ALCOHOL AND OTHER DRUG INFORMATION FOR PROFESSIONALS

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- Introductions
- What would you like to learn today?

Agenda

- Definition of Alcoholism and Addiction
- Phases of Alcoholism
- Effects of Alcohol and Other Drugs on the Brain
- Stages of Recovery From Alcoholism/Addiction
- Identifying Denial
- Screening, Assessment, and Diagnosis
- 12 Step Model Of Recovery

Alcoholism

- Alcoholism- Alcoholism or alcohol dependence is defined by the American Medical Association (AMA) as “a primary, chronic, disease with genetic, psychological, and environmental factors influencing its development and manifestations”.

Alcoholism

- Alcoholism is characterized by:
- A prolonged period of frequent, heavy alcohol use.
- Inability to control drinking once it has begun.
- Physical dependence manifested by withdrawal symptoms.
- Increased tolerance, or need to use more alcohol to achieve desired effect.
- A variety of social and/or legal problems resulting from alcohol use.

Addiction

- Addiction is a persistent, compulsive dependence on a behavior or substance.
- Addiction has been extended to include mood-altering behaviors or activities.
- Some researchers speak of two types of addictions: substance addictions (alcohol, drug abuse, and smoking); and process addictions (gambling, eating, shopping, spending money, and sexual activity).
- Many addicts are addicted to more than one substance or process.

Addiction

- Addiction is one of the most costly public health problems in the United States.
- It is a progressive syndrome, it increases in severity over time unless it is treated.
- Substance Abuse is characterized by frequent relapse, or return to the abused substance.
- Substance Abusers often make repeated attempts to quit before they are successful.

Phases of Alcohol Dependency

- E. Morton Jellinek, 1960, proposed 4 phases of alcoholism, which has been generalized to describe dependency on other chemicals as well.

Phase 1- Pre-alcoholic Phase

- Characterized by social drinking, control over drinking behavior, occasional alcohol use for stress reduction; at later stages of this phase, frequent drinking related to stress reduction.

Phase 2- Early Alcoholic Phase

- Begins with first blackout; characterized by sneaking drinks, preoccupation with drinking, gulping drinks, avoidance of reference to drinking, frequent blackouts and loss of control of drinking.

Phase 3- Middle Alcoholic Stage

- It is impossible for the person to stop after one drink; characterized by gross physical and psychological changes, chain drinking, maintenance of supply, resentments, some attempts at seeking help, attempts at abstinence, family changes, work-related problems, social decay, aggressive behavior, extravagance, alibis for behavior; life revolves around alcohol.

Phase 4- Late Alcoholic Stage

- Drinking begins all morning and lasts all day; characterized by benders, physical dependence, ethical deterioration, paranoid thinking, alcoholic jealousies, indefinable fears, religious need, severe liver and brain damage.

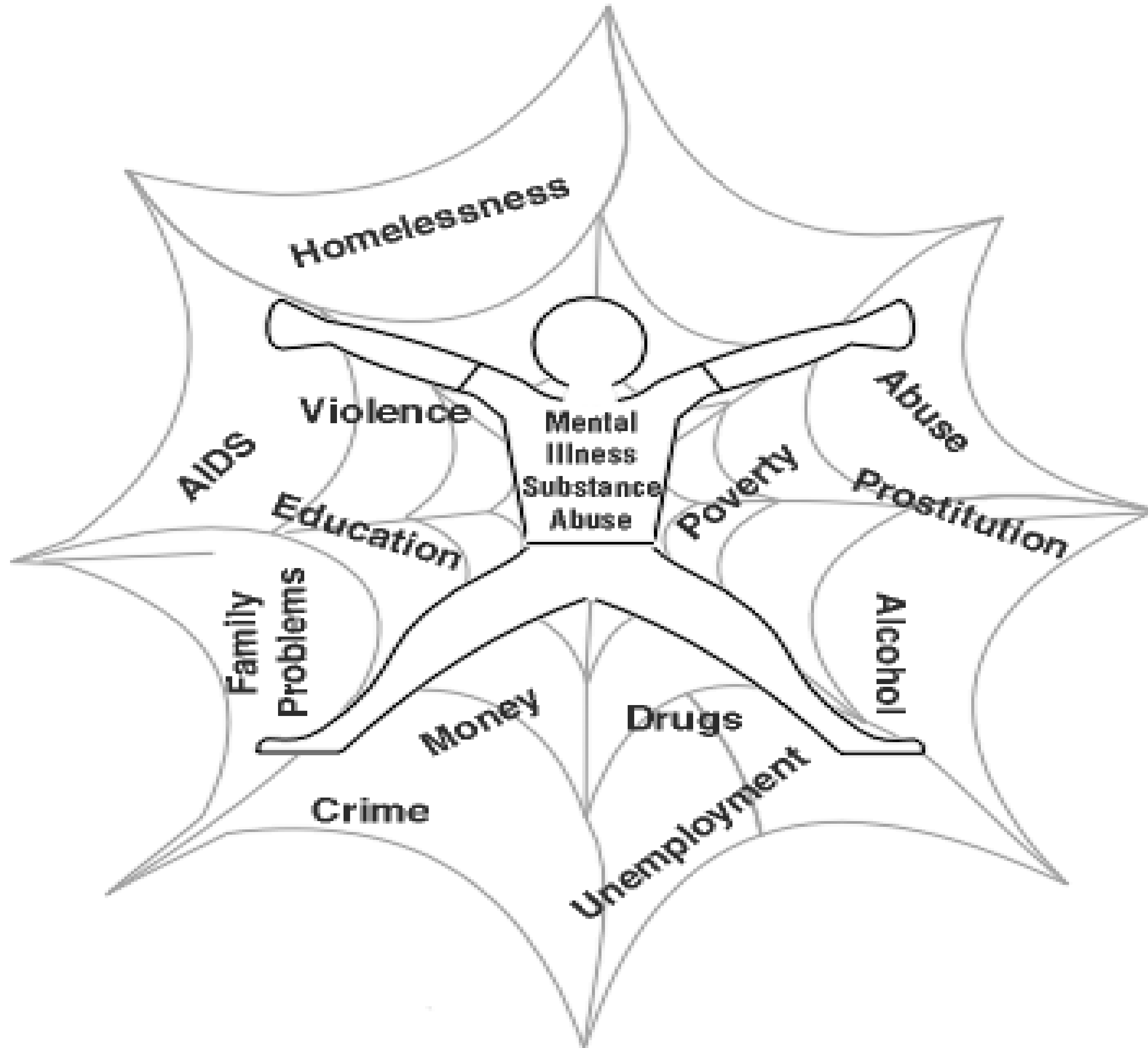
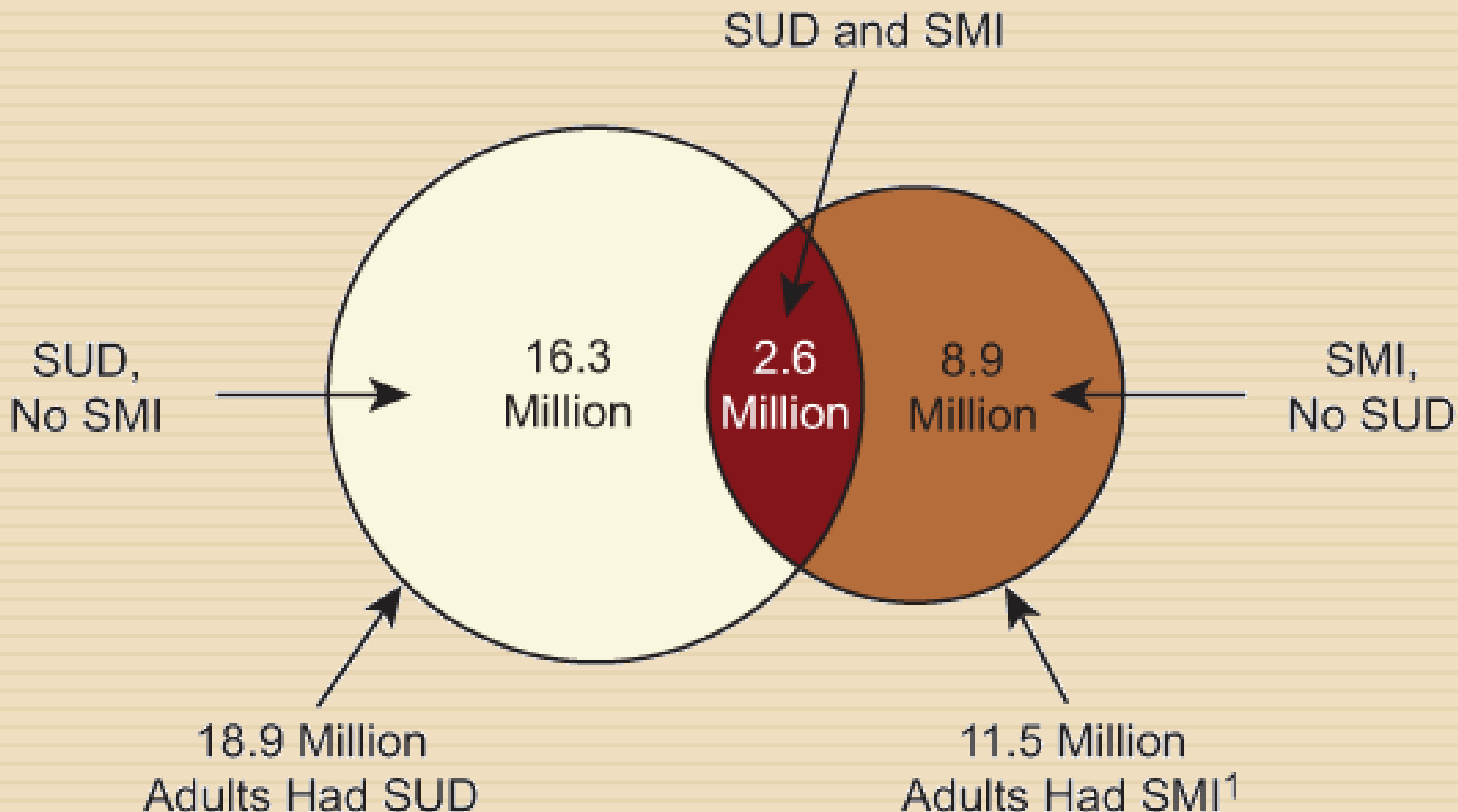


Figure 2–D.—Caught in a Web of Social Problems
Homelessness
Violence
AIDS
Education
Family
Problems
Mental
Illness
Substance
Abuse
Abuse
Poverty
Prostitution
Alcohol
Money
Drugs
Crime
Unemployment

How Many Americans Need Help?

- Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Survey on Drug Use and Health,
- 23.5 million persons aged 12 or older needed treatment for an illicit drug or alcohol abuse problem in 2009 (9.3 percent of persons aged 12 or older).
- Of these, only 2.6 million—11.2 percent of those who needed treatment—received it at a specialty facility.

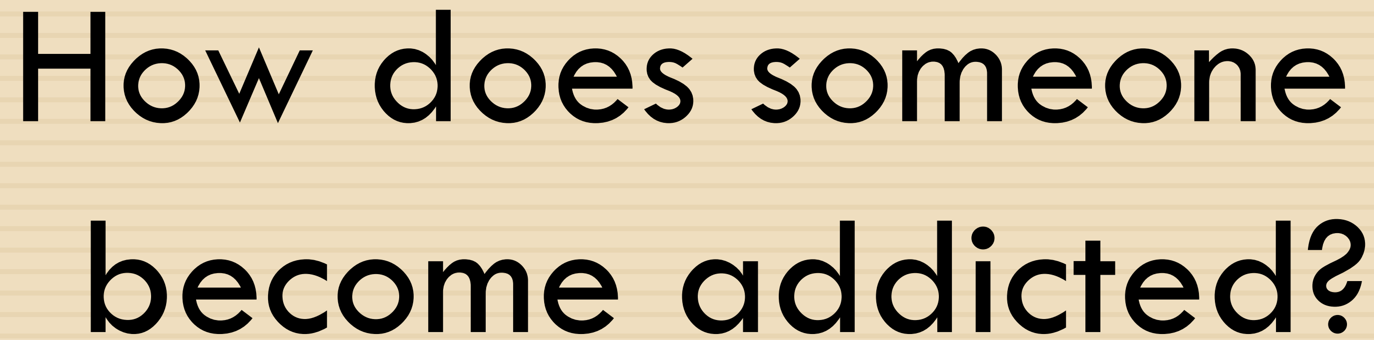
Past Year Substance Dependence or Abuse and Serious Mental Illness among Adults Aged 18 or Older: 2011



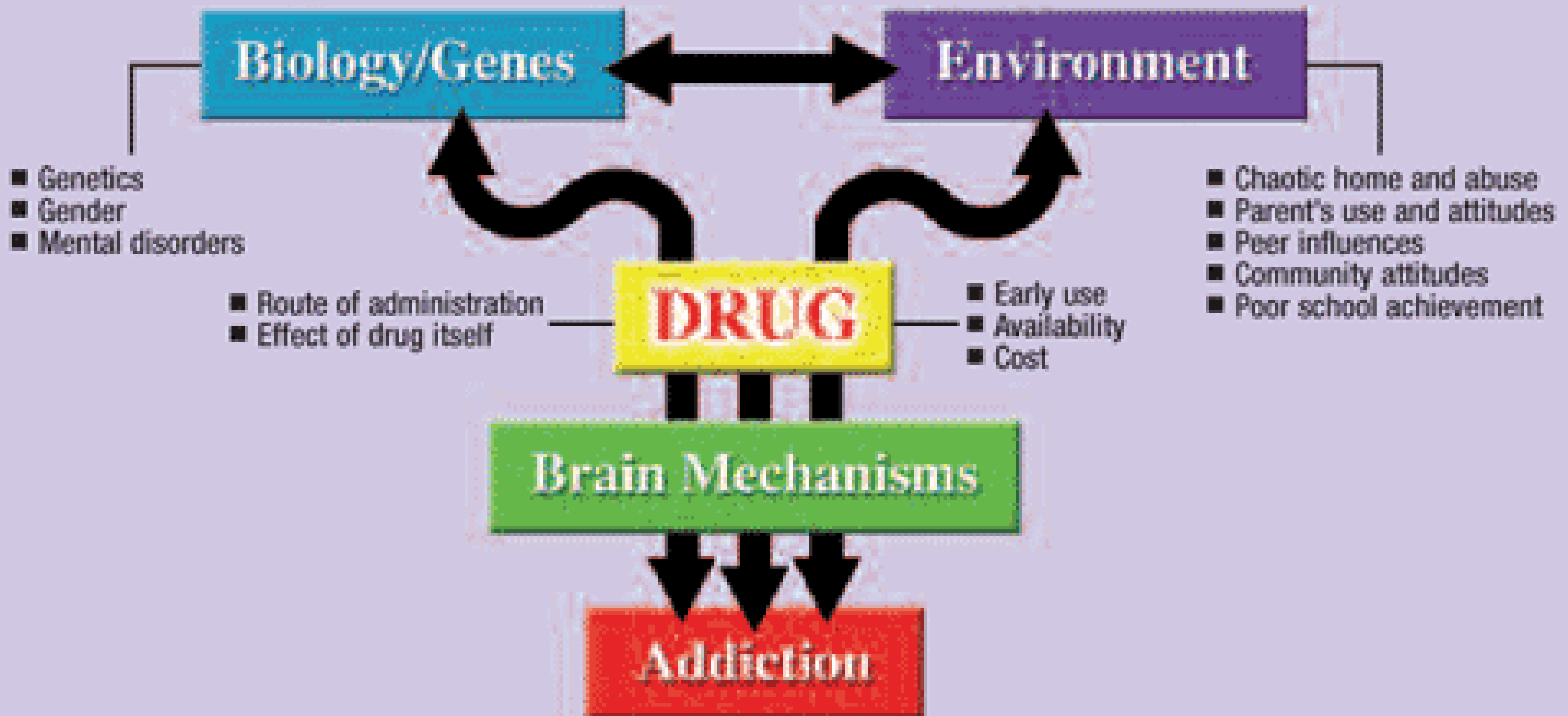
Why People Who Need it Don't Seek Treatment

- **Perception of the Problem, e.g., isn't that bad.**
- **Perception of Self, e.g., should be able to handle this on my own.**
- **Perception of Treatment, e.g., ineffective, unaffordable, inaccessible or "for losers"**
- **Perception of Others, e.g., fear of stigma and discrimination**

Source: Cunningham, et, al, 1993; Grant 1997


How does someone become addicted?

RISK FACTORS



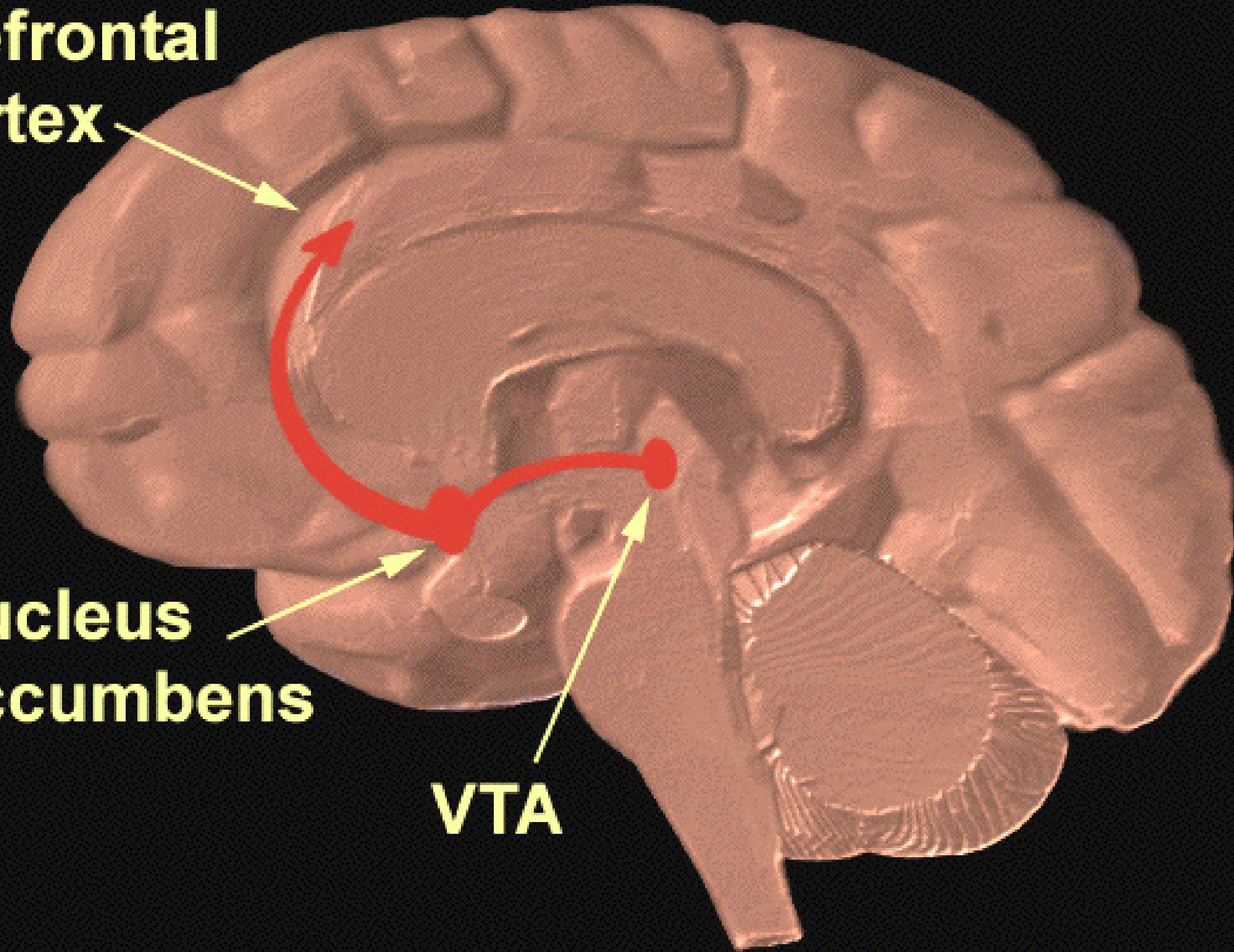
Why Study the Brain of Drug Abusers

- We don't know how much of the damage drugs do is permanent.

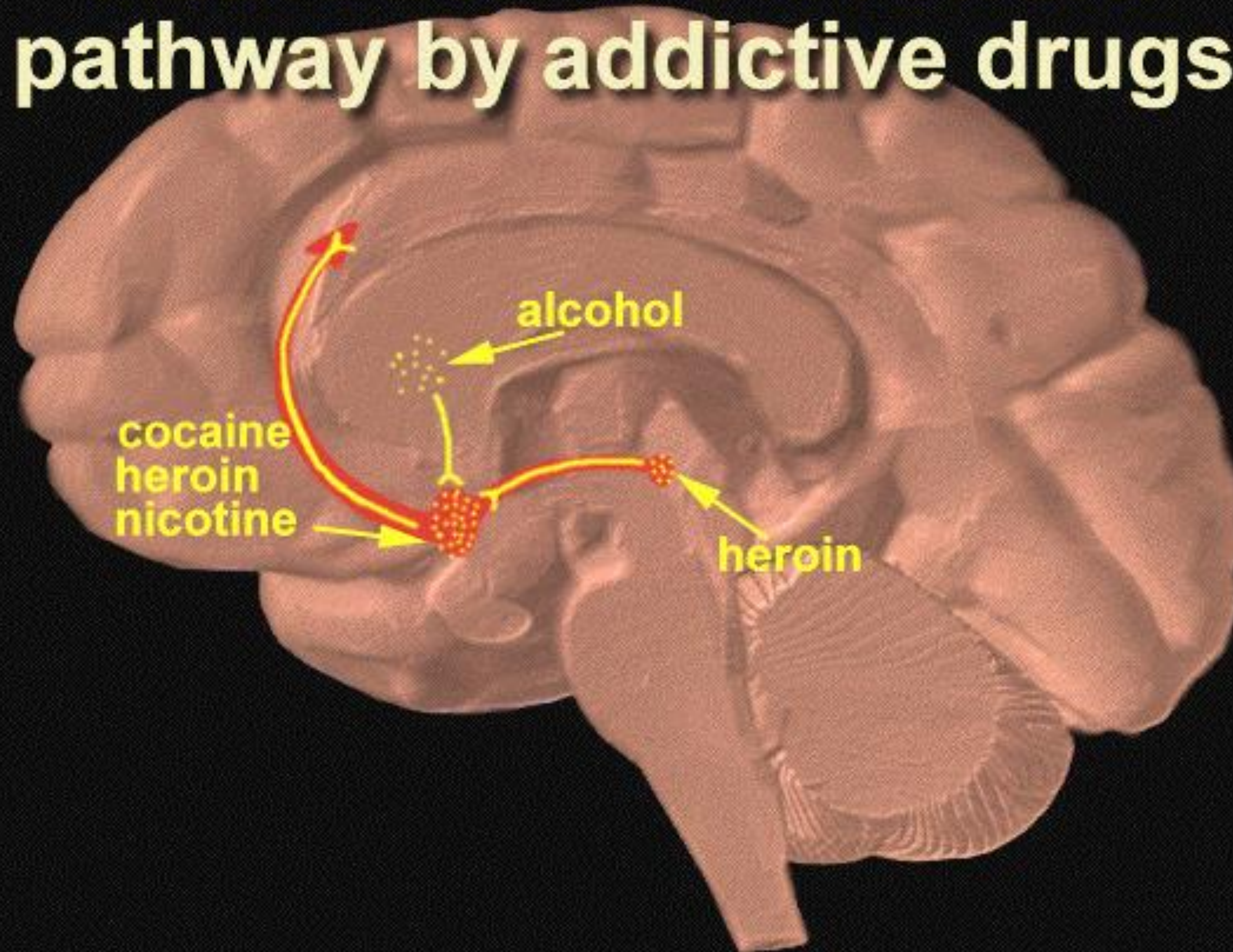
- We do Know: Methamphetamine abusers abstinent for a long period— 6 to 12 months—their dopamine transporter levels started to improve. This suggests that if you stop using the drug for long enough, the brain cells can actually recover.

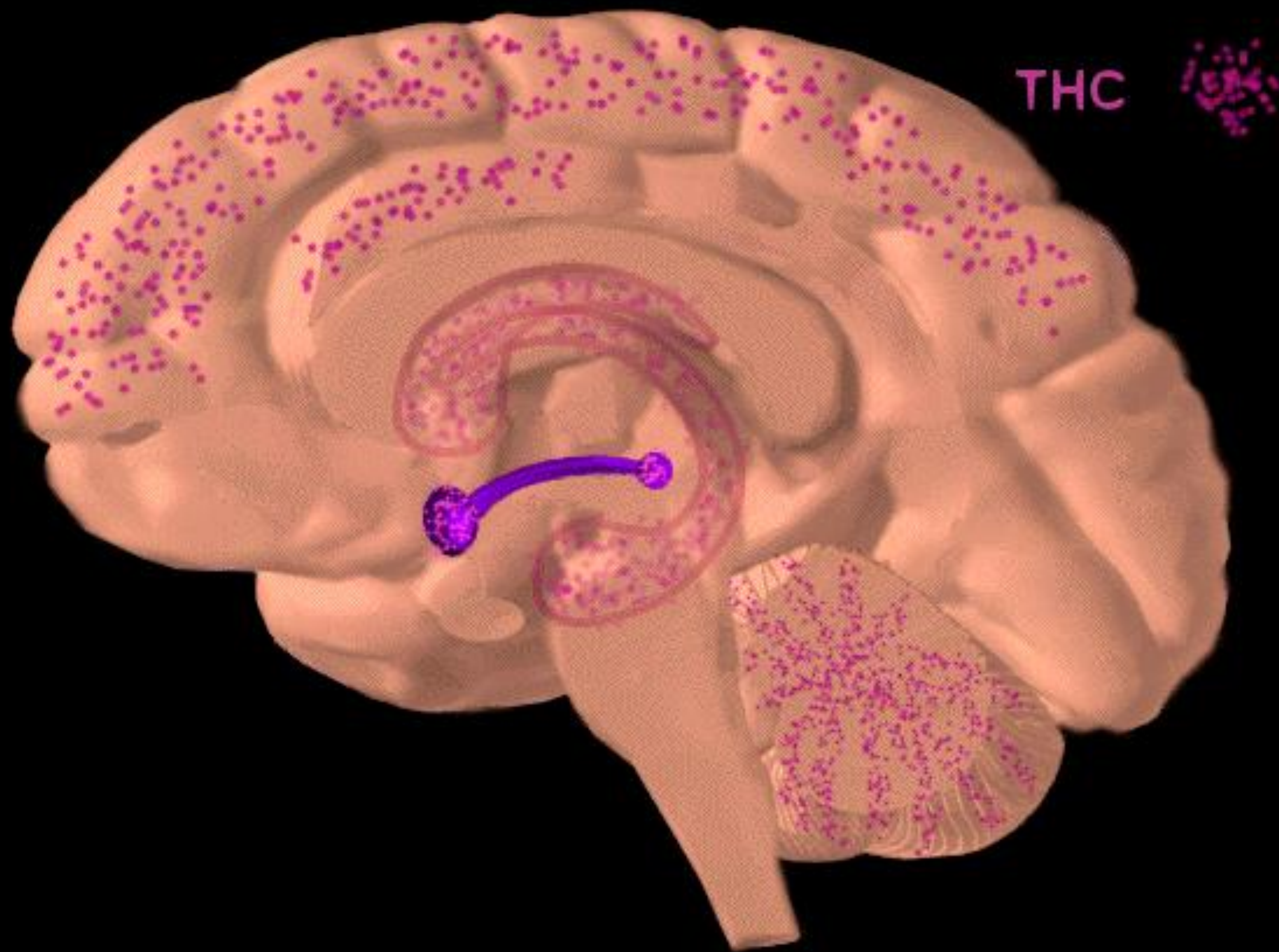
  (Linda Chang, 2007)

HOW DO SUBSTANCES IMPACT THE BRAIN

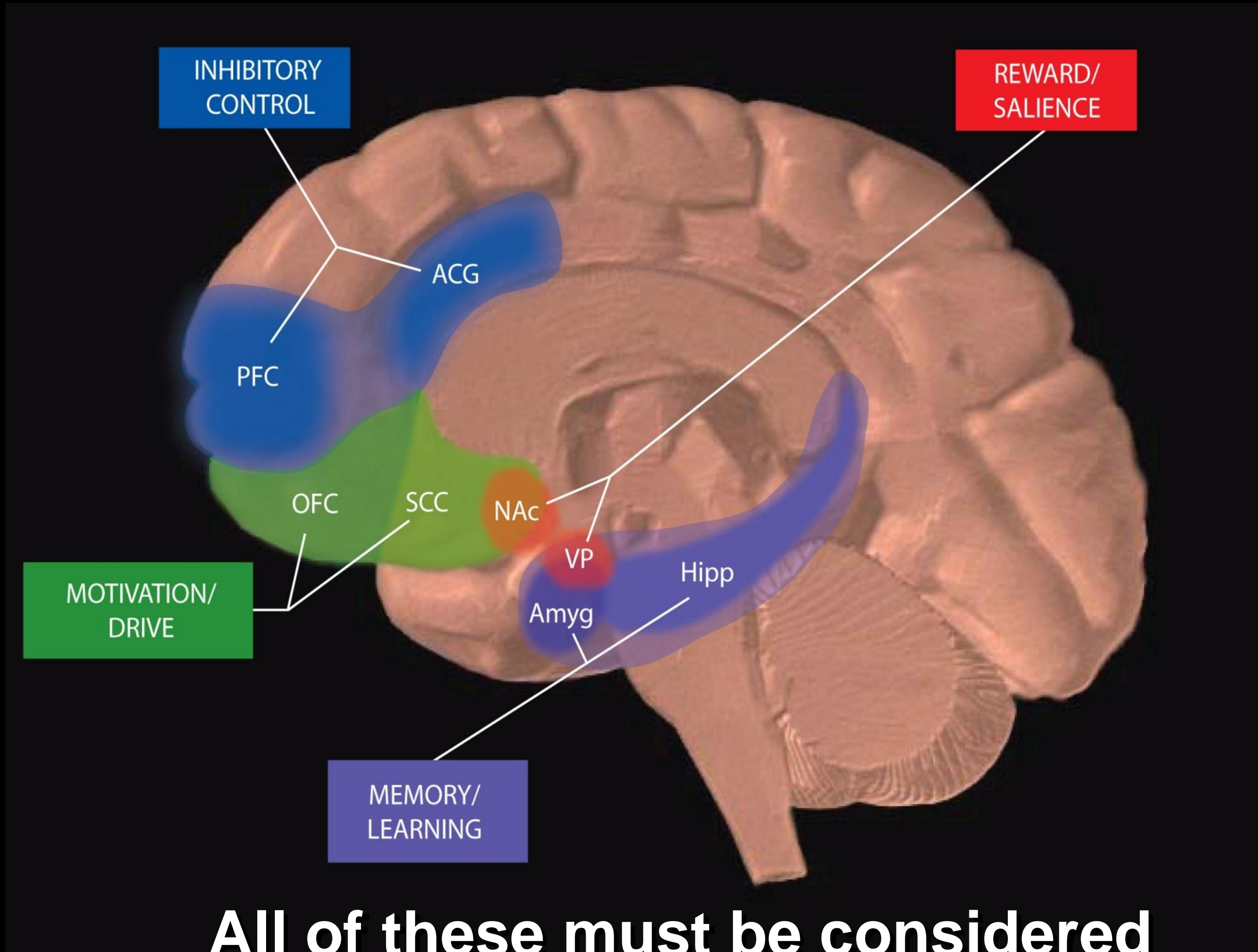

prefrontal cortex
nucleus accumbens
VTA

Activation of the reward pathway by addictive drugs




THC

Circuits Involved In Drug Abuse and Addiction



All of these must be considered in developing strategies to effectively treat addiction

movement

sensations

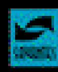
vision

judgement

reward

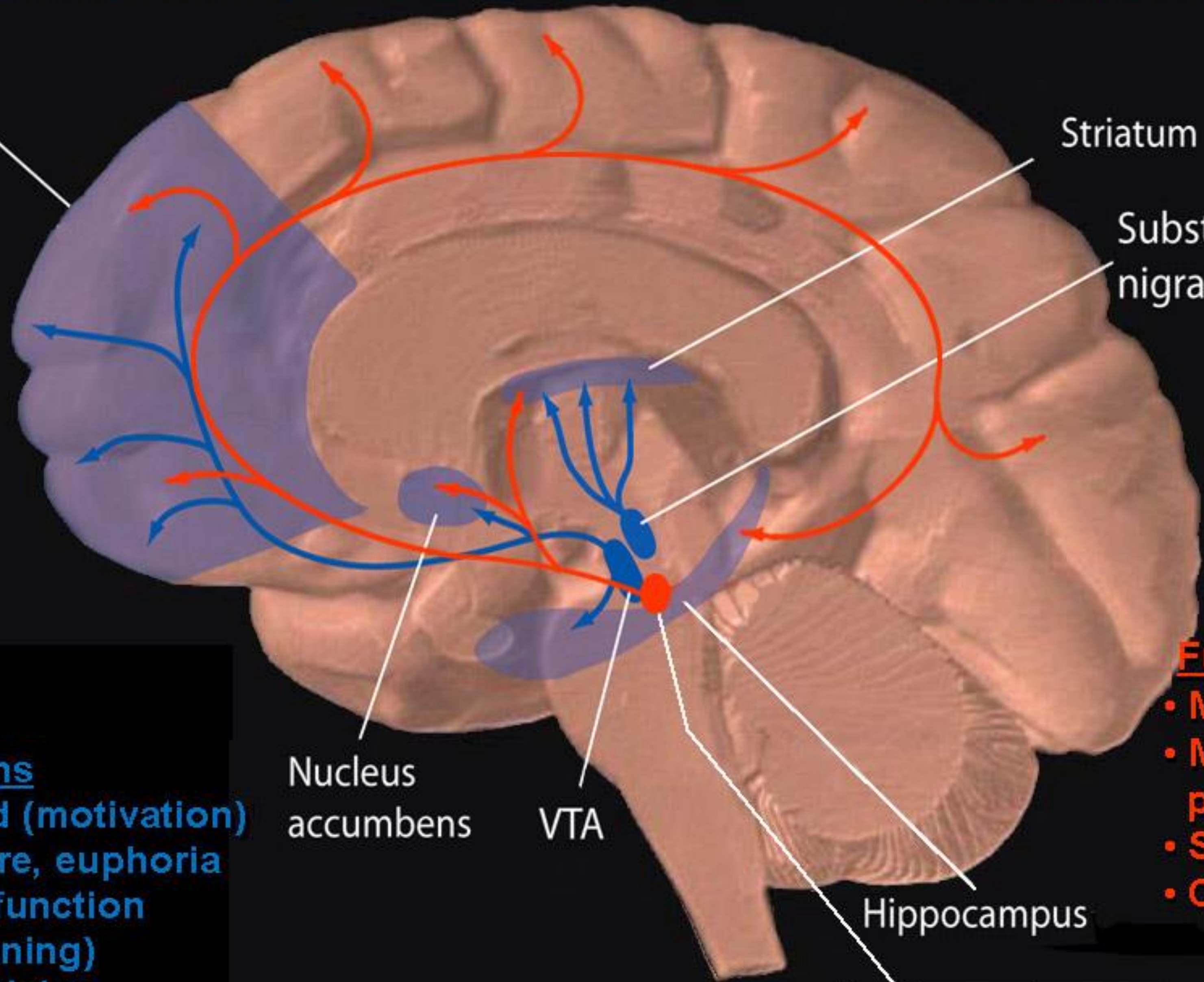
memory

coordination



Dopamine Pathways

Serotonin Pathways

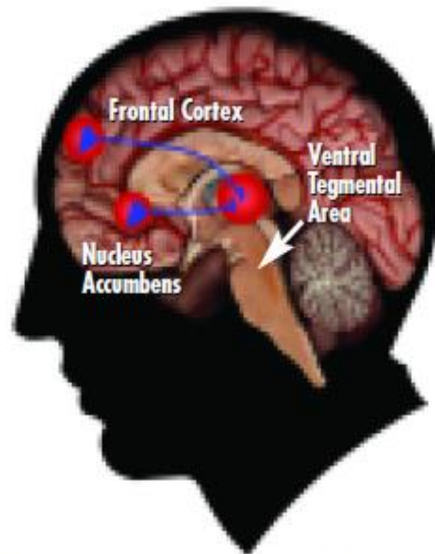


Functions
- Reward (motivation)
- Pleasure, euphoria
- Motor function (fine tuning)
- Compulsion
- Perseveration

Functions
- Mood
- Memory processing
- Sleep
- Cognition

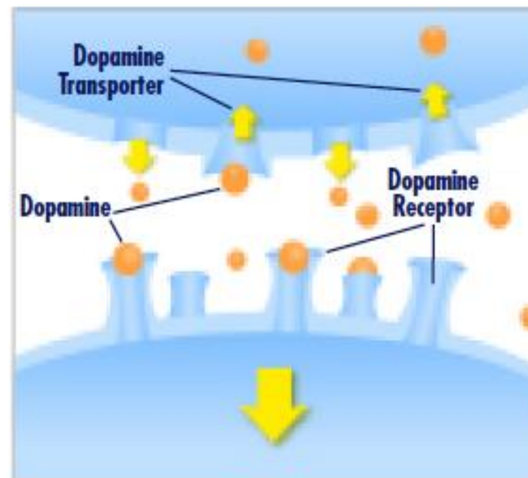
DRUGS OF ABUSE TARGET THE BRAIN'S PLEASURE CENTER

Brain reward (dopamine) pathways

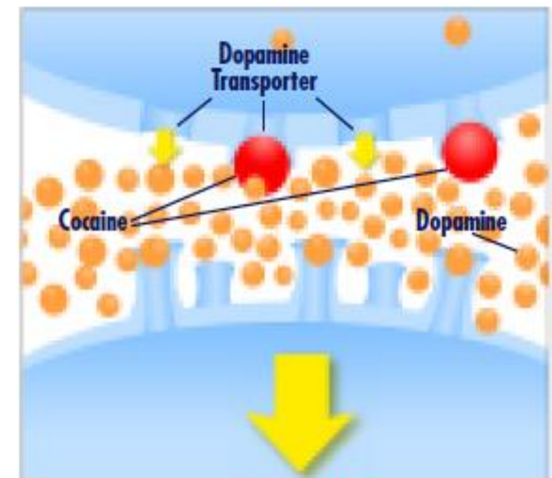


These brain circuits are important for natural rewards such as food, music, and sex.

Drugs of abuse increase dopamine



FOOD



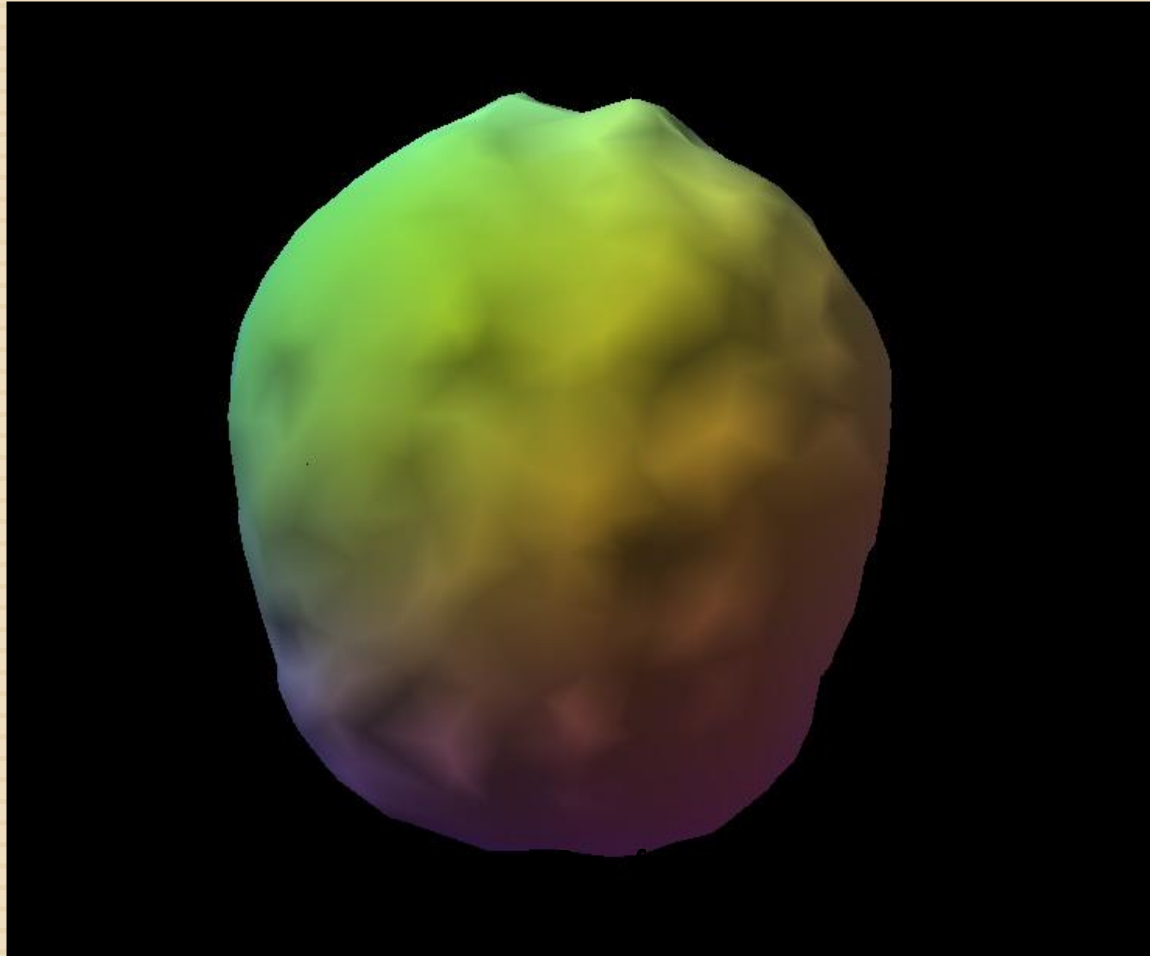
COCAINE

Typically, dopamine increases in response to natural rewards such as food.
When cocaine is taken, dopamine increases are exaggerated, and communication is altered.

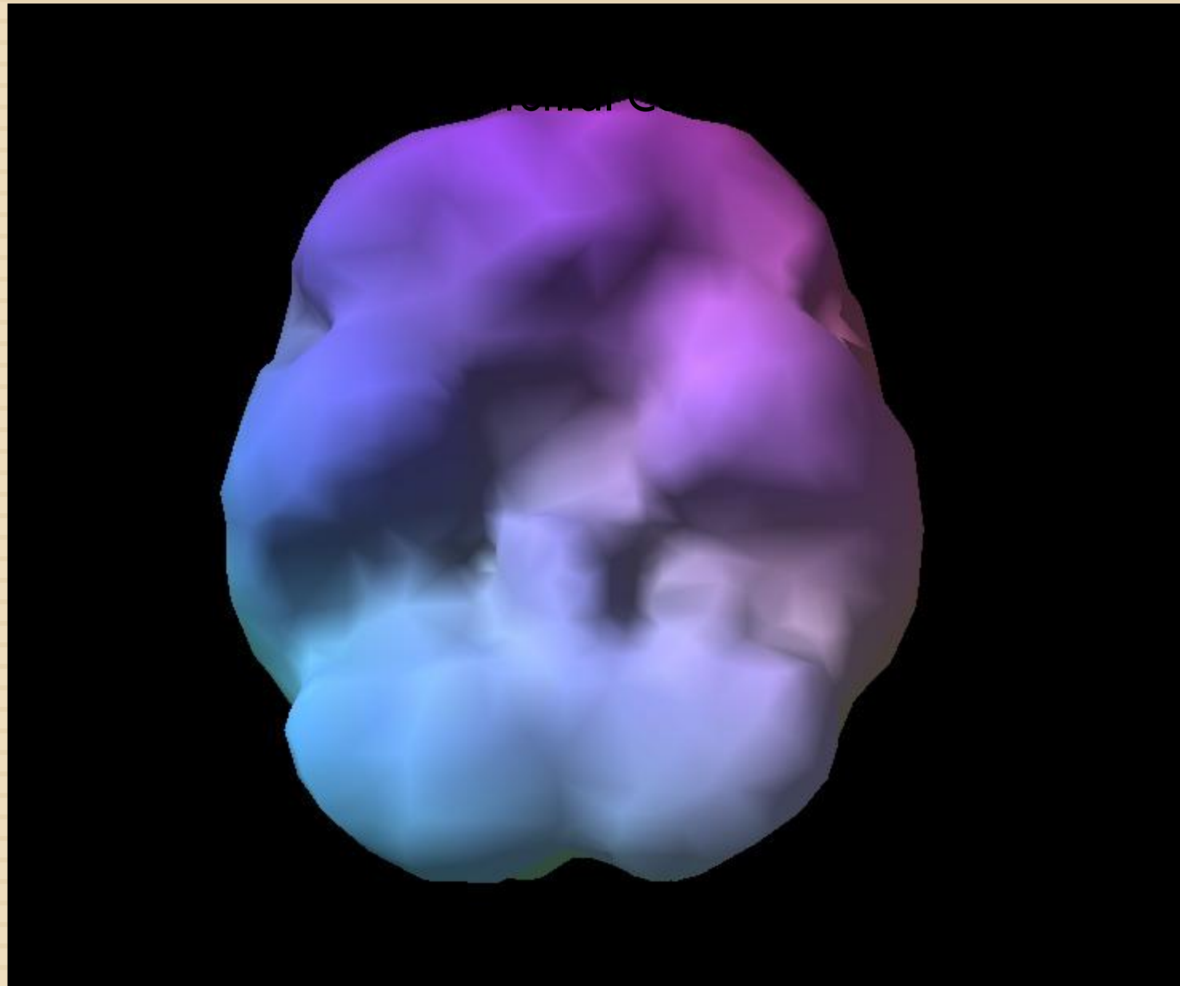
Brain Imaging

- What is SPECT?
- It is an acronym for Single Photon Emission Computerized Tomography
- Nuclear medicine method to study cerebral blood flow and indirectly at brain activity (or metabolism).
- A radioactive isotope is bound to a substance that is readily taken up by the cells in the brain

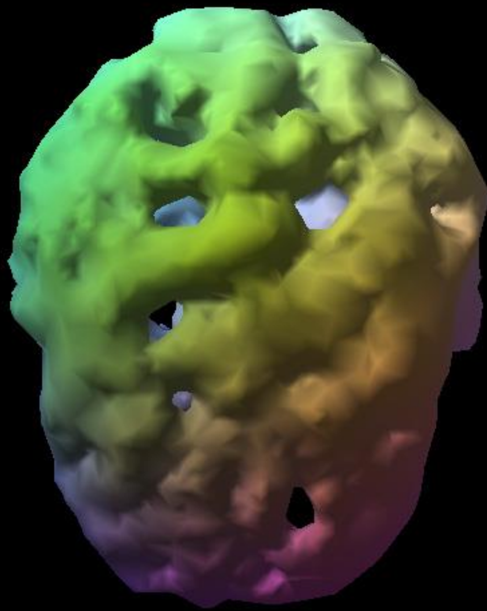
Normal Top View

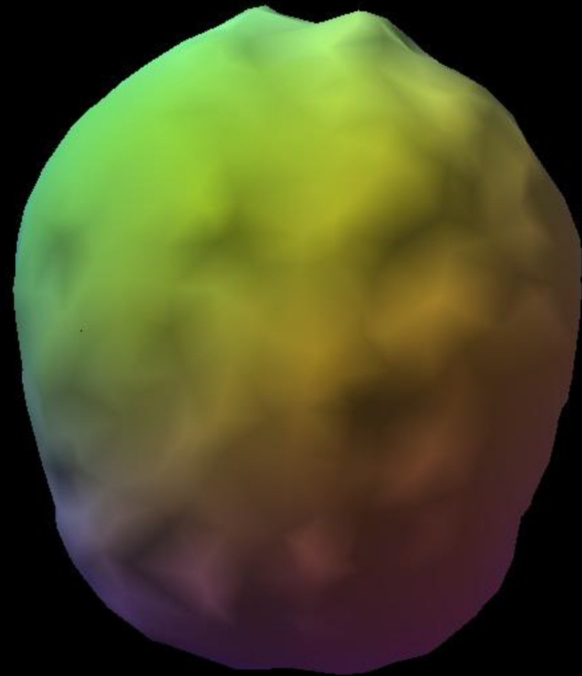


Normal Under Side

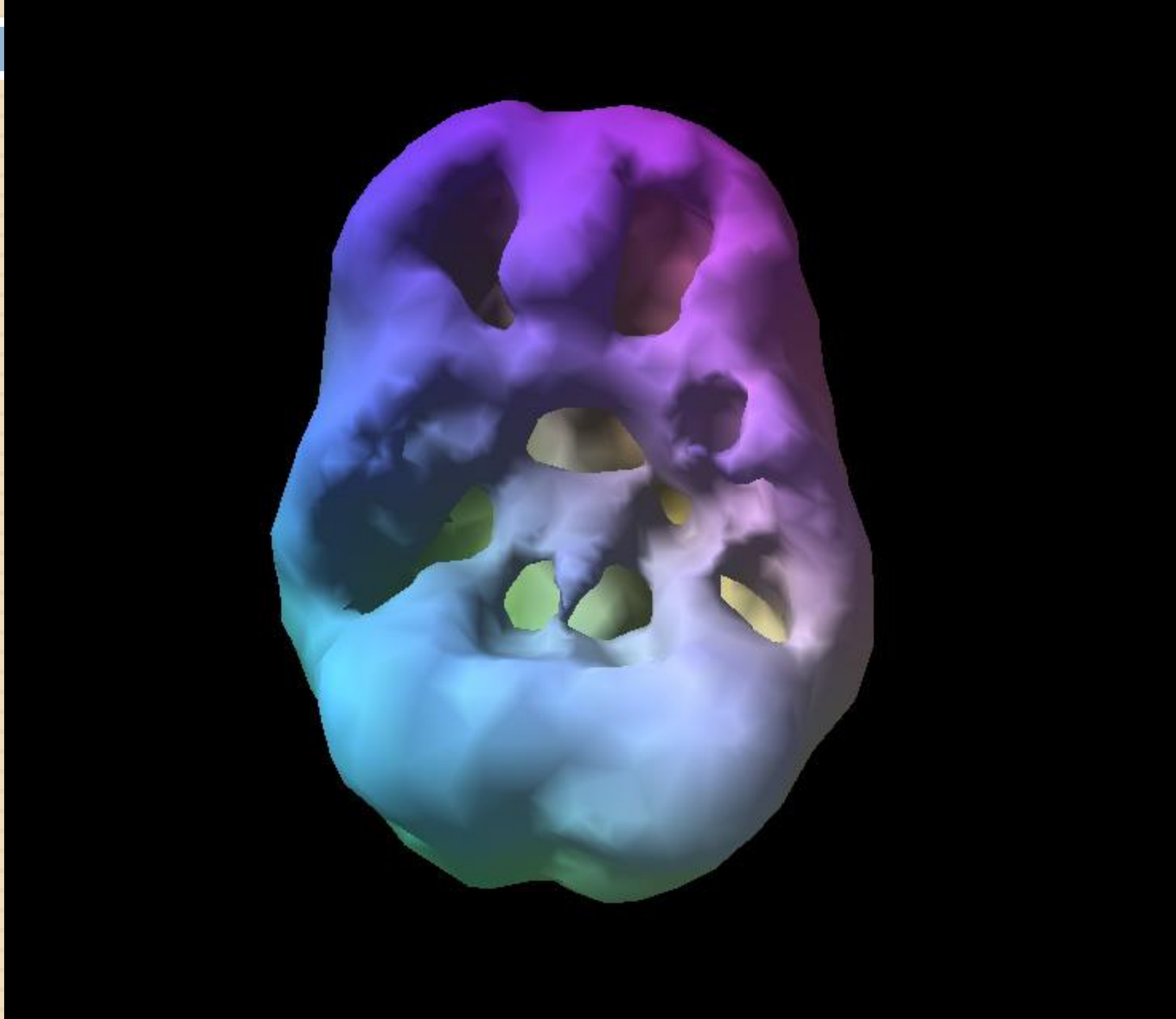


Use VS Non Use

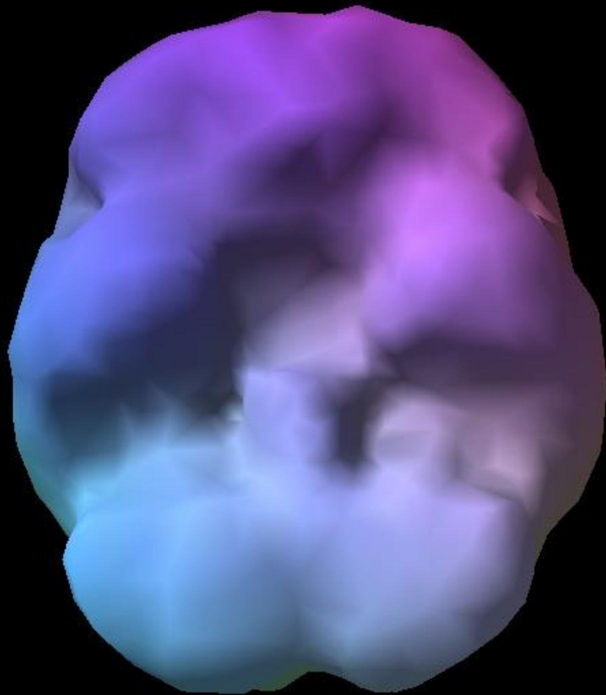


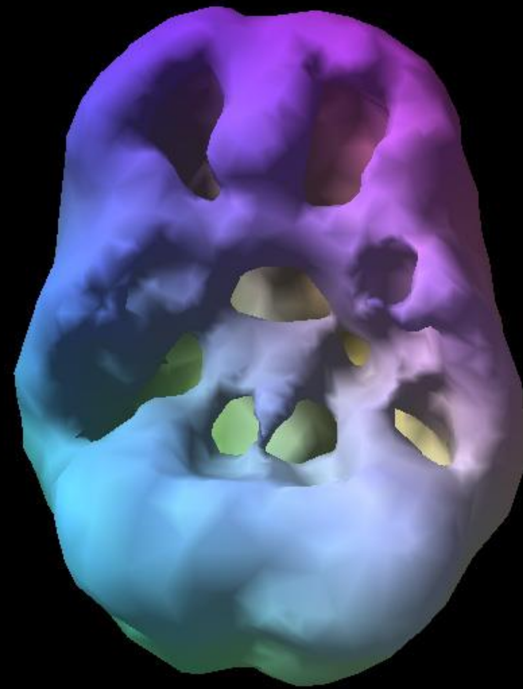


Marijuana: 16 year Old 3yrs Weekly Use

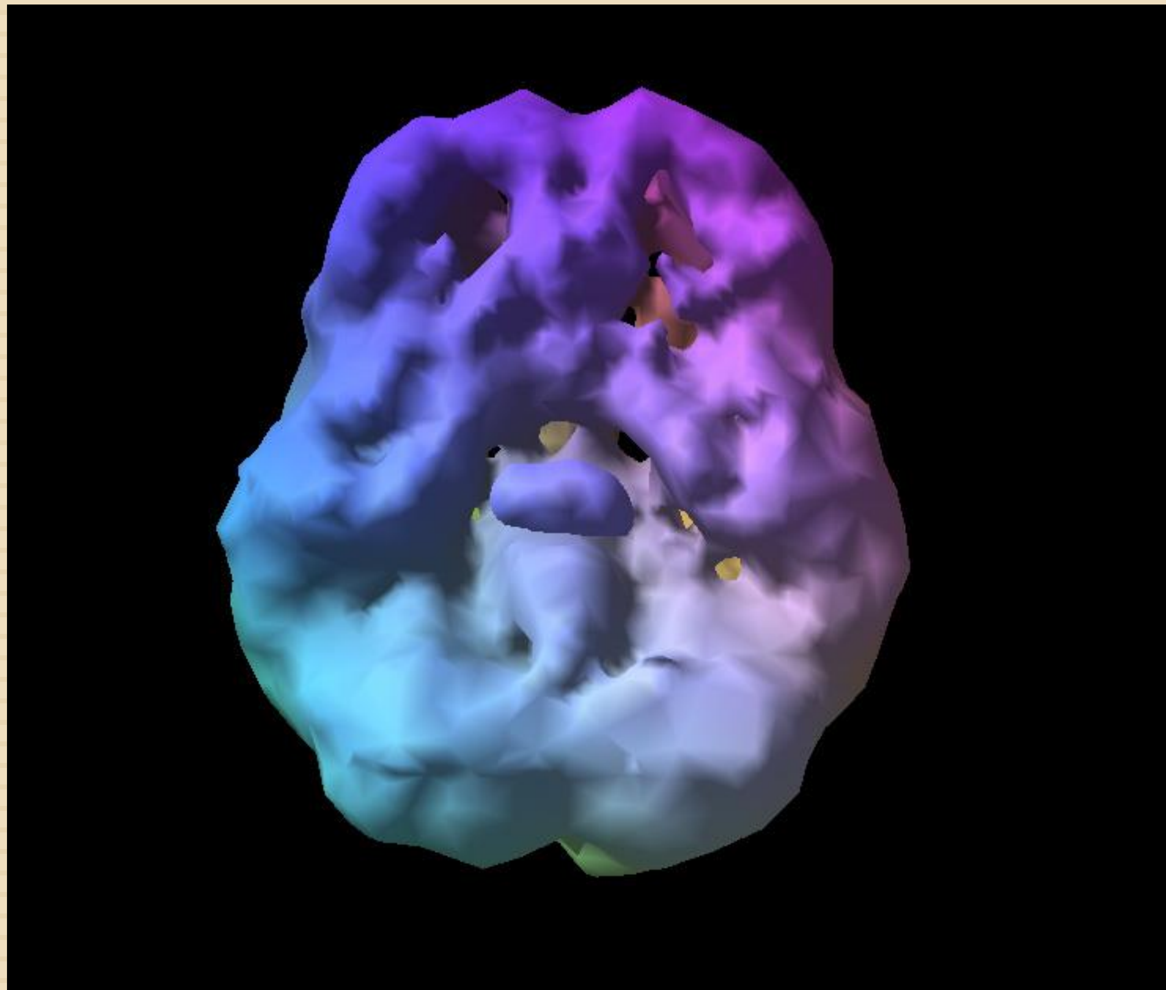


Normal Vs Marijuana User

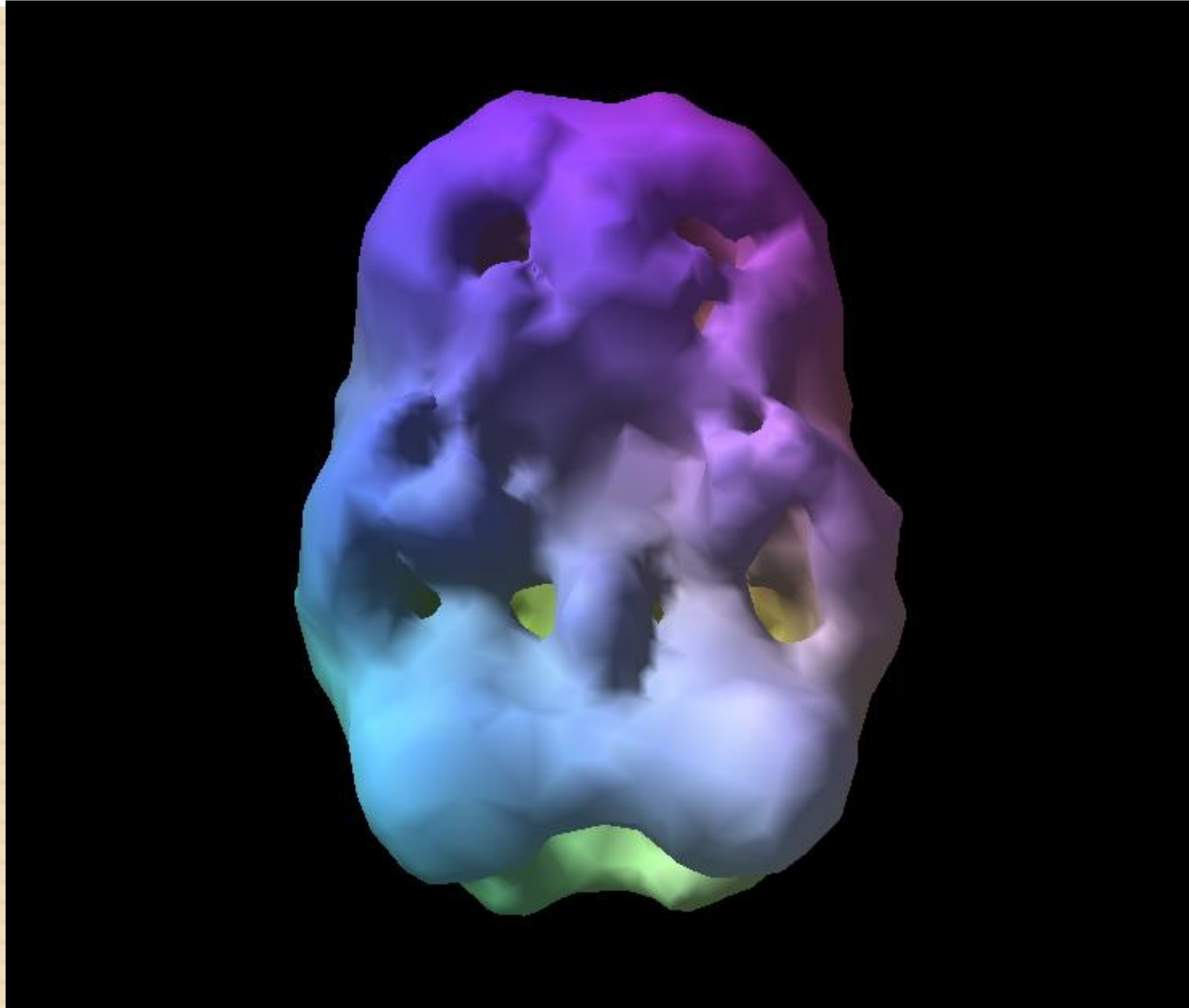




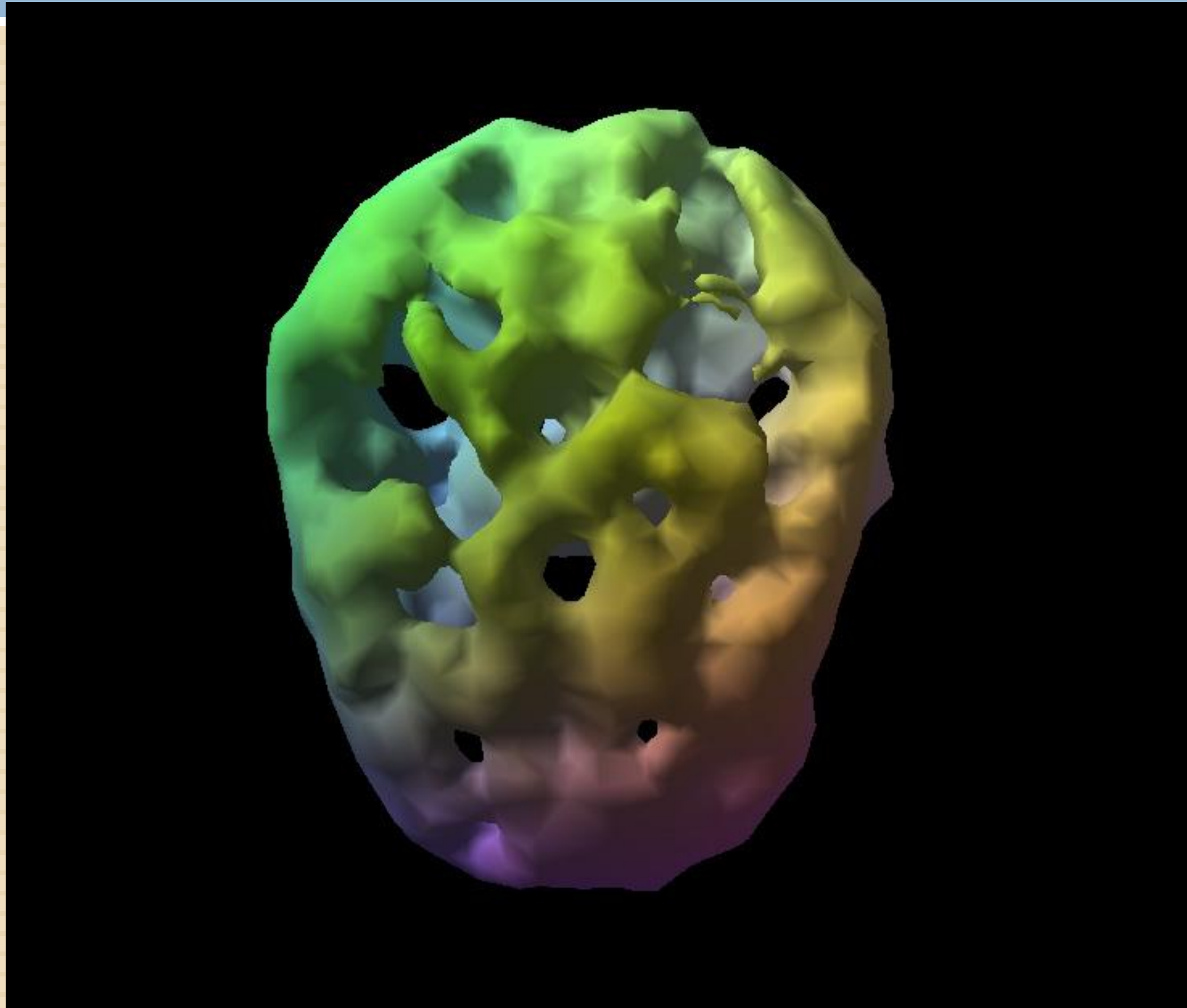
Marijuana: 28 year old 10yrs weekend use



Alcohol: 45 year old 22 yrs daily use



Alcohol: 38 year old 17 yrs weekend use



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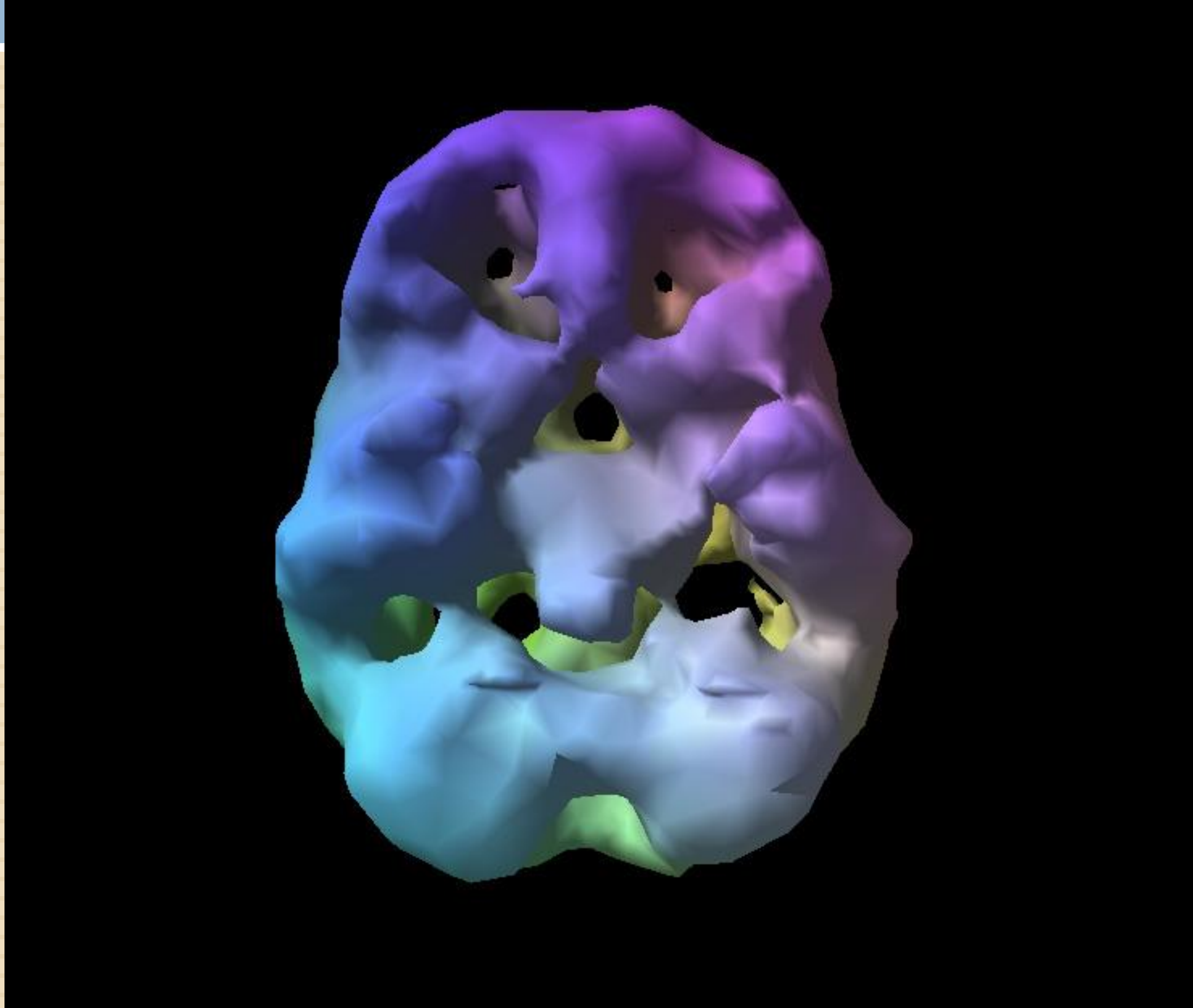
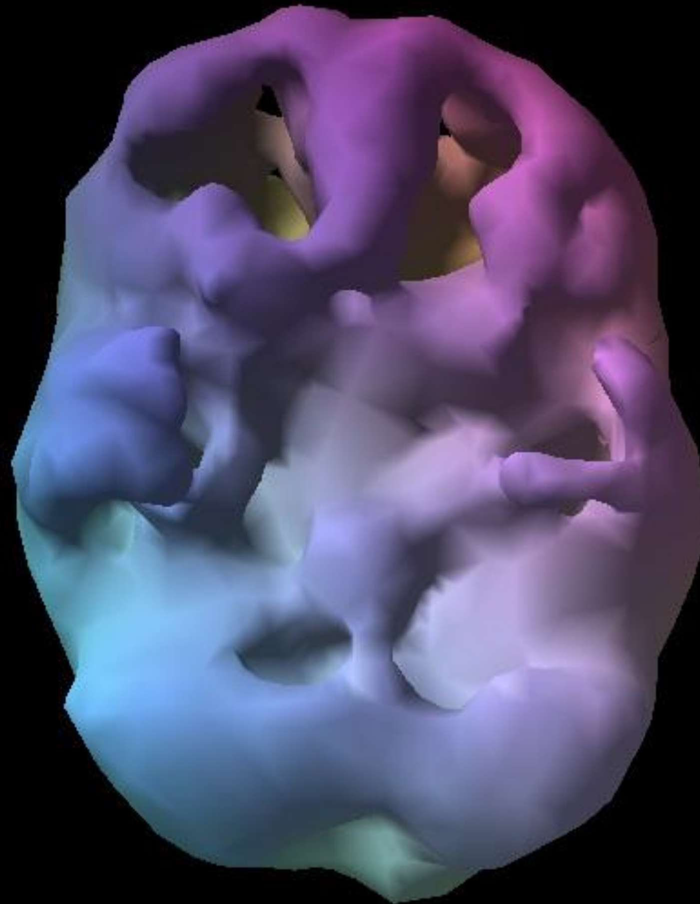
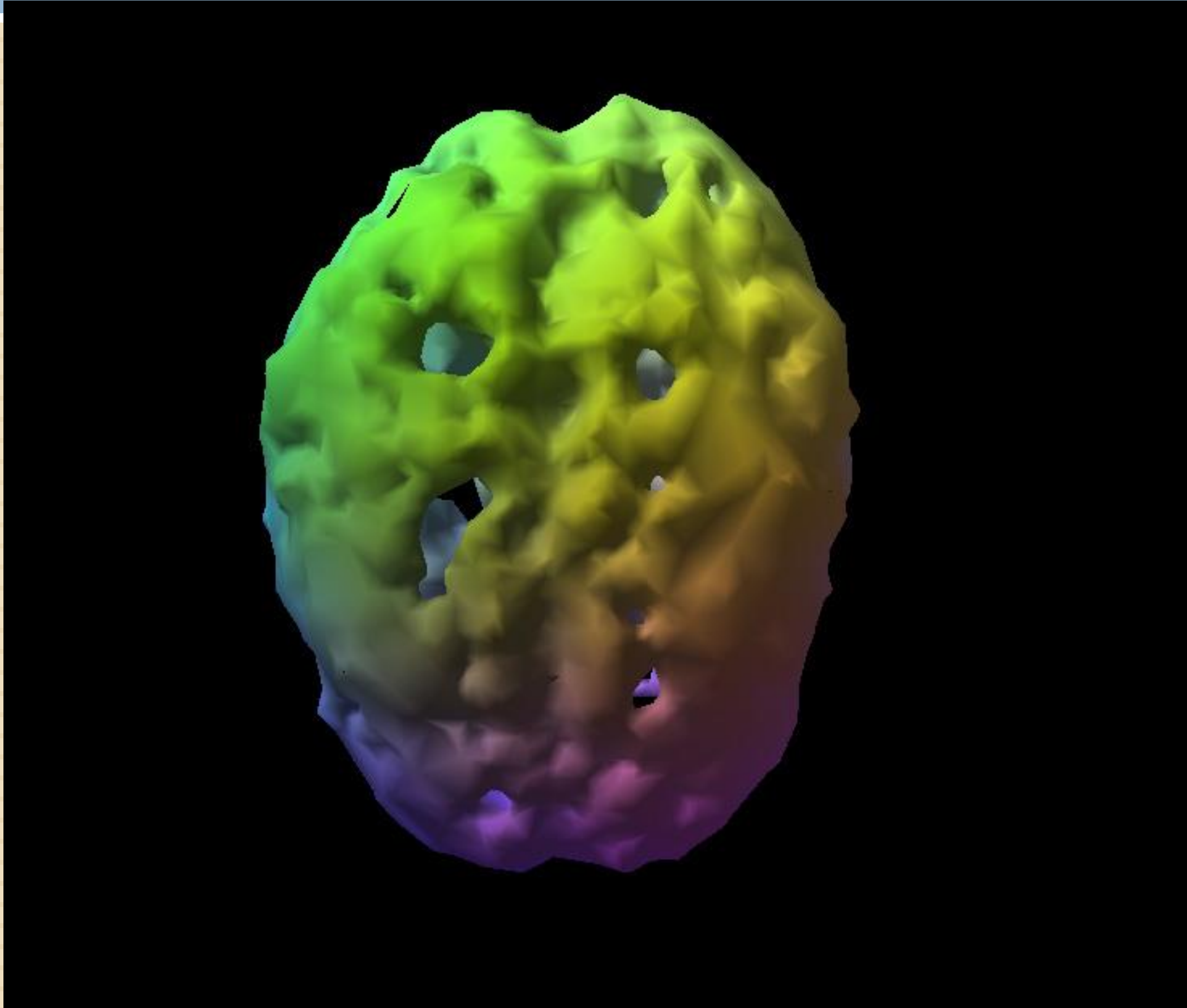


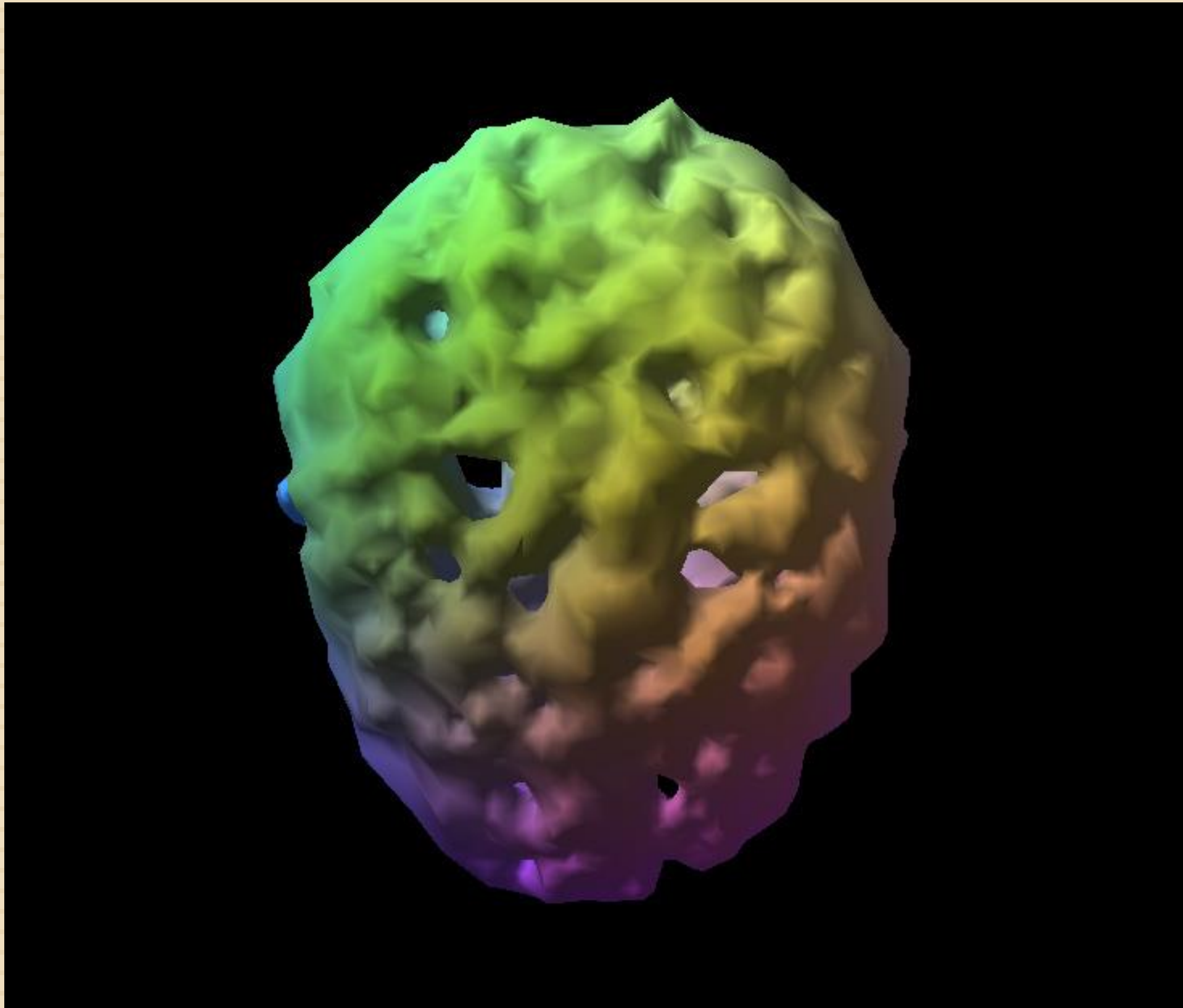
Alcohol: 44 year old 18 yrs daily use



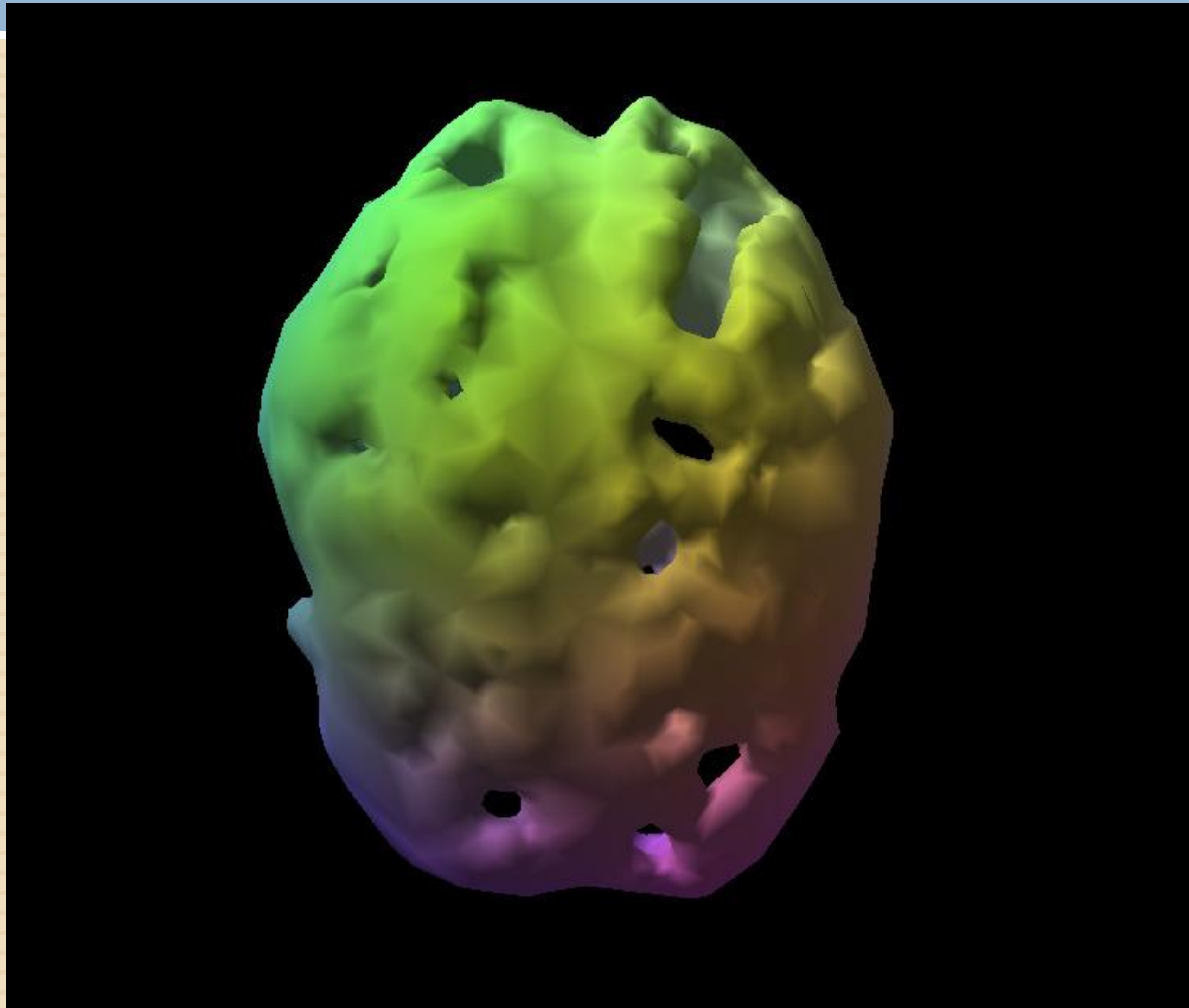
Cocaine: 24 year old 2 yrs use



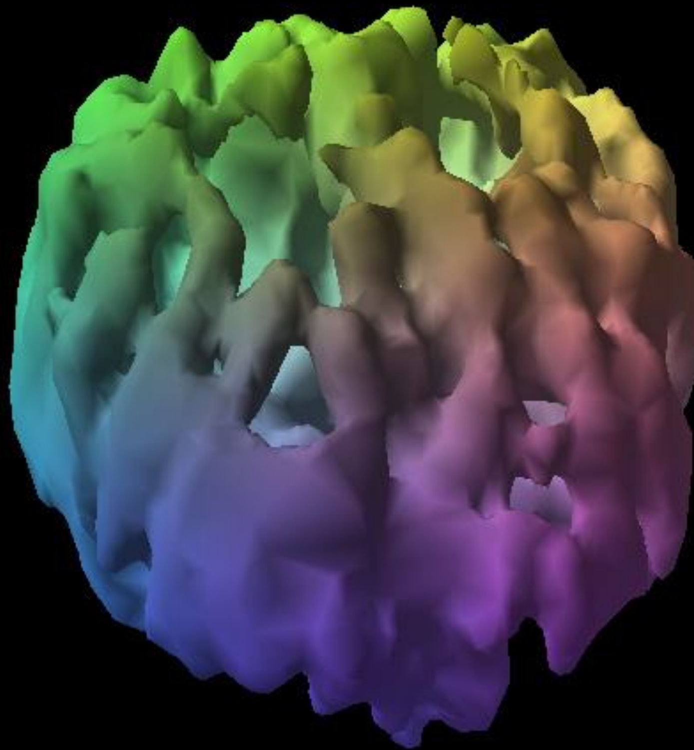
Methamphetamine:28 year old 7 yrs use



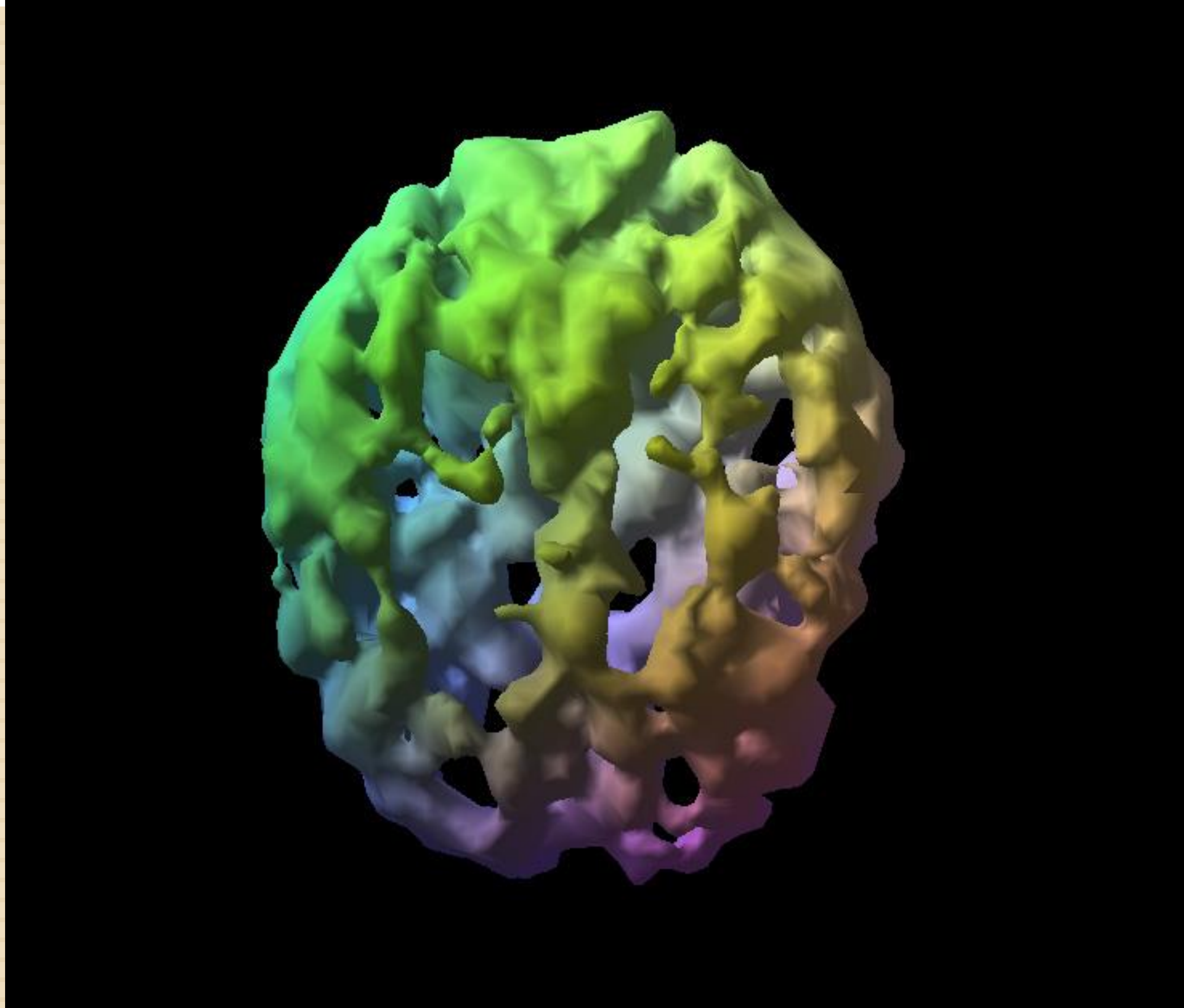
Methamphetamine: 36 year old 10 yrs use



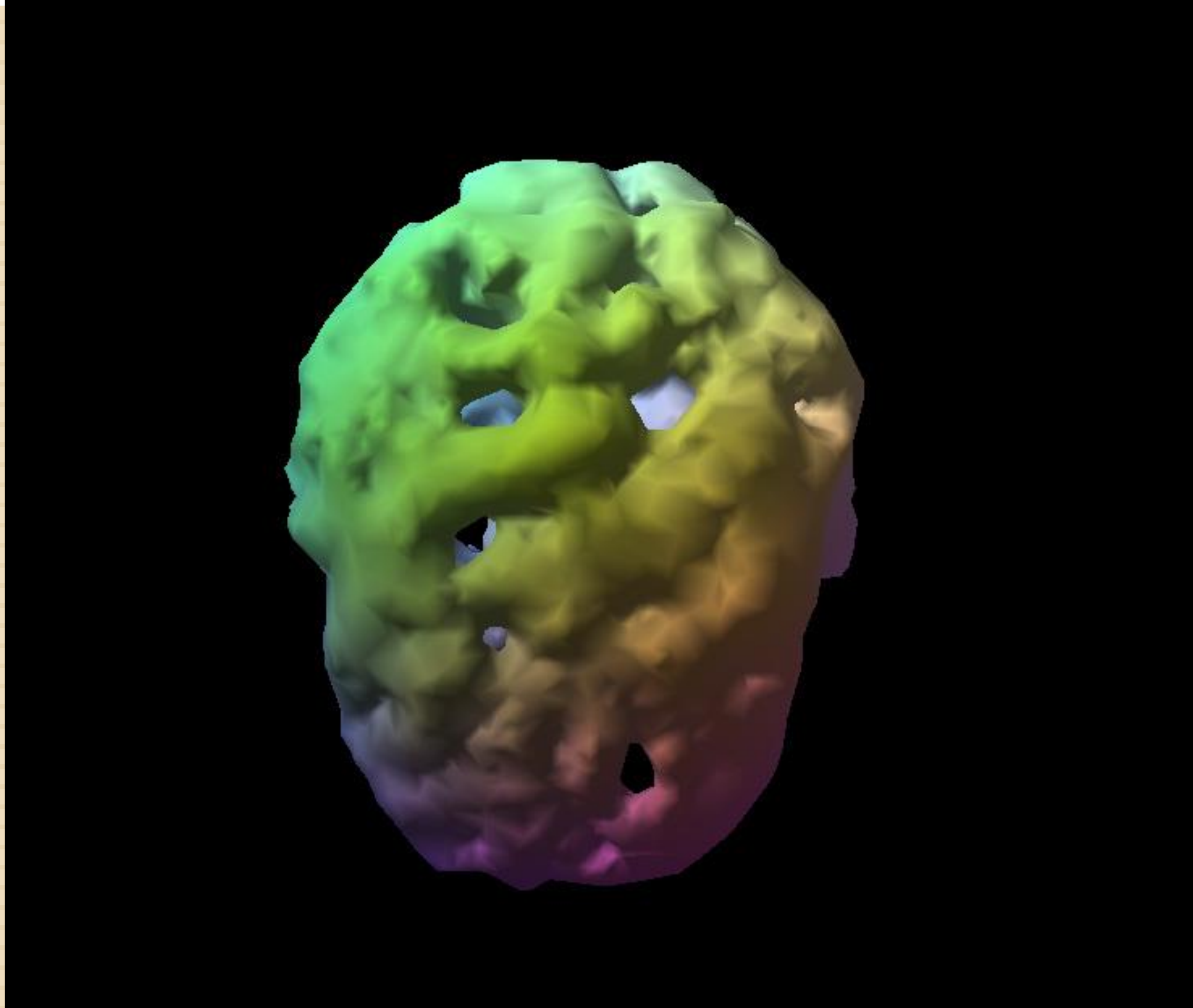
Heroin: 39 year old 25 yrs use



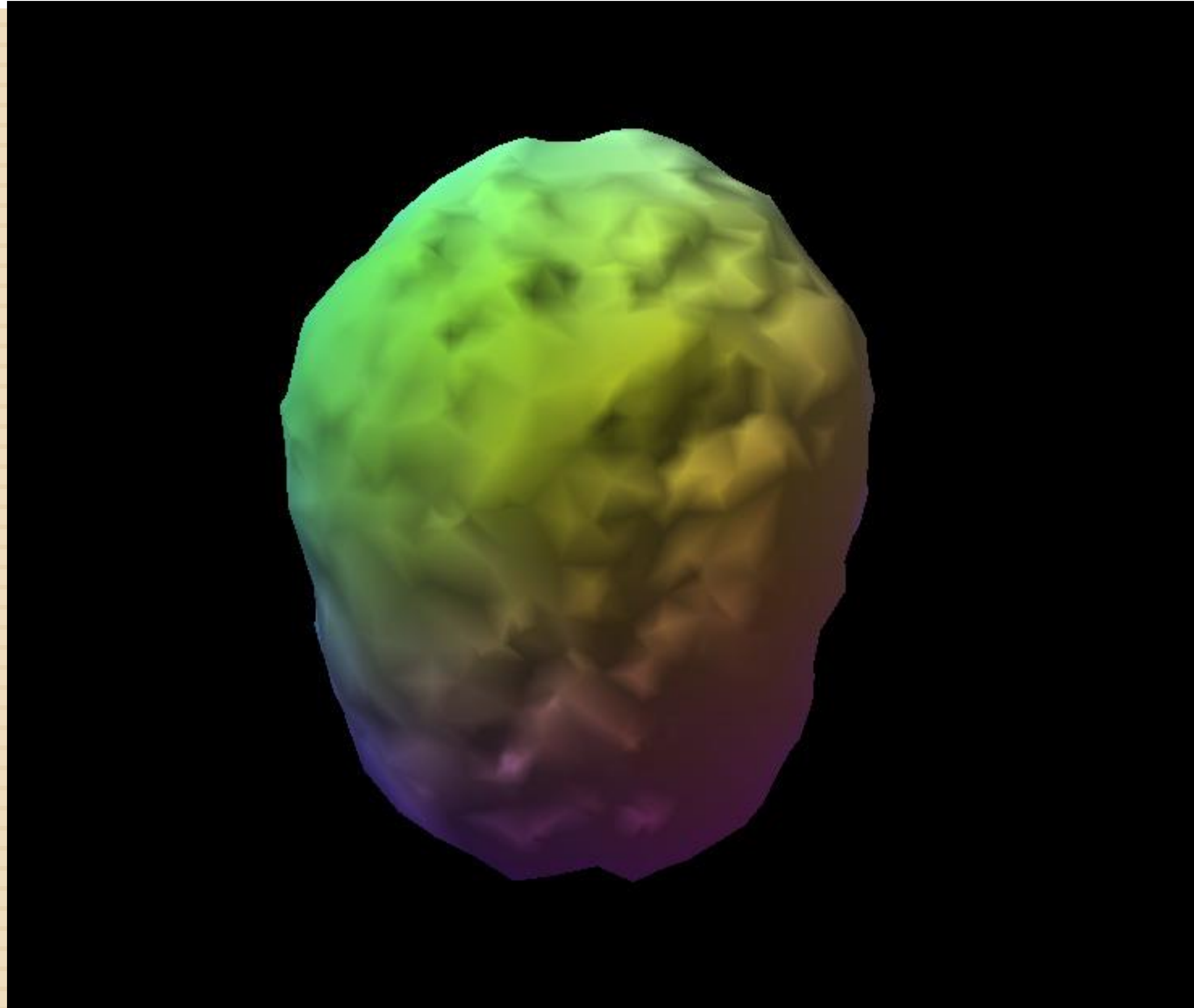
Methadone: 40 year old 7 yrs of use



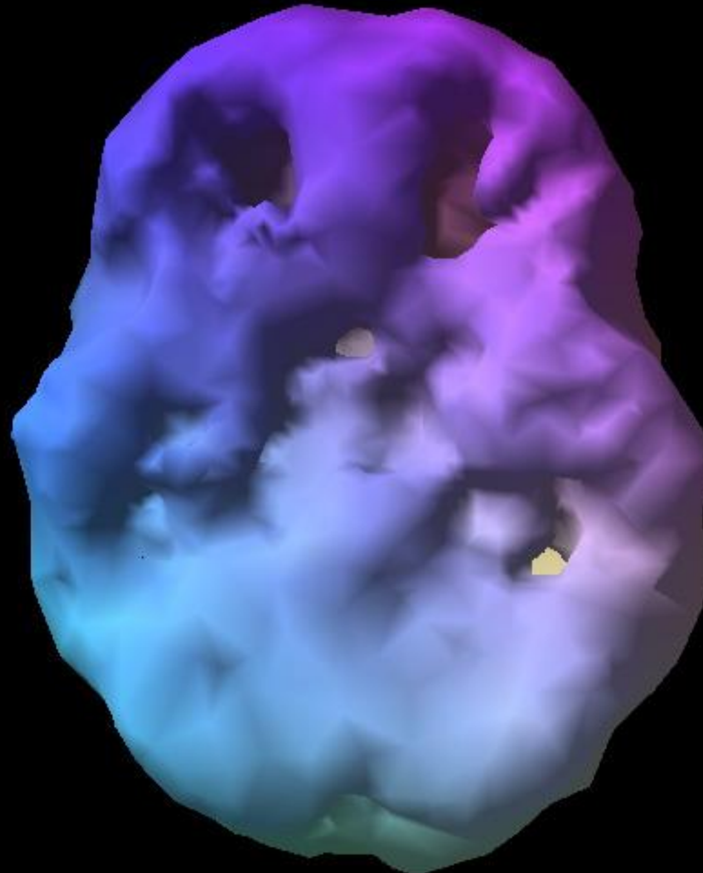
Poly-drug Abuser



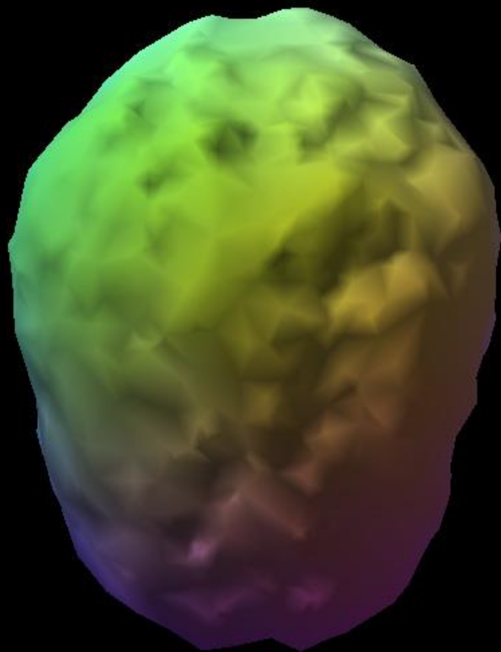
One Year Alcohol and Drug Free

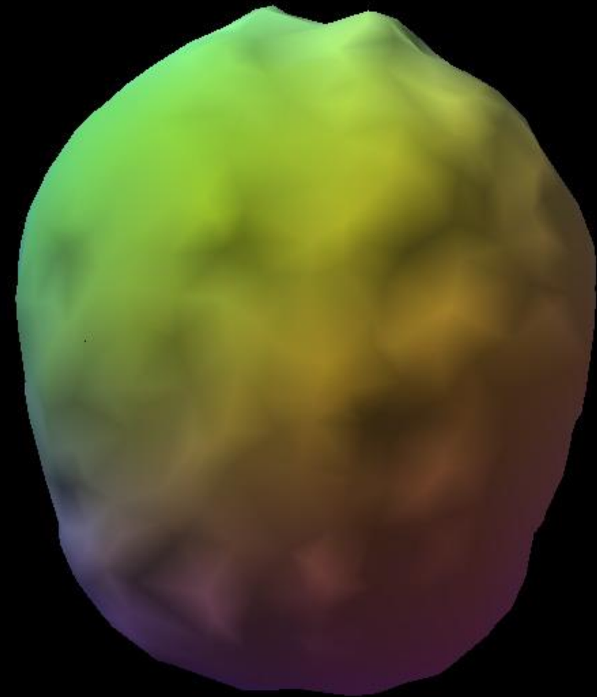


One Year Alcohol and Drug Free

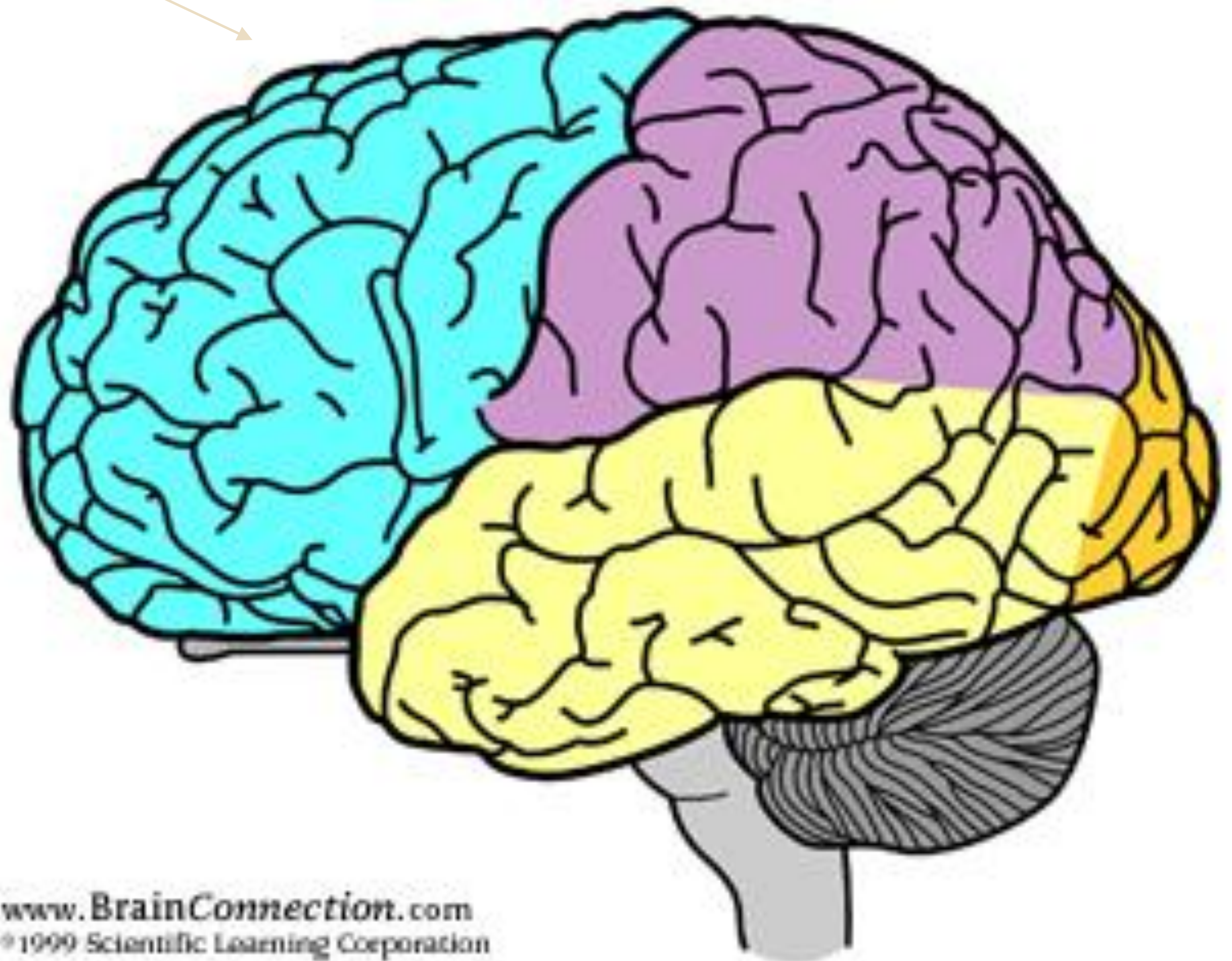


Recovery VS Normal





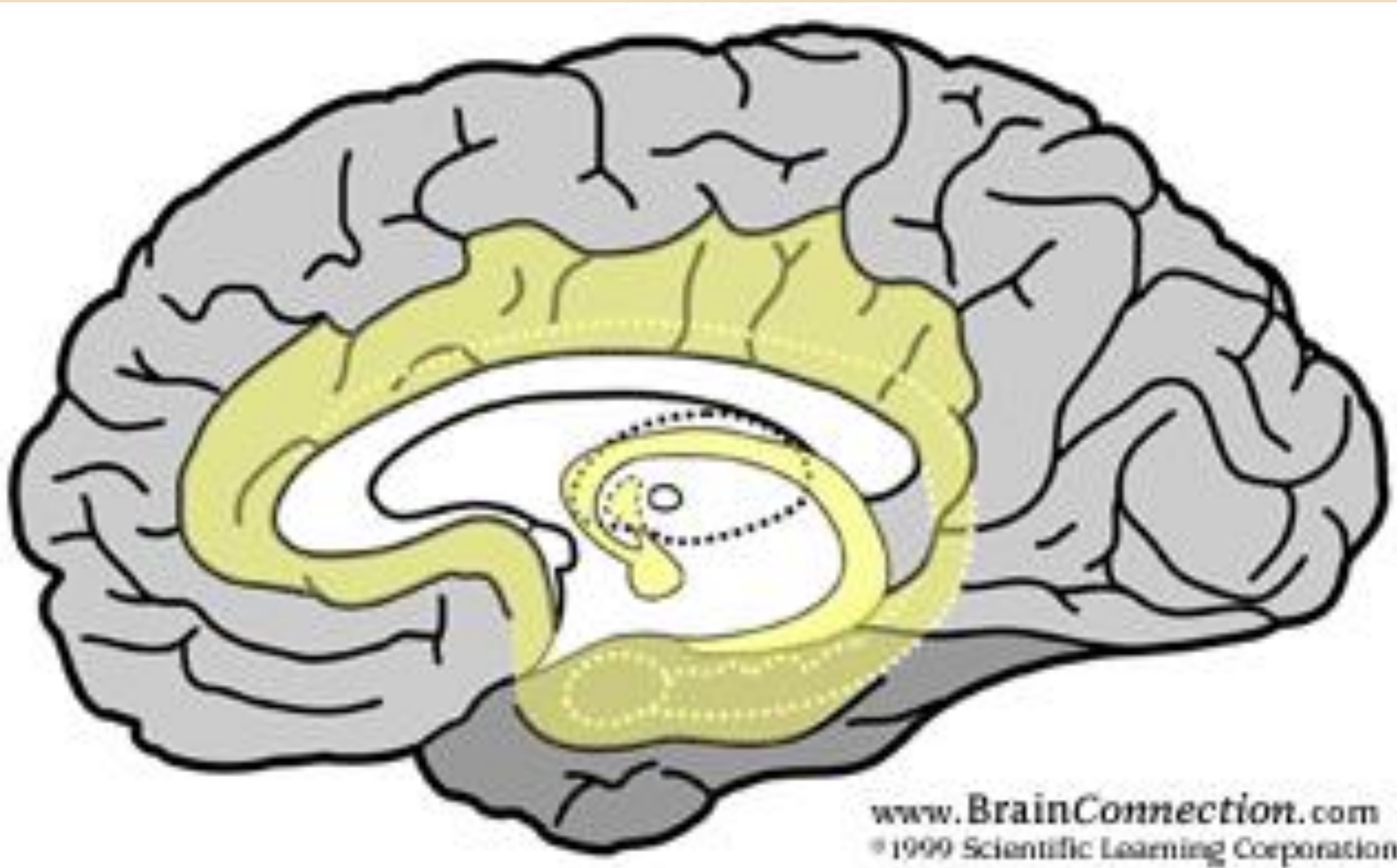
The Prefrontal Cortex



Prefrontal Cortex

FUNCTIONS	PROBLEMS
•Attention Span (focus)	•Short attention span (distractibility)
•Perseverance	•Lack of perseverance
•Impulse Control	•Impulse control problems
•Self Monitoring and Supervision	•Hyperactivity
•Problem Solving	•Chronic lateness and poor time management
•Critical thinking	•Disorganization
•Organization	•Procrastination
•Forward thinking	•Trouble learning from experience
•Learning from experience	•Unavailability of emotions
•Ability to feel and express emotion	•Poor judgment (Misperceptions)
•Judgment (supervisor)	•Short-term memory problems
•Empathy	•Social and test anxiety
•Interaction with limbic system	

The Deep Limbic System



Deep Limbic System

FUNCTIONS	PROBLEMS
•Sets the emotional tone of mind •Filters external events through internal states (emotional color) •Tags events as internally important •Stores highly charged emotional memories •Modulates motivation •Controls appetite & sleep cycles •Promotes bonding •Directly processes sense of smell •Modulates libido	•Moodiness, irritability, clinical depression • Increased negative thinking • Perceive events in a negative way • Decreased motivation • Flood of negative emotions • Appetite and sleep problems • Decreased or increased sexual responsiveness • Social isolation

Basal Ganglia

Basal Ga

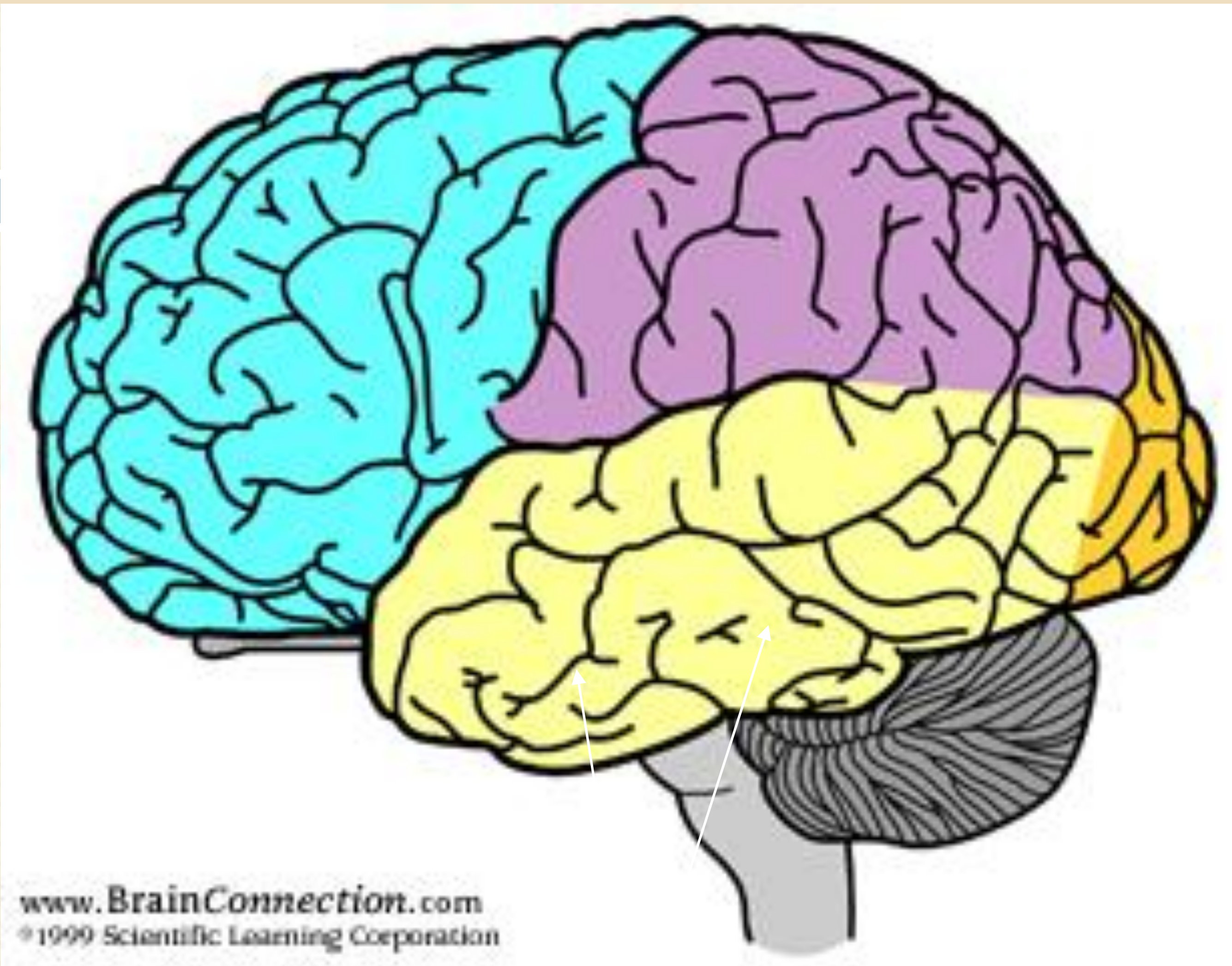
Basal Ganglia

FUNCTIONS	PROBLEMS
•Integrates feeling & movement • Shifts and smoothes fine motor behavior • Suppression of unwanted motor behaviors • Sets the body's idle or anxiety level • Enhances motivation • Pleasure/ecstasy	• Anxiety, nervousness • Panic attacks • Physical sensations of anxiety • Tendency to predict the worst (awfulizing) • Conflict avoidance • Muscle tension, soreness • Tremors • Fine motor problems • Headaches • Low or excessive motivation

Cingulate Gyrus

Cingulate Gyrus

FUNCTIONS	PROBLEMS
•Allows shifting of attention •Cognitive flexibility •Adaptability •Helps the mind move from idea to idea •Gives the ability to see options •Helps you go with the flow •Cooperation	•Worrying •Holds onto hurts from the past •Stuck on thoughts (obsessions) •Stuck on behaviors (compulsions) •Oppositional behavior, argumentative •Uncooperative, tendency to say no •Addictive behaviors •Cognitive inflexibility •OCD spectrum disorders •Eating disorders, road rage



Temporal Lobes

Temporal Lobes Functions

Non-dominant Side (usually the right)

FUNCTIONS	PROBLEMS
•Recognizing facial expression •Decoding vocal intonation •Rhythm •Music •Visual learning	•Difficulty recognizing facial expression •Difficulty decoding vocal intonation •Implicated in social skill struggles

Temporal Lobes Problems

- **Either/Both Temporal Lobe Problems**
- Memory problems, amnesia
- Headaches or abdominal pain without a clear explanation
- Anxiety or fear for no particular reason
- Abnormal sensory perceptions, visual or auditory distortions
- Feelings of déjà vu or jamais vu
- Periods of spaciness or confusion
- Religious or moral preoccupation
- Hypergraphia, excessive writing
- Seizures

Problems With Either or Both Temporal Lobes

- Periods of spaciness or confusion
- Religious or moral preoccupation
- Excessive writing
- Seizures

Brain Regions and Drug Effects

BASIL GANGLIA

Anxiety, nervousness

Panic attacks

Awfulizing

Conflict avoidance

Muscle soreness

Headaches

PREFRONTAL CORTEX

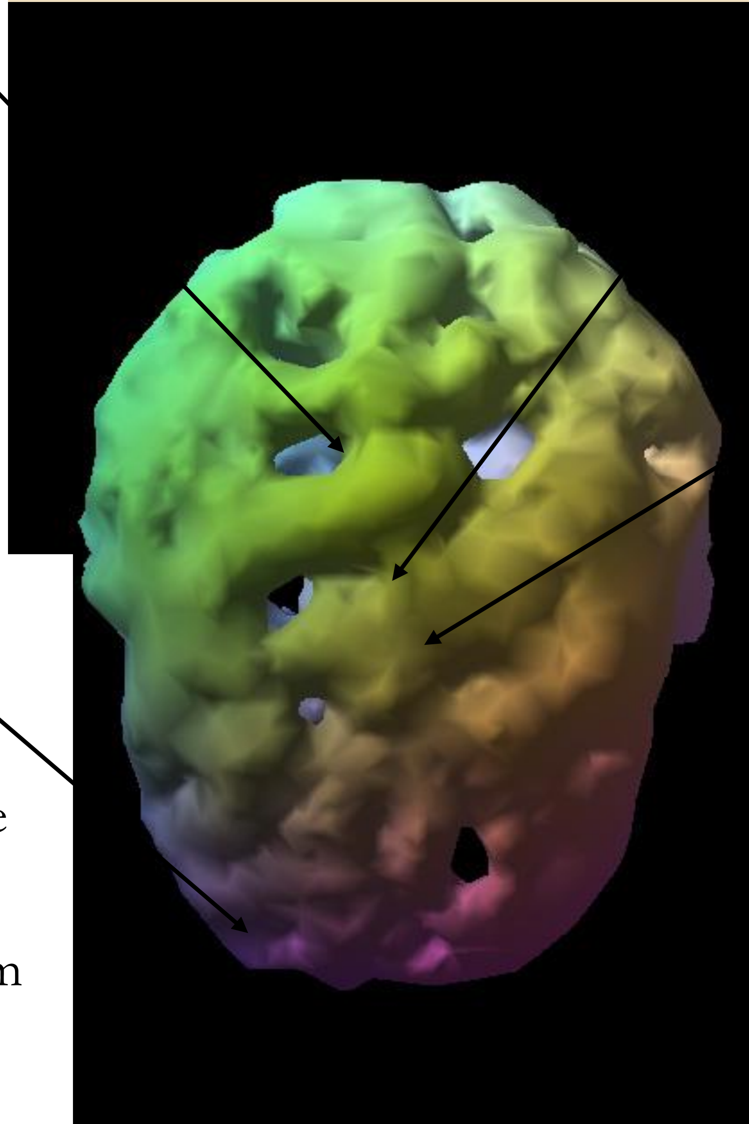
Short attention span

Lack of perseverance

Chronic lateness a

Trouble learning from experience

Poor judgment (Misperceptions)



LIMBIC REGION

Moodiness, irritability, clinical depression

Flood of negative emotions

Social isolation

CINGULATE GYRUS

Worrying

Holds onto hurts

Obsessions/Compulsions

Oppositional behavior

Argumentative

TEMPORAL LOBES

Aggression

Dark or violent thoughts

Sensitivity to slights, mild paranoia

Emotional instability

Traditional Treatment Design

Notice how the flow is most intensive during period of greatest impairment

Group, individual, lectures, long writing assignments during period of poorest brain function

Intensive Services in first 2-4 weeks

Less intensive services

Months 1-3

No to little services

Months 6-12

Logic Model View Based on Healing Process

Fewer services with focus on stabilizing behavior
& 12 steps

Weeks 2-6

Increased counseling services with focus on problem solving
More Step Work

Months 1-3

Introduction of more intensive therapy for issues such as trauma Family Therapy, and Other Emotional or Personality Issues

Months 6-12

Transtheoretical Model of Change

The process someone goes through to obtain a healthier behavior.

The 5 Stages of Change from Alcoholism/Addiction.

- Pre-contemplation Stage
- Contemplation Phase
- Preparation Stage
- Action Stage
- Maintenance Stage

Pre-contemplation Stage

- Denial of alcohol and drug use.
- Almost entirely unapproachable in this phase unless they believe they may have a problem with alcohol or drugs.
- “I don’t have a problem”
- “I am in control”
- “I can handle my alcohol or drugs.

Contemplation Phase

- Uncertainty and conflicting emotions begin to arise about alcohol and/or drug use.
- Consequences may be occurring legally, socially, with family and friends and co-workers.
- The problem is becoming more obvious and awareness begins to take place.
- They want to change but unsure how and are fearful of treatment, recovery, expense, detox, etc.

Preparation Stage

- The person begins to prepare for recovery.
- They may attend some 12 step meetings and make a resolution to stop drinking or using drugs.
- This is the "trying to control use phase".
- They may switch out liquor for beer, replace their main drug of addiction for another, try to control the amount and/or frequency they use.
- They may get discouraged in this phase because they cannot stop using on their own.

Action Stage

- The alcoholic/addict will begin to take action toward their recovery.
- They may go to an Inpatient Treatment Program and follow a continuum of care.
- They learn about the disease of alcoholism/addiction.
- They accept they cannot drink or use again.
- Gain an understanding that they can change.

Maintenance and Relapse Prevention

- The most important phase, even after treatment.
- Focus will be on maintaining their recovery program.
- Implement tools they learned in treatment.
- Be active in a 12 step program.
- Build support groups and systems.

Denial

- According to Terence T. Gorsky
- Denial is a normal and natural psychological defense that has both advantages and disadvantages.
- Advantage- temporarily removes the pain caused by consciously confronting a serious problem and creates the illusion that the problem is resolved.
- Disadvantage- Denial blocks recognition and Problem solving.

Denial

- Denial results from the natural tendency to avoid pain caused by recognizing the presence, severity, and responsibility for dealing with serious problems.
- Denial is a set of automatic and unconscious thoughts, feelings, urges, actions, and social relations that defend against the pain, of recognizing the presence, severity, and responsibility for dealing with a serious problem.

Denial

- Denial operates on four levels:
- Level1-lack of accurate information or internalized wrong information.
- Level 2- consciously defensive.
- Level 3- unconsciously defensive.
- Level 4- delusional

Denial

- Level 1- Lack of accurate information- about alcoholism/addiction.
- Intervention- Provide new and more accurate information about alcoholism/addiction that will help the client see alternative solutions.

Denial

- Level 2- Conscious Defensiveness
- Knowledge that something is wrong, but refuse to face the pain of knowing.
- Intervention- Use inner dialogue techniques to consciously examine and resolve the conflict.

Denial

- Level 3- Unconscious Defensiveness
- Automatic evasion and distortion that guards against severe pain and helplessness.
- Intervention- Teach clients about the common denial patterns and use self-monitoring and directive feedback in sessions to expose the denial patterns.

Denial

- Level 4- Delusion
- Deeply entrenched mistaken beliefs held in spite of overwhelming evidence that they are not true.
- Intervention- These clients usually do not respond to interventions in levels 1,2 , and 3. The delusions are linked to brain dysfunction caused by alcohol or drug use or to coexisting mental or personality disorders. With treatment of these conditions the client will usually drop to lower levels of denial.

Denial Patterns

- Twelve Denial Patterns
- Big Five Denial Patterns:
- Avoidance, Absolute Denial, Minimizing, Rationalizing, and Blaming.
- Seven Small Denial Patterns:
- Comparing, Manipulating, Scaring Myself Into Recovery, Compliance, Flight Into Health, Strategic Hopelessness, The Democratic Disease State.

WHAT DO PROFESSIONALS NEED TO LOOK FOR?

Signs

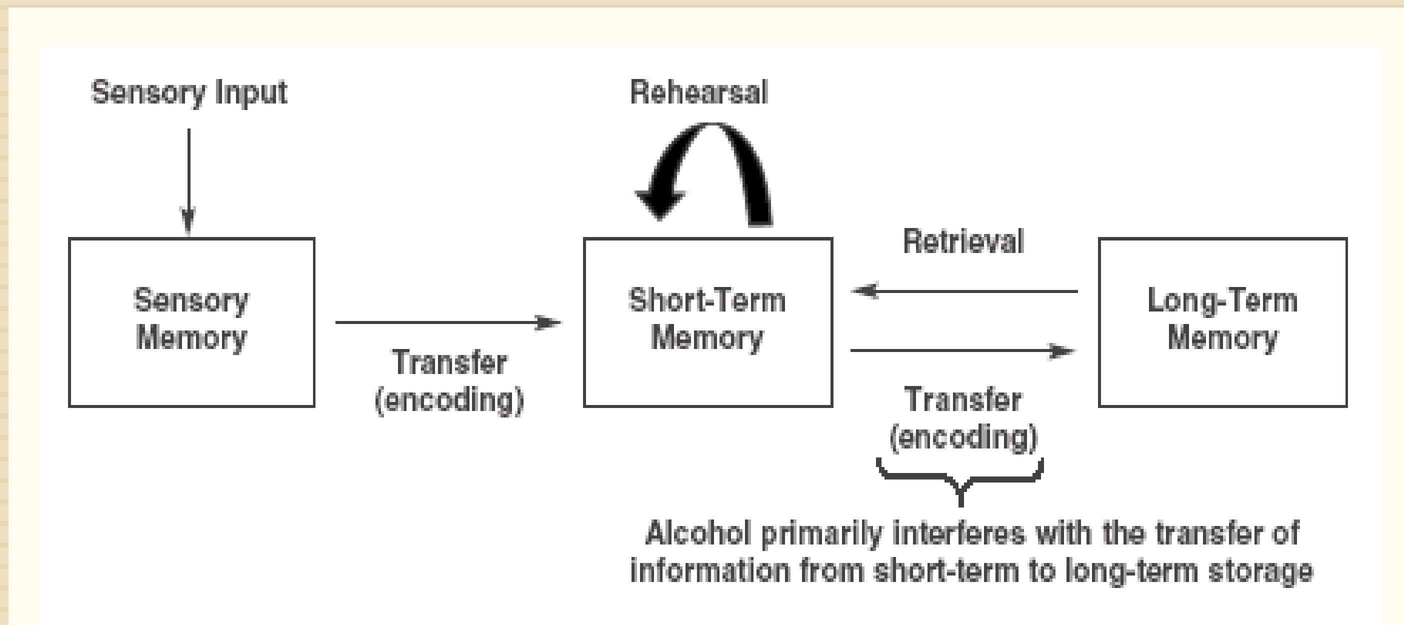
- Legal Problems (80% of prisoners report use of alcohol or drugs during the month they committed their crime).
- Job Problems
- Alibi's (dishonesty sometimes a outright lie or more often failure to include important details

Symptoms

- Tolerance - Requires more to get same effect of diminished effects using same amount
- Loss of control - Inability to consistently predict what will happen, who much the will use, or the consequences of use

Symptoms

- **Blackouts** - No memory of certain events while using alcohol/drugs



Symptoms

- Loss of interests in important activities
- Seeking counseling or help
- Feeling of paranoia, intense jealousy, or need for religious intervention
- Tremors & Shakes

Signs & Symptoms

- Behaviors will continue and progressively become more problematic until appropriately treated
- Structure may improve problems temporarily
- Addicts & alcoholics rarely experience natural recovery or spontaneous remission but they do change drugs

Weak Engagement & Attrition

- Dropout rates between the call for an appointment at an addiction treatment agency and the first treatment session range from 50-64% (Gottheil, Sterling & Weinstein, 1997).
- Nationally, more than half of clients admitted to addiction treatment do not successfully complete treatment (48% "complete"; 29% leave against staff advice; 12% are administratively discharged for various infractions; 11% are transferred) (OAS/SAMHSA 2005).

Screening & Assessment

Screening a brief process used to:

- Determine presence of a problem
- Substantiate reason for concern
- Identify need for further evaluation

- Screening **can** and **should** occur in any setting

Screening & Assessment

Screening Interviews

- Should be Non Threatening
- Should be Confidential
- Should be Coupled with Instruments
- Is Not Diagnostic

Drug Screens, Surveys, and Collateral Data

Key Considerations

1. Conduct screening on at risk persons, using a variety of settings & professionals
2. Collaboration instruments, processes, techniques
3. Instrument sensitivity race, gender, culture, etc.
4. Screening should be brief
5. Get collateral information

CAGE

Have you ever felt you should **CUT** down on your drinking?

Have people **Annoyed** you by criticizing your drinking?

Have you ever felt bad or **Guilty** about your Drinking?

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover **(Eye-opener)?**

CAGEAID

The Have you ever felt you should **CUT** down on your drinking *or drug use*?

Have people **Annoyed** you by criticizing your Drinking *or drug use*?

Have you ever felt bad or **Guilty** about your Drinking *or drug use*?

Have you ever had a drink/*drug* first thing in the morning to steady your nerves or get rid of a hangover *or get the day started* **(Eye-opener)?**

A process to determine (diagnose) the nature and complexity of the individuals spectrum of drug abuse and related problems

ASSESSMENT is DIAGNOSTIC

Purpose of Assessment

1. Identifies those having alcohol/drug problems or who have progressed to addiction
2. Examines the full spectrum of problems that will require attention in treatment
3. Plans appropriate interventions
4. Involves important others in the individuals treatment
5. Evaluates the effectiveness of the interventions that are implemented

Core Elements of Assessment

- History of use
- Social Support and Social Roles
- Employment/Educational History
- Medical History
- Psychiatric History
- Legal History

Other Relevant Factors

- Gender
- Ethnic/Cultural
- Language
- Sexual Orientation/Identity
- Religious/Spirituality
- Physical Disability
- Collateral Information

Purpose of Assessment

- Assessments should always be interpreted by a trained **professional**
- Assessment information is used to develop the Treatment plan
- The Treatment Plan dictates the course of treatment

Diagnosis DSM-5

DSM-5 criteria for Substance Use Disorder

A problematic pattern of substance use leading to clinically significant impairment od distress, as manifested by at least two of the following, occurring within a twelve month period:

Substance is often taken in larger amounts or over a longer period than was intended.

There is a persistent desire or unsuccessful efforts to cut down or control use.

A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from it's effects.

Craving, or strong desire or urge to use the substance.

Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.

DSM-5 Criteria

- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the substance.
- Important social, occupational, or recreational activities are given up or reduced because of the substance use.
- Recurrent substance use in situations which are physically hazardous.
- Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

DSM-5 Criteria

- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of alcohol to achieve the intoxication or desired effect.
  - A markedly diminished effect with continued use of the same amount of alcohol.
- Withdrawal, as manifested by either of the following:
  - The characteristic withdrawal syndrome for the substance (refer to Criteria and B of the criteria set for the substance withdrawal). All are listed after the substance in DSM 5.
  - The substance or a closely related substance is taken to relieve or avoid withdrawal symptoms.

DSM-5 Criteria

Severity

Mild: Few if any symptoms in excess of those required to make a diagnosis; symptoms result in no more than mild impairment in social, occupational, recreational, or relational functioning **(SORRF)**

Moderate: Symptoms are between mild and severe, some serious impairment in one of the **(SORRF)** areas.

Severe: Many symptoms in excess of those required to make a diagnosis; symptoms markedly interfere with **(SORRF)**

Twelve Step Facilitation

Twelve Step Facilitation (TSF)

- Short-term individual counseling approach
- Twelve to Fifteen sessions
- Pharmocotherapy
- Focus on an abstinence goal

Twelve Step Facilitation

Sessions

- Directive and individual
- Counselor and Client both talk
- Assignments important in sessions
- Family therapy important component
- Focus on concepts surrounding steps work and not necessarily the steps
- Focus on acceptance, surrender, and getting active in the program

Twelve Step Facilitation

Counselor's Behaviors Proscribed

- Sessions with an intoxicated client
- Attend AA or NA with the client
- Act as a sponsor
- Threaten reprisals for noncompliance
- Advocate controlled drinking/drug use
- Allow therapy to drift excessively onto collateral issues, i.e. marital or job conflict

Twelve Step Models

Minnesota Model

- Multidisciplinary team approach began in 1950's
- Staff: Counselors, psychologists, nurses, and clergy.
- Therapy: Treat the disease w/abstinence goal.
- Emphasizes working the Twelve Steps & AA.
- Theoretical rationale:

  Changing beliefs about relationship,

  Develop self-reflection

  Coping Skills

Twelve Steps

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.

Twelve Steps

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.

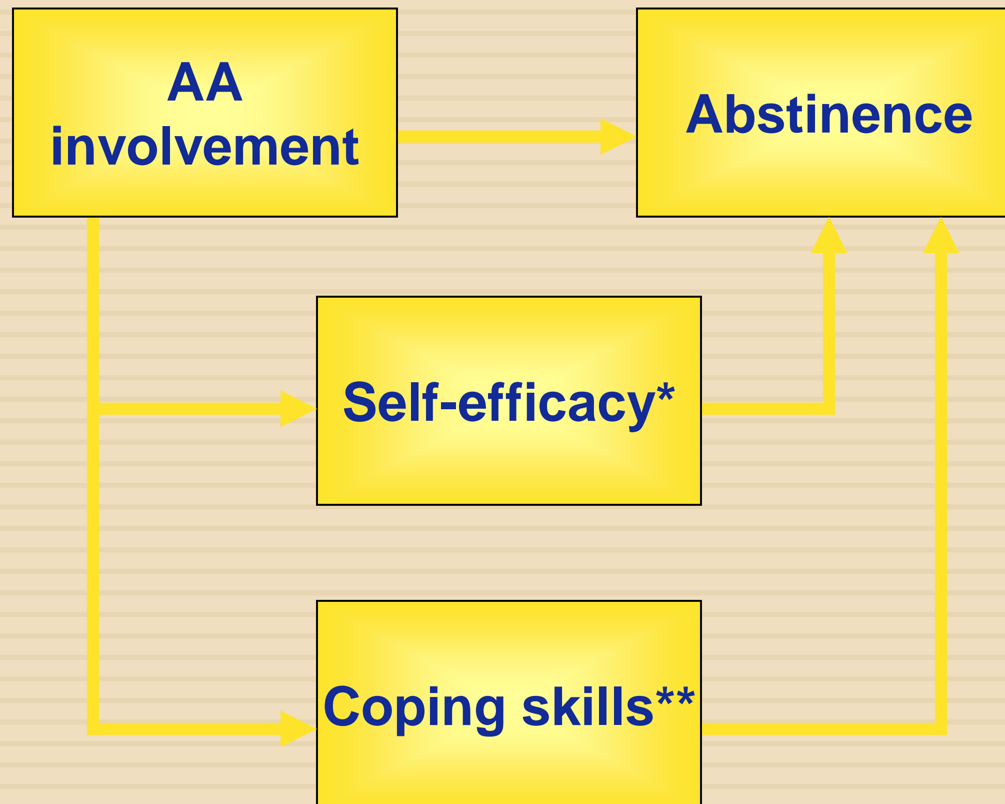
Twelve Steps

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.

Twelve Steps

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.

Evidence of mechanism: cognitive behavioral



*[1] Morgenstern et al., *J Consult Clin Psych* 1997
*[2] Kelly et al., *J Stud Alcohol* 2002
**[1] Timko et al., *ACER* 2005
**[2] Humphreys et al., *Ann Behav Med* 1999

*[1] Resi or IOP n = 100
*[2] asolescent inpatients n=74
**[1] initially untx PDs n=466
**[2] male VA inpatients n=2,337

Initially attending frequent meetings: *Abstinence at 1 & 8 yrs.*

AA meetings	Abstinence	
Year 1	Year 1	Year 8
No AA	21%	35%
2-4 mtgs/week	43%	57%
5+ mtgs/week	61%	73%

Moos & Moos, *Jnl Cons Clin Psy* 2004

The Role of AA Affiliation in Alcoholism Treatment

Tonnigan 2006

- Focus on abstinence in therapy has a main effect on outcome, but does not explain TSF benefit
- Stressing loss of control and adverse alcohol related conseq. in TSF may have limited value..
- Facilitating AA engagement is an active therapeutic mechanism of TSF explaining TSF benefit
- AA engagement is more than AA attendance.
- Spiritual gains have a function in AA, they appear to sustain AA participation which, in turn, predicts increased abstinence
- Self efficacy gains occur among AA exposed persons, which accounts for later abstinence

The Role of AA Affiliation in Alcoholism Treatment

Humphreys,Mavis, & Stoffelmayr, 1994 In spite of allegations to the contrary, recent studies confirm A.A. affiliation and recovery rates for women, people of color, young people, and people with co-occurring psychiatric disorders (including those on medication) are comparable to those reported for general A.A. membership

Fiorentine & Hillhouse, 2000 Completion of addiction treatment AND participation with recovery mutual aid groups is more predictive of long-term recovery than either alone

Clinician Guidelines

We need to prepare clients for 12 Step program participation and refer them to 12 Step groups.

- Learn the 12 Steps and principles associated with 12 Step recovery
- Learn the language and culture of 12 Step programs
- Learn about Twelve Step Facilitation Therapy
- Distinguish religion from spirituality
- Address myths associated with 12 Step groups
- Help clients find appropriate 12 Step groups
- Encourage active membership and attendance at least three times a week
- Encourage long-term attendance

Drug Refusal Skills

Components of Functional Analysis

- Discovering Triggers (places, persons, situations that may set off an urge)
- Identifying persons, places, & situations least likely to use
- Identifying places persons, places, & Situations most likely to use

Drug Refusal Skills

No should be the first thing you say.

Tell the person not to ask you now or in the future if you want to drink alcohol or use drugs.

Use appropriate body language

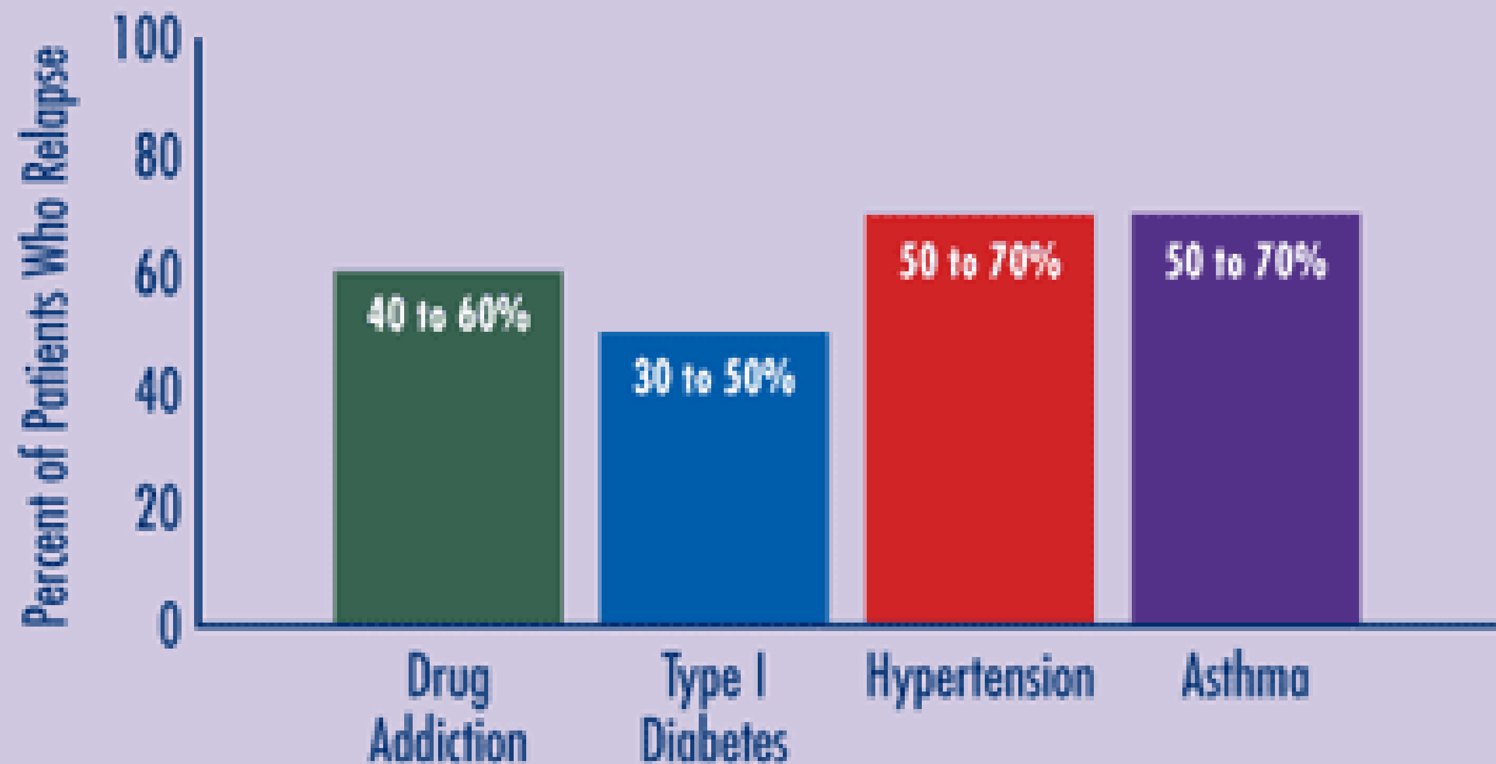
Make good eye contact; look directly at the person when you answer.

Your expression and tone should clearly indicate that you are serious.

Offer an alternative (if you want to do something else with that. person) that is incompatible with alcohol or drug use.

Change the subject

RELAPSE PREVENTION


COMPARISON OF RELAPSE RATES BETWEEN
DRUG ADDICTION AND OTHER CHRONIC ILLNESSES
Percent of Patients Who Relapse
100
80
60
40
20
0
40 to 60%
30 to 50%
50 to 70%
50 to 70%
Drug Addiction
Type I Diabetes
Hypertension
Asthma

Relapse Prevention

Popularized by Terence Gorski provides a comprehensive method for preventing the addicted client from returning alcohol and drug use after initial treatment.

- Endorses the disease model
- Focuses on identifying warning signs
- Relapse intervention plan
- Theoretical basis is cognitive and behavioral

Transition Stage – Recognition that control is no longer possible

Stabilization Period - major cause of inability to abstain during the stabilization period is the lack of stabilization management skills.

The Developmental Model of Recovery

Early Recovery Period

Primary cause of relapse during the early recovery period

- lack of effective social skills
- Lack of effective recovery skills necessary to build a sobriety-based lifestyle.

This period last approximately 1- 2 years

The Developmental Model of Recovery

Middle Recovery Period

Major cause of relapse during the middle recovery period is the stress of real-life problems.

Allow time to:

- Re-establish relationships with family,
- Set new vocational goals,
- And expand social outlets

The Developmental Model of Recovery

Late Recovery Period

Major cause of relapse during the late recovery period

- Either inability to cope with the stress of unresolved childhood issues
- Or an evasion of the need to develop a functional personality style

The Developmental Model of Recovery

Late Recovery Period Problems are generally not experienced until in recovery 3 to 5 years <u>no matter when recovery begins</u>.

In others (non-using) these unresolved childhood issues surface in their mid twenties

The Developmental Model of Recovery

Maintenance Stage

Major causes of relapse during the maintenance stage

- Failure to maintain recovery program
- And encountering major life transitions
- Any use of alcohol or drugs during the maintenance stage will reactivate physiological, psychological, and social progression of the disease.

The Developmental Model of Recovery

Stuck Points in Recovery

A “stuck point" can occur during any period of recovery

- Usually caused by lack of skills
- Or lack of confidence in one's ability to complete a recovery task.

The Developmental Model of Recovery

Other problems

- Situations (physical, psychological, or social) that interfere with the ability to use recovery supports (such as changing job, having children, major illness).

The Developmental Model of Recovery

When recovering people encounter stuck points,

- They either <u>recognize</u> they have a problem and take action,
- Or they <u>lapse</u> into the familiar coping skill of denial that a problem exists
- These lapses can occur in the form of alcohol and drug use or behaviors that lead to use.

The Developmental Model of Recovery

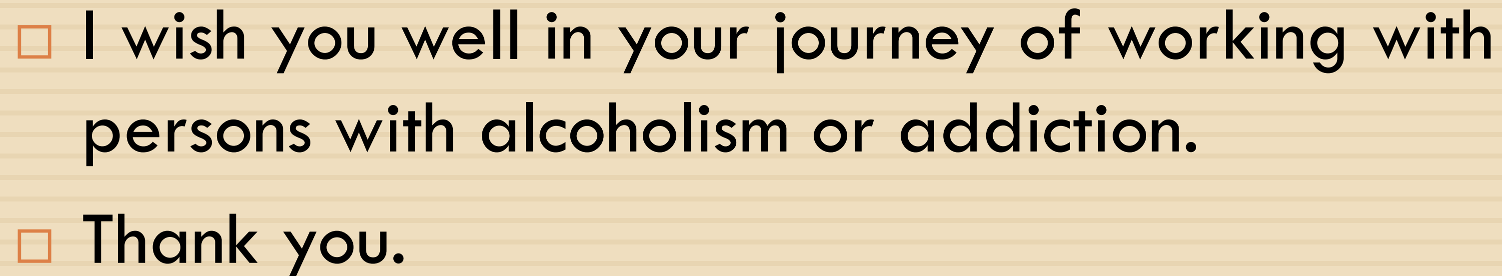
- Effects of lapses
- Without specific relapse prevention skills to identify and interrupt denial, stress begins to build. Becoming Chronic and Inescapable
- Eventually, the stress will cause the patient to cope less and less well. This will result in relapse.

Recovery Process

- One – Five years of abstinence
- Return to Self Esteem
- Sustained employment
- Engagement in healthy social activities
- Development of fulfilling relationships (romantic or friendship)
- Establishment in support system

  (self help, church, peer)

Questions, Comments, Discussion



- I wish you well in your journey of working with persons with alcoholism or addiction.
- Thank you.

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