SUBSTANCE ABUSE

Substance abuse refers to the use of any psychoactive substance, including alcohol and other drugs, to the extent that it interferes with physical, psychological or social well-being. For instance, a person is considered to be “abusing,” as opposed to “using” substances when use continues despite the loss of a job, legal troubles or difficulties with relationships. Treatment refers to medical or psychological intervention that combats a person's physical or psychological dependence as well as the addictive disease process. Recovery is a process of abstaining from substance use and gaining or regaining emotional and physical health and spiritual balance. Treatment and recovery programs are often used in combination.

RESEARCH UPDATE

Substance use and abuse is widespread. Based on national averages, it is estimated that most Californians use substances, and one of every 30 abuses substances.

Substance use can directly and indirectly increase the threat of HIV infection. There is a direct risk between HIV and injection drug use because HIV can be transmitted through sharing injection drug needles. Substance use can indirectly lead to HIV infection because a person under the influence of substances may be more likely to share needles without taking precautions such as cleaning them. In addition, regardless of whether a person uses injection drugs, substance use can impair judgment, making someone more likely to engage in unprotected sex.

For someone infected with HIV, substance use may be a way, consciously or unconsciously, to avoid facing and managing one’s infection. Further, the harmful effects of substances on the body can be detrimental to a person’s health.

This Update discusses current approaches to substance abuse assessment and intervention.

Assessment

Assessing a substance abuse problem involves analyzing substance use patterns and reasons for taking substances. Assessment considerations include whether substances are used to cope with or escape from stressful events and whether a person loses control over his or her decision-making or behavior when using substances.

Clients often do not know the answers to such questions. Therefore, health care providers perform risk assessments in which many areas of a person’s life are discussed to learn patterns of use.

There are no minimum quantity requirements to determine if a person is abusive in his or her substance use because many abuse substances only sporadically. Therefore, assessment measures based solely on quantities can fail to detect abuse.

Substance abuse is characterized by impaired control over the use of the substance, distortions in thinking — most notably denial — preoccupation with substances, and use of substances despite adverse consequences. These characteristics can be ongoing or periodic.

Substance abuse may result in a range of effects, from euphoria to death. Death may occur through overdose, suicide or health complications. Many who abuse substances find their professional and personal lives in ruins — some may be unable to keep or find shelter — while others may have order and control in many parts of their lives. The disease related to substance abuse is progressive: it persists over time, and its physical and emotional effects are often cumulative. If a person is willing to stop abusing substances, intervention at halting use can be effective regardless of the stage of a person’s substance abuse.

Addiction and Withdrawal

Depending on the substance used, abuse can be a physiological addiction — or physical disease — in which the body is dependent on receiving a substance. Or, the addiction can be psychological, based on an emotional need for a substance. These forms of ad-
Based on a survey of 416 men:

31% used alcohol at levels suggesting chemical dependency.

33% of HIV-infected men had unsafe sex in the past year while drunk or high.

28% reported they were “recovering” from alcohol or other drug use.

Substance Abuse Among Gay and Bisexual Men

In those whose addiction is primarily physiological, removing substances from the body can lead to an acute physical reaction, known as detoxification. During this period, the body is removing the poisonous effects of substances from its system. For a person with a psychological addiction, the period of withdrawal can be marked by severe anxiety or depression. Emotional needs, which were met or hidden by substance use, are not being met. Symptoms, including “craving” for a substance, may be no less intense for a psychological addiction than for a physiological one. Intensity of withdrawal varies among individuals; it can be life-threatening and may require treatment with prescription medicine. However, not all substance abusers experience acute symptoms.

People can remain in detoxification or “detox” units of hospitals or treatment centers for several days. This period, which can bring on a heightened awareness and fear of the dangers of substance abuse, is enough to cause some people to stop using or abusing substances. Most people, however, choose ongoing regimens such as inpatient or outpatient treatment programs and 12-step programs or other types of formal social support.

Treatment can be based on a medical model of care and include the use of drug therapies, such as methadone, or it can be based on a social model, which may consist of counseling, education and peer support meetings. Hospital-based programs often rely on a medical model, while care in recovery and residential treatment homes and most outpatient treatment is usually based on a social model. The following is a summary of these options.

Inpatient or Residential Programs

Costs for inpatient treatment can range as high as several hundred dollars a day for hospitalization, to little or nothing for some shelter facilities. Some programs receive government subsidies and accept limited-income patients at lower rates. Inpatient program stays often range from 14 to 28 days in “private pay” institutions to between several days and up to two years in some publicly funded programs. Inpatient and residential programs may allow clients little or no communication with anyone outside the facility.

Substance Abuse Hospitals and Chemical Treatment Centers. Several chains of abuse treatment hospitals provide residential treatment. These programs are often the most expensive option; length of stay often depends on what a person’s insurance allows. In addition to the use of prescription medication, where appropriate, programs may include oversight by physicians, several sessions of group therapy and mandatory attendance at 12-step meetings.

Addiction Units in General or Psychiatric Hospitals. These programs, which vary in the breadth of their services, have grown to respond to the need for immediate care in the communities served by these hospitals. Some offer services similar to specialized treatment hospitals. About half the nation’s Veterans Administration (VA) hospitals have inpatient programs.

Halfway Houses. Halfway houses provide a transition from institutions, such as inpatient treatment programs, prisons and mental health facilities, to living in a home setting with the responsibilities of job seeking, working and getting along with others. A person may live in a halfway house after detoxification and may stay indefinitely or for a time-limited period. Facilities offer an informal, supportive refuge that, like most other residential programs, remove people from drug-using environments and allow them to focus on personal living skills while building self-esteem.

Recovery or Residential Treatment Homes. Recovery homes are residential programs where a person may participate in formal counseling as well as peer support groups and other self-help interventions, while living in a residential program setting. Applicants
may be required to commit to stay at the home for a designated period, perhaps 30 days.

Shelters. Shelters generally offer food and housing, but do not require ongoing abstinence.

Day Treatment. Some programs admit substance abusers for eight hours a day, five days a week to provide treatment similar to that offered through inpatient programs.

Outpatient Programs

Before beginning outpatient treatment, clients generally meet with counselors to discuss what they desire from the program and to set specific goals. Most programs require patients to commit to refrain from substance use. Many are staffed by people with personal experiences of previous substance abuse, and follow the concept developed by Alcoholics Anonymous (AA) that a person with a substance abusing history is the best person to help another.

Fees for outpatient programs vary. Many operate on a sliding scale, and some people may qualify for free programs. Many programs, both inpatient and outpatient, have waiting lists for services. Publicly funded programs often give priority to people who are indigent and, in some cases, priority is given to people based on their identified drug of choice. Private programs often accept only those with sufficient financial resources or private insurance. Some public programs and non-profit private programs give highest priority to those with HIV infection. Others, however, may discriminate against HIV-infected people.

Individual Professional Counseling. Psychiatrists, licensed therapists, social workers and clergy counsel clients with difficulties related to maintaining abstinence, while building coping skills. Counseling can include examining "bigger picture" issues to learn more about a person's reasons for abusing substances, though psychotherapy focused on deeper issues is often not recommended for people in early stages of abstinence.

Professionally Facilitated Groups. In groups, which may be short-term or ongoing, members gain support from others with similar problems and learn and strengthen interpersonal skills. Groups may meet once a week or several times weekly.

Family counseling. Several or all members of an extended family, including partners and close friends, as well as the substance abuser, participate in group counseling. This approach acknowledges the family's role in the addiction process, in how abuse may have been supported in the past, and in how to change such behaviors.

Recovery

Recovery, which is an ongoing process of living without alcohol or other drug use while de-

A Related Issue: Substance Use — Harm Reduction

For someone abusing substances, the thought of abstaining from a behavior over a lifetime can be overwhelming; such a prospect is a reason most treatment and recovery programs are based on the concept of facing abstinence on a daily basis.

However, some people may not grasp this approach or may simply reject it. For many, a "cold turkey" approach to quitting may be an obstacle to stopping use. Clients who have unsuccessfully tried to abstain may be willing to attempt to reduce their substance abuse. This may be particularly valuable in helping people reduce their risk for HIV infection or disease progression. However, these methods are not recommended unless supervised.

The following are approaches to altering substance use behaviors: 7

Experimental Abstinence. This approach urges a person to try abstaining for a specific period, perhaps three months, on an experimental basis. This gives the client the chance to learn what it feels like to be "clean and sober." It reduces tolerance and breaks current patterns and habits of use. And, it helps the client determine how dependent he or she has become, while showing others the client has an interest in changing and is taking steps to do that.

Tapering Use. The aim of tapering is to gradually reduce substance use. This approach, which has been successfully used by some cigarette smokers, can help a person set progressively lower daily and weekly limits for substance use, while working toward complete abstinence.

Trial moderation. With this approach, a person sets an amount of substance use that is tolerable and vows to maintain this limit. Failure to meet this means the trial is not successful. Health care providers overseeing this client's trial will suggest that if a client tries this approach and it is not successful, then the client will return for follow-up care and be willing to consider abstinence.
The Twelve Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

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er, in many parts of the country, including California, there are groups specifically for women, Spanish and Asian language speakers, young people, atheists and agnostics, and gay men and lesbians. Because AA meetings are the most numerous, some people deal with cocaine or narcotics addictions through AA involvement. Twelve-step groups for families and friends help people better deal with their own behaviors — perhaps including their own “addiction” to a substance abuser — while seeing that they are not alone. Many people help, or enable, another person’s addictive behavior without knowing it. They may also seek to control behavior of a substance abuser and show more concern for the life of the substance abuser than for their own.

Acceptance and Biases

Client willingness and readiness to stop using substances is a key to the success of any program. Surveys and clinical experience have shown that clients must be ready to stop using substances. Some people abstain from substance use, and then return to abusing substances. Others are able to stop and never return to using.

Care providers may have biases regarding what they consider the most effective approaches. For instance, some consider methadone and other drug therapies to be harmful alternatives that replace one drug addiction with another. Others may be frightened by the rigidity of 12-step programs. These biases may result from work or personal experiences. Biases also result from misinformation or misinterpretation.

References

IMPLICATIONS FOR COUNSELING

In addition to the direct HIV-related threat from sharing unclean syringes when injecting drugs, substance use may lead people to engage in other risk behaviors for HIV infection. Therefore, a discussion of clients’ substance use behavior is essential to HIV risk reduction and to a test counseling session.

Substance use impairs judgment, leading a person to make decisions and take actions he or she might not otherwise choose. A client may accept education regarding risk-reduction behavior, and may commit to avoid unsafe behaviors, but when actively using substances, this client will engage in unsafe behaviors.

Unfortunately, health providers often fail to discuss substance abuse with clients. While thorough intervention and substance use assessment is best performed by specialists, the HIV test counselor can offer significant help. Clients may be relieved that a counselor is taking interest in them. Some have attempted unsuccessfully to control their substance use and may feel they are alone with their problem.

Clients may be reluctant to broach the topic of substance use. They often believe they will be unfavorably judged or criticized for using substances. Explain to clients that the counselor’s role is to assist and not to be critical.

Clients may be unwilling to acknowledge a substance abuse problem or the extent of their use, or they may be unaware of a problem. They may feel pleasure from substance use without suffering from it. Until they are willing to halt their substance use, there is little or no reason to expect that they will. Some people need to fail repeatedly in their own attempts to halt substance use before they are willing to accept help.

By talking about substance use in the context of a person’s overall health — covering topics such as smoking, nutrition, caffeine consumption and sleeping habits — a client may gain awareness about the dangers of substance abuse. Do not assume a person abusing substances is aware of his or her substance abuse or its health dangers.

Once a person is comfortable talking about histories of various behaviors, ask about the client’s substance use history, including the quantity and frequency of use. Answers to these questions can be useful, but they are not essential. More relevant for HIV test counselors are the reasons a client is using substances. The client may not know these reasons, but learning more about coping mechanisms during stressful events and the nature of family or home surroundings can provide valuable information. For instance, a client may find it difficult to avoid substance use because he or she is surrounded by it when with peers or family.

Denial

Substance abuse is characterized by denial. Denial may keep someone from acknowledging risks for HIV infection, and it may keep a person who is infected from seeking medical care or otherwise acknowledging infection.

As part of the disease process
of addiction, someone abusing substances relies on denial to maintain maladaptive behavior. Denial about substance abuse can lead a person to be defensive when questions about the denial are raised. It is likely that defending the denial will be an unconscious goal of the client who has not reached a “bottom,” or a point at which substance abuse feels intolerable.

Many people have internal conflicts about their substance abuse, and may live in constant turmoil with themselves or others instead of stopping use. They may be willing to ignore health, financial and other needs, rather than face their addiction. Such people have placed the importance of substance use above other considerations. They may acknowledge having a great deal of trouble in their lives, but do not view substance abuse as a possible cause of the trouble. Substance use is viewed as a solution, or as a tool to avoid pain or confrontation. Do not underestimate the powerful nature of denial as it relates to addictive behaviors, even in the face of serious health or other consequences. However, do not assume that a person, even someone whose addictive process has significantly progressed, will not or cannot gain sobriety.

When clients voice denial, do not immediately confront them about it. Instead, learn about the concerns they have. For instance, ask about reasons for seeking a test and concerns about being infected with HIV. A client may voice concern about engaging in unsafe behavior but not see a relationship between this and his or her substance use. Discuss risk behaviors and then ask if it is possible that substance use may have increased the risk of being unsafe. By relating HIV risk to specific instances of use, counselors can help clients see substance abuse as a problem and not as a solution.

Counselors often reach an impasse with clients who present denial. When this occurs, perhaps because clients have told counselors they no longer want to talk about their substance abuse, counselors should halt attempts at direct intervention and return to a basic discussion about risk reduction. Counselors will meet with little apparent success in dealing with many clients. Nonetheless, seemingly unsuccessful counseling efforts may benefit clients. A counselor may produce some small change in a client’s perception of his or her substance abuse, even though this change may not be immediately noticeable.

Be aware that many people who enter treatment or recovery programs relapse into substance abuse. Substance abuse specialists do not view this as failure. Many people in recovery state that they entered programs several times before achieving long-term abstinence. Even more common, before seeking treatment or recovery, people try to abstain on their own from substance use, achieve short-term success, and then fail.

While the words “addict” and “alcoholic” are used to describe people who abuse substances, these labels can imply judgment or create an image of someone stigmatized by society. Follow the client’s lead in choosing language to describe substance abuse.

Reducing Use

Some clients may express unwillingness to halt substance use, but they may be willing to reduce it. Accept this proposal as a sign that a client recognizes the problem and wants to do something about it, state the value of being supervised in this effort, and offer referrals.

Clients in Recovery

Be aware of special concerns of clients in recovery or treatment, particularly those who are new to such programs. For these clients, learning about HIV status may be especially challenging. They may return to substance use while awaiting test results, or after learning results. Ask about their social support and suggest coping strategies for the stress that may arise while awaiting a result. For clients in 12-step recovery, ask if they have someone in the program with whom to discuss this.

Referrals

Learn the names of people who specialize in issues related to sub-
Case Study

Joe is a 21-year-old gay man who is seeking his first HIV test. He acknowledges he has had unsafe sex on several recent occasions, though he says he can’t explain his reasons for doing so. When asked about overall health practices and use of substances, he acknowledges that he consumes several drinks three or four nights a week. He says he has “probably” been intoxicated most of the times he has had sex, though he often does not remember later how much alcohol he has consumed or what he has done under its influence. Joe says, however, that he doesn’t see alcohol as a problem. “It’s pleasurable. And I don’t have a problem with it.”

Counseling Intervention

At the pre-test counseling session, begin by supporting Joe in describing his alcohol use and sexual behavior, and for seeking a test. Seek to learn his motivations for being tested. Proceed with an assessment of Joe’s substance use behavior. Ask him more about the occasions during which he drinks and the circumstances that precede or follow his drinking. Describe the effects of alcohol on reducing a person’s inhibitions to engage in unsafe sex, and state that many people engage in unsafe sex only when they are under the influence of alcohol. Ask if he understands this and if he has seen this happen with himself or others.

If Joe has seen that substance use makes him more susceptible to unsafe sex, yet he has been unable to avoid unsafe sex or engage in sex without first using alcohol, it may signal a possible dependence or addiction to alcohol. The inability to retain memory of significant events even a short time afterwards may be a sign of addiction.

While these signs may be clear to the counselor, Joe’s denial may keep him from seeing the compulsive nature or potential harm of his substance use. It may be useful to describe the possible relationship between substance use and his risk of becoming infected, and to describe the value of changing substance using and sexual behaviors. This may be an effective way to indirectly confront denial. If Joe responds to this, the counselor may then make a reflective comment such as, “It sounds like you have all the information and that you will need some additional support to work through it.”

Begin to help Joe consider any contradictions between his use of substances and the reasons he is seeking a test. His motivation for testing may conflict with his use of substances.

Provide Joe with names of two or three providers who are aware of issues related to alcohol use, and who understand the role of alcohol in HIV risk behaviors. Referrals should be able to provide specialized counseling, further assessment and referral. In addition, provide him with a meeting list for Alcoholics Anonymous (AA) and a local AA telephone number. State that he need not identify as an alcoholic to attend an open meeting. Acknowledge that making a phone call or going to a meeting can be a difficult step, but that he has already taken a step by seeking an HIV test.

A counselor can determine whether an approach is appropriate by asking him or herself, “Will my intervention communicate an understanding of Joe’s concerns and my compassion for Joe? Will it build his trust in me and my recommendations so that he will take follow-up steps?”

Joe may resist the intervention. If the counselor believes further discussion about substance use will be detrimental, move to another relevant topic, such as the need to use condoms during sex, while still providing referrals at some point. Client resistance and the need to shift focus is not a sign of failure of either the counselor or Joe.

Counselors are encouraged to attend AA, NA or Al-Anon meetings that are “open” to non-members.

stance abuse and who also understand the relationship between substance abuse and HIV infection. These specialists can offer support, perform assessments and discuss in greater depth approaches of treatment and recovery.

Provide schedules for 12-step meetings. To obtain these, contact AA, NA, CA, Al-Anon and other groups, which are listed in the telephone directory. Self-help groups also can be located through the National Institute on Drug Abuse (NIDA) Hotline: (800) 662-4357. Learn if a client is familiar with the 12-step approach, and what he or she thinks about 12-step programs. Stress the value of remaining open to such programs.

Remember that some people have stopped abusing substances without direct assistance. Others have been able to recover and abstain through various methods, including church-based programs or through involvement with religious, social or political groups. Respect these methods, and offer appropriate referrals.
TEST YOURSELF

1. True or False: In assessing a client's substance use, a counselor need only consider the amount a client uses; patterns of use and reasons for use are irrelevant.

2. True or False: Substance abuse recovery, such as 12-step recovery, is prohibitively expensive.

3. True or False: More people are believed to have maintained long-term abstinence from substance use through 12-step programs than from all other programs combined.

4. True or False: In some cases, withdrawal from a substance can pose serious health risks and may require pharmaceutical treatment.

5. True or False: Length of stays at inpatient programs can vary from a few days to far longer periods.

6. People have resisted 12-step recovery for what reason? a) they are frightened by it, b) they believe it is religious, c) they deny having a problem, d) all are possible reasons.

7. True or False: Treatment and recovery are generally unsuccessful in helping a person halt substance abuse when that person is not ready or willing to stop use.

8. True or False: People seeking treatment and recovery should not have any role in deciding which approach to follow; decisions should be left entirely to professionals.

DISCUSSION QUESTIONS

- Many people who abuse substances are in denial about the danger of their substance use. How can counselors recognize this denial and work appropriately to help clients break through it?

- How can a counselor respond to a client who denies that his or her substance abuse is harmful yet engages in unsafe sex or needle use?

- How can a counselor help a client feel comfortable discussing use of alcohol or other drugs, topics not often discussed by health care providers?

- Harmful power struggles can develop between a counselor and a client when substance use issues are discussed. How can a counselor recognize the possibility of such struggles before they begin and respond to them?

- What counseling can be offered to someone who is a friend or family member of someone who is abusing substances?

- Someone who has recently entered treatment or recovery programs may have special needs. How can a test counselor be aware of this client's needs and respond to them?

Answers to "Test Yourself"

1. False. Information about patterns of substance use and reasons for use are at least as relevant in assessing substance use as are answers to questions about the amount of a client's substance use.

2. False. Many recovery programs, including 12-step programs, charge no fees.

3. True.

4. True. Withdrawal from substances can pose serious health risks.

5. True. Length of time for inpatient stays can vary significantly.

6. D. All of the above are reasons for resistance.

7. True. Treatment and recovery programs are often unsuccessful at helping a person stop abusing substances until a person is ready and willing to halt use.

8. False. The substance abuser should have a role in deciding which modes of treatment or recovery to follow.

How to Use PERSPECTIVES:

PERSPECTIVES is designed as an easy-to-read educational resource for HIV test counselors and other health professionals. Each issue explores a single topic with a "Research Update" and an "Implications for Counseling" section.

The Research Update reviews recent research related to the topic. In Implications for Counseling, the research is applied to the counseling session, and a case study is presented. PERSPECTIVES also includes two sets of questions to consider yourself or discuss with others.