e.g., Culliford, 2002; W. R. Miller & Thoresen, 2003). Evidence shows an inverse relationship between involvement in religion (e.g., attending services, considering religious beliefs important) and substance use (B. Johnson, 2001; National Center on Addiction and Substance Abuse, 2001). For instance, religiosity reduced the impact of life stress on both the initial level of substance use and the rate of increasing substance use over time among adolescents (Wills et al., 2003). Possible benefits of religious involvement may include avoidance of drugs, time-occupying activities incompatible with substance use, and the adoption of prosocial values (Morjaria & Orford, 2002).

In addition, a growing body of empirical research supports the notion that religiousness and spirituality may enhance the likelihood of attaining and maintaining recovery from addictions, and recovering persons often report that religion and/or spirituality are critical factors in the recovery process (e.g., Flynn et al., 2003; Kaskutas et al., 2014). Moreover, there is evidence that spirituality may assist recovering individuals in avoiding future substance use and that among recovering individuals, higher levels of religious faith and spirituality are associated with a more optimistic life orientation, higher stress resilience, and more effective coping skills (A. E. Brown et al., 2013).

12-Step Affiliation

Affiliation with 12-step fellowships, both during and after treatment, is a cost-effective and useful approach to promoting recovery from substance use problems (e.g., Greenfield & Tonigan, 2013; Humphreys & Moos, 2001; Humphreys et al., 2004). Furthermore, evidence suggests that 12-step affiliation benefits extend to psychosocial functioning and enhanced quality of life (e.g., Gossop et al., 2003; Moos et al., 1999). The principal helpful components likely include the sense of social support and the reduced stigma associated with being in a community with others who share similar struggles (Morgen & Morgan, 2020; Morgen et al., 2010).

Coping Skills

Coping skills are a critical component of the treatment and recovery process (Martindale et al., 2013). Coping strategies include cognitive, behavioral, emotional, communication, and social strategies to deal with the various life stressors faced by those in recovery. Consequently, an inquiry into where an individual feels strong in withstanding daily stressors will help focus on their areas of coping strength. Some questions I ask to accomplish this task are the following:

- Can you think of a recent time you were really stressed but still managed to get a task done? What was the task, what was causing the stress, and how did you manage to accomplish this feat?

- Do you have any specific strategies to relax? What are they, and how well do they work?
- How do you handle any negative thoughts that appear?

Post-Traumatic Growth (PTG)

Later (in Chapter 9) we discuss the hypothesis of addiction as a trauma and recovery as a PTG process. PTG is defined as the positive outcome following a change process in the aftermath of a traumatic event (Tedeschi & Calhoun, 2004). PTG permits the examination of emotional and social difficulties via a positive framework to examine the growth/health that arises (with client work) post-trauma (again, post-trauma can be defined as recovery). Specific areas of inquiry include relationships with others, new priorities, personal strength(s), spiritual change, and new possibilities for a post-trauma (recovery) life.

Discussion of PTG concepts occurs in intrapersonal and interpersonal domains. Intrapersonal session dialogue focuses on newfound life priorities in recovery that may also include different perspectives of life meaning, spirituality, and self-assessment of personal strength and self-efficacy for recovery management. Many of these discussions would likely bridge interpersonal concepts such as new/improved meaningful relationships. Most importantly, these PTG concepts are not unique issues to raise in an intake or counseling session. Rather, PTG areas (like the 12 steps) are a framework for all counseling dialogue focused on addiction and recovery. The client is the expert on their recovery, so relationships, priorities, strengths, spirituality/life meaning, and new possibilities for life all must be addressed with the client. Each recovery is different, so you need to learn about these PTG concepts from *this client* to understand *this version* of recovery for *this client*. Consequently, PTG is not recommended as a theory to introduce new counseling content. Rather, PTG is recommended as a paradigm to better understand counseling content already covered.

Spirituality

“But, I’m not spiritual.” I hear that from countless counseling students and SUD clients. One of the big obstacles to working with spirituality is to first recognize that any good assessment of spiritual support extends beyond a simple census-type yes or no question during the interview process. That is why and how my colleagues and I first posed the concept of considering spirituality as a core component of countless counseling micro-skills such as empathic listening and patience (Morgen et al., 2010). In this paper we likened spirituality to a puzzle piece perceived as “missing,” thus explaining why and how all of counseling is looking for it. But, in the end, spirituality may be right out there in the open as these counseling micro-skills.

So, whether a counselor trainee, a new counselor, or an experienced veteran of the profession, spirituality needs to be considered in a two-fold manner. One, how does the counselor define and think about the concept of spirituality? This needs to be far from a dichotomous “I have” or “I do not have” answer. If the counselor is that rigid in the spiritual definition, then their assessment for this critical support ingredient will be limited.

Two, the same intrapersonal work the counselor did to come up with a spirituality definition and understanding also needs to be applied to all of their clients. In essence, a spiritual

development parallel process between client and counselor must occur. If the client states they have no spirituality, then the counselor needs to investigate if that is truly so. Perhaps they do not. That is OK. Or perhaps they do but just do not recognize the existence of spiritual elements in their life.

C. C. H. Cook (2004) reviewed this concept of multiple definitions for spirituality. Some may not seem “spiritual” as we tend to typically consider it. But, if you consider spirituality as a factor that helps improve recovery potential while enhancing the individual’s health, these alternate definitions seem to make sense. Some of Cook’s (2004) broad categories of spirituality are as follows:

Relatedness. This pertains to the quality of interpersonal relationships within the individual’s life.

Transcendence. This is the client’s recognition of the transcendent quality of the human existence.

Humanity. This area of spirituality focuses on the distinct quality of humanity within one’s life.

Core, force, or soul. This can be conceptualized as the inner strength of the person.

Meaning. Does the individual have a purpose to their life?

Authenticity and truth. Does the individual feel as if they are living a life truthful to whom they wish to be?

Values. Similar to authenticity, does the client feel as if they have a sense of self-worth?

Self-knowledge. Does the individual have a good grasp of who they are and what they wish to become?

So, the question to consider is how to assess spirituality. Instead of asking, “Are you spiritual?” the counselor should inquire about some of C. C. H. Cook’s areas listed above. For example, a client who outright denies being “spiritual” very likely is experiencing some cognitive and emotional issues relevant to meaning in their life or the quality of their interpersonal relationships. If the client feels a strength in these areas, for instance, how and why does this positive component contribute to their recovery? Explore those areas. That is a discussion and assessment of spirituality!

Conversely, if the client feels a deficit in these areas, explore this gap. How and why does this “lacking” bother them? In this case, the spiritual discussion is one of how being without this support impedes their recovery and perhaps leaves them vulnerable for a relapse. How do interventions for support, like the 12-step programs, then play a role in their bolstering of their spiritual support?

The best assessment tool is the interview. The unstructured dialogue between client and counselor allows the counselor to investigate countless areas of value to the treatment process. But regarding spirituality, the counselor needs to be informed on matters of spirituality so that

they can be flexible and see the spirituality inquiry as an open-ended (and not closed) question. It is not a matter of yes or no but rather a matter of how and why.

COVID-19/Long COVID

The COVID-19 pandemic was marked by a decline in overall psychological well-being alongside an increase in substance use (e.g., Melamed et al., 2022). Furthermore, the condition known as long COVID has been established as causing and exacerbating a broad range of mental health and addiction symptoms (Crook et al., 2021; Håkansson, 2021; Wang et al., 2021). Consequently, those with long COVID should be evaluated for SUDs and treatment referrals, and those with long COVID and in recovery should be monitored for a potential renewal of mental health symptoms and/or addictive behaviors (Tam et al., 2023).

The pandemic is over; however, emotional damage (sometimes significant) does linger from the traumatic experience. For instance, in the *DSM-5-TR* criteria for PTSD, Criterion A (APA, 2022, p. 301) indicates a traumatic event as “exposure to actual or threatened death.” During the pandemic, technically, all were exposed to threatened death. Though many did not see the pandemic via that perspective, many others did. Consequently, the COVID-19 pandemic can be considered a mass trauma event from which some clients are still recovering, have recovered, or have not yet begun to process some or all the emotional, financial, community, and overall life-defining issues brought on and/or exacerbated by the pandemic.

The interview should probe for two COVID-19-related areas. (1) Has the client experienced, or is the client experiencing, symptoms of long COVID? If yes, what are those symptoms, and how do they impede day-to-day functioning? Do these symptoms also challenge recovery progress? Did long COVID exacerbate already present physical or cognitive or psychological symptoms, or did the condition facilitate the first onset of a physical, cognitive, or psychological condition (including addiction)? (2) Is the client experiencing any difficulties resulting from surviving the mass trauma event of the COVID-19 pandemic? Probe the client’s experiences during and after the pandemic. Did they fear illness and death? Did they lose someone or know someone who fell victim to COVID-19? What happened to their pre-pandemic life regarding career, school, relationships, finances, and other areas? COVID-19 and the aftermath are a “new type of trauma that has never been conceptually or empirically analyzed in our discipline” (Kira et al., 2023, p. 51). Consequently, any inquiry you make into the association between COVID-19 and trauma is an entry into a new area of interview and assessment that the counseling profession is *just now* starting to practice and study.

ASSESSMENT

This is the impossible section of the book to write. There are countless assessments for any issue warranting of assessment during the intake and counseling process. If I started listing assessments, the lists would be endless and quite cursory in coverage. In Table 2.8, I tried to provide some of the most used and/or most readily available assessments for the key areas of interviewing discussed in the prior pages. Critical to remember, assessments never take the place of a thorough counseling interview, intake session, or diagnostic inquiry. These reviewed

TABLE 2.8 ■ Some Recommended Assessment Measures

Substance Use/Process Addiction	
Measure	Overview
Alcohol Use Disorders Identification Test–Concise (AUDIT-C)	The AUDIT-C is a modified version of the AUDIT instrument consisting of three questions and is scored on a scale of 0 to 12. In men, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders. In women, a score of 3 or more is considered positive (Saunders et al., 1993).
The Michigan Alcohol Screening Test–Geriatric (MAST-G)	The MAST-G consists of 24 questions about alcohol use behaviors with yes/no responses tailored for an older adult population. A score of 5 or more questions answered positively indicates alcohol misuse (Blow et al., 1992).
Timeline Followback Method Assessment (TLFB)	The TLFB is a clinical and research tool for estimating marijuana, cigarette, and other drug use. The TLFB can be administered by an interviewer, self-administered, or administered by computer and asks clients to retrospectively estimate their drug, marijuana, or cigarette use 7 days to 2 years prior to the interview date (S. M. Robinson et al., 2014).
Drug Abuse Screening Test–10 (DAST-10)	DAST-10 is a brief, self-report instrument for population screening, clinical case finding, and treatment evaluation research for use with adults and older youth (Skinner, 1982).
Clinical Decision Support (CDS) for Substance Abuse	As a follow-up to the DAST-10, the CDS consists of additional questions needed for clinical decision support to address types of substances, frequency of use, any injection drug administration, and SUD treatment status (Ghitza et al., 2013; Tai et al., 2012).
The Fagerström Test for Nicotine Dependence (FTND)	The FTND assesses the intensity of physical addiction to nicotine (Heatherton et al., 1991).
Problem Gambling Severity Index (PGSI)	The PGSI assesses at-risk and problem gambling during the past year (Ferris & Wynne, 2001).
PATHOS	The PATHOS is a brief six-item instrument to assess for sex addiction (Carnes et al., 2012).
Impact of Non-Suicidal Self-Injury Scale (INS)	INS assesses the social, behavioral, and emotional consequences of non-suicidal self-injury (Burke et al., 2017).
Psychiatric	
(available at www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures)	
Measure	Overview
*The <i>DSM-5-TR</i> Level 2–Anger–Adult	The <i>DSM-5-TR</i> Level 2–Anger–Adult measure is a client self-report five-item version of the PROMIS Anger Short Form that assesses anger in adults. Each item on the measure is rated on a 5-point scale (1 = never; 2 = rarely; 3 = sometimes; 4 = often; and 5 = always) with higher scores indicating greater severity of anger.

TABLE 2.8 ■ Some Recommended Assessment Measures (Continued)

*The <i>DSM-5-TR</i> Level 2–Anger–Child	The <i>DSM-5-TR</i> Level 2–Anger–Child (ages 11–17) is the six-item PROMIS Calibrated Anger Measure assessing anger in children and adolescents where clients self-report anger in the prior 7 days. Each item on the measure is rated on a 5-point scale (1 = never; 2 = almost never; 3 = sometimes; 4 = often; and 5 = almost always) where higher scores indicate more severe anger.
*The Severity Measure for Depression–Adult	The Severity Measure for Depression–Adult (adapted from the Patient Health Questionnaire–9 [PHQ-9]) is a client self-report nine-item measure assessing severity of depressive symptoms in adults during the prior 7 days. Each item on the measure is rated on a 4-point scale (0 = not at all; 1 = several days; 2 = more than half the days; and 3 = nearly every day) with higher scores indicating greater depressive symptoms severity.
*The Severity Measure for Depression–Child	The Severity Measure for Depression–Child (ages 11–17) is adapted from PHQ-9 modified for Adolescents (PHQ-A) and is a nine-item self-report measure assessment of the severity of depressive disorders and episodes over the prior 7 days. Each item on the measure is rated on a 4-point scale (0 = not at all; 1 = several days; 2 = more than half the days; and 3 = nearly every day) with higher scores indicating greater depression severity.
Geriatric Depression Scale (GDS)–Older Adult	GDS is a 30-item self-report measure in reference to depressive symptoms over the prior 7 days (Yesavage et al., 1982). A Short Form GDS (Shiek et al., 1986) consists of the 15 items from the GDS Long Form with the highest correlation with depressive symptoms in validation studies. Higher scores reflect more severe depressive symptoms.
*The Severity Measure for Panic Disorder–Adult	The Severity Measure for Panic Disorder–Adult is a 10-item self-report measure assessing panic disorder symptoms in adults over the prior 7 days. Each item on the measure is rated on a 5-point scale (0 = never, 1 = occasionally, 2 = half of the time, 3 = most of the time, and 4 = all of the time) with higher scores indicating greater panic disorder symptoms severity.
*The Severity Measure for Panic Disorder–Child	The Severity Measure for Panic Disorder–Child (ages 11–17) is a 10-item self-report measure assessing the severity of symptoms of panic disorder in children and adolescents during the prior 7 days. Each item on the measure is rated on a 5-point scale (0 = never, 1 = occasionally, 2 = half of the time, 3 = most of the time, and 4 = all of the time) with higher scores indicating greater severity of panic disorder.
*The Severity Measure for Generalized Anxiety Disorder–Adult	The Severity Measure for Generalized Anxiety Disorder–Adult is a 10-item self-report measure that assesses the severity of generalized anxiety disorder in adults in the prior 7 days. Each item on the measure is rated on a 5-point scale (0 = never, 1 = occasionally, 2 = half of the time, 3 = most of the time, and 4 = all of the time) with higher scores indicating greater severity of generalized anxiety disorder.

(Continued)

TABLE 2.8 ■ Some Recommended Assessment Measures (Continued)

*The Severity Measure for Generalized Anxiety Disorder–Child	The Severity Measure for Generalized Anxiety Disorder–Child (ages 11–17) is a 10-item self-report measure assessing severity of generalized anxiety disorder in children and adolescents during the prior 7 days. Each item on the measure is rated on a 5-point scale (0 = never, 1 = occasionally, 2 = half of the time, 3 = most of the time, and 4 = all of the time) with higher scores indicating greater severity of generalized anxiety disorder.
Geriatric Anxiety Scale (GAS)–Older Adult	The GAS is a 30-item self-report measure to screen for anxiety symptoms in older adults over the past 7 days. Higher scores reflect higher levels of anxiety. The GAS includes three subscales: somatic symptoms, cognitive symptoms, and affective symptoms (Segal et al., 2010).
*The National Stressful Events Survey PTSD Short Scale (NSESSS)	The National Stressful Events Survey PTSD Short Scale (NSESSS) is a nine-item self-report measure assessing the severity of post-traumatic stress disorder in adults over the prior 7 days and following an extremely stressful event or experience. Each item on the measure is rated on a 5-point scale (0 = not at all, 1 = a little bit, 2 = moderately, 3 = quite a bit, and 4 = extremely) with higher scores indicating greater PTSD symptoms severity.
PTSD Checklist for DSM-5 (PCL-5)	The PCL-5 is a 20-item self-report measure assessing the 20 DSM-5 symptoms of PTSD. A total symptom severity score (range 0–80) is obtained by summing the scores for each of the 20 items (though there are other mechanisms to score as well). If using the total score, a cutoff score of approximately 31–33 reflects likely PTSD (Blevins et al., 2015)
*The (NSESSS) Child	The (NSESSS) Child is a nine-item self-report measure assessing severity of post-traumatic stress disorder in children (ages 11–17) following an extremely stressful event or experience and in the 7 days prior. Each item on the measure is rated on a 5-point scale (0 = not at all, 1 = a little bit, 2 = moderately, 3 = quite a bit, and 4 = extremely) with higher scores indicating greater severity of post-traumatic stress disorder.
*The Clinician-Rated Dimensions of Psychosis Symptom Severity	The Clinician-Rated Dimensions of Psychosis Symptom Severity is an eight-item clinician-administered measure assessing severity of mental health symptoms across psychotic disorders. Each item on the measure is rated on a 5-point scale (0 = none, 1 = equivocal, 2 = present but mild, 3 = present and moderate, and 4 = present and severe) with a symptom-specific definition of each rating level. Responses per each item are interpreted independently when assessing the severity of the psychotic disorder.
*The Personality Inventory for DSM-5 Brief Form (PID-5-BF)–Adult	The Personality Inventory for DSM-5 Brief Form (PID-5-BF)–Adult is a 25-item self-rated personality trait assessment scale for adults that assesses the personality trait domains of negative affect, detachment, antagonism, disinhibition, and psychoticism, with each trait domain consisting of five items. Each item on the measure is rated on a 4-point scale (i.e., 0 = very false or often false, 1 = sometimes or somewhat false, 2 = sometimes or somewhat true, 3 = very true or often true) with a domain score ranging between 0 and 15 and overall scores 0 to 75, where higher scores reflect greater personality dysfunction.

TABLE 2.8 ■ Some Recommended Assessment Measures (Continued)

Recovery Capital	
Measure	Overview
Multidimensional Inventory of Recovery Capital (MIRC)	The MIRC assesses resources across the social, physical, human, cultural recovery capital domains. Total scores on the MIRC can range from 28 to 112, with lower scores indicating less recovery capital and higher scores indicating more recovery capital (E. Bowen et al., 2023).
The Recovery Capital Questionnaire (RCQ)	The RCQ is a 36-item questionnaire that considers RC across the four domains of social, physical, human, and community capital constructs, with higher scores reflecting items indicative of client personal experience/recovery capital (Burns & Yates, 2022).
Post-Traumatic Growth	
Measure	Overview
The Posttraumatic Growth Inventory (PTGI)	The PTGI assesses post-traumatic growth on a 21-item scale using the five factors of personal strength, new possibilities, improved relationships, spiritual growth, and appreciation for life. Items are scored on a 0–5 scale, with higher scores reflecting more change resulting from the experienced trauma (Tedeschi & Calhoun, 1996).
COVID-19 Pandemic Impact	
Measure	Overview
The COVID-19 Exposure Scale	The COVID-19 Exposure Scale assesses the types of potentially traumatic exposure(s) an individual had to the COVID-19 pandemic. This 28-item scale uses dichotomous yes/no responses and can be scored cumulatively by summing the number of “Yes” responses (range of 0–28) or individual items may be examined independently (National Center for PTSD [NCPTSD] COVID-19 Workgroup, 2021).
COVID-19 Traumatic Stress Scale	The COVID-19 Traumatic Stress Scale is a 12-item scale with three subscales “threat/fear of infection and death,” “economic hardship,” and “disturbed routines/isolation.” Items are scored on a 5-point scale, with higher scores reflecting more severe traumatic impact (Kira et al., 2021a, 2021b).

measures simply serve as a complement and supplement to those counseling dialogue processes. By reviewing all the concepts discussed in this chapter, and using assessments as needed to gather quantitative data to inform diagnostics (Chapter 3) and treatment planning (Chapter 4), the counselor can develop a comprehensive course of care to address co-occurring substance use/addiction, mental health, and pain disorders in addition to the numerous psychosocial factors that either help or hinder the treatment and recovery process.

QUESTIONS TO CONSIDER AS YOU MOVE ON TO CHAPTER 3

Question 1. Can you think of any specific problems a client with cognitive deficiencies (due to substance use) would encounter in the interview and assessment process? How could you as a counselor (or program administrator) reorganize some day-to-day interview tasks to better accommodate this client?

Question 2. This chapter was all about asking clients questions. Going back to Chapter 1, which parts of the brain are being activated when being asked various types of questions in the interview and assessment process?

Question 3. Some of these concepts discussed for the interview and assessment, such as PTG and COVID-19 impact/trauma, are novel areas of inquiry. How would you initiate and maintain a dialogue around these issues in an effort to determine what role (if any) these factors played in the client's difficulties and need for care?

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