INCASE
International Coalition for Addiction Studies Education

# The Addiction Educator

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## Spring Newsletter 2022

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Check Us Out!

## The Cards You're Dealt: SUD Risk Classroom Exercise

*Alan A. Cavaiola, PhD, Monmouth University, and Margaret Smith, EdD Keene State College*

This article offers an exercise to assist students with learning about risk factors associated with biopsychosocial assessments. When teaching students how to do biopsychosocial assessments, addiction educators sometimes forget to emphasize that the main purposes of doing a biopsychosocial Assessment is three-fold. First, counselors are trying to explore ways in which the client's substance use has impacted their lives negatively. Second, counselors are also tasked with gathering other relevant background information about the client and third, counselors are also tasked with exploring possible Substance Use Disorder risk factors. This is important because we know that not all clients enter treatment voluntarily and therefore may be likely to avoid self-disclosure. Therefore, an exploration of risk factors may be a way of gaining information about a client that might be perceived as less-threatening. For example, it may be easier for clients to talk about whether they experienced any problems in school or other significant childhood history events rather than talking about whether they have experienced blackouts as a result of excessive drinking.

When addiction counselors gather information as part of a biopsychosocial assessment, we are essentially looking for possible biological, psychological and/or social or environmental risk factors. In the risk factors exercise described below, the BIOLOGICAL Risk Factors include those indicating a genetic history of Substance Use Disorders (SUDs) in the family. Although there are some studies that suggest there's a greater risk factor in males because of father-to-son genetic transmission, there are other studies that suggest that mother-to-son and mother-to-daughter genetic transmission also presents genetic risk. Also, while a specific, singular "alco-gene" has yet to be determined, it is theorized that there are probably a number of genes that predispose one to develop a SUD. Some recent research hypothesizes that perhaps what "gets inherited" are neurotransmitter imbalances e.g. low serotonin, low dopamine or low endorphin levels.

*(Continued on page 2).*

The PSYCHOLOGICAL risk factors include those items that impact one's emotional development, specific personality traits and particular mental health disorders. For example, there is a great deal of research which examines the correlation between early adverse childhood experiences (ACES) and later predisposition to SUDs. Similarly, traits such as high sensation-seeking and low frustration tolerance are also hypothesized to correlate with SUDs.

SOCIAL risk factors include racial/ethnic and cultural factors as well as the impact of living in a crime and substance-ridden neighborhood. Other social/ environmental risk factors include how racism, gender bias, poverty and a lack of educational/occupational opportunities impact negatively on some individuals, thereby predisposing him or her to use substances. There's a great YouTube video by Johann Hari entitled, "Everything You Know About Addiction is Wrong" that explores that impact of environment as an SUD risk factor.

When examining risk factors it's also important to emphasize that Substance Use Disorders are often multi-determined. In other words, it's often a combination of risk factors that might predispose individuals to developing Substance Use Disorders rather than one, singular risk factor alone. This bring us to what's referred to as the Diathesis-Stress model that recommends that disorders such as Substance Use Disorders be viewed as developing from the combination of biological, psychological and social risk factors. There's a saying that best encapsulates the spirit of Diathesis Stress: Biology loads the gun, psychology points the gun but environment pulls the trigger.

For further reading regarding risk factors, we highly recommend that you read our book:

Cavaiola, A. & Smith, M. (2020). *A Comprehensive Guide to Addiction Theory and Counseling Techniques,* New York: Routledge/Taylor & Francis.

For an activity to use in your classroom, refer to the Substance Use Disorders Risk Factors "The Cards You're Dealt Exercise". The directions for this exercise are included.

A Final Note

I wish we could say that we originated this risk factors exercise, however, the first time we heard of this exercise was at an INCASE conference that had taken place in Jersey City, NJ several years ago. At the time, Professor Nancy Roget had presented a version of this exercise. She mentioned that she became aware of this type of risk factors exercise through a NIAAA or NIDA monograph.

## Substance Use Disorders Risk Factors

### "The Cards You're Dealt Exercise"

**INSTRUCTIONS:**

Have your class break into small groups of 4 or 5 students each. Each group is given a deck of standard playing cards. One student is asked to volunteer to be "the dealer" and he or she will shuffle the deck of cards and deal five cards to each student. Students are then given the Risk Factors list and scoring directions and are then asked to calculate their scores. Ask the students to voluntarily share their score with the class and what their "risk factors" are.

Discuss with the class the risk factors and how those risk factors might come to light when doing a Biopsychosocial Assessment.

*(Continued on page 3).*

## Substance Use Disorders Risk Factors

**"The Cards You're Dealt Exercise"**

| Points | Card | Risk Factor |
|---|---|---|
| 20 | Ace | Both parents have SUD history & other family history |
| 10 | King | Father has SUD history, you have Low P-3 levels |
| 10 | Queen | Mother has SUD history |
| 10 | Jack | You have an older brother (named Jack) who has SUD |
| 10 | 10 | You have a history of Bipolar Disorder or Major Depressive Disorder |
| 9 | 9 | Your father has a history of SUD and you are a high sensation or novelty seeker |
| 8 | 8 | You have a history of childhood/teen trauma with high ACES scores (e.g. abuse, abandonment) |
| 7 | 7 | You have a history of ADHD |
| 6 | 6 | You live in poverty & a neighborhood where drug use is rampant |
| 5 | 5 | You have a history of childhood Conduct Disorder |
| 4 | 4 | You have low resiliency, low frustration tolerance, & have difficulty with affect regulation |
| 3 | 3 | You have low self-esteem, low self worth |
| 2 | 2 | You have an external locus of control |

**Score Interpretation**

| | | |
|---|---|---|
| 40+ | = | Extremely High risk potential for SUD |
| 25 – 39 | = | Moderately high risk potential |
| 15 – 24 | = | Moderate-Low risk potential |
| 14 > | = | Low risk potential |

# Subcultural Language Barriers: Relevance for the Helping Professions

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**Back Story**

During my Post Graduate training in Pastoral Counseling at New York Theological Seminary in New York, most of our courses were given at the Post-Graduate Center for Mental Health in Lower Manhattan. The Post Graduate Center was the largest Freudian based center for training therapists in the US. In one of our final clinical experiences, we had to bring in a "real client" and conduct a counseling session behind a one-way mirror (in 1974, this was before closed circuit video). The client and I were in an office being observed by our LCSW instructor and the rest of the class.

My client was in his early twenties, the son of Cuban immigrants living in Union City, NJ (a primarily Cuban cultural center). The client was born in the US, so was very bi-cultural. The client had completed approximately six months of his twelve-month residential treatment program. (Dismas House, at Straight and Narrow, Inc. in Paterson, NJ) I thought the session went very well. I thought I was being very culturally appropriate. The client and I did, however, use the "F-word" frequently, as this was the vernacular language with which the client grew up.

At the conclusion of the session, the client left, and I went into the next room with my class and the instructor. It should be noted that the class was made up of clergy/ministers of a broad range of denominations. Most were Protestant ranging from "high church/mainstream" to store-front independent Christian groups. Out of about 35 students there were only 5 Catholics (4 priests and one sister), we had 3 Rabbis, and one "Ethical Humanist" leader/minister/teacher (the best term for him was "agnostic"). I entered the room believing I had done a decent job. The class however gave a horrible evaluation. Note that even though the class was multi-cultural, their brains were very white middle/upper class in their cultural status. They determined that I had been:

very unprofessional
stooped to the client's level
was a poor "ministerial role model"
etc. etc. etc.

The instructor allowed the class to provide their negative evaluation much longer than I had any level of comfort. He finally interrupted and asked the class: "What would Ed have to have done if the client only spoke Spanish"? Answer: "He would have had to speak Spanish". The instructor then explained that "although the client was speaking American English, he actually spoke a specific dialect…he spoke "Street"….a very real subcultural dialect. We then had a discussion about language and culture.

I was then given an assignment for the following week. I had to do a class presentation on the "Therapeutic Uses of the Word Fuck". The following is a revised version of the content from 1974:

Frequently, cultural barriers between counselor and client can make that relationship counter-productive. In the case of "American Street English", there are a number of words that tend to "shock" or "turn off" many professionally trained members of the "helping professions". In order to develop a therapeutic relationship with clients, it is important for the helper to be open, and non-judgmental towards the sub-culture to which the client belongs.

In most cases (at the time) then "middle-class-white-suburban" helping professionals, who have been trained in like social and educational structures, assume that certain words are "dirty", "gross", "vulgar", and "below them".

One of our languages' classic words, which fits into this category is the word "fuck". It is a magical word that just by the tone of pronunciation, and position in the sentence can describe pain, pleasure, hate and love.

*(Continued on page 5).*

One tradition of this English word, is that it is derived from the "German" or "Anglo-Saxon" word "friken" which means "to strike". The second English/Anglo Saxon tradition is "Fornication Under Consent of the King". This was from a tradition that, at a marriage, the King had a "first strike" at intercourse with the bride (and maybe even the groom)!

Fuck falls into many grammatical categories of the "American Street English" language.

it can be used as a verb, both transitive (John fucked Mary) and intransitive (Mary got fucked by John).
It can be used as an adverb (Mary is fucking-well interested in John)
As a noun (John is a good fuck)
As an adjective (Mary is fucking beautiful)
As an expletive (Fuck!...verbalized in a variety of tones, ranging from a high pitched squeal to a low pitched moan)

In addition to the sexual meaning, however, there are also a variety of other uses:

Fraud—I got fucked at the used car dealer, or I got fucked by the Judge.
Ignorance—Fuck if I know.
Trouble—I guess I am fucked now.
Aggression—Fuck you!
Difficulty—This is a fucking mess.
Displeasure—What the fuck is going on here?
Incompetence—He's a fuck off.
Suspicion—What the fuck are you doing?
Enjoyment—This is a fucking good time.
Request—Get the fuck out of here.
Hostility—I'm going to knock your fucking head off.

The word fuck is not to be assumed to be a vulgar word. For many people, it is one of the most versatile, descriptive, and emotion expressing words in our language.

As with counselor self-disclosure, the use of this (or similar) words or expressions, should never be done to self-aggrandize, or to show that you are "street"—you need to be true to yourself—if you try to be something that you are not, it will never work. If, however, you use it as part of the language of communication it is a relationship builder.

**Teaching and Supervision Examples**
**Case 1:**

I was teaching Medical Ethics at a suburban Catholic Nursing school. The lecture hall was filled with over 100 nursing students (again in the 1970s). There was few if any women of color or men. Most of the female students were white middle or upper-class students—stereo-typical of the times. I spent a class discussing the above content. I told the class that the reason was that they were going to be working (as student nurses) in Urban center hospital wards. They had to become desensitized to the word. The chances of them hearing the word "fuck" when working in the wards, was 100%--and I didn't want them to drop the meds that they were carrying. Prior to my doing this I discussed it with the President of the college. She was a four-foot six nun, in her early 70s. I would not do this without her approval. She not only gave her approval, but she wanted to sit in the back of the lecture hall to see the student reactions. I had a difficult time keeping a straight face, as I could see her giggling throughout the lecture!

**Case 2:**

I had a pastoral care intern who was a stereo-typical nun who spent her career teaching at an all-girls prep school in the Hamptons. She was preparing for a second career in pastoral care. When sitting in on groups, it was obvious to the clients that she could not deal with the word "fuck". They were "betting" how many minutes it would take to get her to blush and not be able to speak. I had a supervision meeting after two weeks and suggested she consider a different practicum, as her inability to deal with the language was not going to work. She was steadfast in her desire to get the addiction ministry experience. I told her she could stay but that she had to get over this hurdle. Her assignment: Every morning and every evening (for the next 2 weeks) after brushing her teeth, she should look in the mirror—and watch and hear herself say "fuck fuck fuck" three times. The goal was to desensitize her to the word. She successfully completed the practicum.

*(Continued on page 6).*

Go ahead two years, I see her at graduation…I go to her to say hello. Her mother superior was there—and she introduced me to her—saying "this is Fr. Ed, the priest I was telling you about. My ego was pumped up till I found out that in the drive over, Mother Superior asked what the most important thing she had learned in Grad School…she said I learned how to say fuck! Mother general was not smiling when we were introduced.

Go ahead another two years…she did get a new second career job. She got hired by the City of New York to be chaplain at "The Tombs"—the hard-core city jail. It worked! She retired in that Job. Had she never learned to speak "Street English" she would have never gotten—or been successful in that role.

**Conclusion**

Cultural sensitivity is essential for all helping professions. If you are working with any subcultural group, you need to speak their language. You do, however need to be appropriate when you get back to your professional setting. You need to be careful not to "slip up" and use it in a professional—non-therapeutic, setting. I recall a Marriage and Family Therapist, who was reported to the Board, complaining about his "gross" language. The therapist and the complainant were both African-American. The complainant was a Social Work Student. The therapist was, for most of his practice, using appropriate "street language" (who grew up using that language) and was not disciplined for using the words. He did get a Letter of Warning that he should not use "profanity" when speaking to the Licensing Board, or the Courts.

Another consideration regarding language, is when forming counseling groups. Usually, it's best when group members suggest group ground rules (e.g. no cell phone use during group, arrive on time and don't leave early, no side conversations etc.) in order that group members feel some ownership and responsibility for appropriate group behavior. Often the issue of the use of profanity comes up. Some groups (especially men-only groups), usually don't have an issue with language and instead feel that it's better to "say it like it is" rather than to censor their language. However, this might not be the case in groups comprised of both men and women or perhaps in women's only groups. One of the purposes of group ground rules that that all group members should feel safe and free to express themselves.

**Epilogue**

If you are reading this article now, and still feel your stomach turn when you read (or hear) the word fuck, you need to understand two things:

1. You need to know how and why the person used it.
2. Why you got so fucking upset.

# Are We Teaching the Right Amount of the Right Thing?

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In our substance use disorder courses, how much time are we dedicating to diagnosing and treating mental health disorders, and how much are we committing to assessing and treating Post-Acute Withdrawal Syndrome (PAWS)? This article presents the position that the presence of PAWS in people-in-recovery is a near certainty while the presence of mental health disorders is far less certain, and that the time given to each should be proportionate to the likely presence of each.

It is well documented that there is significant neurological impact from the use of substances (Paulson, 2021), and that this neurological impact extends well into recovery through a syndrome called Post-Acute Withdrawal Syndrome (Semel Institute for Neuroscience and Human Behavior, n.d.). PAWS is also known as Protracted Withdrawal (Center for Substance Abuse Treatment, 2010) or Medication/Substance Induced Disorders (American Psychiatric Association, 2013). PAWS impacts multiple areas of functioning, including the executive functions of planning and decision-making; memory; empathy; impulsivity; stress management; visual/motor skills; hormonal stability; and various aspects of sleep.

*(Continued on page 7).*

PAWS and its clinical management are a central component in the treatment of people with substance use disorders and their families (Rosenfeld, 2021). The few longitudinal studies focused on people-in-recovery demonstrate that the symptoms of PAWS often mimic those of other mental health disorders (Iqbal, Levin, & Levin, 2019; Yalisove, 1997; SAMSHA, 2020), and generally dissipate over time in recovery without additional interventions (Vaillant & Hiller-Sturmhöfel, 1996; Cosgrove, 2016).

Less certain than the existence of PAWS, is the percent of people who have a substance use disorder and a mental health disorder. Research indicates with a fair amount of certainty that people with "severe and profound mental illness" have significant rates of substance abuse at or above 50% (Hunt, Siegfried, Morley, et al., 2019). However, in the converse, we do not have consistent estimates regarding the number of people with a primary substance use disorder who also have a mental health disorder. Estimates regarding the number of people with comorbid substance use and mental health disorders range from 15 - 30% (McLellan 1986), 38% (Han, Compton, Blanco, et al 2017), up to 95% of clients (Maley, 2020).

This difficulty in confirming the number of people with comorbid disorders exists for five reasons. First, the data is collected from clinics and is dependent on the judgement of the clinic's diagnosticians. The diagnoses that appear in literature or media have not been verified by a third party. Independent verification would be important not only due to the long-standing problem of low inter-rater reliability (Wakefield, 2016), but also to reduce the impact of the diagnosticians' prejudgments regarding people-in-recovery. Examples of prejudgments would be the belief that all persons in recovery have a pre-existing mental health disorder, or that all have histories of trauma.

Second, diagnoses are made by a clinic's Medical Director or by clinicians with advanced degrees. Currently, there are only 3,000 physicians trained in substance abuse disorder medicine in the United States (Scutti, 2019), and we know that a person can gain an advanced degree in a Human Service without ever having had one course in substance abuse disorders. This all points to the possibility that many of the people conducting assessments have training around common mental health diagnoses, but may not be aware of PAWS and its neurological, emotional, and behavioral implications.

Third, many diagnoses are reliant on client recollections of previous diagnoses or symptomology. Comprehensive assessments are seldom done due to the limits of clinic resources. Clients' recollections may be inaccurate, manipulative, or attempts at drug seeking (Zweben, 1986, Prescription Drug Monitoring Program, 2016).

Fourth, there is seldom time taken to allow for a period of recovery before the mental health diagnoses are made. This provides little to no time to distinguish between a mental health disorder and PAWS (Rosenfeld, 2021; Schuckit & Monteiro, 1988; Yalisove, 1997). Despite the lack of research and uncertainty regarding the incidence of co-morbid substance abuse and mental health disorders many treatment providers are diagnosing people with mental health disorders. These include, but are not limited to, Attention Deficit Hyperactivity Disorder, Depression, and Anxiety Disorders. This can result in misdiagnoses, unnecessary and stigmatizing labeling (Yalisove, 1997), and avoidable prescribing.

Finally, insurance companies have not been reimbursing substance abuse treatment at the levels mandated by either the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, or the Affordable Care Act of 2010 (Meyer, 2019). Providers perceive it to be easier to gain reimbursement and continued stays for mental health disorders, such as Depression, than for substance abuse disorders. In addition, in many stats reimbursement rates are better for those with state licenses (Isvan, 2019; Panacea Healthcare Services, 2019; Steinberg, Weber, and Woodworth, 2021). These licenses often require advanced degrees. However, as stated above, having an advanced degree does not ensure that the practitioner has had training in substance use disorders. These factors may artificially inflate the rate of diagnosis of mental health disorders versus PAWS. There is no explicit diagnosis of PAWS in the DSM-5 (Umhau, 2019), although as stated above, there are multiple Medication/Substance Induced Disorders included in the manual.

*(Continued on page 8).*

A properly controlled study would provide more insight into this issue. A longitudinal inquiry could identify two groups of clients with similar symptoms, such as distractibility, depression, mood swings, and interpersonal difficulties. Symptoms that could be either PAWS or a mental health disorder. One group would receive a diagnosis of a mental health disorder and receive the recommended treatment for that disorder. While the second group would be diagnosed with PAWS and receive standard recovery care. Each group of clients would be monitored over a period of three to five years to see how their respective interventions worked out.

We do know is that PAWS is present in people-in-recovery, and that neurological, emotional, and behavioral functioning normally improve with time in recovery. This improvement occurs without the need for additional interventions (Brown, 1985; Hagen, Erga, Hagen, et al. 2017, Svendsen, Bjornestad, Slyngstad, et al, 2020). We are less certain regarding the presence of other mental health disorders within the substance use disorder recovery population. This is not to imply that education on mental health disorders, or on the treatment of co-morbid conditions is unnecessary. Only that the amount of time spent on these topics should be proportionate to the certainty regarding the presence of the condition. So, the question is again put forward, are we giving as much classroom time to Post Acute Withdrawal Syndrome and its treatment as we are to mental health disorders and their treatment? If not, we are doing people-in-recovery and our students a disservice.

**References for this article can be found on pages 9 – 11**

# What the Addiction Counseling Profession Needs Now: Ken Langone

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Unless you live in the New York City metropolitan area, you're probably unfamiliar with New York University's Langone Medical Center and even more unlikely to know of its benefactor, Kenneth Langone. Langone made his fortune as founder and CEO of the ubiquitous Home Depot big-box hardware stores. In addition to his philanthropic donations to NYU Medical Center, in an unprecedented act of charity, Langone had walked into an assembly of NYU medical students and told them he would wipe out their entire medical school student loan debt. There were, however, strings attached. The offer of student loan debt eradication would only be made to those students who agreed to go into residency programs where there were doctor shortages. These residencies are often considered to be the "less glamorous or less profitable" and include primary care or family practice, OB-GYN and pediatrics. The offer was therefore, not made available to those accepting residencies in cosmetic surgery or anesthesiology that are more lucrative and therefore do not suffer from doctor shortages..

Having taught for many years in a mental health graduate program that offers students several counseling specialization areas and electives in equine/animal-assisted counseling, ecotherapy, family & couples counseling and child/adolescent counseling; addiction counseling has become one of the less attractive specializations. Often, many of the graduate students who do specialize in addiction counseling have a personal commitment to the addiction profession often based on friends or family members impacted by Substance Use Disorders or based on their own personal recovery.

In addition, there are those graduate students who immediately figure out that by being dual-credentialed in both mental health counseling as well as addiction counseling, they have just increased their job-finding possibilities exponentially. For example, there are many more job opportunities in the Substance Use Disorder counseling profession, given the numerous treatment programs that have sprung up since the beginning of the opioid epidemic as well as programs that focus on treating individuals with co-occurring disorders.

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However, one of the problems that addiction studies graduate students face when seeking internships and employment is that they're often competing with students with associate degrees and bachelor degrees who also specialized in addiction studies or those with counseling degrees who may have taken addiction-related, non-degree workshops/trainings. No other counseling profession seems to encounter this type of competition, therefore many Masters-level students often decide to specialize into other areas of counseling.

Interestingly, for those seeking an LPC (Licensed Professional Counselor) or licensure as a Clinical Mental Health Counselor (LCMHC), the only path to licensure is to complete coursework in a graduate –level accredited program. They do not have the option of substituting counseling workshops or non-graduate level coursework. This conundrum has both advantages and disadvantages. One advantage is the ever-increasing need for addiction counselors. The disadvantage is the competition between Associates, Bachelors and Graduate trained counselors.

Counseling individuals with Substance Use Disorders also must have a solid base of knowledge of substance use disorders that includes things such as intoxication and withdrawal complications, physical health effects as well as psychological and cognitive impact. Incompetent or poorly-trained counselors can put SUD clients in danger. Accurate assessment and diagnosis is essential, especially when formulating treatment plans with SUD clients. Our profession has been plagued from within by mental health counselors claiming to have expertise in treating SUDs in order to help boost their client numbers. Our professional is also plagued from without by "body-brokers" and for-profit programs, that deplete a client's health insurance allotment and then kick them to the curb (also known as "the Florida shuffle").

So why does the addiction treatment profession need a Ken Langone? I think that most of us would agree that that counseling individuals with SUDs is intrinsically rewarding. However, if our profession is going to attract the best and brightest, it would be helpful if there were additional incentives. As I write this article the graduate program I teach in, has recently been considering phasing out our Masters degree in Addiction Studies (and this is in the midst of the opioid epidemic which is still raging in New Jersey). Go figure.

*Are We Teaching the Right Amount of the Right Thing?

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