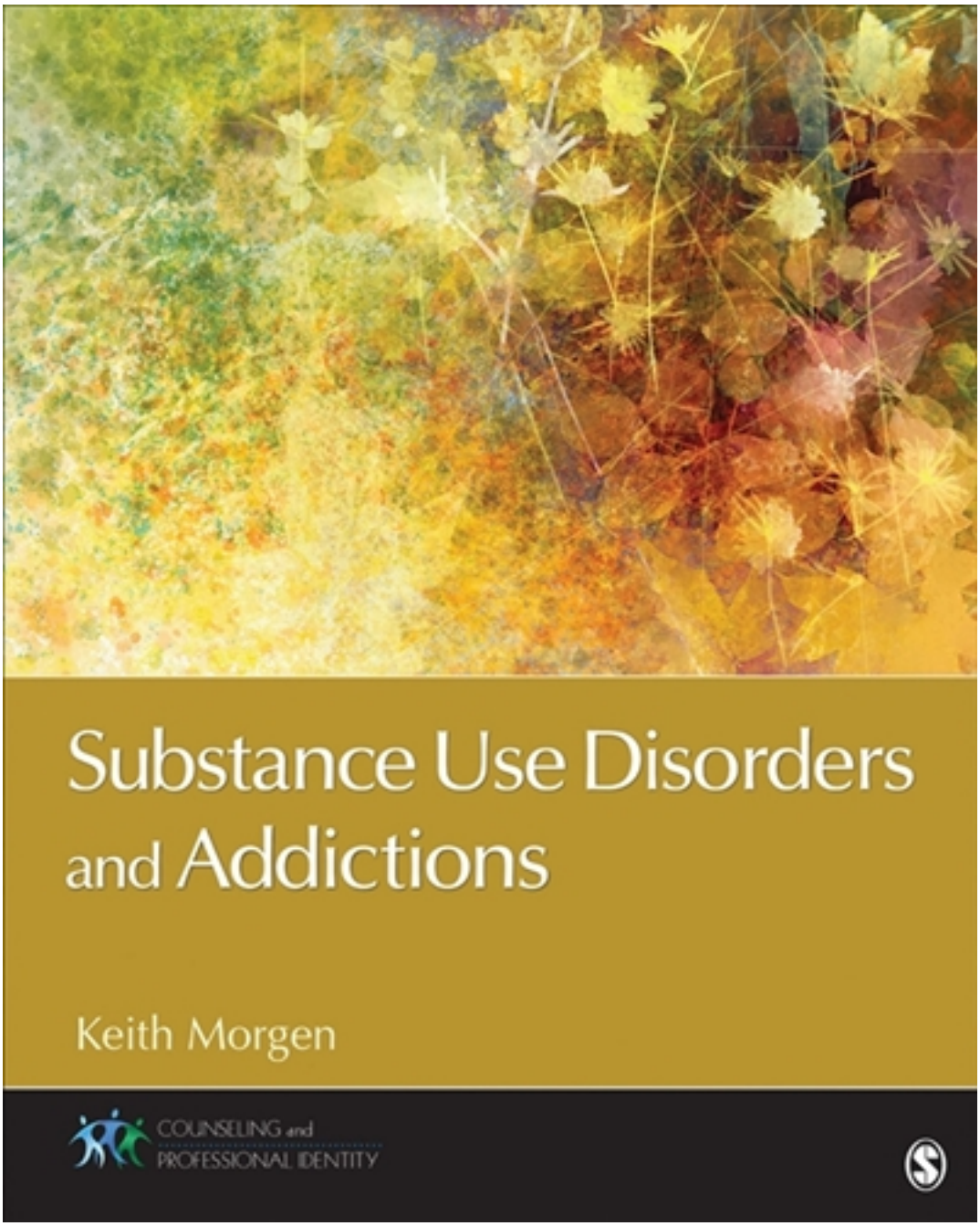
Test Bank for Substance Use Disorders and Addictions 1st Edition by Morgen

CLICK HERE TO ACCESS COMPLETE Test Bank



Test Bank

Test Bank Template

Chapter 2: Interview, Screening, and Assessment

Multiple Choice Questions:

1. Interview and assessment *directly* influence which of the following clinical issues?
a. Diagnosis
***b. Problem conceptualization**
c. Treatment plan
d. Treatment placement
Answer Location: Page 26

2. Which of the following content is *not* recommended by Morgen for inclusion in a review of substance use history?
a. Age at first use
b. Frequency, amount, and administration of the substance
***c. Reason for first use**
d. Any periods of prior abstinence > 30 days
Answer Location: Pages 28–37

3. As per NIDA, which of the following substances—when combined with alcohol—can result in dangerously low blood pressure?
a. Cocaine
b. Heroin
***c. Inhalants**
d. Marijuana
Answer Location: Page 30

4. As per NIDA, which of the following substances—when combined with alcohol—can dangerously increase hear rate?
a. Cocaine
b. Heroin
c. Inhalants
***d. Marijuana**
Answer Location: Page 31

5. As per NIDA, which of the following substances—when combined with alcohol—increases the risk of overdose well beyond the risk from just alcohol or this substance alone?
***a. Cocaine**

b. Heroin
c. Inhalants
d. Marijuana
Answer Location: Page 29

6. As per NIDA, which of the following substances—when combined with alcohol—increases the risk of cardiovascular slowdown, respiratory slowdown, coma, or death?
a. Cocaine
***b. Heroin**
c. Inhalants
d. Marijuana
Answer Location: Page 29

7. As per NIDA, cocaine is associated with all of the following health/medical issues with exception of:
***a. liver issues**
b. respiratory issues
c. HIV/Hepatitis
d. gastronitestinal
Answer Location: Page 43

8. As per NIDA, heroin is associated with all of the following health/medical issues with exception of:
a. cardiovasuclar issues
b. respiratory issues
***c. muscoskeletal issues**
d. liver issues
Answer Location: Page 43

9. The *2013 Treatment Episode Dataset – Admissions* indicated that approximately this percentage of clients entered SUD treatment with a co-occurring psychiatric disorder.
a. 40%
***b. 33%**
c. 25%
d. 50%
Answer Location: Page 39

10. Psychiatric symptoms in SUD clients can be due to:
a. intoxication effects
b. subsyndromal experiences
c. withdrawal effects
***d. all of the above**
Answer Location: 39

11. Which of the following is not a part of the client social history information obtained during the initial intake interview?
a. Financial
b. Educational
c. Criminal justice / legal
***d. All of the above are social history components**
Answer Location: Pages 43–44

12. According to SAMHSA, which of the following is NOT a function of drug testing?
a. Prevention of adverse pharmacotherapy effects
b. Mechanism to evaluate appropriate level of care
***c. Information to provide to drug courts and the CJS**
d. Monitoring of adherence to abstinence and/or pharmacotherapy
Answer Location: Page 46

13. Which substance besides alcohol is typically evaluated in drug testing?
a. Cocaine metabolites
b. Amphetamines
c. Opiate metabolites
***d. All of the above**
Answer Location: Page 47

14. Drug testing technology entails the use of:
a. hair
b. urine
c. sweat
***d. all of the above**
Answer Location: Page 47

15. This testing technology has the briefest window of detection.
***a. Blood**
b. Hair
c. Sweat
d. Urine
Answer Location: Page 47

16. The NIDA Common Data Elements (CDEs) were designed for use in what type of setting?
a. Counseling
b. K-12 school
***c. Medical setting**
d. All of the above
Answer Location: Page 49

17. Which measure is NOT a CDE from the NIDA Clinical Trials Network?
a. DAST-10
b. AUDIT-C
***c. BDI**
d. PHQ-2
Answer Location: Pages 49–50

18. The PHQ-2 targets which disorder(s)?
a. Anxiety
***b. Depressive**
c. Psychotic
d. Both a & b
Answer Location: Page 50

19. The CDS first consists of what?
***a. Single-item screener followed by the DAST-10**
b. DAST-10 followed by the single-item screener
c. Single-item screener followed by the AUDIT
d. AUDIT followed by the single-item screener
Answer Location: Page 50

20. The single question test does NOT target which of the following substances?
a. Heroin
b. Cocaine
c. Marijuana
***d. Alcohol**
Answer Location: Page 50

True/False Questions:

21. Hallucinations are part of the *content of thought* section of the mental status exam.
***a. True**
b. False
Answer Location: Page 45

22. Psychiatric symptoms should be included in the initial interview, regardless if these symptoms appear substance-related due to intoxication or withdrawal.
***a. True**
b. False
Answer Location: Page 46

23. How and why this client wound up being interviewed is irrelevant data for the clinical interview.
a. True
***b. False**
Answer Location: Page 46

24. The level of a metabolite in the urine corresponds with levels in the blood.
a. True
***b. False**
Answer Location: Page 47

25. The American Academy of Pediatrics Committee on Substance Abuse (2011) recommended that adolescents are screened for substance use only at mental health related appointments.
a. True
***b. False**
Answer Location: Page 53

Essay Questions:

26. What are the challenges to an effective interview for an older adult diagnosed with SUD?

Suggested Answer: Older people may under-report their substance misuse due to perceived stigma. Ageism may distract clinicians from signs of substance misuse, such as low energy and mood changes, which may instead be misattributed to general physical illness or depression. Stereotyping may blind detection of symptoms, for instance, ignoring substance use in older women due to the misnomer that substance use is an uncommon occurrence for this population. In addition, when performing an interview, it is crucial to identify the psychosocial factors that may make substance misuse more likely in older adults, for instance, issues such as bereavement, retirement, or physical immobility. SAMHSA (2011) also highlighted the complexities in assessing older adult SUDs and related psychiatric conditions such as major and mild depression and dysthymia. For example, older adults may demonstrate depression-like symptoms such as hopelessness, worry, and loss of interest in tasks deemed once pleasurable. Furthermore, there are no established older adult DSM diagnostic guidelines (e.g., Morgen & Voelkner, 2014). SAMHSA (2011) reviewed other diagnostic issues, such as how in major depression impairment in functioning is less severe as compared to younger adults and how minor depression is often not detected in older adults. Screening for substance misuse in older adults is primarily limited to alcohol. The most commonly used screen for older adults is the Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G) (Blow et al.,1992). The SMAST-G identifies problems common for older adults, such as drinking after a significant loss. Other alcohol measures designed specifically for the older adult population include an adaptation of the AUDIT (SAMHSA, 2001), with sensitivity and specificity shown for a cutoff score of 5 for older men and 3 for older women.

Answer Location: Pages 53–54

27. Explain why Laudet, Morgen, and White (2006) is a critical article for understanding the need to include strengths-based assessment into the interview process.

Suggested Answer: Laudet, Morgen, and White (2006) found that social supports, spirituality, religiousness, life meaning, and 12-step affiliation buffer stress effects on enhanced life satisfaction, with the buffer constructs accounting for 22% of the variance in life satisfaction. Though this study was focused on individuals already well into the treatment and recovery process, the buffer constructs are perfect examples of strengths to assess. First, regarding social support, empirical evidence has linked social support to increased health, happiness, and longevity (Lin, 1986). Among substance users, lower levels of social support has shown to be a reliable predictor of relapse (Havassy, Wasserman, & Hall 1993), while higher levels of social support predict a diminished rate of substance use (Humphreys & Noke, 1997; Noone, Dua, & Markham, 1999; Rumpf, Bischof, Hapke, Meyer, & John, 2002). Moreover, social support is a significant concept in the perceived well-being of those with co-occurring substance use and psychiatric disorders (Laudet, Magura, Vogel, & Knight, 2000). Second, Laudet et al. (2006) highlighted that religious and spiritual beliefs function as protective factors between life stressors and overall perceived quality of life (e.g., Culliford, 2002; Miller & Thoresen, 2003). Third, Laudet et al. (2006) emphasized that affiliation with 12-step fellowships, both during and after treatment, is a cost-effective and useful approach to promoting recovery from substance use problems (e.g., Greenfield & Tonigan, 2013; Humphreys & Moos, 2001; Humphreys et al., 2004). Furthermore, evidence suggests that 12-step affiliation benefits extend to psychosocial functioning and enhanced quality of life (e.g., Gossop et al., 2003; Moos, Finney, Ouimette, & Suchinsky, 1999). The principal helpful components likely include the sense of social support and the reduced stigma associated with being in a community with others who share similar struggles (Morgen & Morgan, 2011; Morgen, Morgan, Cashwell, & Miller, 2010).
Answer Location: Pages 26–27

28. What are the components and challenges to assessing psychiatric history in the interview?

Suggested Answer: This interview is complicated. For example, the clinician must address the following components. One, is there a history of an independent DSM-5 diagnosed psychiatric disorder? Two, regardless of history, is the client demonstrating any current symptoms that may reflect a psychiatric disorder? Three, what is the history of the client's psychiatric symptom experiences in conjunction with substance intoxication, withdrawal, or prolonged abstinence? Four, are there any instances of distressful emotional experiences that may resemble diagnosable disorders but fail to adhere to any nosology?

The challenges are two-fold. One, there is tremendous overlap between substance use and psychiatric symptoms. For example, experiences of anxiety, depressed mood, or paranoia are symptoms of numerous psychiatric disorders but also occur in various instances of substance

intoxication or withdrawal. Considering that many clients enter treatment or an ER setting while still actively using or in the early withdrawal phase, it can become very difficult to tease out the temporal and causal relationship (if any) between substance use and psychiatric symptoms. Two, you are asking about psychiatric symptoms and history with an individual who (due to substance use past and present) is not the best equipped to provide a lucid and organized recollection of all symptoms and experiences.
Answer Location: Pages 39–40

29. Briefly explain how the interview process fits into the larger assessment, diagnosis, and treatment planning context.

Suggested Answer: The initial interview serves as a data-gathering dialog where the counselor can also begin to craft the narrative regarding the need for treatment and what strengths the client brings to the treatment process. The interview also informs the need for any screening applications. Screening is not just testing, but rather a purposeful and applied clinical measurement to determine the existence of various problems. Assessment is a more comprehensive application where the pervasiveness or severity of various problems (including substance use disorder) may be further determined. In brief, the initial interview, screening, and assessment serve such functions as conceptualizing the problem or problems, clarifying the severity of these problems, and informing/motivating the client for the need for treatment. Consequently, the interview, screening, and assessment phases of the initial sessions eventually inform the diagnostic and treatment plan development process. Furthermore, these critical tasks are conducted not only within a substance use disorder (SUD) treatment facility. The substance use interview, screening, and assessment processes have expanded to such populations as emergency room (ER) patients (e.g., Lank & Crandall, 2014), primary health care practices (e.g., Stoner, Mikko, & Carpenter, 2014), and college/university counseling centers (e.g., Denering & Spear, 2012) in an attempt to target not only those with diagnosable substance use disorders but also those individuals who present with unhealthy use that does not yet rise to a diagnostic level.
Answer Location: Page 25