Substance Abuse Curriculum

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Part I: Overview

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Defining our terms

In this presentation we'll be using some technical jargon you should get used to. The purpose of the jargon is not to throw you off, but to help make sure we're all talking about the same things!

First we'll review these concepts:

1. What is the "substance" in substance abuse?
2. What is "tolerance?"
3. What's the difference between "abuse" and "dependence"?
5. What is "addiction"?
6. Where does "alcoholism" fit in?

1. What is a “substance?”

When we use the word “substance” in such as “substance abuse” or “substance dependence,” we are talking about drugs of abuse. Drugs of abuse are any chemical agents (natural or artificial) that affect the mind and are known to be used in an abusive manner.

- ✓Alcohol
- ✓Illegal street drugs (such as marijuana or cocaine)
- ✓Addictive prescription drugs (like Xanax or Rohypnol)
- ✓Over the counter drugs (like Dramamine or even mouthwash)
- ✓Other mind altering substances (like model glue)

Clinical File

DXM, a powerful mind-altering drug, is very addictive. It is found in many cough preparations such as cough syrup.

Science guy says:

Cough syrup abusers can obtain their drug from their doctors by making up cold symptoms. Examples of cough preparations include Robitussin AC, Dectuss, Phensedyl, Drixoral Cough Liquid Caps, and Pherazine with Codeine. (1)

2. What is “tolerance?”

Tolerance is a word describing certain changes in the way an addict reacts to a drug.

A person who develops tolerance needs more and more of the drug to get the same effect as before.

For example, a person might be able to get a “buzz” after just a couple of beers in the beginning. But when dependence develops, the person is likely to need to drink more and more to get that buzz.

3. Substance Abuse vs. Substance Dependence

Substance Abuse basically means that a person's use of substances is causing problems in life ("failure to fulfill major role obligations at work, school, or home"). For example, "alcohol abuse" would describe any use of alcohol that causes harm.

The substance abuser may show lapses in parenting skills, job functioning, or even legal charges (such as DUI) because of using the substance.

A person diagnosed with substance abuse is not considered to be addicted or dependent (otherwise the diagnosis would be substance dependence). (2)

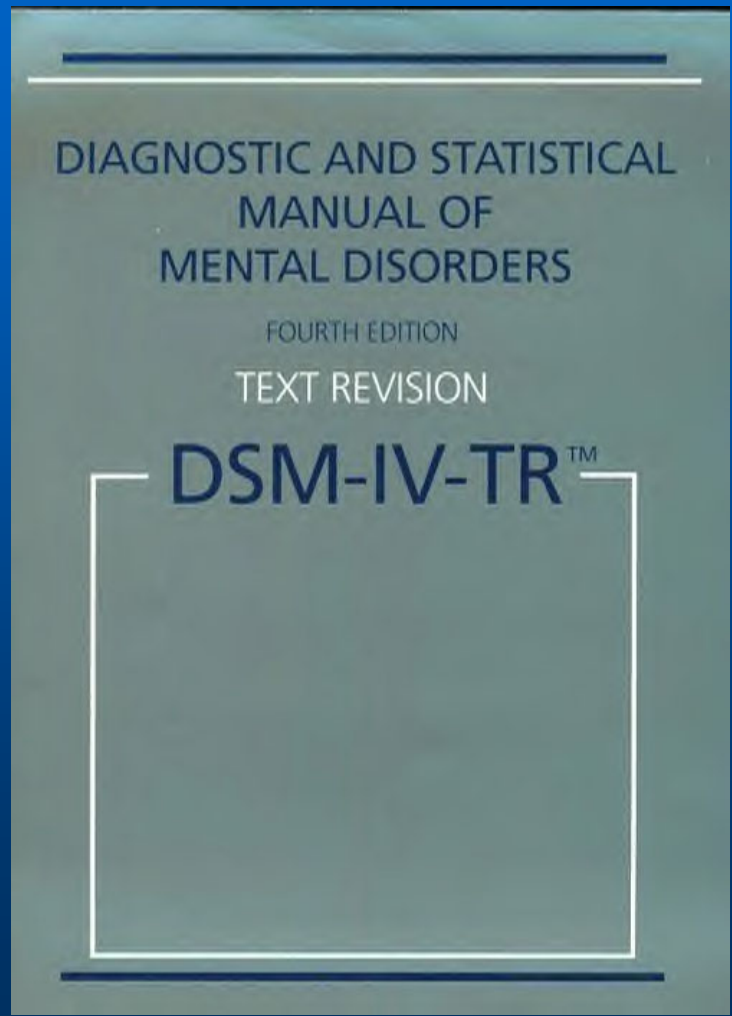
3. Substance Abuse vs. Substance Dependence (continued)

Substance Dependence is a more advanced problem, accompanied by certain changes in the way the person relates to the substance. Signs of dependence include all the signs of abuse plus some additional problems:

- ✓Experiences withdrawal when not using
- ✓Seems unable to stop
- ✓Devotes a lot of time and energy to getting and using
- ✓Needs more and more to get the same effect (tolerance)
- ✓Gives up things that used to be important in order to use
- ✓Compulsions or cravings to keep using

Spotlight: DSM-IV

Formal diagnosis of substance abuse or dependence is made by professionals based on standards set by the Diagnostic and Statistical Manual of Mental Disorders (DSM). The current version of the DSM is the DSM-IV [3].



4. What is “addiction?”

Addiction is another way of saying “dependence.” When a person is addicted to a drug, say for example alcohol, we refer to the condition as “alcohol dependence.”

As we have just learned, addiction (or dependence) is a syndrome including withdrawal symptoms, tolerance, inability to quit or cut back, and other problems.

Science guy says:

Addiction seems to have both a psychological and a physiological component. More on this later.

5. Where does alcoholism fit in?

Alcoholism is another way of saying "alcohol dependence." A person diagnosed with alcoholism is therefore addicted to alcohol.

Remember: addiction (or dependence) is a syndrome including withdrawal symptoms, tolerance, inability to quit or cut back, and other problems.

So an alcoholic would show signs of withdrawal when not drinking, would show increased tolerance to alcohol, would be unable to control the amount of drinking, and so on.

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Part II: Drugs of Abuse

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Types of Drugs of Abuse

Alcohol is a legal, addictive drug that depresses the central nervous system. Driving while intoxicated is illegal in all states in the US. Even after one drink (1 oz of hard liquor, 1 beer, 1 glass of wine), driving ability is impaired. Alcohol is cumulatively poisonous, and damages many organs of the body when used excessively (including the brain, liver, and heart). Chronic, heavy use of alcohol may lead to irreversible physical and neurological damage.

In 2001, Nebraska logged 96 DUI fatalities. (4)

In Nebraska, a "drunk driver" is defined as a blood alcohol content (BAC) of .08 or 8%. 1st offense gets 90 days license suspension. (5)

Types of Drugs of Abuse

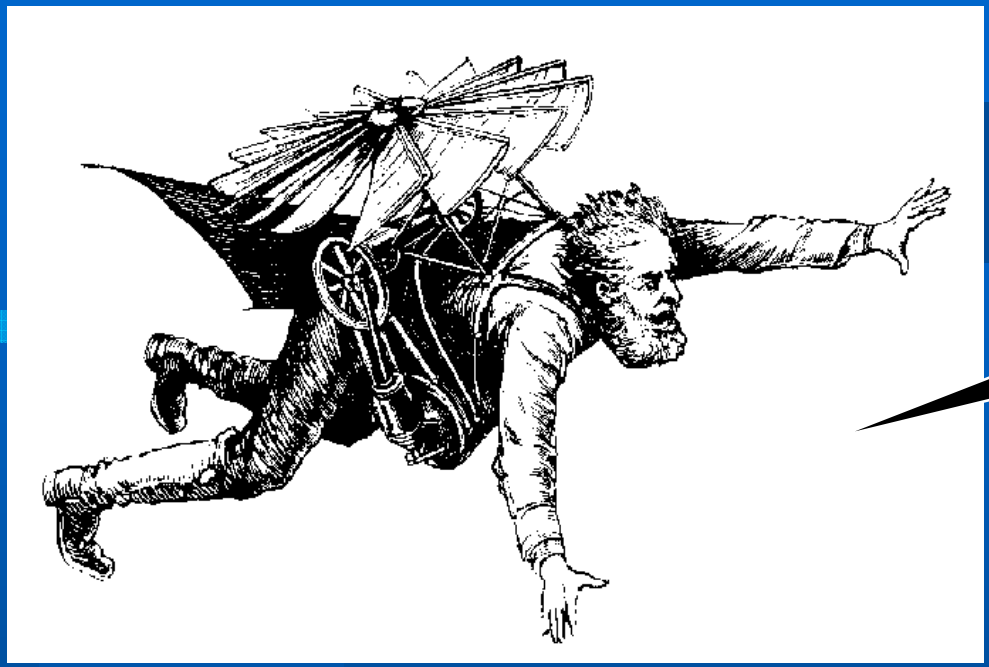
Cocaine is a strong central nervous system stimulant that affects the distribution of dopamine, a chemical messenger associated with pleasure. Dopamine part of the brain's reward system and helps create the high that comes with cocaine consumption. Cocaine usually looks like a white powder used for sniffing or snorting, injecting, and smoking (in the case of free-base and crack cocaine). In addition to the desired high, cocaine may produce feelings of restlessness, irritability, and anxiety, or even mania or psychosis.

Heroin is a very addictive drug processed from morphine, a substance extracted from the seedpod of the Asian poppy plant. Heroin produces a feeling of euphoria (a "rush") and often a warm flushing of the skin, dry mouth, and heavy feelings in the arms and legs. After the initial euphoria, the user may go into an alternately wakeful and drowsy state. Heroin is the second most frequent cause of drug-related deaths.

Types of Drugs of Abuse

Marijuana (weed, or cannabis) is one of the most common drugs of abuse in Nebraska. Marijuana looks like a dry, shredded green/brown blend of flowers, stems, seeds, and leaves of a particular hemp plant. It usually is smoked as a cigarette, pipe, or in blunts, which are cigars that have been emptied of tobacco and refilled with marijuana. The main active chemical in marijuana is THC (delta-9-tetrahydrocannabinol), which quickly passes from the lungs into the bloodstream, and on to organs throughout the body, including the brain. Some of the short-term effects of marijuana use include problems with memory and learning; bizarre or distorted perceptions; difficulty in problem solving; loss of coordination; and increased heart rate.

A study has suggested that a user's risk of heart attack more than quadruples in the first hour after smoking marijuana. (6)



But marijuana isn't even addictive, and besides, everybody does it!

Wrong on both counts, actually. But this illustrates the *permission thoughts* that serve to enable continued substance abuse. Permission thoughts (called "stinking thinking" in 12-step programs) make it "okay" for the individual to keep using, and you're likely to encounter them if you ask a user about his or her habits.

Types of Drugs of Abuse

Methamphetamine ("meth") is made in illegal laboratories and has a high potential for abuse and dependence. It is often taken orally, snuffed, or injected. Methamphetamine hydrochloride, clear crystals resembling ice, can be inhaled by smoking, and is referred to as "ice," "crystal," and "glass." Use of methamphetamine produces a fast euphoria, and often, fast addiction. Chronic, heavy use of methamphetamine can produce a psychotic disorder which is hard to tell apart from schizophrenia (methamphetamine induced psychosis). The drug also causes increased heart rate and irreversible damage to blood vessels.

According to the Arrestee Drug Abuse Monitoring Program, 11 percent of adult male arrestees in Omaha tested positive for methamphetamine in 2000. (7)

Meth produced by Mexican criminal groups in Mexico, California, and southwestern states is the predominant type available in Nebraska. (8)

Types of Drugs of Abuse

Ecstasy (MDMA) is the so-called “party drug," It has both stimulant (like cocaine) and hallucinogenic (like LSD) effects. Ecstasy is neurotoxic (poisonous to brain cells), and in high doses it causes a steep increases in body temperature leading to muscle breakdown, and possible organ failure. Side effects may last for weeks after use, and including high blood pressure, faintness, confusion, depression, sleep problems, anxiety, and paranoia. (9)

Acid (LSD) LSD, also called "acid," is sold in the street in tablets, capsules, or even liquid form. It is clear and odorless, and is usually taken by mouth. Often LSD is added to pieces of absorbent paper divided into small decorated squares, each containing one dose. LSD is a hallucinogen and a very powerful mood-altering chemical. (10)

Types of Drugs of Abuse

Prescription drugs. Using a prescription drug in a manner other than the intended prescription constitutes drug abuse. Some of the more commonly abused prescription drugs are:

- ✓ Pain-relieving narcotics (Percodan, Codeine, Vicodin, Percocet)
- ✓ Tranquilizers and sedatives (Halcion, Xanax, Ativan, Valium, BuSpar, Valium, Phenobarbital)
- ✓ Muscle relaxants (Soma)
- ✓ Prescription amphetamines (Ritalin, Cylert, Adderall)
- ✓ OxyContin

Types of Drugs of Abuse

Over the counter drugs. Many different types of over-the-counter drugs and other substances can be abused. Just a few examples include:

- ✓ Inhalants (paint thinners, nitrous oxide, model glue, magic marker fluid, spray paints, propane, butane, etc.)
- ✓ Dramamine
- ✓ Mouthwashes
- ✓ Diet aids
- ✓ Cough and cold medications (especially those containing DXM, like Drixoral Cough Liquid Caps, Robitussin AC, Dectuss, Phenergan etc.)

This is another example of a permission thought. The distinction between “hard” and “soft” drugs is actually meaningless because ALL drugs of abuse can lead to the same consequence….addiction.

Once a person becomes addicted to ONE drug (marijuana, alcohol, prescription meds, heroin, etc), he or she is as good as addicted to ALL drugs of abuse. For this reason, we train addicts for ABSTINENCE from all drugs of abuse.

Do doctors always know best?

Educate your doctor?? All this talk about abuse of medications makes you wonder: are physicians aware of how addictive these drugs can be?

Many otherwise excellent physicians haven't been well trained in the addiction. During the four years doctors spend in medical school, addiction issues often get little attention. A doctor may not recognize than even one pain-reliever pill can set off powerful and destabilizing cravings in an addict.

It's a good idea for any addict to tell their doctor about his or her addiction, and to get proactive about avoiding all drugs of abuse.

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Part III: Concepts in Substance Abuse

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Reviewing our terms

Now you should be familiar with these important concepts. If you need to review, go back until you've got it.

1. What is the "substance" in substance abuse?
2. What is "tolerance?"
3. What's the difference between "abuse" and "dependence"?
4. What is "addiction"?
5. Where does "alcoholism" fit in?

Characteristics of Dependence

Let's look at four important dimensions of addiction. Addiction is:

- ✓ Chronic
- ✓ Primary
- ✓ Progressive
- ✓ Incurable

Let's review each concept in turn so that we know what this means.

1. Addiction is CHRONIC

A disorder that is CHRONIC continues for a long time. The opposite of chronic is "acute," which means relatively sudden and short. Let's look at other examples of chronic vs. acute disorders.

Acute disorders	Chronic disorders
Flu	**Diabetes**
Food poisoning	**Hypertension**
Concussion	**Epilepsy**

Notice that "acute" disorders are treated once and they're gone. "Chronic" disorders are *managed*, not cured.

2. Addiction is PRIMARY

A disorder that is PRIMARY means that it is not the “result” of something else. It is a disorder in its own right, requiring specific treatment.

For example, a man may start drinking to control the painful feelings of depression. However, when that man becomes an alcoholic (addicted to alcohol), he now has a separate and “primary” disorder that needs treatment.

Treating the depression does not mean the alcoholism will also go away.

3. Addiction is PROGRESSIVE

A disorder that is PROGRESSIVE tends to get worse over time.

With drug addiction, we see that the consequences of the addiction tend to worsen over time. One important mechanism of this progressive quality is tolerance, which we've discussed.

The development of tolerance tends to ensure that a person has to get more, spend more, hide more, and use more over time.

Later we'll look at some of the particular consequences of progression, including medical problems.

4. Addiction is INCURABLE

We say that addiction is INCURABLE because the biological changes involved in addiction tend to be permanent.

As a result, an addict will never be able to safely use the drug of abuse (or any other drugs of abuse). An alcoholic will never be able to "drink normally."

Likewise, a cocaine addict will never be safe using stimulating drugs (for example, ephedra, which is an over-the-counter stimulant). A person addicted to one drug can easily switch over the another drug and still be an addict. This is called cross-addiction (more on this later).

Egads…all this bad news! Primary, chronic, progressive, incurable…. Is there no hope?

Of course there is hope!

We said “incurable,” not “untreatable.” Remember the comparison with diabetes? We don’t cure diabetes, we manage it with proper diet, blood sugar monitoring, and other acts of discipline.

Unfortunately, the addict rarely wants “discipline.” That’s what makes it so hard. By definition, an addict wants to keep using!

The Stages of Change

No discussion of addiction is complete without a quick look at the "Stages of Change" model, by Prochaska and DiClemente.

Basically, the model describes 5 stages of change:

1) **Precontemplation**
2) **Contemplation**
3) **Preparation**
4) **Action**
5) **Maintenance**

Prochaska, J.O., & DiClemente, C.C. (1982). Transtheoretical therapy toward a more integrative model of change. Psychotherapy: Theory, Research and Practice, 19(3), 276-287.

The Stages of Change, continued

Precontemplation

A person has no intention to change within the next 6 months

Contemplation

A person to take action within the next 6 months.

Preparation

A person intends to take action within the next 30 days, and has taken some concrete behavioral steps in this direction.

Action

A person has changed overt behavior for less than 6 months

Maintenance

A person has changed overt behavior for more than 6 months.

The Stages of Change, continued

One reason it's important to assess for stage of change is to determine the right kind of intervention. For example, people in "precontemplation" probably aren't ready to take treatment seriously. Other examples of appropriately-timed interventions:

1) **Precontemplation: Encourage self-awareness, personalize risk**
2) **Contemplation: Encourage analysis of the "pros and cons" of changing behavior; identify and promote new goals**
3) **Preparation: Encourage the first small steps, identify social support**
4) **Action: Bolster self-efficacy, deal with feelings of loss, reinforce gains and benefits**
5) **Maintenance: Plan follow-up support, reinforce internal rewards**

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Part II: Biological Bases of Addiction

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Biological Bases of Addiction

This point that “addicts just want to keep using” brings us to an important point about addiction and its biological roots.

Science guy says:

Addiction is associated with permanent changes in the brain’s neurochemistry. The addict is biologically “programmed” to need the drug in order to feel normal.

Let’s take a quick look at what happens in the brain of an addict (without getting too technical).

Biological Bases: the reward center

First let's take a look at a part of the human brain which has been called the "reward center" deep in the brain. This area includes specialized neural pathways which process experience of pleasure.

Clinical File

<u>3 elements of the reward center:</u>

- Medial forebrain bundle

- Nucleus accumbens

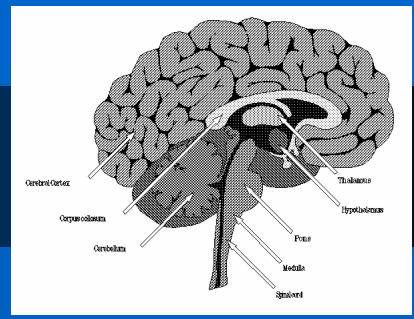
- Ventral tegmental

Biological Bases: the reward center (continued)

The reward center seems to process many experiences of pleasure, such as eating and sex. Experimental rats trained to stimulate their own reward centers with electric switches have been known to press on the switches thousands of times per hour! They neglect all other activities in order to keep stimulating themselves. (11)

Does this kind of behavior sound familiar?

Biological Bases: The Reward Center (continued)



Now, you may not be surprised to learn that many drugs of abuse stimulate the reward centers. As a result, using mind-altering drugs is pleasurable. The addict is almost like one of those experimental rats, stimulating itself again and again, neglecting anything else.

Doesn't sound that bad so far. What's wrong with a little pleasure?

The problem is this: while the drugs are stimulating all this pleasure, they also cause permanent changes.

Repeated use of certain drugs of abuse can result in depletion of brain chemicals that allow the experience of pleasure.

What happens next is this: more and more of the drug becomes necessary to generate pleasure, and other sources of pleasure lose their effects. Eventually, the addict can't even feel just normal without the drug.

As a result, the addict needs the drug to feel normal, and without it, they feel bad! It's no longer a matter of pleasure…it's a matter of avoiding pain. This is the mechanism for tolerance.

Spotlight: Dopamine

The brain chemicals that help generate pleasure are called dopamine, a brain chemical belonging to a group called neurotransmitters.

For example, both alcohol and heroin result in a build-up of dopamine, resulting in (temporary) pleasure.

Clinical File

Neurotransmitter

A "messenger chemical" in the brain, which have many different effects.

Neuroadaptation

As we discussed above, the brain adapts to this higher level of dopamine in the system. It's almost as if the body tries to "normalize" the new levels of pleasure by "raising the bar" to experience pleasure. These changes are referred to as neuroadaptation.

In other words, neuroadaptation means that it gets harder and harder to experience pleasure as you use more drugs. Addicts get the point that only their drug….in ever-increasing amounts…makes them feel good. (12)

The trap of addiction

In a sense, addicts get trapped by their own drug. They started using it to feel good, but end up needing it just to avoid feeling bad.

But can't the addict ever go back to normal? Even if he quits?

The Trap of Addiction (continued)

Addicts can learn to experience pleasure in ways other than using. Unfortunately, research and clinical experience shows that the biological changes are permanent.

This is why addiction is considered incurable, as we discussed before.

Implications of addiction

We've seen now how repeated drug use causes permanent biological changes in the brain. An important implication of these changes is this:

Once an addict, always an addict.

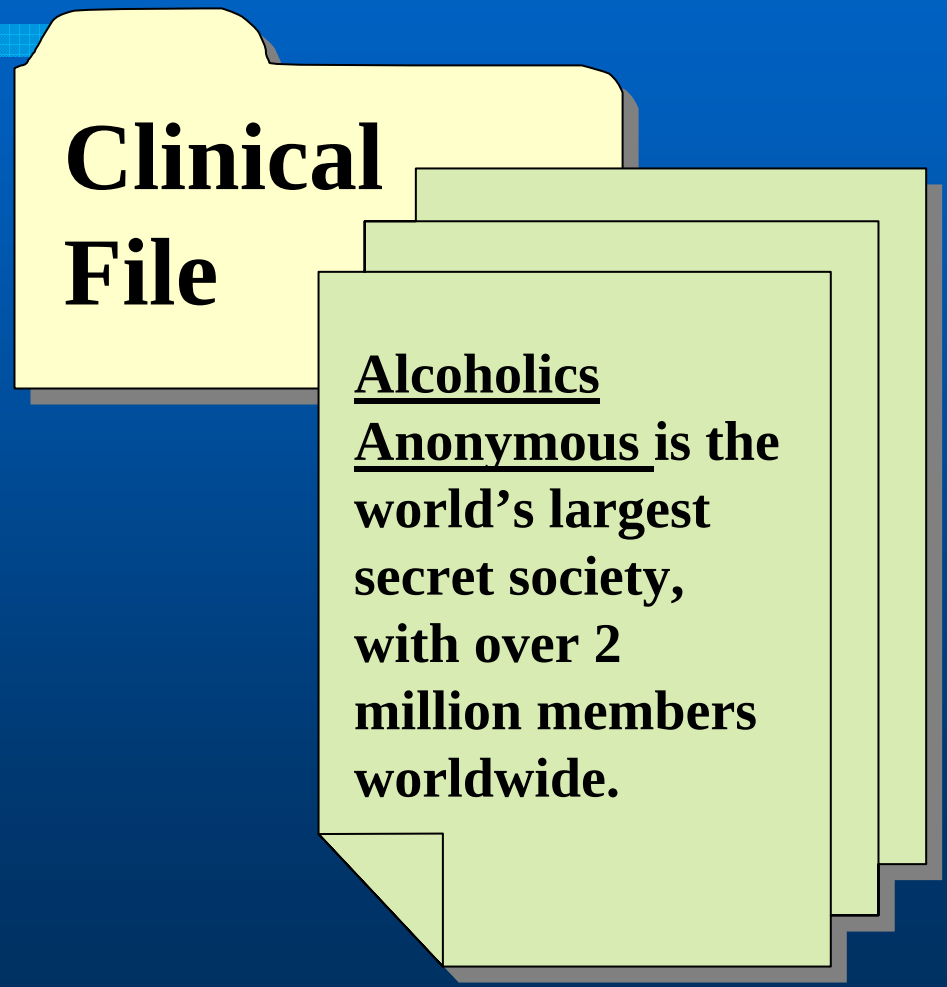
An addict can never assume it's safe to resume using addictive drugs. Using <u>even once</u> will get the addict back to Square One. 12-Step programs call this "waking the tiger."

Spotlight: 12-Step Traditions

In 12-step programs, a person commemorates the beginning of sobriety with a “sobriety date.”

If a person relapses, he or she starts with a new sobriety date.

This tradition emphasizes the fact that addiction never “goes away.”



The biology of cravings

Giving up drugs isn't just a matter of giving up on the pleasure. It can be a very painful experience because of cravings.

As we've discussed, the brain becomes "used to" the drugs of abuse after repeated use. If an addict stops using, the brain (and the mind) will put pressure on the person to start again…to restore the balance. This pressure is experienced as cravings.

Cravings can be very painful and difficult to resist. Managing and resisting cravings are an important aspect of treatment.

Spotlight: Managing Cravings

Cravings are painful but manageable with training and discipline. A helpful thing to remember with cravings is that they come and go like a wave: they approach, get stronger, reach a crescendo, and then taper off. Knowing this, a person can "ride out" the cravings by several means:

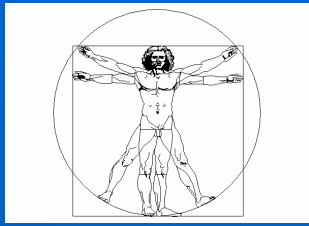
- ✓Distract herself with something interesting (movie, game, etc)
- ✓Contact someone else for support (sponsor, supportive friend)
- ✓Go to a safe place where giving in is less likely

The Disease Model of Addiction

In many different treatment models, addiction is seen as a disease. It may be hard to appreciate why at first, because it seems different from other types of "diseases" like cancer or bronchitis.

One of the reasons for defining addiction as a disease is in order to ensure that addiction is treated as a healthcare problem, thus allowing addicts access to the healthcare system. (13)

Addiction is widely considered a disease, by such organizations as the World Health Organization (WHO), American Medical Association (AMA), and American Psychiatric Association (APA).



The Disease Model (continued)

Defining addiction as a disease carries several implications which tend to increase the healthcare available to addicts:

- ✓ It follows a predictable course of development
- ✓ It causes disorder of bodily functions (affecting not only the brain but typically the liver, pancreas, and other organs)
- ✓ It causes significant mortality and morbidity (alcoholism is one of the leading causes of death in the U.S.)
- ✓ It can be tracked and measured by epidemiological research
- ✓ It has a significant genetic loading [14]

Does everybody believe that addiction is some kind of disease?

No; there has been a lot of controversy about this idea.

People who don't like to accept the disease model point out:

- Seeing addiction as a disease sounds like addicts have no responsibility for their behavior
- If we designated every form of self-destructive behavior as a disease, then almost everyone would be diagnosable with something!

The Disease Model (continued)

We won't settle the question of the Disease Model here. However, now you are familiar with the idea and some of the arguments on both sides.

At any rate, the Disease Model is so prevalent today that most treatment programs you are likely to encounter in the State of Nebraska use the model.

What's more, the Disease Model is supported by the world's largest organization devoted to helping people with addiction… Alcoholics Anonymous (and other 12-step programs such as Narcotics Anonymous).

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Part V: The psychology of addiction

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The Psychology of Addiction

Now that we've looked at the biological bases of addiction, let's spend some time on the psychology of addiction. We'll review these concepts:

1. Progression of the disease
2. The concept of Recovery
3. Denial and other defense mechanisms
4. Relapse (chemical and behavioral)
5. Co-dependency

Progression of Addiction

We've already discussed how addiction is a progressive disorder (getting worse over time). As such, we can identify certain characteristics of "early stage" and "late stage" addiction.

However, it's important to keep in mind that some people progress quickly to more serious problems, while others follow a long progression.

Progression of Addiction (cont.)

EARLY STAGES: A person uses drugs of abuse to achieve a feeling of euphoria or to relieve stress. Using is escapist, sociable, and fun.

However, the person begins to need more and more. The fun begins to go out of the situation as the person realizes she cannot feel normal without her drug. The person begins to feel guilty and ashamed, and increasingly uses denial.

There may be the first damaging consequences (problems at work, in the family, etc). [16]

Progression of Addiction (cont.)

LATE STAGES: Using drugs feels more like a necessity of survival than a form of recreation. The problems often begin to mount, and the person becomes increasingly unable to function.

The addict loses interest in anything besides using. If the addict has been able to hide her using, this becomes more and more difficult as the addiction progresses.

Typically, the later stages of addiction are characterized by increasing physical problems and illness. For example, an alcoholic may experience liver failure or hepatitis.

Spotlight: High & Low Bottoms

In 12-step programs people talk about “high bottoms” and “low bottoms.” These terms remind us that some people fall faster and harder than others. A person’s “bottom” is the point at which they seek help or walk away from the drugs of abuse.

A person with a high bottom walks away from it with only minor damage. The first this person gets reprimanded at work for coming in late, he cleans up his act and stops excessive use.

A person with a low bottom has to fall further down before dealing with the problem. Such a person may have to get very ill, or lose his family, or even become homeless before taking action.

Defense Mechanisms

Defense Mechanisms are psychological strategies for dealing with stress. These strategies are used by the mind (often unconsciously) to keep us from being overwhelmed with stress.

Defense mechanisms are normal and necessary. We can't worry about everything at once, or we couldn't function! There has to be some "filter" for keeping things from becoming too intense or too painful.

However, sometimes defense mechanisms become so rigid that we lose our flexibility, and we find it hard to change…even when change would be good. (17)

Defense Mechanisms (continued)

All defense mechanisms distort reality to some extent, because they “tailor” reality to feel a little more comfortable. The question becomes, just how much distortion is safe?

In addiction, defense mechanisms often distort reality to a dangerous extent. It gets harder to cover up the truth when the consequences start to pile up…broken families, legal charges, ruined careers.

Also, the defense mechanisms in addiction can harm the addict’s loved ones…some of them start to wonder if they are the crazy ones, because the addict is so adamant that they have no problems.

Defense Mechanisms (continued)

Let's look at a list of some of the defense mechanisms that are commonly used to promote addictive behavior.

- ✓Denial
- ✓Rationalization
- ✓Isolating
- ✓Blaming
- ✓Minimizing

Defense Mechanisms (continued)

Denial is an example of a defense mechanism that is often seen with addiction. The defense of denial is to deny the truth.

Denial is useful to an addict because it serves to cover up the extent of the problem, and allow the using to continue.

Remember that in addiction, people become “biologically programmed” to need their drug at all costs. Denial is a powerful way of “keeping the pressure off” so the addict can continue to use.

Other Defense Mechanisms

Rationalization is another example of a defense mechanism that is often seen with addiction. The purpose is to make the irrational sound rational through the uses of justification and excuses. Many addicts have a ready supply of rationalizations to use on themselves and others, such as:

- "I'm not hurting anybody."
- "I can stop anytime I want (I just don't want to yet)."
- "I had a hard day today. I deserve a drink."
- "It relaxes me."

Other Defense Mechanisms

Isolating is a behavior that also serves to protect the addiction. Although drug use may start out as a social behavior, addiction ends up driving a wedge between the addict and others. Efforts to hide and maintain the addiction distances them from loved ones, and the company of non-addicts becomes too intrusive and painful.

As a result, some addicts end up shooting themselves up in dark rooms, or drinking alone, far from others. Others sink into a drug "subculture," in which there are no true friendships, but only alliances of convenience in the continuing drive for self-gratification.

Other Defense Mechanisms

Blaming. It can be very convenient to point the finger at someone else, when we want to avoid notice! Blaming takes the heat off by putting it on someone else. Naturally, this is painful and frustrating for others, and self-defeating to the addict.

- "If my husband had fixed that tail-light, I wouldn't have gotten this DUI."
- "If you lived here, you'd drink too."
- "If my wife/husband treated me right, I wouldn't have to do this."

Other Defense Mechanisms

Minimizing involves "watering down" the problem by acting cavalier about the consequences, or dismissive of the wreckage caused by addiction.

- "All my DUIs are five years apart."
- "I never drink before noon, I can't be an alcoholic."
- "At least I don't use as much as X."
- "I may miss some work, but I still get more work done than all those other slobs."

Relapse

The disease model of addiction, discussed above, encourages us to think of “relapses” in addictive behavior. A relapse is a return to a previously abusive level of using or drinking.

The very idea of “relapse” suggests the idea of the disease model, because it describes addiction as a chronic condition that never goes away, but can only lay dormant.

Relapse is a very important concept in treatment, because many treatment models focus upon relapse prevention as a key intervention for reducing addictive behaviors.

Kinds of Relapse

It's useful to anticipate relapse before it becomes a reality. The addict in recovery wants to stop relapse in its tracks before taking the first drink (or smoke, or injection), not after.

For this reason, we conceptualize two types of relapse: behavioral relapse (also called dry relapse, or "dry drunk") and chemical relapse.

Let's look closer at these two concepts…

Kinds of Relapse (continued)

Behavioral relapse describes a time of eminent danger of relapse. The addict may start having old thoughts of using, or going back to places where she used, or suffering from some of the emotional pains that caused her to use in the first place.

In 12-step programs, they talk about people, places, and things you associate with using…and can trigger using again.

Kinds of Relapse (continued)

Chemical relapse describes a time of actual using the drug. Usually when you hear a person say "I relapsed last month," they mean a chemical relapse in which they actually used. But as we have seen, the actual using part can be seen as the end of a process that was building up towards using.

Relapse prevention is all about making sure behavioral relapse doesn't become chemical relapse.

Codependence

Codependence describes loved ones of an addict who act as enablers of that addict. Enabling means that the loved one "enables," or facilitates, the addiction. Types of enabling behavior include:

- ✓Making excuses for the addict ("I'll call your boss to tell him you're sick again today")
- ✓Giving the addict a long string of "one more last chances"
- ✓Bailing them out of jail (again)
- ✓Loaning them money (again)

Codependence (continued)

A word of caution about codependency and enabling. Enabling an addict does not make addiction the codependent person's fault.

In fact, enabling behaviors usually begin with well-meaning intentions, and may be borne out of love or concern.

But at some point, protecting the addict might mean protecting the addiction. Unfortunately, many addicts are all-too-willing to enlist the help of others in protecting them from the consequences of their actions.

Remember: Often, negative consequence are what helps the addict to achieve recovery! The loving thing to do may be letting them happen.

First Step
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Part VI: Treatment Options

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Treatment for Substance Abuse

Finally, let's take a look at the treatment options available for substance abuse and dependence.

Speaking very generally, there are two types of organized care available: peer-support programs and professional treatment programs.

Peer support programs include the many types of 12-step programs available to addicts and their loved ones. Examples are AA, NA, and CODA.

Professional programs are run by trained mental health, medical, and/or substance abuse professionals. Examples are outpatient programs, residential programs, and inpatient programs.

Peer Support Programs

Alcoholics Anonymous (AA). A 12-step program is designed for anyone with a desire to stop drinking. Look in your local telephone directory or call: (212) 870-3400

Cocaine Anonymous (CA). 12-step program focusing on cocaine. Call the Omaha referral line at: (402) 978-8881

Narcotics Anonymous (NA). 12-step program for all drugs of abuse.

McCook	345-5839
Scottsbluff, Gering, & Sidney	(866) 466-3673
Lincoln	474-0405
Omaha	660-3662

Peer Support Programs

Codependents Anonymous (CODA). A program designed for people in relationships with addicts, and to help end the enabling. Call the Fellowship Services Office at (602) 277-7991.

Al-Anon. Designed “To help families and friends of alcoholics recover from the effects of living with the problem drinking of a relative or friend.” National service line at 888-4AL-ANON.

Al-Ateen. “A fellowship of young Al-Anon members, usually teenagers, whose lives have been affected by someone else's drinking. National service line at 888-4AL-ANON.

Spotlight: 12-Step groups

We've looked at some of the different 12-step groups you're likely to find in Nebraska.

- All the 12-step programs are confidential and pledge to protect your identity. Most organizations have meeting throughout the state; the larger cities may have dozens of meetings. Some meetings are open to the public (including non-addicts), while others are open only to members.

- Some meetings focus on readings (such as from AA's "Big Book"), some on speakers, and others more on fellowship. The important thing is for the addict to find a meeting he or she finds comfortable. If one doesn't work, try another.

Spotlight: Finding a sponsor

Most 12-step groups operate on the sponsor system. A sponsor is an individual (same sex, as a rule) who “coaches” the addict through recovery.

The sponsor is a recovering addict who has at least several years of sobriety and some experience in helping.

All sponsors are not alike. Some require a disciplined program, such as checking in every day. Others are more casual and play-it-by-ear.

Some 12-step meetings have lists of available sponsors. Sometimes the addict just has to network or ask around.

Formal Treatment Programs

We will look at the more common types of formal treatment in Nebraska, from least to most restrictive.

Education Classes. These are brief educational seminars offered by professional staff. They are recommended for people just beginning to show a pattern of abuse (not dependence).

Outpatient Treatment. Outpatient treatment meets usually 2-3 times per week, in the form of groups led by a credentialed therapist or counselor. It consists of education about substance abuse and some counseling. They are recommended for people with an established pattern of abuse (not dependence).

Formal Treatment Programs

Intensive Outpatient Treatment. This form of treatment takes the form of a group that meets usually 4 or more times per week. It emphasizes counseling and treatment more than just education, and provides more "structure" than just outpatient treatment. It is for people with substance dependence who are otherwise able to live independently.

Residential Treatment. This is a structured program in which the addict lives in a supportive environment, usually with highly structured days including treatment and education episodes. There is usually access to a professional staff who may offer multidisciplinary services.

Formal Treatment Programs

Inpatient Treatment. This form of treatment requires hospitalization of the addict. The person receives round the clock monitoring and structure, and a trained staff is always on hand. This type of treatment is indicated for people who are too disorganized or dangerous to themselves to live independently, or who suffer from psychiatric or physical problems that prevent minimal functioning.

Obviously, the more restrictive the setting, the fewer resources are available. Outpatient programs of various types are more common that inpatient facilities, of which there are only a handful around the State of Nebraska.

Spotlight: 12-step vs. Treatment

Q. What's the difference between going to a 12-step program and going to treatment?

A. 12-step programs are especially useful for social and interpersonal support. A sponsor may be there for you day and night, while the clinic is closed. Treatment programs are useful when when the consequences of using have become too severe to handle with meetings alone.

Keep in mind: formal treatment AND 12-step meetings are a powerful combination. Many treatment programs even require 12-step participation.

Spotlight: 12-step vs. Treatment

Q. How do I know if a person needs more than 12-step meetings, and should go to treatment?

A. Many addicts and abusers end up in formal treatment because of a referral (for example, from a physician, attorney, case worker, or probation officer). In general, the more harmful and disruptive the behavior has become, the more necessary it is to seek formal treatment. Ask an expert.

Once in formal treatment, the abuser or addict is more likely to get access to skilled help that may be necessary (mental health care, medication, case management, etc).

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