

# Chapter 4

## Possibilities and Limits in Psychological Assessment of Individuals with Substance Use Disorders



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### Introduction

Understood as a scientific technical process of data collection about the subject's psychic functioning, the psychological assessment (PA) has proven effective for diagnosis, prognosis, and intervention planning in a range of problems. It is dynamic in nature, and its purpose is to explain psychological phenomena and to subsidize the decisions of the psychologist himself in his professional performance or of other professionals in the clinical, institutional, and labor sphere, among other scenarios.

In recent years, the ethical and political responsibility of the PA has been the subject of discussions in the academic community. It is known that the historical-cultural dimension of people or groups influences psychic functioning, and the outcome of the PA has psychosocial impacts on individuals (Conselho Federal de Psicologia [CFP], 2013). In the case of users of psychoactive substances (PS), these recommendations may become larger and more complex.

According to the II Home Survey on Psychotropic Drug Use in Brazil – a study involving the 108 largest cities in the country (Carlini, Galduróz, Silva, Noto, & Fonseca, 2006) – the consumption of PS is common practice in the country. In relation to licit substances and their use in life, it was verified that 74.6% of the interviewees used alcohol and 44% tobacco. Regarding illicit substances, it was observed that about 22.8% of the population had already had at least one episode of use. Marijuana appears as the most used (8.8%), followed by solvents (6.1%), cocaine (2.9%), and crack (1.5%).

Additionally, we know that the use of PS has been configured as a social problem. Such use is related to the increase in violence, crime, morbidity and mortality, automobile accidents, antisocial behavior, etc. (Bastos, Vasconcellos, Boni, Reis, & Coutinho, 2017; Carlini et al., 2006). However, the use of PS, especially when

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linked to a pattern of abusive use, should be analyzed from several perspectives (Perrenoud & Ribeiro, 2011; Pillon & Luis, 2004).

It is called drug addiction when the user-drug relationship is markedly abusive to the subject. The drug addiction is characterized by impulsive and recurrent behavior related to consumption and extreme difficulty in interrupting or controlling use. Although it is configured in a controversial concept, governed by an infinity of theoretical orientations, it is consensual that the relationship built by the individual with a certain substance can be dysfunctional and harmful, both for him and for his environment.

Although a good portion of users do not develop drug addiction or show significant losses, the statistics show expressive numbers. According to the III National Survey on Drug Use by the Brazilian Population (Bastos et al., 2017), in a population between 12 and 65 years of age, it was observed that approximately 2.3 million people were dependent on alcohol; 1.2 million individuals were dependent on some substance other than alcohol or tobacco, the most frequent being marijuana, benzodiazepines, and cocaine, respectively; 3.3 million presented criteria for alcohol dependence, and finally, about 4.9 million Brazilians presented a high or very high degree of dependence on tobacco.

We will see that the current concept of drug addiction is descriptive. Although the mechanisms for the drug addiction are still the subject of debate, we know that the individual progresses from experimentation to occasional use, intense use reaching total dependence. However, this progression is complex and depends on the interaction between the drug, the user, and the context. All these factors make the PA phenomenon in this target audience a complex and arduous process.

In view of this, this chapter aims to describe the PA process in PS users, bringing to the reader a clinical perspective. First, we discuss the fundamental concepts and diagnostic criteria for substance use disorders. The factors that influence the harmful use of PS and the development of substance use disorders are discussed. In the following moment, suggestions for the conduct of PA are presented. The chapter closes with some problematizations about the PA as a theoretical practical field.

## **Psychoactive Substances (PS): Fundamental Concepts and Diagnostic Classification**

“Drug” is any substance, harmful or having a curative potential, capable of causing changes in the functioning of the living organism. However, modern taxonomy uses the term psychoactive substances (PS), so-called because they are capable of causing significant and functional changes in the psychism (Mitsuhiro, 2013). The nature of these changes is correlated to the type of substance, which is why it has been agreed to classify PS as depressants, stimulants, and central nervous system (CNS) disrupters.

Depressant substances are mainly characterized by causing a decrease in the overall or specific activity of the CNS, causing reduced motor activity and little reactivity to pain and anxiety. Their use provokes an initial effect of euphoria and a later identification of information processing, usually relaxation and sleepiness. Alcohol, barbiturates, benzodiazepines, and opioids are representative of this group. On the other hand, stimulant substances, such as amphetamines and cocaine, increase brain activity and differ in essence from mental activity disturbances in that they do not produce abnormal psychic phenomena, such as delirium and hallucinations. In the latter group, we find marijuana, tobacco, LSD, and ecstasy (Nicastri, 2014).

The routes of administration may be enteral, parenteral, inhalation, or topical and will determine the extent of cognitive reactions and/or damage. Paths of administration that cause faster absorption tend to influence the progression of use. Moreover, the greater the action potential, that is, the ratio between the time a substance begins to take effect and its duration, the greater the probability of provoking more intense intoxication and a dysfunctional consumption pattern by the subject.

Two other central concepts are abstinence and tolerance. Abstinence refers to a set of symptoms resulting from the interruption or reduction of a substance that causes dependence, while tolerance alludes to the need for increasing amounts of the same substance to achieve the desired effect. The presence of these two clinical phenomena is configured in strong evidence that the individual has progressed from a state of abusive use to drug addiction (Laranjeira et al., 2003).

The International Classification of Diseases (ICD-10) rejected the notion of dependent and nondependent to the detriment of a less polarized rationality. According to this code, there would be a differentiation in the pattern of consumption of users: there are those individuals who make harmful or abusive use of a certain psychoactive substance, without, however, being chemical dependent. Thus, it creates differentiating criteria for harmful use and criteria for addiction.

For illustration purposes, let us consider three individuals (A, B, and C) and their alcohol consumption patterns. Individual A has sweating, vomiting, and morning shakes that are stopped after using the drug, which is why he drinks daily (addiction). Individual B, on the other hand, drinks eventually, but when he does, he has difficulties in regulating his consumption. For this reason, he has driven drunk, caused accidents, got involved in fights, and had unprotected sexual behavior when he was drunk (harmful consumption). In contrast, individual C consumes alcohol in low doses but takes the necessary precautions to ensure his safety and that of others (low risk consumption) (Laranjeira et al., 2003; Peuker & Kessler, 2016).

The ICD-10 criteria for harmful substance use (abuse) require that actual harm must have been caused to the user's physical and mental health, the frequency of consumption is criticized by others, and the harmful pattern of consumption is associated with diverse social consequences of various kinds. For addiction, the criteria are more extensive and involve compulsion to consume, increased tolerance, abstinence syndrome, relief or avoidance of abstinence by increased consumption, relevance of consumption, narrowing or impoverishment of the repertoire (behavioral and social), and reinstallation of the addiction syndrome. These guidelines guided the diagnosis of addiction syndrome of psychoactive substances (Box 4.1).

### Box 4.1 Diagnostic criteria for substance dependence syndrome (ICD-10; WHO, 2019)

A definitive diagnosis of dependency should usually only be made if three or more of the following requirements have been experienced or displayed at some point in the previous year:

- (a) A strong desire or sense of compulsion to consume the substance
- (b) Difficulties in controlling the consumption behavior of the substance in terms of its beginning, end, and levels of consumption
- (c) A state of physiological abstinence when the use of the substance has ceased or has been reduced, as evidenced by the following: Abstinence syndrome for the substance or the use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms
- (d) Evidence of tolerance, such that increasing doses of the psychoactive substance are required to achieve effects originally produced by lower doses
- (e) Progressive abandonment of alternative pleasures and interests in favor of the use of the psychoactive substance, increasing the amount of time needed to recover from its effects
- (f) Persistence in the use of the substance despite clear evidence of clearly harmful consequences. Clear efforts should be made to determine whether the user was actually aware of the nature and extent of the harm

In the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the dichotomy between harmful use/substance abuse and substance dependence has been focused on the understanding that drug use varies along a *continuum* of severity. This means that the individual's relationship with the drug is not restricted to the frequency and amount of substance use but to the risks and negative consequences, both for him and for others. Thus, despite the criticism of the tendency to pathologize the use, the new version of the manual assists in a comprehensive analysis of the pattern of use and allows the evaluation of the damage caused by the use of the substance.

According to DSM-5, substance use disorders (SUDs) are based on a pathological pattern of substance use-related behaviors. It covers 10 classes of drugs, namely: alcohol, caffeine, *cannabis*, hallucinogens, inhalants, opioids, sedatives, hypnotics and anxiolytics, stimulants, tobacco, and other substances (or unknown substances).

SUD is characterized by the presence of a grouping of cognitive, behavioral, and physiological symptoms, indicating continuous use by the individual despite significant substance-related problems. The diagnosis of SUD is given through general groupings involving low control (Criteria 1–4), social harm (Criteria 5–7), risky use (Criteria 8–9), and pharmacological criteria (Criteria 10–11). The disorder occurs in a *continuum*, based on the number of diagnostic criteria met, and may be mild (presence of 2 or 3 criteria), moderate (presence of 4 or 5 criteria), or severe (presence of 6 or more criteria) (see Box 4.2).

### **Box 4.2 Diagnostic criteria for psychoactive substance use disorder (APA, 2014)**

1. The substance is often consumed in larger quantities or for a longer period than intended
2. There is a persistent desire or unsuccessful efforts to reduce or control the use of the substance
3. Much time is spent on activities necessary to obtain the substance and its use or to recover its effects
4. Craving or a strong desire or need to use the substance
5. Recurring use of the substance resulting in failure to meet important obligations at work, school, or at home
6. Continued use of the substance despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use
7. Important social, professional, or recreational activities are abandoned or reduced due to the use of the substance
8. Recurrent use of the substance in situations where this represents a danger to physical integrity
9. The use of the substance is maintained despite the awareness of having a persistent or recurrent physical or psychological problem that tends to be caused or exacerbated by it
10. Tolerance
11. Abstinence

For information purposes, the above-mentioned manual also presents a general category called substance-induced disorders. It includes substance-induced intoxication, abstinence, and other substance/medicinal disorders (e.g., substance-induced psychotic disorder, substance-induced depressive disorder).

According to Ribeiro and Rezende (2013), the conceptualizations and diagnostic criteria aim to create a proper language among professionals, in addition to optimizing the approach of the subject and the direction of treatment. For the authors, when professionals have knowledge of these concepts and put them into practice, they are able both to identify at an early stage when the individual presents problems as to the consumption of substances, recognize the subtleties of the symptoms and various damages, as well as decide about the appropriate referrals that avoid or minimize future complications.

## **Factors Associated with Harmful Use of PS and SUD Development**

### ***Risk and Protection Factors***

In general, the clinical profiles of individuals with SUD are single, young adults, non-white, low schooling, unemployed and/or undefined profession, and without religious practice (Almeida, Anjos, Vianna, & Pequeno, 2014; Lacerda, Pinto, Pinto, & Salomão, 2015; Ribeiro et al., 2012)

The consumption of licit substances, such as cigarettes and alcohol, is higher in males (Targino & Hayasida, 2018). Where schooling is concerned, the punctual prevalence of *binge drinking* – an expression meaning “heavy episodic drinking” or “drinking if drunk” – is more common among individuals with a complete higher level or more. In contrast, individuals with this level of education have lower rates of cigarette consumption (Bastos et al., 2017).

Some studies have identified that college students are considered a critical group for PS use and abuse. Health science students, for example, represent a population with a high rate of alcohol use (Mendonça, Jesus, & Lima, 2018). According to Neves Jr. and Bittar (2014), entry into university by young adults is a period of greater vulnerability for the initiation and maintenance of harmful use of PS. This is because experiences such as family distance, living alone or with other students, and still experiencing the absence of supervision can increase the desire to try alcohol and other drugs.

Other studies show that students with low scores in spirituality levels and no religious affiliation tend to consume alcohol at more problematic levels than adherents of a religion (Pillon, Santos, Gonçalves, Araújo, & Funai, 2010). In high school students, the presence of religious education in childhood was also a protective factor (Soldera, Dalgalarondo, Corrêa, & Silva, 2004).

In adolescents, the reasons that lead to consumption are correlated to the effects of the substances, such as facilitating sociability with peers, recourse to induction of a state of well-being, a strategy for dealing with unpleasant emotions, markedly anxiety and depression, and also ease of access (Oliveira, 2005).

Low school performance, early age, weak family ties (family violence and lack of parental supervision), and friends or family members who use or trade drugs and attend private school represent risk factors for greater involvement, consumption, and abuse of drugs among adolescents. In contrast, those with healthy patterns of interaction and adaptability, religion, access to information, and ultimately satisfactory parental and community relationships tend not to experiment and/or abuse substances (Cordeiro et al., 2019; Pratta & Santos, 2013; Soldera et al., 2004; Targino & Hayasida, 2018).

## ***Psychological Factors***

It is not known for sure which motivational factors lead to drug use; however, it has been said that many users seek to reduce aversive internal states (anxiety, tension, end shyness, etc.) and create or maximize pleasant emotional states (euphoria, relaxation, increase and/or activation of sexual desire, etc.).

It is estimated that the stimulation of the reward system, that is, a set of structures responsible for reinforcing behavior and creating new memories, contributes to the establishment of the SUD. The prolonged consumption of PS causes neurochemical

imbalances, in which the feeling of well-being/pleasure, commonly produced by natural rewards (food, sex, etc.), is strictly linked to the action of the substance in the body, hence the appearance of symptoms of tolerance and abstinence (Formigoni, Kessler, Baldisserotto, Pechansky, & Abrahão, 2018; Messas & Vallada Filho, 2004; Mitsuhiro, 2013).

Classic conditioning (association of neutral stimuli that then become conditioned), operant conditioning (strengthening certain patterns of behavior to the detriment of others), and social learning seem to assume a significant role in the use, abuse, and development of SUD. According to Peuker, Fogaça, and Bizarro (2006), in an environment where the individual does not have an established behavioral repertoire, processes such as modeling, imitation, or reinforcement are put into action. The intensity, type of drug, and the frequency with which pairs consume PS can be perceived by the individual as a reinforcement of his own behavior, which motivates him to act in line with this perception.

Research has shown that PS consumption can be related to positive expectations about its effects. Expectations, that is, anticipatory cognition, have motivating properties that can influence the emission of a specific behavior. It is a mnemonic content constructed over time through the observation of family models, peers, direct experiences with drugs, or exposure to media information. In this way, individuals who have never used alcohol or other PS can have positive expectations about their effect (joy, pleasure, etc.). Therefore, the belief that drinking behavior can generate certain affective states may be sufficient to lead the individual to experiment and repeat use, if the initial expectations are confirmed (Junior, 2004; Peuker, Rosemberg, Cunha, & Araujo, 2010).

It is assumed that “if-so” assertions that relate events to their respective consequences (beliefs of consequences), together with other cognition such as relieving beliefs (expectation that use will mitigate or remove some subjective discomfort or suffering) and permissive or facilitating beliefs (ideas that the use of the substance, despite the vicissitudes, is both acceptable and desirable), interact with environmental and cultural aspects and strongly predict the harmful use of PS (Junior, 2004).

On the presence of significant cognitive impairment in individuals with SUD, the specialized literature has not yet reached a consensus (Sayago, Lucena-Santos, Horta, & Oliveira, 2014). However, there are records of commitment to tasks that require constructive visual skills, attention, memory, and executive functions, in addition to the reduction in processing speed (Ferreira & Colognese, 2014; Kolling, Silva, Carvalho, Cunha, & Kristensen, 2007). However, the longer time of abstinence seems to contribute to reverse these damages (Oliveira, Laranjeira, & Jaeger, 2002; Rocha, Setúbal, Calheiros, & Bergamini, 2018).

The emotional and behavioral changes were identified more precisely. Among them, difficulties in anger management, deficits in social skills, impulsiveness, depressive and anxious symptomatology, and the presence of suicidal ideation are frequent (Almeida, Flores, & Scheffer, 2013; Sayago et al., 2014; Scheffer, Pasa, & de Almeida, 2009; Silva, Hatanaka, Rondina, & Silva, 2018).

## ***Psychiatric Comorbidities in SUD***

There is extensive literature debate about the high prevalence of undiagnosed comorbidities in SUD. It is claimed that the lack of treatment leads to greater chronicity and worse prognosis for both clinical conditions (Laranjeira et al., 2003).

Among the most common psychiatric comorbidities are anxiety disorders, mood disorders, personality disorders, and psychotic disorders (Hess, Almeida, & Moraes, 2012; Zaleski et al., 2006). In adolescents, comorbidity is frequently found with disruptive disorders (conduct disorder and opposition defiant disorder) and with attention deficit/hyperactivity disorder (Oliveira, 2005; Torales et al., 2014).

It is not possible to establish causal relationships between SUD and the development of another mental disorder, which makes genetic vulnerability, hypothesis of toxicity, or self-medication as possible causes. In fact, aspects involving gender, ethnicity, and socioeconomic condition may act as predisposing factors both for SUD and for other psychiatric comorbidities (Diehl & Souza, 2013; Messas & Vallada Filho, 2004; Zaleski et al., 2006).

In establishing a second concomitant diagnosis of SUD, Diehl and Souza (2013) argue that in clinical practice, instead of the terms “primary” and “secondary,” it would be more significant to recognize that some disorders develop independently, while others are induced or derived. Other difficulties prevent greater flexibility of double diagnosis, such as the need for the patient to find at least 1 month in abstinence and theoretical/practical knowledge of mental health professionals.

## **The Psychological Assessment in SUD**

The PA can be indicated from the moment the subject or family is interested in knowing better their psychic functioning and their relationships, until when the use of PS causes significant and lasting damage to the individual and his environment, such as a drop in academic or work performance, reduction in the behavioral repertoire, difficulties in interpersonal relationships, presence of emotional and cognitive alterations, and psychic suffering intensified by the action of psychiatric comorbidities. The source of referral varies substantially and may be requested by professionals working in public or private institutions in the health area or in services with an educational focus, by spontaneous referrals, arising from the counseling of a friend and/or family member, or still be motivated in a legal context.

First of all, it must be clear to the psychologist what the purpose of the referral is: to obtain a broader knowledge of the individual’s functioning or to evaluate some specific area? The objectives are as diverse as the strategies selected and may vary from screening, diagnosis, evaluation of cognitive deficits, and personality characteristics, among others.

Bureaucratic issues such as testing space (real estate, lighting, noise-free room that guarantees privacy) and the time available to the professional (how much time



the psychologist has and will need to apply instruments and collect and interpret data and whether there is urgency in issuing the report) should be considered, especially if the psychologist works in a service where the demand is large. Individual characteristics regarding the individual's current overall state should also be appreciated (treatment regimen the patient is in – outpatient or hospitalization – use of medication, presence of diagnosis, whether or not he is abstinent, and, finally, whether he is able to respond to certain instruments, such as those of the autorelate type) (Peuker & Kessler, 2016).

It is indicated that the psychologist conducts an anamnesis interview to understand how the use of PA has become problematic. At that moment, a survey is made of the whole history of the individual (support network, eating habits, clinical and psychiatric history, issues related to development, family dynamics, work, etc.). At the end of the anamnesis, the psychologist needs to know the individual's consumption pattern, how the risk and protective factors are related to his or her subjective characteristics, and the presence of mental disorders not diagnosed or in remission.

It is suggested that the factors maintaining and aggravating the problem, the coping strategies already used and/or available, as well as the individual potentialities be investigated, bearing in mind that this information is a guide for the treatment and can be used in the writing of the report.

The symptoms and warning signs (*red flags*) of harmful use of PS can provide greater understanding in PA. According to Laranjeira et al. (2003), the signaling symptoms of problems resulting from harmful PS use are sleep disorders, depression, anxiety, mood instability, excessive irritability, altered memory and sense of perception, history of trauma and recurrent accidents, sexual dysfunction, and frequent absences (school, work, social commitments). The physical signs are as follows: mild tremor, changes in blood pressure (possible abstinence from alcohol), gastric and/or intestinal problems, enlargement of the liver, irritation of the nasal mucosa (suggests inhalation of cocaine) and conjunctiva (signals use of marijuana), frequent use of eye drops and sprays to clear the nose, odor (breath), and, finally, “oral hygiene syndrome” (use of chewing gum or mouth rinse to disguise the breath).

Interviews with third parties and home or institutional visits are indispensable tools, serving as a reliable means of triangulation of data and validation of information dispensed by the appraiser since, for numerous reasons, he may be motivated to simulate or conceal information. Especially the interview with relatives or significant people (parents, spouse, cousins, etc.) provides data that cannot be reached by other ways, such as understanding the relationships in the nuclear and extensive family, the available social support, delimitation of social roles, existence of cases of relatives with SUD, involvement with justice, and domestic violence, among others.

In what concerns psychological testing, Faccio and Ferreira (2017) in a recent study executed the survey of instruments in the System for Evaluation of Psychological Tests (SATEPSI) specific for the evaluation of behavior related to the abusive use of PS. At the time of the consultation – June 2015 – the authors found a list of 156 tests with a favorable opinion for use by psychologists. The analysis made from the description of each test available on the site returned only one test

favorable for clinical evaluation in cases of use of alcohol and other psychoactive substances: IECPA – Inventory of Expectations and Personal Beliefs About Alcohol (Pinto-Gouveia, Ramalheira, Robalo, Costa Borges, & Rocha-Almeida, 1996), with adaptation and evidence of validity for different samples of the Brazilian population (Amaral & Saldanha, 2009; Oliveira & Werlang, 1993).

In order to update the search in the SATEPSI system, we implemented a new consultation in March 2020, using the descriptors “psychoactive substances,” “drugs,” and “alcohol.” At the moment, no psychological instruments with this description have been found nor among those of non-private use by psychologists. Considering that the system consists of the platform that technically and legally guides the selection of psychological instruments for professional use (CFP, 2018), it faces a difficulty in proceeding with the psychometric analysis of constructs related to the subject, and, although this is not the only possibility of reading about the demands in this field, it could contribute with relevant information about the population studied.

Despite these weaknesses, it is important that in the course of the PA, as many strategies as possible are included. Scales, psychological tests (psychometric, neuropsychological, projective, scales that evaluate other constructs, such as personality, and social skills), behavioral observation, and interviews, among other resources, selected according to the reason for referral can be used. Exams of biological material, psychophysiological responses, and brain functioning can be used as complementary sources.

The literature documents three instruments used with PA users in both clinical and research settings, namely, the Alcohol Use Disorders Identification Test (AUDIT); the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST); and the Addiction Severity Index (ASI-6). However, until the last SATEPSI consultation, these instruments were not on the list of tests with a favorable opinion from the Conselho Federal de Psicologia for use by psychologists.

The AUDIT questionnaire is a measure that assesses the frequency, dependency, and negative consequences of alcohol consumption. It is an appropriate measure to investigate the presence of harmful or hazardous alcohol consumption (Méndez, 1999; Santos, Gouveia, Fernandes, Souza, & Grangeiro, 2012). The ASSIST is a screening tool that covers nine classes of PS (tobacco, alcohol, marijuana, cocaine, stimulants, sedatives, inhalants, hallucinogens, and opiates). Its translation and validation for the Brazilian population presents good sensitivity and content specificity in identifying harmful use and dependence on alcohol, marijuana, and cocaine (Henrique, De Micheli, Lacerda, Lacerda, & Formigoni, 2004).

The sixth version of the Addiction Severity Index (ASI-6) is a tool for an overall assessment of the individual in the last 30 days or 6 months prior to the PA. Already with satisfactory psychometric properties for the Brazilian population, the questionnaire provides the index of severity of problems and the degree of need for intervention in various areas of life of the individual according to their own perception (Kessler et al., 2012).

Tests of biological material, also called toxicology, detect whether the individual is under the effect of the substance during the sample collection, which can be

blood, saliva, or exhaled air for alcohol use. The examination of urine and keratin (hair, nail) can detect whether the individual has used the substance over several days. It is important to emphasize that each biological matrix has a detection window and depends strictly on the PA used (Sanchez, 2016).

Neuroimaging techniques and psychophysiological examinations are other valuable means capable of providing relevant information about the body and brain dynamics. Based on these data, it is possible to make a clinical reading, for example, cerebellar atrophy, ventricular dilation, reduction of blood flow, and cerebral glucose metabolism are some of the clinical indicators of chronic alcohol use (Nicastri, 2001). The results of psychophysiological tests (blood pressure, heart rate, and galvanic responses of the skin) can be used to identify various complications resulting from the use of PS.

It should be emphasized that all conduct of the PA should be exempt from judgments of value. Far from it, the presence of empathy must be ensured in an atmosphere of real welcome, both during the process and in the devolution. Finally, the report should be written in accordance with the guidelines present in the Code of Ethics of the Profession (CFP, 2005) and in Resolution Conselho Federal de Psicologia no. 06/2019 (CFP, 2019), which establishes rules for the preparation of written documents issued by the psychologist.

## Final Considerations

In this chapter, we did a clinical reading of SUD and how PA could be conducted to help people who make harmful use of PS. The literature on the use and abuse of PS is vast. Historical, sociocultural, ethnographic analyses, and clinical models, among so many other guidelines, have contributed to the understanding of the subject. However, the PA, as a theoretical and practical field, has advanced timidly, although it has much to add.

The absence of PA protocols and psychometric instruments, recognized and authorized by the Conselho Federal de Psicologia for use in the population studied here, points to a universe still to be explored. One of the main and most attractive goals of psychological testing is to operationalize mental models of functioning, refute them, and point out limitations. Knowing the cognitive and emotional processes involved in people with SUD serves as a basis to predict the prognosis and establish the diagnosis with greater reliability. From a clinical point of view, this could also mean the possibility of validating scientifically proven interventions. In addition, both the psychologist and other professionals can take advantage of the knowledge coming from the PA and add to their area of knowledge and practice.

In general, in the context of public policies in Brazil, the PA has not been a constant practice. Recently, the document *Referências Técnicas para Atuação de Psicólogos* (the Technical References for the Performance of Psychologists in Public Policies on Alcohol and Other Drugs) (Centro de Referência Técnica em Psicologia e Políticas Públicas do Sistema Conselho de Psicologia [CREPOP],

2019) was published, and it does not mention PA or psychological testing. We raise some hypotheses that justify this data: the historical development of the construction of the tests, their purpose, and application took place in the educational and organizational sphere; the public services do not have an adequate testing environment or psychological tests available; we do not have theoretical and practical guidelines to conduct a PA in these services, since this context is relatively new for psychologists; there are limitations regarding psychological instrumentation, and, finally, the predominant approach does not take the PA as a relevant and/or appropriate process for these spaces.

Finally, the proposal in this chapter was to update the reader on the resources available for the PA and the factors indicated by the literature as related to the abusive use of PS. However, this may change with other perspectives and socio-historical-cultural changes. Furthermore, as has been demonstrated, PS users or people with SUD can benefit from the PA, without the ethics and respect for this population being neglected. We hope to have contributed with the theme and to have incited in the reader new reflections, criticisms, and other possibilities of care.

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