

Mitch Earleywine

Advances in Psychotherapy –
Evidence-Based Practice

Substance Use Problems

2nd edition



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Advances in Psychotherapy – Evidence-Based Practice

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1

Description

1.1 Terminology

This first section reviews diagnostic terms, epidemiology, prognosis, differential diagnosis, comorbidities, and diagnostic procedures for drug-related problems. A clear understanding of each of these topics will lay a foundation for efficient assessment and treatment.

1.1.1 Diagnostic Terms

Defining problem drug use can seem like a fool's errand. Some people clearly have their lives altered by their use of psychoactive substances; others seem to use without troubles. The range of substances, intoxication experiences, and negative consequences is vast. Several terms appear to describe drug problems adequately, but many others are imprecise, ambiguous, or pejorative. The definition of problematic use reflects tacit assumptions about drugs and drug users. These assumptions can alter our interactions with clients in ways that may escape our awareness. Those who consider illicit drug use (or any illegal behavior) inherently wrong can find that their interactions with these clients differ dramatically from their interactions with other clients. The moral implications of using drugs change in different environments and different eras. Perhaps the best perspective for defining problem drug use requires understanding the goal of the definition. Ideally, identifying drug problems could serve as a step toward building a productive therapeutic relationship. Precise names for these problems can also aid communication within a treatment team. When everyone involved gives the same meaning to terms like *addiction* or *substance use disorder*, it is easier to avoid confusion.

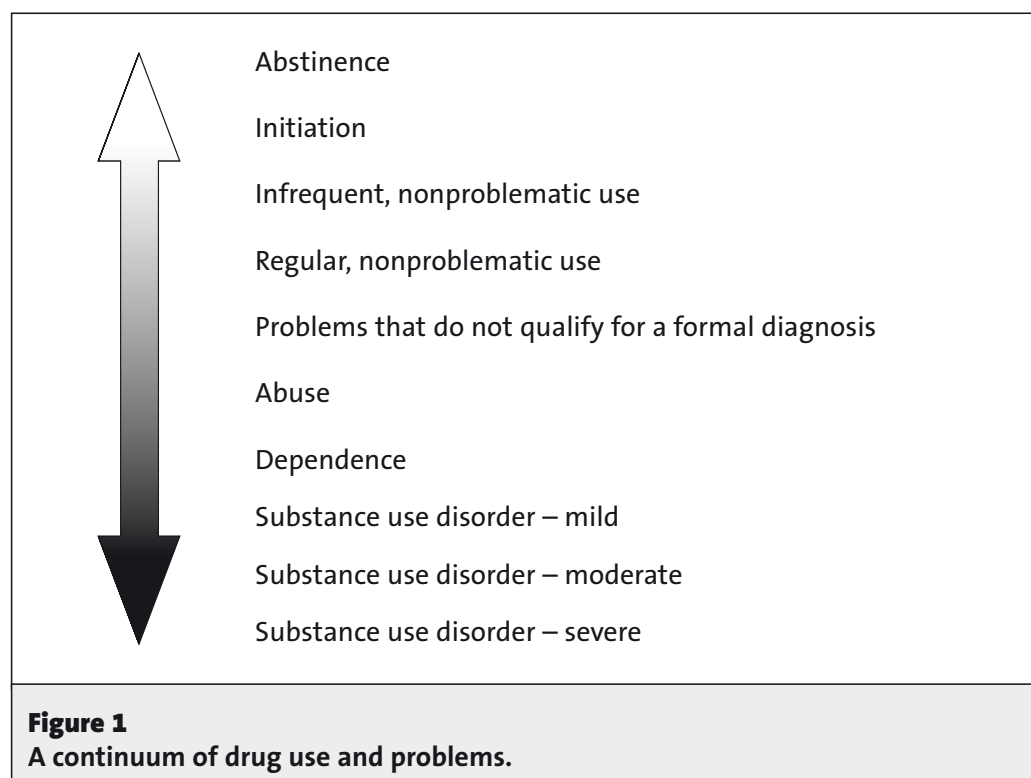
Categories and Continua

Many used the term *addict* without a formal definition for years, which often led to misunderstandings. *Dependence* and *abuse* had specific meanings with acceptable discriminant validity, giving them the potential to improve communication, but subsequent research revealed that they seemed to stem from a single, underlying factor dubbed *substance-related and addictive disorders*. Recent work focuses on adapting substance-related and addictive disorders to provide a convenient way for clinicians and researchers to communicate. Nevertheless, two people with this diagnosis may not share a single symptom. A rigid focus on these diagnostic categories can also lead clinicians to miss a chance to prevent problems before they start. A client experiencing negative

consequences unrelated directly to the chosen symptoms might not qualify for a diagnosis, or at least not a severe one, but could still benefit from altering drug use. Thus, thinking about the impact of drugs on quality of life can prevent problems in a way that a premature focus on diagnoses might neglect.

Unfortunately, lay conceptions of diagnostic categories confuse both clients and the public. For example, some people define any use of an illegal drug as problematic, but busy clinicians rarely have time to split hairs over who does or does not qualify for a label. Perhaps the best approach to defining misuse relies on cataloging problems that stem from the drug. This approach may provide the most specific information for treatment. Many view drug problems categorically – either substance use interferes with someone’s life or it does not. Nevertheless, examining drug problems on a continuum has considerable utility and empirical support (Denson & Earleywine, 2006). One useful way to look at this range of troubles would place complete abstinence on one end of a continuum and serious troubles, including a diagnosis of severe substance use disorder, on the other. Unfortunately, the word *abstinence* has some odd connotations. People who do not use a drug might not be showing some effortful attempts to abstain. They might not show any interest. *Non-use* remains an awkward alternative but gets the meaning across. Nonproblematic use might fall near the abstinence end of the continuum, while troubles that might not qualify for a diagnosis might lie closer to the diagnosable disorder. Variation within substance use disorder is also acknowledged, from mild to severe, depending upon the number of symptoms. This continuous model might challenge those of us trained in the tradition of diagnosis or disease, but could also heighten awareness for the prevention of problems (see Figure 1). This continuous approach is also consistent with the reformulation of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013).

Substance misuse problems can lie along a continuum



1.1.2 Common Drugs

Terms

Different psychoactive drugs can wax and wane in popularity, and it is challenging to keep up with trends in use and the rituals and slang associated with new drugs. Nevertheless, a little effort can go a long way in clinical work. Clients appreciate therapists who know their world. Professionals with some background information about common drugs can gain credibility in their clients' eyes. Few therapists have time to become experts in every substance, but a general familiarity with commonly used drugs, the subjective effects that appear to motivate use, and common street names can prove helpful (see Table 1 for a focused list).

Subjective effects of drugs vary with dosage, set, setting, and experience

Table 1
Some Common Drugs, Reported Effects, and Street Names

Drug	Reported effects	Street names
Marijuana	Euphoria, laughter, hunger, sedation, aphrodisiac	Pot, grass, weed
Powder cocaine	Stimulation, confidence, improved focus, aphrodisiac	Coke, dust, powder, flakes, coca, snow
Crack cocaine	Extreme euphoria, stimulation, confidence	Crack, rock, sugar, bazooka, devil rocks
Heroin	Euphoria, sedation, analgesia	H, hard candy, dope, junk
Hallucinogens	Tangential thinking, perceptual aberrations, spiritual connection	Acid, X, candy, trips, 'shrooms
Inhalants	Laughter, analgesia, sedation	Rush, gas, huff, poppers
Pain relievers	Analgesia, euphoria, numbness	Oxy, Vics
Sedatives	Tranquility, relaxation	Reds, downers, downs
Stimulants	Increased arousal, improved focus	Uppers, ups, speed, crank, meth

Subjective Effects

Subjective effects vary with dosage, expectations, experience, and setting, so there are vast individual differences in response. An individualized approach is ideal, but general knowledge about substances can save clinicians time and effort. Drugs often produce certain effects as a result of straightforward physiological processes, and thus a few heuristics can apply across many drugs because we all share comparable nervous systems. Higher doses generally produce larger effects. For example, stimulants almost invariably increase heart rate, regardless of the user's beliefs or situation. This effect increases as the amount of the drug increases. Other effects arise, at least in part, because users

believe these effects will occur. For example, those who believe that alcohol makes them more adept socially can feel more relaxed with others. Curiously, this social enhancement can arise even after drinking a placebo. In addition to expectations, a user's previous experience with a drug can alter the drug's impact. Those who have developed tolerance from prior use will experience a weaker effect from many drugs. By contrast, repeated exposure can make some individuals more sensitive to the negative consequences of drugs. For example, on the day after using MDMA, experienced users of the hallucinogen are more likely to report depressive symptoms than those who used the drug for the first time.

The intoxication experience also varies with setting. The same drug can have dramatically different effects in different circumstances. People who repeatedly use opiates in comparable settings can develop a conditioned tolerance to their effects, and the same dosage will fail to produce the euphoria or analgesia associated with earlier uses. This tolerance might not appear, however, when the drug is consumed in a different setting. Dramatic, sometimes lethal, sensitivity can return when individuals use the same drugs in the same amount but in a different environment. Setting can contribute to the subjective effects of a drug even independent of conditioning. Cannabis intoxication, for example, can feel relaxing in a group of friends but induce paranoia in a police station.

The subjective effects of drugs are difficult to describe but nearly all produce a reinforcing euphoria and relief from stress (Earleywine, 2005; see Table 1). Reactions to various drugs and the culture that often develops around them can be idiosyncratic. Clients often have their own slang, preferred effects, and other distinctions related to drugs. The street names of various drugs can change quickly in different eras and locations, too. Mental health professionals who let clients educate them about drugs often gain a great deal in little time. This information can prove useful for assessing drug use and for performing a functional analysis of the predictors and consequences of use. The most efficient way to learn about any drug is to ask clients about it directly.

Clinical Pearl **Recalling Quantities of Drugs Consumed**

The recall of quantities, especially for some illicit drugs, can get complicated. Any unit of measurement that appeals to the client is usually best. Cannabis users have reported bowls, blunts, grams, joints, and even bong hits. Crack cocaine users often conceptualize quantity in terms of dollar amounts. Intranasal cocaine users frequently remember amounts in grams. Users of prescription drugs often recall the number of pills they took. Almost invariably, clients reach a certain day and claim that the amount was tremendously large but impossible to recall. Responses like, "I don't know, but it was a lot," can actually be a great place to start. Comparing that day to other days with large amounts often helps jog their memories. Mentioning an absurdly large amount can often help clients move toward a reasonable estimate. "Do you think you snorted 4 g?" can help clients overcome any embarrassment they might have about snorting 2 g. Questions like, "Was it more than on the 24th?" can help clients put the day's use in perspective relative to other sessions of use. Throwing out a range of responses comparable to those reported from other days can also help. Questions like, "Do you think it was more than \$700 worth?" or "Was it more than four pills?" can start a series

of questions moving higher and lower to get a good estimate of consumption. Precise estimates of quantity can prove particularly important as clients make progress toward recovery.

Many clients initially claim a specific, invariable pattern but later realize that their use ranges more than they thought. Those who say that they drink a six-pack and take four painkillers each night are often surprised when they walk through individual days and discover that, for example, weekdays they use markedly less and weekends they use considerably more than their average. This type of variation will actually prove useful when planning for high-risk situations later in treatment. This assessment also lays the groundwork for a functional analysis of the predictors, correlates, and consequences of use, as detailed in Section 4

An important but untouted bonus of the Timeline Followback or any interview is its potential for the development of a good therapeutic relationship. The recall of each day's use should focus as much as possible on different drugs and their amounts. However, it can be counterproductive to sacrifice rapport simply to get precise data. If a client recalls that a specific date marked a negative life event, express empathy and support before moving to the next date. Any client could lose heart when the pursuit of exact amounts grows too persistent. After revealing that a day marked the death of a parent or the initiation of a divorce, few would like the therapist's first response to be, "And did you snort cocaine that day?" Acknowledging that these events must have been difficult can encourage a candid assessment of use and builds good connections between client and therapist.

1.1.3 Nonproblematic, Recreational Drug Use

Abstinence is easily defined as the complete absence of drug use. It makes an excellent anchor for the nonproblematic end of the drug use continuum. Fine distinctions moving from this end of the continuum to the problematic end, however, can generate heated debate. The idea that people can use drugs recreationally without negative consequences remains controversial despite the prevalence of controlled use of many psychoactive substances. The idea is worthy of our consideration, however, to prevent a premature or inappropriate focus on drug use when other problems might be more important for a specific client (Beck, Liese, & Najavits, 2005). For example, the modal consumer of alcohol drinks infrequently and rarely experiences so much as a hangover. The idea that people might use other drugs in a comparable way strikes some clinicians as odd. Many of us learned that certain drugs create inescapable biological changes that lead inexorably to problems. However, data do not always support this idea (Advokat, Comaty, & Julien, 2014), and important individual differences exist. Unfortunately, we have no way of knowing if any specific person will make the transition from initiation of use of a drug to problematic use. In addition, the use of illicit drugs invariably carries more risk because of their potential to create trouble with the law.

Lifetime and Recent Use

Table 2 lists the percentage of Americans who use various drugs. These epidemiological data show that many people have used an illicit drug at least once

Over 48% of Americans have tried an illicit drug

in their lives, but relatively few have used one recently. Over 48% (more than 153 million) of Americans have used an illicit drug, but only about 9% (less than 30 million) have used one in the last month. These data support two intriguing ideas: First, it is obvious that not all drug use leads inexorably to continued use. Clients who mention use of an illicit drug might actually experience no negative consequences, and their therapy might not focus on drugs. Second, many clients with drug problems often emphasize that nearly everyone has tried illicit substances. Social psychology research on assumed similarity, the idea that others resemble ourselves, reveals that we all tend to guess that others behave as we do. Drug users are no exception. They are often surprised to learn that although many people have tried illicit drugs, few have used these drugs recently. Current users of illicit drugs are, in fact, in the minority.

Table 2
Drug Use (Aged 12 or Older) in the United States: Percentages

	Lifetime	Past year	Past month
All illicit drugs	48.6	15.9	9.4
Marijuana	43.7	12.6	7.5
Alcohol	81.3	84.9	51.9
Cocaine	14.3	1.6	0.6
Heroin	1.8	0.3	0.1
Hallucinogens	15.1	1.7	0.5
Inhalants	8.0	0.6	0.2
Pain relievers	13.5	4.2	1.7
Sedatives	2.9	0.2	0.1
Stimulants	8.3	1.3	0.5

Note. ^aMarijuana is not illegal in some states in the US currently.

Adapted from "Results From the 2013 National Survey on Drug Use and Health: Summary of National Findings" by Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Health and Human Services, 2014.

1.1.4 Problematic Drug Use

Separating safer drug use from problematic use depends upon our definitions of problems, and distinguishing between problem-free and troubled drug use can prove difficult. Clients who consider themselves problem-free users frequently fail to attribute negative life events to drugs. Thus, they often describe their troubles to clinicians but fail to mention their consumption of substances. The stigma commonly associated with the use of illicit drugs can also make clients reluctant to mention them spontaneously. Mental health professionals who are familiar with the numerous substance-related diagnoses and different

domains of drug problems invariably have a better chance of connecting drug use to negative life events. Although diagnostic systems differ, assessments of drug problems generally tap multiple domains. Most clients would like to build a life that includes a romantic partner, gratifying family relationships, close friends, satisfying work, financial stability, good health, delightful recreation, and a sense of personal development. Although the issue is often contentious, the popularity of 12-step approaches to problems has also led many clients and clinicians to reexamine the importance of a spiritual life and an appreciation for the divine. Drug use has the potential to interfere in all of these domains, making them appropriate targets for assessment. Most definitions of problems focus on at least some of these limitations to optimal functioning.

1.2 Definitions

The formal definitions for disordered drug use previously fell generally into categories of dependence and abuse (or harmful use). Clinicians applied the diagnoses reliably in many studies, but some of the nuances of symptoms were lost in the simple lists that often appeared in publication or questionnaires. For example, raters agreed quite well on diagnoses of abuse and dependence made from structured interviews (Ustün et al., 1997), but simplified questionnaires based on symptoms potentially created deviant estimates of the prevalence of these problems (Grant et al., 2007). Continued work suggested that the distinction between abuse and dependence might have been illusory, leading to a single, continuous diagnosis with a severity rating instead. Symptoms appear in the tables, with details below (American Psychiatric Association, 1994, 2013).

1.2.1 Substance-Related and Addictive Disorders

The DSM-5 (American Psychiatric Association, 2013) defines substance-related and addictive disorders to include intoxication, withdrawal, and substance use disorder. The substance use disorder requires at least two of 11 symptoms, with more symptoms suggesting more severity (see Table 3). Those who experience two to three symptoms receive the mild severity rating. Four to five symptoms lead to a diagnosis of moderate severity, with six or more qualifying for the severe category. These symptoms must create meaningful distress and occur within the same year. Each symptom reflects the idea that a person cannot function without the drug and makes maladaptive sacrifices to use it. Assessing these symptoms requires genuine clinical skill. Many clients associate drug use and related symptoms with stigma. A warm, nonjudgmental, empathic approach with questions that use straightforward, simple language will improve rapport and encourage candor (Beck et al., 2005). Frequent nods, smiles, and eye contact are essential, even when the clinician must take notes, as detailed in Section 3.

Focus on Consequences

The current diagnosis focuses on specific behaviors or consequences, not on the amount or frequency of consumption. There are no hard and fast rules linking the quantity or regularity of use to a diagnosis. The DSM-5 committee also took great strides to avoid some consequences that seemed more likely among drug users of specific socioeconomic or ethnic backgrounds, dropping the DSM-IV's abuse symptom related to trouble with the law. Substance-related disorder symptoms include tolerance (a decreased response to the same amount of a drug or a need for more to achieve the same effect) and withdrawal (a marked discomfort when the drug is not ingested), which were once considered the physiological hallmarks of disordered use of drugs. The DSM-5 does not distinguish between disorders with and without a physiological component. That is, clients with two symptoms other than tolerance or withdrawal still qualify for the diagnosis. The additional symptoms appear in Table 3; all must occur within the same 12-month period. Over the years, diagnosticians can drift away from the formal definitions of these symptoms, so a review of their definitions can prove helpful. Nevertheless, DSM-5 diagnoses are at least as reliable as those made under DSM-IV. Reliability is slightly lower for mild than for moderate or severe disorders (Denis, Gelernter, Hart, & Kranzler, 2015). The prevalence rates of DSM-5 substance use disorders are comparable to or slightly higher than those found with DSM-IV (Goldstein et al., 2015).

Clinical Pearl Stimulant Withdrawal

A great many people who use stimulants problematically find withdrawal particularly aversive. Although fatigue would seem an obvious sign of stimulant withdrawal, some experience it as a jittery, nerve-racking, edgy feeling. These withdrawal symptoms can precede lapses. Oddly enough, some of the arousal that these people experience may stem from exaggerated caffeine and nicotine effects. Caffeine and nicotine are eliminated more slowly once other stimulants are no longer increasing a client's metabolism. This decreased metabolism may mean that doses of caffeine and nicotine that used to produce only minor effects now create whopping stimulation, which users often interpret as extreme withdrawal symptoms. An educational warning about this predicament may help users moderate their consumption of caffeine and nicotine and offer a reasonable explanation for some of the jitters they experience during withdrawal.

Table 3 Substance Use Disorder Symptoms

1. Use that exceeds intention
2. Failed attempts to quit or constant desire for the drug
3. Time lost
4. Craving or a strong desire or urge to use
5. Failure to fulfill obligations at work, home, or school
6. Continued use despite social or interpersonal problems
7. Reduced activities
8. Use in unsafe settings
9. Continued use despite physical or psychological problems
10. Tolerance
11. Withdrawal

1.2.2 Codes From the DSM

The DSM provides an extensive list of categories based on the drug of choice as well as whether a particular client is experiencing intoxication, withdrawal, or a substance-related disorder. Drug of choice includes: alcohol; caffeine; cannabis; hallucinogens (with separate categories for phencyclidine and other hallucinogens); inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants (including amphetamine and cocaine); tobacco; and other (or unknown) substances. The decision to include intoxication for some drugs but not others has generated some controversy. For example, tobacco intoxication does not appear, while caffeine intoxication does. The notion that intoxication or withdrawal alone might qualify as a disorder has also created considerable debate. Withdrawal has often served as a hallmark of drug problems.

DSM codes for drug-related disorders vary with drug of choice

The DSM-5 has added caffeine and cannabis withdrawal diagnoses, but suggests that data have yet to support the idea of hallucinogen withdrawal. The substance-related disorder diagnosis also does not apply to all drug categories. The DSM-5 suggests that data do not yet support a diagnosis of caffeine use disorder, but all other drug categories include the diagnosis. In addition, drug-induced disorders like caffeine-induced anxiety or cocaine-induced depressive disorder receive specific codes that supersede the codes for substance-related disorders, but still attend to severity (as described in Section 1.2.1). Establishing that another set of symptoms is drug-induced, and not generated from other biological, psychological, or social origins, is no easy feat. Generally, if symptoms covary with use of the drug such that long periods of abstinence also lead to a decline in features of the other disorder, diagnosticians should consider the disorder substance-induced. The focus disorder of treatment, or at least the primary reason for the visit, is listed first (principal diagnosis), followed by the other diagnoses in descending order of clinical importance.

Currently codes correspond to those in the ICD-10 (World Health Organization, 1992). Initial digits reveal the target drug. For example, F11 refers to opioids. F11.23 is opioid withdrawal. F11.10 is Mild opioid disorder while F11.20 is moderate or severe opioid disorder. F12 refers to cannabinoids, F13 to sedatives or hypnotics, and F14 to cocaine. Subsequent digits can indicate the simple presence of withdrawal. Alternative codes reveal the presence and severity of the disorder, often with F1x.10 for mild and F1x.20 for moderate or severe. Drug intoxication codes usually begin with the target drug's corresponding numbers. Subsequent digits reveal if perceptual disturbances are present or absent, with additional digits revealing the presence, absence, or severity of the associated drug disorder. Drug-induced disorders are coded in accordance with the symptoms the drug has purportedly generated, with separate codes for the absence, presence, and severity of a substance use disorder.

1.2.3 Drug Problems

Many drug-related troubles do not serve as formal symptoms of any diagnosis, but an astute clinician and a willing client can view these as opportuni-

ties to prevent further problems. Candid discussions often reveal volatile or estranged relationships with family and friends that can arise from conflict about drug use, financial problems, or other behaviors related to drug problems. These would all suggest less than optimal functioning even if these individuals do not quite qualify for any of the aforementioned diagnostic categories. Popular assessment devices ask about problems with physical and mental health, social skills, family functioning, school and work, peer relationships, and leisure.

1.3 Epidemiology

1.3.1 World Statistics

Estimating how many people use illicit drugs is daunting because of the potential for self-report bias. Many large epidemiological studies rely on phone interviews that participants might not perceive as particularly anonymous. Estimates of use might be underestimates given the understandable tendency to avoid admitting to an illegal behavior. Worldwide estimates of the number of people who used an illicit drug in the past year remain around 200 million, with considerable variation across countries. The number who have used in the past month is smaller, around 110 million. Reported rates of illicit drug use can vary dramatically across different countries, with Asia reporting dramatically lower rates (Devaney, Reid, & Baldwin, 2007). These comparisons across countries require cautious interpretation, however, as variations in penalties and associated stigma may contribute to different rates of underreporting. For example, Portugal has decriminalized possession of small amounts of all recreational drugs while maintaining certain penalties for production and sales, apparently decreasing some negative consequences such as new HIV cases (Laqueur, 2015). Demand for treatment focuses on the opiates in Asia, cannabis in Africa, and cocaine in South America, suggesting that availability is the best predictor of drug of choice.

Marijuana remains the most prevalent illicit drug across nations; the stimulants and opiates are used markedly less often (Degenhardt & Hall, 2012). The legal status of cannabis (marijuana) remains in flux and could alter consumption, reports of consumption, and associated problems in unpredictable ways. Uruguay has legalized cannabis and plans to allow the purchase of 10 g per week. Alaska, Oregon, Colorado, and Washington State in the United States have made arrangements for taxed and regulated markets in recreational cannabis, which might increase use and perhaps related problems. These markets can decrease perceptions of risk associated with the plant, increase availability, and lead to higher reports of problems among younger citizens (see Pardo, 2014; Schuermeyer et al., 2014). Decreasing stigma has the potential to improve the validity of self-reports and might lead to candid discussions of cannabis use earlier in the therapy process. Nevertheless, as stigma changes, self-report biases might also change, leading people to be more likely to report truthfully about their use of marijuana when they might not have done so in the past.

As Table 2 demonstrates, the prevalence of illicit drug use has received considerable attention in the United States. Over 45% of people have used illicit drugs at some time in their lives, with marijuana the most common and heroin the least. Rates of use vary dramatically across the different drugs, perhaps as a function of perceived risk of negative consequences. More people try drugs that are perceived to be less harmful. Polydrug use is common. Use of one illicit drug tends to predict use of another (Degenhardt et al., 2010), so the total percentage of drug users is smaller than the sum of the users for each drug.

1.3.2 Demographic Correlates

A slightly different data set reveals that rates of use vary with gender, age, and ethnicity (see Table 4). Currently, a higher percentage of men than women have tried illicit drugs. Young adults aged 18–25 are more likely to have used a drug in their lifetime than people of other age groups. In addition, a higher percentage of Native Americans have used a drug than members of other ethnic groups. Theories for these links to gender, age, and ethnicity focus on everything from the physiological to the societal.

Table 4
Rates of Illicit Drug Initiation by Demographics (in Percentages)

Demographic characteristic	Lifetime
Total	48.6
Age	
12–17	23.3
18–25	57.0
26 or older	50.2
Gender	
Male	53.0
Female	44.4
Hispanic origin and race	
Not Hispanic or Latino	50.3
Caucasian	52.9
Black or African American	47.3
American Indian or Alaska Native	60.9
Native Hawaiian or Other Pacific Islander	48.3
Asian	21.4
Two or more races	58.3
Hispanic or Latino	39.1

Note. Adapted from “Results From the 2013 National Survey on Drug Use and Health: Summary of National Findings” by Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Health and Human Services, 2014.

1.3.3 Recent Use

The majority of lifetime use is experimental (SAMHSA, 2014). Despite the large percentage of people who have tried an illicit drug at some time, the number who have used in the past month is remarkably small (see Table 2). This fact often comes as a surprise to current users, who frequently overestimate the prevalence of current drug use. Fewer than 1 in 10 US citizens reported using an illicit drug other than marijuana in the past month, and 1 in 100 or fewer reported using hallucinogens, inhalants, methamphetamine, crack, or heroin.

1.3.4 Problematic Use

Although the research literature from DSM-5 diagnoses has yet to catch up with all the work done on DSM-IV, a few key themes likely generalize: Substance-related disorders are less common than simple measures of use and they vary with other disorders as well as with demographic variables. Rates for abuse and dependence are markedly smaller than these rates for lifetime or recent use (Compton, Thomas, Stinson, & Grant, 2007). Face-to-face interviews with over 40,000 US residents revealed that 12-month drug abuse prevalence was 1.4% and lifetime abuse was 7.7%. Rates of dependence were even lower at 0.6% for past year and 2.6% for lifetime. Abuse and dependence are markedly less common than use. Other Axis I disorders, particularly the anxiety and mood disorders, are also much more common than abuse and dependence. Lifetime rates for anxiety are around 29%, with 18% affected in a given year. For mood disorders, lifetime rates are approximately 21% with approximately 10% affected in a given year. Rates of abuse and dependence varied with demographics in ways comparable to use. Men, Native Americans, and those aged 18–44 received diagnoses more often. In addition, those who lived in the Western United States, those with fewer financial resources, and those who were unmarried were also more likely to receive a diagnosis. Seeking treatment or help of any kind was remarkably rare, with only 8.1% of those with an abuse diagnosis and 37.9% of those with a dependence diagnosis reporting any sort of assistance for drug-related problems. The majority of those with drug problems do not seek outside help (Compton et al., 2007; Klingemann & Sobell, 2007).

1.4 Course and Prognosis

The course and prognosis for those with drug problems vary dramatically from person to person, across time, and for different drugs. A candid summary reveals the inherent difficulties associated with treating these troubles but leaves room for optimism about each individual client. Extensive treatment outcome and chronicity data for the DSM-5 diagnoses are not yet available, but they will likely parallel results from DSM-IV. About two thirds of those who met diagnostic criteria for substance abuse disorder did not meet those criteria 3 years later, even though few of them receive formal treatment