Substance Use Disorders and Adolescents

Thomas G. Kimball, Ph.D., LMFT
Sterling T. Shumway, Ph.D., LMFT

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Syllabus for AAMFT Institute

Course Name: Substance Use Disorders and Adolescents
The disease of addiction is now considered an epidemic that touches individuals, families and communities in profound and personal ways. Adolescent substance use is tearing families apart and has huge implications for our clinical practice as marriage and family therapists. MFTs are in a unique position to offer help to families who have struggled with addiction or have children currently suffering from addictive disorders.

Presenters:

Thomas G. Kimball, PhD, LMFT, is an associate professor at Texas Tech University and the associate managing director for the Center for the Study of Addiction and Recovery. In addition to his responsibilities at Texas Tech, Dr. Tom (as he is called by his students) maintains a private therapy practice and enjoys presenting on recovery in multiple venues. He has been married for 21 years and has five children.

Sterling T. Shumway, PhD, LMFT, is an Evelyn M. Davies Regents Professor at Texas Tech University in the Center for the Study of Addiction and Recovery. In addition to his private therapy practice where he sees individuals, couples, and families, Sterling facilitates multifamily groups at The Ranch at Dove Tree, an inpatient drug and alcohol treatment facility located in Lubbock, Texas. He has been married for 30 years and has five children.

Course Description:

In this institute, family therapists will gain skills necessary to helping adolescents and their families with this all too common concern. Participants will begin by gaining a basic understanding of the neurobiology of addiction and recovery, as well as the general landscape of addiction and recovery, in order to develop valuable therapeutic insight into adolescents’ unique issues related to the process of addiction. Important considerations stemming from the impact of ethnicity, gender, and sexual orientation on treatment and recovery will be explored.

Drs. Kimball and Shumway will prepare participants to work with adolescents and their families from assessment through long-term needs that begin after the initial intervention is complete. Attendees will learn how to support families of adolescents in recovery, from renegotiating parental roles, to tending to each element of sustaining a long lasting recovery.

Learning Objective:

Participants will be able to:

- Identify and understand two models describing the addictive cycle
- Relate family systems principles to addiction and recovery
• Understand and be able to briefly assess substance use disorders
• Think about the assessment of addiction from a “stages” perspective and understand basic intervention using the techniques of motivational interviewing
• Articulate the process of multifamily groups and their potential for use with adolescents and families
• Learn how to help with renegotiation of parent/adolescent relationships and rebuilding positives within families
• Understand the Six Essentials to Achieve Lasting Recovery
• Apply these recovery Essentials in a therapeutic context with adolescents and their family members

Recommended Reading List:

Books


Shumway, S.T., & Kimball, T.G. (2012) *Six essentials to achieve lasting recovery*. Hazelden, MN.

Articles


*Screening and Assessing Adolescents for Substance Use Disorders, TIP 31. CSAT, SAMHSA.* [www.samhsa.gov](http://www.samhsa.gov)

*Substance Abuse Treatment and Family Therapy, TIP 39. CSAT, SAMSHA.* [www.samhsa.gov](http://www.samhsa.gov)

**Websites**

The Institute For Addiction Study: [http://www.instituteforaddictionstudy.com/](http://www.instituteforaddictionstudy.com/)
See Recovery Resources and Read Articles Under Special Topics

Six Essentials to Achieve Lasting Recovery: [http://www.achievelastingrecovery.com](http://www.achievelastingrecovery.com)

Stages of Change Model: [http://www.uri.edu/research/cprc/TTM/StagesOfChange.htm](http://www.uri.edu/research/cprc/TTM/StagesOfChange.htm)

Motivational Interviewing: [http://www.motivationalinterview.org/](http://www.motivationalinterview.org/)
Videos


Course Schedule

Day 1:
I. Introduction (30 minutes)

II. General Overview of Addiction and Recovery (60 minutes)

III. Neurobiology of Addiction (120 minutes)
   a. Specific Research Related to Adolescent Addiction
   b. “Pleasure Unwoven” and HBO Clips

IV. General History and Models of Addiction Treatment (60 minutes)
   a. History
   b. Kitty Harris and Patrick Carnes: The Cycle of Addiction
   c. A Developmental Model

V. Discussion Groups (30 minutes)

Attendees will be able to:
1. Articulate the general landscape of addiction and recovery
2. Have a basic understanding of the neurobiology of addiction and recovery
3. Identify and understand two models describing the addictive cycle

Day 2:
VI. Family Systems and Addiction/Recovery (90 minutes)

VII. Process Addictions and Adolescents (120 minutes)
   a. Intervention Video Clips
   b. Eating Disorders and the Family (PBS video clips)

VIII. Special Considerations (60 minutes)
   a. Gender and Ethnicity
   b. Sexual Orientation
   c. Childhood Trauma and Addiction/Recovery

IX. Discussion Groups (30 minutes)
Attendees will be able to:
1. Relate family systems principles to addiction and recovery
2. Understand the unique issues related to process addiction and adolescents
3. Describe special considerations of ethnicity, gender, and sexual orientation that impact addiction, treatment and recovery

Day 3:
X. Assessment of Substance Disorders (90 minutes)
   a. Level of Care
   b. Treatment and Recovery Options

XI. Stages of Change and Motivational Interviewing (60 minutes)

XII. Multifamily Groups (30 minutes)

XIII. Renegotiation of Relationships (90 minutes)
   a. Parent’s Bill of Rights and Responsibilities
   b. Salutary Recognition, Small-Talk and Ego-Building Comments

XIV. Discussion Groups (30 minutes)

Attendees will be able to:
1. Understand and be able briefly assess substance use disorders
2. Think about the assessment of addiction from a stages perspective and understand basic intervention using the techniques of motivational interviewing
3. Articulate the process of multifamily groups and there potential for use with adolescents and families
4. Learn how to help with renegotiation of parent/adolescent relationships and rebuilding positives within families

Day 4:
XV. 6 Essentials to Achieve Lasting Recovery (270 minutes)
   a. Hope
   b. Identity
   c. Healthy Coping Skills
   d. Achievement and Accomplishment
   e. Capacity for Meaningful Relationships
   f. Reclamation of Agency

XVI. Discussion Groups (30 minutes)

Attendees will be able to:
1. Understand the Six Essentials to Achieve Lasting Recovery
2. Apply these recovery Essentials in a therapeutic context with adolescents and their family members
General Overview of Addiction and Recovery

Introduction to Addiction

What is Addiction?

- “A behavior pattern of compulsive substance abuse, relationships, or other behaviors characterized by over involvement with the relationship or abuse as well as a tendency to relapse after completion of withdrawal”

- Latin root “addictus” means to give over or award to someone or be attached to a person or cause.

- Addiction Defined by Merriam Webster: “Compulsive need for and use of a habit forming substance (e.g., heroin, nicotine, alcohol) characterized by well-defined physiological symptoms upon withdrawal—persistent compulsive use of a substance known by the user to be harmful.”

The Addiction Continuum

Abstinence: refrain from using
Experimentation: try something new, to have the experience
Abuse: when using a substance to alter your state of mind, using for other than intended purposes
Dependency: trouble not using, physical & mental dependence on the substance or behavior
Addiction: extreme dependence, cannot NOT use
Death: end result if addiction is not resolved
The DSM

- The DSM (Diagnostic & Statistical Manual) is used cross-discipline. Gives a common language to many different fields.

- Why is it important? One reason, it’s used for insurance reimbursement.

- Two categories of diagnosis:
  Substance Abuse
  - Recurrent use resulting in failure to meet major role obligations of work, school or home.
  - Recurrent use in situations where it is physically hazardous.
  - Recurrent substance related legal problems.
  - Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
  - Last resort before dependence diagnosis
  - Excludes caffeine and nicotine

Substance Dependence- Need at least 3
- Tolerance (need more to get high and have diminished effect).
- Withdrawal (symptoms of withdrawal or using substance to prevent symptoms of withdrawal).
- Taken in larger amount over longer periods of time
- Persistent desire or unsuccessful efforts to cut down or control use.
- Great deal of time is spent procuring, using, or recovering from use.
- Important activities given up or reduced because of use.
- Use continues despite adverse physical or psychological problems.
- Distress, impaired functioning, change in behavior
- Does not apply to caffeine

- For Diagnosis specify type of substance, type of problem, time period of use, onset of problem behavior
- Discuss the difference between a dichotomous diagnosis vs. a diagnostic continuum

Important Notes:
- Ambivalence regarding change
- Need to hit Bottom
- Relapse as the rule
- People can and DO recover
**Neurobiology of Addiction**

The Institute For Addiction Study: [http://www.instituteforaddictionstudy.com/](http://www.instituteforaddictionstudy.com/)

Kevin T. McCauley, M.D.

**Is Addiction Really a 'Disease'**?

Not long ago, the American Society of Addiction Medicine celebrated its fiftieth anniversary. Yet even after a half-century of accomplishments, the field of addiction medicine struggles for legitimacy. And while a recent study by Harvard University and the Robert Wood Johnson Foundation demonstrated that most Americans believe that addiction is a medical problem, the debate over whether or not addiction can truly be considered a disease continues.

The argument against calling addiction a disease centers on the nature of free will. This argument, which I will refer to as the Choice Argument, considers addiction to be a choice: the addict had the choice to start using drugs. Real diseases, on the other hand, are not choices: the diabetic did not have the choice to get diabetes. The Choice Argument posits that the addict can stop using drugs at any time if properly coerced.

As evidence, the Choice Argument offers this scenario: a syringe of drugs is placed in front of an intravenous drug addict and the offer is made to "Spike up!" When the addict picks up the needle and bares his arm, a gun is placed to his temple and the qualifier is added that if the addict injects the drug his brains will be blown out. Most addicts given this choice can summon the free will to choose not to use drugs. The Choice Argument claims this proves that addiction is not a disease. But in real diseases - diabetes, for instance - a gun to the head will not help because free will plays no part in the disease process. So the Choice Argument draws a distinction between behaviors - which are always choices - and diseases.

This is a powerful argument. It is also wrong.

In making the argument in favor of calling addiction a disease, I think it is first important to tacitly admit that the behavior of addicts is unpleasant. To be sure, addicts can be frustrating, revolting, even criminal. But in medicine we try separate the character of the patient from their symptoms - however unpleasant or even harmful. We do not judge patients based on the palatability of their symptoms. If we did, patients with cholera - who exhibit profuse, explosive and lethally infectious diarrhea - would get the death penalty.

I would like to think that physicians do this out of a sense of clinical humility for medicine’s past mistakes. We have often thought we were looking at badness when, in fact, we were looking at a disease process. (Many years ago, a group practice of doctors in Salem, Massachusetts made this mistake regarding patients with rye fungus poisoning resulting in multiple acts of malpractice.) Just because we observe bad behavior in a patient, we cannot always be certain that what is driving that behavior is some kind of intrinsic badness.

The law makes a similar distinction: except in cases of strict liability, a truly just conviction requires more than the commission of a harmful act. The prosecution must show intent, a *mens rea* - a state of mind bent on doing harm.

So when we ask the question, "Is addiction really a disease?" we find we have a question about causality: I'm seeing bad behavior, *what's the cause?* Are addicts sociopaths? Are they inherently liars, cheats and thieves? Do they have an "Addictive Personality Disorder?" Did their parents raise them improperly? Perhaps they learned addictive behavior from a bad crowd - such as a gang? We have bad acts, yes, but do we have bad actors? Or are these symptoms of a disease?
To answer the disease question, we must have a standard. What is disease? What does it take to get into the "Disease Club" and earn all the rights and privileges that go along with that distinction? In medicine, the causal model we use to explain illness is simply called "The Disease Model." This model is only about one hundred years old. It emerged from Germ Theory - the theory described by early microbiologists such as Louis Pasteur and Robert Koch (we still use Koch's Postulates today to prove causation in medical research).

Simply put, the Disease Model says that you have an organ (bone, liver, whatever) which gets a physical, cellular defect (cells die, cancer develops, or an infection, a bullet whizzes through the organ, whatever), and as a result, you see symptoms - and you will see the same symptoms in all the patients with that defect in that organ, differing only by severity or stage of the illness.

It's easy to see how the Disease Model works. Let's take a broken leg: the organ is the femur, the defect is a fracture, and the symptoms (all the patients get the same ones) are the screaming, the bleeding, the bone deformity and the disability that we see in these patients. The beauty of the Disease Model is that it strips away the nonsense about personality and social environment and what Mom did. There is no "Femoral Personality Disorder." We don't have a problem with "Femur Gangs." The Disease Model gets us to the real cause of the problem: the fracture. It tells us how to treat this patient: we do not go after the symptoms, we go after the defect - fix that, and the symptoms go away. In the case of diabetes: the organ is the pancreas, the defect is islet cell death leading to a lack of insulin, and the symptoms are all the seemingly unrelated symptoms that go along with diabetes. We can't cure diabetes, but the model reveals how to treat it - we replace the insulin and the symptoms get better. It may not look like much (organ > defect > symptoms) but the Disease Model is so powerful a causal model that it has doubled the human lifespan in less than a century.

And one hundred years ago, doctors knew they had a winner. Doctors knew the Disease Model would boost medicine's reputation, and, for the credibility of medicine, they had to decide what was a disease and what wasn’t. It was easy to see how a broken leg fit the Disease Model. They could even fit diabetes to the model. But addiction? What was the organ? The brain? Some doctors thought it might be the liver. What was the defect in addiction? And what about the symptoms? At first glance, the symptoms of addiction don't look like symptoms at all. They look like badness. And so doctors made a decision that effects every day of every addict's life: they decided that addiction was no longer a disease.

Almost overnight, all treatment innovation for addiction ended. All research into the problem of addiction stopped. And all advocacy on the part of physicians for their addicted patients ceased. When doctors could not fit addiction to the new disease model, they walked away. That didn't mean that addiction disappeared. It meant that another group of professionals had to come in and handle the problem. That group is the criminal justice system.

And so today we have over two million people in prison - many of them are non-violent drug offenders, many more were convicted for offenses committed under the influence of drugs and alcohol. Because doctors abdicated their responsibility to addicted patients, the United States deals with addiction punitively, and has one of the highest per capita incarceration rates in human history. When you start getting into numbers like two
million, this problem stops looking like a criminal justice problem and starts looking like a public health problem. The problem falls back into medicine's lap.

If ever we could fit addiction to the Disease Model - if we could show what part of the brain was involved in addiction, what the nature of the defect was, and link that defect in that organ to the symptoms of addiction, then addiction would be a disease. Everything would change. And for one hundred years we've been unable to do that.

Until now.

Just in the last few years we have finally learned enough about the brain - we have finally gotten enough pieces of the puzzle - that we know exactly what part of the brain is involved in addiction. We know exactly the nature of the defect. And we can link that defect in the brain to the frustrating, revolting and criminal symptoms of addiction. For the first time in the history of medicine we have some hard and fast knowledge about what happens in the human brain when it becomes addicted to drugs. There are very good brain chemistry reasons for the things addicts do. We can explain everything about addiction without having to resort to the tired and lazy causal variables like "bad choices" and "addict personality."

That information is very powerful. I believe it has the power to change the world. I believe that in our lifetimes, we will see everything that we do for addiction change. I believe that the people you see in my treatment center today are the last generation of Americans who will be faced with the threat of a jail cell if they don't get sober on somebody else's time frame. That is the power of this data.

Here is a brief summary of what we know in neuroscience about addiction:

1. Drugs work in the midbrain. This is not the part of the brain that handles morality, personality, parental input, sociality or conscious choice. That processing takes place in the cerebral cortex. The midbrain is the amoral, limbic, reflexive, unconscious survival brain. As humans, we have a bias in favor of the cortex: we believe that the cortex should be able to overcome the libidinal impulses of the midbrain. Normally that's exactly what happens. But in addiction, a defect occurs at a level of brain processing far earlier than cortical processing. The midbrain becomes stronger than the cortex.

2. While predisposing factors are important - genetic burden especially - the primary cause of addiction is stress. We all face stress, yes, but not all of us experience it in the same way. The stress that changes the midbrain is chronic, severe and unmanaged. When the cortex does not resolve the stress, the midbrain begins to interpret it as a threat to survival.

3. Persistent severe stress releases hormones such as Corticotripin Releasing Factor. CRF acts on genes for novelty-seeking and dopamine neurotransmitition. People under severe stress increase their risk-taking behavior in the search for relief. At the same time, the brain's ability to perceive pleasure and reward - mediated through dopamine - becomes deranged. The patient becomes anhedonic. They are unable to derive normal pleasure from those things that used to be pleasurable. Addiction is a stress-induced defect in the midbrain's ability to properly perceive pleasure.

4. Drugs of abuse, whether uppers or downers, strong or weak, legal or illegal, all have one common property: they cause the rapid release of dopamine in the midbrain. If the stressed and anhedonic patient is exposed to this drug-induced surge of dopamine, the midbrain will recognize a dramatic relief of the stress and tag the drug as a survival coping mechanism. At this point the line is crossed - from the normal or drug using or
even drug abusing brain to the drug addicted brain. The drug is no longer just a drug. As far as the midbrain is concerned it is life itself. This process tagging of the drug is unconscious and reflexive. Conscious cortical processing is not involved.

5. Increases in stress (and CRF) trigger craving - a very cruel tool the midbrain has to motivate the individual to seek the drug. For non-addicts, craving is simply an unusually strong desire. Even though the word is the same, it is critical to remember that craving for the addict is a constant, intrusive, involuntary obsession that will persist until the drug is ingested and the survival threat is relieved. **Craving is true suffering.** The tendency to underestimate the misery of craving is a major reason for the failure of healthcare professionals to effectively intervene in addictive behavior. Brain imaging is able to demonstrate a difference in the midbrain activity of the addict and non-addict during craving. These scans also demonstrate a relative inactivity in the cortex - the part of the brain.

In the light of this new understanding of addiction in neuroscience, the Choice Argument takes several hits:

* Punishment will not work to coerce addicts into making the right choice because the drug is tagged at the level of survival. Nothing is higher than survival. And so nothing used as leverage - threat of loss of job, prison, loss of child custody - can compete with an existential threat. The midbrain give the addict the message that the way to take care of the children, keep the job, calm the probation officer is to first secure survival (by using the drug). When the craving really kicks in, punishment has no effect, and coercion is useless.

* Addiction is a disorder of pleasure. I believe all the moral loading of addiction stems from the fact that the patient with a disorder in their ability to correctly perceive pleasure is much more likely to be interpreted as being immoral before they are ever seen as being blind or deaf.

* Under stress, the addict craves drugs. As far as the midbrain is concerned, the addict's moral sense is now a hindrance to securing survival. It is not that addicts don't have values. It's that in the heat of that survival panic, the addict cannot draw upon their values to guide their behavior. Their values and their behavior become progressively out of congruence, thus increasing stress. In order to consummate the craving, the addict's cortex will shut down. **But that's not the same as badness.** The absence of one thing (cortical function) cannot stand for the presence of another thing (criminal intent).

* While it is true that a gun to the head can get the addict to chose not to use drugs, the addict is still craving. **The addict does not have the choice not to crave.** If all you do is measure addiction by the behavior of the addict - using, not using - you miss the most important part of addiction: the patient's suffering. The Choice Argument falls into the trap of Behavioral Solipsism.

* Just as a defect in the bone can be a fracture and a defect in the pancreas can lead to diabetes, a defect in the brain leads to changes in behavior. In attempting to separate behaviors (which are always choices) from symptoms (the result of a disease process), the Choice Argument ignores almost all of the findings of neurology. Defects in the brain can cause brain processes to falter. Free will is not an all or nothing thing. It fluctuates under survival stress.

This information allows us to fit addiction to the Disease Model: the organ is the midbrain, the defect is a stress-induced hedonic (pleasure) dysregulation, and the symptoms of addiction are loss of control of drug use, craving and persistent use of the drug despite negative consequences.

But something very important happened when I was able to fill in the Disease Model for addiction.

Addicts became patients!
And that means addicts earn all the same rights as the patient with diabetes and broken legs. If I cannot ethically punish the diabetic, I cannot do so to the addict. If I cannot effectively treat broken legs with incarceration, neither can I do so to addicts. This begs an important question: does the treatment of addicts fall under equal protection? If punitive treatment constitutes an ethical breach for other patients, does it also for addicts? Does the demonstration of addiction's status as a disease demand parity legislation? Are coercive interventions a violation of informed consent laws? Can the same arguments used in Lawrence v. Texas be used in the defense of the rights of addicted patients? I'm beginning to wonder if the sharpest tool in an addiction doctor's black bag may be a law degree!
1. Is addiction a disease? What are the arguments for and against this notion?

People often disagree with the idea of calling addiction a disease in the same way we call conditions like diabetes a disease. The behavior of addicts is frustrating, ugly - even criminal. How can driving drunk be a symptom of a disease?

The best argument against calling addiction a disease states that addicts make the choice to use drugs and that their inability to stop is simply immature and irresponsible behavior. Diabetics, for instance, do not have a choice about whether or not to have a high blood sugar. These arguments make sense, and are often embraced for their intuitive appeal alone.

When doctors use the Disease Model of Illness to think about a disease, they think of a specific physical defect in some organ or physiologic system of the body. That defect, once discovered, provides a causal explanation for the patient’s symptoms and points the way to treatment. With diseases like diabetes, the defect is easy to understand.

With brain disorders however, it is not that simple. Our understanding of brain disorders has not kept pace with our understanding of other diseases - like diabetes. A big part of our difficulty in calling addiction a “disease” stems from the fact that no one could ever find the defect in the brain that caused addiction. Without a physical brain defect to point to, addiction never earned the status of “disease” like diabetes did. The addict’s symptoms were assumed to be due to their intrinsic badness – their immaturity, their irresponsibility, or worse.

But guess what? In the last ten years we have learned a lot more about the brain. We know what the physical defect of addiction is and where in the brain it is. Addiction is a defect in the hedonic system, or the system that perceives pleasure, which is deep in the part of the brain that handles basic survival. Because of this defect, the addict unconsciously thinks of the drug as life itself. A beer is not just a beer anymore – the addict needs the beer to get through life and when the beer is unavailable they crave it.

While it is true that the addict may have a choice in whether or not to use drugs, they do not have the choice over whether or not to crave. If craving gets bad enough, even the strongest-willed, most mature and most responsible person will return to using drugs. No brain can ignore that survival imperative. One of the big reasons we have difficulty calling addiction a disease is our inability to grasp the true nature of craving. Craving is a very real mental suffering the addict endures when they come to the point in their addiction when they are using drugs even when they do not want to.

If you are in medical school and you write, “addiction is not a disease” on one of your exams – you will flunk. In medicine, we now know that the addict’s brain really is different than normal brains, and from a physiologic standpoint we now know how it is different. This explains a lot of the symptoms we see in full-blown addiction and helps us develop better, more effective treatments to help the addict recover. It also means that addiction fits the Disease Model of illness as well - if not better - than many other diseases. Like say, diabetes.
2. How far have we come with regards to recognizing and treating addictions compared to years past? Kevin T. McCauley, M.D.
For thirty years, research in neuroscience, psychology and pharmacology has been steadily building in the search for clues about addiction. Recently, this information has coalesced to the point that we now have a good working model of the physiology of addiction. Answers are starting to present themselves about the symptomology of addiction that in the past were perplexing. This more complete picture of addiction leads to better clinical tools to help addicts who in the past were branded as “unwilling” or “reluctant” to recover. One crucial challenge remains: finding an objective test for the predisposition to develop addiction and for the presence of addiction already in progress. Currently, no such test exists to tell us who is an addict or who will become addicted, but the area of brain imaging holds some promising leads.

3. Is addiction a mental or physical disorder?
This is a truly loaded question. The other big reason, besides the mystery of craving, that we have trouble calling addiction a disease, as we would a clearly physical disease like diabetes, is our reliance on terms like “mental” and “physical” (or “mind” and “body”) and the assumption that the two are distinct entities without causal relation to one another.
This idea of a separation between the mental and the physical goes way back to the seventeenth century French philosopher Rene Descartes (1598-1650). In the Philosophy of the Mind, Descartes’ solution to the mind/body problem is that there is the mind (soul) and then there is the body (brain) – and never the twain shall meet, or causally affect one another. This solution is called Cartesian Dualism, and while dualism persists in our everyday thinking, made obvious by such terms as “mind” and “body”, it is considered an unsatisfactory explanation. Dualism is obviously at odds with our experience. I think about raising my arm and then I raise it, or I get a brain tumor and my personality changes. Clearly, the mental influences the physical and vice versa. Nevertheless, Cartesian Dualism has crippled our understanding of the nature of consciousness. We are still unable to take “mental” disorders as seriously as we do “physical” diseases. We have no trouble accepting that a physical disorder of the pancreas causes diabetes, but the idea of a physical disorder in the brain causing the very unpleasant behavior of addiction is still tough for us to swallow. It is easier to simply write off addictive behaviors as caused by a weak character or simply moral turpitude.

The consequences of Cartesian Dualism have hit addicts especially hard. If you told me that your daughter has cancer, I can muster some comforting comments about courageous surgical techniques or life-saving chemotherapy that leads to good cure rates. Conversely, if you come to me and tell me that your daughter has a crystal meth addiction, my heart goes in my throat. I cannot promise you she will not die in prison. These are the very real consequences of our inability to reconcile the “mental” and the “physical.”

The philosopher of the mind John R. Searle at U.C. Berkeley suggests a solution to the mind/body problem and thus a way out of Cartesian Dualism. Searle argues that consciousness is simply a feature of the physical organization of the brain. When we refer to the “mental,” we are really just describing the “physical” at another level in the same way we refer to the “physical interaction between water molecules” as “wetness” or the “arrangement of tree cellulose in this desk” as “hardness.” Thus, the mental and the physical are really just the same thing.

Once this solution is in place, the confusion about whether addiction is a “mental” disorder as opposed to a “physical” disorder clears up nicely, as does the skepticism of calling addiction a “disease”. Addiction is simply a defect in the brain’s ability to perceive
pleasure that so severely influences the addict’s conscious experience of drug use that they form a pathological attachment to the drug. On one level, we are talking about the defective response to increases in dopamine in the cellular structures of the midbrain, and on another level we are talking about relapse to meth despite a judge’s promise to send the addict to prison.

4. What part(s) of the body or brain plays the greatest role in addiction?
All drugs of abuse work in the reward centers of the limbic brain. This is the part of the brain that handles immediate survival – not long-term planning or anticipation of consequences. In addiction, a defect in the limbic brain changes the addict’s perception of the drug’s survival salience. This is the first part of the mechanism of addiction – the part that is unconscious. Then, that misperception of the drug experience is sent to the frontal cortex where an emotional connection is made to the drug based on the misinformation received about the drug’s salience. This is the second part of the mechanism of addiction – the drug takes on a conscious meaning to the addict. They love it when it is there. They miss it when it is gone. The drug hijacks the same parts of the brain that handle survival and love. This will have major consequences for behavior.

5. What needs to happen physically or chemically within the body for addiction to occur?
The best descriptive model of addiction attributes the disorder to a dysregulation of the hedonic, or pleasure, system in the brain and a change in the “pleasure threshold” – or the brain’s ability to perceive pleasure. Dr. George Koob of the Scripps Neuroscience Institute in San Diego, CA developed this model. His idea is that closely spaced and intense drug use can cause the release of dysphoric chemicals and stress hormones in an effort to maintain balance in the hedonic system subsequent to drug use. This may cause the drug user to counteract the body’s attempt to maintain the “balance of pleasure” by using more and more of the drug, which will result in greater and greater release of dysphoric chemicals. In essence, when the drug pushes, the body pushes back.

If the body is no longer able to maintain the homeostatic balance due to ever-increasing drug levels, it will give up on homeostasis and resort instead to allostasis in a compromise to maintain stability of the hedonic system. Whereas homeostasis is maintaining balance around a certain level, allostasis is an overall change in the entire level in order to keep the system stable overall. This is the point at which the “pleasure threshold” changes, and where the drug abuser crosses over into the diagnosis of substance dependance. Now the addict is not using the drug to feel good (positive reinforcement), rather he is using the drug just to feel normal (negative reinforcement). In thinking about Koob’s theory, it struck me that it might be possible to have the dysphoric stress chemicals already present prior to actual drug use – say from some chronic, unmanaged stress that has accumulated to the point that the brain interprets the stress on the survival level. This alone may change the “pleasure threshold” resulting in anhedonia – a term in psychiatry that means the inability to derive pleasure from those things that used to be pleasurable. At this point, the old pleasures no longer work to make life worthwhile. The pre-addict may search for something to regain a normal feeling of pleasure. If at this point they should stumble across a drug, such as alcohol or crystal methamphetamine, the very high increase in dopamine concentration in the brain’s pleasure centers will cause that drug to be tagged with survival coping value. The pre-addict will seek out that drug – in fact, their entire behavioral repertoire may narrow around the attainment and use of the drug. The pre-addict is now a full addict, using the drug as their primary means of coping.

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6. Does stress contribute to addictions? If so, how?
Koob’s theory, as discussed above, attributes the cause of hedonic dysregulation at the level of the drug use itself: stress hormones (Corticotropin Releasing Factor, Adrenocorticotropic Hormone) are dysphoric and the addict accelerates drug use to counteract that dysphoria, resulting in greater release of dysphoric stress hormones, resulting in greater drug use. I agree with this, but would also add that drug use itself may not be necessary for these dysphoric stress hormones to be present. The presence of the stress hormones may be to motivate the individual to find coping mechanisms for stress. For example, stress of hunger results in search for food and eating results in relief of stress. As such, they may be released in varying amounts all the time, but in situations of severe stress that are not promptly managed, these stress hormones may rise to levels that cause the hedonic system to dysregulate (war, emotional abandonment, physical illness, mental illness, sexual or physical assault, domestic violence). The individual is then motivated to seek relief of the stress. If the stress coping mechanism is healthy (church, friends, family, hobbies) then there will be no problem. If however, the stress coping mechanism is a drug, then addiction may form. The brain, subjected to chronic, severe, unmanaged stress is “fertile soil” for addiction. If a drug comes along at this time of severe stress, the effect and benefit that the drug has for continued survival, will not likely go unnoticed.

7. Tell me about the Hedonic threshold and its connection to addiction.
A big part of the brain’s job is to keep the various physiologic systems of the body in balance. This is easy to understand for systems such as blood glucose level and body temperature, but it is harder to grasp that the body has a system for regulating something like pleasure. Nevertheless, such a system exists – it is called the Hedonic System. Normally, this balance, or "homeostasis," is maintained around a hedonic "set point," which could be considered a kind of "pleasure threshold." Addiction is an inability to maintain the “balance of pleasure,” as it were.

When this hedonic set point is changed, such as in times of severe stress, the brain becomes anhedonic: it is unable to derive pleasure from things that were formerly pleasurable. In essence, the brain is “deaf” to pleasure. The only pleasures it can now sense are VERY “LOUD” pleasures – or those pleasures that cause large fluctuations in dopamine in the limbic structures of the brain. Usually, the things that cause these fluctuations are drugs. If this happens, the limbic (survival) brain is likely to attribute special salience to these drugs as coping mechanisms. Behavior may reorient itself around the drug until the stress is gone.

This may seem like a strange and abstract concept, but the brain has another example of a temporarily changed “set point” in order to cope with one kind of stress: a fever. Under the stress of an infection, the brain may reset the body temperature set point from 98.6 degrees F to 102 degrees F. This is because at that raised temperature, the body’s immune system is much better at fighting infections. When the infection is gone, the body temperature set point returns to normal, and the fever is over.

In the case of addiction, the change in hedonic set point gets “stuck” and will stay that way until a real coping mechanism (not a drug) is introduced to relieve the underlying stress.

8. Is there any connection between drug and/or alcohol addiction and eating disorders such as bulimia? If so, what is it?
When I read the research that revealed that all drugs of abuse cause the increase of dopamine concentration in the limbic reward structures of the brain, I wondered if only drugs could cause such an increase. If dopamine is the currency of pleasure and reward in the brain, and
addiction is a defect in dopamine processing, then shouldn’t anything that is pleasurable cause such an increase in dopamine – and potentially be addictive, too?

It turns out, that is correct and it was known long before I thought of it. We see close relationships between chemicals that involve addiction and behaviors that involve addiction. This is especially true with eating disorders.

People with eating disorders value a high degree of control over their body weight. Major stimulants are excellent at helping them to do this – especially amphetamines. We see a high correlation between methamphetamine addiction and eating disorders like Bulimia Nervosa.

In the past, patients came to drug treatment and only their addiction to their drug of choice was addressed. Now we are realizing that we must address both the drug addiction and the behavioral addiction to fully help the patient overcome the back-and-forth synergistic effect between the two.

9. How common is it for someone to have two separate addictions at the same time; in other words, they are addicted to both cocaine and sex?

It is common enough that once I know the patient’s drug of choice, I immediately start looking for the secondary drug of choice – or behavior of choice – that might be paired with the core addiction and even contributing to it.

There are some drugs that I especially expect to be accompanied by a secondary addiction. I have a theory that all (well, let’s say 99%) stimulant abuse, cocaine and methamphetamine, in men is about one thing: sex. And that sex is about one thing: anger. If I am only addressing the drug in treatment, without dealing with other two, then I am not fully treating the patient. It is entirely likely that the addict in treatment – while abstinent from their drug of choice – continues to use the secondary drug/behavior to cope in the absence of the primary drug. If this occurs, relapse once the person is discharged is highly likely because, in essence, the addict really never stopped using while they were in treatment. The secondary drug/behavior will lead the patient back to their primary drug if not dealt with. In addition, if a patient is experiencing particularly bad cravings it may be the use of the secondary drug/behavior that is perturbing the hedonic system into seeking the primary drug. In stimulant addicts, especially men, I expect to see compulsive use of sexual behaviors (masturbation, pornography, inappropriate liaisons) as part of the early recovery process. This should not be a source of shame – it is part of the common clinical picture. Classically, stimulant drugs are used to enhance sexual experiences. Recovery from stimulant drugs will have to include a change in the use of sexual behaviors. I also expect that work on anger issues will ameliorate much of the preoccupation with the drug and with sex.

This is, by the way, a good reason to segregate the genders in drug treatment centers. Stimulant addicts tend to hook up in treatment – not because they are promiscuous, but because they are suffering severe discomfort as a result of the removal of their drug from their coping armamentarium, and because they have learned that sex can be used in a pinch to cope. These relationships in treatment are often terribly likely to result in relapse, and are particularly destructive to the woman’s recovery. For this reason, gender segregation will probably become the standard of practice in addiction treatment in the future. Men get sober with other men. Women get sober with other women. Only in the context of gender-specific treatment and twelve-step meetings are stimulant addicts likely to get to the more personal and loaded issues that drove their addiction.

10. Do you have any idea how common it is for doctors to develop addictions, whether we hear about it or not?

Most research indicates that doctors and other health care professionals do not have a higher prevalence of addiction than other professions. I think the cause for concern about addiction
in healthcare professionals is the easy access to controlled medications along with the potential for disaster due to the high-risk nature of working on patients. State medical boards (led by a few pioneering physicians in addiction medicine) have been very successful in minimizing the risk of untoward outcomes for patient and physician alike by instituting diversion programs for impaired physicians. These programs have proven themselves to be so successful that other professions (aviation, legal, and managerial, for example) have duplicated them.

Professional organizations have found that they have a greater margin of safety if they have programs that allow the addict or alcoholic to self-refer themselves to treatment and ongoing monitoring of abstinence in the context of continued employment. Interestingly, these programs are based on those first developed by the U.S. military in the days prior to zero-tolerance. These programs allow for retention of personnel and training assets as well as providing a “vicarious learning” process for other individuals who may want to seek help for alcohol and drug problems. Professional programs for doctors, pharmacists, lawyers, dentists, nurses, pilots and others have enjoyed astronomical success rates for long-term recovery. I do not see why other workers, besides professionals, could not benefit equally from similar programs. I would like to see self-referral addiction treatment and monitoring policies in place for all employed individuals at various levels throughout the nation’s workforce. This would allow us to identify the patient’s addiction at its earliest stages, initiate appropriate treatment and arrest the addiction before it could progress to a point where intervention is more difficult. I think if we thought of addiction medicine in terms of occupational medicine, the morbidity and mortality caused by addiction would diminish dramatically in this country.

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11. Does it help for someone to have been through addiction himself/herself in order to effectively treat it in another person?

I look at the issue of addicts in recovery entering the field addiction medicine in the same way I look at male doctors entering the field of gynecology: some patients do not want a male gynecologist, some don’t – but gender is not necessarily a bar to delivering competent, compassionate care. There are talented, helpful and sought out men working in gynecology in the same way there are talented, helpful and sought out non-addicts working in the field of addiction medicine for the simple reason that a past history of addiction is not a prerequisite for empathy for the addicted patient. So I would leave the choice up to the patient. Interestingly, there is a strong current in addiction research that shows that the variable most predictive of treatment success is the interpersonal functioning of the professional delivering that treatment. Additionally, the act of identification of the professional with the addict (sympathy) has been shown to be detrimental to long-term sobriety. This speaks to the fact that the treatment professional’s own experience (as well as the kind of treatment he or she delivers) has less influence on long-term sobriety than simply the degree of empathy shown toward the patient.

12. As someone at the forefront of addictions and treatment, can you tell me if you have seen any trends on either side?

Your question implies a division between trends in addictions and trends in addiction treatment. I will answer each in turn.

With regard to current and future trends in addictions themselves, there is still a strong emphasis these days on the use of M.D.M.A. (“ecstasy”) and the controversy over whether or not the drug causes permanent damage to serotonigic neurons in the brain (possibly predisposing the user to Major Depression). I notice that most of the people I see presenting themselves for treatment for ecstasy addiction are sent by their parents or come due to a job or legal requirement. I do not see a lot of self-referral for ecstasy abuse or addiction, and I am not willing to speculate on what that means.
I am pleased to see a continuing emphasis on getting Oxycontin abusers and addicts into treatment. I think users of this narcotic preparation have a higher prognosis than the average heroin addict who presents to treatment (that is not to say that heroin addicts do not get sober all the time), so I am encouraged that Oxycontin users (and users of other prescription narcotic preparations) are seeking treatment prior to graduation to heroin. Club drugs other than ecstasy (GHB, Rohypnol) get a tremendous amount of media attention but are a very small percentage of those coming to treatment. Methamphetamine abuse and addiction continues to be strong in the western U.S. with increasing incidence in Rocky Mountain and Midwest states, although I hear that the quality of the meth has diminished markedly from the meth addicts coming to treatment. The usage of meth use has been moving eastward for some time, with the line currently about Ohio and Appalachia. There is concern that meth use will surge again as it reaches the eastern U.S. seaboard, especially since the current trendy drug there - cheap, high-grade heroin – may become scarce due to the war in Afghanistan.

With regard to trends in treatment, the shift away from “one size fits all” treatment continues in settings geared to middle class and upper-middle class patients. For low-income and fixed-income populations, access to treatment is still limited and the nature of the treatment that is available tends to be twelve-step, non-medical model and generally punitive. I continue to be optimistic that the general turn away from past punitive treatment tactics will continue as more medical/pharmacologic adjuncts become available such as bupropion and naltrexone treatments.

Lastly, the recognition of the needs of special populations (elderly, dual-diagnosis, battered women, gay and lesbian) who are entering addiction treatment is growing – a trend that I think will help patients who in the past were lost to treatment because of a lack of support groups for these patient populations.

13. What do you believe is the most effective method(s) for treating addiction?

Treatment should be tailored to the individual and his or her special needs. Some patients can go to outpatient treatment and get a good start at recovery. Other patients will need a higher level of care including inpatient treatment followed by a long-term sober living environment. Generally, the length of time spent in treatment correlates with long-term abstinence but the intensity of the treatment (inpatient vs. outpatient) may not be as crucial.

Of course, I have a strong personal prejudice against treatments that are more punitive, including behavior modification, therapeutic community model and social model treatment centers. Although there are patients who are appropriate for these modalities, and I would not want to deny them the opportunity, I do not believe these treatments should be the first line treatment choice in any circumstance. I believe Medical Model/Minnesota Model treatment approaches are the best first line treatment choice.

For those patients who are not yet willing to consider abstinence, there is a growing body of addiction professionals who will consider treatment methods that do not insist on immediate abstinence as a requirement for initiation of therapy. Modalities such as Motivational Interviewing and the Matrix Model are being embraced, albeit slowly, by professionals as a means of helping patients who in the past were barred from addiction treatment.

My standard recommendation for any severe addiction remains: thirty day detox/inpatient treatment, immediate transition to an outpatient day treatment center with a sober living environment for three to six months, subsequent weekly random urine testing, weekly consultation with a licensed therapist or attendance of group therapy, and monthly consultation with a certified addictionologist for the first one to two years sober, preferably two years. All of this should of course occur in the context of regular A.A./N.A. attendance and a good, working twelve-step program. I have not yet seen any unfavorable outcomes in
those who have followed this regimen. This is consistent with my experience treating pilots with addiction and my belief that if addressed fully and quickly the first time around, the addiction goes into remission quite nicely.

14. Must one suffer in order to obtain sobriety? How important is punishment in the treatment process?

If suffering and/or punishment worked to fix addiction, even a little, than the U.S. should have the highest treatment success rates of any country in the world. I am not sure why a treatment center would ever consider it appropriate to use punishment in the treatment of any patient, but sadly I must confess to you - it happens. I am quite certain that punishment only serves to further cement the addiction into place. In fact, I spend a lot of my time trying to unscrew the mess a previous treatment professional has made by punishing the addict who now comes to me because the past punitive treatment did not work.

I think it comes down to whether or not the treatment professional believes that addiction is a disease or not. Unfortunately, sometimes everything that we say about addiction being a disease is undermined by the fact that everything we do shows that we do not really believe it ourselves. If we do not show some integrity in our beliefs by demonstrating them in our actions, why should we demand that the patient show it? If addiction really is a disease (it is), then that means that addicts are patients just like any other patient who seeks treatment. That means that addiction has parity with every other disease – and if you cannot punish a diabetic in order to get their blood glucose down, that means you cannot punish an addict either. Why should we think that the disease of addiction would respond to punishment when other diseases do not? By definition, diseases do not respond to punishment.

Not only that, when addiction fit the disease model there were BIG implications ethically – that meant that the biomedical ethical principles that apply to the diabetic now also apply to the addict, and the addict has the same right to quality, compassionate, and effective care as the diabetic.

Most treatment professionals do not see the ethical follow-through to the statement that, “Addiction is a disease.” They believe that they must aggressively confront and punish the addict to break through their defense mechanisms. This is simply rubbish. Anytime one group of patients is parsed out from other groups of patients for suspension of ethical treatment, then all patients are in danger. The addiction treatment professional that tells me that they cannot see patients without these punitive tactics is really telling me that they cannot see patients at all. Not only is this reasoning clinically unsound but the law has also not supported such utilitarian logic - to the point of awarding large malpractice judgments against treatment professionals who do not get it. This is a good thing, as it will serve to improve the integrity of the field of addiction medicine. My belief is that treatment fails in the U.S. because it is punitive. Take out the punishment, and the treatment success rates will go through the roof. I draw support for this belief from the fact that diversion programs for doctors, dentists, lawyers and pilots – all of which are non-punitive – show extraordinarily high success rates. A fellow flight surgeon and I conservatively estimate that the U.S. Navy has a 97% return to flying status rate in its treated alcoholic pilots.

97%. Not 3%, or 13% or whatever other dismal number most treatment centers give.

But 97%!

I want that 97% for all addicts. There is nothing so male, or white, or college educated about those Navy pilots that gets them sober and back into the plane faster than other people. The variable at work is the fact that the Navy does not punish them. There is nothing that the Navy gives to their pilots that we could not give to every American.

All it takes is a little courage not to punish sick people.
Videos


Models of Addiction

The Process Model of Addiction

Overview

The Process Model of Addiction is based on the premise that everyone experiences pain. Pain can be physical (a broken arm or a cut), mental (depression, anxiety, or phobias), emotional (frustration, disappointment, tragedy, grief, or resentments), social (isolation, loneliness, or alienation), or spiritual (feeling lost, lacking purpose, or feeling a void in life). When an individual experiences pain, he/she must choose how to react to the pain. An individual can choose to cope or choose to turn to a compulsive behavior to feel relief.

In the Process Model of Addiction (see Figure 1), pain is followed by behavior. In response to the behavior, compulsive behavior or coping, the behavior brings relief or self-esteem respectively. A response is followed by a negative or positive consequence. Depending on negative or positive consequence, the result is guilt and shame or resiliency.

The Process Model of Addiction incorporates cycles of compulsive behaviors and a cycle of coping and recovery. The cyclic nature of the process model of addiction makes the process harder to break the longer it is in motion. The compulsive cycle of addiction has levels of intervention that interfere with the constant motion of the cycle. The coping cycle promotes outside involvement in order to encourage growth and solidify the infrastructure. Both sides of this model utilize the source of cyclic motion, which is pain, to form a common denominator. Pain is the place where intervention and outside involvement should begin and offer the greatest amount of support.

Compulsive Cycle

In the compulsive cycle, the Process Model of Addiction (see Figure 2) states that a person turns to a compulsive behavior to find relief from the pain. Compulsive behaviors include using substances, purging, restricting, self-harm, gambling, acting out sexually or gaming/internet use. These behaviors offer escape, relief, and serve as coping mechanisms for an individual's pain. However, as a result of these compulsive behaviors, the person experiences negative consequences. The compulsive cycle of the process model defines five areas of negative
consequences which include: 1) **health** (cirrhosis of the liver, esophageal hemorrhage, decreased brain functioning), 2) **relationships** (unable to maintain personal relationships), 3) **employment/school** (loss of employment or failure to meet grade expectations), 4) **financial** (debt, bankruptcy), and 5) **legal** consequences (felony, prison time, DWI). As a result of the negative consequences, an individual often feels **guilt** (feeling bad about what you have done) and **shame** (feeling bad about who you are). Guilt and shame lead to more pain, feeding the cycle all over. Guilt and shame help fuel the cycle of addiction because the compulsive cycle always ends in guilt and shame. Guilt and shame cause isolation and loneliness which, in turn, result in more pain. As the cycle becomes a way of life and addictive behaviors are normative, the cyclic process strengthens as addiction becomes unmanageable.

*Coping Cycle*

The coping cycle (See Figure 3) illustrates how recovery from an addictive disorder can occur according to the Process Model of Addiction. In the coping cycle, and individual begin to use coping behaviors rather than compulsive behaviors to deal with pain. Utilizing coping behaviors rather than compulsive behaviors lends itself to developing self-esteem. Attending a recovery support group or talking through struggles with a mentor could serves as healthy coping behaviors. Self-esteem established through healthy coping behaviors breeds confidence within the individual. This confidence and self-esteem leads an individual to experiencing the positive in his/her life, including positive consequences for choosing coping behaviors. Positive consequences include rebuilding close personal relationships, having the ability to focus in school, physical health, or experiencing the benefits of having more money. Using healthy coping behaviors and experience positive consequences for these behaviors develop an individual’s ability to be resilient. **Resiliency** is the ability to recover from the strain of the negative situation or to overcome obstacles despite their impact on an individual’s life.

*Levels of Intervention*

Levels of intervention (See Figure 4) refer to the points of intersection between the compulsive cycle of addiction and outside interference in the cyclic process. Outside intervention can come from treatment professionals, community and society or family and friends. Different entities intervene at different points along the compulsive cycle. However, the Process Model of Addiction suggests that the most effective level of intervention is at the source of the cycle, pain.

Treatment professionals intervene with at the level of compulsive behavior. Abstinence from compulsive behaviors is the main focus in the treatment of addiction. For example, during inpatient treatment, policies implemented during a client’s stay restrict use of substances and do not permit addictive behaviors.

Community and society intervene at the level of negative consequences. The judicial system intervenes when a person is incarcerated, placed on probation,
mandates treatment due to frequent indiscretions. Financial institutions intervene when financial irresponsibility occurs. Property foreclosures, bankruptcy, or collection agencies could all freeze assets due to these financial missteps. Colleges/universities often intervene on compulsive behaviors by mandating counseling sessions or restricting class registration. Friends and family can also intervene using negative consequences. An individual may be grounded as a result of his/her behavior or an individual may be “cut off” from financial resources as a result of an addiction.

Conclusion

The Process Model of Addiction illustrates active addiction and recovery through coping. Each cycle in the Process Model of Addiction lends itself to change, in that, each cycle strengthens through repetition. Strength and change of the cycle does not refer to only positive strength, it refers to the change in the person. With the compulsive cycle, life becomes unmanageable in addiction. In the coping cycle, strength rests in resiliency, which also means personal growth. The Process Model of Addiction is based on pain; response to pain creates the pathway to addiction or recovery.
FIGURES

Figure 1: The Process Model of Addiction

THE PROCESS MODEL

PAIN

BEHAVIOR

COMPULSIVE

RESPONSE

RELIEF

CONSEQUENCE

NEGATIVE

RESULT

GUILT & SHAME

COPING

SELF-ESTEEM

POSITIVE

RESILIENCY

Figure 2: The Compulsive Cycle

COMPULSIVE CYCLE

PAIN

COMPULSIVE BEHAVIOR

RELIEF

NEGATIVE CONSEQUENCES

GUILT AND SHAME
Figure 3: The Coping Cycle

COPING CYCLE

PAIN

COPING BEHAVIOR

SELF-ESTEEM

POSITIVE CONSEQUENCES

RESILIENCY

Figure 4: Levels of Intervention

COMPULSIVE CYCLE

INTERVENTIONS

PAIN

TREATMENT

PROFESSIONALS

COMPULSIVE BEHAVIOR

RELIEF

COMMUNITY & SOCIETY

NEGATIVE CONSEQUENCES

FAMILY & FRIENDS

GUILT AND SHAME

A Developmental Model: Addiction: A Developmental Perspective

- Developmental Theories
  - Piaget: Cognitive-Developmental Theory
    - Children construct knowledge as they interact with the world around them.
    - 4 Stages
      - 1) Sensorimotor (Birth to Two): learn by interacting with the world through their five senses.
      - 2) Preoperational (Two to Seven): concerned with language development and learn to play make believe
      - 3) Concrete Operational (Seven to Eleven): Thinking is based on logic, develop hierarchies, but can’t think abstractly
      - 4) Formal Operational (Eleven and Beyond): Can think abstractly.
  - Ford and Lerner: Developmental Systems Theory
    - Theory asserts that individuals are shaped by their interactions with other people, and identity is developed by the systems within which they develop
  - Freud: Psychosexual Stages of Development
    - 1) Oral (Birth-1 year): Babies develop sucking abilities. Unmet needs lead to things like nail biting and smoking later in life
    - 2) Anal (1-3 years): Toilet training, conflict over anal control. Needs not met may lead to extreme cleanliness or messiness
    - 3) Phallic (3-6 years): Genital stimulation brings pleasure. The balance between id, ego, and superego influences the basic personality for lifespan.
    - 4) Latency (6-11 years): sexual desires fade. Social skills and values are learned from adults and same-sex peers
    - 5) Genital (Adolescence): Puberty causes sexual feelings and desires to resurface. Successful development will lead to mature sexual identity and interpersonal relationships.
  - Erickson: Stages of Psychosocial Development
    - Thoughts Freud’s model lacked contextual components
    - Added stages that covered the entire lifespan
    - Added components that showed the interaction between social and biological components
    - Nine Stages: (See the Chart on the next page)
    - Each stage is defined by a crisis or challenge that needs to be resolved
    - If the crisis wasn’t solve an individual would get “stuck” in an inappropriate age stage
    - The underlying theme of each stage is identity development
<table>
<thead>
<tr>
<th>Psychosocial Stage</th>
<th>Crisis</th>
<th>Description of Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1 (Birth to 1 year)</td>
<td>Trust vs. Mistrust</td>
<td>Attempt to determine safety and security of environment. Asks ‘will I be cared for?’ If yes, trust is formed. If not, mistrust develops, creating a sense that the world is inconsistent and unpredictable. Infants gain trust/confidence when caregivers provide responsive care; mistrust when handled harshly or wait too long for care. Psychosocial strength to be gained: HOPE.</td>
</tr>
<tr>
<td>Stage 2 (Age 2 to 3 years)</td>
<td>Autonomy vs. Shame and Doubt</td>
<td>Attempt to attain autonomy (independence) by using new skills/abilities to make own decisions. Autonomy comes from caregivers allowing reasonable free choice without using force or shame. Shame/doubt occur from too rigid boundaries and power struggles. Best outcome is a sense of self control without sacrificing self-esteem. Psychosocial strength to be gained: WILL.</td>
</tr>
<tr>
<td>Stage 3 (Age 4 to 5 years)</td>
<td>Initiative vs. Guilt</td>
<td>Attempt to manipulate objects and the environment. Develop initiative (sense of ambition and responsibility) when caregivers support child’s purpose and direction. Demanding too much self control leads to guilt. Goal is to learn direction and purpose. Children experiment with the person they can become using play and pretend. Psychosocial strength to be gained: PURPOSE.</td>
</tr>
<tr>
<td>Stage 4 (Age 6 to Puberty)</td>
<td>Industry vs. Inferiority</td>
<td>Primary environment is ‘school’ (defined by the culture). Gain knowledge and skills in various areas (ex: literacy, technology, relationships). Discover how things work/are made. Goal is to develop sense of mastery and competence in own abilities. Develop ability to work with others. Negative experiences (school, home, peers) can cause inferiority. Psychosocial strength to be gained: COMPETENCE.</td>
</tr>
<tr>
<td>Stage 5 (Adolescence)</td>
<td>Identity vs. Role Confusion</td>
<td>Attempt to formulate a sense of self and concrete identity. Answer the question “who am I?” Compare others’ views of self to own understanding. Concerned with integrating various roles, perceptions of self, and group memberships. Peers become more influential than family. Without formulating this identity, there is confusion about future adult roles. Psychosocial strength to be gained: FIDELITY.</td>
</tr>
<tr>
<td>Stage 6 (Young Adulthood)</td>
<td>Intimacy vs. Isolation</td>
<td>Attempt to fuse self (identity) with others. Attempt to form intimate relationship. ‘Intimate relationships’ consists of affiliations, partnerships, and relationships with romantic partners, friends, colleagues, etc. Work toward career and family. Failure to form these intimate relationships can lead to isolation. Psychosocial strength to be gained: LOVE.</td>
</tr>
<tr>
<td>Stage 7 (Middle Adulthood)</td>
<td>Generativity vs. Stagnation</td>
<td>Move focus outside of self to larger society and future generations. Goal is to launch and guide the new generation. Begin a family, raise children, care for other people, or engage purposeful work. Stagnation occurs from feeling a lack of meaningful accomplishment. Psychosocial strength to be gained: CARE.</td>
</tr>
<tr>
<td>Stage 8 (Late Adulthood)</td>
<td>Ego Integrity vs. Despair</td>
<td>Look back on past life, and reflect on the kind of person they have been and the life they’ve lived. Goal is to feel satisfaction with life. Despair results from dissatisfaction with life, and may be associated with fearing death. Psychosocial strength to be gained: CARE.</td>
</tr>
<tr>
<td>Stage 9* (Very Old Age, over 85 years)</td>
<td>Despair vs. Hope and Faith</td>
<td>Come to terms with a new sense of self, including their own need for care and adjusting to physical and mental limitations. The goal is to gain wisdom and feel transcendent. Added as the ninth stage by Erikson’s wife after his own experiences in old age.</td>
</tr>
</tbody>
</table>
Ecological Model with Horizontal and Vertical Stressors

- Bronfenbrenner: Ecological Model
  - An individual develops within multiple layers of complex systems
  - Layers can interact
  - Five layers: 1) Individual, 2) Immediate family (microsystem), 3) extended family (mesosystem), 4) Community (exosystem), and 5) Larger society (macrosystem)

- Carter and McGoldrick: vertical and horizontal stressors
  - Vertical Stressors: All past and present issues that can influence each of the ecological layers.
    - Examples: child abuse, unemployment, family secrets or legacies, inflexibility of workplace, loss of a sense of community, racism, sexism, homophobia, etc.
  - Horizontal Stressors: Stressors that influence the development of the individual as they transition from one life cycle stage to the next.
    - Examples: untimely death, accident, natural disaster, war, or change in political climate.

STAGE 4: Industry vs. Inferiority (Ages 6-12)

- Trends and Prevalence
  - Not typically included in the discussion of addiction
  - Many children are starting to use during this stage
  - Commonly used substances include: alcohol, tobacco, marijuana, inhalants, and over the counter prescriptions

- Risk Factors and Protective Factors
  - Risk Factors: Comparing self to others, incorporating feedback from others when evaluating self-esteem, searching for group membership, risk factors among family members and peers, leaving home for the first time to attend school, poor school performance
    - For children who have several risk factors, waiting until adolescence to educate or intervene will likely make it more difficult to overcome the risk factors
  - Protective Factors: easy temperament, warm and organized family life, support of adults outside of the family, parental monitoring and supervision

- Why this Age?
  - Prevention programs are more successful with this age
  - People may think kids are too young at this age, not true!

STAGE 5: Identity vs. Role Confusion (Ages 13-18)

- Experience rapid changes in physical appearance and psychological processes
- Feel pulled to fit in with their friends, develop their own identity, and meet the demands and expectations of their parents
- They try a lot of new things, not just addictive things

- Trends and Prevalence Rates
Use hit an all time high in 1981, gradual fall for about a decade and the a
steadying off period since
Most common illicit drugs for this age group: marijuana, non-medical
prescriptions, inhalants
- These stats don’t include tobacco, nicotine, or alcohol
- Drinking increases with age
- Little information available on process addictions

Risk Factors/Reasons for Use- See the chart in the chapter
- Biological Factors
- Psychological Factors
- Social Factors

Stages of Use
- 1) Preparation Stage, 2) Initiation Phase, 3) Experimentation phase, and 4) Transition

Why do Adolescents Use?
- 1) Feel grown up, 2) take risks or rebel against authority, 3) fit in, 4) relax or feel good, 5) satisfy curiosity, 6) self medication

Barriers to Treatment
- Belief that their behavior is normal, desire to fit in with peers,
hypersensitive about the stigma associated with asking for help, may feel they are disappointing family members who use, cost of inpatient treatment, lack of insurance, may be unaware that treatment is an option, and treatment centers are generally not gear toward adolescents

Treatment Considerations
- Treatment staff should be trained to work with adolescents and know about their worldview
- Treatment should include a wide variety of services to engage teenagers
- Cultural heritage should be respected and honored

Protective Factors
- 1) Child protection aimed at the cycle of violence and substance misuse,
2) School-based prevention programs directed toward social influences promoting youth to smoke, 3) Information dissemination approaches focusing on the immediate consequences of smoking (bad breath, breathing problems, etc), 4) Mass media campaigns showing the negative side of alcohol, tobacco, and other drug misuse, 5) Social resistance and personal competence skills approaches (e.g., anxiety management skills, assertiveness training), 6) Campaigns to reduce or eliminate TV beer ads, student newspaper local bar ads, and national beer ads, 7) Advocacy for hiring more school counselors and social workers to work with high-risk students (bullies, victims, children who suffer from mental disorders, children of alcoholics/addicts), and 8) The creation of small schools to reduce the sense of alienation and provide a personalized learning environment
- Most teens who use recreationally don’t become addicts. They are their own best protective factor.
Special Considerations
- Prefrontal cortex controls your self-control, judgment, novelty seeking, etc and is not fully developed until after age 20

Adolescent Recovery
- Relatively unknown until recently
- Recovery schools: exist at both high school and college level
- High schools are in 8 states: California, Indiana, Massachusetts, Minnesota, New Hampshire, Oklahoma, Pennsylvania, and Texas
- Goal is to facilitate academic and recovery success simultaneously

STAGE 6: Intimacy vs. Isolation (Ages 19-40)
- Recent Trends and Prevalence Rates
  - 6.1% report illicit drug use in 2006
  - Current decrease in those who use crack
  - College students add to the rates of binge drinking (42.2% for this age group)
  - College students use was less than non-college students of the same age group
- Risk Factors and Special Considerations
  - Substance use is often a rite of passage
  - Binge drinking has become an epidemic
  - Long-term use has implications for health and posterity

STAGE 7: Generativity vs. Stagnation (Ages 40-65)
- Recent Trends and Prevalence Rates
  - There has been a leveling off recently
- Risk Factors and Special Considerations
  - Similar risk factors as stage 6
  - Family implications
  - Often experiencing isolation

STAGE 8: Ego Integrity vs. Despair (Age 65 and up)
- They are working to understand the meaning of their life
- Evaluating life as well as dealing with isolation as friends and family members pass away
- Trends and Prevalence Rates
  - Unique consideration include, drugs of choice, age of addiction onset, lack of recognition that it is a problem
  - Alcohol and prescription drugs are the drugs of choice for this age group
  - 6-16% of this group experience alcohol problems
  - At least 3 times more likely than younger individuals to abuse prescription drugs
  - Early Onset: habits developed over the lifespan
  - Late Onset: habits that developed later in life
  - Risk Factors: Males, experiencing major life changes, loss, substance abuse earlier in life, co-morbid psychiatric disorders, family history of abuse, simultaneous use of nicotine and other psychoactive drugs
General Risk Factors
- Social Isolation: more likely to live alone, and not to be in treatment
- Older adults who are married are less likely to use, again related to isolation
- Social isolation, limitations, loneliness, stigma, other illnesses, gender, loss/grief, multiple medications, white hair syndrome
- Women use more prescription drug of all types than men
- **White Hair Syndrome:** People who use early in life phase out of it by the time they are in their 40’s

Barriers to Treatment
- Stigma associated with therapy and treatment
- Think they are a burden or problem

Special Considerations
- Physical health, SES, social isolation, and loss
- No best treatment has been identified
- Attention to making meaning of life and planning for death should be included

STAGE 9: Despair vs. Hope and Faith (Ages 85 and older)
- Not one of Erikson’s original stages, but he added it later in life
- Coming to terms with their new self and their new limitations
- People can achieve long-term recovery
**Family Systems and Addiction**

Sterling T. Shumway, Ph.D. and Thomas G. Kimball, Ph.D.

**Introduction**

General systems theory focuses on the interdependent relationships and interrelated parts or elements of a system. Systems theory first originated in biology in the 1920’s out of the need to explain the interrelatedness of organisms in ecosystems. In the 1940’s and 50’s mathematicians, physicists, and engineers began using systems theory as a tool to develop comprehensive models that helped to describe complex systems like the human brain. Currently, systems theory is an interdisciplinary field and is utilized to explain complex phenomena in science, nature, and society.

Family systems theory was developed based on the concepts of General Systems Theory (GST) and focuses on family as a system with interrelated and interdependent parts. The individuals who make-up a family system (the parts), impact the structure and function of the family as a whole. From a family systems perspective, these parts or elements may include parents, spouses, partners, children, siblings, uncles, aunts, cousins, and other persons that family members consider part of the system. As a result, the process of helping individuals who struggle with addiction may be more effectively approached by taking into consideration the interdependence of each family member within the system and using this information to develop more effective and long-lasting systems-based interventions for recovery.

McCollum and Trepper, in their book *Family Solutions for Substance Abuse*, describe that viewing addiction from a family systems perspective is much like “zooming a camera lens from a close-up to a wide-angle view. In wide-angle mode things come into the frame that are not visible in the close-up (p.3).” Systems theorists would argue that being able zoom both in and out helps to better assess, understand, and treat dysfunctional dynamics within family systems. These dynamics may include family boundary making, triangulation, role assignment, rules, hierarchy, power, problematic communication patterns and feedback loops.

Although this chapter will not deal with specific interventions or therapeutic modalities, there are multiple family systems/therapy models that provide helpful information and will inform the material in this chapter. Though not an exhaustive list, these models include behavioral family therapy, Bowenian therapy, strategic family therapy, structural family therapy and other more brief models such as solution-focused therapy. These models describe key concepts that will allow for a more “wide-angle view” and hence, a better understanding of addiction and recovery.
Family Definition and Systems Concepts
There is much debate regarding what constitutes “family” and how to best define it. For purposes of this chapter, a basic systemic definition of the family is offered by Hill and Mattessich, "...a small group system that is relatively closed, boundary maintaining, equilibrium seeking, purposive, and adaptive..." (p.165). Though you may not fully understand the importance of this definition and its relationship to systems concepts at this time, we hope that as you read this chapter the concepts will help you better understand this definition of the family and that the definition will help you better understand the concepts.

The Whole is Greater than the Sum of its Parts
This concept, the whole being greater than the sum of its parts, refers to the idea that individual and family functioning is dependent upon all of the individual parts. For example, the human body works best when the heart, lungs, liver, kidney (parts) work together. If one of these parts ceases to function properly the whole (the body) is effected and unable to function at its maximum potential. In families, if one member is not doing well (part), it impacts family and may ultimately effect the family's functioning as a whole. In short, systems proponents would argue that we are stronger if all parts come together to create a functioning whole. Applied to addiction and recovery, the whole is greater than the sum of its parts implies that individual recovery can be strengthened by family participation and support. Like wooden matches, it is much more difficult to break 10 of them banded together than it is to break one of them on its own.

Homeostasis and Feedback—Systems and Change
Family systems resist change and strive to maintain balance and/or stability, a term known as homeostasis. Homeostasis works like a good heating/cooling thermostat. When feedback is received by the thermostat that the temperature in a room is either too cold or too hot, a signal is sent to the heating or cooling system so the appropriate temperature can be maintained. Like the thermostat on the wall, families attempt to maintain their current temperature. When change opportunities arise, families tend to resist them and maintain old ways of interacting. This is compounded in families where there is addiction. Interactional patterns that support the addictive behaviors may be highly entrenched and there may be little motivation to change them by both the addict and the family members. Patterns of behavior, including ways of communicating, are reinforced and allow (or enable) the addict or alcoholic to continue using. It takes an incredible amount of effort by both individuals and families to change the temperature and develop new interactional patterns. This is accomplished when feedback is received by the family thermostat that change is necessary and members begin the process of making those changes (changing behaviors).

Family Structure
Family structure is the manner in which families are organized. Who’s in charge? Who makes the rules? Who enforces these rules? Who do you reach out to when you need help? These are all questions that define structure. Family structure is maintained by family boundaries, roles, rules, hierarchy and power as discussed below. From a family systems perspective, change can be facilitated by a reorganization of structure. For example, if the
children are in control in a particular household and things aren’t going well, parents may want to get back in-charge. This simple change in structure may have a ripple effect that creates positive change throughout the family system. Changing the structure of a family is more difficult when addiction is present but necessary if the family temperature is to change.

**Subsystems**
Subsystems are the various units within a family system. These units include parental subsystems, husband/wife subsystems, sibling subsystems, etc. Subsystems must be understood if we are to understand family structure and hierarchy given that subsystems provide the context for individual relationships (e.g., relationship between husband and wife; husband and wife subsystem, relationship between older brother and little sister; sibling subsystem).

**Power and Hierarchy**
When discussing family structure, it is important to understand power and hierarchy. Power is the relative influence of each family member on the course or outcome of an activity. Power relations within the family deal with aspects of both freedom and restraint within family organizations. It is the way in which the family demands, rewards, protects, punishes, and tries generally to shape the interaction of its members. Power issues are often dealt with through hierarchy. For example, in some households parents establish most of the rules when their children are young. In some significant other relationships, the man might make all of the decisions. These examples show how hierarchy may distribute power within a family system both appropriately and inappropriately.

In families that struggle with addiction, the addiction often wields the power. We would argue for recovery to be successful that the old hierarchy and power structures need to be removed and replaced with a new more appropriate structure where hierarchy and the distribution of power are more balanced. For example, within a 12 step model of recovery, individuals admit their powerlessness and turn their will over to their Higher Power. By first giving up this power, families become more capable of receiving it back and then redistributing it in more equitable ways (changing the structure and hierarchy within the system).

**Boundaries**
The boundaries within a system are where subsystems interact. They are the walls, borders, or limits of a system and determine who participates in a given activity and who does not. Boundaries can be both physical and emotional in nature and can be placed on a continuum from rigid to diffuse.

Rigid boundaries exist when family members are disengaged from each other and from outside systems by inflexible rules. Their rules are rigid and there is little room for negotiation or accommodation. Diffuse boundaries exist when family members are so enmeshed (connected) that individuality and autonomy is impossible. Family members are highly reactive to each other and family activities seem chaotic and disorganized. In families where addiction is present, families lean toward one extreme or the other. For example, some families may lean toward the rigid end of the continuum and create a wall
between them and other outside systems to maintain secrecy. This maintaining of secrecy is meant to protect the family but ultimately may end up supporting and maintaining the addictive behaviors. Other families may lean toward the chaotic or diffuse end of the continuum. The members of a family with these type of boundaries may be connected too closely and in ways not appropriate. For example, chaotic boundaries exist when a mother smokes marijuana with her children in an effort to be “cool.”

Healthy families, including families who find recovery from addiction, embrace flexible boundaries where family members are connected enough to see the effects of others’ behavior without disrupting family functioning. They also allow family members to tolerate autonomy (disagreements, separate interests, etc.). Flexible boundaries allow family members to function without unnecessary interference from others (this is extremely important in the process of recovery). Finally, such boundaries allow family members to experience the consequences of their own actions and prevent one person from over-functioning to protect others. A good example of a flexible boundary is curfew. Curfew should be age appropriate and needs to be adjusted as the age of children increases within a household.

Family Rules
Family rules ultimately determine the boundaries of a system. Rules are established through stated expectations and/or through repeated patterns of behaviors over time. Rules often function as a way to maintain homeostasis or the status quo. As stated above rules can be expectations that are explicitly or implicitly stated, such as a parent telling their child, “don’t have sex before marriage” or can be established through patterns of interaction like the way a parent models drinking behavior over time for their children as opposed to what they say about drinking.

Family Roles
Family roles are the collection of rights and duties based on cultural expectations and how individuals play their parts. Family roles are the script by which the actors of a family carry out their individual parts. In healthy families, roles are fluid and individuals in a system have a say in the part or role they play. In families struggling with addiction boundaries are often prescribed from the top down (by those who wield the power) or are developed by individual members through a process of default (no other place of fit exists). These roles are difficult to change given homeostatic forces. Classic alcoholic family roles are listed below. vi

- **The Victim/Chemical Dependent** – The person who demands the focus of the family. Everything just happens to this person. It is someone else's fault.

- **Enabler (often the spouse or parent)** – The caretaker of the family. He/she is super responsible one. This person often intervenes so that others do not have to take responsibility for their actions.
- **Hero** – The person who is going to give legitimacy to the family. The hero represents someone in the family who is “good” as opposed to all of the “bad” ones in the family. As the functioning of the family worsens, the hero will try harder to succeed.

- **Scapegoat** – The troublemaker in the family. The scapegoat takes the blame for all of the family’s problems. He/she often withdraws from the family and looks for belonging somewhere else. He/she gets attention in destructive ways and is often a distraction.

- **Lost Child** – Spends much time alone or being busy. The lost child has learned to stay out of the whirlwind of the family. They receive little attention, either positive or negative.

- **Mascot** – The family member who brings comedy relief into the family. It is the mascot’s job to lessen the tension in the family via the use of comedy.

For families who find recovery, establishing and maintaining good boundaries is a key to transforming unhealthy roles into healthy more flexible roles.

**Triangulation**

Triangulation is the joining or opposition of one family member with another in carrying out an operation. In the family systems literature this is talked about in two distinct ways. First, a triangle where one member of a dyad reaches out to a third person in an effort to spread the tension more evenly throughout the system or to shift the tension away from themselves. Second, a triangle is created where one member of a dyad reaches out to a third person in an attempt to create a coalition and get their own way. This is an example of majority rules, two against one. Triangulation is an unhealthy process as it does not encourage two people to work things out but encourages them to bring another person into the problematic situation as a solution. Triangulation occurs regularly in families who struggle with addiction. For example, when a parent becomes suspicious of a teenagers drug use, the child under suspicion may reach out to an older sibling who may begin to argue with the parent to “lay off” their sibling; thus spreading the tension and conflict between the parent and older child. Effectively, this triangle creates an argument between parent and older sibling and allows the teenager under suspicion to relax and enjoy their high.

**Multi-Generational Transmission**

Multi-generational transmission is the idea that emotional responses and the behaviors that follow are often passed down from generation to generation. All generations are part of a continuous process where each generation presses up against the next so that previous generations impact current and/or future generations. According to Friedman (1991), “...
not only can the future be predicted on the basis of the past, but the past can be reconstructed on the basis of the ever-evolving present” (p.148).

In families who struggle with addiction, family problems are often repeated through many generations. In relation to addiction, it is common to observe addictive patterns within families across multiple generations. (Note: genograms are often used to illustrate this principle). A discussion of multi-generational transmission sets an accurate context for the individual and their family to understand that the development of addiction may depend upon generational influences (the impact of previous generations on the current generation). From a systems perspective, a better understanding of multi-generational transmission will allow us to recognize that addiction is much more than an individual problem.
Process Addictions

Process/Behavioral Addictions
- Involve everyday, legal activities, like eating, shopping, gambling, sex, etc
- Compulsive and obsessive
- Addicted in the brain- euphoria from these actions, not substances

Eating Disorders

General Causes of Eating Disorders
- Trauma
- Media/images
- Social pressures
- Family messages
- Being teased
- Others?

Anorexia Nervosa
- “Typical Patient”
  - Adolescent
  - Female
  - High SES
  - Caucasian
  - Someone involved in sports, fashion, dance, etc

- Symptoms/Red Flags
  - Unusual eating patterns- ritualized, avoiding meals, moving food around the plate, eating only certain foods, weighing or portioning food
  - Repeatedly checking weight
  - Depression, isolation, irritable
  - Fatigued

- Addiction Criteria
  - Refusal to maintain body weight (be at less than 85% body weight)
  - Intense fear of weight gain (despite being underweight)
  - Abnormal self perception → Distorted body image (see fat when it is not there), unduly emphasis weight or shape in self evaluation, deny seriousness of low weight
  - Amenorrhea (absence of at least three consecutive periods)

- Physical Complications
  - Slow heart rate
  - Extremely low blood pressure
  - Constipation, abdominal pain
  - Affect fertility
  - Prevent bone growth, can lead to osteoporosis and brittle bones
  - Anemia
  - Dry, flaky skin
Hair growth on body (lanugo)
◆ Lose hair (head)
◆ Brittle nails

**Death from Anorexia**
◆ Highest mortality rate of mental illnesses
◆ The mortality rate among people with anorexia has been estimated at 0.56 percent per year, or approximately 5.6 percent per decade, which is about 12 times higher than the annual death rate due to all causes of death among females ages 15-24 in the general population
◆ Usually from starvation, suicide, or electrolyte imbalance

**Misc.**
◆ About 95% are women
◆ Approximately 0.5 to 3.7% of US population (NIMH)
◆ About 20% never recover - live with disease until death

**Treating Anorexia**
◆ First Step - restoring weight lost to severe dieting and purging
  ◦ acute management of severe weight loss is usually provided in an inpatient hospital setting, where feeding plans address the person's medical and nutritional needs
  ◦ In some cases, intravenous feeding is recommended
◆ Treating psychological disturbances such as distortion of body image, low self-esteem, and interpersonal conflicts
  ◦ Once malnutrition has been corrected and weight gain has begun, psychotherapy (often cognitive-behavioral or interpersonal psychotherapy) can help people with anorexia overcome low self-esteem and address distorted thought and behavior patterns
  ◦ Families are sometimes included in the therapeutic process
  ◦ Individual therapy, family therapy, group therapy, cognitive behavioral therapy
◆ Achieve long-term remission and rehabilitation, or full recovery
◆ Can be inpatient, outpatient, hospitalization
◆ Should include ongoing aftercare

**Bulimia**

**Symptoms/Red Flags**
◆ Usually weight within normal range for age and height
◆ Usually practice behaviors in secret
◆ Feel shame and guilt for binging, relieved after purging
◆ Eating large quantities of food without gaining weight
◆ Going to the restroom after meals
◆ Ritualized eating

**Addiction Criteria**
◆ Binge
  ◦ consumes more food than most people generally would during a given period of time and similar circumstances
○ feel that eating is out of control
◆ control weight with inappropriate means
  ◊ purge
  ◊ fasting
  ◊ laxatives
  ◊ exercise
◆ on average, both binge and purge must occur twice a month for three consecutive months
◆ emphasis on weight and shape

❖ Physical Complications
◆ Irregular heartbeat, heart failure
◆ Irregular periods
◆ Dental problems- damaged or discolored teeth: gastric acids erode enamel
gastrointestinal problems: irritation of esophagus, stomach, salivary glands and throat from persistent vomiting
◆ lung irritation: choking while vomiting causes food particles to lodge in lungs, causing inflammation
◆ chronic loss of bodily fluids: depletes blood potassium, sodium and chloride levels, resulting in muscle spasms, weakness, irregular heartbeat and kidney disease
◆ Calluses or scars on the knuckle (from forced throwing up)
◆ Swollen glands

❖ Misc.
◆ Affects 1-4.2% of adult women (NIMH)

❖ Treating Bulimia
◆ Primary goal: to reduce or eliminate binge eating and purging behavior
◆ Nutritional rehabilitation
◆ psychosocial intervention
◆ medication management
◆ Establish a pattern of regular, non-binge meals
◆ Encourage healthy but not excessive exercise
◆ Resolve co-occurring conditions such as mood or anxiety disorders
◆ Individual psychotherapy (especially cognitive-behavioral or interpersonal psychotherapy), group psychotherapy that uses a cognitive-behavioral approach, and family or marital therapy
◆ Psychotropic medications, primarily antidepressants such as the selective serotonin reuptake inhibitors (SSRIs) particularly for those with significant symptoms of depression or anxiety

Binge Eating Disorder
❖ Symptoms
◆ Recurrent episodes of binge eating
  ◊ eating an excessive amount of food within a discrete period of time
  ◊ by a sense of lack of control over eating during the episode
◆ The binge-eating episodes are associated with at least 3 of the following:
eating much more rapidly than normal
eating until feeling uncomfortably full
eating large amounts of food when not feeling physically hungry
eating alone because of being embarrassed by how much one is eating
feeling disgusted with oneself, depressed, or very guilty after overeating

Marked distress about the binge-eating behavior
The binge eating occurs, on average, at least 2 days a week for 6 months
The binge eating is not associated with the regular use of inappropriate compensatory behaviors (e.g., purging, fasting, excessive exercise)

Misc.
NOT the same thing as being obese, but has similar complications and manifestations
Many are overweight because they binge but do not purge
Most common eating disorder- but not diagnosable
Affects 2-5% of population
More common in women, about 3 to 2
Affects Caucasian and African American at same rates, other ethnicities unknown

Treatment
Should be treated on both a physical and psychological level
Physicians and nutritionists can help monitor weight gain/loss.
Cognitive-behavioral therapy → monitor and change eating habits as well as to change the way they respond to difficult situations.
Interpersonal psychotherapy → examine their relationships with friends and family and to make changes in problem areas.
Medications such as antidepressants may be helpful for some individuals.
Self-help groups also may be a source of support.

Gambling Addiction

Some form legal in all but three states: Hawaii, Utah, Tennessee
14,000 employed in Gulf Coast Casinos prior to Hurricane Katrina
Revenues from Gambling for 2004: Nevada- $10.8 billion, NJ- $4.8 billion, Mississippi- $2.7 billion
Gambling addiction estimated to effect about 3% of the US population

DSM Diagnosis

Pathological Gambling
Usually develops in adolescence. Adolescents about 3 times more likely to become addicts than adults.
Feel “high” or aroused
Takes several years for gambling to become a problem
Idea of “the big win” produces overconfidence & risk taking
Affects approximately 2% of adults
About 2:1 male/female
Men prefer action/skill games
Must have five or more of the following symptoms
1. preoccupied with gambling
2. must increase amount played
3. tried and failed (repeatedly) to stop gambling
4. feels irritable when trying to control gambling
5. use gambling as an escape/cope
6. try to recoup money from previous losses
7. lying to cover up extent of gambling
8. steal to finance gambling
9. jeopardize family, school, friends, work, etc for gambling
10. has to rely on others for money to relieve consequences

Problem Gambling
Less severe
Cannot officially be diagnosed

The Custer Three Phase Model (Robert L. Custer, M.D.)
Winning phase- Experience a big win or a series of wins, leaves them with unreasonable optimism that winning will continue. Feel great excitement when gambling, begin increasing the amounts of their bets.

Losing phase- brag about wins they had; gamble alone; think more about gambling; borrow money legally or illegally. Start lying to family and friends; become irritable, restless, withdrawn. Home life unhappy, unable to pay off debts. Begin to "chase" their losses, believing they must return as soon as possible to win back their losses.

Desperation phase- marked increase in time spent gambling. Accompanied by remorse, blaming others, alienating family and friends. May engage in illegal acts to finance gambling. May experience hopelessness, suicidal thoughts and attempts, arrests, divorce, alcohol and/or other drug abuse, or an emotional breakdown.

Robert L. Custer’s six types of gamblers:
1. Professional gamblers
   - Make their living by gambling, consider it a profession.
   - Skilled in the games they choose to play, able to control both the amount of money and time spent gambling.
   - Are not addicted to gambling. They patiently wait for the best bet and then try to win as much as they can.

2. Antisocial or personality gamblers
   - Use gambling as a way to get money by illegal means.
They are likely to be involved in fixing horse or dog races, or playing with loaded dice or marked cards.
They may attempt to use a compulsive gambling diagnosis as a legal defense.

3. Casual social gamblers
- Gamble for recreation, sociability and entertainment.
- May be a distraction or a form of relaxation.
- Does not interfere with family, social or vocational obligations. Examples of such betting are the occasional poker game, Super Bowl bets, a yearly trip to Las Vegas and casual involvement in the lottery.

4. Serious social gamblers
- Invest more of their time in gambling.
- Major source of relaxation and entertainment, yet second in importance to family and vocation. Could be compared to a "golf nut," whose source of relaxation comes from playing golf.
- Serious social gamblers still maintain control over their gambling activities.

5. Relief and escape gamblers
- Gamble to find relief from feelings of anxiety, depression, anger, boredom or loneliness.
- Use gambling to escape from crisis or difficulties. Provides an analgesic effect rather than a euphoric response.
- Relief and escape gamblers are not compulsive gamblers.

6. Compulsive gamblers
- Have lost control over their gambling.
- Gambling is the most important thing in their lives.
- Compulsive gambling is a progressive addiction that harms every aspect of the gambler's life. As they continue to gamble, their families, friends and employers are negatively affected.
- In addition, compulsive gamblers may engage in activities such as stealing, lying or embezzling which go against their moral standards.
- Compulsive gamblers cannot stop gambling, no matter how much they want to or how hard they try.

FAQs
- Q: Are gamblers addicted to money?
  A: Pathological gamblers are addicted to action, not money. Many pathological gamblers will gamble to lose in the desperation phase of their addiction, because it is the action they seek, not the money.
- Q: Is there one type of gambling that is more addictive than others?
  A: Video poker and slot machines have been referred to as the "crack cocaine of gambling." Because of their immediate and effective reinforcement schedules, problem gamblers who regularly play these machines appear to progress into pathological gambling much faster than problem gamblers who only gamble at horse races, or other games that do not have such an immediate rate of gratification.
Effects of Gambling on the Family
  - Spouse/Partner
  - Parents
  - Children
  - Extended Family
  - Financial
  - Emotional
  - Others?

Co-occurrence with Other Disorders
  - Substance use disorders in 25-63%
  - Three times more likely for depression, schizophrenia, alcoholism

Treatment Problems
  - Not many options/treatment centers
  - Usually can’t pay due to debt
  - Not funded by insurance

**Codependency**

**How do you define codependency?**
  - Reliance or dependence upon a one-sided relationship, in which individuals have difficulty maintaining healthy personal boundaries and experience loss of self.
  - Commonly present dysfunctional relational development and families dealing with addiction.

**How does one acquire co-dependent characteristics?**
  - Parental involvement/ family values and beliefs
  - Relational modeling/ experiences
  - Twelve-step model beliefs
  - Personality trait

(All of these possibilities are highly controversial and can exist together or not at all.)

**Important facts about codependency:**
  - No specific DSM diagnosis
  - Can have codependent tendencies without being addiction.
  - Common co-morbidity factors
  - Popularized by the Twelve-Step program based on co-addict definition.

**Love Addiction**

What is a Love Addict?
  - One involving a preoccupation with an unhealthy relationship or dependence upon another individual with a difficulty in obtaining healthy emotional intimacy with others.
- Often involves lack of ego boundaries, difficulty in relating to other’s perceptions of them, lack of self-worth.
- Roots of love addition are often found in our family beliefs and values. One’s ability to attach and relate to others is a significant indicator of problematic or addictive behavior.
- Recognize need versus want within relational boundaries.

Common characteristics:
- Constant ‘love at first sight.’
- Weak or absent boundaries
- Abnormal jealousy
- Feel as though one is controlled by libido
- Excessive fantasizing about relationship
- Exaggerated fears concerning relationships
- Confusing need with want
- Tolerant of deceit, dishonesty, etc.

**Sex Addiction**

What is a Sex Addict?
- Similar to substance use, what began as a compulsion has spun out of control, and made life unmanageable. Addicts may have started addicted to one behavior, and it may or may not have increased, but regardless, are now powerless to stop the behavior.

Are you a Sex Addict?

1. Do you keep secrets about your sexual or romantic activities from those important to you? Do you lead a double life?
2. Have your needs driven you to have sex in places or situations or with people you would not normally choose?
3. Do you find yourself looking for sexually arousing articles or scenes in newspapers, magazines, or other media?
4. Do you find that romantic or sexual fantasies interfere with your relationships or are preventing you from facing problems?
5. Do you frequently want to get away from a sex partner after having sex? Do you frequently feel remorse, shame, or guilt after a sexual encounter?
6. Do you feel shame about your body or your sexuality, such that you avoid touching your body or engaging in sexual relationships? Do you fear that you have no sexual feelings, that you are asexual?
7. Does each new relationship continue to have the same destructive patterns which prompted you to leave the last relationship?
8. Is it taking more variety and frequency of sexual and romantic activities than previously to bring the same levels of excitement and relief?
9. Have you ever been arrested or are you in danger of being arrested because of your practices of voyeurism, exhibitionism, prostitution, sex with minors, indecent phone calls, etc.?
10. Does your pursuit of sex or romantic relationships interfere with your spiritual beliefs or development?
11. Do your sexual activities include the risk, threat, or reality of disease, pregnancy, coercion, or violence?
12. Has your sexual or romantic behavior ever left you feeling hopeless, alienated from others, or suicidal?

(if YES to more than one)

What’s the Difference between being a sex addict and having a high sex drive?
- High sex drive: ENJOY what you’re doing
- If partner says “no” it doesn’t make you feel angry, rejected, out of control, etc

Can you be addicted to masturbation?
- YES!
- Difference between addicted and enjoyment?

What role does pornography play in sex addiction?
- Role of women as objects
- Power of the fantasy
- Anything you desire can happen

How does Sexual Addiction effect partners, families, etc?
- Emotional
- Financial
- Shame/guilt
- Depression

Shopping Addiction

What is compulsive shopping and spending?
- People who "shop 'till they drop"
- Run their credit cards up to the limit
- Believe that if they shop they will feel better.
- Compulsive shopping and spending generally makes a person feel worse.
- Similar to other addictive behaviors and has some of the same characteristics as problem drinking (alcoholism), gambling and overeating addictions.
- Can be a seasonal balm for the depression, anxiety and loneliness during the December holiday season. Can occur when a person feels depressed, lonely and angry. Shopping and spending will not assure more love, bolster self-esteem, or heal the hurts, regrets, stress, and the problems of daily living. It generally makes these feelings worse because of the increased financial debt the person has obtained from compulsive shopping.

How can you tell if you are a compulsive shopper?
- Shop for a “pick-me-up.”
- Go out and buy, to get a high, or get a "rush" just like a drug or alcohol addict.
- Buy things they do not need.
- May be compulsive about buying certain items, such as shoes, kitchen items or clothing; some will buy anything.
- Often have racks of clothes and possessions with the price tags still attached which have never been used.
Go to a shopping mall with the intention of buying one or two items and come home with bags and bags of purchases.

In some cases shopoholics have an emotional "black out" and do not remember even buying the articles.

Often hide the things they buy.

Because they can not pay their bills their credit rating suffers, they have collection agencies attempting to get what is owed, may have legal, social and relationship problems.

They sometimes attempt to hide their problem by taking on an extra job to pay for bills.

How do you control and treat this condition?

It is recommended that spending addicts seek professional counseling or a self-help group to deal with this problem. Addictive behaviors tend to come in clusters, so if you have an eating disorder, a problem with drugs or alcohol, or gambling, you may be a candidate for shopping addiction. Many communities have credit counseling centers that will also help with shopoholism.

How do I prevent shopping binges?

Pay for purchases by cash, check, debit card.
Make a shopping list and only buy what is on the list.
Destroy all credit cards except one to be used for emergency only.
Avoid discount warehouses. Allocate only a certain amount of cash to be spent if you do visit one.
"Window shop" only after stores have closed. If you do "look" during the day, leave your wallet at home.
Avoid phoning in catalog orders and don't watch TV shopping channels.
If you're traveling to visit friends or relatives, have your gifts wrapped and call the project finished; people tend to make more extraneous purchases when they shop outside their own communities.
Take a walk or exercise when the urge to shop comes on.
If you feel out of control, you probably are. Seek counseling or a support group such as Debtors Anonymous.
Videos


Special Considerations

 Considerations for Women
  ◆ Biological
    o Metabolize alcohol at different rates
    o Telescoping
    o Higher fat ratios
    o Physical injury
    o Violence
    o Other illnesses
  ◆ Psychological
    o Stigma/connotations
    o Psychiatric disorders
    o Trauma and/or violence
  ◆ Social
    o Linked to relationships
    o Family roles/caretaking
    o Role of motherhood

 Sexual Orientation
  ◆ Membership in marginalized group
  ◆ Difficulty determining percentages of population that use
  ◆ Methodological difficulties
  ◆ Identity development
  ◆ Violence
  ◆ Socialization
  ◆ Pressure
  ◆ Community expectations
  ◆ Homophobia, heterosexism & discrimination

What Can You Do?
 Strategies for Culturally Competent Treatment
  o Each client has the right to be treated with sensitivity and respect
  o Be knowledgeable and competently trained to work with LGBT issues
  o Be aware of myths and realities regarding LGBT people
  o Display cultural symbols such as the rainbow flag and LGBT 12-step literature in your office as a sign of affirmation
  o Be aware of Stages of Change model and how these stages might be affected by the client’s stage of sexual identity development
  o Do not confront sexual identity- explore, work collaboratively, and use empowerment strategies
  o Challenge agency discrimination and prejudice against this population, including exclusionary language
  o Remember that LGBT clients live in a heterosexual world and are not given the same legal protections and privileges of heterosexual indvs
Client should not be required to discuss sexual identity or relationship issues in mixed groups if uncomfortable doing so

If counselor is uncomfortable working with LGBT clients, should refer to someone competent and gay friendly

Do not try to change sexual orientation of client

Self monitor countertransference. Examine own biases and reactions with a supervisor, colleague, etc.

Be diligent in exploring own heterosexist assumptions and language

Remain flexible and individualize treatment strategies based on unique context of the client

How to be an Advocate for LGBT-affirmative treatment:

♦ Create a zero tolerance policy about heterosexism and homophobia. Make sure policy is enforceable and meaningful

♦ Create a team that conducts an assessment of how LGBT-friendly the addiction setting appears to others.

♦ Hold focus groups and workshops in the LGBT community

♦ Write letters to representatives and local straight and queer newspapers about LGBT issues in addiction.

♦ Use your knowledge of local addiction, mental health, and the LGBT community resources to raise awareness about LGBT issues in addiction.
Multiculturalism: Culture, Ethnicity and Addiction
Lecture Notes

Culture & Ethnicity

- Clarify the importance of not stereotyping by using race and gender as defining characteristics of addiction. Instead, generalize the ideas of culture and ethnicity as issues that are differing entities for every individual.
- Race is important to discuss in terms of how it affects our ideas and beliefs about addiction, but stay away from listing prevalence rates for each race.
- Introduce difference between culturally tailored interventions vs. culturally specific interventions.

Culture, Ethnicity and Substances

- Alcohol
  Discuss prevalence rates and allow students to discuss popular beliefs and social mores attached to alcohol use within Western Culture. Discuss worldly differences as they pertain to ethnic and culture issues.

- Prescription Drug Use
  Discuss prevalence rates and make note of the teenage and elderly increase in use. Discuss why this might be so and how to manage this as an epidemic. How do high profile celebrity cases affect our perspective on this addiction?

- Illegal Drug Use
  Discuss prevalence rates and nation-wide anti-drug movement. Have they been helpful? If so, to which populations? Discuss the cultural boundaries surrounding anti-drug movements and their effect on cultural beliefs about addiction.

Cultural and Ethnic Differences and Substance Abuse

For this section take time to discuss each characteristic and the role they play in both maintaining stereotypes and creating benefits/obstacles in understanding addiction within varying cultures.

- Religion
- SES
Culture, Ethnicity and Process Addictions

For each of these process addictions discuss what they would look like in different cultures? Would they be recognized as such? How might one define them differently based on their value and belief system? Also, discuss the importance of breaking barriers and stereotypes.

- Self Harm
- Sex and Love
- Eating Disorders
- Shopping
- Gaming and Internet Gambling
- Codependency

Biases of AA

While this is one particular model of recovery, there have been many criticisms of the value system and rules of AA.
- Gender roles, expectations
- Understanding of a Higher Power
- Defining Addiction
- Foundation of AA beliefs
- Abstinence only
Assessment of Substance Disorders

Master Treatment Plan (Outline)

Diagnostic Summary:
DSM Diagnosis:
Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

Give an initial assessment & justification for each of the six dimensions:

Intoxication and/or withdrawal:

Biomedical conditions/complications:

Emotional and behavioral complications:

Treatment acceptance or resistance:

Relapse potential:

Recovery/living environment:

Problem list. Complete 5 for your client. (Should reflect your concerns listed above)

1.
2.
3.
4.
5.

Client Strengths (list at least 3):

1.
2.
3.

Problem 1:

As evidenced by:
Resulting in:

Goal:

Objective:

Intervention:

Responsible Staff:

Target Date:

Problem 2:

As evidenced by:
Resulting in:

Goal:

Objective:
Intervention:
Responsible Staff:
Target Date:

Problem 3:
As evidenced by:
Resulting in:

Goal:
Objective:
Intervention:
Responsible Staff:
Target Date:

Problem 4:
As evidenced by:
Resulting in:

Goal:
Objective:
Intervention:
Responsible Staff:
Target Date:

Problem 5:
As evidenced by:
Resulting in:

Goal:
Objective:
Intervention:
Responsible Staff:
Target Date:

Preliminary Discharge Criteria:
1.
2.
3.
4.
5.
Treatment Plan (Example)

1. Give a 5 Axis Diagnosis for Catherine:

Axis I: Alcohol abuse, over medicating (prescribed Xanax), severe anxiety, and slight depression, bulimia (while in high school)
Axis II: Diagnosis Deferred
Axis III: Diagnosis Deferred
Axis IV: Physical abuse, sexual abuse, occupational problems (difficult working conditions)
Axis V: 55

2. Give an initial assessment & justification for each of the six dimensions:

Intoxication and/or withdrawal: Catherine is having slight withdrawal symptoms but they will more than likely become more severe in the future because of the amount and frequency in which she drinks.
Biomedical conditions/complications: There are not any chronic or physical illnesses at this time.
Emotional and behavioral complications: Catherine has severe anxiety and slight depression that both will play a role in her treatment.
Treatment acceptance or resistance: Catherine is admitting herself into treatment; she feels she needs treatment in order to make a better life for her son.
Relapse potential: She does not have any coping skills to help with cravings or impulses; she does however agree that her current job is not good for her recovery process.

Recovery/living environment: Catherine’s boyfriend, Brandon, is a threat to her treatment success but she does have support from her mother and her son.

3. Based on Questions 1 & 2, what level of treatment would you recommend for Catherine and why? I would put Catherine in a residential/inpatient treatment center because she has few, if any, coping skills and she uses alcohol and medication together. She has a very high tolerance and drinks daily.

4. Create a problem list for Catherine. List at least 5 problems.
   1. Inability to maintain sobriety outside of a structured facility
   2. Anxiety
   3. Depression
   4. Slight withdrawal symptoms
   5. Still struggles with her eating disorder

5. Create a Treatment Plan for Catherine based on the problem statements.
Client Strengths:
   4. Believes in God and frequently goes to church
   5. Is a very caring and loving mother
   6. Smart & motivated – completed 2 years of community college
Problem 1: Inability to maintain sobriety outside of a structured facility

As evidenced by: Report of daily drinking (about 5 drinks per day)

As evidenced by: Slight alcohol withdrawal symptoms

Resulting in: High Tolerance

Resulting in: Fights at work with clients

Goal: The patient will learn skills necessary to maintain a sober lifestyle.

Objective: The patient will attend three AA meetings each week.

Intervention: Provide a partner to go with Catherine to the meetings by 2/20/2010.

Problem 2: Anxiety

As evidenced by: Prescribed Xanax (uses to overmedicate)

As evidenced by: Claims she drinks to keep from having panic attacks

Resulting in: Panic Attacks (come and go every 9 months – last 3-4 months)

Goal: Client will learn to tolerate and control uncomfortable feelings without using medication.

Objective: The patient will keep a daily log of when she becomes anxious throughout the day and what made her feel that way.

Intervention: In group, have Catherine share what made her feel anxious by 3/1/2010

Problem 3: Depression

As evidenced by: 1-2 episodes in the past 6 months

Resulting in: Poor Appetite

Resulting in: Sleep Disturbance

Goal: The patient will learn to express negative thoughts and feelings to loved ones.

Objective: Have Catherine say three positive things about herself throughout the day.
**Intervention:** Have Catherine log each of the positive things she thought about herself and report them to her counselor by 2/17/2010.

**Problem 4: Withdrawal Symptoms**

*As evidenced by:* Continuous Movements

*As evidenced by:* Restlessness

*Resulting in:* Hand tremors

**Goal:** Client will learn to understand the illness of addiction.

**Objective:** Have the client list 10 positive and 10 negative things that came from their addiction and have them share during group.

**Intervention:** Assign Catherine the homework of making a list of when she was positively and negatively affected by alcohol 10 times and have her share in group by 2/22/2010.

**Problem 5: Struggles with Eating Disorder (Bulimia)**

*As evidenced by:* Reports purging after meals

*Resulting in:* Russell’s Signs (Callus on fingers)

**Goal:** Client will learn to communicate when thoughts of purging occur

**Objective:** Have Catherine engage in activities (15 minutes walk, call her counselor, talk to a friend for 10 minutes, etc.) when she feels the need to purge.

**Intervention:** Have Catherine share with her counselor her thoughts and feelings before and after she engaged in her activity and see if there was any change by 2/25/2010.
Stages of Change
Motivational Interviewing

Stages of Change Model
http://www.uri.edu/research/cprc/TTM/StagesOfChange.htm

- Therapeutic intervention should be matched to the client’s level of readiness.
- **Precontemplation:** is the stage at which there is no intention to change behavior in the foreseeable future. Many individuals in this stage are unaware or underaware of their problems.
- **Contemplation:** is the stage in which people are aware that a problem exists and are seriously thinking about overcoming it but have not yet made a commitment to take action.
- **Preparation:** is a stage that combines intention and behavioral criteria. Individuals in this stage are intending to take action in the next month and have unsuccessfully taken action in the past year.
- **Action:** is the stage in which individuals modify their behavior, experiences, or environment in order to overcome their problems. Action involves the most overt behavioral changes and requires considerable commitment of time and energy.
- **Maintenance:** is the stage in which people work to prevent relapse and consolidate the gains attained during action.
- **Relapse:** is included as a normal part of the change process, in that most people do not maintain change on their first try and cycle through the stages several time before achieving stable change.

Motivational Interviewing
http://www.motivationalinterview.org/


Our best current definition is this: *Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.* Compared with nondirective counselling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counselor is intentionally directive in pursuing this goal.

- Created by Miller (1983). . . . Helps enhance the treatment process and can be used as a stand alone.
- Express Empathy
- Develop Discrepancy
- Avoid Argumentation
- Roll with Resistance
- Support Self-Efficacy
Multifamily Groups


The Parents Bills of Rights and Responsibilities

Bill of Rights (Robinson, Newby, & Hill, Manipulating Parents, p.21.)

Parents have a right to:
1. Raise their children as they see fit
2. Preside in the family
3. Enjoy their children
4. Influence their children
5. Expect service from their children
6. Have their own lifestyle
7. Make mistakes in childrearing

Bill of Responsibilities (Sterling T. Shumway, Copyright 1995, Parenting Seminar Handout)

Parents have a responsibility to:
1. Provide Unconditional Love
2. Nurture (cultivate, encourage, & support)
3. Provide Basic Physical Needs (food, clothing, shelter, & safety)
4. Instill Positive Values
5. Teach Responsibility and Progressive Self-Reliance
6. Ensure there are Consequences for Life Choices
7. Engender Hope for the Future
8. Practice what they Preach
Renegotiating Parent/Adolescent Relationships: A Process of Differentiation
Sterling T. Shumway, Copyright, 2002

The process of renegotiating a relationship is an effort for parents to maintain some degree of influence (influence that might generate positive change) in an addicted/errant child’s life by attempting to establish a more adult-to-adult interaction with them.

Renegotiating Parent/Adolescent Relationships: A 10-Step Process

1. Get Rid of the Grudge
   Parental grudges are developed over a long period of time and result from the scars of many lost battles. These scars can limit, or even completely block, a parent’s ability to have a positive influence in their children’s lives.

2. Seek and Find Unconditional Love
   Replace the grudge with unconditional love. It is important to note that unconditional love is NOT unconditional acceptance; to the contrary it is the process of loving our children even when we cannot accept their behavior. The key is to detach with love.

3. Metaphorically Send your Child Away to College
   Consider what your relationship would be like with your child if he/she were away at college. How involved would you be in the daily management of their lives? The key is to move to a more macro level of monitoring and discipline. This means to limit the level at which you monitor and manage your adult child and pull back to a less involved position, especially in relation to rules and consequences.

4. Begin Limiting your Battlefields
   The goal of this stage is to limit the number of requests that you make and subsequently the number of consequences that you have to provide. This will help to assure that your battles are limited and that you can WIN them consistently—the battles you select should only be ones you can win!

5. Establish a Written Contract
   A written contract to define the rules and clearly layout the consequences is essential. A contract is the best way to define the “limited battlefields” previously considered and the consequences that must follow. It may be the first opportunity for both parents and adolescents to get clear about expectations and outcomes. Remember, the contract should be worded in a way that puts the responsibility for obeying the rules as a choice the adolescent makes.
(6) Let the Consequences do the Work
This is the stage where parents need to stop the lectures and the over-functioning and let the consequences do the “talking” and the “walking.” This is where the tough decisions are made and the process of learning from the natural consequences of life choices begins. Parents must be willing to allow their children to suffer the consequences of their choices no matter how severe they may be!

(7) Block Reaction-Seeking and Goal-Getting Behavior
Reaction-seeking and goal-getting misbehaviors are the techniques used by our children to back us down. Remember, if their misbehaviors bring more profit than consequence the misbehaviors will continue. As parents it will be our effort to block them from reaching these goals and getting the reactions they seek. This occurs via a process of “extinction.”

(8) Be Consistent, Be Consistent, Be Consistent
Consistency is the “KEY” to extinguishing previously persistent misbehaviors. Putting your child on a variable reinforcement schedule via the inconsistent application of consequences will only prolong your efforts to create a more adult-to-adult relationship. Parents must be on the same page—this is critical.

(9) Hold the Line, Don’t Control the Line
Control and all the frustration that comes with control are what we are trying to relinquish by renegotiating the relationship. Setting up appropriate and limited consequences that can be enforced, whether by us or by the broader system, is the key to “holding” the line.

(10) Seek out Support
Parents, particularly single parents, need support in this effort. Whether from a good parent support group, therapist, pastor, friend, or other family member (not other children), parents will need support and assurance that their efforts will ultimately be successful.
“SEVEN WAYS TO MAKE YOUR RELATIONSHIP
A PLACE WHERE YOU BOTH WANT TO BE” (Shumway, 1998)

1. Salutary Recognition (Greetings): Individually acknowledging each other throughout the day in verbal and nonverbal ways. Verbal greetings can take the form of a simple “hello” or a “hey, how was your day.” Nonverbal greetings such as a hug, kiss, or touch of the hand are just as important, if not more.

2. Small Talk: Talking with your spouse about the things he or she wants to talk about no matter how unimportant you might judge them to be. It’s important that we set aside time to engage in this process—if we don’t, it will never happen. When Small-Talking, you should avoid topics that may lead to tension or argument (i.e., finances, politics, extended family, etc.).

3. Ego-Building Comments (Praise): Praising your spouse for the positive things he or she does and for who he or she is. When your spouse does something thoughtful or nice it is important to praise them for their efforts. Examples might include: “You did a great job handling the finances this month” or “I sure was proud of the way you handled the kids last night.” However, despite the importance of these comments, it is just as important to praise your spouse for who they are—these are comments that our spouses don’t have to do anything to receive. Examples might include: “Wow you’re beautiful” or “You’re nice to be around!”

4. Identity: Finding both an individual identity and a group identity for your relationship. Individual identity is something that each partner uniquely brings to the partnership and is celebrated by the other. The group identity is something that makes the partnership unique e.g., interests, hobbies, shared stories, etc…

5. Exciting Activities: Regularly engaging in activities that both of you find enjoyable and exciting. These activities don’t have to be exotic or expensive, they just require you to block off some time to be together. Activities might include going to the park, going out for dinner or a movie, putting the kids to bed and watching some television together, or just sitting in your car and talking.

6. Expanding Shared Memories: Making an effort to create positive memories within your relationship and then reminiscing about those memories. Looking at old pictures, talking about the crazy things you did when you first met, or just talking about the wonderful time you had last weekend at the lake are all opportunities to build the kind of bond that will last a lifetime.

7. Feedback: Mutual honesty between spouses. There are two important parts to effective feedback: (1) encouragement when our spouse does something well, and (2) being able to express your concern when your spouse does something wrong. Each of these must occur within a relationship where there is listening, understanding, and validation.

Six Essentials to Achieve Lasting Recovery

Shumway, S.T., & Kimball, T.G. (2012) *Six essentials to achieve lasting recovery*. Hazelden, MN.

1 **Hope:** A reawakening after despair. To expect with greater confidence.

2 **Healthy Coping Skills:** The development of skills that allow for more productive coping.

3 **Sense of Achievement and Accomplishment:** Moving beyond the limitations of addiction toward personal achievement.

4 **Capacity for Meaningful Relationships:** Positive support and connection with peers and family.

5 **Unique Identity Development:** The emergence of a unique personal identity.

6 **Reclamation of Agency:** The internal feeling that you have choices in your behavior.

**See the Website: [achievelastingrecovery.com](http://achievelastingrecovery.com)**