

PRACTICE BRIEFS



Substance Use Disorders

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ABSTRACT: Substance use and substance use disorders (SUDs) are common in counseling practice, and counselors must be well-versed in their etiology, symptomology, and treatment. Counselors must be prepared to recognize, screen, and assess for SUD and potentially co-occurring mental health disorders. When possible, counselors are prepared to treat SUDs and their impacts in ethically and culturally informed ways, or to provide appropriate referrals.

Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2023) defined drug addiction as such:

Drug addiction is a chronic disease where people compulsively seek and use drugs despite harmful consequences. Repeated drug use changes the brain, making it hard to resist intense cravings. These changes can persist, which is why addiction is considered a “relapsing” disease—people may return to drug use even after long periods of sobriety. Relapse is common but doesn’t mean treatment failed. Like other chronic illnesses, addiction treatment must be ongoing and adapted to fit the person’s needs.

Biology, environment, and psychological functioning are the primary factors influencing addiction risk. Although genetics play a role in biological factors related to addiction and substance use disorder (SUD) there are wide-ranging variations based on substance. For instance, genetics can account for 40–60% of risk for alcohol use disorder (American Psychiatric Association [APA], 2022), and genetics can account for 40–70% of risk for nicotine addiction (Clark, 2021). Based on current research, addiction can best be understood as a neurobiological condition given the evidence related to brain responses that can vary based on substance, gender, and ethnicity (Hatoum et al., 2023; Heilig et al., 2021; SAMHSA, 2023).

Environmental risk factors can include family influences, peer relationships, trauma exposure, and economic conditions (van Wormer & Davis, 2024). Environmental drug/alcohol use, peer pressure, and early drug exposure within one’s environment can increase addiction risk. Within the scope of environment, adverse childhood experiences (ACEs) can have detrimental effects. Over the last 20 years, researchers have found a higher occurrence of ACEs in adults with SUD than within the general population, as well as positive correlations between ACEs and SUD development and severity (Leza et al., 2021).

Psychological functioning, especially co-occurring mental health disorders, can increase risk for SUD though the inverse is also true: Developing a SUD can increase risk for additional mental health disorders (Lai et al., 2015; Volkow & Blanco, 2023; SAMHSA, 2020). Concomitantly, it is evident that there is a correlation between SUDs and other mental health disorders such as depression, anxiety, attention deficit/hyperactivity disorder (ADHD), personality disorders and schizophrenia (Iqbal et al., 2019; Jones & McCance-Katz, 2019; National Institute on Drug Abuse [NIDA], 2020; Tesselaar et al., 2025).

Additional SUD Risk Considerations

Development factors must be considered within the context of substance use that can lead to disorder. One's current life stage, such as adolescence or older adulthood, can increase SUD risk in different ways. For example, teenaged brains are not fully developed and impact self-control and decision-making, placing them at greater risk for substance use and subsequent addiction (SAMHSA, 2023). Alternatively, older adults have different risk factors such as chronic pain, physical disabilities, overuse of prescribed and over-the-counter medications, as well as isolation, bereavement, and avoidant coping skills (Jaqua et al., 2022).

Notably, *risk* for addiction does not necessarily equate to an individual developing a SUD. Risk simply denotes the potential that SUD may be more likely to develop given certain conditions. Whether an individual's substance use will become a SUD has many variants that include the risk factors we discussed above, as well as the substance type and availability, whether the substance is legal, and the level of social acceptability (Volkow & Blanco, 2023). Furthermore, whether the individual receives intervention can make a difference. For instance, early intervention with children and adolescents with high ACEs scores can reduce the risk of developing a SUD (Leza et al., 2021). Similarly, identifying individuals who are *pre-addiction* (i.e., those who are in early development of a SUD) and engaging them in interventions can slow or eliminate SUD development (Volkow & Blanco, 2023).

Substance Prevalence

Alcohol and marijuana are the most used substances in the United States. The most recent SAMHSA (2025) survey indicated four key findings: (a) 134.3 million people aged 12 years or older used alcohol in the past month; (b) 57.9 million people aged 12 years or older were past-month binge alcohol drinkers; (c) among the past-month binge drinkers, 14.5 million people were identified as heavy alcohol users (eight or more alcohol drinks a week for women, or 15 or more alcohol drinks a week for men); and (d) 4 million underage persons 12 to 20 used marijuana in the past month. Notably, overall alcohol use percentages did not change between 2021 and 2024, and past-month alcohol use for individuals aged 18–25 decreased 3.4% during the same time period. For individuals 12 and older, binge drinking has decreased 1.6% from 2021 to 2024 (SAMHSA, 2024).

Although alcohol use has remained stable or decreased, marijuana use has increased in the overall population from 37 million past-month users in 2021 to 44.3 million past-month users in 2024. The most notable increase (2.8%) was for adults 26 years of age and older who represent 34.3 million of the 44.3 million individuals who use marijuana. There was no change in use rates for individuals aged 12 to 25 (SAMHSA, 2024).

Opioid use involving heroin and prescription opioids outside of medically necessary treatment affected 7.8 million people, representing 2.7% of the population ages 12 and older. Importantly, these statistics do not include individuals who used illegally made fentanyl. Estimates of illegally made fentanyl use are approximately that of legal fentanyl used for purposes other than medically directed pain relief, which is approximately .01% of the prescription opioid subtypes (SAMHSA, 2025). Prescription opiate use outside of medically necessary treatment represents most use (7.6 million) rather than heroin.

Optimistically, between 2021 and 2024 overall opioid use for purposes other than medically directed treatment declined by about a half of a percent for individuals aged 12 and older. However, although opioid use rates are on the decline, opioid use outside of medically directed care continues to be public health concern due to high overdose rates (SAMHSA, 2025). In 2023, opioids were a major contributor to overdose deaths. Specifically, 76% of overdose deaths involved an opioid, with 69% including a synthetic opioid (U.S. Centers for Disease Control and Prevention [CDC], 2026). These percentages are more than 100% because they account for polysubstance use in overdose deaths. Additionally, individuals who have had a non-fatal opioid related overdose have a higher risk for a fatal overdose in the future due to continued use (Olfson et al., 2018).

Cocaine use within the past month period among surveyed people aged 12 or older was 4.3 million people (SAMHSA, 2025). Among surveyed people aged 12 or older in 2024, (a) 556,000 reported previous heroin use in the past year, (b) 2.4 million reported methamphetamine use in the past year, and (c) 10.4 million reported hallucinogen use in the past year. Of those ages 12 or older, 48.4 million people qualified in the past year for SUD.

Across substances and based on recent overdose death demographic reports, people who are most at risk for overdose death are adults aged 35–44, men, and individuals who are American Indian or Alaska Native people (CDC, 2026). Most overdose deaths are not attributed to a single substance, but rather polysubstance ingestion whether knowingly or unknowingly. In 2023, 76% of overdose deaths included opioids, 69% synthetic opioids, 33% psychostimulants (e.g., methamphetamine), and 28% cocaine (CDC, 2026).

Diagnostic Criteria

Substance-related and addictive disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev., *DSM-5-TR*; APA, 2022) offers two diagnostic categories: substance use disorders and substance-induced disorders. Within these categories are 10 drug classes: alcohol; caffeine; cannabis; hallucinogens (including phencyclidine); inhalants; opioids; sedatives, hypnotics or anxiolytics; stimulants; tobacco; and other or unknown substances. Across drug classes there are three commonalities:

1. “...the ability to directly activate the brain reward systems, which are involved in the reinforcement of behaviors and establishment of memories” (p. 543).
2. The reward system is overactivated—normal activities are often neglected.
3. The drug induces feelings of pleasure (APA, 2022).

Substance Use Disorders

SUD diagnoses include clusters of cognitive, behavioral, and physiological symptoms that result in ongoing and clinically significant distress. Diagnosis of a SUD does not simply rely on the presence of substance use: “the diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance” (APA, 2022, p. 544). Diagnosis is substance-specific, meaning that the substance class replaces the term *substance* in diagnostic application (e.g., alcohol use disorder or cannabis use disorder), rather than “substance use disorder” as a general diagnostic category.

To meet diagnostic criteria for SUD, individuals must meet a minimum of two indicators across four domains for all substances except caffeine: impaired control, social impairment, risky use, and pharmacological criteria, (APA, 2022). When needed, clinicians include appropriate specifiers regarding *severity* (e.g., 2–3 symptoms, mild; 4–5 symptoms, moderate; 6 or more symptoms, severe) and *course and descriptive features* (e.g., in early remission, 3–12 months; in sustained remission, 12 months or longer; on maintenance therapy, applies to opioids, tobacco; in a controlled environment, access to drugs/alcohol is restricted). Although recording procedures differ slightly between the *DSM-5-TR* and the ICD-10-CM, the diagnostic process remains the same, requiring identification of the appropriate code and applicable specifiers within each manual.

Substance-Induced Disorders

Substance-induced disorder (SID) diagnoses capture intoxication, withdrawal, and substance/medication-induced mental disorder diagnoses. Like SUD diagnosis, SID diagnosis is substance class specific and notes whether the diagnosis is related to intoxication, withdrawal, or substance/medication-induced mental disorder (e.g., alcohol intoxication disorder, cannabis withdrawal disorder). SID should only be used when a SUD does not accurately capture symptoms.

Importantly, substance/medication induced mental disorders (SMID) are not necessarily SUDs primarily because of differing etiology (Revadigar & Gupta, 2022; SAMHSA, 2020). SMIDs represent the physiological effects of substance use that result in mental health symptoms like depression, hallucinations, and anxiety. Although SUDs can include negative mental health symptoms, they are more encompassing because the diagnostic criteria include a cluster of cognitive, behavioral, *and* physiological symptoms as the result of ongoing substance use. Finally, counselors must consider whether the mental health symptoms a client is experiencing were present and/or troublesome prior to substance use. If the client's mental health symptoms are enduring, it is likely that the primary diagnosis is outside of the addictive disorders; however, SUD or SID could be a secondary diagnosis.

To receive an SID diagnosis of *substance intoxication*, the individual must meet the following criteria:

- **Criterion A:** Recent ingestion of a substance;
- **Criterion B:** Clinically significant problematic behavioral or psychological changes due to the substance's impact on the central nervous system that developed during, or shortly after, substance ingestion;
- **Criterion C:** Criterion B is accompanied by substance-specific signs and symptoms (Note: There are specific signs/symptoms listed for each drug class in the DSM-5-TR); and
- **Criterion D:** Symptoms are not attributed to or better explained by a medical condition or other mental health disorder.

Individuals diagnosed with substance intoxication may or may not be diagnosed with SUD. Tobacco is the one drug class for which intoxication may not be diagnosed (APA, 2022).

Substance withdrawal disorder may be diagnosed for all the drug classes except inhalants. Typically, withdrawal disorders are associated with SUD, though a SUD diagnosis is not necessary to diagnose substance withdrawal disorder. Individuals must meet the following criteria:

- **Criterion A:** Problematic behavioral change with physiological and cognitive concomitants due to the cessation or reduction of heavy, prolonged substance use;
- **Criterion B:** Substance specific signs and symptoms specific to substance;
- **Criterion C:** Signs and symptoms in Criterion B causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and
- **Criterion D:** Signs/symptoms are not attributable to another medical condition or better explained by another diagnosis (APA, 2022).

SMIDs (e.g., alcohol-induced alcohol disorder, cannabis-induced anxiety disorder) are a distinct diagnosis that is used when one of the 10 substance classes is the defined cause of the mental health disorder the individual is exhibiting. In other words, a physical exam, laboratory evidence, or history denote that the symptoms are due to the drug rather than another etiology. If the mental health symptoms are the result of another etiology, it should be diagnosed separately using the criteria for the primary diagnosis (e.g., depression, anxiety). Individuals must meet Criterion A through E in the *DSM-5-TR* to receive this diagnosis (APA, 2022).

Assessment Strategies

Identifying potential problematic substance use and SUD often begins with routine screening in counseling and health-care settings. Screeners are succinct, easy-to-deliver questions that help clinicians determine whether additional assessment is warranted. Two typical screeners are CAGE (Ewing, 1984) and TWEAK (Russell, 1994). CAGE stands for *Cutting down, Annoyance by criticism, Guilty feeling, and Eye-openers*, and is used to screen for potentially problematic alcohol use. TWEAK stands for *Tolerance, Worried, Eye-opener, Amnesia, Kut down*, and can be used to screen for either alcohol or drug use.

An approach to screening that utilizes a brief intervention is SBIRT: Screening, Brief Intervention and Referral to Treatment (DeSalle & Agley, 2015). SBIRT is used primarily in health and medical settings that

are not equipped for in-depth SUD treatment. As part of referral in any setting, clinicians are encouraged to consult the fourth edition of the American Society of Addiction Medicine (ASAM) Criteria (2023).

In the Resources section of this brief, we provide a list of common assessments used in clinical practice for alcohol, drugs, readiness for change, and follow-up assessment during treatment. With all assessments, clinicians must familiarize themselves with administration and scoring procedures, use the assessment with clients for whom the assessment was normed, and read studies and reports regarding the assessment's efficacy and usefulness.

Treatment Approaches

There are many effective treatment and intervention strategies for SUD; the citations we list in the Resources section is a small representation. This list can be used for direct treatment or for referral to appropriate services depending on the client's needs. Counselors are encouraged to consult the ASAM Criteria (2023) for determining appropriate level of care.

Prior to and throughout treatment, clinicians are encouraged to assess the client's readiness for change. The transtheoretical model (DiClemente et al., 2004) continues to be the forerunner for understanding client's motivation and readiness for change and treatment. The transtheoretical model is comprised of precontemplation, contemplation, preparation, action, and maintenance, and relapse is considered to be a normal part of the process.

Treatment approaches including cognitive behavioral therapy, motivational interviewing, peer support models, harm reduction, and couples and family therapy have all been successful. However, choosing the most appropriate approach is client-dependent and requires careful consideration. Cultural context can shape treatment engagement and outcomes, with differences across racial, ethnic, and gender groups; culturally responsive approaches may strengthen access, retention, and treatment effectiveness (SAMSHA, 2025; Volkow & Blanco, 2023).

Cultural and Ethical Considerations

SUDs do not develop or resolve outside the cultural and social environments in which people live (Volkow & Blanco, 2023). Sociocultural norms shape perceptions of substance use, stigma, and help-seeking behaviors, whereas structural inequities can affect exposure to substances and access to treatment. National data continue to document disparities in treatment access and engagement across racial and ethnic groups, with recent research further indicating differences in treatment utilization and completion by race, gender, and insurance status (SAMHSA, 2025; Wright, 2025).

SUDs frequently co-occur with other mental health disorders, and the relationship is bidirectional, further complicating assessment, treatment planning, and continuity of care (Volkow & Blanco, 2023). Despite this clinical complexity, access to integrated care remains uneven, as facilities located in communities with high proportions of Black and Hispanic residents are less likely to offer integrated mental health services despite elevated co-occurring need (Pro et al., 2025). Substance use stigma may compound existing racial stigma, contributing to barriers in disclosure engagement, and continuity of care (Ghonasgi et al., 2024).

Ethical SUD care requires culturally responsive and trauma-informed approaches that acknowledge structural inequities and avoids reinforcing bias. Building trust, clearly explaining confidentiality, practicing cultural humility to support engagement and the therapeutic alliance, and continual client-counselor collaboration are key features. Ethical responsibility extends to equitable data collection practices and advocacy aimed at reducing disparities in service availability and long-term outcomes (SAMHSA, 2025). Ethical practice within clients who have SUDs cannot only occur at the client-counselor level; it must also address structural level inequities that fuel substance use and stymie equitable access to treatment.

Conclusion

Substance use, SUDs, and their effects are ubiquitous in counseling practice in all treatment modalities and specializations, so counselors must be well-versed in their etiology, symptomology, and treatment. Counselors must be prepared to recognize, screen, and assess for SUD and potentially co-occurring mental health disorders. When possible, counselors are prepared to treat client SUD and their impacts in ethically and culturally informed ways, or to provide appropriate referrals.

Resources

Assessments

- [The Adult Substance Abuse Subtle Screening Inventory-4 \(SASSI-4\) User Guide & Manual](#)
- [The Stages of Change Readiness and Treatment Eagerness Scale \(SOCRATES\)](#)
- [Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide](#)
- [Screen and Assess: Use Quick, Effective Methods](#)
- [Instructions for Interviewers Administering the Timeline Followback \(TLFB\) Calendar to Drinkers](#)
- [The Alcohol Use Disorders Identification Test \(AUDIT-C\)](#)

Cognitive Behavior Therapy for SUD

- [An evaluation of cognitive behavioral therapy for substance use disorder: A systematic review and application of the Society of Clinical Psychology criteria for empirically supported treatments](#)
- [Digital cognitive-behavioral therapy for substance use: Systematic review and meta-analysis of randomized controlled trials](#)

Motivational Interviewing

- [Recent trends in motivational interviewing and motivational enhancement therapy for alcohol use disorder: A systematic review of studies from 2014–2024](#)
- [Motivational interviewing for substance use reduction](#)

Peer Support Models

- [Women for Sobriety: 35 years of challenges, changes, and continuity](#)
- [An investigation of SMART Recovery: Protocol for a longitudinal cohort study of individuals making a new recovery attempt from alcohol use disorder](#)
- [Empowering your sober self: The LifeRing approach to addiction recovery](#)
- [Al-Anon intensive referral to facilitate concerned others' participation in Al-Anon Family Groups: A randomized controlled trial](#)
- [The beneficial role of involvement in Alcoholics Anonymous for existential and subjective well-being of alcohol-dependent individuals? The model verification](#)

Harm Reduction

- [Systematic review of SMART Recovery: Outcomes, process variables, and implications for research](#)
- [Harm reduction therapy: A practice-friendly review of research](#)

Couples and Family Therapy

- [Family intervention models for young adults with substance abuse: A systematic review](#)
- [Effects of family therapy for substance abuse: A systematic review of recent research](#)
- [Facilitating implementation of a substance use intervention for youth: Outcomes from a randomized trial of the SIC-coaching implementation strategy](#)
- [Multidimensional family therapy for justice-involved young adults with substance use disorders](#)

Cultural Considerations

- [Improving cultural competence: A treatment improvement protocol \(Tip 59\)](#)

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