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Recovery Coaching

Instructor Note: Welcome students to the world of Recovery Coaching. In this introduction you will read about some history of drug & alcohol treatment, which is important as it provides a framework of understanding of where we started and perhaps, where we will be going. However, a significant portion of the introduction explains who a Recovery Coach is, what is expected of Recovery Coaches, who we help, how do they come to us and more importantly, how do we keep them and move them forward. Read carefully this section has a wealth of information that you will need to have the appropriate, professional mindset.

Understanding Addiction

So many people entering the field of addiction treatment come with the mindset of “I have personal experience and that is enough to help others” or “I want to help others and I have clinical knowledge of therapy and that is enough”. While these experiences and knowledge will add to your coaching experience it will not be enough to frame your whole scope.

Most of society has some level of knowledge and understanding of drug and alcohol use and abuse. There are articles, books, TV shows, movies etc. Of course, most have some level of personal experience with addiction. Does this mean you have an understanding of addiction, how it happens, how it progresses, how it effects our brains, our bodies, our psyche??? The answer is NO.

This course covers a significant amount of information to help you see the whole picture of addiction, a picture that goes beyond what our client’s use, how much and how long. To work in addictions your level of knowledge and understanding of addiction will help you work clients on a different level. You will be able to assist the client in seeing themselves as a whole person, not just an addict. You will have the tools to educate, guide and answer questions posed by your client’s with confidence and clarity.

Let’s start by defining addiction.



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Definition of Addiction

American Society of Addiction Medicine (ASAM)

Public Policy Statement: Definition of Addiction

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, and craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Dictionary.com

The state of being enslaved to a habit or practice or to something that is psychologically or physically habit-forming, as narcotics, to such an extent that its cessation causes severe trauma.

Merriam-Webster Dictionary

1. (Noun) The quality or state of being addicted <*addiction* to reading>. An unusually great interest in something or a need to do or have something.
2. A strong and harmful need to regularly have something (such as a drug) or do something (such as gamble).
3. (Medical Definition) Compulsive need for and use of a habit-forming substance (as heroin, nicotine, or alcohol) characterized by tolerance and by well-defined physiological symptoms upon withdrawal; broadly: persistent compulsive use of a substance known by the user to be harmful.

Wikipedia

Addiction is a state characterized by compulsive engagement in rewarding stimuli, despite adverse consequences. It can be thought of as a disease or biological process leading to such behaviors. The two properties that characterize all addictive stimuli are that they



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are (positively) reinforcing (i.e., they increase the likelihood that a person will seek repeated exposure to them) and intrinsically rewarding (i.e., they activate the brain's "reward pathways", and are therefore perceived as being something positive or desirable).

Psychology Today

Addiction is a condition that results when a person ingests a substance (e.g., alcohol, cocaine, nicotine) or engages in an activity (e.g., gambling, sex, shopping) that can be pleasurable but the continued use/act of which becomes compulsive and interferes with ordinary life responsibilities, such as work, relationships, or health. Users may not be aware that their behavior is out of control and causing problems for themselves and others.

National Institute on Drug Abuse (NIDA)

Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain; they change its structure and how it works. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors.

What is the Medical Definition of Addiction

1. **Tolerance.** Do you use more alcohol or drugs over time?
2. **Withdrawal.** Have you experienced physical or emotional withdrawal when you have stopped using? Have you experienced anxiety, irritability, shakes, sweats, nausea, or vomiting? Emotional withdrawal is just as significant as physical withdrawal.
3. **Limited control.** Do you sometimes drink or use drugs more than you would like? Do you sometimes drink to get drunk? Does one drink lead to more drinks sometimes? Do you ever regret how much you used the day before?
4. **Negative consequences.** Have you continued to use even though there have been negative consequences to your mood, self-esteem, health, job, or family?
5. **Neglected or postponed activities.** Have you ever put off or reduced social, recreational, work, or household activities because of your use?



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6. **Significant time or energy spent.** Have you spent a significant amount of time obtaining, using, concealing, planning, or recovering from your use? Have you spend a lot of time thinking about using? Have you ever concealed or minimized your use? Have you ever thought of schemes to avoid getting caught?
7. **Desire to cut down.** Have you sometimes thought about cutting down or controlling your use? Have you ever made unsuccessful attempts to cut down or control your use?

Illegal Drugs in America – A Modern History

Since the 19th century when Americans first discovered new wonder drugs like morphine, heroin, and cocaine, our society has confronted the problem of drug abuse and addiction. Drug abuse and addiction has been a social problem in America for nearly a century. What may be surprising is that many of these illegal drugs were first introduced by doctors as legal over-the-counter and prescription medications. Here's more about the history of illegal drugs in America.

When the 20th century began, the United States--grappling with its first drug epidemic--gradually instituted effective restrictions: at home through domestic law enforcement and overseas by spearheading a world movement to limit opium and coca crops. By World War II, American drug use had become so rare, it was seen as a marginal social problem. The first epidemic was forgotten.

During the 1960s, drugs like marijuana, amphetamines, and psychedelics came on the scene, and a new generation embraced drugs. With the drug culture exploding, our government developed new laws and agencies to address the problem. In 1973, the U.S. Drug Enforcement Administration was created to enforce federal drug laws. In the 1970s, cocaine reappeared. Then, a decade later, crack appeared, spreading addiction and violence at epidemic levels.

Today, the DEA's biggest challenge is the dramatic change in organized crime. While American criminals once controlled drug trafficking on U.S. soil, today sophisticated and powerful criminal groups headquartered in foreign countries control the drug trade in the United States.

History of Marijuana in America

Perhaps one of the oldest drugs in American history is marijuana, which was grown by the Jamestown settlers around 1600. Before the Civil War marijuana was a major source of revenue for the U.S., and marijuana plantations flourished during the 19th century. Marijuana was widely used as a medicinal drug from 1850 to 1937 and could even be purchased over the



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counter in pharmacies and general stores. Marijuana became an attractive alternative to alcohol after the price of alcohol was raised in 1920.

In the 1930s, studies began to emerge that linked marijuana use by lower class communities to crime and violence, leading to the eventual banning of marijuana in 1937. In the 1960s, marijuana use became a popular drug of choice among white Beatniks, and stricter penalties for marijuana offenses were passed under the Comprehensive Drug Abuse Prevention and Control Act of 1970. Since then, citizens and politicians alike have pushed to have marijuana decriminalized, but it remains an illegal drug in the U.S. Marijuana was, however, legalized for medical use in California in 1966 for people with serious illnesses, and medical marijuana still remains legal in some states.

History of Methamphetamine in America

The stimulant amphetamine first became popular in the medical community in the 1920s, where it was used for stimulating the central nervous system, raising blood pressure, and enlarging nasal passages. Amphetamines were widely distributed to soldiers during World War II to combat fatigue and improve endurance and mood, and were prescribed by doctors after the war to help fight depression.

Amphetamine abuse began during the 1930s when it became an over-the-counter inhalant drug marketed under the name Benzedrine. As more and more people legally used amphetamines, an illegal black market began to emerge. Illegal amphetamines were used commonly by truck drivers who wanted to stay alert on long commutes and athletes looking to improve their performance. Students also began taking illicit amphetamines to help them study.

The practice of injecting amphetamines gained popularity in the 1960s, which led the emergence of underground labs that were mainly controlled by outlaw motorcycle groups. During the 1970s, amphetamine use began to decline due to increased public awareness of its dangers and remained on a decline until the 1990s when crystal methamphetamine, a smokable form of methamphetamine, emerged. Since then, crystal meth has remained a popular drug of choice for three main types of users: high school and college students; blue-collar Caucasians; and unemployed persons in their 20s and 30s.

History of Cocaine in America

Cocaine was a popular medical drug in Europe for decades before it became popular in America. In 1886, “Coca-Cola” was introduced and contained syrup derived from coca leaves. That same year the Surgeon-General of the United States Army endorsed medical use of



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cocaine. Over the next few decades various unregulated medicinal “tonics” were sold in the U.S. containing cocaine, and hundreds of Hollywood silent movies depicted scenes of cocaine use. By 1902 there were an estimated 200,000 cocaine addicts in the U.S.

Cocaine was finally outlawed in 1914 and declined in usage over the decades until it regained popularity in the 1970s as a recreational, glamorized drug, eventually reaching its peak in 1982 with 10.4 million users. Some U.S. media declared cocaine as non-addictive and it was viewed as a relatively harmless drug until the emergence of crack in 1985.

History of Crack Cocaine in America

Crack, a form of cocaine that is sold as “rocks” and smoked, first appeared in large U.S. cities around 1985. Crack became a popular alternative to cocaine in urban and working-class areas because it was much cheaper than cocaine. This led to a dramatic increase in crack use known as the “Crack Epidemic of the 1980s.” A major crackdown on crack abuse was launched, leading to its eventual decline in usage.

History of LSD in America

LSD first emerged on the American scene during the 1950s, when the U.S. military and CIA researched the use of LSD as a “truth drug” that could be used to make prisoners talk. This led the psychiatric community to become interested in LSD for its possible therapeutic capabilities for depressed, psychotic and epileptic patients.

Illegal use of LSD began to escalate during the late 1950s and 1960s as mental health professionals and research study participants began to distribute the drug among their friends. LSD was only available through connections to the medical field until 1962, when a black market for LSD emerged in America. LSD was made illegal in 1966 and, soon after, an LSD black market emerged. Users began experiencing growing problems with the “new” LSD, which was contaminated and of a poorer quality than the medical-grade LSD they were used to. Despite its poorer quality, LSD was a popular drug of choice for “hippies” during the mid- to late-1960s. LSD use declined in the 1970s and 1980s, but reemerged in the 1990s in the rave subculture along with other hallucinogens.

History of Heroin in America

Opiates were popular in the United States throughout the 19th century, particularly among upper- and middle-class women who were prescribed tonics and elixirs containing opium to cure “female problems.” The practice of smoking opium was introduced in the 1850s and 1860s by Chinese laborers who came to the U.S. to work on railroads.



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The opiate-based drug morphine was created in 1803 and widely used during the American Civil War as an injectable pain reliever, leading to the first wave of morphine addiction. Interestingly, the drug heroin was created in 1895 and marketed three years later as a potential solution to the increasing problem of morphine addiction. The charitable St. James Society even mailed free samples of heroin to morphine addicts as part of a campaign against morphine addiction. As a result, heroin addiction began to take root and grow.

The second major wave of opiate addiction in America began in the 1930s and 1940s Harlem jazz scene, and again during the Beatnik subculture of the 1950s. During the Vietnam War, heroin abuse became rampant among U.S. soldiers stationed abroad, with an estimated 10% to 15% of servicemen addicted to heroin. Heroin users began smoking and snorting heroin after improvements were made in the purity of street heroin in the 1980s and 1990s. As a result, heroin usage rose significantly in the 1990s.

Brief Overview of Addiction – The Basics

Why study drug abuse and addiction?

Abuse of and addiction to alcohol, nicotine, and illicit and prescription drugs cost Americans more than \$700 billion a year in increased health care costs, crime, and lost productivity. Every year, illicit and prescription drugs and alcohol contribute to the death of more than 90,000 Americans, while tobacco is linked to an estimated 480,000 deaths per year.

How are drug disorders categorized?

NIDA continues to use the term “addiction” to describe compulsive drug seeking despite negative consequences. However, “addiction” is not considered a specific diagnosis in the fifth edition of The Diagnostic and Statistical Manual of Mental Disorders (DSM-5)—a diagnostic manual used by clinicians that contains descriptions and symptoms of all mental disorders classified by the American Psychiatric Association (APA).

In 2013, APA updated the DSM, replacing the categories of substance abuse and substance dependence with a single category: substance use disorder. The symptoms associated with a substance use disorder fall into four major groupings: impaired control, social impairment, risky use, and pharmacological criteria (i.e., tolerance and withdrawal).



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What is the difference between physical dependence, dependence, and addiction?

Physical dependence is not equivalent to dependence or addiction, and may occur with the regular (daily or almost daily) use of any substance, legal or illegal, even when taken as prescribed. It occurs because the body naturally adapts to regular exposure to a substance (e.g., caffeine or a prescription drug). When that substance is taken away, symptoms can emerge while the body re-adjusts to the loss of the substance. Physical dependence can lead to craving the drug to relieve the withdrawal symptoms. Drug dependence and addiction refer to substance use disorders, which may include physical dependence but must also meet additional criteria.

How do drugs work in the brain to produce pleasure?

Nearly all addictive drugs directly or indirectly target the brain's reward system by flooding the circuit with dopamine. Dopamine is a neurotransmitter present in regions of the brain that regulate movement, emotion, cognition, motivation, and feelings of pleasure. The overstimulation of this system, which rewards our natural behaviors, produces the euphoric effects sought by people who use drugs and teaches them to repeat the behavior.

Is drug abuse a voluntary behavior?

The initial decision to take drugs is mostly voluntary. However, when addiction takes over, a person's ability to exert self-control can become seriously impaired. Brain-imaging studies from people addicted to drugs show physical changes in areas of the brain that are critical for judgment, decision-making, learning, memory, and behavior control. Scientists believe that these changes alter the way the brain works and may help explain the compulsive and destructive behaviors of an addicted person.

Can addiction be treated successfully?

Yes. Addiction is a treatable, chronic disease that can be managed successfully. Research shows that combining behavioral therapy with medications, where available, is the best way to ensure success for most patients. Treatment approaches must be tailored to address each patient's drug use patterns and drug-related medical, psychiatric, and social problems.

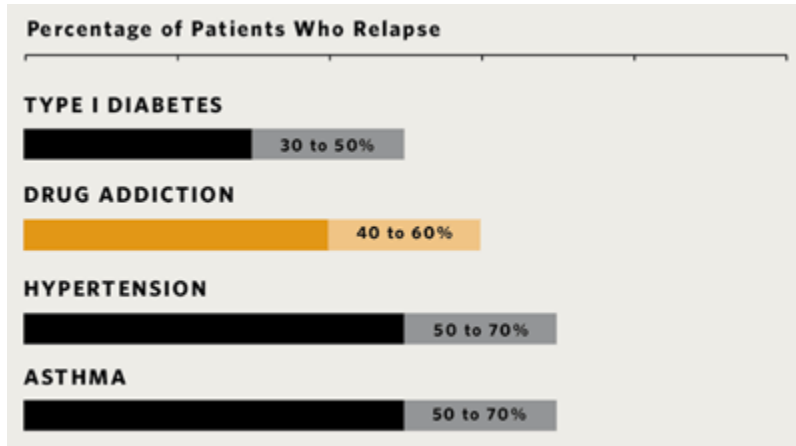
How many people die from drug use?

The Centers for Disease Control and Prevention (CDC) report that there were more than 40,000 unintentional drug overdose deaths in the United States in 2011, a 118-percent increase since



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1999. More than 22,000 people die every year from prescription drug abuse, more than heroin and cocaine combined.



Relapse rates for drug-addicted patients are compared with those suffering from diabetes, hypertension, and asthma. Relapse is common and similar across these illnesses (as is adherence to medication). Thus, drug addiction should be treated like any other chronic illness, with relapse serving as a trigger for renewed intervention.

Source: McLellan et al., JAMA, 284:1689-1695, 2000.

How Common is Drug or Alcohol Addiction

Approximately 10% of any population is addicted to drugs or alcohol. **Addiction is more common than diabetes**, which occurs in approximately 7% of the population.

Addiction crosses all socio-economic boundaries. 10% of teachers, 10% of plumbers, and 10% of CEOs have an addiction.

The terms alcohol addiction, alcoholism, and alcohol dependence are all equivalent. The same is true for the terms drug addiction and drug dependence.



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The Cost of Addiction

The dollars and cents cost of addiction is mind boggling. At least twice as many people die from alcoholism in the US every year as die from motor vehicle accidents.

Alcohol intoxication is associated with 40-50% of traffic fatalities, 25-35% of nonfatal motor vehicle injuries, and 64% of fires. Alcohol is present in nearly 50% of homicides, either in the victim or the perpetrator.

Alcohol intoxication is involved in 31% of fatal injuries, and 23% of completed suicides.

One study found that 86 % of homicide offenders, 37 % of assault offenders, and 57 % of men and 27 % of women involved in marital violence were drinking at the time of their offense.

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Five Things to Know about Alcohol

1. Almost one in 10 people in the United States experience alcohol dependence at some time during their lives.

Alcoholism occurs in both sexes, all ethnic and racial groups, and in people from all walks of life. It develops when someone drinks too much too often. Drinking more than three drinks a day if you are a woman or four drinks if you are a man increases health risks, including risk for alcohol dependence.

2. Alcoholism usually starts in the late teens or early twenties, yet most people don't seek help until 15- 20 years later.

Earlier treatment is more successful and results in far less destruction to individuals and their families.

3. Only about one in 10 people with alcoholism ever receives professional treatment.



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Recent research suggests that newer medications are effective treatments for alcohol dependence when combined with brief counseling by a health professional. This means that many more people can receive treatment from their family, or primary care, doctor. Specialized alcohol counseling also works well, and all approaches (12-step, cognitive and motivational) are about equally effective. Some people will need more intensive programs.

4. Whatever treatment a person receives, the most important thing is they stick with it. The longer a person stays in treatment, the more likely they are to succeed.

If a person has a relapse, recognize that this is a chronic disease, and try to help them get back on track as quickly as possible. If they are taking medication for alcohol dependence, be sure to check they are taking it as prescribed. Encourage them not to discontinue it even if they don't notice feeling any different. The medicine is working if they are not drinking, or if they are drinking much less.

5. Twelve-step and other support programs really do work! Recovering people who attend groups on a regular basis do better than those who do not.

If the recovering person is taking medication for alcohol dependence, allay worries about whether it is a "crutch." Medication can improve recovery rates by 20-40% in the first three months after stopping. Also, it's fine to take medication and to attend support groups or alcohol counseling.

Instructor Note: There are many, many more statistics and trends now, research has grown by leaps and bounds in the area of addiction and because of that we know so much more than ever before. Which in turn finally arms us with the ability to answer some of our clients baffling yet heartfelt questions about why they do what they do.

This Is Your Brain On Drugs:

Understanding Addiction from the Inside out






Understanding Drug & Alcohol Use, Abuse & Addiction

People experiment with drugs for many different reasons. Many first try drugs out of curiosity, to have a good time, because friends are doing it, or in an effort to improve athletic performance or ease another problem, such as stress, anxiety, or depression. Use doesn't automatically lead to abuse, and there is no specific level at which drug use moves from casual to problematic. It varies by individual.

Why do some drug users become addicted, while others don't?

As with many other conditions and diseases, vulnerability to addiction differs from person to person. Your genes, mental health, family and social environment all play a role in addiction.

Risk factors that increase your vulnerability include:

-  Family history of addiction
-  Abuse, neglect, or other traumatic experiences in childhood
-  Mental disorders such as depression and anxiety
-  Early use of drugs
-  Method of administration—smoking or injecting a drug may increase its addictive potential

Substance Addiction and the Brain

Addiction is a complex disorder characterized by compulsive drug use. While each drug produces different physical effects, all abused substances share one thing in common: repeated use can alter the way the brain looks and functions.

- Taking a recreational drug causes a surge in levels of dopamine in your brain, which trigger feelings of pleasure. Your brain remembers these feelings and wants them repeated.



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- If you become addicted, the substance takes on the same significance as other survival behaviors, such as eating and drinking.
- Changes in your brain interfere with your ability to think clearly, exercise good judgment, control your behavior, and feel normal without drugs.
- Whether you're addicted to inhalants, heroin, Xanax, speed, or Vicodin, the uncontrollable craving to use grows more important than anything else, including family, friends, career, and even your own health and happiness.
- The urge to use is so strong that your mind finds many ways to deny or rationalize the addiction. You may drastically underestimate the quantity of drugs you're taking, how much it impacts your life, and the level of control you have over your drug use.

How Substance Addiction Can Develop

People who experiment with drugs continue to use them because the substance either makes them feel good, or stops them from feeling bad. In many cases, however, there is a fine line between regular use and drug abuse and addiction. Very few addicts are able to recognize when they have crossed that line.

How does Addiction Feel?

An addictive substance feels good because it stimulates the pleasure center of the brain through neurotransmitters such as dopamine and GABA. If you have a genetic predisposition, addictive substances don't just feel good. They feel so good that you will want to chase after them.

This is where addiction comes in. If you have a genetic predisposition, addictive substances feel so good that you are willing to suffer negative consequences in order to get more and to continue to feel the high.

Addictive substances feel different inside an addict's brain than they do to a non-addict. This is why the two sides have difficulty understanding each other. In someone who is not addicted, drugs and alcohol only produce a mild high. Therefore, a non-addict cannot understand why the addict would go to such lengths, when it is clearly destroying their life.

The Genetics of Addiction

The Role of Family History



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Addiction is due 50 percent to genetic predisposition and 50 percent to poor coping

skills. This has been confirmed by numerous studies. One study looked at 861 identical twin pairs and 653 fraternal (non-identical) twin pairs. When one identical twin was addicted to alcohol, the other twin had a high probability of being addicted. But when one non-identical twin was addicted to alcohol, the other twin did not necessarily have an addiction. Based on the differences between the identical and non-identical twins, the study showed 50-60% of addiction is due to genetic factors. Those numbers have been confirmed by other studies.

The children of addicts are 8 times more likely to develop an addiction.

One study looked at 231 people who were diagnosed with drug or alcohol addiction, and compared them to 61 people who did not have an addiction. Then it looked at the first-degree relatives (parents, siblings, or children) of those people. It discovered that if a parent has a drug or alcohol addiction, the child had an 8 times greater chance of developing an addiction.

Why are there genes for addiction?

We all have the genetic predisposition for addiction because there is an evolutionary advantage to that. When an animal eats a certain food that it likes, there is an advantage to associating pleasure with that food so that the animal will look for that food in the future. In other words the potential for addiction is hardwired into our brain. Everyone has eaten too much of their favorite food even though they knew it wasn't good for them.

Although everyone has the potential for addiction, some people are more predisposed to addiction than others. Some people drink alcoholically from the beginning. Other people start out as a moderate drinker and then become alcoholics later on.

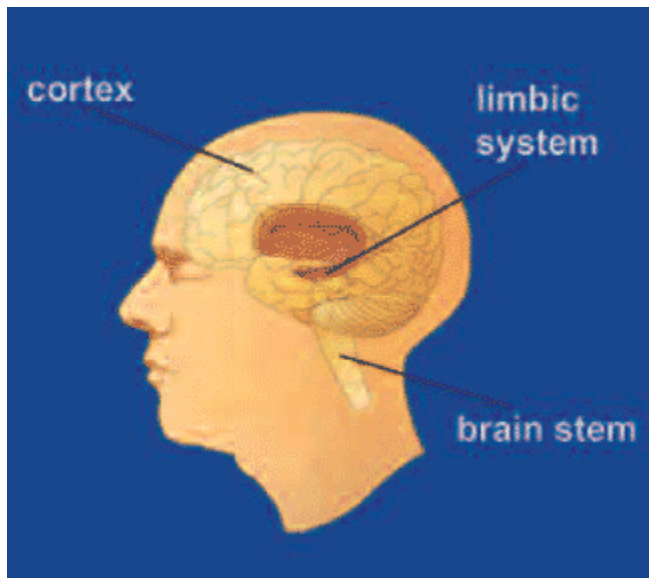
Repeatedly abusing drugs or alcohol permanently rewires your brain.

If you start out with a low genetic predisposition for addiction, you can still end up with an addiction. If you repeatedly abuse drugs or alcohol because of poor coping skills, then you'll permanently rewire your brain. Every time you abuse alcohol, you'll strengthen the wiring associated with drinking, and you'll chase that buzz even more. The more you chase the effect of alcohol, the greater your chance of eventually developing an addiction.

Genes are not your destiny. The 50% of addiction that is caused by poor coping skills is where you can make a difference. Lots of people have come from addicted families but managed to overcome their family history and live happy lives.

Let's Look Inside the Brain😊

The brain is made up of many parts that all work together as a team. Different parts of the brain are responsible for coordinating and performing specific functions. Drugs can alter important brain areas that are necessary for life-sustaining functions and can drive the compulsive drug abuse that marks addiction. Brain areas affected by drug abuse include:



- **The brain stem**, which controls basic functions critical to life, such as heart rate, breathing, and sleeping.
- **The cerebral cortex**, which is divided into areas that control specific functions. Different areas process information from our senses, enabling us to see, feel, hear, and taste. The front part of the cortex, the frontal cortex or forebrain, is the thinking center of the brain; it powers our ability to think, plan, solve problems, and make decisions.
- **The limbic system**, which contains the brain's reward circuit. It links together a number of brain structures that control and regulate our ability to feel pleasure. Feeling pleasure motivates us to repeat behaviors that are critical to our existence. The limbic system is activated by healthy, life-sustaining activities such as eating and socializing—but it is also



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activated by drugs of abuse. In addition, the limbic system is responsible for our perception of other emotions, both positive and negative, which explains the mood-altering properties of many drugs.

Cocaine, Marijuana and Heroin in your Brain

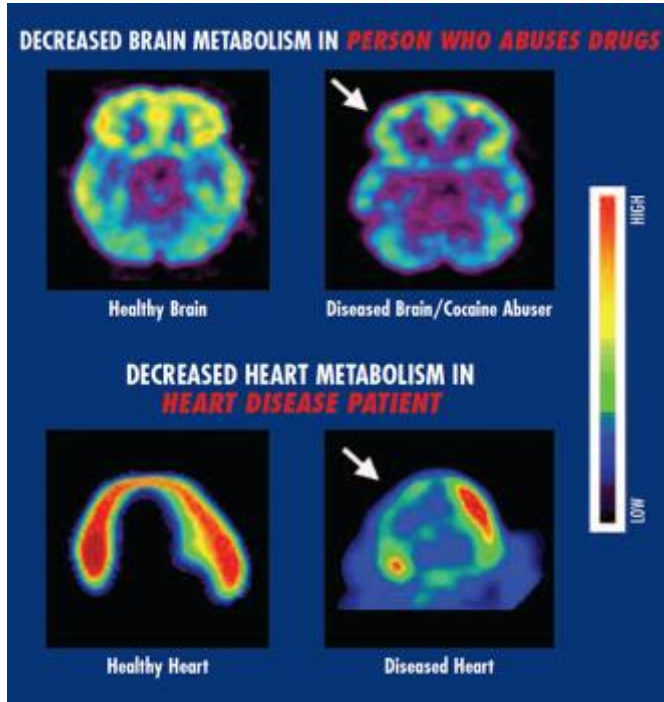
Drugs are chemicals that affect the brain by tapping into its communication system and interfering with the way neurons normally send, receive, and process information. Some drugs, such as marijuana and heroin, can activate neurons because their chemical structure mimics that of a natural neurotransmitter. This similarity in structure “fools” receptors and allows the drugs to attach onto and activate the neurons. Although these drugs mimic the brain’s own chemicals, they don’t activate neurons in the same way as a natural neurotransmitter, and they lead to abnormal messages being transmitted through the network.

Other drugs, such as amphetamine or cocaine, can cause the neurons to release abnormally large amounts of natural neurotransmitters or prevent the normal recycling of these brain chemicals. This disruption produces a greatly amplified message, ultimately disrupting communication channels.

Deeper in the Brain

We know addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain—they change its structure and how it works.

Check out the pictures of the brain impacted by substances below.



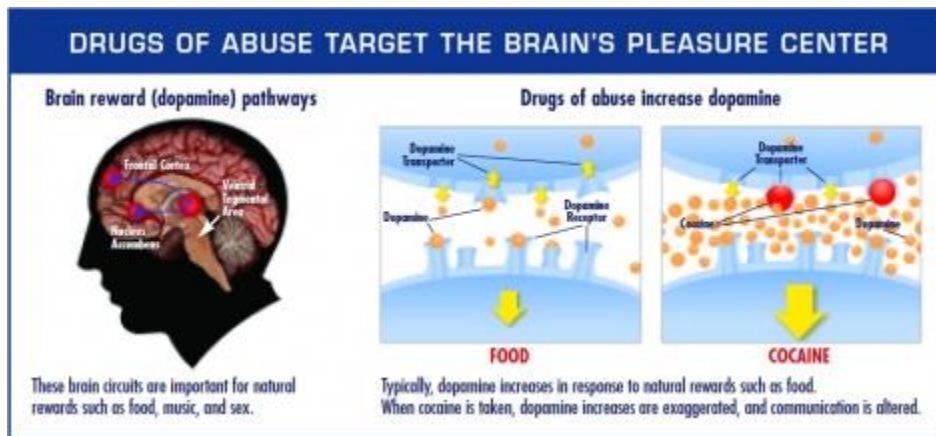
Source: From the laboratories of Drs. N. Volkow and H. Schelbert

Addiction is a lot like other diseases, such as heart disease. Both disrupt the normal, healthy functioning of the underlying organ, have serious harmful consequences, and are preventable and treatable, but if left untreated, can last a lifetime.

How do drugs work in the brain to produce pleasure?

Most drugs of abuse directly or indirectly target the brain's reward system by flooding the circuit with dopamine. Dopamine is a neurotransmitter present in regions of the brain that regulate movement, emotion, motivation, and feelings of pleasure. When activated at normal levels, this system rewards our natural behaviors. Over stimulating the system with drugs, however, produces euphoric effects, which strongly reinforce the behavior of drug use—teaching the user to repeat it.

Most drugs of abuse target the brain's reward system by flooding it with dopamine.



How does stimulation of the brain's pleasure circuit teach us to keep taking drugs?

Our brains are wired to ensure that we will repeat life-sustaining activities by associating those activities with pleasure or reward. Whenever this reward circuit is activated, the brain notes that something important is happening that needs to be remembered, and teaches us to do it again and again without thinking about it. Because drugs of abuse stimulate the same circuit, we learn to abuse drugs in the same way.

Why are drugs more addictive than natural rewards?

When some drugs of abuse are taken, they can release 2 to 10 times the amount of dopamine that natural rewards such as eating and sex do. In some cases, this occurs almost immediately (as when drugs are smoked or injected), and the effects can last much longer than those produced by natural rewards. The resulting effects on the brain's pleasure circuit dwarf those produced by naturally rewarding behaviors. The effect of such a powerful reward strongly motivates people to take drugs again and again. This is why scientists sometimes say that drug abuse is something we learn to do very, very well.

Motivation for Drug Use

The motivation for taking substances is to achieve a desired effect in a reasonably short period of time. This effect or altered mood state is brought about by the effects drugs have on the brain and neurotransmitter systems. The effects on the neurotransmitter systems include action on the levels of the neurotransmitters (i.e., the chemical messengers) and the receptor sites (i.e., the sites where the specific chemical messengers have their effects). The use of drugs may prevent a neurotransmitter from breaking down, leading to a build-up of the neurotransmitter; it can block the reuptake of the neurotransmitter by the sending cell thus making more of the neurotransmitter available to the receiving cell.

Drugs can prevent a neurotransmitter from being produced at the normal level, or may block the receptor sites preventing the neurotransmitter from having its normal effects. Also, drugs can have an effect on the nerve cells in general as a toxin or just making them function slower than normal (Ray & Ksir, 2004; Carroll, 2000).

Neurotransmitters, the chemical messengers, are: GABA relates to inhibitory factors and slows communication. Norepinephrine usually associated with arousal reactions and moods. Dopamine usually associated with feeling of pleasure, Serotonin, usually associated with feelings of anxiety, depression, and aggressiveness, and Acetylcholine, which may be associated with arousal reactions or inhibitory factors (Ray & Ksir, 2004; Carroll, 2000).

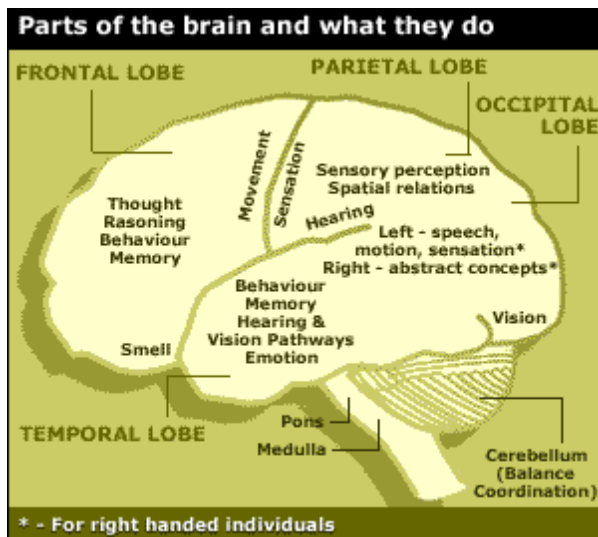
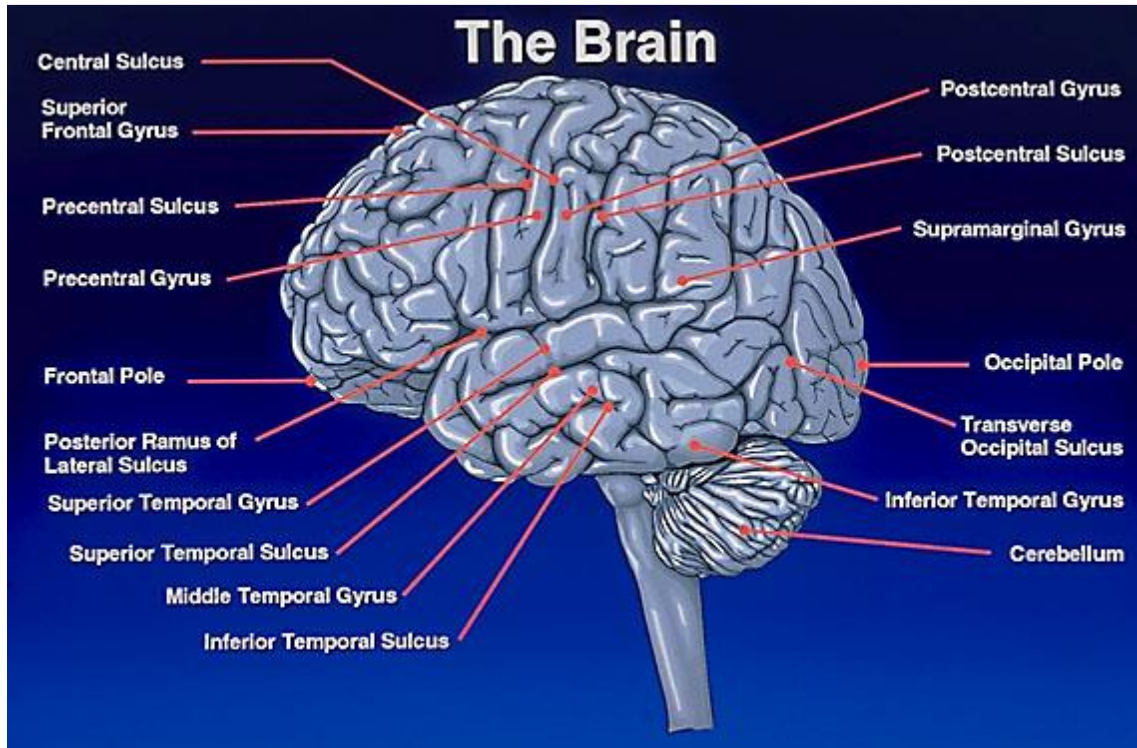
Drugs also activate the pleasure/reward center of the brain, which is made up of the ventral tegmental area (VTA), and the nucleus accumbens and other structures of the brain. These are two structures of the brain that are involved in the reward system for all drugs, although other mechanisms might be involved for specific drugs (Inaba, et al., 1997; Carroll, 2000).

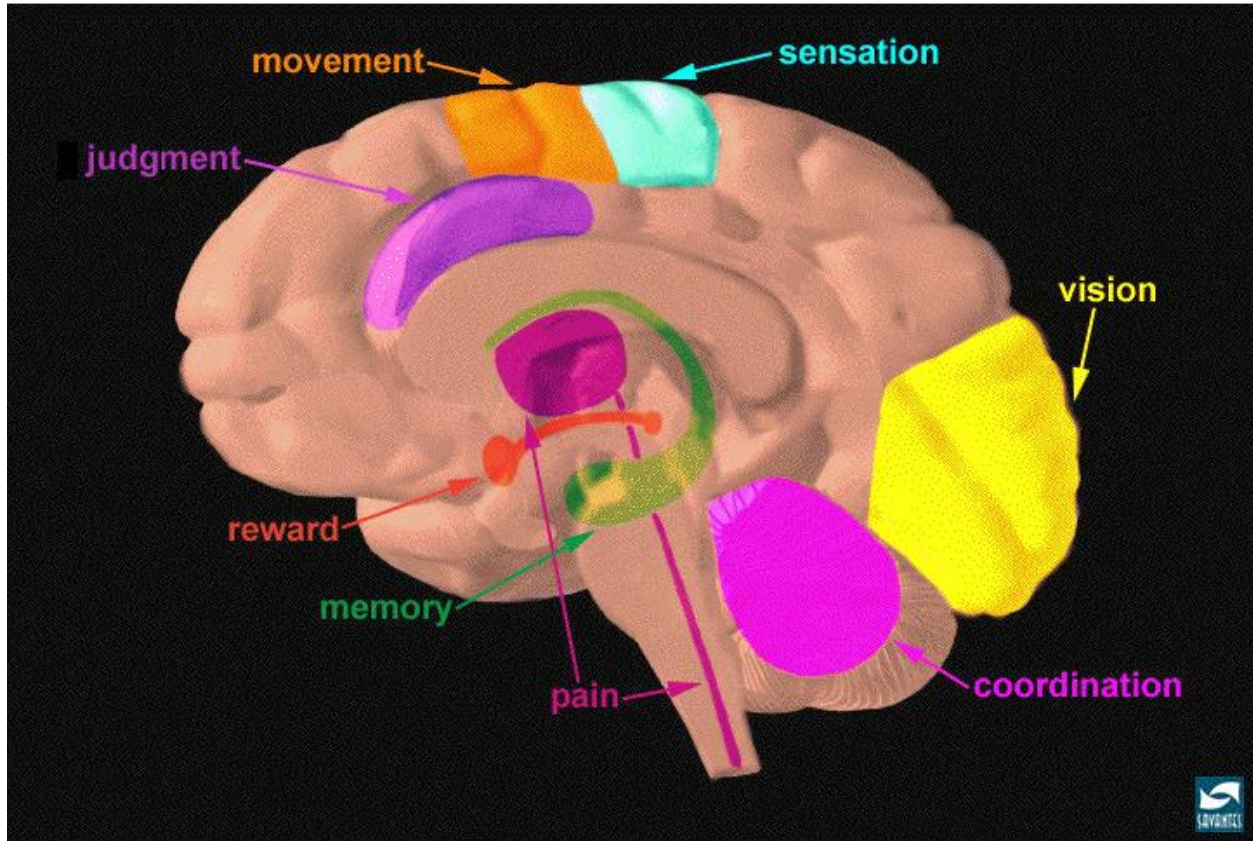
How a drug is distributed throughout the body, where it is stored, and how long it is stored are determined by whether the drug is fat or water-soluble. Fat-soluble drugs store in the fatty areas of the body can have longer lasting traces in the body that water-soluble drugs do not (Ray & Ksir, 2004; Carroll, 2000).

Abuse potential is generally related to the drug's speed of action and how long the effects last. Drugs such as cocaine and nicotine with effects that are felt quickly and also wear off quickly have a high abuse potential. Abuse potential is a pharmacological term based on the effects of a drug; however, there are social factors that may influence it such as social acceptance of use, and opportunity for use (Ray & Ksir, 2004; Carroll, 2000).

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Mountain West ATTC. (2005). *The Brain: Understanding Neurobiology Through the Study of Addiction*. Reno, NV: Author.





Addictions' Effect on the Cerebral Cortex: Impaired Decision-making, Impulsivity, and Compulsivity

The cerebral cortex is the outer most layer of the brain. The cerebral cortex is further divided into four areas. These four areas are: the frontal lobe (or frontal cortex), parietal lobes (left and right), temporal lobes (left and right), and occipital lobes (left and right). Each area is associated with certain brain functions: One area of the frontal cortex is called the prefrontal cortex. It has a vital role in higher-order functions. These functions include language, spatial learning, conscious thought, judgment, and decision-making. The process of addiction can negatively affect this area and alter its functioning.

The prefrontal cortex enables us to make rational, sound decisions. It also helps us to override impulsive urges. If acted upon, these impulsive urges can cause us to act without thinking. This is usually not in our best interest. For instance, suppose I've had a bad day at work. I may have an



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impulsive urge to tell my boss exactly what I think of her. To act on this impulse is not in my best interest. Fortunately, my prefrontal cortex is functioning quite well. I still have my job!

Obviously, this ability to inhibit impulses is very helpful. It enables us to function well in society. It protects us from harm by allowing us to consider the consequences of our actions. However, when the pre-frontal cortex is not functioning correctly, the opposite occurs. Addiction causes changes to the prefrontal cortex. These changes account for two characteristics of addiction: impulsivity and compulsivity.

Impulsivity is the inclination to act upon sudden urges or desires without considering potential consequences. Sometimes people describe impulsivity as living in the present moment without regard to the future. Compulsivity is a behavior that an individual feels driven to perform to relieve anxiety. Once a person performs the compulsive behavior, the anxiety goes away and restores comfort. Thus, the presence of these behavioral characteristics in addicted persons indicates that changes to the prefrontal cortex have occurred. Unfortunately, these changes also make the discontinuation of drug use more difficult.

Addiction is a process that coordinates the transition from impulsive to compulsive behavior. Impulsivity occurs during the early stages of addiction. During this phase, people impulsively act on powerful urges to experience the pleasure of their addiction. Anxiety is not associated with the urges during these early stages. Instead, addiction reflects acting on impulsive desire to receive immediate pleasure from the drug or activity. People are not considering the future consequences.

As addiction progresses a shift begins to occur. At this point, the compulsive aspect of addiction takes hold. When this shift occurs, people are no longer pursuing their addiction solely for pleasure. The compulsions compel them to participate in their addiction to relieve anxious, uncomfortable feelings. These may arise at the mere thought of stopping the addiction for any reason (supply shortages, lack of opportunity, etc.). At this later compulsive stage, "pleasure" comes in the form of relief from these anxious, uncomfortable feelings. Thus, despite the negative consequences of addiction, the addictive behavior continues in a compulsive manner.

Another way to describe the pre-frontal cortex is to think of it as a braking system. The pre-frontal cortex acts as the brain's brakes. It sends out signals to inhibit particular behaviors or actions. When addiction damages this brain area, it limits the brain's ability to control other behavioral systems as well. Imagine how difficult it would be to operate a car without brakes. At this point, we might say the brain is "high-jacked" by the addiction. The prefrontal cortex also projects to other brain regions associated with addictive problems. These include the reward system; memory and emotion; and stress regulation centers of the brain. Therefore,



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damage to the prefrontal cortex may further interfere with the functioning of these other brain regions as well.

Although addiction damages the brain's brakes (pre-frontal cortex) this is not to say there is a complete loss of control. We are not slaves to our biology. We have a tremendous amount of control over our actions. This is true even when impulsive and compulsive forces are operating. This recognition is vitally important if someone wishes to recover from addiction. When a person consciously decides the costs of addiction outweigh its benefits, they become motivated and able to stop. This allows them to actively counter the effects of addiction on the frontal cortex and other brain regions.

Unfortunately, people's addictions limit their ability to use rational thought. This is due in part to the damage to the prefrontal cortex. They may incorrectly tally the costs and benefits of their addiction; over-estimating the benefits, while minimizing the costs. The addict is often told, "You're in denial." This is incorrect. When people use this phrase, they are applying it improperly. Denial refers to a psychological defense, or justification for a negative behavior. This is quite different than a loss of rational brain functioning that occurs with addiction. This is where addiction treatment professionals can be very helpful. They can guide addicted persons to make an accurate assessment of the costs and benefits. This more accurate assessment often leads to the motivation to change. Once someone decides it is time to change, they have taken the first step toward recovery.

The addiction process relies on learning and memory to drive the addiction cycle forward. Addiction chemically alters the system. However, people can learn how to counteract these changes. There are specific techniques that people can learn to oppose powerful urges. As people become more skillful, the wonderfully adaptive brain makes adjustments and corrections. This in turn leads to lasting recovery from addiction. In some cases, pharmacological intervention may also be beneficial.

Addictions' Effect on the Amygdala: Habit Formation, Craving, Withdrawal, and Relapse Triggers

People often describe addiction as a habit, and one that is difficult to break. This is because when people attempt to discontinue an addictive behavior (drug use or addictive activities) they experience withdrawal. Because withdrawal is such an unpleasant experience, it serves as a powerful motivator to resume the addictive behavior. Eventually, the relief from withdrawal (by resuming use) becomes pleasurable in and of itself. To illustrate how this occurs, go ahead and pinch yourself on the arm for one full minute. Not too hard, just enough to cause some discomfort. Then stop. Notice the sudden absence of pain has become pleasurable. This is the



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same way that the removal of withdrawal effects (via return to addiction) becomes pleasurable. Because it is pleasurable, it is rewarding. Because it is rewarding, it will be repeated. Some drugs, such as alcohol and opiates, have withdrawal effects that are both physical and emotional. Other drugs or addictive activities may primarily involve emotional symptoms. This characteristic of addiction occurs because of several changes in the brain.

As drug use or addictive activity escalates, the involvement of various brain regions associated with our emotional state also increases. The brain region most often associated with our emotional state is the extended amygdala. Scientists think this brain region plays an important role in addiction because of its association with emotions and stress.

The amygdala affects emotions and memory. We all have both "good" memories and "bad" memories about various events in our lives. What makes a memory "good" as opposed to "bad" are the emotional states that occurred during those events. When the brain forms these memories, it stores the memory of the event along with the emotions that accompanied it. When I smell the sea air, feel the ocean breeze, and hear the seagulls, I have a pleasant memory and emotional experience. This is because these things have been repeatedly associated with relaxing and enjoyable times. The memory of the sea is stored along with a pleasant emotional state. So I can merely think of the sea, without actually being there, and I will experience a pleasant emotional state. Likewise, an addicted person may only need to think about engaging in their addiction and they will experience pleasure. The memory of engaging in the addiction is stored with a pleasant emotional state. Thus, the pleasing memories of engaging with an addiction can lead to repeating those behaviors and a habit forms.

Emotional memory has another role in the development of addiction, called **cue anticipation**. Cue anticipation refers to environmental cues that can initiate or elevate craving. Cravings often lead to relapse. For this reason, these cues are often called *relapse triggers*. Therefore, a successful recovery plan will include a strategy for coping with cues (relapse triggers).

These environmental cues (relapse triggers) can be anything that is associated with the addiction. It could be a certain time of day, a place, a person, or an activity. For instance, suppose a man is addicted to pornography use. He usually gets online after his wife goes to bed. The mere act of his wife *getting ready* to go to bed serves as a cue that prompts powerful cravings. Later, even his own *anticipation* of his wife going to bed will serve as a powerful cue. The amygdala's role in emotional memory is responsible for these cues taking root. The brain forms an association between pleasant memories of drug use or addictive activities, and the cues. The more a person repeats this cycle, the more it strengthens the emotional memory circuits associated with these cues. Eventually, this leads to a complete pre-occupation with the addiction.

So far, we've been discussing the role of the amygdala and positive emotional memories. The brain may also form an association between unpleasant emotions and a memory (forming a "bad" memory). These negative emotional memories play an important role in withdrawal. The negative emotional memory of anxiety becomes associated with the physical signs of withdrawal. As withdrawal begins, the symptoms trigger an unpleasant emotional memory. This increases the negative experience of withdrawal. Withdrawal avoidance (via returning to the addiction) often becomes the cornerstone of the addiction in the later stages. Thus, in the earlier stages of addiction the pleasurable experience of the drug motivates a repetition of that behavior. In the later stages, relief of withdrawal symptoms (physical and/or emotional discomfort) achieves pleasure. This pleasurable relief from withdrawal symptoms continues to motivate the repetition of that behavior.

Stress Regulation and Withdrawal: Addictions' Effect on the Hypothalamus

Addiction affects another area of the brain called the hypothalamus. The hypothalamus has many duties. It controls body temperature, hunger, thirst, and sleep. The hypothalamus plays a key role in our response to stress. Stress regulation is highly relevant to our understanding of addiction. When an individual experiences stress, the hypothalamus releases chemicals called hormones. These hormones allow the brain and the body to respond to that stress. Unlike neurotransmitters (which are chemicals limited to the brain) hormones travel throughout the body via the blood system. Therefore, hormones can exert an effect on other body systems as well. When these chemical hormones operate in the brain, we refer to them as neuromodulators. These hormones (neuromodulators) can act just like neurotransmitters in the brain. Like neurotransmitters, they have their own receptors associated with them.

Stress is a well-known relapse trigger. It can prompt powerful cravings in addicted persons. Many of us know someone who tried to quit smoking but ultimately relapsed when they became "stressed out." Unfortunately, during the initial period of recovery withdrawal symptoms create stress. This creates an unfortunate cycle. Stress prompts addictive use, while efforts to discontinue use prompt stress. During withdrawal, these stress hormones are elevated. Even though stress levels are high, the brain's anti-stress neuromodulators appear to decrease, as do dopamine and serotonin in the nucleus accumbens. This suggests that withdrawal affected the reward system (evidenced by decreasing dopamine and serotonin). At the same time, withdrawal activates the stress and anxiety systems. This "1-2 punch" heightens the negative experience of withdrawal. This prompts people to seek relief via the addictive substance or activity (i.e., relapse).

In summary, the neurotransmitter pathways associated with the amygdala and the hypothalamus play a crucial role in sustaining the addiction process. This occurs thorough:

- The negative emotional memory that is associated with drug withdrawal.
- The positive emotional memory that is associated with drug cues.
- The disruption that occurs to stress regulation.
- The pleasurable relief from withdrawal symptoms that occurs by resuming drug use or addictive activities.

The High-jacked Brain

We do not yet know all the relevant mechanisms, but the evidence suggests that those long-lasting brain changes are responsible for the distortions of cognitive and emotional functioning that characterize addicts, particularly including the compulsion to use drugs that is the essence of addiction.

This brain-based view of addiction has generated substantial controversy, particularly among people who seem able to think only in polarized ways.

Many people erroneously still believe that biological and behavioral explanations are alternative or competing ways to understand phenomena, when in fact they are complementary and integrative.

Modern science has taught that it is much too simplistic to set biology in opposition to behavior or to pit willpower against brain chemistry.

Addiction involves inseparable biological and behavioral components. It is the **quintessential bio-behavioral disorder**.

Many people also erroneously still believe that drug addiction is simply a failure of will or of strength of character. Research contradicts that position.

The Brain Also Helps to Reverse Addiction

There's no question. Addiction wreaks havoc on the brain. Addiction causes significant chemical, structural, and molecular changes that quite literally hijack the brain. However, treatment can reverse or counteract these effects. Moreover, as the recovery process proceeds, the brain continues to heal.

It is true that many changes occur in the brain after addiction takes hold. But, we must also remember that the brain is a dynamic and ever-changing system. Changes to the brain's neuronal circuits, chemistry, and structures powerfully drive the addiction forward.



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However, a strong motivation to change, can just as powerfully counter these changes. People can learn new coping skills. They can practice behavioral modification techniques. These efforts will counter those damaging changes. Professional assistance can be enormously helpful as someone learns to overcome addiction's effect on the brain.

Abstinence from addictive substances or activities can lead to a reversal of many physical changes that occurred during addiction. Combination therapies (medications plus psychotherapy) help the recovery process by managing the physiological effects of addiction and withdrawal. Cognitive-behavioral treatments work to mend and repair the psychological impact of addiction.

Instructor Note: WOW! Our brain is truly amazing. It has the capacity to control its own physiology and is highly adaptive. Each behavioral step we make forward has a beneficial physiological effect on the brain. A sincere effort to change behavior is a powerful tool that mends the damaged brain.

When we change our behavior and find healthy outlets for satisfying cravings, we correct damaged brain function. These positive changes form new memory and behavioral circuits in the brain that strengthen and reinforce recovery efforts. Yes, the brain has changed because of the addictive process. Nevertheless, even people with severe addiction problems succeed in overcoming their addictions. Motivation is the key.

Signs and Symptoms of Addiction

Although different drugs have different physical effects, the symptoms of addiction are similar. See if you recognize yourself in the following signs and symptoms of substance abuse and addiction.

Physical warning signs of drug abuse

- Bloodshot eyes, pupils larger or smaller than usual
- Changes in appetite or sleep patterns. Sudden weight loss or weight gain
- Deterioration of physical appearance, personal grooming habits
- Unusual smells on breath, body, or clothing
- Tremors, slurred speech, or impaired coordination

Behavioral signs of drug abuse

- Drop in attendance and performance at work or school



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- Unexplained need for money or financial problems. May borrow or steal to get it.
- Engaging in secretive or suspicious behaviors
- Sudden change in friends, favorite hangouts, and hobbies
- Frequently getting into trouble (fights, accidents, illegal activities)

Psychological warning signs of drug abuse

- Unexplained change in personality or attitude
- Sudden mood swings, irritability, or angry outbursts
- Periods of unusual hyperactivity, agitation, or giddiness
- Lack of motivation; appears lethargic or “spaced out”
- Appears fearful, anxious, or paranoid, with no reason

Key Components of Addiction

- Compulsion
- Continued use despite negative consequences
- Craving
- Denial

Warning Signs of Commonly Abused Drugs

Marijuana: Glassy, red eyes; loud talking, inappropriate laughter followed by sleepiness; loss of interest, motivation; weight gain or loss.

Depressants (including Xanax, Valium, GHB): Contracted pupils; drunk-like; difficulty concentrating; clumsiness; poor judgment; slurred speech; sleepiness.

Stimulants (including amphetamines, cocaine, crystal meth): Dilated pupils; hyperactivity; euphoria; irritability; anxiety; excessive talking followed by depression or excessive sleeping at odd times; may go long periods of time without eating or sleeping; weight loss; dry mouth and nose.

Inhalants (glues, aerosols, vapors): Watery eyes; impaired vision, memory and thought; secretions from the nose or rashes around the nose and mouth; headaches and nausea; appearance of intoxication; drowsiness; poor muscle control; changes in appetite; anxiety; irritability; lots of cans/aerosols in the trash.



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Hallucinogens (LSD, PCP): Dilated pupils; bizarre and irrational behavior including paranoia, aggression, hallucinations; mood swings; detachment from people; absorption with self or other objects, slurred speech; confusion.

Heroin: Contracted pupils; no response of pupils to light; needle marks; sleeping at unusual times; sweating; vomiting; coughing, sniffing; twitching; loss of appetite.

Warning signs of teen drug abuse

While experimenting with drugs doesn't automatically lead to drug abuse, early use is a risk factor for developing more serious drug abuse and addiction. Risk of drug abuse also increases greatly during times of transition, such as changing schools, moving, or divorce. The challenge for parents is to distinguish between the normal, often volatile, ups and downs of the teen years and the red flags of substance abuse. These include:

- Having bloodshot eyes or dilated pupils; using eye drops to try to mask these signs
- Skipping class; declining grades; suddenly getting into trouble at school
- Missing money, valuables, or prescriptions
- Acting uncharacteristically isolated, withdrawn, angry, or depressed
- Dropping one group of friends for another; being secretive about the new peer group
- Lying about new interests and activities

Does drug abuse cause mental disorders, or vice versa?

Drug abuse and mental illness often co-exist. In some cases, mental disorders such as anxiety, depression, or schizophrenia may precede addiction; in other cases, drug abuse may trigger or exacerbate those mental disorders, particularly in people with specific vulnerabilities.\

Damage due to Addiction

Regardless of the drug abused, addiction leads to

- Physical deterioration
- Psychiatric problems
- Intellectual impairment
- Personality deterioration
- Increased risk of accidents and higher susceptibility to high risk behavior in the form of unprotected sex or use of unsterile needles

- Legal risks

But when a drug is taken for reasons other than medical, in an amount, strength, frequency or manner that causes damage to the physical or mental functioning of an individual, it becomes 'drug abuse'. Any type of drug can be abused; drugs with medical uses can also be abused.

Tolerance refers to a condition where the user needs more and more of the drug to experience the same effect. Smaller quantities, which were sufficient earlier, are no longer effective and the user is forced to increase the amount of drug intake.

Slowly, drug dependence develops. Some drugs produce only psychological dependence while others produce both physical and psychological dependence.

Psychological dependence is a state characterized by emotional and mental preoccupation with the effects of the drug and a persistent craving for it. As psychological dependence develops, the user gets mentally 'hooked' on to the drug.

When physical dependence develops, the user's body becomes totally dependent on the drug. With prolonged use, the body becomes so used to functioning under the influence of the drug that it is able to function normally only if the drug is present.

Alcohol / drug abuse causes general physical deterioration in addition to affecting at least a few organs in particular. Mental health status is also affected. Safety risks are also another issue for concern. Moreover, drug abusers generally eat poorly, have irregular sleep patterns and do not seek timely medical help which only further worsen the situation.

Medical and psychiatric complications can be studied under four major heads.

- a. Problems due to intoxication
- b. Problems due to withdrawal
- c. Psychiatric disorders associated with substance abuse
- d. Systemic disorders associated with substance abuse



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Continuum of Alcohol and Drug Use

The continuum of substance abuse is a term that is used to refer to the stages of substance use and abuse. The use of a drug can be only labeled drug abuse when the user becomes dysfunctional as a result of their use. If a person can maintain healthy relationships, does not suffer financial hardships, does not become unwell or is harmed from the use of the substance, then the use is maintained as drug use and not abuse. However, if a person begins to exhibit adverse reactions from a drug, has considerable problems with relationships with others, acts in a harmful, dangerous or reckless manner and begins to use significant amounts of energy acquiring and using a drug, then it can be considered that the individual has a drug abuse problem.

The theory of a continuum of drug use can be used to assess where a person is at in terms of their drug use and evaluate the type of treatment that may be appropriate, if any. Policymakers may also use the continuum to make decisions on education, harm minimization and policing. Some stages in the continuum, such as experimental or occasional use, can be considered as relatively harm free. Others such as regular or dependent use may require some intervention to alleviate or prevent further harm from occurring.

4 Stages of Addiction – In Brief

- **Use – Socially accepted/medically approved**
- **Misuse – Regular use of illegal drugs/Higher quantities than prescribed**
- **Abuse – Continued use of substances despite negative consequence**
- **Addiction – Compulsive using, negative consequences, tolerance, withdrawal potential**

Risk and Protective Factors

Why do some people become addicted to drugs, while others do not?

As with any other disease, vulnerability to addiction differs from person to person, and no single factor determines whether a person will become addicted to drugs. In general, the more *risk factors* a person has, the greater the chance that taking drugs will lead to abuse and

addiction. *Protective factors*, on the other hand, reduce a person’s risk of developing addiction. Risk and protective factors may be either environmental (such as conditions at home, at school, and in the neighborhood) or biological (for instance, a person’s genes, their stage of development, and even their gender or ethnicity).

Risk and Protective Factors for Drug Abuse and Addiction

Risk Factors	Protective Factors
Aggressive behavior in childhood	Good self-control
Lack of parental supervision	Parental monitoring and support
Poor social skills	Positive relationships
Drug experimentation	Academic Competence
Availability of drugs at school	School anti-drug policies
Community poverty	Neighborhood pride

What environmental factors increase the risk of addiction?

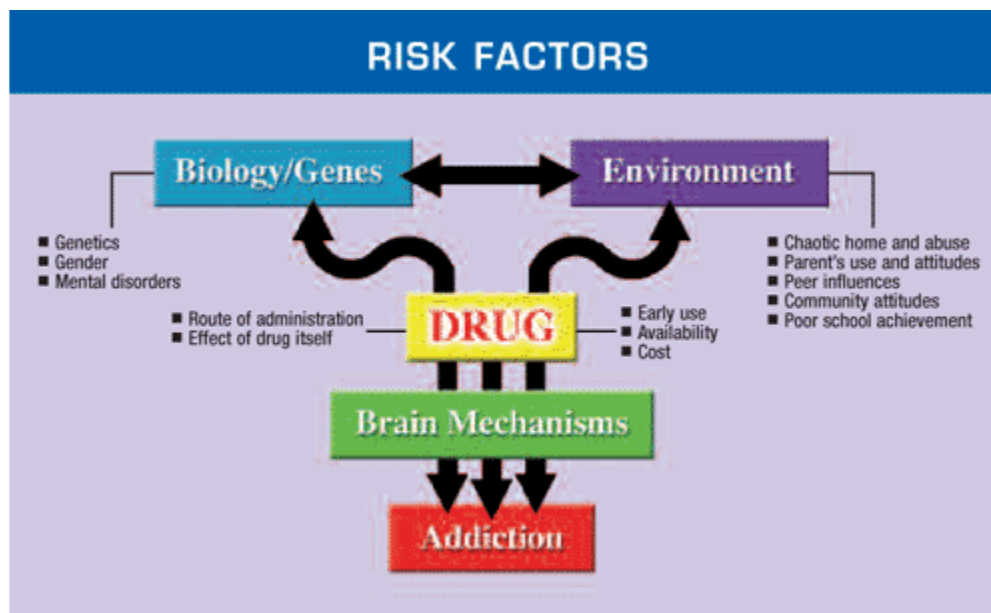
- **Home and Family.** The influence of the home environment, especially during childhood, is a very important factor. Parents or older family members who abuse alcohol or drugs, or

who engage in criminal behavior, can increase children's risks of developing their own drug problems.

- **Peer and School.** Friends and acquaintances can have an increasingly strong influence during adolescence. Drug-using peers can sway even those without risk factors to try drugs for the first time. Academic failure or poor social skills can put a child at further risk for using or becoming addicted to drugs.

What biological factors increase risk of addiction?

Scientists estimate that genetic factors account for between 40 and 60 percent of a person's vulnerability to addiction; this includes the effects of environmental factors on the function and expression of a person's genes. A person's stage of development and other medical conditions they may have are also factors. Adolescents and people with mental disorders are at greater risk of drug abuse and addiction than the general population.



Children's earliest interactions within the family are crucial to their healthy development and risk for drug abuse.



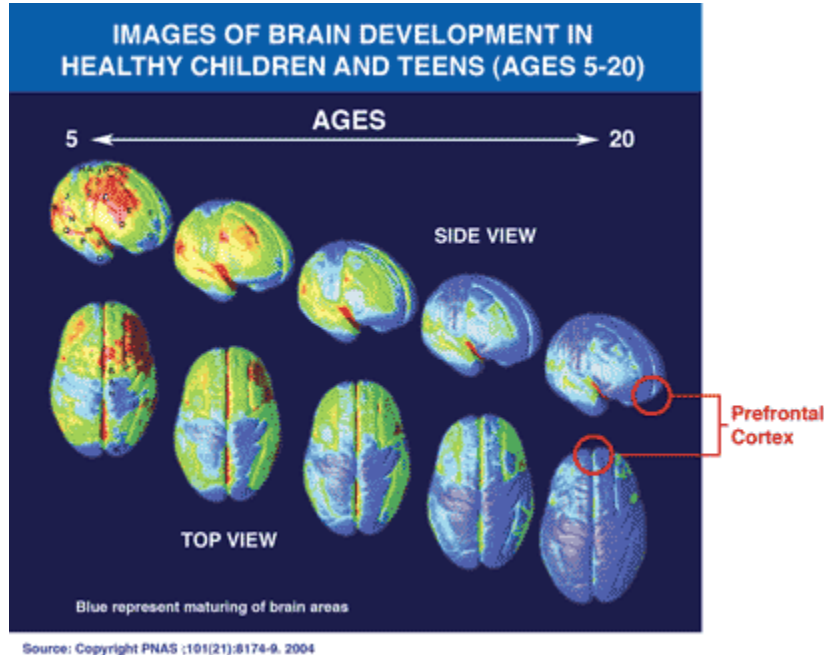
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What other factors increase the risk of addiction?

- **Early Use.** Although taking drugs at any age can lead to addiction, research shows that the earlier a person begins to use drugs, the more likely he or she is to develop serious problems. This may reflect the harmful effect that drugs can have on the developing brain; it also may result from a mix of early social and biological vulnerability factors, including unstable family relationships, exposure to physical or sexual abuse, genetic susceptibility, or mental illness. Still, the fact remains that early use is a strong indicator of problems ahead, including addiction.
- **Method of Administration.** Smoking a drug or injecting it into a vein increases its addictive potential. Both smoked and injected drugs enter the brain within seconds, producing a powerful rush of pleasure. However, this intense “high” can fade within a few minutes, taking the abuser down to lower, more normal levels. Scientists believe this starkly felt contrast drives some people to repeated drug taking in an attempt to recapture the fleeting pleasurable state.

Addiction is a developmental disease—it typically begins in childhood or adolescence. The brain continues to develop into adulthood and undergoes dramatic changes during adolescence

One of the brain areas still maturing during adolescence is the prefrontal cortex—the part of the brain that enables us to assess situations, make sound decisions, and keep our emotions and desires under control. The fact that this critical part of an adolescent’s brain is still a work in progress puts them at increased risk for making poor decisions (such as trying drugs or continuing to take them). Also, introducing drugs during this period of development may cause brain changes that have profound and long-lasting consequences.



Instructor Note: Prevention is the best form of medicine. That old saying is still around because at it's heart is the truth. Recognizing risk factors, warning signs and symptoms of potential for substance use and misuse helps us to intervene BEFORE the person increases their use and with that all the potential health risks that come along with addiction.

Physical Health Risks Associated With Alcohol/Drug Use

Physical health risks from the use of alcohol can be associated with the amount used, duration of use, and the condition of the individual using. Because of the potential for fetal alcohol syndrome and fetal alcohol effect, it is suggested that women who think they might be pregnant should not drink alcohol. Those with other medical conditions such as diabetes, seizure disorders, gastric ulcers, various skin conditions, and osteoporosis should not drink alcohol.

The chronic use of alcohol can affect all systems of the body and can have definite visible signs as well as have physical effects. Physical signs and symptoms of chronic alcohol use can include a weakened overall appearance, hyper-pigmented, jaundiced skin or a yellowish pigment to the whites of the eyes. There may be hoarseness in the voice; ataxia, a wide spaced unsteady gate;



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the appearance of spider veins; and dilated capillaries and acne-like lesions on the face and body. The nose may be enlarged and bulbous (Kinney, 2003).

The chronic use of alcohol affects the internal systems of the body as well as the outward appearance. The irritation caused by the alcohol may cause inflammation, abdominal pain, and bleeding of the esophagus and stomach (Kinney, 2003). Chronic alcohol use is many times associated with acute pancreatitis

Alcoholic hepatitis often follows a heavy or extended bout of alcohol use and can occur in non-alcohol dependent persons. There is inflammation of the liver, metabolism is disrupted, jaundice, the yellowing of the skin and whites of the eyes, as well as other symptoms present with alcoholic hepatitis. Alcoholic hepatitis may be completely reversible in some people if they stop alcohol consumption and receive proper medical care (Kinney, 2003).

Cirrhosis is caused when there is permanent, widespread destruction of liver cells, which are replaced with nonfunctioning scar tissue. The liver cells are unable to perform their necessary functions and while progression may possibly be slowed down by stopping the consumption of alcohol, it is irreversible and fatal if alcohol is continued to be consumed (Kinney, 2003).

Anemia is the most common red blood cell related problem in chronic alcohol users. Alcohol use can negatively affect one's ability to achieve good, restful sleep (Kinney, 2003).

Heavy alcohol consumption can lead to a blackout which is an amnesia-like state in which the individual may appear to be functioning normally yet later has no memory of what transpired. Blackouts are usually associated with alcohol dependence and are related to the dose taken. However, blackouts can occur in nondependent individuals as a result of a heavier than normal drinking episode in those who drank to the point of intoxication.

Is there a difference between physical dependence and addiction?

Yes. Addiction—or compulsive drug use despite harmful consequences—is characterized by an inability to stop using a drug; failure to meet work, social, or family obligations; and, sometimes (depending on the drug), tolerance and withdrawal. The latter reflect physical dependence in which the body adapts to the drug, requiring more of it to achieve a certain effect (tolerance) and eliciting drug-specific physical or mental symptoms if drug use is abruptly ceased (withdrawal). Physical dependence can happen with the chronic use of many drugs—including many prescription drugs, even if taken as instructed. Thus, physical dependence in and of itself does not constitute addiction, but it often accompanies addiction. This distinction can be difficult to discern, particularly with prescribed pain medications, for which the



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need for increasing dosages can represent tolerance or a worsening underlying problem, as opposed to the beginning of abuse or addiction.

Does drug abuse cause mental disorders, or vice versa?

Drug abuse and mental illness often co-exist. In some cases, mental disorders such as anxiety, depression, or schizophrenia may precede addiction; in other cases, drug abuse may trigger or exacerbate those mental disorders, particularly in people with specific vulnerabilities.

Five Things to Know about Adolescents' Brain Development and Use

1. The brain's "front end," the part above the eyes, exists to slow us down or stop our impulsive behaviors. It considers the risks and benefits of our actions, and it helps us "hit the brakes" when we consider doing things that are too risky.
2. This front part of the brain is still developing connections to the rest of the brain until adulthood, so adolescents' brains lack some of the "wiring" that carries "brake" or "stop" messages to the rest of the brain.
3. Drugs of abuse are often available to adolescents. These drugs feel good, but they can be very harmful. Lacking some of the wiring for the "stop" message, adolescents' brains may not fully weigh the risks of drug use.
4. The two drugs that cause the most death are also the most available drugs: tobacco and alcohol. Late adolescence, before the brain is fully matured, is the peak time for developing dependence on these (and other) drugs.
5. Heavy drug use during times of critical brain development may cause permanent changes in the way the brain works and responds to rewards and consequences. Therefore, it is important to begin to address a developing substance use problem as early as possible.

Concerning Behaviors to look for in an Adolescent Who Might be Using Drugs

- Changes in school performance (falling grades, skipping school, tardiness)
- Changes in peer group (hanging out with drug-using, antisocial, older friends)
- Breaking rules at home, school, in the community
- Extreme mood swings, depression, irritability, anger, negative attitude
- Sudden increases or decreases in activity level
- Withdrawal from the family; keeping secrets



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- Changes in physical appearance (weight loss, lack of cleanliness, strange smells)
- Red, watery, glassy eyes or runny nose not due to allergies or cold
- Changes in eating or sleeping habits
- Lack of motivation or interest in things other teenagers enjoy (hobbies, sports)
- Lying, stealing, hiding things
- Using street or drug language or possession of drug paraphernalia/items
- Cigarette smoking

What Adolescents Are Using

By a wide margin, teenagers abuse alcohol more than any other substance. It is legal and widely available. Nationwide, teens with alcohol dependency are the majority of adolescents admitted for treatment. Each year, the federal government conducts a survey to determine Americans' patterns of using alcohol and other drugs. This survey, the National Survey of Drug Use and Health (NSDUH), provides vital information on a wide array of topics. The survey showed that in 2005, the illicit substances that 12- to-17-year olds reported that they had used the most were, in this order:

- **marijuana**
- **prescription drugs including stimulants, tranquilizers, sedatives, and pain relievers such as OxyContin and Vicodin**
- **inhalants**

Marijuana use among adolescents is second only to alcohol. Many believe marijuana is harmless, the brain shows that is simply not true.

Early Onset Alcoholism

Alcohol dependence, or alcoholism, can begin very early, even as early as 12 or 13 years old. Most teens obtain alcohol first from their parents; alcoholic beverages should be kept locked away. Prevention educates parents and guardians, the first thing parents and guardians need to know is if they believe their teen is beginning to drink, they need to talk about it, and be clear that they do not approve and that they expect different behavior. Parents/guardians need to keep track of where their teen is, and with whom.



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FIVE WARNING SIGNS

1. Heavy drinking and alcoholism are more likely to occur when a parent has a similar problem. A family history of alcohol dependence increases risk of alcohol dependence four-fold.
2. Other early risk factors include serious childhood behavior problems requiring treatment, such as attention deficit hyperactivity disorder (ADHD), depression or anxiety, and health problems such as asthma. Parents/guardians need to talk about this with their teens and let them know how important it is not to drink. Let them know help is available if they need assistance.
3. Often, early onset alcoholism results in serious problems such as emergency room visits, injuries, fights or declining school performance. These serious problems may occur very early, even the first time teens drink on their own. If these occur an evaluation from a professional needs to be obtained.
4. If drinking problems develop early, be sure that any treatment includes a thorough evaluation of other possible disorders such as ADHD, depression or anxiety. Treatment of coexisting disorders helps with recovery from alcoholism. Also, teens that drink heavily often use other drugs, especially marijuana. Be sure to have this evaluated as well.
5. If an older child begins drinking a lot, younger siblings are more likely to do so as well. Be especially vigilant as your younger children grow.

8 Myths about Drug Abuse and Addiction

- MYTH 1: Overcoming addiction is a simply a matter of willpower. You can stop using drugs if you really want to. Prolonged exposure to drugs alters the brain in ways that result in powerful cravings and a compulsion to use. These brain changes make it extremely difficult to quit by sheer force of will.
- MYTH 2: Addiction is a disease; there's nothing you can do about it. Most experts agree that addiction is a brain disease, but that doesn't mean you're a helpless victim. The brain changes associated with addiction can be treated and reversed through therapy, medication, exercise, and other treatments.
- MYTH 3: Addicts have to hit rock bottom before they can get better. Recovery can begin at any point in the addiction process—and the earlier, the better. The longer drug abuse

continues, the stronger the addiction becomes and the harder it is to treat. Don't wait to intervene until the addict has lost it all.

- MYTH 4: You can't force someone into treatment; they have to want help. Treatment doesn't have to be voluntary to be successful. People who are pressured into treatment by their family, employer, or the legal system are just as likely to benefit as those who choose to enter treatment on their own. As they sober up and their thinking clears, many formerly resistant addicts decide they want to change.
- MYTH 5: Treatment didn't work before, so there's no point trying again. Recovery from drug addiction is a long process that often involves setbacks. Relapse doesn't mean that treatment has failed or that you're a lost cause. Rather, it's a signal to get back on track, either by going back to treatment or adjusting the treatment approach.
- MYTH 6: Addicts should be punished, not treated, for using drugs. Science is demonstrating that addicts have a brain disease that causes them to have impaired control over their use of drugs. Addicts need treatment for their neuro-chemically driven brain pathology.
- MYTH 7: Addicts cannot be treated with medications. Actually, addicts are medically detoxified in hospitals, when appropriate, all the time. But can they be treated with medications after detox? New pharmacotherapies (medicines) are being developed to help patients who have already become abstinent to further curb their craving for addicting drugs. These medications reduce the chances of relapse and enhance the effectiveness of existing behavioral (talk) therapies.
- MYTH 8: Addicts are bad, crazy, or stupid. Evolving research is demonstrating that addicts are not bad people who need to get good, crazy people who need to get sane, or stupid people who need education. Addicts have a brain disease that goes beyond their use of drugs.

The Latest View in Understanding Addiction

Instructor Note: We have presented a lot of information in this chapter about the science of addiction, how substances impact various areas of the brain and how, in turn, addiction develops from voluntary, experimental use. The following is a newer, updated viewpoint and explanation of addiction. Not all is new but enough to warrant it's inclusion in this chapter.

The Essence of Addiction

The entire concept of addiction has suffered greatly from imprecision and misconception. In fact, if it were possible, it would be best to start all over with some new, more neutral term.

The confusion comes about in part because of a now **archaic distinction between whether specific drugs are “physically” or “psychologically” “addicting.”**

The distinction historically revolved around whether or not dramatic physical withdrawal symptoms occur when an individual stops taking a drug; what we in the field now call “physical dependence.”

- However, 20 years of scientific research has taught that focusing on this physical versus psychological distinction is off the mark and a distraction from the real issues.

From both clinical and policy perspectives, it actually does not matter very much what physical withdrawal symptoms occur.

- Physical dependence is not that important, because even the dramatic withdrawal symptoms of heroin and alcohol addiction can now be easily managed with appropriate medications.
- Even more important, many of the most dangerous and addicting drugs, including methamphetamine and crack cocaine, do not produce very severe physical dependence symptoms upon withdrawal.

What really matters most is whether or not a drug causes what we now know to be the essence of addiction, namely

- **The uncontrollable, compulsive drug craving, seeking, and use, even in the face of negative health and social consequences.**

This is the crux of how the Institute of Medicine, the American Psychiatric Association, and the American Medical Association define addiction and how we all should use the term.



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It is really only this compulsive quality of addiction that matters in the long run to the addict and to his or her family and that should matter to society as a whole.

Thus, the majority of the biomedical community now considers addiction, in its essence, to be a brain disease:

- **A condition caused by persistent changes in brain structure and function.**

This results in compulsive craving that overwhelms all other motivations and is the root cause of the massive health and social problems associated with drug addiction.

Updating the Definition of Addiction

In updating our national discourse on drug abuse, we should keep in mind this simple definition:

Addiction is a brain disease expressed in the form of compulsive behavior.

Both developing and recovering from it depend on biology, behavior, and social context.

It is also important to correct the common misimpression that drug use, abuse and addiction are points on a single continuum along which one slides back and forth over time, moving from user to addict, then back to occasional user, then back to addict.

Clinical observation and more formal research studies support the view that, once addicted, the individual has moved into a different state of being.

Very few people appear able to successfully return to occasional use after having been truly addicted.

The Altered Brain

Unfortunately, we do not yet have a clear biological or behavioral marker of that transition from voluntary drug use to addiction.

However, a body of scientific evidence is rapidly developing that points to an array of cellular and molecular changes in specific brain circuits. Moreover, many of these brain changes are common to all chemical addictions, and some also are typical of other compulsive behaviors such as pathological overeating.

The complexity of this brain disease is not atypical, because virtually no brain diseases are simply biological in nature and expression. All, including stroke, Alzheimer's disease, schizophrenia, and clinical depression, include some behavioral and social aspects.

What may make addiction seem unique among brain diseases, however, is that it does begin with a clearly voluntary behavior- the initial decision to use drugs. As previously stated, not everyone who ever uses drugs goes on to become addicted.

- **Individuals differ substantially in how easily and quickly they become addicted and in their preferences for particular substances.**

In fact, estimates are that between 50 and 70 percent of the variability in susceptibility to becoming addicted can be accounted for by genetic factors. Although genetic characteristics may predispose individuals to be more or less susceptible to becoming addicted, genes do not doom one to become an addict.

Over time the addict loses substantial control over his or her initially voluntary behavior, and it becomes compulsive. For many people these behaviors are truly uncontrollable, just like the behavioral expression of any other brain disease.

Environmental Cues

Addictive behaviors do have special characteristics related to the social contexts in which they originate.

- All of the environmental cues surrounding initial drug use and development of the addiction actually become “conditioned” to that drug use and are thus critical to the development and expression of addiction.
- Environmental cues are paired in time with an individual’s initial drug use experiences and, through classical conditioning, take on conditioned stimulus properties.
- When those cues are present at a later time, they elicit anticipation of a drug experience and thus generate tremendous drug craving.

Cue-induced craving is one of the most frequent causes of drug use relapses, even after long periods of abstinence, independently of whether drugs are available.

The significance of environmental or contextual cues helps explain why reentry to one’s community can be so difficult for addicts leaving the controlled environments of treatment or correctional settings and why aftercare is so essential to successful recovery.

- The person who became addicted in the home environment is constantly exposed to the cues conditioned to his or her initial drug use, such as the neighborhood where he or she hung out, drug-using buddies, or the lamppost where he or she bought drugs.
- Simple exposure to those cues automatically triggers craving and can lead rapidly to relapses.



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This is one reason why someone who apparently overcame drug cravings while in prison or residential treatment could quickly revert to drug use upon returning home.

- One of the major goals of drug addiction treatment is to teach addicts how to deal with the cravings caused by inevitable exposure to these conditioned cues.
- It is no wonder addicts cannot simply quit on their own.
- People often assume that because addiction begins with a voluntary behavior and is expressed in the form of excess behavior, people should just be able to quit by force of will alone.
- However, it is essential to understand when dealing with addicts that we are dealing with individuals whose brains have been altered by drug use.

Instructor Note: Finally, let's look briefly at relapse. We will discuss relapse both here and in the Treatment and Recovery chapter. Here we look at relapse from the various perspectives presented throughout this chapter. Later, we look at relapse as it pertains to recovery and treatment. Both perspectives are equally important in understanding addiction.

What is Relapse?

Relapse is a cardinal feature of addiction, and one of the most painful.

Most people who struggle with addiction will have one or more relapses - the return to drug use after a drug-free period - during their ongoing attempts to recover. This can be extremely frustrating for patients and for families, as they have already experienced great pain.

What leads to relapse?

Multiple - and often interactive - factors can increase the likelihood of relapse. These are some of the commonly cited precursors:

- drug-related "reminder" cues (sights, sounds, smells, drug thoughts or drug dreams) tightly linked to use of the preferred drug(s) can trigger craving and drug seeking
- negative mood states or stress
- positive mood states or celebrations
- sampling the drug itself, even in very small amounts

The motivation to seek a drug, once triggered, can feel overwhelming and sometimes leads to very poor decision-making: the user will pursue the drug, despite potentially disastrous future negative consequences (and many past negative consequences).

Individuals have different brain circuitry

Brain-imaging is helping us to understand the paradox of the decision to pursue a drug reward despite such consequences. For example, very recent imaging research shows that visual drug cues as short as 33 milliseconds can activate the ancient reward ("go") circuitry, and that this process does not require conscious processing - it can begin outside awareness.

By the time the motivation does reach awareness, and is recognized and labeled, the reward circuit has a strong head start. This head start means the frontal brain regions may be less effective. This area of the brain is responsible for weighing the consequences of a decision and for helping to "stop" or inhibit the impulses toward drug reward.

Imaging research also shows that some individuals have less effective "stop" circuitry. For these people, the job of managing the powerful impulses toward drug reward may be even more difficult.



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When it comes to the vulnerability to relapse, and to addiction itself, we are not all created equal. We differ both in our brain response to drug rewards and in our ability to manage the powerful impulses toward drug reward.

Hope through research

Relapse is a long-term vulnerability, but intensive ongoing research is targeting the problem. The tools of brain imaging and genetics promise to help us understand our vulnerabilities - and our strengths - to help us realize more effective relapse prevention. Many different clinical research trials are underway, and new anti-relapse interventions (behavioral or medication-based) may be available in a location close to you.

Stuck Points in Recovery

Although some patients progress through the stages of recovery without complications, most chemically dependent people do not. They typically get stuck somewhere. A “stuck point” can occur during any period of recovery. Usually it is caused either by lack of skills or lack of confidence in one's ability to complete a recovery task. Other problems occur when the recovering person encounters a problem (physical, psychological, or social) that interferes with his or her ability to use recovery supports.

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. Without specific relapse prevention skills to identify and interrupt denial, stress begins to build. Eventually, the stress will cause the patient to cope less and less well. This will result in relapse.

Symptoms of Becoming Stuck in Recovery

When people become stuck they may experience symptoms such as:

- An increase in negative thinking. The individual may feel disappointed with life in recovery because it has not lived up to their expectations. They are likely to feel pessimistic about the future.
- Anger outbursts and feelings of resentment
- Problems at work, home, or with friends. When people become stuck in recovery it usually means that relationships will suffer.
- The individual can begin to isolate. They stop talking about their problems and concerns with other people.
- They may begin to romance the drink or drug. This is when they remember the days when substance abuse seemed to help them.



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The Dangers of Becoming Stuck in Recovery

Recovery from an addiction is a process. This means that the individual needs to be progressing all the time or else they begin to backslide. The dangers of becoming stuck in recovery include:

- It causes people to become dissatisfied with life away from addiction. It can take a long time before people manage to build a good life in sobriety. If people become stuck then they may lose hope of every achieving such happiness.
- If people are stuck they will usually experience a great deal of stress. They may turn to new maladaptive behaviors to deal with this discomfort. This could include becoming a workaholic, a fitness fanatic, or turning to other forms of substance abuse. Addiction substitution is just more avoidance and can ultimately only lead to further pain
- Becoming stuck is the first stage of the relapse process
- People become sober because they want to improve their life. When they are stuck in recovery it just delays them reaching that day when they will experience true peace and contentment. Life is short so it is probably best to avoid wasting time.
- Those individuals who become stuck in recovery may develop into dry drunks. Such individuals might manage to remain sober, but life away from their addiction will not be full of happiness. Instead it is more likely to feel like a prison sentence. The dry drunk tends to not only make their own life miserable but also the lives of those close to them. Such an individual may no longer be using alcohol or drugs but in many ways it is still business as usual.

Becoming Stuck and the Relapse Process

Those individuals who return to alcohol or drug abuse will often pass through a number of stages before reaching that point. This is known as the relapse process and involves:

- Becoming stuck in recovery
- The individual tries to ignore the fact that they are stuck
- They turn to negative coping strategies to deal with the discomfort of being stuck. This increases their level of internal suffering.
- A trigger event occurs and this causes the internal suffering to become far more obvious
- The individual experiences a great deal of emotional turmoil
- The inner turmoil is now impossible to ignore
- The individual feels like they are out of control
- They return to alcohol or drug abuse in order to escape the pain



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History of Drug and Alcohol Treatment in America – Timeline of Notable Events

The phrase, **drug treatment**, is currently used to refer to treatment for problems with a wide array of substances including both illegal drugs and prescription medications. From the 1950's through the 1970's, however, drug treatment programs focused primarily on heroin and other opiates and were operated separately from programs focusing on alcohol. This division is reflected to this day in the fact that the federal government still maintains a National Institute on Drugs (NIDA) separate from the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Significant Events in the History of Addiction Treatment and Recovery in America

1750 to Early 1800s Alcoholic mutual aid societies (sobriety "Circles") are formed within various Native American tribes. Some are part of, or evolve into, abstinence-based Native American cultural revitalization movements and temperance organizations.

1784 Dr. Benjamin Rush's Inquiry into the Effects of Ardent Spirits on the Human Mind and Body catalogues the consequence of chronic drunkenness and argues that this condition is a disease that physicians should be treating. Rush's writing marks beginning of American temperance movement.

1810 Dr. Benjamin Rush calls for creation of a "Sober House" for the care of the confirmed drunkard.

1844 – 1845 Lodging Homes and later (1857) a Home for the Fallen are opened in Boston -- marking the roots of the 19th century inebriate home. As inebriate homes spread, they will spawn several alcoholic mutual aid societies such as the Godwin Association.

1845 Frederick Douglass (having earlier acknowledged a period of intemperance in his life) signs a pledge of abstinence and becomes involved in promoting temperance among African American people. His call for abstinence as a foundation of the drive to abolish slavery and prepare Black people for full citizenship anticipated modern Afrocentric models of addiction recovery.

1849 The Swedish physician Magnus Huss describes a disease resulting from chronic alcohol consumption and christens it Alcoholismus chronicus. This marks the introduction of the term alcoholism.



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1864 The New York State Inebriate Asylum, the first in the country, is opened in Binghamton, NY. A growing network of inebriate asylums will treat alcoholism and addiction to a growing list of other drugs: opium, morphine, cocaine, chloral, ether, and chloroform.

1867 The opening of the Martha Washington Home in Chicago marks the first institution in America that specialized in the treatment of inebriate women.

1870 The American Association for the Cure of Inebriety founded under the principle "Inebriety is a disease." The Association's Journal of Inebriety is published from 1876-1914.

1870's New alcoholic mutual aid societies - the Ribbon Reform Clubs -- begin in the Northeast and spread throughout the U.S. over the next two decades. They are named for their members' practice of wearing a colored ribbon on their clothing so that they could recognize one another and convey a message of hope about recovery to the larger community.

1879 Dr. Leslie Keeley announces that "Drunkenness is a disease and I can cure it." He opens more than 120 Keeley Institutes across the U.S., marking the beginning of franchised, private, for-profit addiction treatment institutes/sanatoria in America.

1880's Cocaine is recommended by Sigmund Freud and a number of American physicians in the treatment of alcoholism and morphine addiction. Bottled home cures for the alcohol and drug habits abound; most will be later exposed to contain alcohol, opium, morphine, cocaine and cannabis.

1891-1892 Keeley League (a Keeley Institute patient mutual aid society) founded. Keeley League members meet under the banner, "The Law Must Recognize a Leading Fact: Medical Not Penal Treatment Reforms the Drunkard." As inebriate homes and asylums close, alcoholics are relegated to city "drunk tanks," "cells" in "foul wards" of public hospitals, and the backwards of aging "insane asylums." Wealthy alcoholics/addicts will continue to seek discrete detoxification in private sanatoria know as "jitter joints," "jag farms" or "dip shops."

1901 The Charles B. Towns Hospital for Drug and Alcoholic Addictions in New York City marks the beginning of a new type of private "drying out" hospital for affluent alcoholics and addicts.

1906 The Emmanuel Clinic in Boston begins the practice of lay therapy in the treatment of alcoholism. The Clinic will generate a number of noted lay therapists (Baylor, Chambers,



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Peabody) who will exert enormous influence on alcoholism treatment for several decades. The Jacoby Club serves as the Clinic's mutual aid society.

1919 – 1924 Forty-four communities establish morphine maintenance clinics (run by public health departments or police departments) to care for incurable and medically infirm addicts. All eventually close under threat of federal indictment. Treatment for narcotic addiction virtually disappears for all but the most affluent Americans.

1920's Most inebriate homes, inebriate asylums and private addiction cure institutes collapse between 1910 and 1925. The Journal of Inebriety ceases publication in 1914 and its parent association collapses in the early 1920s.

1935 The opening of Shadel Sanatorium marks the introduction of aversive conditioning in an institutional alcoholism treatment setting.

The first federal "narcotics farm" (U.S. Public Health Prison Hospital) opens in Lexington, Kentucky. The second facility opens in Fort Worth, Texas in 1938. This marks the beginning of federal involvement in addiction research and addiction treatment.

The meeting of Bill W. and Dr. Bob S. (and Dr. Bob's last drink) mark the beginning of Alcoholics Anonymous (AA).

1939 The book, Alcoholics Anonymous, is published.

1940- 1945 Recovered alcoholics in AA are recruited at Remington Arms, DuPont, Kaiser Shipyards, and North American Aviation to work in the first modern industrial alcoholism programs -- forerunners of today's employee assistance programs (EAPS).

1943 Yale Center of Alcohol studies initiates a significant research program, the Summer School of Alcohol Studies, the Yale Plan Outpatient Clinics, and the Yale Plan for Business and Industry. The Center will move to Rutgers in 1962.

1944 Marty Mann founds the National Committee for Education on Alcoholism (today the National Council on Alcoholism and Drug Dependence) around the following propositions:

1. Alcoholism is a disease.
2. The alcoholic, therefore, is a sick person.
3. The alcoholic can be helped.



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4. The alcoholic is worth helping.
5. Alcoholism is our No. 4 public health problem, and our public responsibility.

Mann calls for a five-prong approach to be achieved by local NCEA affiliates:

1. Launching local public education campaigns on alcoholism.
2. Encouraging hospitals to admit alcoholics for acute detoxification.
3. Establishing local alcohol information centers.
4. Establishing local clinics for the diagnosis and treatment of alcoholism.
5. Establishing "rest centers" for the long-term care of alcoholics.

The first state alcoholism commissions are founded. They support fledgling efforts at local community education and treatment.

1947 An Addicts Anonymous group begins meeting at U.S. Public Health Hospital in Lexington, Kentucky. Meetings begin outside the institution in New York City under the name Narcotics Anonymous (NA) in 1949 but dissipate over time. The roots of today's NA can be traced to groups that began in California in 1953. International Doctors in AA founded.

1948 Alcoholics Victorious is founded within the Chicago Christian Industrial League and spreads as a Christian, recovery support group within many of the nation's urban missions.

1948 – 1950 The "Minnesota Model" of chemical dependency treatment emerges in the synergy between three institutions: Pioneer House, Hazelden, and Willmar State Hospital. (Antabuse) introduced as an adjunct in the treatment of alcoholism in the U.S. Other drugs used in the treatment of alcoholism during this period include barbiturates, amphetamines (Benzedrine), and LSD.

1950 The Twelve Traditions are formally adopted to govern the group life of AA. The National Institute of Mental Health establishes a special division on alcoholism Marty Mann's Primer on Alcoholism is published. American Medical Association (AMA) resolves to create a special committee to develop a program for "medicine's aggressive participation in the work of solving the problems of alcoholism."

Early 1950's AA membership surpasses 90,000 as America (and Hollywood) becomes interested in the subject of alcoholism. Cinema portrayal of alcoholism includes such noted films as Lost Weekend, Days of Wine and Roses, and Come Back, Little Sheba.



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1950's The halfway house movement culminates in the founding (1958) of the Association of Halfway House Alcoholism Programs of North America.

1951 Lois W. and Anne B. start a Clearing House for the growing number of Family Groups that have grown in tandem with AA through the 1940s. The opening of the Clearing House marks the formal organization of these groups into Al-Anon Family Groups.

1952 American Medical Association first defines alcoholism. R. Brinkley Smithers establishes the Christopher D. Smithers Foundation, a charitable organization that focuses its primary mission on the support of alcoholism education and treatment efforts. This focus followed Smithers' own recovery from alcoholism and his participation in the Yale Summer School of Alcohol Studies. By the mid-1990s, the Foundation and the Smithers family had donated more than \$37 million to support alcoholism-related projects.

1954 Ruth Fox, MD establishes the New York City Medical Society on Alcoholism, today known as the American Society of Addiction Medicine (ASAM). The Minnesota State Civil Service Commission becomes the first such body in the United States to approve a state job classification position for "Recovery Coach on Alcoholism."

1956 The American Medical Association stops short of declaring alcoholism a disease but does recognize alcoholics as legitimate patients: "Hospitals should be urged to consider admission of such patients with a diagnosis of alcoholism based upon the condition of the individual patient, rather than a general objection to all such patients."

1957 The Veteran's Health Administration begins developing alcoholism treatment units within its national network of VA hospitals. American Hospital Association passes resolution to help prevent discrimination against alcoholics. Fordham University School of Social Services offers first full university course on alcoholism for credit.

1958 The first ex-addict-directed therapeutic community - Synanon -- is founded by Charles Dederich. It will be widely replicated in the 1960s and 1970s.

1960 E.M. Jellinek publishes The Disease Concept of Alcoholism.

Early 1960's Several states initiate civil commitment programs for narcotic addicts.



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1963 American Public Health Association adopts an official statement on alcoholism, identifying it as a treatable illness. Dr. Vincent Dole, an endocrinologist, and Dr. Marie Nyswander, a psychiatrist specializing in addiction, introduce methadone blockade therapy in the treatment of narcotic addiction.

1964 – 1975 The insurance industry begins to reimburse the treatment of alcoholism on par with the treatment of other illnesses. This leads to a dramatic expansion in private and hospital-based inpatient treatment programs.

1966 Two federal Appeals Court decisions support the disease concept of alcoholism. President Johnson appoints first National Advisory Committee on Alcoholism and becomes the first President to address the country about alcoholism. He proclaims: "The alcoholic suffers from a disease which will yield eventually to scientific research and adequate treatment."

The National Center for the Prevention and Control of Alcoholism is created within the National Institute on Mental Health.

The Narcotic Addict Rehabilitation Act (NARA) marks a milestone of increased federal involvement in supporting development of local addiction treatment services.

The New York Medical Society alters its mission to become the American Society on Addiction Medicine.

1967 – 1971 Special alcoholism Recovery Coaching/treatment initiatives begin within all major branches of the U.S. Armed Forces.

1970 Congress passes the "Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act," known as the Hughes Act for its sponsor in the Senate, Harold E. Hughes. The legislation establishes the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Those testifying in support of the legislation include Marty Mann of NCA and Bill Wilson, Co-founder of AA.

1972 The Joint Commission on Accreditation of Hospitals develops accreditation standards for alcoholism treatment programs.

The Alcoholism Report, the first newsletter devoted exclusively to the field of alcoholism, begins publication.



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The National Association of Alcoholism Recovery Coaches and Trainers is founded at a meeting of Organization for Economic Opportunity regional alcoholism programs. It will evolve into the National Association of Alcoholism and Drug Abuse Recovery Coaches (NAADAC).

The Food and Drug Administration approves use of methadone for treating heroin addiction.

The Drug Abuse Treatment Act of 1972 creates the Special Action Office for Drug Abuse Prevention that will lay the groundwork for the creation of the National Institute on Drug Abuse in 1974.

TASC (Treatment Alternatives to Street Crime) is created by the Drug Abuse and Treatment Act to screen addicts in the criminal justice system and then to link and manage their involvement in treatment services.

1973 U.S. investigators first describe fetal alcohol syndrome (FAS), a pattern of birth defects observed in children born to alcoholic mothers.

Vernon Johnson's book, *I'll Quit Tomorrow*, introduces intervention technologies that will be widely used to reach alcoholics and addicts before they "hit bottom."

1974 The first of a series of studies on credentialing of Recovery Coaches working in alcohol and drug treatment programs marks the beginning of a sustained process of certification and licensure of addiction Recovery Coaches.

1978 First Lady Betty Ford speaks to the nation about entering recovery from addiction to alcohol and other drugs.

1980 President Carter appoints the National Commission on Alcoholism and Other Alcohol Related Problems chaired by Senator Harold Hughes. It only meets once.

Mothers Against Drunk Driving, a powerful grassroots advocacy group, is formed.

1981 The U.S. Postal Service issues a first-class stamp imprinted with "Alcoholism. You can beat it!"

Nancy Reagan's "Just Say No" anti-drug campaign is launched within a broader "zero tolerance" campaign that will reduce federal support for treatment and mark the beginning of the



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dramatic rise in the number of drug users incarcerated. The growth of addicted offenders in the 1980s will lead to the demand for drug courts and in-prison treatment in the 1990s.

1982 The federal Block Grant Program transfers responsibility for the delivery of treatment and prevention services to the states.

Former First Lady Betty Ford lends her name to a treatment center for alcoholism and other drug addictions.

Cocaine Anonymous is founded.

1982 – 1992 The number of women-only treatment units triple as NIAAA and NIDA focus attention on the special needs of addicted women.

1983 First certification exam for addiction medicine specialty is offered in California. National Association for Children of Alcoholics is founded.

1985 First appearance of crack cocaine focuses enormous public attention on the illegal drug problem. Concerns about cocaine-exposed infants lead to expansion of treatment resources for women and specialized programs to treat women involved in the child protection system.

American Academy of Psychiatrists in Alcoholism and Addictions is founded.

1985 – 1990 Addiction treatment becomes increasingly concerned about "special populations" and launches specialized treatment tracks for women, adolescents, the elderly, gays and lesbians, and the "dually diagnosed." As the challenges of treating new patterns of cocaine addiction grow, relapse tracks also become a common treatment innovation.

1987 President Reagan formally announces a renewed "War on Drugs"; the shift away from treatment toward punishment and incarceration intensifies.

American Medical Association calls all drug dependencies diseases whose treatment is a legitimate part of medical practice.

1989 The publication of Stanton Peele's *Diseasing of America: Addiction Treatment Out of Control* marks the full emergence of a movement whose primary mission is opposition to Twelve Step programs and Twelve Step-oriented addiction treatment.



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The first specialized "drug court" is started by Miami Judge Stanley Goldstein. It will spur a national movement to link addicted, non-violent offenders to treatment as an alternative to incarceration.

1989 – 1994 Following an erosion of alcoholism treatment reimbursement benefits by insurance carriers, an aggressive system of managed care all but eliminates the 28-day inpatient treatment program in hospitals and private, free-standing centers. The downsizing and closure of hospital-based treatment units sparks a trend toward the integration of many psychiatric and addiction treatment units and a renewed community trend of incorporating addiction treatment services under the umbrella of mental health or "behavioral health" services. Most inpatient treatment programs shift their emphasis toward outpatient and intensive outpatient services. The loss of residential services adds fuel to a growing recovery home movement.

1991 The American Society of Addiction Medicine publishes its ASAM Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders. The ASAM criteria shift treatment toward a "levels of care" system rather than a single modality indiscriminately applied to all those entering treatment.

1992 The Center for Substance Abuse Treatment created to expand the availability and quality of addiction treatment.

The Americans With Disabilities Acts extends job protection (except in safety-sensitive positions) to alcoholics and recovering drug addicts in the private sector.

1995 U.S. Food and Drug Administration approves prescription use of naltrexone in treatment for alcoholism. Naltrexone marks the emergence of a new generation of pharmacological adjuncts in the treatment of alcoholism and other addictions.

2000 In a milestone article in the Journal of the American Medical Association, Drs. McLellan, Lewis, O'Brien, and Kleber call for the re-conceptualization and treatment of addiction as a chronic medical illness.



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Who Becomes a Recovery Coach?

People do not gravitate to the Recovery Coaching profession in the same way that people choose to become insurance agents, plumbers, or corporate executives. In working with students and in many discussions with my colleagues over the years, I find that behind a vague desire to “help people” there is usually a person searching for a life of more meaningful connection, both with self and with others. Often the student’s life had seemed filled with bad choices or ventures down blind alleys to dead ends, leaving the student looking for a better way to channel interpersonal energy. Sometimes individuals consider becoming Recovery Coaches after overcoming some major life challenge such as addiction or a history of bad relationships. Perhaps an individual has encountered a particularly effective Recovery Coach or therapist and has a desire to follow in those footsteps. Others may have had a bad experience with Recovery Coaching and concluded that it can be done better.

People do not think of this work so much as a job, or even as a career. More typically, a constellation of life experiences that demand explanation and a sense that others seek one out for assistance and emotional sustenance become driving forces leading one toward the Recovery Coaching. Many people feel that they have been called to it in some fashion (Foster, 1996).

You may think of yourself as having some unique talents or gifts for understanding others. Maybe you have led a successful, outwardly exemplary work life—making lots of money and building a reputation—but have been left feeling unfulfilled and dissatisfied. You may come to this work from a history of personal pain or trauma.

All kinds of life experiences and a wide variety of motivations for wanting to become a Recovery Coach are legitimate. Any and all of these provide fuel for the self-examination mill. You will want to examine your motivations because you will want to work cleanly with people, only minimally encumbered by your own unfinished business. This examination should involve both an intellectual review of your motivations and a review of the emotional issues related to your desire to do this work. Evidence (Goleman, 1995, 1998) suggests that your ***emotional connections to your desire for this work are at least as important as your intellectual ones.***

Some people are, of course, drawn to this profession for the wrong reasons—to take advantage of others’ vulnerabilities or to work out their own personal problems (Witmer & Young, 1996). While you should not be primarily involved with this profession to promote your own self-awareness and understanding, you can nevertheless take comfort in the fact that the profession can lead you toward a greater understanding of yourself.



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The Nature of the Work

You are being called to a noble cause. It is a cause with many rewards and with attendant responsibilities. It is a privilege and an honor to be invited to share in some of the intimate details of another's life, and you are obliged to respect the gift that that sharing implies. But what is it, exactly, that you may anticipate being called upon to do? The reasons people seek out Recovery Coaches are many and varied. Many people come for Recovery Coaching to resolve some kind of personal or life problem. Usually, these people come with a genuine, positive desire to be helped, but you will also encounter the occasional client who will manipulate and con you (Kierulff, 1988). Sometimes personal problems precipitate crises, periods of deep emotional pain. People can become extremely distraught, and you may be called upon to help them through these difficult times.

With desperate people who are trying to simply stay afloat in turbulent waters, your job is to provide an emotional life raft and maybe to help find the resources for them to move toward the safer shallows. In addition to their addiction issues the client may have marital or financial problems, or problems dealing with a child. Sometimes problems are poorly defined—just a vague dissatisfaction or feeling of emptiness or depression. The problems may be multiple, overlapping, and complex or relatively simple and easily remedied. Some people may have emotional, mental, or physical problems that severely impair their ability to function well in the world.

Whatever problems clients may feel they have, they are looking to a Recovery Coach to help make things better. If someone is in critical straits, some kind of crisis intervention may be necessary.

Similarly, you may work to help people reconcile and correct serious behavioral problems. Those problems may have gotten them in trouble, and other people may have directed them toward Recovery Coaching. They may have problems not only with drugs/alcohol, but, also with the law, their jobs and, of course, their families. Your job may be to help monitor, supervise, and support positive behavioral change. The work here is most certainly not always “warm and fuzzy,” and it may run counter to what many people think of when they consider the nurturing, supportive role of the Recovery Coach. You may function in a kind of cheerleading or coaching role, providing suggestions and support for new courses of action. Much of this work will be helping people to see their hidden talents and to recognize their own strengths that have gone unsupported.

Other clients of yours may function perfectly well but feel trapped within their functional lives,



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yearning for more but not knowing exactly what they want. A vast group of potential clients are those who are searching for personal growth and increased authenticity. They function well in their lives, may have solid jobs and intact families, and are successful by all traditional notions of the word “success.” Yet they feel incomplete, unfulfilled, and have deep longings for something more, something just out of the grasp of their awareness.

Your job as a Recovery Coach may thus be to call your client to greatness, to become an ally in the search for nobility and for the heroic that resides within us all. You may need to help some of your clients acknowledge the ways they keep themselves from becoming truly free and self-directed, the ways they have created their own little prisons, their “mind-forged manacles,” and some of the complex reasons for such retreat from real freedom. At its best, Recovery Coaching is about assisting clients in responding to their particular calls to greatness. You will want your clients, to repeat the clichéd phrase, to be “the best that they can be.”

We all search for the heroic within us. When we shrink from our desires to embrace our unique talents and the gifts we might bring to the world, we are eaten from within by our own dissatisfactions and stunted growth. It is this call to greatness that we assist many of our clients in answering and that we naturally seek to answer in our own lives. It stands to reason that the questions asked by our clients are similar to those with which we grapple ourselves.

The Rewards & Challenges of Recovery Coaching

Learning to be a Recovery Coach involves building a repertoire of responding, and helping skills. It involves, in other words, developing tools to help you help your client repair the mental and emotional “house” in which he or she lives. But it is much more than that. It is the development of wisdom; it is about learning how to connect effectively with people. It requires that you learn about yourself in the midst of assisting others (Guindon, 2011; Reinkraut, Motulsky, & Ritchie, 2009). It is both science and art. You should find particular joy in an endeavor where learning about yourself is prerequisite to learning how to do the work with others. Moreover, learning to do this work has the tremendous potential for reaching into the other realms of our lives and enriching them. There is distinct potential for improving the general quality of your relationships with others, particularly your most intimate relationships, as a side benefit of becoming an effective Recovery Coach.

This work is not without its difficulties and challenges, however. It can be emotionally draining and difficult, particularly when you deal every day with people who move from one crisis situation to another. It can at times be difficult to not take problems home with you.



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Instructor Note: I oftentimes suggest to my students that they interview Counselors working in the field, either as part of a formally assigned experience or more informally for their own education. They sit down and talk with Counselors working in various substance abuse facilities, mental health agencies, and schools and ask them about their joys and frustrations with the work. They come back with interesting reports of these talks. It is not unusual for me to hear talk of the passion and dedication many of these Counselors take in watching their clients, grow and experience their lives in health & recovery. They talk of how these Counselors themselves report that they grow and learn from their interactions with their clients. My students are inspired by these stories. It is confirmation of their own initial desires to enter the field.

Ongoing Recovery Coach self-understanding and personal examination is more than a casual, self-indulgent preoccupation with self, or ego gratification. It is an obligation that you manage your relationship matrix variables, your own history, and your current emotional life so that full attention can be paid to your client's relationship variables, history, and emotional life. You are also obliged to come to grips with Recovery Coaching work itself should it ever become stale and unrewarding, for whatever reason, so that you can either quit and move on to something else or find ways to become revitalized and enthusiastic.

Instructor Note: For myself, I cannot thank this profession enough for giving me the tools and wherewithal to deal more effectively with my own family, friends, and other close relationships. I am not the perfect listener, and still have lapses in how closely I attend to friends and family, but I do at least know the difference between good and poor listening, the importance of solid emotional contact, and the need for give and take in a relationship. It is my fervent hope that this work benefits you in a similar fashion. I am convinced it has that potential. As much as this work is about helping others, it is also about helping yourself. You will become involved in reciprocal learning relationships with your clients, and they may teach you significant things about life.

There is even more about this work that is important. If we think of our own work as having the possible rippling effect of sending others out into the world with a greater appreciation of good communication and solid relationship skills, a greater sense of our shared humanity, we could consider ourselves pioneers for global connection.

The Purpose, Practice & Role of the Substance Abuse Recovery Coach

Recovery Coaching includes methods that are sensitive to individual client characteristics and to the influence of significant others, as well as the client's cultural and social context. Competence in Recovery Coaching is built on understanding of, appreciation of, and ability to appropriately use the contributions of various addiction recovery principles as they apply to modalities of care for individuals, groups, families, couples, and significant others.

Competency: Facilitate the client's engagement in the treatment and recovery process.

Before we continue on with the Recovery Coaching coursework, let's talk about the role of the Recovery Coach. What is the purpose of Recovery Coaching in general, for any client but particularly the substance abusing client. The following is an overview of primary and significant roles an addiction Recovery Coach must play. An extended in-depth explanation will be included in the chapters that follow.

The role of the Recovery Coach in addiction treatment is to provide support, education, and nonjudgmental confrontation. The Recovery Coach must establish good rapport with the patient. The patient recovering from chemical addiction deserves to feel understood and that he or she has an ally. The Recovery Coach wants to convey to the patient that he or she appreciates the difficulty of this struggle and the need for support through the recovery process.

Overall, drug use is thought to be a multi-determined, maladaptive way of coping with life's problems. It sometimes becomes compulsive and leads to a progressive deterioration in one's life circumstances. Compulsive drug abuse is addiction, which is defined as a disease. It damages the addict physically, mentally, and spiritually.

The metaphor of the hiker and the guide is useful for conceptualizing the relationship. The Recovery Coach guides the patient through at least the early stages of recovery, oftentimes before formal treatment has begun, but the recovery process ultimately belongs to the patient. It is the patient alone who is responsible and accountable for his or her recovery. The Recovery Coach must emphasize this point to facilitate personal responsibility.



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The client is the effective agent of change. It is the client who must take responsibility for working on and succeeding with a program of recovery. Although recovery is ultimately the client's responsibility, the client is encouraged to get a great deal of support from others, including Recovery Coaches and treatment staff, one's sponsor, peers and family members.

The Recovery Coach must find a balance between being directive and allowing the client to be self-directed. The Recovery Coach identifies the relevant topic for discussion, based on what the client seems to need, and introduces that topic.

The client also is encouraged to be self-directed. For example, within the framework of a particular topic, perhaps coping with "social pressure to use," the client may explore how to manage this problem best and the Recovery Coach will respond to the client's direction. If the client seems unable to change some aspect of addictive behavior - for example, being around dangerous situations - the Recovery Coach should accept where the client is and assist the client to explore those perceptions or situations in a way that might allow himself or herself to do it differently, i.e., in a better way, the next time. However, the Recovery Coach should discourage regressive or other movements that lead back toward addiction. A balance needs to be struck so there is respect for the client and acceptance of where he or she is and continual, ongoing focus in the direction of abstinence and recovery.

Finally, addiction Recovery Coaching *focuses primarily on the present* rather than the past.. The client's past only becomes part of the present if issues from the past are directly impacting their current everyday life.

Behaviors That Should Not Be Done

The Recovery Coach should not be harshly judgmental of the client's addictive behaviors. After all, if the client did not suffer from addiction, he or she would not need a Recovery Coach, so blaming the client for exhibiting these symptoms is useless. Also, clients often feel a great deal of shame associated with their addictive behaviors. In order to help resolve those feelings of shame and guilt, the Recovery Coach should encourage the client to speak honestly about drug use and other addictive behaviors and be accepting of what is said.

The Recovery Coach should be respectful of the client. The Recovery Coach should always be professional, including not being late for appointments and never treating or talking to the client in a derogatory or disrespectful manner. The Recovery Coach should avoid too much self-disclosure. While occasional appropriate self-disclosure can help the client to open up or motivate the client by providing a role model, too much self-disclosure removes the focus from the client's own recovery. ***A good rule for when to self-disclose, if the Recovery Coach is***



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indeed so inclined, is for the Recovery Coach first to have a clear purpose or goal for the intervention and then to analyze why he or she is choosing to self-disclose at this particular time. If any doubt results from this analysis, it probably should lead to a more conservative, nondisclosure position.

Lastly, Recovery Coaches need to be aware of when their own issues are kicked up by a client's problem and refrain from responding from the context of their own personal issues. For example, consider the case where a Recovery Coach in recovery feels that it was extremely important for him or her to break ties with addicted peers. Now this Recovery Coach is working with a particular client who has an addicted spouse or partner and does not want to break these relationship ties. It is imperative that the Recovery Coach be flexible and responds creatively to the client's own perception of the problem. In this case, the Recovery Coach must not rigidly adhere to the notion of insisting that breaking ties with *all* addicts is the *only* acceptable path to recovery. In general, the reflexive, noncritical projection of the Recovery Coach's own needs or experiences onto that of the client's situation can be damaging or, at least, counterproductive.

Being the Recovery Coach & Recovery Coaching Basics

Building Multicultural and Ethical Competence

As you embark on the process of learning more about yourself and your motivations to be a Recovery Coach, as well as about the skills necessary to do this work, you will want to simultaneously heighten your appreciation of the multicultural, diverse nature of the world in which you work. It is part of your obligation to make sure that you work in ways that protect the safety of your clients and yourself. An awareness of issues related to dealing with people who might be different from you, and of the ethical principles that guide our profession, are as critical to doing solid Recovery Coaching work as are self-understanding and a repertoire of skills. You want your clients to leave you feeling and doing better than when they started—or at the very least no worse. Your attention to the ethics of good practice, as well as to the worldview people bring to Recovery Coaching, helps to ensure that no harm will be done.

Adopting a multicultural perspective and learning about ideas related to Recovery Coaching from such a multicultural perspective are essential for those who want to be effective Recovery Coaches. You live in a rapidly changing, incredibly diverse world, and you will encounter clients who have experiences and perspectives that are very different from yours. Rather than seeing these differences as a block to understanding, you can embrace such differences as a great opportunity to stretch your own thinking. This is yet another opportunity to learn more about yourself in relation to others, to learn from the clients you serve.

Cultural awareness includes an awareness of one's own philosophies of life and capabilities, recognition of different structures of reasoning, and an understanding of their effects on one's communication and helping style.

Another Recovery Coaching barrier is language. Language differences may be perhaps the most important stumbling block to effective multicultural Recovery Coaching and assessment. (Romero) Language barriers impede the Recovery Coaching process when clients cannot express the complexity of their thoughts and feelings or resist discussing affectively charged issues. Recovery Coaches, too, may become frustrated by their lack of bilingual ability.



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Multicultural Recovery Coaching seeks to rectify the imbalance of power, appreciating the value of the culture and using it to aid the client.

Although it is impossible to change backgrounds, Recovery Coaches can avoid the problems of stereotyping and false expectations by examining their own values and norms, researching their troubled individual's backgrounds, and finding Recovery Coaching methods to suit those needs. Recovery Coaches cannot adopt the troubled human being's ethnicity or cultural heritage, but they can become more sensitive to these things and to their own and their clients' biases.

Personal Characteristics of Effective Recovery Coaches

What is a healthy, or whole, Recovery Coach? What are those naturally occurring traits and features of personal awareness that contribute to wholeness and health and that result in effective Recovery Coaching outcomes?

Researchers have uncovered evidence that certain factors do tend to contribute to better work in this field. For example, Recovery Coaches who are more personally confident and socially adept (Williams, 1999) will have an easier time relating to their clients. The following ten favorable personality characteristics are also the least teachable to those who do not already possess them (Pope, 1996; Scheffler, 1984):

- Acceptance
- Empathy
- Emotional stability
- Flexibility
- Open-mindedness
- Interest in people
- Genuineness
- Confidence
- Sensitivity
- Fairness

Other lists of characteristics retain this range of personal characteristics and add specific qualities suggesting wisdom and maturity like inner directedness, feeling reactivity, spontaneity, self-regard, and capacity for intimate contact (Ritter, 1984), and spirituality and self-actualization.



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The role of the Recovery Coach in addiction treatment is to provide support and education to those alcohol and or drug troubled human beings. It is essential that a Recovery Coach establish a good relationship with the alcohol and or drug troubled human being.

A human being recovering from a specific addiction deserves complete attention from the Recovery Coach and to feel understood. Consequently, the Recovery Coach should convey to this human being, their understanding of the struggles in all stages of recovery, and are willing to support the human being throughout the recovery process or Recovery Coaching sessions, i.e. limited sessions sometimes due to HMO insurance regulations or insurance.

The trend in Recovery Coaching for the twenty first century stresses the values and behaviors of the Recovery Coach. The quality of the relationship between the Recovery Coach and the troubled human being seems to be the most important factor to foster growth for the person troubled.

The Recovery Coach as a “Whole Person”

Like addiction counseling, Recovery Coaching can be draining and difficult work, particularly when one works with a number of people who are consistently in serious difficulty. Wegscheider (1981) proposed looking at the Addiction Counselor’s state of wellness from the perspective of “wholeness,” which also applies to Recovery Coaching. In this model different aspects, or “selves,” comprise the whole Recovery Coach, each of which needs care and attention. These “selves” of ours are comprised of the following elements:

- Physical self
- Emotional self
- Social and familial self
- Intellectual self
- Working self
- Aesthetic self
- Spiritual self

It should be obvious that Recovery Coaches who wish to do good work with people need to function at relatively high levels in each of these areas. Effective Recovery Coaches acknowledge that a balanced personal life is central to doing good Recovery Coaching work (Reyak-Schelar & Feldman, 1984). A life that overemphasizes one or two of these areas, to the exclusion of others, is a life that runs a bit off balance and compromises the capacity to respond to those needs in others.



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The Effective Recovery Coach

Nobody said learning to become a Recovery Coach is easy.

Who you are as a person will largely determine how effective you will be in working with others as a Recovery Coach. You are, in your individual person, your own single best tool for helping others. Your values, beliefs, and personal background— simply how you live your daily life—will influence the lives of your clients. All of your history, your personal conduct, and your attitudes about people and the world around you are at play in the Recovery Coaching relationship. The degree to which you understand yourself will have a lot to do with how effective you will be with your clients (Kottler, 1993).

Life experience helps to shape the person of the Recovery Coach; the wider and more divergent the life experience, the greater the capacity of the Recovery Coach to do this work.

Recovery Coaches in Recovery Themselves

Many Recovery Coaches in this field are either in recovery themselves or have a family member who was addicted. Our view is that an in-depth knowledge of addiction and the tools for recovery and an ability to empathize with the client are essential attributes of an effective addiction Recovery Coach. One way, but not the only way, to acquire this knowledge and ability is to be in recovery oneself. If a Recovery Coach is in recovery, he or she should be relatively emotionally healthy and stable.

Client Vulnerability – Respecting the Power Differential

The requirement for Recovery Coach personal growth and self-examination may also provide a good firsthand introduction to how vulnerable it can feel to be a client. For anyone who has never experienced the joys, or the terrors, of being a client, it is an excellent empathy-enhancing experience. What better way to begin to understand how it feels to be a client than to sit in that other chair? It is a truism that seeking Recovery Coaching is a courageous act. Seeking help or asking for assistance puts one in a position of vulnerability. Many people who come to treatment may have tried other ways of solving their problems, including using family, friends, and their own internal resources. This may be particularly true for people from some cultural backgrounds where seeking help outside the family is not valued and may be frowned upon (Pedersen & Ivey, 1993).



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Recovery Coach, Heal Thyself

Recovery Coaching students often begin to doubt themselves, particularly their own relative mental health and emotional stability. They ask, “How can I help someone else, when I’m such a wreck myself?” ***This is a legitimate question (and unfortunately too rarely asked by those who need to ask it most).*** There is such a lot to think about and work through. Your own personal family history, your work life, your loves, your other relationships, your belief system—not to mention all of the course work you are trying to absorb—can all conspire to make you feel inadequate. At times it seems too complex, too cumbersome to sort through, yet there are glimpses of light and clarity that can give you hope and inspiration.

It is important to remember that coaching does not require us to be perfect people. If it did, it would be a lonely, unpopulated field. Some of your greatest difficulties and struggles may, in fact, become your greatest assets in understanding the pains and difficulties of others.

You need to give yourself the time to learn about this work and about yourself. The process of increasing your self-understanding and the parallel process of learning to work effectively as a Recovery Coach is a magnificent journey. The two processes feed upon and nurture each other; in this mutual nurturance lies much of the great satisfaction of this work.

Basic Principles of Recovery Coaching

Respect for the client

The skill of a Recovery Coach lies in communicating a sense of self-respect to the client. The client needs to accept the belief that every person possesses the inherent strength and capacity to ‘make it’ in life, and that each person has the right to choose his their own alternatives and make their own decisions. It is also important that respect for the client should be reflected in the manner the Recovery Coach conducts themselves. Recovery Coaches should always be professional; for instance they should not be late for appointments and never talk to or treat the client in a derogatory or disrespectful manner.

Being a Role Model

The Recovery Coach should set an example to the client through their personal behavior and attitude.



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Confidentiality

Maintaining confidentiality is very important in a Recovery Coaching relationship as this leads to the development of trust. The Recovery Coach should not reveal the client's identity, personal details and such information to other people without the client's permission. In addition, they must assure the client that confidentiality will be maintained to gain client trust.

Emphasizing the Client's Personal Responsibility for Recovery

The Recovery Coach should be able to guide the client in the early stages of recovery and convey the understanding that the recovery process ultimately rests with the client.

Providing Direction and Encouraging Self-Direction

The Recovery Coach must strike a balance between providing direction and allowing the client to be self-directed. It is essential that the Recovery Coach create a structure in the session that includes giving the client feedback on their progress in recovery. The Recovery Coach identifies the relevant topics for discussion, based on what the client seems to need, and introduces those topics.

If the patient seems unable to change some aspect of addictive behavior, the Recovery Coach should accept the situation and assist them to explore those perceptions or situations in a way that might allow them to deal with them differently. A balance needs to be maintained so that there is respect for the patient, acceptance of where they are, and still provide motivation for abstinence and recovery.

Conscious of their Own Issues

The Recovery Coach needs to be aware of the possibility of their own issues being triggered by a client's problems; the Recovery Coach must consciously refrain from basing their response in the context of their own personal issues. For example, a Recovery Coach in recovery may feel that it is personally important for them to break ties with addicted peers to maintain sobriety. If this Recovery Coach happens to work with a client who has an addicted sister with whom the patient has a valuable relationship, it is important that the Recovery Coach be flexible and respond creatively to the client's own perception of the problem.

Communication Skills Needed in Recovery Coaching

The outcome of a meeting between the Recovery Coach and the client will depend a great deal on how comfortable the client feels with the Recovery Coach, so that they may entrust their genuine feelings to the Recovery Coach, including information which the client may feel is very private and personal and which they are reluctant to share. This can be achieved by the use of certain communication skills that create an atmosphere of support for the client and the process.

The process of communication between the client and the Recovery Coach in the Recovery Coaching situation is a continuous two-way sequence. This sequence of events ensures that the Recovery Coach listens (receives the message); processes (considers the message in combination with previous knowledge and experience); and responds (delivers a response to the original message).

LISTENING

Attending

This refers to a concern by the Recovery Coach with all aspects of the client's communication. It includes listening to the verbal content, observing nonverbal cues and then communicating back to the client that s/he is paying attention. The skill of attending is the foundation on which all other skills are built.

Guidelines for effective attending:

- communicate listening through eye contact and facial expression
- maintain a relaxed physical posture and lean forward occasionally, using natural hand and arm movements
- verbally 'follow' the client, using a variety of brief encouragements such as 'um-hm', 'yes', or repeating key words.

Attending helps the client to:

- relax and feel comfortable
- express his ideas and feelings freely in his own way
- trust the Recovery Coach
- feel more responsible for what happens in the session by enabling them to direct the session.



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Attending enables the Recovery Coach to:

- obtain accurate inferences about the client through careful observation.

Paraphrasing

Paraphrasing is a response that restates the content of the client's previous statement. It concentrates primarily on the words spoken, the content which refers to events, people and things. In paraphrasing, the Recovery Coach reflects to the client the verbal essence of his/her last comment or last few comments. More often, paraphrasing uses words that are similar to the client's, but fewer in number.

For example:

Client – My mother constantly irritates me. She picks on me for no reason at all. She likes only my younger brother and pampers him all the time. She is the reason for my drug taking. Even if I give up drugs, she will not change.

Recovery Coach – You are having problems in getting along with your mother. You are concerned about your relationship with her.

Paraphrasing helps the client to:

- realize that the Recovery Coach understands what he is saying
- get a sense of direction
- clarify his remarks

It enables the Recovery Coach to:

- verify her perceptions of the verbal content of the client's statements
- spotlight an issue

Reflection of Feelings

The Recovery Coach expresses the essence of the client's feelings, either stated or implied; this is 'reflection of feelings'. Unlike paraphrasing, the focus is primarily on the emotional element of the client's communication. The Recovery Coach tries to perceive the emotional state of the client and feed back a response that demonstrates his/her understanding of the client's state. It lets the client know that the Recovery Coach understands what s/he is experiencing and feeling. This empathy reinforces the client's willingness to express his/her feelings more openly. It also gives the client an opportunity to recognize and accept his/her feelings.



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Through reflection of feelings problem areas can be identified without the client feeling pushed. It also helps the client understand that feelings cause certain types of behavior.

Reflection of feelings helps the client to:

- realize that the Recovery Coach understands what the client feels and experiences
- bring to the surface any feelings that may have been expressed only vaguely
- learn that feelings and behavior are connected.

It enables the Recovery Coach to:

- check whether or not she is accurately reflecting what the client is experiencing
- bring out problem areas without the client being pushed

Summarizing

Summarizing is the tying together by the Recovery Coach of the main points discussed in a Recovery Coaching session. Summarizing can focus on both feelings and content (information), and is appropriate after discussion of a particular topic within the session or as a review, at the end of the session, of the principle issues discussed. In either case, the summary should be brief, to the point, and without new or added meanings.

Recovery Coach – We discussed your relationship with your wife. You said that there were conflicts right from the start. The conflicts related to the way money was handled and that she often felt you gave more importance to your friends. Yet on the whole, things did go on well and you were quite happy until 3 years ago. Then the conflicts became more frequent and more intense so much so that she even left you twice and talked of divorce too. This was also the time when your drinking was at its peak. Have I understood the situation properly?

Summarizing clarifies the client's meaning by pulling his/her scattered thoughts and feelings together. It can terminate a session in a logical way through a review of the major issues discussed in the entire session and also help link one session to the next.

Summarizing helps the client to:

- clarify meaning
- realize that the Recovery Coach understands what he is saying and feeling
- have a sense of movement and progress.

It enables the Recovery Coach to:



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- ensure continuity in the direction of the session by providing focus
- verify her perceptions of the content and feelings discussed
- terminate a session in a logical way
- focus on one issue while acknowledging the existence of other concerns.

PROCESSING

The information given by the client and his family in bits and pieces is put together using the Recovery Coach's own judgment and observations. S/he then understands the situation in its totality. Based on this processing, the Recovery Coach helps the client develop a meaningful plan for the future.

Responding

Probing

Probing is the Recovery Coach's use of a question or statement to direct the client's attention inward to explore their situation in greater depth. A probing question should be open-ended, requiring more than a one-word answer ('yes' or 'no') from the client. Probing helps to focus the client's attention on a feeling or content area. It may encourage the client to elaborate, clarify or illustrate what s/he has been saying. It sometimes enhances the client's awareness and understanding of their situation and feelings. Probing directs the client's attention to areas that, according to the Recovery Coach, need attention.

The Recovery Coach should use her/his judgment to identify the subject or feelings touched upon by the client that needs further exploration. It is important that the Recovery Coach uses the technique of 'probing' only after 'attending' to the client.

Probing helps the client to:

- focus his attention on a feeling or content area
- become aware of and understand his situation or feelings
- focus his attention on areas the Recovery Coach thinks need attention.

It enables the Recovery Coach to:

- better understand what the client is describing.

Interpreting



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Effective interpreting has three components – determining and restating basic messages; adding Recovery Coach’s ideas for a new frame of reference; and checking out these ideas with the client.

It is very important that the Recovery Coach uses the skills of attending, paraphrasing, reflection of feelings and summarizing prior to and in conjunction with interpreting. The first step in interpreting is to determine the basic messages the client has expressed or displayed, and restate them. As the Recovery Coach is restating them, s/he will have some idea about alternative ways of viewing the client’s situation, or may begin to see connections, relationships or patterns in the events the client describes. When these ideas are included in the material being restated to the client, the Recovery Coach adds his/her ideas to offer the client a new frame of reference from which to view their situation.

Because the Recovery Coach is offering alternative viewpoints, it is very important to phrase them tentatively or to check the client his reaction to the new point of view. Tentative phrases like ‘The way I see it ...’ or ‘I wonder if ...’ are appropriate ways to begin an interpretation. Then there is a better chance that the client will see the offered interpretation as a possibility rather than as a judgment. He is thus more likely to react to an interpretation openly if it is offered tentatively.

Interpreting helps the client to:

- realize that there are more ways than one to look at most situations, problems and solutions
- become more flexible and to explore new points of view
- understand his problems more clearly.

Interpreting enables the Recovery Coach to:

- share a new perspective for the client to consider
- open out new coping strategies to deal with the issues.

Silence

Silence can be very powerful. It can be a time when things really ‘sink in’, and feelings are strongly felt and recognized. When combined with ‘attending cues’, it can serve to encourage the client to continue sharing. Silence can allow the client to experience the power of his/her own words.



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Through commitment and experience, the Recovery Coach acquires skills to help the client in the process of achieving an addiction free, qualitatively better life.

Two Powerful Aspects of Recovery Coaching (Individual, Family, Couples & Group)

TRANSFERENCE

The client may consciously or unconsciously cast the Recovery Coach in the role of a parent or sibling (or other significant person from their life) in an effort to establish emotionally close ties, and to feel recognized and worthy of attention, in order to enhance self-esteem. In many cases transference can enhance the benefits of therapy. Transference can be intensive, with a great deal of dependence coupled with hostile manipulative and testing behavior. When it progresses beyond an acceptable level and the client replays the conflicts and power struggles of his/her other relationships in the present Recovery Coaching relationship, it can become unhealthy. Discussing these issues specifically and openly helps.

When it grows in an unhealthy direction especially with sexual connotations, transference interferes with therapy and it is best to transfer the client.

Transference refers to clients' placement of feelings originally directed towards significant others in their life onto the Recovery Coach (Wallin, 2007). For example, clients might project feelings related to their mother or father figure onto the Recovery Coach. In some cases this may lead to a belief that the Recovery Coach is nurturing and loving; in other situations feelings of anger and mistrust may arise. In the clients' mind the Recovery Coach may also come to represent their ideal partner or friend; this may lead to platonic, romantic, or sexual attraction.

Depending upon the life history of the client, the Recovery Coach may also represent oppressive systems or an opposing cultural group (i.e. higher social class, an ethnic group the client may have had conflict with previously, etc).

COUNTER-TRANSFERENCE

Counter-transference can grow out of conscious or unconscious thought processes of the Recovery Coach. The Recovery Coach may project her/his own feelings or conflicts to the client and lose the professional objectivity that is necessary. Being sensitive to one's own feelings and behavior helps one become sensitive to the issue. Consider talking about it with the senior



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Recovery Coach, peers and, of course, seek your clinical supervisor's help. Being able to ask one why, and deal with it helps the Recovery Coach grow professionally. However, if the counter-transference is intensive, it would be best to terminate (with the guidance of your clinical supervisor) the relationship with the client.

There are scores of other special issues like counter-transference, that confront the Recovery Coach. Understanding when professional help or supervision is needed, is therefore critical. The depth of care one really feels for the client along with the professionalism that one brings into practice is what sets apart an effective and successful Recovery Coach from the rest of the crowd.

Additional definition & information on the all-important subject of counter-transference:

Counter-transference occurs when Recovery Coaches' emotions, beliefs, and biases are projected onto their client; as with transference this is typically related to the Recovery Coach's life history. Counter-transference involves an emotional connection with the client beyond what other Recovery Coaches would deem as appropriate within the therapeutic relationship. The Recovery Coach's acceptance of the client's transference is another example of counter-transference (Gelso & Hayes, 2007). For example, when clients project feelings related to their parental figure onto their Recovery Coaches, the Recovery Coaches may find themselves wanting to protect the clients and reach beyond their boundaries to assist the clients. In such cases it is important to explore issues of both transference and counter-transference in order to rebalance the therapeutic relationship, reestablish boundaries, and promote client growth. There are many ways to recognize and respond to counter-transference during individual and group supervision. When not addressed, counter-transference can lead to violations of boundaries and potential harm to clients.

Instructor Note: In conclusion, I am hoping that in reading this chapter you all got the message, the purpose, the idea, the framework of who Recovery Coaches are, who they can be, the importance of this role in people's lives. I am passionate about teaching and about helping others help themselves. I have allowed myself to be open to the process and over the years I have changed many many times in both my clinical practice and in personal life as a result. The journey has been and continues to be daunting, difficult, confusing, heartfelt, joyous, painful and outright wonderful.....I wouldn't change a single thing. It is my sincerest hope that you, the student open yourselves to the learning process, the clinical process and the self-discovery process. Enjoy the ride 😊

Crisis and Risk Assessment

Chapter 3

Crisis - An acute physical and/or emotional event. An event occurring during treatment that threatens to impact progress. For addicted clients, crisis often increases the risk of relapse.

Crisis intervention - “Those services which respond to an alcohol and/or other drug abusers needs during acute emotional and/or physical distress.” (Herdman, 2001)

Steps in crisis intervention

1. Establish a helping relationship. Help the client achieve symptom relief.
2. Assure safety. To self or others as well as the client’s safety from others. Help the client return to his/her level of functioning prior to the crisis
3. Conduct an assessment. Discover what caused the crisis (death in the family, loss of job, end of a relationship, etc.).
4. Give support. Provide resources and support to remedy the situation. If the client is dealing with a loss, a referral to a grief support group may be appropriate.
5. Assist with action plans.
6. Arrange for follow-up.

What to do

- Intervene right away. A crisis often gets worse without immediate intervention.
- Instill hope
- Provide support
- Problem solve right away rather than striving for insight
- Provide positive feedback



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Suicide

Instructor Note: I have only one thing to say.....GET PROFESSIONAL HELP.....IMMEDIATELY! EVEN IF YOU THINK THE CLIENT MAY NOT REALLY BE SUICIDAL. THIS IS AN ASSESSMENT AND DECISION THAT SHOULD BE MADE BY A CLINICIAN!

Group Recovery Coaching

Group therapy has been acclaimed over the years as by far the most effective method of treatment for addiction. The gains of group therapy are now well established. The following are a few therapeutic gains that are unique to this treatment method:

- Provides an opportunity to share and identify with others who are going through similar problems. Groups help in developing a sense of belonging.
- Spontaneous sharing of older members, of their progress and the changes they have achieved, instills hope in the new skeptical members.
- Helps clients understand their own attitudes about drugs / alcohol abuse and their defenses against giving it up by identifying similar attitudes and defenses in others.
- Verbalization of thoughts and feelings, open feedback from others about positive and negative behavior and being a witness to successful conflict resolution, helps clients develop socialization skills.
- Teaches members interdependence (in contrast to dependence on *chemicals*) and thus build a better social network. This also helps *chemical dependents* to work through isolation.
- Provides a congenial atmosphere to powerfully confront denial, and assess high-risk situations. Members utilize the group as a laboratory for developing new responses and new skills.
- Provides an opportunity to formulate realistic goals and plans.
- Sharing insights, offering suggestions and support gives an individual the pleasant feeling of helping another. This altruism aids in strengthening self-esteem.

These gains prove beyond doubt that group therapy can be effective. The task then for the Recovery Coach is to maximize the gains within the available timeframe. The following are a few basic guidelines that contribute to effective group therapy sessions.

Size of the Group

Five to ten members in a group is the acceptable range. When there are less than five members, it fails to function as a group; with more than ten, the group can become unwieldy – both making it less effective.

Duration of the Group Meeting



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A minimum of one to an hour and a half is needed for the group to settle down and get to work on an issue. However, if a group session stretches beyond 90 minutes, fatigue sets in and diminishing gains are reported.

Frequency Of Meetings

This depends on the treatment modality. Residential settings have multiple groups in a day, day treatment programs have at least one group per day for the 4-6 days the client attends, and intensive outpatient and traditional outpatient settings use group as their main form of treatment.

After discharge and/or during follow-up, meetings may be held once or twice a week to strengthen changes made and offer support through the recovery process.

Physical Environment

A pleasant quiet room that ensures privacy is a pre-requisite for group meetings. The seats should be similar and placed in a circle that all are equal. Moreover, everybody is visible to the rest of the group; face-to-face interaction is made possible and non-verbal behavior can be easily observed.

Rules and Limit Setting

At the beginning of the session, the Recovery Coach has to clearly spell out basic rules like punctuality, regular attendance, staying for the entire session and not leaving midway, not attending under the influence of drugs.

The following norms are a requisite as they help members function appropriately.

Confidentiality

Any information gained about another group member in the group therapy setting is to be treated in strict confidence. In short, 'What happens in the group, stays within the group' should be repeatedly stressed.

Listening

Maintaining eye contact, willingness to listen to other person's feelings and words without interrupting, are important. Interruptions are not to be made unless



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- the member is repetitious
- the member is rambling without focusing on issues relevant to the topic of discussion
- the listener has not understood and wishes to clarify his thoughts.

Using 'I' Statements

'We' and 'they' statements lead to superficial sharing on generalized issues. 'You' statements usually turn into critical, judgmental ones. 'I' statements, on the other hand, help the member speak only for himself and own responsibility for his feelings, thoughts and behavior. (Example: 'I feel ashamed. I have hurt my parents.')

Open, Honest, Spontaneous Sharing

Group therapy offers an unique opportunity for handling issues. It should be emphasized that to maximize gains, the wholehearted participation of the group is essential. Each member needs to remember that the more he puts into a group, the more he will benefit from the experience. All participants are considered equal, irrespective of their drinking or drug taking status, number of days they have stayed at the center, or nature of the damage. The Recovery Coach, as a facilitator of the group, need not share any details regarding her/him-self.

Feedback

Guidelines for Giving Feedback

Feedback is an essential component of group therapy. Here are a few guidelines to be discussed with clients prior to entry into the group. These guidelines facilitate involvement in the session and help them relate appropriately to other group members. Members should talk about behavior they can see. The feedback should be specific and relevant.

I notice that you are late by 5-10 minutes everyday. So we are unable to start the group meeting on time.

Feedback should be given caringly and not by hurting or attacking another member. No judgmental statements should be made. For instance, the following should be avoided:

You have been lazy and irresponsible at work. You cannot be upset now with your boss for criticizing you. You just have to take it – you asked for it.

The proper feedback would be to say, ‘you talked about your repeated absences, delay in submitting reports and not meeting sales targets. Your work has definitely suffered due to addiction. You are now upset that your boss has expressed dissatisfaction. Considering your work pattern, this is not surprising and your boss’s reaction seems reasonable.

- Members should avoid sarcasm and condescending remarks while giving feedback. No advice is to be given – only responses.
- Members should be encouraged to share positive feedback also.

THE PROCESS OF GROUP SESSIONS

During group therapy sessions, groups gradually move through a process of development. The early phase is the beginning of the group, particularly the first few meetings. The middle phase is the substance of the group, with the clients coming together, interacting, sharing, growing and changing in the Recovery Coach’s presence. The last phase is when the client completes the program and leaves the group.

Advantages of Groups

Adult clients in groups has many advantages, as well as some risks. Any treatment modality—group therapy, individual therapy, family therapy, and medication—can yield poor results if applied indiscriminately or administered by an unskilled or improperly trained leader. The potential drawbacks of group therapy, however, are no greater than for any other form of treatment.

Some of the numerous advantages to using groups in substance abuse treatment are described below (Brown and Yalom 1977; Flores 1997; Garvin unpublished manuscript; Vannicelli 1992).

- *Groups provide positive peer support and pressure to abstain from substances of abuse.* Unlike AA, and, to some degree, substance abuse treatment program participation, group therapy, from the very beginning, elicits a commitment by all the group members to attend and to recognize that failure to attend, to be on time, and to treat group time as special disappoints the group and reduces its effectiveness. Therefore, both peer support and pressure for abstinence are strong.
- *Groups reduce the sense of isolation that most people who have substance abuse disorders experience.* At the same time, groups can enable participants to identify with others who are struggling with the same issues. Although AA and treatment groups of

all types provide these opportunities for sharing, for some people the more formal and deliberate nature of participation in process group therapy increases their feelings of security and enhances their ability to share openly.

- *Groups enable people who abuse substances to witness the recovery of others.* From this inspiration, people who are addicted to substances gain hope that they, too, can maintain abstinence. Furthermore, an interpersonal process group, which is of long duration, allows a magnified witnessing of both the changes related to recovery as well as group members' intra- and interpersonal changes.
- *Groups help members learn to cope with their substance abuse and other problems by allowing them to see how others deal with similar problems.* Groups can accentuate this process and extend it to include changes in how group members relate to bosses, parents, spouses, siblings, children, and people in general.
- *Groups can provide useful information to clients who are new to recovery.* For example, clients can learn how to avoid certain triggers for use, the importance of abstinence as a priority, and how to self-identify as a person recovering from substance abuse. Group experiences can help deepen these insights. For example, self-identifying as a person recovering from substance abuse can be a complex process that changes significantly during different stages of treatment and recovery and often reveals the set of traits that makes the system of a person's self as altogether unique.
- *Groups provide feedback concerning the values and abilities of other group members.* This information helps members improve their conceptions of self or modify faulty, distorted conceptions. In terms of process groups in particular, as specific themes emerge in a client's group experience, repetitive feedback from multiple group members and the leader can chip away at those faulty or distorted conceptions in slightly different ways until they not only are correctable, but also the very process of correction and change is revealed through the examination of the group processes.
- *Groups offer family-like experiences.* Groups can provide the support and nurturance that may have been lacking in group members' families of origin. The group also gives members the opportunity to practice healthy ways of interacting with their families.
- *Groups encourage, coach, support, and reinforce as members undertake difficult or anxiety-provoking tasks.*

- *Groups offer members the opportunity to learn or relearn the social skills they need to cope with everyday life instead of resorting to substance abuse.* Group members can learn by observing others, being coached by others, and practicing skills in a safe and supportive environment.
- *Groups can effectively confront individual members about substance abuse and other harmful behaviors.* Such encounters are possible because groups speak with the combined authority of people who have shared common experiences and common problems. Confrontation often plays a part of substance abuse treatment groups because group members tend to deny their problems. Participating in the confrontation of one group member can help others recognize and defeat their own denial.
- *Groups allow a single treatment professional to help a number of clients at the same time.* In addition, as a group develops, each group member eventually becomes acculturated to group norms and can act as a quasi-therapist himself, thereby ratifying and extending the treatment influence of the group leader.
- *Groups can add needed structure and discipline to the lives of people with substance use disorders, who often enter treatment with their lives in chaos.* Therapy groups can establish limitations and consequences, which can help members learn to clarify what is their responsibility and what is not.
- *Groups instill hope, a sense that “If he can make it, so can I.”* Process groups can expand this hope to dealing with the full range of what people encounter in life, overcome, or cope with.
- *Groups often support and provide encouragement to one another outside the group setting.* For interpersonal process groups, though, outside contacts may or may not be disallowed, depending on the particular group contract or agreements.

Fixed and Revolving Member Groups

The way groups are developed varies by the type of group. A wide range of therapeutic groups may be used with people who have substance use problems. For the purpose of this discussion, however, groups have been classified into two broad categories, each with the same two subcategories:

1. Fixed membership groups



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- A. Time-limited - in which the same group of people attend a specified number of sessions, generally starting and finishing together
 - B. Ongoing - in which new members fill vacancies in a group that continues over a long period of time
2. Revolving membership groups
- A. Time-limited - that members generally join for a set number of sessions
 - B. Ongoing - that clients join until they accomplish their goals

ROLE OF THE RECOVERY COACH

Making group therapy a powerful source for change is an art and a skill. Here, as in an individual Recovery Coaching relationship, the basic personality of the Recovery Coach, their professional training and experience can make a world of difference. The Recovery Coach has to maintain a relationship characterized by warmth, empathy, concern, acceptance and genuineness. An effective Recovery Coach will be sensitive and flexible to the needs of the group and flow with it, all the while making valuable interventions.



Helping members belong

The group therapy situation may be stressful for the newcomer. Members are strangers to each other and look to the Recovery Coach as the unifying force. By using this 'special member' status, the Recovery Coach goes on to create one physical entity, 'a group', from a collection of members with different experiences and problems. Being sensitive, accepting and supportive to all members and displaying this through appropriate verbal and non-verbal behavior, the Recovery Coach can create a sense of 'oneness' or togetherness. Late coming, absenteeism, sub-grouping (two or three members carrying on interactions while actively excluding others) and 'scape-goating' (majority of the group making one member the target of their negative feelings) threaten cohesiveness. The Recovery Coach should act early and decisively to counteract these forces.



Encouraging 'feeling level' interaction

Shame, guilt, resentment and fear are the predominant negative emotions. Being able to talk about them in a supportive, caring environment to people who have actually experienced them, is what makes group therapy effective. Handling anger and resentment means coming to grips with the true underlying feelings. Members who are eloquent may find it easy to share on a superficial level. By encouraging and emphasizing 'feeling level'

statements, the Recovery Coach can help them get in touch with their negative feelings, which they try to run away from. Separating thoughts from feelings and labeling feelings, helps deal with them better. This exercise stands them in good stead in their future communication patterns and problem-solving efforts.

Facilitating growth

The Recovery Coach should never forget that her involvement is of prime importance in shaping the group norms. Too exacting behavior or being too passive – both can inhibit members. She needs to play her role with confidence and poise. Basic rules that are set at the start of the group process may sometimes need further strengthening. The Recovery Coach can draw attention to the norms through statements, observations, questions and display of appropriate non-verbal behavior. For example, to encourage member-to member communication, the following methods can be used:

- ❖ asking for other members' reactions
- ❖ refusing to answer questions directly

Nodding, smiling, verbal reinforcements and other good attending behavior help shape positive behavior among members. The Recovery Coach has to respond to unacceptable behavior like hushed or whispered conversations or late coming. Unhealthy practices like frequent interruptions or excessive criticism can grow quickly and it is the Recovery Coach's responsibility to guard against them.

The Recovery Coach should encourage feedback. When a member is criticized or confronted, caring questions like 'How do you feel about what was just said? help that member respond. When many suggestions or comments have been made in response to one member's sharing, asking him 'What did you find most helpful? How did you feel to receive so much?', helps the member give appropriate feedback.

The Recovery Coach is a 'model setting participant' in many ways. Good attending behavior displayed by the Recovery Coach is quickly copied by the members. By giving support and encouragement, the Recovery Coach invites members to follow suit. The Recovery Coach's handling of conflicts by permitting expression of negative feelings and working through them rather than suppressing them, helps members learn to do the same even in real life situations.

Recognizing the group's power

The primary therapeutic agent in a group is always the interaction between the members and not the Recovery Coach. As an effective Recovery Coach recognizes that the group's power is more than their own, and makes the group assume responsibility to make the interactions. If the Recovery Coach takes the responsibility, the members would sit back and wait for the Recovery Coach to make the interventions as if watching a movie. The Recovery Coach needs to resist the urge to quickly intervene with the right answers, and should wait for a discussion to follow and allow it to move slowly to a conclusion. The group values the decisions that they arrive at and does not look for quick fix answers from the Recovery Coach even if the solutions are just as, if not more, effective.

Recording

The progress or lack of it among each member in the group and the Recovery Coach's impressions need to be recorded. This will help the treatment professional to see and clarify the level of progress and plan further directions. In case a different Recovery Coach takes over, they will be able to:

- ❖ assess the progress of each member
- ❖ set specific goals for each member
- ❖ identify and help him deal with negative factors so that they don't grow stronger and interfere with the recovery process
- ❖ use those facts to give appropriate feedback to members.

Recording is thus extremely useful and clearly necessary. But for the 'time pressed' Recovery Coach, if recording needs a lot of time, it can become stressful and poor compliance will result. To prevent this, recording should be structured, and carefully structured recording should not take more than 10 minutes.

If 5 sessions are held in a week, a weekly recording will suffice (in most agencies). If the session is once a week, recording can be done immediately. Changes initiated in group therapy may continue between sessions also. Recording helps the Recovery Coach keep tabs on the issues discussed and maintain continuity between sessions.

The ultimate goal of group therapy is to aid self-understanding and initiate change to the maximum level possible in each and every member of the group. Three factors contribute to this outcome.

1. The skill of the Recovery Coach
2. The openness of the members who constitute the group



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3. The (genuine) interaction between the members

Therefore, the skill of the Recovery Coach needs to be sharpened periodically through frequent self-assessment, clinical reviews with peers, openness to new techniques and readiness to explore directions suggested by group therapy research studies. The Recovery Coach has some control over the second factor also in the sense that through a display of supportive care and concern, the Recovery Coach can facilitate the group to become open and honest in their sharing. This will lead to genuine 'feeling level' interaction and conflict resolution. To put it plainly, the Recovery Coach, even though a catalyst, is the key player and her skill is of prime importance.

To Sum Up

The effectiveness of group therapy session depends on three major forces – the skill of the Recovery Coach, composition of the group and the interaction between the two. As the Recovery Coach is largely responsible for the first and the third, effectiveness is largely dependent on them. Maintaining group therapy records and inviting supervision by an experienced group Recovery Coach can help sharpen their skills. With experience and willingness to learn from one's own experience, one can emerge as a skillful group leader.

Instructor Note: It is interesting how many students over the years have told me that running group is the scariest thing for them, much more so than individual Recovery Coaching (which is strange to me since it is just you & the client in individual sessions). And, as you know, group is the main form of treatment practice in every addiction treatment facility, no matter what level of care. I recommend that if you are already working in a treatment facility to speak with your supervisor and ask to sit in on a few different type of groups, then after a couple of months of that, perhaps your supervisor will allow you to co-facilitate a few groups. This is the time you can ask a few questions about the group process and about how the group or particular situations were handled during group. All this adds up to great experience.

Coaching Clients with Co-Occurring Issues

Maintaining a therapeutic alliance with clients who have co-occurring disorders (COD) is important—and difficult. This chapter describes techniques effective in Recovery Coaching clients with COD. One is the use of motivational enhancement consistent with the client's specific stage of recovery. This strategy is helpful even for clients whose mental disorder is severe. Other strategies include contingency management, relapse prevention, and cognitive-behavioral techniques. For clients with functional deficits in areas such as understanding instructions, repetition and skill-building strategies can aid progress. Finally, 12-Step and other dual recovery mutual self-help groups have value as a means of supporting individuals with COD in the abstinent life. Clinicians often play an important role in facilitating the participation of these clients in such groups. This chapter will provide a basic overview of how Recovery Coaches can apply each of these strategies to their clients who have COD. The purpose of this chapter is to describe for the addiction Recovery Coach how these guidelines and techniques, many of which are useful in the treatment of substance abuse or as general treatment principles, can be modified specifically and applied to people with COD.

Guidelines for Developing Successful Therapeutic Relationships with Clients with COD

- | |
|------------------------------------------------------------------------------------|
| 1. Develop and use a therapeutic alliance to engage the client in treatment |
| 2. Maintain a recovery perspective |
| 3. Manage counter-transference |
| 4. Monitor psychiatric symptoms |
| 5. Use supportive and empathic Recovery Coaching |
| 6. Employ culturally appropriate methods |

7. Increase structure and support

Challenges in working with clients with serious mental and substance use disorders –

- These individuals “present and maintain a less involved and more distant stance in relation to the coach than do non-substance-abusing individuals with mental health disorders
- The presence or level of these deficits may vary widely for people living with mental health disorders, and also may vary significantly for that individual within the course of his illness and the course of his lifetime.

Varied meanings of “recovery”

The word “recovery” has different meanings in different contexts. Substance abuse treatment clinicians may think of a person who has changed his or her substance abuse behavior as being “in recovery” for the rest of his or her life (although not necessarily in formal treatment forever). Mental health clinicians, on the other hand, may think of recovery as a process in which the client moves toward specific behavioral goals through a series of stages. Recovery is assessed by whether or not these goals are achieved. Consumers with mental disorders may see recovery as the process of reclaiming a meaningful life beyond mental disorder, with symptom control and positive life activity.

While “recovery” has many meanings, generally, it is recognized that recovery does not refer solely to a change in substance use, but also to a change in an unhealthy way of living. Markers such as improved health, better ability to care for oneself and others, a higher degree of independence, and enhanced self-worth are all indicators of progress in the recovery process.

Monitor Psychiatric Symptoms

At a minimum, the clinician should be knowledgeable about the overall treatment plan to permit reinforcement of the mental health part of the plan as well as the part specific to recovery from addiction.

The coach can ask such questions as, “How are your meds doing? Are you remembering to take them? Are you having any problems with them? Do you need to check in with the prescribing



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doctor?” It also is prudent to ask the client to bring in all medications and ask the client how he is taking them, when, how much, and if medication is helping and how. Clinicians should help educate clients about the effects of medication, teach clients to monitor themselves (if possible), and consult with clients' physicians whenever appropriate.

A number of different tools are available to substance abuse treatment providers to help monitor psychiatric symptoms. Some tools are simply questions and require no formal instrument. For example, to gauge the status of depression quickly, ask the client: “On a scale of 0 to 10, how depressed are you? (0 is your best day, 10 is your worst).” This simple scale, used from session to session, can provide much useful information. Adherence to prescribed medication also should be monitored by asking the client regularly for information about its use and effect.

To identify changes, it is important to track symptoms that the client mentions at the onset of treatment from week to week. The clinician should keep track of any suggestions made to the client to alleviate symptoms to determine whether the client followed through, and if so, with what result. For example: “Last week you mentioned low appetite, sleeplessness, and a sense of hopelessness. Are these symptoms better or worse now?”

Suicidality is a major concern for many clients with COD. Persons with mental disorders are at 10 times greater risk for suicide than the general population, and the risk for suicidal behavior and suicide is increased with almost every major mental disorder. Of adults who commit suicide, 90 percent have a mental disorder, most frequently a major affective illness or posttraumatic stress disorder (PTSD). Alcohol and substance abuse often are associated with suicides and also represent major risk factors. Clients with COD—especially those with affective disorders—have two of the highest risk factors for suicide.

For clients who mention or appear to be experiencing depression or sadness, it is always important to explore the extent to which suicidal thinking is present. Similarly, a client who reports that he or she is thinking of doing harm to someone else should be monitored closely. The clinician always should ask explicitly about suicide or the intention to do harm to someone else when the client assessment indicates that either is an issue.



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Using Culturally Appropriate Methods

The consensus panel recommends the following approach for using culturally appropriate treatment methods with clients with COD:

- **Take cultural context, background, and experiences into account in the evaluation, diagnosis, and treatment of clients from various groups, cultures, or countries.**
- **Recognize the importance of culture and language, acknowledging the cultural strengths of a people.**
- **Adapt services to meet the unique needs and value systems of persons in all groups.**
- **Expand and update [the provider's/system's] cultural knowledge.**
- **Work on stigma reduction with a culturally sensitive approach.**

Source: Center for Mental Health Services 2001.

Use Repetition and Skills-Building to Address Deficits in Functioning

Finally, in applying the approaches described above, keep in mind that clients with COD often have cognitive limitations, including difficulty concentrating. Sometimes these limitations are transient and improve during the first several weeks of treatment; at other times, symptoms persist for long periods. In some cases, individuals with specific disorders (schizophrenia, attention deficit disorder) may manifest these symptoms as part of their disorder.

General treatment strategies to address cognitive limitations in clients include being more concrete and less abstract in communicating ideas, using simpler concepts, having briefer discussions, and repeating the core concepts many times. In addition, individuals often learn and remember better if information is presented in multiple formats (verbally; visually; or affectively through stories, music, and experiential activities).

When compared to individuals without additional disorders or disabilities, persons with COD and additional deficits often will require more substance abuse treatment in order to attain and maintain abstinence. A primary reason for this is that abstinence requires the development and

utilization of a set of recovery skills, and persons with mental disorders often have a harder time learning new skills. They may require more support in smaller steps with more practice, rehearsal, and repetition. The challenge is not to provide more intensive or more complicated treatment for clients with COD, but rather to tailor the process of acquiring new skills to the needs and abilities of the client.

Termination

Instructor Note: The termination process begins the moment a client enters treatment. We, as Recovery Coaches, know that our clients will be with us for a brief period of time in the client's life. And though it may be difficult to believe or visualize, especially in the first few days of treatment, many of our clients become attached (in a healthy way) to their Recovery Coaches and the treatment program. This is actually a good thing in many ways. When a client "buys" in to the treatment process and the treatment community they increase their likelihood of incorporating the new ways of living, thinking and behaving once they leave the treatment facility. The fact that this may be the first time the client has trusted anyone, connected to their emotions and incorporated new beliefs about themselves and their capabilities makes them vulnerable emotionally.

One of the goals for the Recovery Coach is to model healthy ways to end a relationship. Recovery Coaches teach the client that in life human beings have many different type of relationships, some will be long-lasting but some will be brief; if it was a good relationship the benefits, joys and sometimes love remain even after that relationship ends, brief does not mean that particular relationship was a "waste of time". It is not at all unusual for the client to express some level of anger or suddenly begin to act out. This is how some clients manage their hurt, fear and feelings of perceived rejection. The Recovery Coach needs to be prepared for this and be aware of signs of grief, yes I said grief, that is in effect what the client is experiencing, the sense of loss of someone important and meaningful in their lives.

The Recovery Coach needs to be sensitive to what's behind these feelings and thoughts, explore with the client their thoughts about leaving through statements like "wow you have done so well here, the thought of going back home must a little concerning or worrisome for you?", "so we are getting near the end of your time here, have you thought what leaving might feel like?" Any statement/question like these will hopefully generate an open self-exploration by the client. The Recovery Coach needs to assure the client that they can be equally as successful in the community as they have been in the treatment facility. The



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Recovery Coach can guide the client to sum up all they have achieved during their time in treatment so the client can own their hard work and the benefits of that hard work.

Another purpose of termination is preparing the client to grow so that s/he is not totally dependent on the Recovery Coach. When the Recovery Coach has repeatedly walked the client through the process of problem identification, goal setting and changing, the client learns these skills and can use them without the help of the Recovery Coach. Over a period of time, the client's social network gets strengthened and s/he is beginning to integrate into society. The Recovery Coach actively encourages the client to handle issues on their own and gradually withdraws involvement and support.

Termination is the logical conclusion to the process of Recovery Coaching.

All through the stages of Recovery Coaching, the Recovery Coach's skill is the primary force that keeps the client actively involved. In practice, however the client may not specifically progress from one stage to the other in a clear-cut manner as previously discussed. The strength of the Recovery Coach lies in staying with the client, helping him stabilize and move forward. This process can be emotionally gratifying and professionally satisfying, but it can also be frustrating. The Recovery Coach's emotional maturity in dealing with setbacks by using the support of treatment team members is of crucial importance.

Recovery Coaching calls for a lot of skill and much depends on the Recovery Coach's own personality style. To be effective, the Recovery Coach needs to be able to strike a balance between being stable and mature as well as being spontaneous. Commitment is expected, but with appropriate detachment. The suffering chemically addicted person who carries a low sense of self-worth needs compassion, but he also needs the steadying hand of firmness and healthy boundaries to help them progress.

To play this role well with a fine sense of balance the Recovery Coach needs to be aware of her own potential as well as limitations. Recovery Coaches need to update their knowledge and fine tune their skills. Feedback from clients and other Recovery Coaches should be received in the right perspective and changes need to be made. Self-evaluation is also necessary. Asking oneself 'How did I handle this client during this session? Could I have done better?' are questions that Recovery Coaches should ask themselves on a regular basis. With experience and willingness to evaluate oneself honestly, the Recovery Coach can develop skills of a high order.

Instructor Closing Remarks: This course is chock full of information. It is a lot to have read and a lot to absorb. But make no mistake, ALL of it is important. There are many sections of



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information that you will be able to use long after you complete these courses. Use the details given, use the example questions, and use the good characteristics to check yourself, self-evaluate on a regular basis. Be honest; strive to grow in technique. You will know if this field is the right one for you. You will know when all these things, these ways of practicing and being become of the utmost importance to you. When you cherish and respect the fact that other human beings are entrusting the well-being to you, their fears, their secrets and their vulnerabilities.

WILL I MAKE A GOOD RECOVERY COACH?

Ask yourself the following questions:

1. Am I happy with myself?
2. Do I have confidence in my own abilities?
3. Am I happy not dominating or controlling others?
4. Do I take a liking to different types of people easily?
5. Do I feel that everyone can take his own decisions and assume his own responsibilities?
6. Do I find different types of people interesting?
7. Can I listen patiently when someone is talking in detail about his/her problems?
8. Do I have the well being of most people around me in my heart?
9. Am I tolerant towards religious and social beliefs that do not agree with mine?
10. Am I warm and loving towards new people who come in contact with me?
11. Can I talk easily and frankly about myself when the need arises?
12. Can I listen to a tragic circumstance without getting weighed down with sorrow?

If you can truthfully answer 'Yes' or 'I think I do' to most of the questions listed above, then you are the type of person who will make a good Recovery Coach. However, if you answer 'no' to a majority of the questions, you will either have to change your outlook, undergo more rigorous training, or accept the fact that you may not make an effective Recovery Coach.

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