ALCOHOL AND OTHER DRUG INFORMATION FOR PROFESSIONALS

Shelia Cundiff, LCSW, LCADC
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 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 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.
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
- Mental Illness
- Substance Abuse
- AIDS
- Education
- Family Problems
- Money
- Drugs
- Crime
- Unemployment
- Poverty
- Alcohol
- Abuse
- Prostitution
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

- 16.3 Million adults had SUD, no SMI
- 2.6 Million adults had SUD and SMI
- 8.9 Million adults had SMI, no SUD
- 18.9 Million adults had SUD
- 11.5 Million adults had SMI

¹ Adjusted SAMHSA estimates.
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?
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

Photo courtesy of the NIDA Web site. From A Slide Teaching Packet: The Brain and the Actions of Cocaine, Opiates, and Marijuana.
Activation of the reward pathway by addictive drugs

cocaine  heroin  nicotine

alcohol

heroin
Circuits Involved In Drug Abuse and Addiction

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

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
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
Alcohol: 38 year old 17 years weekend use
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

www.BrainConnection.com
©1999 Scientific Learning Corporation
## Prefrontal Cortex

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

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

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

<table>
<thead>
<tr>
<th>FUNCTIONS</th>
<th>PROBLEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Allows shifting of attention</td>
<td>- Worrying</td>
</tr>
<tr>
<td>- Cognitive flexibility</td>
<td>- Holds onto hurts from the past</td>
</tr>
<tr>
<td>- Adaptability</td>
<td>- Stuck on thoughts (obsessions)</td>
</tr>
<tr>
<td>- Helps the mind move from idea to idea</td>
<td>- Stuck on behaviors (compulsions)</td>
</tr>
<tr>
<td>- Gives the ability to see options</td>
<td>- Oppositional behavior, argumentative</td>
</tr>
<tr>
<td>- Helps you go with the flow</td>
<td>- Uncooperative, tendency to say no</td>
</tr>
<tr>
<td>- Cooperation</td>
<td>- Addictive behaviors</td>
</tr>
<tr>
<td></td>
<td>- Cognitive inflexibility</td>
</tr>
<tr>
<td></td>
<td>- OCD spectrum disorders</td>
</tr>
<tr>
<td></td>
<td>- Eating disorders, road rage</td>
</tr>
</tbody>
</table>
Temporal Lobes
## Temporal Lobes Functions

Non-dominant Side (usually the right)

<table>
<thead>
<tr>
<th>FUNCTIONS</th>
<th>PROBLEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognizing facial expression</td>
<td>Difficulty recognizing facial expression</td>
</tr>
<tr>
<td>Decoding vocal intonation</td>
<td>Difficulty decoding vocal intonation</td>
</tr>
<tr>
<td>Rhythm</td>
<td>Implicated in social skill struggles</td>
</tr>
<tr>
<td>Music</td>
<td></td>
</tr>
<tr>
<td>Visual learning</td>
<td></td>
</tr>
</tbody>
</table>
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
- 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.
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:
  - Level 1 - lack of accurate information or internalized wrong information.
  - Level 2 - consciously defensive.
  - Level 3 - unconsciously defensively.
  - 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:
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**)?
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)?
Assessment

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.
DSM-5 criteria for Substance Use Disorder

A problematic pattern of substance use leading to clinically significant impairment of 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 its 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 A 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.
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 (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
Minnesotta 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.
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

- AA involvement
- Self-efficacy*
- Coping skills**
- Abstinence

References:
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.

<table>
<thead>
<tr>
<th>AA meetings</th>
<th>Abstinence</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>Year 1</td>
<td>Year 8</td>
<td></td>
</tr>
<tr>
<td>No AA</td>
<td>21%</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>2-4 mtgs/week</td>
<td>43%</td>
<td>57%</td>
<td></td>
</tr>
<tr>
<td>5+ mtgs/week</td>
<td>61%</td>
<td>73%</td>
<td></td>
</tr>
</tbody>
</table>

Moos & Moos, *Jnl Cons Clin Psy* 2004
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 consequences 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.
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

- Drug Addiction: 40 to 60%
- Type I Diabetes: 30 to 50%
- Hypertension: 50 to 70%
- Asthma: 50 to 70%
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
The Developmental Model of Recovery

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

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.
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 recognize they have a problem and take action,
- Or they lapse 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)
I wish you well in your journey of working with persons with alcoholism or addiction.

Thank you.


