LEARNING MADE EASY

2nd Edition

Addiction & Recovery

for dummies®
A Wiley Brand

Identify your struggles and find the support you need

Choose the best treatment plan

Handle slips and relapses with confidence

Paul Ritvo, PhD
Department of Psychology,
York University

Addiction & Recovery

2nd Edition

By Paul Ritvo, PhD

for dummies®
A Wiley Brand

Addiction & Recovery For Dummies®, 2nd Edition

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Introduction

You've likely picked up this book because of addiction troubles, either your own or those of someone you care about. It's immediately important to know that no one is singly responsible for these troubles. We live in an addiction-inducing society. A lot of money is made from addictions. When more people become addicted, more money is made. Despite this, addictions are more treatable now, and the scientific support for such treatments and for what you can do for yourself or for a loved one is more powerful and reliable than ever before.

You may often hear people say that they're battling an addiction. Addiction *is* a life and death battle. There's no compromise with addiction. People with addictions are either becoming less addicted or getting more addicted. But there is another analogy to consider: a journey through life where loving people support those with addiction in finding a natural life-path — a path that is increasingly free of addictions.

First, it's important to destigmatize addiction. Addiction is unfortunately associated with technological progress. As technology progresses, newly developed substances powerfully target pleasure centers in the brain, mostly to ease the pain in those severely ill. As a result, substances have been created that are more accessible, tempting, and frequently used than before. With more technological development, addictive behaviors may increase during the 21st century, and they've already reached alarming levels. Therefore, we scientists, caregivers, and people with addictions must work together to use evidence-based methods to free ourselves from the powerful effects of society, technology, marketing, and the very human drive to consume.

Second, it is important to remember that recovery is an inner journey, and people with addiction often feel alone. In their aloneness, they ache and yearn for healthier states of mind and body. To recover, people with addiction must find inner strength, and often need help in doing so. This book can help those with addiction rediscover and feed inner strengths and recover — so they can reclaim the joys of life as healthy human beings.

About This Book

This book is written for two audiences. It is first and foremost written for people seeking freedom from addiction. You may still be deciding whether you need help and whether you really want to be free from your addiction. You may have already tried to overcome addiction and failed (perhaps many times). But now you *can* effectively do it. *Yes, you can.*

In this book, I inform you of all the effective available options. This book addresses them in language you can understand and with references that take you to the scientific core of reliable knowledge. It helps you determine how big a problem your addictive behavior is. It helps you assess your readiness for treatment and which treatment you're ready for. It describes all the evidence-based professional and self-help treatment approaches including:

- Pharmacotherapies and detoxification treatments
- Psychological outpatient treatments and residential treatments
- Different types of self-help and their likelihood of truly helping
- Treatment programs based on the Alcoholics Anonymous twelve-step model

This book is also written for family and friends of addicted people. In my experience, the family is often first to seek help for a loved one's addiction. This book guides family members in considering treatment options. It provides information and direction on how to communicate with the family member whose addiction worries you. It also provides support and guidance in helping family members ensure their own needs are not neglected despite the desperate needs of the addicted relative.

The book includes specific information for teens and adults, and addresses substance addictions (such as drugs and alcohol) and behavioral addictions (such as gambling and sex). It is organized into five parts and 20 chapters. Chapter titles and chapter subheadings let you know who the particular chapter or section is addressing. I use a minimum of professional and medical jargon. When jargon or medical terminology is used, I highlight and define the terms and mark them as *technical stuff.*

I incorporate many case studies of individuals as illustrations. The identities of these people are carefully disguised to protect confidentiality. In many instances, an individual's story represents a composite of experiences with multiple clients. When these case examples are used to embellish a point and aren't central to the information or guidance discussed, the story is highlighted in a sidebar. Sometimes the case examples are part of a point I'm trying to make. In those cases, you find them in the regular body text. You should consider the sidebars as extra material that you don't have to read if you don't want to.

There is no need to read the chapters in order — instead, start with the chapter that is of most interest to you at the moment. Nor do you need to read the entire book. This is a reference guide on how to recover successfully. You need only refer to the chapters relevant to your needs. But of course, if you want to read the whole book cover to cover, that's best!

Accordingly, start with the chapter(s) of most interest. Most chapters assume that the primary audience is the person struggling with an addiction. However, some chapters are specifically written for the families of addicted persons.

Foolish Assumptions

I assume that if you are still reading this introduction, you are struggling with an addiction yourself and want to learn more about how to be free from your addiction, or you are a family member or friend of an addicted person and are searching for help. If either of these descriptions fits, this book is written for you.

Icons Used in This Book

Throughout this book, I use icons in the margins to quickly identify different types of information. Here are the icons I use and a brief description of their meaning:

TIP

As the name implies, the Tip icon alerts you to pieces of practical information or things you can do to handle your addiction problem.

REMEMBER

The Remember icon highlights information I don't want you to forget.

TECHNICAL STUFF

The Technical Stuff icon is used to indicate that the information in the paragraph is of a technical nature, and you need not read it unless you want to find out more about the professional and scientific aspects of addictions.

WARNING

The Warning icon alerts you to things you should avoid. It is also used to highlight cautionary points about addictions.

CASE STUDY

This icon highlights case studies of individuals experiencing addiction, either themselves or when helping a loved one. These case studies are often set as sidebars to the main text.

Beyond the Book

For some helpful information about how to recognize addiction in yourself or a loved one and some practical approaches to treatment and recovery, check out the Cheat Sheet for this book by visiting `www.dummies.com` and entering the book's title in the search field.

Where to Go from Here

You are not alone in what you're confronting. A lot of people are facing the same problems right now. You don't deserve to be stigmatized in any way. We are currently experiencing a pandemic of addiction. Whether you accept one or another of the evidence-based theories about why this is true, your main concern is, and should be, to get healthier and less inclined to sip, inject, smoke, and otherwise ingest poison.

That is much easier said than done.

My writing of this book humbly reflects the gap between being informed and doing what you know is "right." Whatever you *do* — whether it's during the next five minutes, five days, or five months — that's the hard part. When you read, please know that all that's written humbly acknowledges the hard part.

Not only can addiction or dependence on a substance or a behavior (which seemed harmless) ruin life, we live in an indulgent time where too many try to take the "easy way out." There's no easy way out of addiction, nor toward healthy states of mind and body. Yet it doesn't have to be purposely hard to get healthy, and part of the difficulty is selecting the steps by which meaningful progress is accomplished. That is what this book is about — to find and do the next step of leaving addiction behind, and welcoming health.

You can go straight to whatever chapter is of most interest to you right now. If you're seriously considering treatment, I suggest you review Part 3 to get informed about the treatment options available to you. I also want to draw your attention to Chapter 7, because it helps you get a full understanding of the factors you must address to free yourself from your addiction.

Now, to get started. Against great odds, humans succeed with great achievements. You *can* recover, and with the help outlined in this book, I will help as much as I can.

1 The Hole in the Heart: Detecting Addiction

IN THIS PART . . .

I help you detect the signs of addiction and determine whether you or someone else is addicted. I provide surprising facts about how common addiction is and about the many forms it takes. I especially focus on substance addictions (such as drugs and alcohol) and behavioral addictions (such as gambling, sex, and eating).

One of the challenges is knowing whether your use of a substance or reliance on a behavior is a problem. In this part, I explain the differences among use, abuse, and dependence. I also discuss how costly addictions are — to you personally and to your family.

IN THIS CHAPTER

- Looking at use, abuse, and addiction
- Understanding your personal risk of addiction
- Reviewing treatment options
- Stepping onto the road to recovery

Chapter 1

Addiction: What Is It?

Congratulations on picking up this book and leafing through it. Even if you just read these few words (and no further), remember that *you are on a path*. Just by choosing to pick up this book means you are seeking to find a non-addictive path for yourself or for someone you love. It could be a path that will lead to a rediscovery of your inner strength and inner peace.

Yes, you have probably had highs that feel so good it's hard to describe them. But they are not sustainable in the way you elicited them. You have to find a non-addictive path to getting high and find a gratifying way of living. You may think you have already found one and that all you have to do is tone things down a bit. But it's hard to "tone down" a poisoning — poisons destroy in both small doses and in large doses. Addiction is the poison of everyday life in the 21st century. Why is that true?

Addiction robs you of freedom and control. You may think you *choose* to use and can choose to use less — but just try to stop. See if it's possible. See whether you have control over the addictive substance or behavior you're afflicted with. If you find you do, great. Abstain for a while. Be sure you have the control you think you have. If you don't have control, if abstaining is unthinkable or impossible, read on.

In this chapter, I tell you about the different forms of addictions, emphasizing substance addictions and behavioral addictions. I tell you about how the medical community views addiction and how your personal view, when it's all said and done, is what you'll likely follow. I also provide a brief overview of what the rest of this book provides.

I designed this book to help you understand where you are, right now, in your control over addictions. This understanding can help you find your path to freedom and well-being, and resume true control of your life.

Defining Substance Use, Abuse, and Addiction

You may hear a number of addiction-related terms and it can be confusing as to what exactly they mean. The less confusion around these terms, the better. The clearer your understanding, the more you know about how to get and make use of the help available.

Understanding what addiction is

In 1964, the World Health Organization (WHO) suggested replacing the term *addiction* with the word *dependence* for describing the feeling that, mentally and physically, you *must* use a substance. Your brain and body yearn for it!

REMEMBER

In this book, *addiction* refers to a combined mental-physical dependence where you're irresistibly compelled to use a substance or behave a certain way. Using the substance or engaging in that behavior is so compelling that even knowing you may face considerable harm does not stop you from doing it.

You're addicted when you no longer direct yourself *out* of harm's way. You're addicted when you use substances or engage in behaviors that *put* you in harm's way.

Simply put, addiction causes a fundamental change in your brain. A change that scientists and clinicians are trying hard to understand. But even though this change is mysterious and powerful, when it occurs, certain urges become irresistible. You become so compelled that nothing else matters. It doesn't matter how smart you are, how accomplished, or how physically strong. It's well proven that addiction can happen to virtually anyone.

Mental dependence

Mental dependence refers to associations that develop in your mind between events (called *triggers*) and emotional and physical urges to use the substance or do the

behavior. The triggers are memory traces that are, in turn, set off by other stimuli. They exert a powerful influence on behavior. Moreover, they're not just *in your mind* — through a series of chain reactions, they induce biochemical changes throughout the body.

What is the difference between mental and physical dependence when both cause fundamental chemical changes? The main difference is that the chemical changes brought on by mental dependence are due to mental associations. Simply put, just thinking about getting high changes your chemistry and affects your whole body biochemically so that physical excitement is felt and is compelling.

Physical dependence

Physical dependence, on the other hand, doesn't require any thinking at all. It's simply related to the physical addictive effects on multiple brain chemicals called *neurotransmitters*. The brain adjusts and tries to tolerate the drug. Then you don't feel "normal" or "good" unless you take the substance. Physical dependence describes your brain's physical adaptation.

As explained in Chapter 10, you can detoxify your brain (get rid of poisonous chemicals). You can clear out a physical dependence relatively quickly (several days). However, your mental dependence can last a lifetime. Much of this book is about reducing mental dependence. My goal is to help you direct yourself away from the disaster and cause the mental *imprint* to fade. If you are successful, the imprint fades so completely that you may wonder why you didn't start a new and better life sooner.

For more of the differences between mental and physical dependence, see Chapter 5.

The difference between abuse and dependence

The difference between abuse and dependence is a matter of time and degree. Essentially, *dependence* is associated with tolerance (you need more and more substance to feel the same high) and withdrawal symptoms (you experience substance-specific withdrawal symptoms when you stop using), and *abuse* is associated with a single or continued substance use despite harmful health, social, and financial consequences. The medical criteria for substance dependence and substance abuse are summarized in the following sections.

Medical criteria for substance dependence

From the medical perspective, dependence is defined as experiencing at least three of the following criteria within a 12-month period:

- You experience tolerance to the substance, which is defined as a need for markedly increased amounts to achieve the desired effect, or there's a markedly diminished effect with continued use of the same amount.
- You experience withdrawal, as evidenced by a withdrawal syndrome for the substance or when medications, prescribed to relieve withdrawal symptoms, are discontinued.
- You've taken the substance in larger amounts or over a longer duration than initially intended.
- You've made unsuccessful attempts to cut down or control substance use.
- A great deal of time in activities is spent obtaining the substance (preoccupation with how and when you will get your next fix).
- You neglect or abandon important social, occupational, or recreational activities because of use.
- Your substance use continues despite knowledge that there are persistent or recurrent problems related to your use.

Medical criteria for substance abuse

The medical definition of abuse is experiencing one or more of the following criteria within a 12-month period:

- Your recurrent use of the substance results in a failure to fulfill major role obligations at work, home, or school.
- You use the substance in situations where it's physically hazardous (for instance, while driving a car).
- You have recurrent substance-related legal problems.
- You continue to use the substance despite persistent or recurrent social or interpersonal problems caused or worsened by use (for instance, arguments with your spouse about the consequences of your use).

Nonsubstance or behavioral addictions

Nonsubstance or behavioral addictions are behaviors you engage in that meet many of the same criteria as substance addictions. The behaviors dominate your

life: You feel compelled to do them. Examples are pathological gambling and sex addiction.

When the medical criteria outlined in the preceding two sections are applied to behavioral addictions, the definitions become less clear. You can readily see how a behavioral addiction meets criteria for abuse (such as pathological gambling), but the dependence criteria don't apply as readily with addictions like workaholism, overeating, and excessive sex. Still, tolerance builds up with behavioral addictions. You need to do more and more of the activity or engage in more and more risk in relation to the activity to get the same high. (For more on behavioral addictions, see Chapter 3.)

Your personal definition of addiction

Regardless of all criteria, you know if you have a substance or behavioral addiction. You know it because the actions involved in getting the substance or doing the behavior dominate your life. You may not want to reveal what you know to anyone else, but it's difficult or impossible to hide it from yourself.

Sometimes the line between heavy use and abuse or dependence gets fuzzy. The case examples of Joe and Mark in the following sections may help you find more clarity about yourself.

Case study: Is Joe abusing marijuana?

CASE STUDY

Joe smoked marijuana every day — his first joint was in the morning. Smoking was his way of approaching the day in a mellow frame of mind. Joe was in his third year of college; he'd started smoking marijuana at the end of his sophomore year. He enjoyed college and felt in no hurry to finish, partly because he was still uncertain about what he wanted to do after college. At least, this is how he rationalized taking half the course load he should have been taking in his third year. At this rate, it would take him twice the normal time to complete college.

Joe supplemented his income from a student loan by working as an assistant in the college library on Saturdays and Sundays. He tried getting other jobs, but found that the hours of work conflicted too much with his recreation time. Other than paying for a steady supply of marijuana, he figured he had few financial needs. The student loan paid for tuition and rent. He even had money left over to sustain a pretty simple diet of bread, peanut butter, jam, and an occasional hamburger. The money he made at his part-time job on the weekends financed his drug habit.

Joe was a bit of a loner. He only had a few friends to get together with on Saturday nights. They often went to a bar to play pool and drink beer, and, of course, smoke

a joint or two. During the weekday evenings Joe kept to himself. He rented a room in a house near campus. The other rooms were also rented out to students, but Joe didn't socialize with roommates. What he most liked to do in the evenings was smoke marijuana and listen to music. He rarely got to bed before 2 a.m.

Is Joe abusing marijuana?

Case study: Is Mark abusing marijuana?

CASE STUDY

Mark's situation was very similar to Joe's. Like Joe, Mark smoked marijuana daily, and Mark was also at college. However, unlike Joe, Mark was very outgoing and sociable. He started smoking marijuana at parties (he met his girlfriend at one party). He and his friends usually socialized as a group, sometimes partying at the local dance club and sometimes getting together at fraternity houses. Mark lived at home, so he seldom had the opportunity to host these parties himself. He worked on the weekends, but because his living expenses were low, he could use most of his earnings to buy marijuana.

By his third year, smoking marijuana had become a daily habit. Mark's room was in the basement of his parent's house and so he could sometimes smoke at home without being detected. However, most of the time, he had a few joints in the evenings when he went out with his buddies.

His girlfriend sometimes joined in, but increasingly she complained that she was tired of the parties. They had been fighting a lot lately because she wanted them to branch out and do a variety of activities. Mark didn't want to fight, but he also didn't want to cut back on seeing his buddies and smoking marijuana.

Mark started to experience problems at college in his third year. He rarely got home before 1 a.m., so getting up in the morning became a big problem. He couldn't keep up with a full course load and dropped two classes. He kept his afternoon courses, reasoning that they were scheduled at a more reasonable time of the day. It wasn't long before his parents noticed the major shift in his sleeping pattern. Arguments became increasingly frequent between Mark and his parents, who complained that he wasn't taking his studies seriously. He complained that they were old fashioned.

Is Mark abusing marijuana?

The answer

Both Joe and Mark are abusing marijuana. Because Joe is a loner by nature while Mark has a sociable personality, and because Joe's lifestyle is so closely aligned with his drug habit, the problems he's having with marijuana use may seem less obvious. Nevertheless, both men are abusing marijuana. In both cases, marijuana

use has interfered with school and occupational activities. The adverse consequences are more apparent in Mark's case because his drug use is causing problems with girlfriend and family. Although his parents may not yet know the underlying cause of the shift in his schedule, they have picked up on the problems he's having with meeting school responsibilities. Thus, Mark's drug use may appear more obvious because it's affecting many areas of his life. However, in actuality, both men's drug use meets criteria for substance abuse. In both cases, marijuana use is interfering with them fulfilling their school and occupational responsibilities.

REMEMBER

You only need to have one of the medical criteria for substance abuse to be diagnosed as having a substance abuse problem.

The line between use and abuse can become blurred because of the gradual nature of addiction. It's very easy for you to rationalize substance abuse as normal. The first step toward freedom from addiction, however, consists of taking an honest look at how the substance use is affecting your life.

The Role of Experimentation

Drug use typically begins with experimentation. ("Hey, try this. It will make you feel so good!") When young, saying no is hard. It may seem okay to experiment, but make it a truthful experiment. Ask yourself how you truly felt after your experimentation.

WARNING

All people with an addiction started by experimenting. No one sets out thinking about becoming addicted. However, substance use affects brain chemistry beyond your ability to detect. You don't realize your brain is changing just as you may not realize that your liver is changing. Before long, experimentation becomes dependence. After a while, dependence becomes addiction.

Assessing Your Addiction Risk

The first step toward getting help is recognizing the problem. Part 2 of this book focuses on recognizing and assessing your addiction risk and what parents and friends can look out for. It also discusses many social influences that may influence you to experiment with substances and behaviors. (See Chapter 4 for information on the social influences.) Knowing what may have led to your addiction problem can help you avoid relapse following treatment. If your use hasn't progressed to abuse and dependence, this information can help you avoid developing a prolonged problem.

Warning signs of addiction

The defining sign of addiction is that you feel compelled to use a certain substance or do a certain activity. In Chapter 5, I provide a tool that assists you in assessing the likelihood you're addicted. I also discuss the risk factors for developing an addiction problem. Following are some factors you need to be aware of:

- **Your family history:** The attitudes, behaviors, and genetic vulnerabilities you inherit and pick up from your family render you more or less susceptible to developing an addiction problem.
- **Your willingness to experiment with risky behaviors:** If you're a risk-taker by nature, you're more likely to experiment with drugs. Experimentation is always the first step and it may be a slippery step.
- **Your mental states:** If you have problems controlling negative mood states like anxiety, depression, and anger, you're more likely to use substances (for instance, alcohol) or addictive behaviors (for instance, overeating) to regulate moods.
- **Your choice of drugs:** Some drugs are more addictive than others. (Check out the addictive potential of different substances in Chapter 5.)

A comment for families and friends of the addicted person

Families can often sense that something is wrong without knowing the specifics of the problem. In Chapter 5, I provide an assessment tool that helps family members and friends determine whether a loved one is battling an addiction. Uncharacteristic and negative changes in moods and social habits are important clues. But ultimately, the only way of getting to the bottom of the problem is to have a sincere talk with your loved one.

WARNING

Be careful not to enable your loved one's addiction. Family members want to protect the addicted person and reduce potential harm. This may take the form of bailing your loved one out of jail, offering housing, or ensuring proper nutrition. All these actions, although they reduce the immediate harm, can enable continued substance abuse. Helping your addicted relative prevents the person from hitting bottom. Harm reduction efforts are important, especially when addiction treatments have repeatedly failed. However, be mindful of the fact that your good intentions may be contributing to continued addiction behavior. Get good advice from professionals about how to best handle addiction in a friend or family member. In Part 2 of this book, I talk about addiction treatment options. In Chapter 18, I provide specific information for family members and friends.

TIP

Look after your own needs. A friend's or family member's addiction problem can quickly dominate the lives of other people like you. Moreover, family members and friends can quickly become discouraged by the repeated failures in efforts to stop the addiction. Thus, you need to look after your own needs. In Chapter 18, I provide information on how to protect your own welfare when battling the consequences of a friend or relative's addiction.

Exploring Methods and Models of Treatment

Do I have an addiction problem? Am I ready for treatment? Do I need to be hospitalized to safely withdraw from a substance addiction? After I've kicked the physical dependence on the substance, can I kick the mental addiction on my own? What are my treatment options? Who typically undergoes this or that type of treatment? What treatment options are available on an outpatient basis and which involve residential stays? What are some of the myths about overcoming an addiction? When are self-help treatment approaches helpful?

These and other questions are addressed in Part 3 of this book. Fortunately, a wide range of treatment methods and models are available to assist you. A few of these are previewed in the following sections.

Treatment centers and professional help

Shame and stigmatization about the addiction is the major barrier to seeking professional help. Most likely, you've tried to quit and even sought advice from trusted advisers (friends, family doctor, minister, priest, or rabbi) before seeking professional help. Unfortunately, many advisers don't have enough knowledge or resources to help you withdraw. Nor can they provide treatment for the mental aspects of addictions. However, they're often a good resource for learning about specific addiction treatment options in your community.

In some situations, you may not be seeking help on your own. Rather, it's your family or employer who is confronting you with treatment options. Thus, your initial exposure to treatment may not have been the treatment of your choice.

TIP

You must want to change to successfully recover. No amount of external persuasion will help overcome an addiction if you don't want to change. After you do get to the point of seriously engaging with treatment, seek out the treatments most suited to your needs.

Things to consider when deciding on your treatment

Many treatment options are available to you. What you choose depends on a number of factors:

- Can you afford the time and money it takes to go into a residential treatment facility? Most require a minimum stay of 28 days. Can you afford not to?
- Residential treatment centers offer some advantages over outpatient programs. They get you away from many of the social and environmental triggers for your addiction. You're exposed to treatment information from the professional staff and from peers within the center. Your peers can share their firsthand experiences about what has and hasn't helped them, and they can be an unconditional source of support.
- Overcoming addiction is often easier than staying substance- or behavior-free over the long-term. Relapse rates are alarmingly high. The mental aspects of addictions are harder to treat than the physical dependence. Addictions affect every aspect of life and triggers are hidden deep within your family and social environments. Therefore, consider a variety of options for help.
- When it comes to treating addictions, take a variety of approaches. Most treatment options allow you the freedom to combine different approaches.
- Abstinence is usually the goal of treatment. In some cases controlled use is possible. Chapter 9 provides information on controlled drinking approaches.

WARNING

If you are physically dependent on a substance like alcohol, controlled use is not an option for you. Your treatment goal must be abstinence.

The twelve-step program and other self-help approaches

Almost everyone has heard of the twelve-step program of Alcoholics Anonymous (AA), but you may not know everything about what twelve-step programs involve. The AA twelve-step program is perhaps the most common treatment model for overcoming addictions. Although it started as a peer-support treatment program for alcohol addiction, it has rapidly proliferated as a treatment for both substance and nonsubstance addictions. You can find an AA program in virtually every community. Many AA groups address multiple types of addictions, so you may not need to find a specific group for your particular addiction. I devote a whole chapter (Chapter 11) to describing the twelve-step program. I also include a self-assessment tool to help you determine whether the AA twelve-step treatment approach is likely to work for you.

REMEMBER

Self-help approaches generally aren't sufficient to help you overcome addiction. You may well need to start with a residential treatment approach early in your recovery program. You can also consider combining various treatment approaches. Because addictions affect every area of your life, you may also need psychotherapeutic approaches to help you unravel the emotional and social aspects of your addiction problem. Chapter 8 provides information on some of the psychotherapy approaches to treating addictions.

The Ins and Outs of Recovery

As you begin the journey of recovery (whether it is the first time or the umpteenth time), I hope that this book will help you find the means to free yourself from addictions.

The treatment of addictions involves both getting clean and restoring a normal way of living. Therefore, recovery means not just abstinence from the addiction, but also repairing the damages that the addiction has brought to your life and addressing some of the vulnerabilities in your emotional makeup and social background that rendered you susceptible to addictions. Effective recovery, therefore, also means building awareness and strategies to resist your triggers. In Part 4 of this book, I focus on these recovery topics.

Overcoming fears and obstacles to recovery

What does it mean to enter treatment? What will your friends and colleagues think? How will you cope with the loss of comfort you associate with the addiction? You need to be aware that your anxiety, shame, anticipated loss, and other issues will act as barriers to getting help for your addiction. Chapter 15 provides guidance to you in overcoming these barriers to change.

Remember that solutions you use to deal with your addiction will also need to address the specific issues in your social and psychological environments that present barriers to successful recovery.

What to do if you slip

REMEMBER

You need to know that recovery is a work in progress. As you repair and rebuild your life after an addiction, you will come face-to-face with temptations and triggers to slip back. You may slip off the wagon once, twice, thrice, or more, but slips are just temporary lapses in your recovery process. Look for what you can learn

from the situation. For example, a longer passage of time of abstinence between slips is positive feedback. Thus, learning about your triggers (when you feel down, for example) can help you plan how to handle the same situation (trigger) more effectively next time. Chapter 16 provides specific guidance in handling slips and relapses.

How to relate to family, friends, and colleagues

By the time you find yourself in treatment for an addiction, a lot of hurtful things have probably been said and done by you to your family as well as by your family to you. If these relationships can be mended, your recovery may proceed more effectively. Therefore, I encourage you and your family and friends to consider actively participating in the forgiveness process. Chapter 17 deals with handling these relationships in recovery.

Recovery can also be a time for the start of new relationships. You've seen the damage that addictions can do to intimate relationships. You may feel anxious about when to trust yourself enough to start a new relationship. You may have questions about how much to disclose to new friends. These and related issues are addressed in Chapter 17.

REMEMBER

Many successfully recovered people liken their process to a rebirth. It's normal and natural for you to seek new friends and relationships. Frequently, you may connect with others you meet in peer group therapy settings.

What family and friends can do

Addiction isn't just the problem of the person battling addiction. The personal problems cause collateral damage to family, friends, and colleagues. Thus, many sections of this book provide tips for friends and family. Chapter 18 focuses specifically on guidance for families and friends.

IN THIS CHAPTER

- Discovering how addiction works
- Looking at different types of substances and their effects

Chapter 2

Substance Use, Substance Abuse, and Addiction

Substance use is part of our heritage. Humans have experimented with mind-altering substances throughout recorded history. As far back as the 6th century BC, a Persian king was identified as an alcohol-abuser. In this chapter, I discuss current *substances of abuse* — those that people use to alter their minds. First, I go over the basics of how drugs and alcohol destabilize and disrupt the body. Then, I present an in-depth list that covers most of the substances abused today that can be tempting, confusing, and destructive.

The Basics of How Substances of Abuse Work

TECHNICAL STUFF

Substances consist of molecules — the smallest analyzable unit — and these molecules affect your brain as *active ingredients* (which readily cross the blood/brain barrier) or *buffers* (chemicals that neutralize or reverse active drug effects) or *fillers* (chemicals with little apparent effect). While the active ingredients of

most drugs and types of alcohol are relatively well-known, what's less known is how they combine over time to leave a detectable imprint in the brain and body. This imprint consists of a complex set of neurophysiological events that render your mind and body beyond your control. This imprint also helps in understanding cross-addictions, where people successfully cease abusing one drug to fall into abusing another. While this is discouraging, an understanding of cross-addiction helps limit and destigmatize abuse. Let's take a closer look.

In an initial addiction or dependency imprint, a need develops in the brain for an external stimulus (a chemical or behavior) required to operate normally. This perceived need (or addictive imprint) fades with withdrawal, but enough remains so that perceived "needs" are often transferred, optimally to a less toxic substance (coffee) or behavior (jogging). However, the imprint remains and can rapidly become a "slippery slope" when even minor instabilities in lifestyle result in recurrent addictions (or dependencies).

I'm not suggesting the imprint never fades, but it fades incrementally and remains surprisingly strong for years later. I've seen successful individuals attend a smoking cessation program and describe a 40-year period of abstinence. Then, they decide to try one more cigarette and return to a two-packs-per-day addiction.

The imprint created can be explained by the active ingredients in drugs and alcohol (and behaviors) that are *psychoactive,* meaning they influence mental activities like thinking, memory, and the processing of sensation. Psychoactive reactivities also affect breathing and the beating of our hearts. The body is so sensitive and so dynamic that we can assume that when we consume a substance, be it health-inducing or toxic, we're changing our brains in one way or another. While psychoactive substances frequently exert *mildly* psychotoxic effects, it's a matter of dose, timing, and combination. The same substance taken during a depressive episode in combination with other noxious substances can be fatal.

REMEMBER

Addiction occurs when, due to tolerance, you need more of a drug or behavioral engagement to get high (or equally high) and you suffer withdrawal when the blood levels in your body drop. Add these biochemical changes to the losses of control that invariably happen when you consume these substances (when you feel controlled by the drug instead of vice-versa), and you realize the price being paid for every intake.

The Drug Lineup

In this section, I discuss the most commonly abused drugs. The major categories include: sedatives, stimulants, narcotics, psychedelics, anti-anxiety and antidepressant drugs, volatile hydrocarbons, dissociative anesthetics, and steroids.

As I discuss the menu of available substances, remember that *all* are dangerous. When you choose to ingest any of these, you are deliberately leaving the map of human safety and caution. Maybe you're doing it because life has felt too cautious up till now. Maybe you've felt unsatisfied or injured. But you need to be clear about the risks, as some substances and behaviors are distinctly more dangerous than others. Exactly *how* dangerous depends on the dose and on your immediate health. Keep in mind that the less sure you are of what you're taking or doing, the more vulnerable you are to a range of uniquely personal reactions — some people have big reactions to even small amounts of a substance (due to genetics, allergies, and other sensitivities).

TECHNICAL STUFF

You may see reference in the addictions field to *controlled substances.* This term refers to the legal status of certain substances. Typically, nicotine and caffeine aren't designated as "controlled" because they've been used for a long time and have become socially acceptable. However, their social acceptability does not account for how addictive they are.

Marijuana (THC)

Marijuana, or cannabis, comes from the hemp plant *Cannabis sativa.* To best estimates, it has been used for mind-altering and medicinal purposes for 12,000 years. The mixture of dried leaves can be green, brown, or gray in color. Marijuana's key chemical is THC or tetrahydrocannabinol; however, more than 400 other chemicals are present as well.

Marijuana is consumed in multiple ways, but it is most often smoked or vaped, brewed in a tea, or mixed into food (such as brownies). Where cannabis is legalized or decriminalized, candies (soft or hard) are mass-produced for consumption and are sold with information regarding dose.

The addiction potential of marijuana is being actively researched. Addictive interactions often revolve around the release of the neurotransmitter *dopamine*. Substances that cause greater amounts of dopamine release are considered to be the most addictive. It's already clear that the THC-related dopamine release is significantly less than with other psychostimulant agents like amphetamine.

REMEMBER

Aside from the addictive potential, the psychological dependence effects of marijuana are firmly established and can become significant over time. You may feel you need marijuana to relax. But keep in mind that using marijuana to relax rather than other methods can result in increasing dependence, which means you may need ever-increasing doses to overcome tolerance. You may also experience negative emotions associated with withdrawal, including feelings of lethargy and reduced motivation that affects your functioning at work, school, and home.

Sedatives and tranquilizers

Sedatives and tranquilizers are *depressant* drugs (they slow and limit brain function). Sedatives are often used for sleep-assistance, relaxation, and anti-anxiety calming effects. Tranquilizers are more often used for their anti-anxiety effects.

Alcohol

Ethanol is a particular form of alcohol produced by fermented foods and grains. The most common sources are barley, hops, grapes, and potatoes. Other available alcohol types are highly poisonous even in small quantities. These include methanol (usually found in glass cleaners), isopropyl alcohol (rubbing alcohol), and ethylene glycol (automobile antifreeze solutions).

TIP

In this book, when I refer to *alcohol*, I solely means ethanol.

Alcohol depresses the actions of the brain, causing progressive impairment and a reduction in the signaling flow altogether. In addition to disinhibition, the most common effects are memory loss (sometimes as extreme as complete blackouts), confusion, disorientation, uncoordinated movement, lethargy, coma, and respiratory shutdown (which can be and often is fatal).

Alcohol, although legal in most countries, has roughly about the same addiction potential as cocaine. Surprised? Unfortunately, the legal status of a drug is not yet based on its addictiveness. Tobacco, another highly addictive substance (even more addictive for lab animals than cocaine), is also legal.

Pharmaceutical sedatives

Sedatives are usually prescribed for sleep and anxiety. These drugs should be used only over a short-term (five to seven days) because they carry significant risks for dependence and tolerance. Over the longer-term, use of this class of drugs will likely bring on irritability, lethargy, decreased motivation, vivid and disturbing dreams, nausea, headache, skin rash, tremors, a change in appetite (loss or increase), and sexual impairment.

The commonly known pharmaceutical sedative drugs are Valium, Librium, BuSpar, Equanil, Miltown Serax, Klonopin, and Halcion. These substances, known as benzodiazepines, are taken by mouth in pill form and give many a welcome sense of relaxation and well-being. They also lead to drowsiness, confusion, slurring of speech, and memory problems. Methaqualone (Quaaludes, Sopor, Parest) became, at one time, a popular party drug although it has most recently fallen into disfavor.

DATE RAPE DRUGS

Two drugs in the pharmaceutical sedative class are known as "date rape" drugs because of their properties (colorless, odorless, only slightly salty), their knockout potential, and the effects on memory.

- GHB (also called *Georgia Home Boy* or *grievous bodily harm*) is a sedative-hypnotic that causes sleepiness and dizziness. With an overdose, there is a loss of consciousness. Combining this drug with alcohol is particularly risky because breathing can become dangerously slow. The primary effect occurs between 10 minutes and 1 hour after ingestion, but it can last 2 to 3 hours with residual effects for as long as 24 hours.
- Rohypnol (often called *Roofies*) is the brand name for a benzodiazepine (flunitrazepam), which is much stronger than Valium (diazepam). Sedation occurs usually within 30 minutes after ingestion and lasts for several hours. Roofies, like GHB, are dangerous when taken with alcohol. If you ingest this drug, chances are your memory will be impaired, and when the drug effect wears off you may have difficulties remembering where or when you took it and what happened afterwards.

WARNING

Sedatives have a high addiction potential because they're short-acting and tolerance builds quickly (requiring more drug to get the same mind-altering effect).

Barbiturates

These drugs include mephobarbital (Mebaral) and pentobarbital sodium (Nembutol). They're used for sleep disorders. Acting on the GABA neurotransmitter system, they slow brain activity, thereby producing a calm feeling. Like all depressants, they have a potential for tolerance, physical dependence, withdrawal effects (watch out for seizures), and, ultimately, addiction.

Barbiturates are controlled substances because of their high addiction potential. They effectively numb your mind although, over time, higher and higher doses are required to achieve similar effects.

Stimulants

Stimulants are a class of drugs that increase alertness and physical activity. They include amphetamines (pharmaceuticals such as Dexedrine and Biphetamine also known as *speed*), methamphetamines *(meth, chalk, ice, crystal, glass)*, and cocaine *(blow, bump, coke, Charlie, rock, snow, toot)*. If you start using these drugs, chances are high that you'll develop intense cravings for more.

Stimulants may be taken in different forms: swallowed, snorted, smoked, or injected. Injecting stimulants is the riskiest method (due to needle infections) and swallowing is the safest— from the immediately physical viewpoint, at any rate.

Stimulants increase heart and respiration rates, increase blood pressure, *dilate* (expand) the pupils, and decrease appetite. The last side effect was once a sought-after attribute of stimulants in their use as weight-loss drugs. Now we know there are much safer and less addictive drugs with appetite suppression properties (such as Liraglutide).

Amphetamines

Amphetamines are psychologically addictive because people become dependent on taking more to avoid feeling the depressing withdrawal. If you suddenly stop using the drug, you end up tired, sleepy, irritable, and depressed. The severity and durations you experience these effects vary depending on the degree of abuse. (See Chapter 10 for more information on withdrawal effects from these substances.)

Cocaine

Cocaine hydrochloride is a white powder derived from the leaves of the coca plant. Cocaine used to be sold over the counter in many forms (yes, in Coca Cola). Crack cocaine is made by altering cocaine powder into crystals or *rocks* that can be smoked. Cocaine is short-acting (the effects peak after 15 to 30 minutes), so users are very motivated to periodically get another hit to maintain the buzz. Cocaine is highly addictive.

Psychedelics

We often think of psychedelics as current drugs, but for thousands of years, psychedelics have been used by people for far-ranging journeys inside their own minds. Psychedelics can profoundly distort reality.

TECHNICAL STUFF

Our five senses — sight, hearing, taste, touch, and smell — are distorted by psychedelics with particular effects on perceived time and space. These drugs disrupt multiple neurotransmitters, with the most recent hypotheses focused on the 5-HT2A receptor, although competing and complementary theories focus on the NMDA receptor. If this sounds complicated, that's because it is. The simpler and most useful point is that psychedelics are making a comeback as effective antidepressant and anxiolytic drugs. Some of the most exciting findings pertain to their use in treating drug abuse. It may seem strange that so-called recreational drugs are now used therapeutically, but gratefully we've said farewell to the costly errors that led to the recreational labeling in the first place. These are serious

substances — psychedelics can have life-altering effects in the course of a few minutes or hours of a psychedelic-affected experience.

Some psychedelics come from plants, but most are now synthesized and manufactured. Mescaline comes from the cactus plant called peyote. Psilocybin comes from mushrooms often referred to as *magic mushrooms* (or *shrooms* for short). LSD (lysergic acid diethylamide, also known as *acid*) and a dissociative anaesthetic, PCP (phencyclidine or *angel dust*) are also widely available synthetic psychedelics.

Yet another psychedelic is called 2C-B (bromo, nexus, spectrum), which was developed in the 1970s with one effect being to make one feel more "in touch" emotionally. When on this drug you may readily experience certain erotic sensations as well and feel acutely responsive to music and color. The drug 2C-B is taken orally in pill form. Although generally well-tolerated (nausea and chills are the main side effects), there is a greater tendency for a bad trip than with psilocybin, MDMA, and LSD.

The abuse potential of psychedelic drugs can be high because the experiences are exciting and some want to re-experience the excitement until, of course, a bad trip unfolds. What's a bad trip? It's a downward spiraling of mood with severe projective effects. Instead of an upsetting mood or emotion being somewhat transparent, as it often seems when not drug-affected, it can seem like the only reality that exists and could exist.

If you value self-control, it's unlikely you'll want to gamble in this way about having a good versus a bad trip. Current experimentation with psychedelics involves careful preparation; counseling before, after, and during the trip; strict protocols; and the use of pure substances. Under these conditions, no one is guaranteed a "good trip," but when there is a bad trip, it's explored and resolved therapeutically, with highly skilled and experienced counselors.

WARNING

If you use LSD or another psychedelic, you may experience *flashbacks* — a repetition of earlier psychedelic experiences. Flashbacks are unsettling because they are frequently beyond your control. Flashbacks can occur later in life and seem to be set off by past associations. A similar experience has been reported by people with post-traumatic stress when reliving their trauma. In a flashback, you have to redirect your attention to the present and relinquish the current state of mind. Flashbacks are a significant concern if they occur when you're driving or in other situations where distractions can result in highly elevated risks.

As stated, psychedelics are now being researched rigorously for potent effects in reducing depressive and traumatic stress symptoms. Ecstasy (MDMA, also called *Adam, Eve, STP, and X*), for example, is one of these mood-elevating psychedelics that has been shown effective in treating individuals with post-traumatic stress. MDMA takes effect 20 to 40 minutes after ingestion, causing mood elevation and

exhilaration (and often nausea). You may feel more empathy for others and an enhanced feeling of warmth and self-acceptance. For this reason, MDMA is sometimes referred to as a love drug.

WARNING

Using MDMA on your own (and not in a medically supervised treatment protocol) carries two main risks. The first is contamination with other drugs during manufacturing (everything from amphetamine to PCP). Some fillers create toxic effects. The second risk is the tendency of users to overheat from exertion (for instance, dancing) and insufficient hydration. In extreme cases, these effects, individually or in combination, can result in serious illness and death.

Opiates and narcotics

Heroin and morphine are the most common drugs in the opiate group. Heroin (*smack, horse, junk,* and *dope*) is made from the opium poppy and is a white or brownish powder (or a brown sticky substance known as *tar*). Heroin is typically cut or mixed with other white powder additives.

Heroin is snorted, smoked *(chased),* or injected (the most common route). After ingestion, you may feel a sense of euphoria, contentment, well-being, and warmth.

While morphine is mainly a pain medication, it's used recreationally. It can be taken orally, sublingually, via inhalation, and by injections into muscle, under the skin, and intravenously. Its maximum effect is reached about 20 minutes after intravenous injection and after 60 minutes when administered by mouth, with a duration between 3 and 7 hours.

As heroin and morphine are analgesics, the side effects that are predictable are nausea, vomiting, itching, and slowed breathing.

Two other powerful painkillers, oxycodone hydrochloride (OxyContin) and hydrocodone bitartrate (Vicodin), are now increasingly popular abuse substances. OxyContin is a controlled-release drug that provides about 12 hours of pain relief. The drug has a very high potential for abuse because the more you take, the better you feel. People who abuse OxyContin avoid the controlled release by chewing, snorting, or injecting the drug to intensify the high.

WARNING

There has been a troubling increase in reported abuse of OxyContin and Vicodin in high school students and the general population (at all ages). Parents, grandparents, and other adults should keep a close eye on medicine cabinets when anyone is taking these drugs.

Opiates, particularly the newer painkillers described here, have an extremely high addiction potential. These drugs seem to pull you back to chasing the high previously experienced. The tolerance effects ensure that you will need to use more and more to get to the same state.

Dissociative anesthetics

Drugs such as phencyclidine (PCP) and ketamine *(Special K)* were developed as general anesthetics. They produce distortions in both sight and sound and a general feeling of detachment (you feel far away from your body). Dextromethorphan, a widely available cough suppressant, when taken in high doses, can produce effects similar to PCP and ketamine. Nitrous oxide, sometimes known as *laughing gas,* is also a member of this same category of substances.

TECHNICAL STUFF

Ketamine, PCP, and dextromethorphan work by preventing a neurotransmitter, glutamate, from attaching to receptors in the brain. Glutamate is involved in the perception of pain, responses to the environment, and memory. Although low doses of these anesthetics increase heart rate, higher doses can depress consciousness and breathing. Combining this category of substances with alcohol or other sedatives is extremely dangerous.

TIP

It is important to inform you that like psychedelics, ketamine, although sometimes used as a recreational agent, is now being reinvestigated as a potent anti-depressant and anxiolytic agent. It is sometimes confused with being a psychedelic due to its disruptive effects on typical brain-behavior routines and habits. But it is not a psychedelic and thus not subject to the same legal restrictions. See Chapter 13 for more about the potentials of ketamine in recovery, especially as an alternative treatment.

Dissociative anesthetics carry the risk of extreme psychological dependence. They separate your perceptions from sensations, which can make it difficult to physically move in this state. You may experience a sense of vulnerability. In fact, you *are* vulnerable to outside dangers because of your immobility.

Anti-anxiety and antidepressant drugs

Anti-anxiety and antidepressant drugs are aimed at controlling negative emotions, such as anxiety and depression. Antidepressants subdivide into the selective serotonin reuptake inhibitors (SSRIs) that include Prozac and Zoloft, and the selective serotonin and norepinephrine reuptake inhibitors (SNRIs) that include Effexor and Cymbalta. The key action is to alter the reuptakes and availability of serotonin and norepinephrine. They have powerful effects designed to change your negative moods.

TECHNICAL STUFF

Serotonin is a neurotransmitter. "Selective reuptake inhibitor" in SSRI means the drug is designed to pick out this particular neurotransmitter — serotonin — in your brain. To inhibit the reuptake of serotonin, the drug works by taking the spot on the brain receptor where the serotonin usually goes. This means that there is more serotonin available in the synapse, and the chemical transmission of the nerve signal is enhanced. The same process affects the reuptake of norepinephrine, again enhancing the chemical transmission of nerve signaling.

Antidepressant drugs aren't known as drugs of abuse because they produce a physical dependency much more slowly and gradually. They help restore normal mood states via their effects on the neurotransmitter system of the brain. While these effects aren't downright addictive, they are habit forming. It is not unusual for a person who becomes accustomed to antidepressant drugs to have substantial difficulties withdrawing from antidepressants, although "weaning" protocols can be helpful.

Anti-anxiety drugs, on the other hand, result in tolerance and dependency and are addictive. They have the mind-altering effects described earlier in the chapter in the "Sedatives and tranquilizers" section. Thus, the addiction potential of anti-anxiety drugs is considerably higher.

Volatile hydrocarbons (inhalants)

Volatile hydrocarbons *(inhalants)* are breathable chemical vapors that produce mind-altering effects. Several products found in the home and workplace contain psychoactive substances that can be inhaled to get high. On the street, this activity is known as *huffing*. Inhalants fall into three main categories: solvents, gases, and nitrates.

Inhalant abuse is most typical in younger people, most frequently in grades seven to nine. Initially, more females than males use inhalants. Males start using with increasing numbers later during the high school years and may sustain the use well into their twenties.

Inhalants differ in makeup but work much like anesthetics. They slow down your body's functions and numb the brain. Inhaled through either your nose or mouth into the lungs, these substances cause you to experience short-term intoxication.

Inhalants can be very dangerous. The primary risks are cognitive impairment, brain damage, and other neurological (nerve-related) problems. If you've been inhaling over a long period, you may eventually start losing consciousness during your inhaling. Also, huffing concentrates chemicals that can directly induce heart failure and sudden death within minutes of use (this is known as *sudden sniffing*

death). This is typically associated with the abuse of butane, propane, and aerosol chemicals. Over time, the liver and kidneys can also be damaged.

WARNING

Using inhalants by way of a plastic bag increases the chances of suffocation. Suffocation occurs as the substance replaces oxygen in your lungs, resulting in oxygen debt and leading your brain to shut down.

Solvents

Many people don't realize that solvents can be used for intoxication. These substances include industrial and household solvents such as paint thinners, paint removers, degreasers, dry-cleaning fluids, gasoline, and glue. Other solvents that may be abused are office supplies, including correction fluids, felt-tip marker fluids, and electronic contact cleaners (the cleaner used to clean computer keyboards and screens). These substances have addictive potential primarily because of easy access and their powerful effects in numbing the person who is trying to escape the realities of life.

Gases

Gases include household and commercial products such as butane lighters, propane tanks, whipping cream aerosols, and refrigerant gases. Household aerosol propellants and associated solvents include spray paints, hair spray, deodorant sprays, and fabric protector sprays.

Medical anesthetic gases include ether, chloroform, halothane, and nitrous oxide *(laughing gas).* Nitrous oxide is the most commonly abused of these gases and can be found in whipped cream dispensers and products used to increase octane in racing cars.

Nitrates/poppers

These substances range from the aliphatic nitrates including cyclohexyl nitrate (an ingredient found in room deodorizers), amyl nitrate (used medically), and butyl nitrate (previously used to manufacture perfumes and antifreeze but now illegal).

Nitrates act primarily to dilate blood vessels and to relax the muscles. They're often used to enhance the experience of sex or before sporting events to reduce stress. On the street, ampules of amyl nitrate and butyl nitrate are known as *poppers* or *snappers*.

Volatile hydrocarbons, altogether, have a high addiction potential because people build tolerance to them over time. Psychological dependence also builds because users may start to count on the substances to avoid reality.

WARNING

Recent research suggests the possibility that the abuse of nitrate inhalants may increase the risk of infection or tumor growth because the body becomes less resistant to disease.

Steroids

Many men, particularly young men, want to develop bodies like bodybuilders. How to do it? Well, steroids are synthetic substances that have a similar chemistry to the male hormone testosterone. The most common names of anabolic (muscle-building) steroids are anadrol, oxandrin, dianobol, winstol, deca-durabolin, and equipoise. The street names of steroids include *roids* and *juice*.

Testosterone is an important male sex hormone that both promotes muscle growth (the anabolic effect) and develops male sexual characteristics (the androgenic effect). So anabolic-androgenic steroids (often referred to as anabolic steroids) are drugs that work like testosterone.

TECHNICAL STUFF

Anabolic steroids were originally developed to treat a condition known as hypogonadism, in which the male's testes don't produce enough testosterone. Steroids also have some limited legitimate medical uses for people with certain types of anemia (loss of red blood cells), and systemic lupus erythematosus. But steroid abuse has nothing to do with these conditions.

Some steroid users pop pills, but others inject the drug directly into muscles. Most users take doses that are 10 to 100 times larger than those that may be legitimately prescribed by physicians.

Steroids are primarily psychologically addicting because of their muscle-building effects. If you use steroids, you will probably feel stronger and gain muscle bulk. But remember, you're putting yourself at risk for cancer, liver disease, and unfortunate sex changes (shrunken testicles for males and male sex characteristics for females). These effects may be irreversible and may take years to develop.

WARNING

Steroids affect your secondary sex characteristics. Males may experience shrunken testicles, the growth of breasts, and reduced sperm count. Females may grow facial hair, develop a deeper voice, and grow excessive body hair. All users are prone to acne, hair loss, tumors (usually liver tumors), and violent, angry mood swings — rampages. Scary stuff!

IN THIS CHAPTER

- Looking at compulsive gambling
- Understanding sex addictions
- Reviewing addictions related to computer and Internet use
- Exploring food addiction
- Working on work addiction

Chapter 3

Behavioral Addictions: Addictions Without Substances

This chapter focuses on actions that become addictive. I explain how emotional problems (like loneliness, depression, and anxiety) underlie behavioral addictions, and increasing isolation, secrecy, and self-destructive behavior.

TECHNICAL STUFF

Behavior refers to how you act, think, and emote. It's scientifically studied in psychology. Behavior is invariably linked to your *physiology* (bodily processes). *Behavioral addictions* refer to actions that are beyond control and dominate your attention, thoughts, and emotional life. Interruptions of these actions produce withdrawal symptoms similar to those experienced when withdrawing from substances.

Behavioral addictions can be even more destructive than substance addictions. Some, like compulsive gambling, are associated with a significant risk to life (via suicide), but all involve extremes that disrupt lives and sometimes the lives of entire families. Like substance abusers, people with behavioral addictions prefer activities that are linked to experiences of pleasure, excitement, and apparent success.

Behavioral addictions take up a great deal of time, and tremendous amounts of energy. More than anything, they undermine relationships. Your addictive behaviors can be so dominating that they get in the way of relating, in a trustworthy and meaningful way, to anyone else.

REMEMBER

An *obsession* involves not being able to stop thinking about something, and a *compulsion* involves not being able to stop doing something. When a behavior becomes obsessive or compulsive, you're driven to think or act beyond control.

Some General Advice

We all act automatically sometimes, but we have control mechanisms that limit such automatic behaviors. When you have a behavioral addiction or are developing one, you find these controls oddly absent. You know cognitively that you're going beyond what's healthy and reasonable, but you just keep going to the point of disruption and ill-health.

This does not indicate a genetic or character weakness so much as an underlying problem that isn't being treated effectively. More powerful treatment and more personal effort are required. Like most patterns of use and abuse, behavioral addictions are more effectively treated when addressed earlier rather than later.

TIP

Try to see whether your problem behaviors are now beyond your own problem-solving abilities. Are your obsessions and compulsions becoming the biggest problems in your life? If they are, seek treatment right *now* rather than *later*. You'll be better off — and so will friends and loved ones.

Compulsive Gambling

Gambling involves the betting or wagering of valuables on uncertain outcomes. It takes many forms — from games of chance to skill-based activity. People have many motivations for gambling, but all involve the hope of winning more valuables without working much or at all. Gambling is sometimes a rite of passage by which people discover more about themselves and competition. It sometimes becomes a way of life (for people such as professional gamblers and escape gamblers). It can be, in its healthy form, a way of socializing and enjoying the company of others.

Pathological gambling involves progressing through different levels of impulse-control problems. The consequences of pathological gambling are severe and may be devastating to the addicted person's career and family relationships. But the

disorder *can* be treated. According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR), pathological gambling is officially defined as "a persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress." As with all addictions, pathological gambling has personal, familial, and neurochemical aspects.

Three phases of compulsive gambling

A progressive gambling problem often occurs in three phases: a winning phase, a losing phase, and a desperation phase.

Winning

In the winning phase, you may experience a "big win" or a series of smaller wins that result in excess optimism. You may feel an unrealistic sense of power and control, and get excited at the prospect of more wins. ("Hey, this is a sure thing. I'm betting the farm.") At the same time, the excitement can't be maintained unless there is continual involvement in high-risk bets. Your bets increase, and ultimately, the increased risk puts you in a vulnerable situation where you can't afford to lose . . . and then, sure as the sun rises, you do lose.

Losing

In the losing phase, you may brag about past wins; but in the immediate situation, you're losing more than winning. This leads to more solitary gambling and when you're not gambling, you're obsessively thinking about how and when to gamble next. You're concerned with raising more money, legally or illegally, to gamble with. The dominant pattern of losing makes the next bet more important to win.

WARNING

As you continue to read these descriptions, you may find yourself feeling more desperate. A sense of futility may be building. You may think "How stupid is that?" or "I don't do that!" The emotions within are building for a reason. Don't ignore the compulsive nature of your gambling behavior. If the shoe fits, explore the fit. If the descriptions fit your experiences, be aware that your behavior may be getting progressively out of control.

As the losing continues, you start or continue lying to family and friends while feeling irritable, restless, and emotionally isolated. You start borrowing money that you are unsure you can repay. As your life becomes further beyond control, you may be plunging into serious financial jeopardy. Your denial of the huge financial pressures that are building may seem unbelievable to some people. They seem unbelievable to you and motivate you to start "chasing losses" by trying to win back what you lost. ("I'll stop, but first I'll get back to even.") When you don't "win back" your loses, however, you'll likely engage in more and more self-destructive behavior.

THE BUSINESS OF GAMBLING

Many groups, from governments to native peoples to criminals are involved in the gambling business. In fact, research reveals that gambling is a $53 billion per year (revenue) business in the United States. That single fact indicates how strong commercial gambling interests are — and how difficult they are to restrain.

Desperation

The desperation phase involves still another marked change in gambling behavior. You may now make bets more often than before, in increasingly desperate attempts to catch up and "get even." The behavior that's now out of control is associated with deep remorse, with blaming others, and with the alienation of family and friends. You may engage in illegal activities to finance your gambling. You may experience a sense of hopelessness and start thinking about suicide and divorce. Other addictions and emotional problems also intensify during the desperation phase and drag you further down.

The impact of compulsive gambling

If any of the preceding descriptions fit you, you may be one of the 3 percent of adults in North America who experiences a gambling problem that results in debt, family disruption, job loss, criminal activity, or suicide. There is another important statistic to keep in mind if you're a youthful gambler or a parent of one: According to current research, people who begin gambling as adolescents are about *three times more likely* to become problem gamblers than people who begin gambling as adults.

TIP

The amount of money involved in gambling debts is staggering. The people who wind up with these huge problems tend to proceed incrementally through the three phases described earlier. If you're unsure about whether you have a gambling problem, try to define which phase you are in. Any perception you have that you are in the losing phase indicates that help is needed as soon as possible. The further down the "slippery slope" you go, the harder it is to regain control and the more important it is to reach out for help.

It's about money

Money is used to pursue fantasies. When people play the lotteries, they dream of winning money and living out dreams. But what really happens to the people who actually win? Most donate to charity; some report being happy afterward; but most stories rarely have happy endings. In fact, many stories of lottery wins remind us that winning doesn't necessarily make life better. As is true for problem gamblers, winning can be the first slippery step in a downfall.

EXAMPLES OF FRAUDS RELATED TO COMPULSIVE GAMBLING

Here are just a few examples of crimes committed because of compulsive gambling:

- The president and CEO of a company fraudulently obtained loans of more than $10 million to pay off gambling debts.
- The chairman of a bank passed $8 million in checks with insufficient funds to cover debts to two casinos.
- A physician borrowed over $8 million to cover gambling debts and then declared bankruptcy.
- A 66-year-old grandmother embezzled $4.9 million to feed her gambling habit.

TECHNICAL STUFF

Due to how the dopamine system works in your brain, working toward rewards can be as stimulating to the brain's pleasure centers as winning rewards. If you watch people play slot machines, what dominates is the compulsion to keep playing. The players can seem to be in a trance-like state. This finding can be understood in combination with the often-observed experience of numbness in casino winners. In other words, winners often put their winnings right back into play in order to recapture the excitement of more betting, as it's the betting that is associated with dopamine release.

CASE STUDY

RYAN LOVED THE RUSH

Ryan is a 26-year-old who was facing several charges of theft and forgery related to his gambling habit. He loved the rush of the casino but was equally at home at the race-track or the poker table. He was on the lookout for *pigeons,* inexperienced people who would get into a game with him. He forgot that as one of the players at the table, he too was caught up in the game. He loved going to the action spots, from Monte Carlo to Las Vegas, more than he loved people or himself.

Ryan won and lost millions. He would be up thousands and although he knew enough to leave, he'd stay, and lose. He was in debt more than $300,000, and he started stealing from his employer to pay off his gambling debts. After serving five years for fraud, he joined Gamblers' Anonymous, and as of today, remains in control.

CASE STUDY

MARY DOESN'T THINK SHE HAS A PROBLEM

Mary was a 66-year-old widow who loved to go to the casino on weekends with her seniors' group. Unlike her friends, Mary loved the casino for its calming influence, a chance to get away from her humdrum life, and, especially, to get away from the grief she typically felt on weekends.

Mary was concerned that her daughter was going to cut her off from her only form of entertainment, because she had gone a little wild and lost $ 1,500 in one weekend, "a silly mistake for a retired person."

Mary was in denial. She didn't see or accept the extent of her problem. In reality, Mary had lost over $60,000 of her life savings. She went to the casino and didn't really care if she won or lost. She only wanted to escape and "have some fun." Mary still hadn't realized the depth of her problem, and her daughter was trying to better understand how to help her mother.

It isn't about money

Some would argue that compulsive gambling isn't about the money. Well, then if not money, then what? Some gamblers are sensation seekers and *action gamblers.* They love the stimulation and excitement. They like being the center of attention, with people admiring their risk-taking and their courage to stay in the game — no matter what it takes.

Other gamblers are known as escape gamblers. If you're an *escape gambler*, you gamble to get away from the tedium of everyday life.

So gambling may not be about the money. The thrills may center on the action and the escape — behaviors that are understandable but highly destructive.

Sex and Pornography

Sex addiction may involve one compulsive activity or several, often progressively intensifying. You can move from masturbatory activities involving pornography to searching for contacts with others that are mostly related to sex and have little to do with building real relationships. If you're addicted to sex, you're likely to experience a sense of powerlessness over your behavior that transforms your life into an intensifying spiral of shame, self-hate, and personal loss (of relationships and jobs).

Pornography addiction

Pornography addiction involves viewing explicit sexual behaviors that typically include abuse, degradation, and/or aggression. There is more to pornography addiction than sex. It is a compulsive process that involves people shaming and humiliating others.

Pornography users and addicts often find multiple forms of stimulation sexually arousing and gratifying. Thus, it may be difficult to define a particular pattern of pornography use and addiction without a detailed history of the behaviors involved. However, masturbation is usually the central process. Pornography addiction is similar to other behavioral addictions in that you lose control and retreat from emotional intimacy, especially in relation to sex.

Sex addiction

Compulsive sexual behavior involves fantasy, excitement, and *satiation* (the process whereby you're no longer turned on by the same stimuli). It may be that you're always looking for that fantasized relationship. Sexual conquests are another side of the same coin, spurred on by the excitement of chasing and finally getting what was once forbidden or dangerous. Over time, with no interest in intimacy, there's satiation and the search for new stimuli and new conquests.

REMEMBER

Sexual addiction is about sex, not love. There is little or no interest in learning about another person and what that person likes or who that person is. Sex addiction is about the act and the orgasm. Sex addiction is largely about conquest, not cooperation.

Here's a puzzle for you: Billy has been with Rachel for four years. They have made love about 1,000 times. Freddy, in the last four years, has had sex about the same number of times as Billy, but with more than 300 women. Who feels better about himself?

Billy has built a relationship with Rachel. They have memories of sexually ecstatic times and emotionally fulfilling times, and vacations in places that, for them, were exotic. They have a tradition of being there for each other and supporting each other through tough times. Freddy, despite the frequency and variety of his sexual conquests, is very much alone.

Sex addicts are always looking for opportunities. "Any time, any place" is Freddy's motto. He does have amazing stories to tell. They're his badges of achievement. But when he looks at life, it's all about sex and it's not about love. Freddy has lost control and needs treatment. It's no longer about having fun — he's behaving compulsively.

CASE STUDY

FRED'S CONQUESTS

Fred was a vulnerable person. He was neglected as a child and felt alone, unloved by family and starved for affection (although he covered it up with a tough-guy act). Women could sense his little-boy vulnerability and unpredictability. Fred started to equate sex with love. He wanted to be loved, and sex seemed like the ultimate expression of love. In this regard, he was sadly mistaken. He would manipulate others in order to have sex, only to feel guilty and worthless after the act was completed. He would leave only minutes after having sex. He was proud of his record: sex with over 200 women in three years (no need to get the calculator out, it averaged out to a date every five days). His conquests were a string of empty victories because his rage and hurt about the earlier abandonment was still dominant and untreated.

Love addiction

Falling in love is inevitably associated with periods where you're consumed with a relationship. The associated thinking may even appear obsessional. There is trouble thinking of anything but your loved one. You can't conceive of not having that person in your life. This belief can be anxiety provoking because of the vulnerability to loss or rejection.

The process of falling in love and the obsessive nature of love addiction are often difficult to differentiate except for a single critical element: Love matures over time and the compulsive nature reduces. But addiction grows more and more compulsive. An increasing sense of desperation marks relationships involving love addictions.

Obsessive thinking is repetitive and centers on events and outcomes that are anxiety provoking. As an anxiety-based response, it redirects emotional pain toward what is familiar and removed from more painful realities.

Love addiction is closely tied to low self-esteem, low self-confidence, and fears of rejection and abandonment. You may behave in a dependent, needy, or desperate way, fantasizing about the ideal relationship and worrying about what will happen if you don't have a current lover. If you insist on one particular person who must love you ("I'm nothing if X doesn't love me"), it's even harder. If these descriptions fit your experience, it is well worth exploring how much these behaviors relate to addiction versus real affection.

CASE STUDY

JUDY FELL IN LOVE WITH A FANTASY

Judy, 33 years old, was an average person. She had a steady job and a good family. She loved reading articles and books on romance and knew that she would eventually find the right guy. She was always open to love, whether at work, while grocery shopping, or while doing her laundry. You just never knew when Mr. Right may show up. Judy was in a holding pattern.

When a man showed interest in Judy, she wanted to do everything "right." She knew that she should not be desperate or needy and should go slowly at first in building a relationship. The trouble was that Judy broke all her own rules. When in a relationship, she became clinging, afraid to lose her man (who didn't have a clue that he was so special). It would only get worse. Judy would behave in ways that went against her own values; she wanted constant attention and was sullen and explosive when she didn't get it. Judy's relationships were extremely intense at first and out of control with passion. She was willing to do anything. But then, like a fire starved for oxygen, the whole relationship would flame out. Judy had a love addiction; her real relationships could never compete with her fantasies. Judy needed treatment.

TECHNICAL STUFF

Just like people who are addicted to substances or gambling, people who are addicted to sex or love are advised to go through periods of withdrawal and abstinence. The goal is to build relationships based on self-respect and to relinquish obsessional thinking and compulsive behavior. How do you do this? During your period of abstinence, pursue real interests and build new skills (any skills). See what turns you on in a nonsexual way. It may involve doing something creative (such as sculpting or photography) or just plain challenging. The goal is to develop a range of interests and activities that are gratifying.

Computer Games and the Internet

In this section, I discuss computer gaming and other compulsive Internet-based activities. Of course, some people regularly surf the Internet to feed pornography or relationship addictions, but that's not the focus here. Those situations are dominated by sex or love addictions. The Internet is just the device by which those addictions are pursued.

REMEMBER

Experts disagree about what constitutes computer game and Internet addictions. Although many behaviors are compulsive, not all compulsive behaviors are addictions. The biggest test of an addiction is the destructive, often antisocial nature of the behavior. Because the Internet is often a very important way of communicating in the 21st century, it is sometimes difficult to judge where normal ends and

compulsion begins. For example, relaxing by playing a game is a common stress-reliever. But if playing that game dominates your life and excludes other responsibilities, the behavior is an addiction.

When a new technology appears, it often promotes a broader and faster network of social connections and knowledge acquisition with increased convenience. Many people can get "caught up" in the new technology and have difficulties restoring balance in their lives. Every interesting and gratifying activity can become an addictive activity if the imbalance created is not addressed. The most difficult part is pulling back from using the new technology with more discretion. Time is an important indicator. For example, the amount of hours of the day you spend interacting with social media, games, and other forms of online discourse can be a good indicator of whether your technology use is spiraling out of control. If the time you spend on the Internet starts to dominate your days, then it follows to look for addictive tendencies and balance-restoring strategies.

REMEMBER

It's important to be mindful of the contrast between enjoyment and addiction. Addictive behavior is compulsive and destructive and characterized by dependence, tolerance, and negative reactions to withdrawal. On the other hand, learning something new and using it as part of your life is encouraging, and even enlightening in ways that do not necessarily represent an addictive process.

BARBARA: AN EXAMPLE OF COMPUTER ADDICTION

CASE STUDY

You know you're addicted when your life is out of control. Barbara was an expert games player. She loved playing and started most afternoons before the kids came home from school. Over time, she played when the kids were already home and even late into the night, long after her husband had gone to bed. Barbara interspersed her game-playing by exchanging instant messages with newfound computer friends.

She appreciated these times. She was a skilled player and liked the social contact of messaging. She preferred being on the computer to housework and to spending time with her husband and gradually, preferred it to looking after her kids. Her family was frustrated. But according to Barbara, they didn't understand. Besides, her "friends" were all online.

Barbara's life started to become unmanageable. She neglected the house and kids. She was always waiting to get back online.

Computer addicts aren't particularly productive. They use the games and their contacts to live in a fantasy world.

Food Addiction

Although there is a wide variety of behavioral addictions, eating is a highly reinforcing behavior just like taking illicit drugs. A recent study reaffirmed that the mere sight, smell, and taste of a favorite food elevated the levels of dopamine in food-deprived subjects. Once again, dopamine levels can increase just from the anticipation of something rewarding like a favorite food.

Eating too much

Obesity is a major public health problem in the Western world, having increased to epidemic proportions since the 1980s. Depending on ethnicity, approximately 42 to 49 percent of American adults are now obese (which is distinctly higher than the 23 percent assessed in 1962). Although the mechanism of obesity is simple (obese people take in more calories than they burn) the reasons for the imbalance are complex. In many cases, imbalances may be partly genetic but behavior fits into the profile as well.

Binge eating is often a critical part of this behavioral pattern. Thousands of calories are consumed over a short period of time. A binge that is followed by purging, through vomiting, laxatives intake, or excessive exercise is known as *bulimia* (for more on this, see the next section). Obesity, on the other hand, results when people fail to balance normal calorie needs with their consumption of food.

The person suffering from obesity faces a daily challenge to eat *some* food but not too much food. We know that controlled drinking and drug use is hard (or impossible for some). Controlled eating is just as hard. Driven to gain pleasure, a person overeats and hopes to find another way (later on) to lose weight. Exercise helps but it's often an insufficient offset if the calories consumed are excessive. Yo-yo dieting is the most likely response. Food becomes the source of constant misery. It's necessary to neutralize food emotionally and find other sources of pleasure and reward that help reduce preoccupations with food and invite a healthier relationship with eating.

Eating too little

Anorexia is a condition whereby the person consumes too few calories. There are a couple of different types:

- **Restricting:** You prevent yourself from eating calories.
- **Purging:** You consume calories but rid yourself of them by vomiting, laxative use, or compulsive exercise.

Those suffering from anorexia often balance or overcompensate for the calories consumed by exercising excessively. Is anorexia part of food addiction? Is the avoidance or restriction of drugs or alcohol part of drug addiction? You can see that specific symptoms only begin to explain complex conditions.

WARNING

Eating too little is a very serious state that can eventually lead to death.

Bulimia is an eating disorder characterized by a cycle of excessive consumption of foods (calories) followed by behaviors that rid the body of these calories. There is a binge-purge cycle. Ultimately, the pattern of behavior leads to several adverse physical consequences, including dental disease (from excessive stomach acid in the mouth) or hair loss.

The compulsive nature of bulimia is like other compulsive behaviors (for example, drug use, sex, eating). There's increasing loss of control and increasing need to engage in the addictive pattern.

Work Addiction

Work, the backbone of our society, is the activity that takes up most waking hours. You may work longer and harder to accomplish more, fearing that if you don't, you'll feel inadequate or worse, perform unsatisfactorily. If you suffer from work addiction, your efforts are typically reinforced and rewarded by praise, promotion, and financial reward. Organizations directly or indirectly support work addictions — as the extra work gives the corporation more bang for their buck. Employees affected by this behavioral pattern are prone to stress, relationship problems, and other addictive behaviors. They're also at risk of being exploited by employers.

Do I have a problem?

Use the Work Addiction Checklist shown in Table 3-1 to help figure out whether you have a problem.

If you answered yes to three or more of these items, you may be work-addicted. Consider seeking a professional opinion.

TABLE 3-1 Work Addiction Checklist

Question	Yes	No
Does the amount of time you spend working cause problems for your family or social life?		
Do you feel out of control or powerless when it comes to setting limits, going home, or leaving work?		
Do you have trouble enjoying life, preferring to work rather than play?		
Do you break promises to your family or friends regarding your work, travel schedule, and related work activities?		
Do you have difficulty dropping tasks or delegating them to others?		
Has your work pattern affected intimate relationships or recreational activities that you used to enjoy?		
When on vacation, is it difficult to relax and disengage from work, so that your time away is contaminated by work or work technology (smartphones, pagers, phone calls from the office, email)?		
Has your physical health suffered because of excessive work? Have you ignored advice given by family, physicians, psychologists, or other therapists?		
Have you been surprised at how quickly you fly off the handle or lose it? Are people you care for having to give you space?		
Have you unsuccessfully attempted to cut down or stop overworking, overcommitting to others, and staying later and later at the office? For instance, you promise to change to spend more time at home, at the gym, or in a recreational activity but don't do it.		

How work addiction starts

Work addiction (like all other addictions) starts because what you're doing feels good! Some people *love* to work — in part because they like to accomplish tasks and because they like the praise (positive feedback). These two sources of reinforcement, the internal and the external, are a powerful combination. Throw in the very likely financial incentive for achievements, and you're on the work-addictive path. What helps people avoid the pitfalls of work addiction?

People with Type A personalities are somewhat prone to engaging in a work-addiction pattern. They are at some risk but should be okay if they do the following:

- Set healthy boundaries when needed (listen to the requests of loved ones).
- Remain in control of work tasks and accept that change will happen incrementally.
- Stop working when experiencing negative consequences; experiment with paying attention to negative consequences rather than stoically denying them.
- Accept, instead of deny, *all* your actions and responsibilities, including those pertaining to family and relationships.
- Genuinely retain your modesty and humility and define yourself by who you are rather than what you do.

REMEMBER

The hard part of work addiction is that it is sometimes difficult to distinguish it from the pure, simple dedication to doing a good job. The esteem you earn with hard work is very reinforcing. ("You're the best! No one else can do what you do! You are so dedicated. You came in over the weekend, wow! We'd be nowhere without you.") The key question is whether you see yourself as valuable. If so, then it's time to take a forced vacation, despite the needs of other people and their rooting you on to do more and more work.

Kicking the habit when everyone is asking for more

Here's the real kicker! Other people, including coworkers, bosses, and sadly, even family, start to get used to your work addiction. They like the money; they like the productivity; they like *you* carrying the ball. This is a blueprint for resentment, however — your own, which can build over time. You may find yourself suddenly out of gas and immersed in feelings of fatigue and irritability. You may feel lousy because you've lost perspective on how much rest, relaxation, and diversion you need to be a truly healthy person and, over the long-term, an effective contributor in the workplace. It may be strange to take time off but you need to — you need to experience a retreat from work. You need to withdraw to restore a healthy balance just like people who withdraw from substances. Don't expect others to reward you for this — they may prefer you to keep on working because you're helping them through your good performance. Despite all of this — you need time off. Take some and experiment with meeting your needs for rest and relaxation.

OTHER BEHAVIORAL ADDICTIONS

This chapter has focused on the most common behavioral addictions, but keep in mind that any behavior can become addictive. The distinguishing feature is whether that behavior starts to dominate your life in an unhealthy way.

Chapter 5 describes how to recognize whether you're addicted. Many behaviors or activities can become addictive, some of which are not injurious at lower levels. For example, you can get addicted to exercise — or to a particular group activity or mission. You can become addicted to collecting things. The list of potential behavioral addictions is endless. If you're reading this book, you may already have some concerns about certain habits. Take a good, slow, and clear look — behavioral addictions are quite common and diverse, and, fortunately, treatable.

IN THIS CHAPTER

- Peering at peer pressure
- Going over the risks
- Looking at how addiction hurts families

Chapter 4

Dancing with the Tiger: The Risks of Experimenting

Dancing with the tiger is an attention-getting phrase. But no one actually dances with tigers because the risks of injury or death are too great. While it may sound exciting, you're betting against survival. The same holds true for experimenting with addictive substances. Some substances are so addictive that before you can withdraw to a safe distance, the "tiger" bites, causing you great pain and lowering your chances of survival.

Of course, experimentation is part of the human DNA. Whether it's with alcohol or high-stakes gambling, you can experiment with something that could, under certain conditions, ruin you. The tiger you dance with is obviously dangerous, but here is where perceptions of addiction become distorted. At first it may not seem that the substance you ingest or the activity you partake in is dangerous, when it most certainly is.

In this chapter, I cover the various addictive substances and activities you may encounter at raves, parties, casinos, and with friends and family members. I explore the surprising power of peer pressure. Most important, throughout this chapter, I explore the progressively slippery slope that links experimentation with addiction.

REMEMBER

While experimentation is a fact of life, addictive substances, themselves, create illusions of safety. Once you ingest a potentially addictive substance, you may feel safe, whereas in reality you're on a precipice. The excitement generated around addictive substances and behaviors lowers inhibitions and increases impulsivity. The feelings of unlimited freedom are artificial. Over time, these desirable feelings give rise to dependencies that have made people, as strong or stronger than you, self-destructive.

Going with the Flow: Peer Pressure and Other Influences

The influence of friends is, of course, powerful. Peer pressure is extremely hard to resist. Psychological research has shown that peer pressure influences people to change right answers to wrong answers, even when people are certain that they have the right answer — because everyone else in a group has given an incorrect answer, one tends to "go along!" A psychologist named Stanley Milgram showed that prohibitions against abhorrent acts, like causing pain for another person, are overwhelmed by peer pressure.

On the other hand, peer pressure is also a force for good. The problem is one must make a judgment, individually, about whether the pressure is positive or negative and whether one can go with the flow or take a stand and risk being chastised and rejected.

REMEMBER

Peer pressure works for good and for not-so-good. If peers are pursuing healthy activities, you can safely follow their lead. People tend to watch out for one another's interests. We generate positive pressure by urging each other to work harder at school, train intensively athletically, and develop skills in art, dance, and music. We want friends to be successful and we support them in becoming successful. We band together in environmental preservation and community service.

But there's the other side to peer pressure, the side where peers egg each other on to take increasing risks. No one wants to be considered cowardly, and peer groups can become hysterical in demanding proof of mutual commitment and solidarity.

Relationships with parents and caregivers also have a profound effect on personal choices and coping behaviors. But the influence of peers in experimentation has the most obvious "dark side" because risk-taking behavior enhances reputations. In adolescents and young adults, reputation is a persistent concern. One way to gain a reputation is to engage in high-risk behavior.

TIP

To decide ultimately which potentially addictive behaviors you will try and which you will pass on, be aware that to make your own choice, you must consider how much you're being influenced by peers. When in doubt, assume your friends are having a big influence on you. Try to think for yourself and slow down your thinking and take time to do so.

Partying and club drugs

Going to a party often means getting into a mental state in which you expect to have fun, meet new people, and present your most attractive qualities. You want to relax and let go! These expectations begin to define how you'll likely behave until late in the evening. How much of the partying will involve addictive substances? What substances will likely be used? Answers to these questions help define the situation and the expectations of the party.

Club drugs (such as Ecstasy, GHB, Rohypnol, ketamine, methamphetamine, and LSD) are now generally available at raves, dance clubs, and bars. Sooner or later, if you go to one of these venues, you will be offered one or more of these. So it makes sense to think ahead about how you'll respond.

TIP

An addictive substance, once offered, is hard to turn down. It's better to create a safe distance from those who will likely be doing the offering and tempting.

WARNING

Using club drugs can cause serious health problems and, in some cases, death. If used in combination with alcohol, these drugs become much more dangerous. As an example, dehydration is a significant side effect of Ecstasy use, which in the long run can cause organ damage. There are others dangers, of course, the most serious being overdose or drug intolerance. You're unique, and therefore you have unique responses to substances. What's tolerated well by someone else can be dangerous for you.

Hooking up

A social phenomenon in the twenty-first century is *hooking up,* or casual, non-relationship sex. Teens and young adults who get into low-commitment or casual sex are often exposed to high-risk substance use. The two go hand-in-hand because substances are used to break down the inhibitions involved when people approach intimacy with another. The closeness of intimacy often involves interpersonal scrutiny, and drugs reduce anxieties about being observed closely.

"I didn't know what I was doing"

Many illegal and unwise actions undertaken due to substance abuse or other altered states are typically linked to addictive behavior and often leave a person even more vulnerable. Using diminished capacity (that is, "I didn't know what I was doing" or "I didn't know what was going on") as the explanation for harming or threatening others is simply unrealistic. Chances are, you'll be held responsible for your actions even if you were "under the influence," especially if the consequences were reasonably foreseeable.

Rebellion and experimentation

The more rebellious you are, the more likely you will experiment with substances and behaviors that elevate risk. The negative reactions expected from parents or establishment-type people are counter-balanced by support from equally rebellious peers.

Punishments linked to your rebelliousness may also have very little cautioning influence. Being the high-risk rebel can be an impressive role to play. But beware of being pushed and urged into especially dangerous and foolhardy risks that combine substance use, sex, and criminality.

WHAT INFLUENCES YOUR BEHAVIOR?

Which of these behaviors do you believe are under the major influence of: a) your friends or peers, b) the media, or c) advertising?

- Drinking alcohol at parties
- Buying clothes
- The type of music you like
- The words you use to describe stuff you like
- Using cannabis/marijuana/shrooms/Ecstasy
- How you describe people outside your preferred group
- Whether you will push limits in terms of sexual behavior
- Your confidence in getting away with something risky

If you answered friends and peers more often than either the media or advertising, you're like most people. Media and targeted advertising have a significant effect, but your friends are a much stronger influence on your behavior.

The Risks of Experimentation and Addiction

Not only can experimentation lead to addiction, but also it can lead to other risks associated with addictive substances and behaviors. Many of these relate to your own health, but some relate to the health of others, including loved ones.

Drinking, drugging, and driving

Is there anyone who doesn't understand the risks of using drugs and alcohol while driving? In North America the statistics about impaired driving remain staggering. According to data from the U.S. National Highway Traffic Safety Administration (NHTSA), 11,654 people were killed in alcohol-related crashes in 2020 — an average of one fatality every 45 minutes. These deaths constituted approximately 41 percent of the 42,915 total traffic fatalities. The problem appears to be getting worse, not better.

REMEMBER

Driving under the influence of mind-altering drugs, other than alcohol, may also be an important cause of traffic crashes. The major risks of acute cannabis use are parallel with the acute risks of alcohol intoxication. Both drugs produce psychomotor and cognitive impairment, especially affecting memory and planning.

A study conducted in the United States illustrated some of the concerns about drug use and driving. Drivers were stopped for careless or reckless driving (speeding, driving on the wrong side of the road, driving at high speed through red lights or stop signs, passing dangerously). Those who had no obvious alcohol use (smell of alcohol on breath, denied alcohol use) were taken to a special van where field urine tests were conducted. Fifty-nine percent of those tested (mostly men in their late teens to early thirties) positive for marijuana or cocaine. Any substance intake degrades driving competence.

Unsafe sexual behavior

Sex is one of the most basic behaviors. Unfortunately, our drives to reproduce are associated with risks — like sexually transmitted diseases, unwanted pregnancies, and plain, old, ordinary embarrassments.

People who suffer from substance abuse and addiction are more likely than others to have unsafe sex. As a result, it is wise to know some of the most common sexually transmitted diseases and how to identify early signs and symptoms. With the exception of chronic infections such as HIV and herpes, most of these diseases can be cured.

REMEMBER

According to the World Health Organization, at least 374 million new cases of sexually transmitted diseases occur every year worldwide. Included are cases of trichomoniasis (an easily treatable infection), genital papillomavirus (which is implicated in cervical cancer), gonorrhea, genital herpes, syphilis, chancroid (a bacterial infection that causes ulcers), and approximately 35,000 new annual cases of HIV.

The difficulty with sexuality, of course, is knowing whether, how, and when to stop. It takes discipline, which requires experience. It helps to know what you can tolerate and what you can't. Appetitive behaviors such as eating, drinking, and sex all require control of the tendencies to overindulge.

The sex trade

Sex and drugs are often interrelated at many different levels. For example, most people in the sex trade also have problems with substance abuse and addiction. Some may even engage in the sex trade to support their addictive habits.

Research shows that sex trade workers are particularly vulnerable to drug addiction. Their drug of choice is usually cocaine or heroin. Drug use may be a way of coping with the acts of prostitution, and prostitution is one way of supporting a drug habit. As many as 85 percent of women involved in street prostitution use addictive drugs.

The influx of cocaine has been devastating to women involved in prostitution. The lowest cost for drugs on the streets often stays close to the lowest cost for sex. In the 1970s, for example, heroin was the drug of choice. A hit of heroin cost about $20, and the lowest cost for sex on the streets equaled $20. Today, one of the drugs of choice is cocaine, which can be purchased for as low as $5. In order to compete in today's prostitution market, women have to work more for less, and under higher-risk circumstances. Working more means more client contact, which increases the risks of customer-related violence and sexually transmitted diseases.

Crime

Contrary to popular views, most people with an addiction aren't hardened criminals. But they are likely to resort to minor crimes to feed their habit. Most of these crimes don't involve violence. As you can imagine, if you're living a life of addiction, it becomes difficult to hold a job. If you don't have a job, you must find other ways to support your habit. One of the sad consequences of addiction is criminal activity.

About two-thirds of all prisoners in the United States may be characterized as having been involved with alcohol or drug use during the time leading up to their arrest. Some data highlights follow:

- Thirty-nine percent of state prisoners and 31 percent of federal prisoners reported in 2016 that they had used drugs at the time of their offenses.
- About one in six (16 percent) of both state and federal inmates said they committed their offenses to get money for drugs.
- Twenty-seven percent of state and 25 percent of federal inmates said they had received drug or alcohol abuse treatment during their current prison terms.
- Forty-five percent of all prisoners are in prison for drug offenses.

Feeding the habit

With drugs, you rarely get what you pay for! Based on data from the United Nations, the retail price of a gram of heroin is roughly $69 (USD) in Europe and $300 (USD) in the United States. And as the drug moves through the distribution system, there's a tendency to cut down the actual proportion of drug received (in powder or pill). So when you pay $20 for a bag of heroin, only a fraction is actually pure heroin; the rest consists of added substances (fillers).

What does it cost to feed an alcohol or drug habit? What does it cost to maintain a gambling, sex, shopping, or other behavioral addiction? It varies greatly from person to person, but over time the costs of keeping the buzz and fighting the withdrawal keep going up.

REMEMBER

As tolerance increases over time with drug use and behavioral addictions, the cost of an addictive behavior increases over time.

Impulsive crimes under the influence

Mind-altering chemicals typically disinhibit you, often to the point of impulsive behavior. With behavioral addictions, the urge to engage or the debts accumulated from engaging in the behavior (for instance, gambling debts) may induce you to resort to crimes such as embezzlement and other types of fraud (including stealing from friends and family) to feed the addiction and to pay off debts.

Anger and aggression

Driving seems to bring out the worst in some people as does waiting in lines. But some people have trouble controlling their anger *all the time*. Uncontrolled

aggression is frightening to others and even to the person experiencing it. You can imagine how the problem is magnified when the hostile person has been using drugs or alcohol: The goal is often to get even and make the other person pay.

Many drugs reduce inhibitions and result in the experience and expression of raw emotion. In addition, many drugs will disinhibit a person to the point of overreacting to small frustrations.

You can't always judge anger by outward behavior. Two people can feel anger with the same intensity but handle it differently. One may show anger by shouting, cursing, or acting aggressively. The other may handle anger by holding it in. How angry you are depends on how intensely and frequently you feel it. Typically, anger is assessed by asking you to rate the frequency with which you experience different degrees of anger. Try completing the anger scale in Table 4-1 to get an idea of how you might score on an anger assessment scale.

TABLE 4-1 Anger Assessment

How Often Do You Feel	Rarely	Some of the Time	Most of the Time	All of the Time
Irritable				
Impatient				
Angry				
Annoyed				
Short-tempered				
Fuming				

If you checked off a high frequency rating with most items, then you probably have trouble handling anger, especially when taking an addictive substance.

TIP

Ask yourself if the angry feelings in Table 4-1 were typical of you even before you started to use addictive substances or behave addictively. If your answer is no, then it's likely that your anger is a consequence of your addiction.

Child abuse and neglect

Parental drug and alcohol abuse and addiction are linked to an increased likelihood of child abuse and neglect. Research on this topic is fraught with difficulties because it is hard to definitively determine which of the many factors may be responsible for the child abuse or neglect. Keeping in mind the inherent

challenges in studying this topic, research surveys appear to implicate alcohol and illegal drug use as potential factors in either causing or exacerbating abuse and neglect. And not only does alcohol and drug use appear to increase the likelihood and frequency that parents will abuse or neglect their children.

Health risks

"This won't happen to me. I'm more fortunate than others." If this is how you think about your health risks, you're like the great majority. The most common response to potential risks is a feeling of unrealistic optimism. The truth is that generally, health risks are the same for the majority of people your age and gender. So what happens to the risks when it comes to addictions?

Following are a few facts about the health risks associated with addictive substances and addictive behaviors:

- If you use injectable drugs and share needles with others, you risk exposure to infections such as HIV and Hepatitis C.
- If you have a sex addiction and have sex with multiple partners, you're at risk for sexually transmitted disease (like HIV) if you don't practice safe sex.
- Because most street drugs aren't pure and you don't necessarily know what has been mixed with them, you run the risk of overdose and possibly death from ingesting the substance. In some cases, the substances added to the drug increase the drug's potency or speed of absorption into your body.
- If you're a gambler, you're at elevated risk for depression and suicide compared with the general population.
- Individuals with a substance addiction are also at a higher risk of suicide than the general population.
- Long-term use of alcohol is associated with multiple organ damage, most commonly to liver and brain cells.
- If you're a pregnant woman who drinks alcohol or takes addictive drugs, you risk the health of the baby you're carrying. Health risks to your baby include learning disabilities, hyperactivity, inability to manage anger, poor judgment, and delayed growth. Certain substances will actually result in your baby being born with addictions (for example, to narcotics).
- Overdoses of amphetamines (stimulants), barbiturates (tranquilizers), alcohol, inhalants (for example solvents, gases, and nitrates), and narcotics can cause death.
- Risks of drugs and alcohol abuse are progressive — the longer you abuse these substances, the greater the health damage.

The bottom line is that both experimentation and long-term abuse can cause serious health problems including death. (In Chapter 5, I discuss the effects of substance use on the brain, and in Chapter 10, I go over the risks associated with acute substance withdrawal.)

The Costs of Addiction to Families

The degree of distress experienced by families affected by addiction is underestimated. In all normal situations, families try to take care of each other, especially in times of illness. What happens when you refuse your family's help, and then seem to go out of your way to upset them? Most people in this situation will try even harder to get the result they want — and most family members want their loved one to stop the drinking or using. It's one of life's ironies that the harder the family members try to help you, the worse your problem sometimes seems to get.

The blame game

In the early stages, family members, especially the person closest to you, don't want to believe what is happening to you. (I discuss the family's responses to addiction more in Chapter 18.) Some very normal personalized beliefs come into play for your loved one, including the following:

- If I were a better wife (or husband, son, daughter, mother), you would love me enough to stop drinking or using.
- As a parent, I must have done something wrong to make you feel so bad that you have to take these drugs.
- I need to work harder to make sure you love me, and then you'll stop, and everything will be okay.

Believing they're to blame, family members begin to bend over backward to make things better for you and to keep the family functioning. Meanwhile, you tend to blame someone for your need to drink or use and you likely pick on those nearest you, like members of your family. No one can talk about what's really happening — after all you may get angry or you may leave.

Communication begins to break down, and the vicious circle goes around and around, with all players locked into their very private painful states.

The consequences to you and your family

The addiction problem of a family member can lead to all sorts of harmful consequences:

- **Socially:** Through embarrassment and shame, families decline invitations, stop inviting friends to their home, and start to ignore friends and hobbies. The family becomes gradually more and more isolated — unable to tell anyone what's happening.
- **Psychologically:** When family members have been lied to many times, they find themselves furiously searching for evidence to support their suspicions.
- **Emotionally:** Living with you and your addiction is like being on a roller coaster. Family members may feel angry, frustrated, helpless, confused, hopeless, desperate, guilty, and ashamed.
- **Physically:** The stress of living in a chronic state of chaos, being on edge all the time (constantly worrying as to what your next phone call will bring and what they'll find when they open the door to your room) eventually takes a toll. Family members of people with addictions have more-than-average rates of anxiety, depression, headaches, migraines, digestive disorders, and heart problems. It's not unusual to find close family members of those with addictions admitting to feeling periodically suicidal.

In short, the family becomes so focused on your behavior that they're distracted from many matters including essential matters. The family develops its way of coping but may become so hooked on helping you that contemplating no longer helping you is unthinkable. A huge fear of making changes builds, and this eventually becomes counterproductive for you and for them.

2 Taking Those First Steps

IN THIS PART . . .

I help you assess your risk of becoming addicted and how close you are to being addicted right now. I explain how your body and mind become addicted and give you information on the various biological tests used to detect addictive substances in your body. I help you assess your readiness for treatment, and I help you detect the triggers for your addictive behaviors and develop strategies to neutralize these triggers. I review the many types of treatments now available for addictions, and I provide information so that you can select a treatment that is best suited to your needs.

IN THIS CHAPTER

- Identifying your addiction risk
- Understanding how people become addicted
- Recognizing addictions in yourself
- Knowing when a loved one is dangerously addicted

Chapter 5

Recognizing Addiction in Yourself and Others

Why do people risk their lives, jobs, and relationships to take addictive drugs and then slide into self-destructive behaviors?

Scientists and clinicians have struggled with this question, and while many mysteries remain, we've come a long way toward answering it. The bottom line is this: Addictive substances and activities that feel good in the beginning can be the darkest and most destructive elements of life later. While not every feel-good activity is addictive, sometimes what feels good can evolve into a deadly addiction.

When caught in the cycle of addiction, your personal strengths dissipate. Your internal states that were once helpful in coordinating life and maintaining equilibrium become chaotic. Your focus revolves around getting and taking the drug, often to the exclusion of your other needs.

Because the only reason people start using drugs is to feel good, they often start using when they feel especially bad and expect to feel worse. There's a desperate hope that some magic bullet inserted in the bloodstream will be transformative. There may be therapeutic relief with drugs prescribed by your doctor, or even with over-the-counter medications. But when you start using illegal substances, the sensitive body (and brain) is subject to effects that are immediately injurious and

can be highly injurious over the long term. And it may not be a substance, but a self-destructive activity like gambling or overeating.

In this chapter, I discuss how a person gets addicted and what drugs and activities are the most dangerously addictive. I also discuss how to know when you or someone you care about is crossing the lines into addiction — and when interventions are needed to bring them to safety and self-integrity.

Am I at Risk?

Knowing your risk of addiction can help you decide how to approach specific substances and activities. How much caution should be applied? Are scientists and clinicians just making a big deal out of nothing? Or are the dangers described real and estimable? To assess your addiction risk, make yourself aware of the following:

- **Your mental state.** If you're anxious, depressed, or chronically angry, you're prone to escape reality via drug use or different addictive behaviors to try to feel better. You may feel isolated and alone, but help is available that will guide you away from falling prey to addiction and toward a healthy lifestyle.
- **Your family history.** Substance abuse and addictive behaviors run in families. If you know a parent or another relative who became dependent on drugs or alcohol, you're at greater risk. Familial risk also applies to behavioral addictions like gambling, overeating, and sexual addiction. (See the section "Genetics: Addiction Across Generations," later in this chapter.)
- **Your willingness to experiment with different drugs.** If you consider yourself a "risk-taker," you're at greater risk of experimenting with addictive behaviors and substances. You're more likely to disregard the stop signs and blinking yellow (cautionary) signals.
- **Your drug choice (some are much more addicting than others).** While some psychedelic drugs are non-addictive, the more powerfully addictive drugs (such as morphine, cocaine, and nicotine) can overwhelm you quickly and thoroughly. The highly addictive drugs are discussed in greater detail in Chapter 2.
- **Your support system of family and friends.** If you have little social support and often feel lonely, you're at greater risk. Drug-taking is a way of finding instant communities of the dangerous kind.

TIP

You need only one of these risk factors to be at risk of developing an addiction problem. When considering all these factors in your life, slow down and think about your life and how you're dealing with personal challenges. Think carefully about what stressors you're facing and how you may be using an addictive substance or behavior to avoid stress.

REMEMBER

Taking a hard, honest look at your daily stresses and feelings is often difficult. This type of honesty is especially difficult for people who are addicted or becoming addicted. Getting in touch with and expressing feelings can be very difficult. Drugs or addictive activities often numb your feelings and can make it harder to know how you feel.

Start by selecting an issue to focus on. Then spend five minutes thinking about everything related to that issue. For example, evaluate your mental state. How have you been feeling the past few days? You may have a tough time determining how you've been feeling, so pick one emotion from the following: mad, sad, glad, or afraid.

How have you been feeling for the past few weeks or the past few months? Think about how you've dealt with your feelings. Have a piece of paper handy to make notes about what you remember. Then look to see what patterns emerge. Do you turn to a particular activity or substance to get through rough spots? Do you celebrate by performing a particular activity or taking a specific drug? If you have addictive tendencies, you'll see the patterns — they are not hidden; you might just tend to ignore them.

REMEMBER

No definitive biological tests exist to determine who is at risk for addiction and who isn't. Nevertheless, you can still find considerable scientific literature on the risk factors of addiction. Many scientists are struggling to find how to detect a person's vulnerability to addiction. But new discoveries emerge all the time and science is ever-evolving. You must come to your own judgment about your risk profile — and you can with careful self-observation.

Genetics: Addiction Across Generations

Most of us know our birth parents, grandparents, and other relatives. We inherit our *genes* (the codes of life that are influential under different conditions) from our birth parents — half from Mom and half from Dad. Although scientists don't completely understand how genes operate, they know that genes interact with environmental factors (stress, diet, exercise). For example, a gene that helps people handle cold weather is found in many people in northern climates. Some genes are *triggered* (turned on) only under certain conditions, and using drugs may be

one of these conditions. Although you're born with your genetic risk for addiction, you're responsible for it, and with effort, you can influence and change it. Read the following sections to figure out whether you may have a genetic risk.

Determining who's susceptible

TIP

To understand your genetic risk, chart out your family tree by first listing your parents, brothers, sisters, and all other relatives related to you by birth. Put a circle around any relative who suffers from substance abuse or who has an addictive behavior like gambling. If you have more than one relative who is addicted to drugs or who engages in a self-destructive, addictive behavior, you may carry this risk yourself. The more circles in your family tree, the higher your risk. By the way, the *addictive tendency* runs in families, but the substance or self-destructive behavior involved may differ from one family member to another.

In addition to the risk associated with a family history of substance abuse or addiction, other family characteristics put you at risk for developing a substance or nonsubstance abuse problem. You're at increased risk of addiction if any of the following characteristics are true of you:

- You consider yourself aggressive by nature.
- You have a personal history of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD).
- You have a family history of depression.

WARNING

Asking relatives about their personal medical histories can set off emotions and stressful reactions. Proceed cautiously and start by telling your relative why you're asking and what you hope to achieve. Remember that not everyone who has a family risk will become addicted. Be respectful and matter-of-fact in your questioning. Above all, try not to be judgmental about the answers you get.

Applying your family history

When facing your vulnerabilities, honesty is important. Obviously, if your family history is loaded with addiction, you need to be very careful about using and experimenting with drugs. In some cases, using certain drugs may place your health at especially high risk. Sometimes, addiction comes down to being hypersensitive to a specific molecule in the drug.

People differ in their sensitivity to drugs and knowing your family history may reveal a pattern of hypersensitivity. If a family member was sensitive to a particular drug, you may have the same reaction. And if some of the relatives with

addictions have overcome them, your family history may also yield clues as to what treatments or interventions may work. It never hurts to hear another person's story, especially stories from family members who have overcome addictions.

How a Body Gets Addicted

The interaction between the mind and the body can't be separated, and addiction has both mental and physical components. For example, the mind can be so powerful that simply thinking about getting high can result in bodily changes (a faster heart rate and increased sweating). Your body can ache and scream out for a specific drug just because your mind is creating a picture of taking the drug.

From the mind out

If you find yourself craving a drug or an activity (gambling, binge eating) and can't get your mind on anything else, you may be psychologically addicted. If you're willing to risk losing family, friends, and work in order to engage in your addictive behavior, then you're addicted.

When your mind is preoccupied with getting the next high, your addiction has taken hold and become dominant mentally. On the other hand, powerful mental experiences can trigger addictions. You can crave a high to distract yourself from a difficult-to-heal emotional wound. Emotional pain is often difficult to describe. You can hurt emotionally when depressed, anxious, angry, shamed, guilty, or just plain physically sick. You can be especially tempted to turn to substance use and abuse when you're just tired of feeling down. (Flip to Chapter 15 to find out how negative moods can act as triggers for substance use and how to resist these triggers.)

Being addicted also brings on certain kinds of mental anguish. In the early stages of addiction, sometimes all you can think about is when and how to get the next fix. Your mind searches for the quickest way to get back to normal, to get back to feeling good. You may even dream about getting loaded or engaging in addictive behavior — as nothing is more important to you. This search becomes more desperate when you use substances to numb emotional pain. You may be using substances or engaging in high-risk activities because you can't bear to think of doing anything else. When this is the case, you can be sure that you're *psychologically addicted.*

From the body in

If you find yourself needing more and more of the substance or activity for the same high, or if you experience physical anguish when you're without it, then you're *physically addicted.*

TECHNICAL STUFF

In your brain are biochemicals called *neurotransmitters.* Some help activate various systems of the body, whereas others are inhibitory. The neurotransmitters that play a role in addictions are listed in Table 5-1. (Note that this table isn't exhaustive.)

TABLE 5-1 Neurotransmitters and Their Triggers

Neurotransmitter	Addictive Substances Believed to Affect It
Dopamine	Opiates, stimulants (cocaine, amphetamines, nicotine), ecstasy, possibly cannabis
GABA	Alcohol, benzodiazepines
Serotonin	LSD, Ecstasy and its derivatives MDA (Adam) and MDEA (Eve), opiates
Glutamate	Solvents, alcohol
Norepinephrine	Opiates

In addition to neurotransmitters, your body's *opioid system* also plays a role in increasing your susceptibility to addiction. Studies of the heritability of addictions suggest that neurotransmitter- and opioid-related genes may increase susceptibility to substances like drugs and alcohol, as well as to self-destructive behaviors like gambling.

Addictive substances such as alcohol, amphetamines, and opiates directly affect neurotransmitters and opioid receptors in your brain, in some cases delivering a pleasurable high, in other cases producing a sense of calm or an emotional closeness with others. Initially, small amounts of the drug get you high, but over time, you need more and more to produce the same effect. This process is called *tolerance.* As you build tolerance to the drug, the more of the drug you need. At some point in your history of using, if you don't put the drug into your system (and hence your brain), your body starts screaming. When you've developed a *dependence* on the drug, it physically hurts if you don't have the drug. You feel sick — your head, stomach, muscles, and bones. You simply must have the drug to function. Your addiction has become a physical one.

When we think of addiction to alcohol and drugs, it's easy to see how a person could build up tolerance. What about the behavioral addictions? How do behaviors escalate to addictive levels?

When you take part in addictive behaviors, you're usually in states of high arousal. Tolerance refers to the fact that it takes riskier and riskier actions to get your arousal up to that high level. For gambling, increasing your risk is often achieved by raising the stakes. For sexual addictions, increasing your risk means having sex that involves greater dangers. For eating, increasing your risk may involve eating more food, different types of food, or more forbidden foods. For computer games, increasing your risk may involve using more violent, explicit games or simply spending more hours playing games where others are competitors.

TECHNICAL STUFF

Interestingly, not only do certain drugs affect neurotransmitters, but behaviors associated with using the substance, over time, also affect neurotransmitters. For example, just seeing a syringe may stimulate a rise in dopamine levels because of the learned association between syringes and heroin injection. Addictive behaviors like gambling also are associated with dysfunction in certain neurotransmitters.

What drugs are the most addictive?

What two substances do you think most people become dependent on? Are you ready for a surprise? You may think the most addicting drugs are illegal. It's true that many illegal drugs are addicting. But legal drugs are also very addicting.

The most addicting drug for humans is nicotine. Yes, nicotine . . . that legal substance adults purchase and use nearly everywhere. Nicotine is most commonly delivered by smoking or chewing tobacco or by using tobacco products such as vapes. Although rates vary by age, gender, state, and culture, about 14 percent of North Americans are addicted to nicotine. Young people are clearly the most vulnerable to picking up the *habit* (which really means the addiction).

The second most addicting drug is caffeine. Caffeine is found in many different products but is most commonly accessed by drinking beverages such as coffee, tea, soda, and energy drinks. Most soft drinks contain this legal stimulant. Caffeine can also easily be obtained in pill form. Over-the-counter pain medications such as Anacin, Excedrin, and Midol contain caffeine. Many food and drink products contain caffeine, and you can even buy caffeinated water!

Think about how your mind focuses on getting that first cup of coffee or tea in the morning. A large majority of people who have tried to reduce their intake of caffeine experience withdrawal symptoms. You may not notice withdrawal until you have been off caffeine for at least two days, so if you consume caffeine daily, you may not even know that you're addicted.

Table 5-2 outlines the percentage of people who become dependent on a drug after a certain amount of time. In reviewing Table 5-2, keep in mind that the samples of people being considered are study participants who were found to use

the particular substance. Also, the samples only include people who actually use the drug for a period of time (for example, three months of smoking ten cigarettes per day). So 32 percent of people (approximately one third of the sample) who use nicotine for a period of time become dependent.

TABLE 5-2 Percentage of People Who Become Dependent on a Drug after a Period of Use

Substance	Percentage
Nicotine	32%
Caffeine	30%
Heroin	25%
Cocaine	17%
Alcohol	15%

REMEMBER

How quickly you become addicted depends upon how addictive the substance is and how physically and mentally vulnerable you are when using it. For example, depending on your physical and mental vulnerabilities, you may become addicted to nicotine after smoking one or two cigarettes per day. On the other hand, it may take you three months of smoking ten or more cigarettes per day to become physically dependent.

Waking Up to Your Own Addiction

One of the most difficult things to face is the realization that you're addicted. Being a person who is addicted is a label most people hate. However, a certain reality hits home when this label is used accurately. And once you confront this reality, you reduce the stigma associated with addiction (as, with caffeine and nicotine, a good proportion of people are addicted to something).

When trying to come to terms with your own addiction, the first question to ask yourself is: "Is my life out of control because of my drug or alcohol use?" The same question can be asked of a nonsubstance-related addiction like gambling, overeating, or sexual addiction.

REMEMBER

You're someone with an addiction when a substance (or an activity) dominates your thinking to the point that you "must do it now." You think about the substance or activity first and all other aspects of your life (like your family or job) afterward. Your addiction trumps all other important events or needs. You may

miss your kid's games, your best friend's wedding, your dinner plans, or intimate time with loved ones. You're determined (as in highly driven and motivated) to use that substance or to do that activity. There is no choosing. You're on a track without control of the steering wheel. You're caught in the web of addiction.

Starting with self-observation

Completing a written test can give you a good indication of whether you've given control of your life to a substance or an activity. But first, approach yourself with utmost honesty. Take a real look, a hard look, at your behavior. Don't waste time and energy on self-deception.

In the world of drugs, sophisticated tests have been developed that tell scientists, in fine detail, whether you have taken a drug and how much of that drug is in your blood stream. (The tests don't reveal the extent to which the drug is affecting your brain chemistry.) No tests, however, can tell you if you're addicted. Everyone experiences drugs in a different way — some people have enormous tolerance for drugs, and others have very little tolerance at all.

WARNING

If your experiences resemble the three following descriptions, you don't really need another test — you may as well admit that you have an addiction:

- You notice increased drug-seeking behavior (for example, contacting your sources, going to places where you can score drugs, checking out the odds and lines for sporting events).
- Your main reason for living becomes using.
- You lose touch with important aspects of your life (like family, friends, job) because of your drug use.

Taking a quick self-assessment

If you suspect you're addicted to something, be it alcohol, drugs, or a nonsubstance behavior like gambling or computer games, ask yourself the following questions:

- Is my life out of control because of my _____ use? (Fill in the blank with the substance or activity you think you may be addicted to.)
- Do I think about my preferred substance or activity first and other aspects of my life (family, job) second?
- Do I use my preferred substance or do my preferred activity almost every day?

- Do I fail to do what is normally expected of me because of _____? (Fill in the blank with the substance or activity you think you may be addicted to.)
- Do I risk my personal safety (or even worse, the safety of my loved ones) to get drugs, alcohol, or to engage in my preferred activity?
- Does my body crave the experience associated with the substance or the activity so strongly that I feel I must have it?

A "yes" response to any of these questions indicates addiction. Also, the more "yes" responses you give, the more severely you're addicted.

DRUG TESTS

The amount of time it takes for a drug to show up in your system depends on four factors:

- The amount and frequency of substance use
- How quickly the substance gets absorbed into your body
- How long after absorption trace elements of the substance, called *metabolites,* linger in your system
- How efficient your system is at *excreting,* or removing, foreign elements from your body

Metabolites are stored in the fatty cells of your body for different lengths of time and can cause you to fail a drug test many weeks or even months after your last drug use. The slower your body metabolizes the substances, the longer the drug can be detected in your system. A slower metabolism can be the result of low body weight, old age, poor health, and shorter length of time using the substance.

The five ways of testing for chemical drug substances in your system are:

- Urine test: Most common, most affordable, level of accuracy equals a blood test
- Hair follicle test: Most accurate, most expensive, can detect toxins consumed five days to six months or more prior
- Blood test: Somewhat common and affordable, level of accuracy equals a urine test
- Saliva test: Least common, generally less accurate than the other tests, can only detect toxins consumed three to four days prior
- Breathalyzer test: Alcohol consumption can be tested through a Breathalyzer

Breaking down the types of addictions

Addictions can take many forms (including substances and nonsubstances). I discuss these forms, one-by-one, in the following sections; I hope you'll recognize whether your experimentation with a substance or behavior has crossed the line to addiction. For more details on each of these substance and nonsubstance addictions, flip back to Chapters 2 and 3. And for information on treatment options for the addictions outlined below, look at the chapters in Part 3 of this book.

Alcohol

Drinking alcohol has become the only way you can feel normal. You may have a drink early in the day to stop feeling lousy ("the hair of the dog"). You may also drink secretly, often alone, and if you haven't had a drink, you may be thinking about how to get your next drink. If you don't have a drink, you feel irritable and discontented. You hate it when family and friends interfere with your drinking. You may find yourself saying things like "It's my life, not yours," and "I don't care what you say."

The *CAGE* test is one of the best-known screening tools to determine whether you have a problem with alcohol. Ask yourself four questions:

- **C:** Have you ever felt you ought to **Cut Down** on your drinking?
- **A:** Have you ever felt **Annoyed** by someone criticizing your drinking?
- **G:** Have you ever felt bad or **Guilty** about your drinking?
- **E:** Have you ever had a drink first thing in the morning (**Eye-Opener**) to steady your nerves and get rid of a hangover?

TIP

Ask these same questions to see if drug use is a problem. The first three questions are also relevant for behavioral addictions such as gambling and sexual addictions.

Street drugs

You feel irritable, agitated, and nervous or jumpy every day. If you crave street drugs (cocaine, heroin, PCP, mushrooms, LSD), your first question of the day is "How do I get today's supply?" You have a reliable "source" to get your drugs from, but dealers you don't even know may approach you. You may not be forced to scour the streets for your drugs because some dealers may come right to your door. If you decide to risk personal safety (or even worse, the safety of loved ones) to get drugs, that's another indication that you're addicted.

REMEMBER

If your body screams out for the drug and you want to do whatever it takes to calm it down, you're addicted. Unsurprisingly, you may feel better as soon as you purchase the drug and before even using it! How to explain this reaction? You know relief is on the way.

Prescription drugs

If you "doctor shop" or have multiple physicians prescribing the same drugs, you're likely addicted. Prescription medicines like anti-anxiety drugs, antidepressants, sleeping pills, and pain medications may create a dependency leading to addiction. The hallmark of any drug addiction is an increased tolerance and dependency on the drug.

WARNING

Physicians are experts in prescribing medicines to cure disease or ease pain and illness. But they may not be experts in addiction. Some physicians are more likely than others to give patients a prescription for their sleep, behavioral, or emotional problems. Be aware that your physician could be inadvertently overprescribing your medication.

Gambling

You get an adrenalin boost when gambling. Your heart races, you breathe faster, your blood pressure rises, and you sweat. Gambling is arousing — the thrill of winning, the threat of losing. If you're in a casino, the level of noise is purposely kept high to keep you aroused. You get a *kick*, a stimulant effect, from gambling that's very much like a drug effect. Over time, you get a sick and tired feeling like any other addict — you're gambling to exist and no longer gambling for fun.

Winning isn't as important as *being in the game*. If you're a compulsive gambler, you hate being on the sidelines and are easily drawn back into playing. You often demonstrate an impulsiveness that drives you to risk more and sometimes everything. The pattern is familiar: When you're losing, you bet more and more money to get even; when you're winning, you bet carelessly until the game ends.

You know you have a problem with gambling if the next game is always on your mind. Family, friends, and responsibilities all fade into the background. Every dollar is held so you can play. Winnings only help prolong the agony and the emptiness.

You'll do anything to get money to gamble: cash in family savings, empty bank accounts, and, in some desperate cases, steal from your employer.

TECHNICAL STUFF

Gamblers come in two types: *action gamblers*, the thrill-seekers who love the action (and usually the attention that goes with it), and *escape gamblers* who love to get away from life and escape into fantasy.

Computer games

It's amazing how dominant computers have become. But in coming to terms with this technology, we need to understand its power in generating a fantasy world. You can be a great warrior, a supreme commander, or a mystical sorcerer in computer games — all outside of the binding consequences of real life. Not only are computers everywhere (cars, offices, phones, homes), they can readily dominate your attention. But sometimes, they can be an escape from real-world consequences and dominate your attention to the point where nothing else matters. You get lost in the limited reality of a "computer world."

Here are some signs of a computer game addiction: you're a person who feels lonely; you may also feel anxious around people and paradoxically, feel most comfortable with strangers than people you know socially. Computer games become a way to tune out troubles and experience pleasurable highs but, increasingly, you live for computer games. The other activities in daily life fade in comparison to the time and effort put into computer games. You play to the point of neglecting important social, vocational, and personal responsibilities.

You know you have a problem if you play computer games to the point that school work or other work is neglected and everyday chores are neglected or forgotten. If this profile fits, you may be on a track where your addiction is out of control. The game dominates real life — *your* real life. That is the nature of a video game addiction.

Eating

If you are someone with a food addiction, food is rarely enjoyable. Instead, you eat to forget and distract — to numb feelings with a near constant flow of calories and tastes. Food relieves you from the pain or boredom of an unfulfilling life. Food serves as a treat, a compulsion, and sometimes as the reason to get up in the morning. Activities are planned around eating, and over time, the mirror becomes the enemy. The filling out of your torso is the critical sign of empty feelings inside. The agony of this experience can't be overstated. Although 43 percent of Americans are obese, the stigmatization is intense. Like all addictions, the addiction to food can dominate and ruin your life.

To tell the difference between normal and possible addiction-level eating behaviors, you need to consider several dimensions:

- **The quantity of food consumed:** If you consistently take in more calories than your body can burn off in a day and the quantity of food consumed is excessive, your eating behavior is likely serving another purpose, such as eating to relieve stress, boredom, and pain.

- **The types of food chosen:** You crave high-fat foods for the calming effect they produce. You turn to certain types of foods to make you feel better.
- **The ability to stop eating when you choose to:** You're unable to control yourself and stop eating when you know that you should.

TECHNICAL STUFF

Binge eating is characterized as eating a quantity of food larger than what most people eat within similar time periods. Binge eating also features a lack of control over how much and what is eaten.

Addiction to food, as you may have guessed, isn't really about food. If you eat a loved food compulsively (perhaps even storing up an extra supply), then the pleasure and enjoyment you receive from that food eventually and ultimately fades away. This fading effect is termed *satiation* and means that foods you may have once craved or loved no longer appeal to you. If you're a binge eater, then you may have experienced satiation with certain foods, but you eat them regardless of satiation. In fact, you may be mystified by why you can't stop eating them when they no longer taste good.

Are you food addicted? The key to the answer is asking yourself if your eating is out of control, if other people have annoyed you by commenting on your eating, and if you feel guilty about your eating behavior.

Sex

Sex addiction is especially painful because, when healthy, sexual acts are the pathways for intimacy and loving. When unhealthy, this remarkable path to intimacy makes a U-turn, and sex becomes antisocial, trust destroying, and isolating.

If you're addicted to sex, you probably don't perceive yourself as a worthwhile person or, at least, believe there is a precarious balance between whether you're a good person or a not-good person. You may not believe other people really care for you (in ways that count) or wish to meet your emotional and sexual needs. Most important, you feel that people won't accept you if they really know you. So you can only get your emotional and sexual needs met in situations that are partially or totally secret from friends and family.

If you have a sex addiction, you substitute sex for true intimacy. Sex makes your isolated life bearable. Being addicted to sex doesn't mean that you appear to be a failure or an undesirable person to others. In fact, you may very well be unusually attractive or magnetic and, thus, better able to persuade others to engage in your addiction.

FETISH BEHAVIOR

Fetishes (behaviors that are associated with sexual relief and orgasm) are common and having one doesn't directly equate to having a sexual addiction. However, you may behave compulsively in looking for fetish actions to arouse yourself. If this compulsive behavior gets out of control, fetishes become more closely associated with sexual addiction. Similarly, you may be turned on by the possibility of getting caught and thus engage in sexual behavior that is inappropriate (in public places or in situations where someone else may see you). This behavior also isn't an addiction until it gets out of control, when there are serious consequences instead of just the embarrassment of getting caught.

You may find yourself in a cycle of sexual addiction that begins with *preoccupation*, a mental state so dominant that it's virtually a trance. You're obsessed with thoughts of sex and the search for sexual stimulation — and that obsession can center on a particular person. You progress to *ritualization*, an individualized set of routines that precedes sexual behavior. You move through the cycle to *compulsive sexuality*, the sexual act that, no matter how unhealthy, risky, and shameful, must happen. You can't control or stop it. In the last part of the cycle, instead of feelings of satisfaction and contentment, you experience depression and despair centered on your compulsion about and degradation of the sexual act.

REMEMBER

Everything else is risked and devalued next to a potent, transitory "hit" of immediate sexuality. As with other addictions, the drive for sexual experiences comes to dominate your life.

Work

Work addiction often, but not always, accompanies other forms, like alcoholism, drugs, addictions, sex, and gambling. If you're addicted to work, you may see it as a retreat from painful emotional circumstances, like a failing marriage or an offspring's death. Or you may find that only when working do you feel secure and free of anxieties about losing your job or your company going belly-up. Whatever the reasons for overworking, you're likely suffering work addiction if you're compelled, from within yourself, to work incessantly.

With a work addiction, work comes to dominate your life. Family responsibilities, your health, and personal obligations are all forgotten or neglected. You may feel that you are working for them but you isolate yourself from your family. Relationships with coworkers replace the challenging intimacies that may occur away from work. Family and friends voice concerns or annoyance at your excessive work habits. You may feel guilty, but you feel and seem to be powerless to reduce your work time.

Work addiction is very tricky for many people to acknowledge because it is, for the most part, socially rewarded. The clue to uncovering work addiction is that despite your outward achievements, inwardly you feel personally degraded by your drive to work. Many achievements or accomplishments feel short-lived and, surprisingly, empty.

Perceiving Addiction in a Loved One

Perhaps one of the most unbelievable stories of the past is how the two young men responsible for the Columbine High School shootings in 1998 were able to stockpile a virtual armory of weapons in their bedroom closets while living in a close-knit American town. Even more surprising is that their parents were conscientious and highly involved in their children's lives.

This painful story is also a powerful example of how much parents of troubled youth and families of troubled adults can deny their loved ones' problems. The tendency to deny, rather than recognize, is more understandable when we examine interventions with an addicted loved one who is in trouble.

The example described in "Case study: Jack and his daughter" reveals the slow and painful journey from denial to discovery regarding a loved one's addiction.

Case study: Jack and his daughter

CASE STUDY

Jack had two daughters. His youngest daughter worked full-time in a job that she enjoyed. Over time, Jack began to feel puzzled by changes he noticed in her. She started to arrive late to family gatherings. Sometimes, she would miss family functions and provide no clear explanation for her absence.

She began to socialize with a new group of friends, and Jack received telephone calls from her old friends asking him if he knew how they might contact her. Jack was concerned, but when he asked his daughter about why she wasn't seeing her old friends, she said that she simply didn't enjoy their company anymore. She said that when the "old group" got together, her friends were only interested in talking amongst themselves. She reported feeling left out and lonely when with them. She also told Jack that she wanted to break up with her long-term boyfriend because she didn't feel she loved him anymore. Jack also noticed that his daughter seemed to be getting ill more frequently than usual. She admitted to missing a lot of days of work due to illness.

In time, Jack noticed that she was complaining more and more about work. In fact, she appeared generally more irritable and emotional. When she eventually quit her job, Jack was very surprised because she had always been a very conscientious and hard-working person. Soon she couldn't afford to pay for an apartment so she asked Jack if she could move in with him until she was able to get another job. He welcomed her but he became increasingly more puzzled and frustrated with her behavior. She stayed up most of the night and slept until the late afternoon. Uncharacteristically, she would sometimes lie to him. Finally, her old boyfriend called because he was worried and wanted to let Jack know that his daughter needed help because she was dependent on drugs. When Jack confronted his daughter about her drug use, she admitted to experimenting with drugs but denied that it was a problem. She said that she appreciated his support and caring but that he shouldn't worry.

Recognizing the warning signs

In Chapter 18, I talk about how to deal with a loved one who has an addiction. But you have to recognize the problem before you're able to deal with it. What follows is a checklist of the signs that your loved one has a substance addiction or is engaging in a self-destructive addictive behavior. Answer yes or no to the following questions.

Does your loved one:

- Turn up late for functions or dates?
- No longer follow through on commitments?
- Have more trouble with illness than usual?
- Have more problems at work than usual?
- Appear to be withdrawing from intimate contacts?
- Have unexplained absences from or inconsistencies in their usual schedule?
- Appear to have a new set of friends who they are highly involved with but who you don't get to meet?
- Have major financial fluctuations (like carrying more or considerably less money than usual)?
- Have lapses of concentration or memory?
- Stay up later at night and sleep in more during the day?
- Have more trouble than usual getting it together in the morning?
- Appear surprisingly secretive about specific aspects of their life?

Although this checklist can't diagnose an addiction in a loved one, the more "yes" answers you produce, the greater the chances are that your loved one is suffering from an addiction.

WARNING

In addition to the signs in the checklist, keep in mind that people are often addicted to more than one substance or behavior. A problem gambler is more likely than the average person to have a problem with alcohol or a sexual addiction. Alcohol helps to calm them down initially so they don't get too excited. In addition, many gamblers like all types of action. Thus, noticing one form of addiction in a loved one is a warning sign that they may have other addictions as well.

Keep in mind, however, that any of the warning signs mentioned can be signs of an addiction in someone no matter what their age. The following list highlights the kinds of addictions most common to specific age groups. I also give you some tips specific to noticing addiction problems with the various people in your life:

- **A child:** The type of substance abused is likely to be different for adolescents who may still be living at home. If adolescents start experimenting with drugs, they usually start with alcohol and nicotine or marijuana and then move on to "party" drugs like Ecstasy. An adolescent with an addiction problem may start to socialize with a new set of friends that you never get to meet. They may have more trouble than usual getting going in the morning or may stay up late into the night and sleep a lot during the day. Your child may become more secretive than usual.
- **A parent:** The choice of substance is more likely to be alcohol or prescription drugs. Also, behavioral addictions are more likely in adults. You notice the parent drinking alcohol daily, usually to the point where the parent appears high or intoxicated, and even drinks when alone. The parent has trouble fulfilling usual daily responsibilities such as preparing meals, going to work, and attending social functions. An addiction to prescription drugs is harder to detect than alcohol addiction. Some of the signs to watch out for with prescription drugs are memory and communication problems and trouble waking up in the morning.
- **A friend:** The choice of addictive substance or behavior may vary depending on the person's age. Keep in mind that if your friend is an adult, they can have any of the addictions mentioned in this book. With teenagers, on the other hand, the choice of substance is usually alcohol, nicotine, marijuana, and party drugs. As a friend, you may well notice an addiction problem more easily and more quickly than you would notice an addiction in a family member because friends tend to confide in each other more freely. You may also be one of first people in the addict's social network to notice his withdrawal from his usual social contacts.

- **A spouse:** The choice of addiction in a spouse can be any of the addictions that I discuss in this book. It can be very hard to recognize addiction in a spouse because you yourself may be caught up in denial and in a web of codependency. By codependency, I don't necessarily mean that you have an addiction like your spouse, although this is always possible. Rather you start to behave in ways that you think may "cure" your spouse's addiction problem but that paradoxically serve to facilitate and support the addiction. An example may be trying to protect your spouse from the negative consequences of their addiction by paying for debts or lying about illegal actions. In Chapter 18, I talk more about codependency and how to break out of it.
- **An elderly family member:** Sometimes, the elderly relapse to a previous addiction because they feel lonely and isolated as more and more members of their social network die or move away. So don't be deceived by age — addictions occur across every age group.
- **An ill loved one:** An ill loved one is likely somewhat limited by their illness and so may have limited access to certain substances or less ability to engage in some of the addictive behaviors. Sick people are at risk for addictions to prescription drugs, over-the-counter painkillers, and alcohol.
- **A coworker:** You may not be able to detect your colleague's type of substance or behavioral addiction, but telltale signs you may notice at work include: a sudden deterioration in behavior such as turning up to work late, appearing poorly rested, missing more work due to illnesses, and perhaps stealing money at work.

IN THIS CHAPTER

- Being a client
- Knowing your options
- Deciding which treatment is right for you
- Choosing when to start

Chapter 6

Assessing Your Readiness: Do You Need Help Now?

Why now? You may struggle with this question. It combines with the other question: If not now, when?

Admitting you're addicted is difficult, because there are no clear-cut indications of the need for medical attention. There is no malignant tumor or heart attack. On the contrary, making your decision to get help for your addiction often involves weighing the pros and cons of *getting help* against the pros and cons of *staying addicted.* The tipping point, that final convincing link, may be an event as heart-breaking as the crying of your child, as terror-inducing as facing time in jail, or as life-threatening as an overdose.

The best time to enter treatment is as soon as you're ready to sincerely aim for change. Clinicians can help you list your whys and help you find the emotional momentum needed for the first step. But only you can get to the crucial point of saying, "Now! Not later. Now."

In this chapter, I help you review treatment options to help you find the treatment types that best suit you. I also help you assess whether you're ready for treatment at this time.

Understanding Your Role as the Client

Family members, friends, and employers want you to stop your addictive behavior. At times, they may seem to want it more than you do. But *you* are the client who will be doing the hard work in treatment. You'll be looking in the mirror and being honest with yourself. The level of commitment that you need may come from the fear of losing what's most important to you and from feeling sick because of your addicted life and sick *of* your addicted life.

The simple goals of treatment are to stop addictive behavior and restore harmony in the mind and body. Only you can learn how to turn your life around and rebuild it. The more you realistically review treatment options and consequences, the more likely you are to make good decisions.

REMEMBER

The institution paying the treatment bills isn't the client. Nor are the family members, friends, and employers who invest in the outcome. Although they may have suffered major losses, emotionally and financially, they aren't the clients. Only *you* are.

TIP

Family members are often the first to confront you about getting help. There is a good chance your addictive behavior is now the dominant topic in all exchanges with your family. Addictions readily destroy family relationships, so it's important to get expert advice about your options as soon as possible.

Assessing the Options

One of the oldest medical guidelines is *primum non nocere*, which means *first, do no harm.* In treating addiction, the major consideration is stopping the addictive behavior. If you're addicted, you may consciously or unconsciously burn bridges with family and friends, meanwhile seeking support from people who share or support your addiction. You're likely to place undue reliance on the support you get from others in the addictive subculture and find yourself hostile or deceptive to anyone who interferes with your addiction, including family members. You may behave in ways that frustrate them and, ultimately, reject their positive efforts.

So when clinicians think of the potential harm of treatment (for instance, treatments that are too harsh or strict), they compare it to the levels of addictive self-destruction. If you're at the point of considering treatment, you're likely aware of the harm your addiction is causing your family, your friends, and *you.* Unconsciously or semi-consciously, you're likely punishing yourself for causing that harm and self-destruction is a way of enacting self-punishment.

Avoiding hopelessness

It is inevitable that you will confront feelings of hopelessness at times during your treatment. Hopelessness is itself an illusion and the primary illusion of depressive states of mind and body. However, that hopelessness can seem real when you don't accept the fact that addiction is, to some degree, a chronic, relapsing disorder. The reality is that all people, each day, make mistakes, and when it comes to recovering from addiction, it doesn't take a major mistake to cause a relapse.

TECHNICAL STUFF

Hopelessness is that mental state where you think that future success is impossible because your problem or illness can't be solved. You feel like quitting treatment and even quitting life because all you see is a never-ending story of pain, hurt, and defeat. Hopelessness is, of course, strongly linked with suicidal ideation and actual self-destructive behaviors. You can see how it might induce you to give everything up. The upside is that once you see through the illusion of hopelessness, you progress in your recovery. The emotions associated with the "hopelessness illusion" are part of the effective treatment of addiction.

If you conclude that you tried hard, and that treatment has failed (however defined), the illusion of hopelessness will dominate you cognitively and emotionally for a while. You're not alone when you wonder how hard it will be to recover from your addiction. Recovery is difficult and many sections in the first chapters of this book are devoted to explaining why. After all, the decision to quit would be faster and easier if quitting were easier or more assured. If you expect quitting to be easy, you're likely to see yourself as a loser after a relapse. If you expect it to be tougher, you're not *so disappointed*. Trial and error is the main form of productivity in the world. If you do away with error, everything becomes impossible. In other areas of medicine, like cancer, diabetes, and depression care, relapses are understandable and acceptable. Why think differently about addiction? Each day the addiction doesn't dominate is a blessing and an incremental and healthy change in your brain and your whole body.

REMEMBER

From a clinician's perspective, it's important to understand that compliance with treatment is the central problem of addiction medicine. If you don't comply with treatment, you increase your risks of relapse and re-establish the addictive behavior in forms that can seem more difficult to get at.

Choosing what's right for you

TIP

There are no perfect treatments, doctors, or patients. You need to remind yourself of this when exploring treatment options. Don't get caught up with searching for the "perfect" treatment, the one that can't fail. The best treatments combine efforts from multiple health professionals and disciplines that terminate addictive behaviors and sustain recovery. It's important to remember that stopping is only the beginning. Sustaining that stop is the critical second step.

Matching Your Characteristics to Treatment Options

Before reviewing the details of different types of treatments (these are described in Part 3 of this book), I want to inform you about particular client and treatment characteristics that may help you narrow your treatment options.

Client characteristics

Addiction spares no group, race, religion, economic class, gender, age, sexual orientation, level of success, level of celebrity, or family structure. Nevertheless, research suggests that your personal characteristics are important to the choice of treatment. One size certainly doesn't fit all. The initial goal of any treatment, especially addiction treatment, is to *stay in* treatment. Dropping out is common and reflects the tremendous pull addiction has on you. Treatment is designed to help you stop addictive behaviors and control the urges and cravings that could drive you back into addictive patterns.

The process of matching a client to a treatment has been the focus of much research. In general, the most important aspect to consider is your motivation for change. Before we get there though, let's review other client characteristics that influence what type of help you need and where and when to get it.

Demographics

Considerable research has focused on demographics. *Demographics* are characteristics that classify people into specific social subgroups. For example, demographics include your age, gender, race, nationality, religion, height, weight, and so on. How are demographics relevant when assessing treatment options? First, certain special interest programs and clinicians focus on specific demographic groups (for example, females versus males). Plus, if you're going to be in a treatment setting where you'll be spending a lot of time with others, it will be

helpful to know if they share or don't share similar demographics. How much difference are you willing to tolerate? Will it matter to you whether people are richer or poorer, have a similar educational background, and have different or similar ethnicities? These are good basic questions to ask. You may be more comfortable going through treatment with others who have similar demographic characteristics to your own.

REMEMBER

Ultimately, your treatment options may be decided by what is available and affordable. Although demographics are important to consider when you have choices in treatment options, the most important consideration is what treatments are available to you when you're ready to start.

Age and extent of addiction

If you're addicted, your age and stage of addiction are important factors. For example, if you're younger, you may be experimenting with drugs and subject to the intense peer pressures associated with younger use. If you're older, you're more likely to be isolated in your addiction and more involved with strangers who support your addictive behavior. Your stage of addiction refers to where you are in an addictive process that can start with a seemingly innocuous first-try but progresses to situations where you're living on a very rough edge.

The extent of risk-taking, how on-the-edge you are, is always an important variable to understand and assess. For example, reflect on whether you're at the stage where you're not taking sufficient precautions and thus exposing yourself to high risks. You may be more cautious and think that you are able to keep the risks at a manageable level. But your thinking may be flawed. You may be at a much higher risk than you think. While you may not be prepared to change your risk level, even thinking about it is a step in the right direction.

WARNING

If you're at the point where you're continually risking more to feed your addiction, the fuse is burning down toward an explosion. The sooner you get help, the better. You're likely at high risk of doing permanent harm to your body and your life. See Chapter 4 to find out more about the risks and consequences of addiction problems. If you're at the stage of experimenting with an addictive behavior, but don't think you're hooked, it's still important to get help soon. It's easier to end an addiction if you're not physically dependent and if your social life doesn't revolve around the addictive behavior. Get help before your drug or behavioral experimentation causes you permanent physical harm.

TECHNICAL STUFF

The term *development* refers to how people and situations progress, but it has many multiple meanings. Development, generally, refers to changes that follow a predictable, predetermined course. For example, children develop rapidly physically and mentally in their early years. Addictive behavior may also develop rapidly at some times and stabilize and change little at other times.

The dual diagnosis factor

Clinicians refer to you as having a *dual diagnosis* if you clearly have a mental health condition or another health problem in addition to an addiction. In healthcare, clinicians use diagnoses to classify signs (observed behaviors, appearances, test results) and symptoms (reported problems, such as sleeplessness and agitated feelings) and other variables like time (when the condition started) and context. The diagnosis also includes events such as trauma and exposure to infectious agents.

Dual diagnosis is more common than you may imagine. According to a report published by the *Journal of the American Medical Association:*

- Thirty-seven percent of alcohol abusers and 53 percent of drug abusers also have at least one serious mental illness.
- Of all people diagnosed as mentally ill, 29 percent have abused either alcohol or drugs at some point in their lives.
- The following mental health conditions are more likely associated with addiction problems: depressive disorders, bipolar disorders (having episodes of mania and depression), anxiety disorders, personality disorders, and schizophrenia.

Table 6-1 shows the percentage of people with a substance dependency who also have a common mental health condition. As you can see, there is an increased likelihood of substance dependency if you have a mental health condition. The percentages of having both a mental health condition and a substance dependency vary with the type of mental health condition.

TABLE 6-1 Risk of Substance Abuse Addiction in People with a Psychiatric (Mental Health) Diagnosis

Mental Health Problem	% with Drug Dependent Co-morbidity
Bipolar disorder I (manic and hypomanic episodes)	10.3%
Bipolar disorder II (at least one hypomanic episode and one episode of major depression but no full-manic episodes)	2.6%
Personality disorder (dependent)	7.3%
Personality disorder (antisocial)	6.4%
Any anxiety disorder	6.0%
Panic disorder with agoraphobia	9.2%

Mental Health Problem	% with Drug Dependent Co-morbidity
Major depressive episode	3.8%
Obsessive-compulsive disorder	4.6%
Phobia (specific)	3.8%
Phobia (social)	4.5%

WHAT CAME FIRST, AND DOES IT MATTER?

With addiction problems, you may not be able to figure out what came first. Sometimes, children with significant mental health problems fall into drug experimentation in early adolescence and sometimes, individuals with other health problems (for example, cancer, heart disease, diabetes, asthma) delay experimentation, as they're *already* taking drugs and know the dangers of drug mixing.

If you have a dual diagnosis, however, you present additional challenges to your doctor and yourself. The first rule, again, is to make sure you're safe. If you've been using mind-altering substances, you may have neglected your adherence to other important medications. Depending on how preoccupied you are with the addiction, you may be incapable of tracking which medications you've missed and for how long. Some drugs taken in excess (for instance, methamphetamine) produce a temporary psychosis that is frightening and debilitating. The temporary psychosis must be treated before you're given other treatments.

REMEMBER

Addiction treatment can be slow and laborious. It isn't a matter of "just saying no." Of course, there's yearning for simple solutions. But having another diagnosis complicates matters because the clinician must focus on short-term and long-term goals. After personal safety and more normal brain functions are re-established, the focus is, once again, on terminating the addictive behavior. In the case of substances, it means getting clean and sober; for behavioral addictions, it means stopping the compulsive activity. In all cases, it means replacing unhealthy patterns with healthy behaviors and healthy relationships.

USING THE PROBLEM LIST TO DECIDE ON TREATMENT

If you have a dual diagnosis, one of the questions you may be asking is: which problem should I get help with first? This is an important question that may influence your chances of treating the addiction problem effectively.

Addiction problems typically occur in combination with other life problems. Sometimes, these problems precede the addiction problem and sometimes the addiction is reactive to other problems. All one's problems cannot be solved all at once. However, even seemingly insoluble problems can give way to major life

changes that, although painful in the short run, ultimately cut ongoing losses and establish a firmer base for future progress.

Table 6-2 lists some of the problems clients have reported at the time they entered an addiction treatment program. This list isn't exhaustive, but it illustrates that an addiction problem is often one of a set of problems that must be resolved. In deciding whether this is the time to seek help for your addiction problem, it may be necessary to review all the possible problems you're dealing with and determine which can be put aside, temporarily, to deal with the addiction. You also must decide which of these problems needs to be dealt with prior to tackling the addiction. There may be some problems that you can deal with *while* undergoing treatment for the addiction.

TABLE 6-2

List of Problems Clients Have Reported at the Time They Entered An Addiction Treatment Program

An addiction problem other than the primary one the client sought treatment for
Serious financial debts
Marital discord
Chronic health problems (for example, HIV, AIDS, cardiac and/or liver disease, head injury)
Trouble with the law
Mental health problem
Restraining orders regarding contact with one's children or partner
Unemployment

ATTITUDES OF CLINICIANS AND CAREGIVERS

Caregivers can get caught up in denial patterns that sometime takes the form of believing that the simple passage of time will be the ultimate cure. Even if sayings like "My child will grow out of it," "It's a stage my child is going through," or "All kids get into trouble" are true, these attitudes put the caregivers into passive positions of waiting for something to happen rather than being pro-active. In treatment, the passive wait-and-see approach has a lower probability of success.

Clinicians, on the other hand, often take a confronting stance — a no-nonsense attitude — in treatment. This attitude focuses on three major goals: (1) it clearly

identifies who is the client (it's you, not your parents, spouse, kids, or boss); (2) it confronts the typical denial ("Really doc, I don't know what the big deal is. So what, if I <fill in the addictive behavior> a lot?"); and; (3) it deals with the sense of entitlement that you may feel and demonstrate ("Do you know who I am? Don't tell me what to do! You don't know what you're talking about.").

I have often heard that helpers in the addictions business are hardened, no-nonsense types. They certainly deal with a lot of disappointment. This attitude toward addicted persons and their families comes from both training and experience. No one is intending to be mean or cynical. It is part of the reality that in addiction treatment, actions speak louder than words.

Treatment characteristics

Treatment means intervening in and changing a person's life using psychological, pharmacological, and sometimes surgical methods. Many treatment options exist and are described in more detail in Part 3 of this book. Here I describe some general characteristics of treatments that may be helpful for you to know about when deciding which treatment option is best. The major treatment characteristics can be classified under four categories:

- **Setting:** Setting characteristics include inpatient (or residential) versus outpatient (or ambulatory) facilities, and community-based facilities (churches, schools, and community centers) that offer self-help or peer-support programs, as well as virtual or remote treatments that enable you to access help via phone and Internet.
- **Modality:** Treatment modalities come in many varieties, including the *treatment team approach* consisting of physicians, counselors, nurses, social workers, psychologists; self-help treatment assistance; and individual counseling based on a specific treatment model (for instance, psychodynamic therapy, interpersonal therapy, cognitive-behavioral therapy, family therapy); group therapy; and novel pharmacology.

  Psychopharmacology is a field of addictive medicine where physicians use medical drugs to help people with symptoms, cravings, and their behavioral problems. The pharmacological methods for treating drug and alcohol dependence are described in Chapter 10.

TECHNICAL STUFF

- **Providers:** These are different categories of clinicians and nonclinicians who provide addiction treatment. The sponsors in twelve-step programs guide people through the process of recovery, supporting them every step of the way. Addiction counselors, physicians (some are addiction specialists), psychologists, social workers, nutritionists, exercise therapists, and others

help you change your addictive behavior and related problems. Each different provider works within one or more modalities, meanwhile invariably bringing his or her own attitudes and orientations to the process of treatment.

- **Duration:** Finally, the duration of treatment is an important consideration. This is an extremely controversial area because of the recurrent nature of addiction, the sparseness of long-term research, and the wide ranging expert opinion. The important factors are easy to point out but difficult to decide on and make use of. How long do you need to be away from your home and local community and in a (residential) treatment setting? How long a treatment of this type (or other types) can you afford?

TIP

The treatment options that are described in Part 3 of this book vary with respect to these four categories. In considering your treatment options, decide whether you have preferences for the setting of the treatment, the treatment modalities available, the kind(s) of treatment providers you'll access, and the duration of your treatment.

Making a treatment choice

Okay, you realize that you're ready to choose a treatment. You're likely to feel more vulnerable now, even though you recognize your strength in taking this step. Try to find some experienced guidance and be prepared to discover that what sometimes sounds easy, is very difficult. Think about the goals of stopping your addictive behavior and finding a new life. Here are some pointers to guide your decision-making about treatment:

- **Make a list of your personal characteristics and your current problems.** Remember that your personal characteristics are those that could influence the types of treatment facilities or approaches that fit with your demographics (for example, your gender). For help with thinking of your current problems, refer to Table 6-2. The problems to list are those that need to be dealt with before or during treatment. Put this list in front of you. Now write out or discuss your reasons for treatment with a highly trustworthy individual. Be thoroughly honest. Hold nothing back.
- **Think about the duration of treatment you want.** Expect it to take longer than you want. Beware of beat-the-clock promises. We're not ignoring the fact that a single interview with an experienced helper can make a huge difference in life and that you certainly want to stop using and to detox as soon as possible. But it is the *long-term* result that counts. Always look to your long-term freedom from addiction.
- **Consider who you can trust to give you the best advice.** It doesn't have to be a professional; in my experience, the advice of someone who has "been

there" is very helpful. That person will give you an example that addictions *can* be beaten. Listen for the detailed explanation of what worked and imagine you're in the same or a similar situation. If the advice fits your situation and you think it's right, you're on track.

- **Consider your level of psychological-mindedness.** This concerns your willingness to think carefully and systematically about who you are and what you're doing. *Psychological-mindedness* is the ability to see relationships among thoughts, feelings, and actions in order to discover the meaning and causes of experiences and behavior. It is also the ability to recognize psychological and interpersonal problems and to use psychological concepts to change symptoms and behaviors. If you see yourself as a psychologically minded person, psychotherapy may be especially appealing and effective as a treatment modality.

TIP

You don't need to be highly psychologically minded to benefit from psychotherapy. However, you probably should be open to exploring feelings and thoughts to benefit from psychotherapy.

Deciding When to Start

So what's right for you? Start slowly with the question, "Is it time for me to quit?" If the answer is yes, get help. Do it now, not later.

If the answer is no, accept it. You're not ready yet. However, whether your response is yes or no, make sure your decision is well thought out. Consider what you have to lose or gain by seeking treatment. There's a lot at stake and the slippery slope can get hyper-slippery resulting in big losses that have a life-long impact.

Cost-benefit analysis of seeking help

The cost-benefit analysis is a useful exercise for any major life decision. In this case, the decision is whether to get help for your addiction. Table 6-3 illustrates a list of potential costs (cons) and benefits (pros). Use this table as a template for drawing up your own table of pros and cons for treatment.

TIP

List the costs (cons) and benefits (pros) of not seeking treatment as well as the costs (cons) and benefits (pros) of seeking treatment.

Now take it to the next step and see how ready you are to seek treatment at this time.

TABLE 6-3 Cost-Benefit Analysis of Seeking Treatment

Impact Area	Pros of Staying Addicted	Cons of Staying Addicted	Pros of Getting Treatment	Cons of Getting Treatment
Health	None	Damage (for example, liver damage)	Detox will help	None
Family	Continuing to get along with my wife who also has this addiction If it's a work addiction, helping others feel financially secure	My family is losing faith in me	Help my relationship with my family	None
Finance	None	Get into further financial trouble	Savings from money no longer spent on the addiction	Expense associated with getting help

Self-assessing your readiness for change now

One way of understanding how close or far away you are from seeking help for addiction is to track the *stage of change* you're in. Two researchers, Dr. James Prochaska and Dr. Carlos DiClemente, pioneered studies of people who successfully made major changes in health behaviors such as eliminating addictive behaviors and found that they typically went through six stages.

The following statements will help you determine which one of these stages of readiness you fit into. Pick the one statement that best describes how you feel about seeking treatment at this time. Use a pencil to circle this statement. After time or after reading more of this book, redo this analysis to see whether you have moved any closer to seeking treatment.

Here are the statements:

- **I am not even seriously thinking about seeking treatment for help with changing my addiction.** This stage of change is called *precontemplation.* Even if you're *not* ready to stop your addiction, mitigate or reduce as many of the risks associated with your addiction as possible. (Chapter 4 tells you more about these risks.)
- **I am seriously considering and debating whether a change is necessary and positive for me now.** This stage is called *contemplation.* It's marked by ambivalence about change. You may have as many reasons for seeking treatment as you do for not seeking treatment at this time. You may also feel

uncertain whether you have what it takes to stop the addictive behavior, even if you were to get treatment. A place to start may be to begin to mitigate the risks associated with your addiction (see Chapter 4) and to review how large the problem of addiction is for you (see Chapter 5).

- **I feel resolved to seek treatment and I have even started to consider my options for treatment.** This stage is called *preparation.* You are actively seeking out treatment. You may even have started to cut back on the addictive behavior. You feel determined to try to tackle the addiction, even if you're not 100 percent certain that you can do it. (You may find it helpful to read Chapter 8 of this book and review other relevant chapters in Part 3.)
- **I am in a treatment program for overcoming my addiction.** This stage is called *action.* In this stage, make sure you're getting all the treatments you need in order to overcome your addiction and recover successfully. (For pointers, review the chapters in Part 3 of this book and read Chapter 15.)
- **I have kicked my addiction.** Although it depends somewhat on how long you have quit, this stage is called *maintenance.* In maintenance, you need to protect yourself from relapse. (For tips on how to do this, read Chapter 15.)
- **I had kicked my addiction but I relapsed.** When this happens, you go back to a previous stage and start the journey over to addiction freedom and recovery.

REMEMBER

When is it too late, hopeless, and time to say, "Forget about it"? Never! I have seen incredible recoveries. I have seen a person leaving the street to go into intensive care and then on to a liver transplant list. That person smiled for the first time in years and expressed amazement that he could actually sense his senses (in this case the smell and taste of apple pie). Tears rolled down his face, and his human spirit was rekindled. Never give up. Addictive behaviors change. People recover. *That's a fact and it applies to you.*

IN THIS CHAPTER

- Stopping addictive behavior
- Understanding your triggers
- Becoming willing to change
- Discovering factors that can help or hinder quitting

Chapter 7

Quitting: Easy to Say, Hard to Do

Your path to becoming free of addiction starts with a leap forward. After much thinking, talking, and planning, an internal struggle begins when your personal strengths and motivations may be tested. Practical strategies aimed at control become very important — strategies that enable you to control your environment. Strategies that enable you to remove yourself from tempting situations that lead back to addiction.

REMEMBER

Although all efforts to become free of addiction have similarities, the most important points of your program are those that work uniquely well *for you*. In this chapter, I give you pointers to help you figure out what those important points are and how they can work for you.

Successful Quitting

Although many paths can lead to becoming free of addiction, the bottom-line of successful quitting is staying free of addiction. It could be for the rest of your life, or one year, six months, or two weeks. The longer the freedom lasts, the longer it's likely to last. During any period of the time you're addiction-free, you learn something about remaining free. All the lessons accumulate — they heap up to help you reach longer and more satisfying *free periods* from addiction.

WARNING

Defining your quit goal will make you choose between abstaining from the addictive behavior versus controlling it. *Abstinence* means the quit goal is to absolutely quit (I'll never use alcohol again; I'll never gamble again). *Controlling* the addictive behavior means still engaging in the behavior some of the time, but in a controlled versus compulsive way (I will not binge eat; I will not engage in compulsive sexual behavior). You must decide what to aim for: abstinence or control.

Some people with addictions must be abstinent because any restart of the behavior ("one drink" or "just one puff") breaks their resolve and starts them down the slippery slope to relapse. Some tolerance of addictive behavior must sometimes be controlled because abstinence is impossible or unrealistic (for example, you can't stop eating). Other addictive behaviors (like compulsive sex) are best managed by a long period of complete abstinence followed by a gradual return to normal behavior.

As you can see, continuous decision-making is necessary to meet your quit for freedom goal. It's impossible to fully consider each method of quitting before you leap into your own unique quit attempt. At some point during your review of them, you feel you have enough information to make the leap.

TIP

After you leap, persistence is the key to success. Stay focused and keep moving toward your goal, even if you encounter bumps and stalls — and relapses (big or small) along the way. A smooth journey isn't necessarily the golden road to success, as long as you learn what works and what doesn't with each bump.

Becoming Aware of Your Triggers

TECHNICAL STUFF

Triggers for addictive behavior are the stimuli preceding the behavior that become associated with the addiction. Most addictive behaviors are *classically conditioned*, which means one stimulus (like the sound of a bell) becomes associated with another stimulus (like food) to produce an *automatic* reaction (salivation). Over time, the bell ringing, by itself, brings about salivation. The Premack Principle describes how any behavior that happens prior to a self-rewarding behavior tends to increase. As with classical conditioning, people respond to more than just the addictive substance or activity — they respond to the stimuli that are associated with the addiction.

You can't always reduce the power of triggers. But you can reduce how often you're exposed to them. In a way, it's simple physics. You keep the matches away from the firewood, and you keep the heads of the matches away from the striking surface that ignites them. In time, with concerted and consistent efforts at stimulus control, your addiction triggers lose power. Even after years of abstinence,

however, their retained power can be surprising. In this section, I review the different types of triggers you may face.

External triggers

Do you feel like engaging in your addictive behavior when you're with certain people? Does being at certain places increase your urge to engage in your addictive behavior? Does the time of day or the sounds of certain songs increase your urges? If the answer is "yes" to any of these questions, your urges to engage in addictive behaviors are influenced by external triggers.

A surprising variety of external events can trigger your addiction. For example, seeing someone give you a "hungry look" may set off a sex addiction. Alcohol use may be stimulated by TV commercials, or being near a liquor store or bar. An external trigger is something in the outside world that sets off the urge or craving that brings on addictive behavior.

WARNING

In particular, you may not realize that people can serve as external triggers. Just being with friends or acquaintances who are tied to addictive behaviors (like gambling) can powerfully increase your addictive urges. You might think that you can handle the temptation. But as a socially sensitive person in terms of your conscious and unconscious mind, it's very likely just being with certain people will cause you to relapse into past addictive behaviors.

Internal triggers

Inner stimuli can also drive you to drink, shoot up, snort, or engage in the compulsions of behavioral addiction. Internal triggers often take one of two forms. It may be a low mood that feels crushing and intolerable, or it may be a high that drives you to throw caution to the wind.

The challenge in learning about internal triggers is that sometimes they're linked to particular relationships. Some people have a special influence in undermining the naturally positive moods you experience, inadvertently convincing you that only with drugs or alcohol or gambling can you find something positive about life.

Combination triggers

External triggers often combine with internal triggers, and when this happens, you can be more susceptible overall because the combined triggers quietly drive you to take on greater risks. In fact, you rarely wind up in a high-risk area (addictively speaking) by accident. Usually an internal trigger is working in ways that function under your radar screen and outside your usual levels of awareness.

REMEMBER

To avoid this, you must figure out how to *actively* steer your life, to keep yourself on the path that is free of addiction. As soon as you feel directionless, it can be a signal that you're headed for trouble, driven by internal triggers of which you're only partially aware. If you suspect this is true, take action before it's too late. Remember that when the stronger conditioned responses or habits take hold, you'll pass close to the slippery slope. You can be driven by inner and outer forces that are temporarily stronger than your capacities to resist. Once you're slipping down the slope you're under the influence of the powerful reactions that cause relapse. It's a very *temporal* relationship — minutes and seconds can be crucial. The more minutes and seconds of temptation exposure, the more slippery the slope gets, until there's a point of no return.

If you ever doubt the power of triggers, pay attention for one day to how many times you're exposed to cues, mostly commercial cues, that encourage eating or drinking or having sex with someone. They are the main means of persuasion and everyone faces hundreds (if not thousands) of these stimuli. Commercials are designed to raise the dopamine levels in the brain. Most relate to fundamental urges or cravings. This is modern advertising. For example, beer commercials often target males from 25 to 35 years of age. The commercials link sex with beer, while emphasizing the camaraderie of friends. The same message is conveyed over and over again — everything goes better when drinking a beer.

Think of other associations (coffee and donuts; gambling and luxury). The commercial marketing machine won't let up because you're fighting an addiction. You will always face a stream of images, voices, sounds, and words designed to link one of your basic urges to a product skillfully placed in your conscious and unconscious mind. The product placement is a mental placement and it influences you to later reach for cash or a credit card to buy it.

Time as a trigger

Time is a very specific cue for addictive behavior. We're conditioned to eat at a certain time of day — and the 5 p.m. round of drinks is a well-known ritual. Later in the addiction process, the song "It must be 5 o'clock somewhere" reflects the attitude that timed cues give way to internal triggers. In some cases, the weekend is the trigger to relax, let go, and indulge addictive tendencies.

Your identity as a trigger

Another type of stimulus control is when you encounter the persuasive attempts of suppliers. Suppliers of addictive substances and activities often treat you with deference, being solicitous and respectful, while looking for that gleam in your eye that signals you're hooked for another sale.

The ease of availability as a trigger

Triggers remind us of the increasing accessibility to addictive substances and environments. Cigarettes, for example, are widely available, with alcohol nearly as available. Prescription drugs are harder to get (although if you're drug-addicted, you can find a way to get them fairly easily). The increased availability of slot machines and other games of chance are clearly tempting for compulsive gamblers. Online betting and pornography are immediately accessible — only a few mouse clicks away. With the Internet, it's all too easy to make a connection around any one of several behavioral addictions.

Magical thinking

Amidst all the temptations of everyday life, you must remember that freedom from addiction begins with deciding you're ready to commit yourself to cessation. To maintain the quit for one day and beyond, you must discover how to control urges, cravings, and symptoms of withdrawal. Unfortunately, people with addictions often exhibit magical thinking in relation to key behaviors. A core magical belief is that change will just happen one day. This is like believing you'll win the lottery. It could happen, but the probability is very, very low. It's fed by procrastinating — believing you can "put it off" without too much trouble happening currently. But trouble *is* happening right now. Your addiction imprint is getting deeper.

I use the term *magical thinking* for thoughts based on wishful thinking or fantasy. Sometimes these thoughts are laced with grains of truth, which makes them more seductive. If a grain of the thought is true, you may not have a hard time believing that all of the thought is true. For example, people often use the start of a new year as the best time to give up an unhealthy behavior or make a positive change in life. Resolving to do something does help strengthen your commitment for change. However, thinking that New Year's Day is an especially good time to make such a resolution is *magical thinking*. The best time to make a change depends on you as an individual. It depends on what's going on in your life and whether you have really resolved to change (see Chapter 6 for guidance in assessing your *readiness for change*).

REMEMBER

Magical thinking is common and is the basis for superstitions and hopes for a miracle. We all need hope, and how we achieve it depends on personal experience. I'm not opposing spirituality and related beliefs here. I'm just challenging the various beliefs people have in magical cures for addiction.

There are, of course, as many triggers as there are people and addictions. Everyone's triggers are slightly different and ultimately unique. I have just covered some and you may have some that are considerably different than those covered.

Review your life carefully and try to understand your triggers. Try to especially focus on the ways they seem similar to those experienced by others, and the ways they seem unique to you as an individual.

Increasing Your Motivation to Change

Motivation is elusive. You will find many ads touting increased motivation as an answer to addictive behavior. For example, one claim was "You can easily quit smoking and drinking. You can find the self-respect you deserve." That logic is quite simple logic. As you'll discover, the initial stop isn't as difficult as sustaining and maintaining the quit.

What follows are some ways to increase your motivation:

- **Give yourself incentives.** Give yourself special rewards that are meaningful to you, knowing that they may not be interesting or meaningful to anyone else. Desire is always motivating but you must appeal to your healthier desires.
- **Love.** Realize that the greatest boosts to motivation are authentic experiences of love. When you feel yourself weakening or need a boost, deliberately bring to mind a loved one — one of the people in your life whose trust and faith mean a great deal. Sometimes, the greatest boost to your willpower lies outside of yourself — in the people who mean the most.
- **Relax.** Consider the view that sometimes, strangely enough, the most direct route to increasing motivation is releasing and letting go of struggle. This means finding a nonaddictive way to thoroughly relax. Getting a deep muscle massage is good. Or taking a relaxing shower, going on a walk, or practicing meditation or yoga. Or you may be the kind of person who responds to taking off into pleasant, natural environments that represent, for you, a retreat from stress.
- **Talk to yourself.** Resort to the simple method of self-talk, be it silent self-talk or actual verbal utterances (if you talk loudly, try it when alone in your car). In self-talk, you're anchoring your thoughts and emotions to your voice, be it a silent inner voice or your regular speech. You're mobilizing the same forces you mobilize when you cheer for favorite athletic teams or athletes. You're simply making yourself the object of your own cheering section. It may sound simplistic or hokey, but if you need to increase your motivation, you don't have time for standoffish sophistication. Don't hold back from trying something new — try it and see whether it works.

Factors That Affect Your Ability to Find Addiction Freedom

As a clinician, when I review the reasons why clients relapse, I learn more about the underlying factors in their lives that influence addiction. Although such factors vary per individual, quitting is easier and more probable if you pick a time when the events in your life permit or support a good attempt. Of course, the opposite is true. Some events in your life will make it hard to muster the focus and the motivation to quit. The emotional upheavals caused by big life changes can be these types of events.

WARNING

Don't be fooled, however, into thinking that just by changing your geography or job or relationships will help if you're not committed in other ways to changing your addicted behavior. When people move or find a new job, for example, it can stimulate addictive behavior and excitement to new heights. As soon as you arrive in the new location or start the new position, for example, you may find yourself looking for new connections that perpetuate your addiction.

REMEMBER

Your attempts at addiction freedom must be active attempts. You must *act* to get it started and you must *act* to sustain it. Whenever it looks easy and you feel you can passively linger, consider that something is likely wrong. A passive approach likely leads back to addiction. As long as you're deliberately moving in the right direction, you can be assured that you're moving away from trouble and temptation. As long as you're actively moving in the right direction, you're actively weakening the imprint of addiction while strengthening your resolve.

Geographical change

The geographical cure is a popular method of controlling addictive behavior. Moving is a significant change that alters your stressors and heightens your hope and enthusiasms. Moving can be the fresh start that many people want in their lives. I have heard people in the depths of their addiction say many times, "I'm going to get out of here, move, and leave my troubles behind."

It can be a good idea to leave your geographic situation for a period to discover something new. This is the thinking behind university professors taking sabbaticals. Several companies have similar leave policies that ensure employees maintain a creative edge and avoid burn out.

It may be necessary for you to leave your home or your job for a period of time to get treatment for addiction. I discuss residential treatments in Chapter 9.

The geographic cure is tempting because it's a routine that many people with addiction already follow. When people build their lives around their addictions (stealing time to feed the addictive behavior), they get into more and more trouble. When they think about quitting, they often think of all of the troublesome situations they want to avoid. Moving on seems attractive because there is just so much to fix in the place where you are. At a certain point in your attempt to break free, a break from your immediate environment can be just the thing to stir you into action. Sometimes this is the best way — or the only way — to take that first important, definitive step.

A change of job

Job stress is often a significant contributor to addictive behavior. The familiar pattern is to blame one's job and related stressors for continuing addictive behaviors. This is often a valid point, by the way. Many people who become addicted first get work-addicted: Their jobs become so intense they end up with little time to engage in normal leisure and quality-time activities with intimates. Under such conditions, they have the understandable desire to pack highly pleasurable activities into some few free moments — particularly at the odd or unpredictable hours when their jobs simmer down. At those times, they often want to "live it up" to prove that all the work and tension is worth it. Thus work stress can increase your risk for addiction in two ways. First, because you're working long hours, addictive behaviors become the quick and easy way to relax. Second, because you're struggling during those long hours, you want to celebrate the major and minor successes with the intake of celebratory substances (drink, food, drug) or activities (gambling).

If this profile fits you, a change in job may be helpful. Perhaps you're ready to embrace more balance. You need time to cultivate relationships with those you love. Keep in mind that love is the all-important element in boosting your motivation.

WARNING

A frequent pattern leading to addictive behavior starts with the attitude "you deserve it," which is a variant of "poor me." You think you have to decompress and find a way to relax, and what better or quicker way than with drugs and alcohol. A psychological dependency readily develops from this mindset.

New relationships

People getting free of their addictive behaviors need to change some (and perhaps, many) relationships. You must find people with interests that aren't related to

your addictive behavior. Finding friends who have no interest in your addiction and instead have a considerable interest in you as a person, is refreshing and healthy.

Patterns of risk-taking and social relationships develop early. You may love the action, the rush, the being cool, the rebellion. It defines you and influences your socializing. Perhaps you find yourself frequently experimenting and taking risks as a way of experiencing the spice of life. Although this willingness to experiment and take risks can be positive when exercised in the right ways, it can also be a pattern that you need to modify if you are to make a sustained effort and have sustained success with quitting. The key to a sustained quit may be a balance of experiences and a balanced set of relationships with other people, in contrast to the excitement of extremes.

Codependency with a partner

The proximity of a live-in partner or spouse is a powerful factor that influences quit attempts. You will have stronger times and weaker times with respect to sustaining a quit, and being exposed to the wrong temptation during a weak moment can push you over the top.

If you're in a serious and committed relationship where your partner supports your addictive behavior, I call it a problem of codependency. *Codependency* was the term initially used to reflect situations where people in relationships with addicted partners acted in ways that denied the problem and enabled the addiction. It has now come to represent the type of relationship where your *autonomy,* or independence, is discouraged or considered threatening to your partner.

The same forces are at work in either or both definitions. One partner denies a problem in the other partner (be it addictive or otherwise) because that partner is anxious about rocking the boat.

This pattern of refusing to observe and communicate honestly can, of course, be present when neither partner is addicted. In most cases, refraining from honest communication happens in a problem area in the relationship. In other words, it occurs in the same area where honest dialogue would be anxiety provoking were it to occur. Communication is anxiety provoking because it reveals truths about the relationship that indicate needs for change — in either individual or both partners. The partners fear the change, so it seems easier to deny the problem and avoid the truth.

A recovering partner

Partners who are recovering together can be incredibly helpful to one another and can find a much more meaningful and connected experience — with addiction out of the way. The mutual support of recovery can be a tremendous strength in the relationship. Healthy relationships depend on open communication, honesty, and trust.

WARNING

Recovery situations can be tricky because partners often progress at different rates in freeing themselves of addiction. The partner who is ahead can feel lonely — or angry that the partner lagging isn't living up to their commitment. On the other hand, the partner engaged in more risky activities can exert a major negative influence on the resolve of the partner who is succeeding in recovering.

3 Examining Treatment Approaches

IN THIS PART . . .

I explain several treatment approaches in detail, including residential treatment, psychotherapy, and detoxification. I specifically review the advantages and disadvantages of twelve-step programs. To help you select a treatment approach, I review the seven different views of addiction that guide treatment, and I provide case stories of people's experiences in treatment. I also provide information on alternative treatment approaches for addictions, and I discuss how different treatment approaches are combined for maximum benefit.

IN THIS CHAPTER

- Looking at different perspectives on addiction
- Understanding how combination treatments work

Chapter 8
Treatment Choices

The treatments that appeal to you have a lot to do with the beliefs and attitudes you hold about yourself and your future. These thoughts and emotions influence what and how you learn, the kinds of information that prompt you to take action, and the kinds of actions you're most likely to try out.

TIP

To help you decide which treatments to explore, first ask yourself whether you're open to new ideas or more inclined to trust conventional methods. The next critical question is how much medicine you're willing to take. You may be willing to take anti-addiction drugs to see if they benefit you. On the other hand, you may feel you've had enough drugs and just want to become progressively drug-free.

In this chapter, I describe the most common treatment options to help you make educated decisions about treatment. I also tell you about combined treatments and why and when it's best to use a combined strategy.

Different Viewpoints on Addiction

In this chapter, I assume you will choose your own treatment and provide you with important information on which to base your decisions. Depending on how you feel and think, one or more of the following perspectives on addiction and treatment may appeal to you. In Chapter 9, I discuss current perspectives on how personal characteristics may make you a good match for certain treatments.

The moral dimension

Experimentation with mind-altering drugs has taken place in every age of recorded history. It has been normal to use a drug or alcohol to celebrate, to reduce anxiety, to soothe pain, to raise spirits, and to cultivate spirituality. Addictive behaviors emerged and became more frequent as we developed the technologies to refine our intoxicants and make them more potent stimulators of pleasure centers in the brain.

The moral dimension enters into thinking about addiction because people with addiction will sacrifice almost anything to feed and sustain their addiction. How much of these destructive actions are under the control of the individual is debatable. But in the society we live in, the responsibility for these choices ultimately, if not initially, rests squarely on your shoulders.

Twelve-step programs are often seen as "moral treatments" because they assume a consciously willed aspect to addictive behavior. However, they also acknowledge that a great deal of addicted behavior is beyond one's control. That is why twelve-step programs place emphasis on appealing to a higher power: The higher power assists you in gaining more control.

An unfortunately consistent part of interpretations of the moral perspective is the assumption that humans are weak by nature. Therefore, if you engage in addictive behaviors, you're an especially weak person and, to balance this weakness, you must appeal to other sources of strength, like a higher power that will forgive past weaknesses (sins). It's not quite true that twelve-step programs assume weakness in a person or in people generally. They assume you may have weak moments but that you can master them and demonstrate strength.

Many treatments have been based on some kind of purification beliefs or purging rituals. However, the modern twelve-step programs have evolved away from these perspectives and now emphasize the disease model and the capacities we share to help ourselves. These developments are covered in Chapter 12.

REMEMBER

All moral questions are debatable — a good case can be made for addiction involving moral deficits, but a good case can also be made for the opposite perspective — that addiction is a disease that undermines choices, especially after greater quantities or lengths of use.

The disease perspective

The notion that addiction is a disease arose because addiction's destructive effects are like those of other illnesses. Most diseases can escalate from mild to moderate and severe forms. During mild stages, symptoms are often unfortunately

confused with the choice to engage in negative behaviors. For example, the fatigue accompanying illness can seem like laziness, or the confusion associated with neurological illness can be viewed as *willful* inattention.

After an illness is properly diagnosed, you can often trace such behavioral changes back to the milder forms of illness that caused them. Addictions are similar. After an addiction is severe and identified, people can look back and recognize its milder forms during which life was more controlled (although the control was already slipping away).

Briefly put, the disease perspective bypasses moral questions and defines the problem as a disease that undermines much, if not most, responsible decision-making. Being influenced by an addiction is seen as similar to having contracted an infectious disease that affects brain function.

The moral and disease perspectives aren't mutually exclusive. For example, if you're aware of some addictive tendencies and patterns in yourself or your family, you may consider it a moral obligation to deal with these tendencies, especially when still in the mild or moderate stages of addiction. (If you're not sure whether your behavior amounts to an addiction problem, read Chapter 5 and use our guidelines to observe yourself and decide.)

REMEMBER

What is known from the disease perspective is that addictive patterns, left to continue uncontrolled, become progressively more severe, leaving you with less control to direct your life in a positive way.

WARNING

Act when you have more room to move and when more of your personal life remains salvageable. The longer you wait to get help and the more addicted you get, the harder it will be to turn your situation around, and the more your life will be destroyed by addiction.

The pharmacological perspective

The pharmacological perspective is that addictions result from the presence or absence of certain biochemicals in your brain. Rather than addictive substances being used to overcome insufficiencies, appropriate psychoactive medications, such as antidepressants and even psychedelics, are prescribed and used.

The pharmacological perspective, like the disease perspective, isn't opposed to the other viewpoints mentioned. You can read more about pharmacological treatment options in Chapter 10.

Thinking your way free: The cognitive-behavioral perspective

This cognitive-behavioral perspective is that the insufficiency leading to addiction originates in your thinking and emotions. In other words, distortions of thinking and communicating are seen as forming the basis of your addiction. The key beliefs concern relying on things (substances) for enjoyment because you believe satisfactions can't be found in sober relationships with others. Simply put, you have little or no confidence in finding satisfaction with another person unless a substance is involved. This perspective doesn't stray far from everyday perspectives — most people develop patterns of relying on something, other than other people, for consolation when disappointed or dissatisfied with other people.

Another central point is that rather than focusing on transforming negative situations when they occur, one tends to retreat into using substances to avoid confronting problems and to forget about them. Instead of learning from problems, the person turns to substance use and addiction.

The good news of the cognitive-behavioral perspective concerns the power and accessibility of clear and healthy thinking. Not only can we resolve problems and find satisfactions, we can understand and resolve the thinking patterns from which addictive tendencies originate.

Addictions as a bad habit: The learning models

The learning perspective of addiction has similarities to the cognitive perspective; however, it emphasizes the many levels of learning and habit formation involved. At the most basic level is conditioning, where you're *conditioned* to react to certain situations with specific physiological and psychological responses. Some of your conditioned responses are *subcortical,* meaning they influence behavior while bypassing your cortical thinking apparatus altogether.

TECHNICAL STUFF

Subcortical areas of the brain are those areas that control the body's basic survival needs. These areas regulate emotional, physiological, and behavioral responses to threat stimuli as well as to reward stimuli. The cortical areas of your brain are where thinking, planning, and judging take place.

Subcortical responses can be very powerful and influential because they seem to stem from the core of your experience and aren't immediately modified by changing how you think. You can see how the learning model combines with the pharmacological model because some drugs, especially during detoxification, reduce subcortically conditioned responses. The right drugs, at the right time,

support stability and keep you focused on positive progress, instead of devoting enormous amounts of energy to avoiding and resisting impulses.

REMEMBER

As can be seen in conditioning, habits form surprisingly quickly and can be difficult to change after they're conditioned.

Habits are typically formed systematically through repeated behaviors and reinforcements that occur day by day. The power of reinforcement helps us understand how both rewards and punishments affect behavior. Behavior can be reinforced by reward and punishment or through the cessation of unpleasant experiences.

TECHNICAL STUFF

Behaviors (drinking, drug-taking) can be reinforced by both the relief associated with terminating an aversive response (anxiety) and by the pleasant feelings associated with positive stimuli (social support).

If you use a substance that temporarily distances you from your problems, you can quickly progress to habitual use because it stops the irritation and pain associated with your problems. The more times you experience a reinforced behavior and the more deeply engrained that behavior becomes, the more you rely on it to feel "normal" and stable. Substance use can insidiously and gradually progress to periodic abuse and on to addiction. You can be unaware of just how far you've progressed down the road to addiction until you are, by objective standards, severely addicted. This type of progression is what is meant by a *slippery slope.* You slip slowly at first and then gain momentum, as the slide becomes a steeper and steeper downhill decline.

The psychodynamic perspective

The psychodynamic view of addiction originates from the views of Sigmund Freud and subsequent followers. According to the psychodynamic view, addiction problems stem from core difficulties or deficits in the *ego,* the executive of your personality.

From this perspective, the primary deficit related to addiction is your inability to manage or regulate emotions, resulting in the experiential extremes of psychic numbing and emotional flooding. Overwhelmed by the alternation of inner emptiness and unmanageably powerful emotions, you choose to retreat from the real world into a world of drug-induced states. From the psychodynamic view, there is no accident about which substances you abuse — you select substances that numb, calm, sedate, excite, sexualize, or narcotize. Whatever the specific effects sought, what's desired is retreat from reality. How you perceive the world as threatening and frightening dictates which substances you use to eliminate fears and retreat from reality.

Naturally, this retreat requires dependency on others, which points to another major ego problem. With extreme dependency needs, you manipulate people around you to provide care and support. Although you may be alienating immediate intimates, these violations of family and friends are all part of an attempt to be taken care of by them. Meanwhile you, with the help of chosen substances, regress to childlike states. This regression characterizes a basic fantasy — that of life without real consequences and tasks that must be done.

Around these basic problems, the psychodynamic model suggests further difficulties in the frequent use of personality defenses like denial, projection, displacement, and minimization of conflict. It certainly is true for many people with addiction problems that denial is a frequent method of avoiding reality, as is *projective identification* (a way of identifying with the status of other people without really getting to know them in depth). Both methods combine in the magical attempt to minimize conflict, wherever and whenever possible.

Regardless of the explanations, a key issue in the psychodynamic treatment of addictions is how treatment proceeds and how the treatment process can lead to recovery. Psychodynamic treatment can take place in both individual and group therapy formats where, for the most part, addiction is seen as a result of ego problems, not as the cause of them. Resolving ego problems involves tracing them back to core events and issues, many of which initially surfaced during childhood and adolescence. Overall, the therapist takes a compassionate position — that your tendency to use substances to escape results from emotional victimizations during childhood. These boil down to situations that were inescapable and emotionally injuring and have since been perpetrated in the development of defenses designed to avoid reinjury. However, this avoidance may lead to addictive behaviors, and these addictive behaviors cause injury to you in the current time frame, as well as to those close to you.

TIP

If you have a distinct feeling that you use or abuse substances because of traumatic past experiences or emotional injuries, and are willing to honestly explore and revisit your past in order to heal yourself, psychodynamic treatment may just be a good match for you.

The biopsychosocial perspective

The biopsychosocial perspective combines all the other perspectives, emphasizing the important impact of social support and contact. In other words, this perspective links purely biological influences (vulnerabilities and changes in your brain chemistry), with psychological (as in the cognitive-behavioral and learning models) and social dimensions (certain social environments increase the likelihood that you will engage in addictive behaviors).

Few current-day scientists dispute the value of the biopsychosocial perspective, because of the strong consensus that all of these pieces of the puzzle ultimately link together. The question is where and how linkage occurs and how useful knowing each link is to delivering and finding effective treatment. Answers derived from the biopsychosocial model are useful in guiding the selection of a comprehensive treatment plan that addresses all components of your addiction problem.

You certainly didn't set out wanting to become addicted when you first started to engage in the addictive behavior. But at some point, your addiction took over and things began to slip. What was at one time under control becomes controlling. That switch point can be hard to define. But you're bound to understand it better when you review all three dimensions — the biological comfort and pleasure that seems to automatically follow use, the psychological dependency that gradually bends your life so that real life has less and less to offer, and finally the social dimension where everyone who doesn't support or know about your use seems to misunderstand you and treat you with less and less respect. Put all these dimensions together, and they form a downward spiral that can seem nearly impossible to turn around. I emphasize *nearly* impossible because although it's difficult, all the dimensions mentioned previously can be used strategically in recovery.

REMEMBER

The best combination for treatment combines excellent physical care and conditioning (including proper drug treatment) with serious counseling and behavior change programs, supported by people who care about you and your recovery.

Combination Treatments

Now that you've reviewed the basic viewpoints underlying treatment, it's time to get down to the all-important details of real applications so that you can make a good choice for yourself. When you approach the bumps-and-grinds of real treatment, you want to feel you're in the right place — that you're with people you trust. You want to believe that all the pain you experience will ultimately be worth it.

If you read more about the specifics of different treatment approaches in the other chapters of Part 3, you'll discover that most treatment approaches are based on a combination of addiction perspectives. However, there are significant differences in what is emphasized and how much it is emphasized, and these differences truly affect the inner experience one has as well as the social experiences that are required, promoted, or facilitated.

REMEMBER

Twelve-step programs, cognitive-behavioral, and learning programs (all discussed later in this chapter) can be undertaken in individual and group formats and in residential communities that emphasize intensive approaches to restructuring your beliefs, your behaviors, and your life. Twelve-step and cognitive-behavioral methods and pharmacological approaches aren't mutually exclusive. You may be changing your addictive behaviors because you feel a higher power is guiding you, or you may be changing them because it simply makes good sense to you — it hardly matters as long as you're progressing toward a productive, loving, and nonaddicted lifestyle. Still, these different emphases are driven by different kinds of enthusiasm and experience — some of which will be more appealing to you than others. Respect your own experience of what you resonate with.

The twelve-step treatments and other variants of the AA model

Although some may feel twelve-step programs and variations on the model of Alcoholics Anonymous (AA) involve a heavy moral agenda, the twelve-step approach combines re-education with a cognitive-behavioral approach and social support. Twelve-step program principles are found in multiple disease models including those that are pharmacologically based, cognitive-behaviorally based, and learning based.

The moral dimension of twelve step is related to seeing the strength to overcome addiction ultimately deriving from a higher power — a presumably divine source of inspiration. This reliance relates to your declaration that you have no control over alcohol (or other substances). This declaration is essential because you're replacing the substance and its central position in your life with rededication to a higher power.

REMEMBER

The *higher power* need not be associated with a particular faith or religion. The higher power could even be something within, an inner strength and intelligence you find during your battle with addictive tendencies. Nonetheless, higher refers to a more moral and uplifted outlook that is discovered only after complete abstinence from alcohol and other drugs is achieved. Higher can also refer to a clearer outlook you find after addressing and modifying the dysfunctional and distorted thinking that led you to the addictive process.

You can learn more about the twelve-step program in Chapter 11 and other variations of this perspective such as the therapeutic communities approach in Chapter 9. These programs have a number of advantages to offer, including the following:

- They welcome everyone who wants help.
- They're widely available in many communities across the globe.
- Meetings and programs are held in safe, supportive locations like churches and community centers.
- Attending these meetings can be very helpful because an immediate connection can be made to others struggling to become free of addiction.
- They combine mutual aid with self-help, because emphasis is placed on each member helping others get well and stay well.

REMEMBER

By helping others progress, you progress yourself — a similar process happens in someone else and in yourself.

TIP

If you're a person who thrives on first-hand contact, a twelve-step program may be a good match, because you can engage in support (receiving and giving) several times weekly or even several times a day. The peer-support process is made up of *oldtimers* who have used the system successfully and *newtimers* who are just now breaking with addiction (and may be still using). It often works brilliantly. The oldtimers are reminded by newtimers that success can be disrupted by a slip from sobriety, and newtimers get to see and model themselves on living, breathing examples of success.

But you may find a certain degree of inflexibility and automatism with twelve-step programs. It may feel like you're expected to become a mindless robot who follows a dictated philosophy. The structure of the meetings may also be a challenge. For more on the negative side of twelve-step programs, see Chapter 11.

Treatments based on cognitive behavioral, psychodynamic, and learning methods

If you don't feel at home with twelve-step models, programs that are less explicitly spiritual and moral may be more appealing. For example, you may feel uncomfortable with the assumptions of a "higher power" and prefer a practical perspective of simply improving your life and your relationships.

TIP

If the more practical focus appeals, the cognitive-behavioral and learning programs may be better matches.

REMEMBER

Whether it is a twelve-step program, a therapeutic community, or a variant of either, most treatment programs address the psycho-behavioral aspects of addiction. Thus, the difference between these programs isn't based so much on what's left in or out but rather on which elements receive more emphasis.

The cognitive-behavioral model approach to treatment

The basic point of cognitive-behavioral programs is that different thoughts and images enter the mind and influence emotions and the body. Some of these thoughts and images are healthier than others. The unhealthy ones are those that drive you back toward depression, helplessness, and addictive behaviors. You can tell the difference, and the goal is to emphasize your most *functional, healthy* thoughts. From this perspective, your behavior is under the influence of your thoughts. In other words, the ways you think about something determines how you act and your mood while acting.

The bottom line is that your behavior can be influenced by healthy thinking, rather than by flawed thinking, which is often indicated by pessimism and hopelessness. An example of this type of thinking is "I can't believe that I had a drink — I'm hopeless. I may as well get hammered now." Your counselor or therapist provides clear and practical tools for modifying such dysfunctional cognitions and for tracking how cognitions influence and are influenced by the relationships in your life. Your counselor will teach you how you can challenge negative thinking and change behaviors, thoughts, and feelings.

TIP

After gaining important insights about what changes you must make (whether they're changes in thoughts or in the behaviors that follow thoughts), you can skillfully change your life for the better.

In terms of addictions, cognitive-behavioral methods are often used to find the *key* cognitions that drive you to use the substances that get you to artificial highs and related harms. You're confronted (frequently) with your own disbelief about being able to find healthy, nonaddictive highs. You may forget that they exist. But honest, caring, reciprocal relationships with others don't require substance use. Kindness between people is possible and when experienced frequently appreciated.

REMEMBER

Working on cognitive change also involves working on behavioral change.

Cognitive-behavioral treatments also include strategies to help you change behaviors. The target behaviors are linked to the cognitions you're trying to change, or to behaviors that help you control the addictive tendencies. Following are examples of both:

- Targeting a behavior with the aim of changing your cognitions can be sitting down to talk to a friend or family member who has done something to hurt

you rather than automatically assuming the hurt was intentional and unchangeable.

- Targeting a behavior intended to control addictive behavior may be taking fewer sips of a drink to make it last longer or taking up an exercise program to help relieve tension.

The psychodynamic approach to treatment

The psychodynamic model focuses on the core conflicts and deficits that people with addiction have. The most prominent issue concerns dependency, an excessive need for solidarity with others. Often, this neediness comes from past experiences of neglect. In the extreme, the person with addiction stops caring for basic needs and has to relearn basic caretaking skills. The two other core focuses are emotion management (learning to identify, understand, and express your feelings) and understanding and improving self-concept (what you think about yourself).

When you struggle with in these ways, you may get into relationships that will bail you out. Therapy, as I discuss in Chapter 9, helps you confront issues, with help and then independently, and develop new ways to manage the conflict.

TIP

To deal with painful addiction-related issues and associated feelings, you *can* find a supportive and safe counseling relationship. Within this relationship, you can gradually learn about and take responsibility for the emotionally corrective actions that lead to healthier approaches to resolving problems.

The learning model approach to treatment

The learning model approach helps you analyze your addictive behavior from the perspective of how it's uniquely rewarding and reinforcing. You can read more about learning model approaches to treatment in Chapter 9.

TECHNICAL STUFF

The term *reinforcing* refers to the needs that addictive behaviors fulfill. For example, you may be using alcohol and drugs to relax, to enjoy a pleasant moment, or to socialize less anxiously. Engaging in the addictive behavior is reinforced by the relief or reward experienced by fulfilling these particular needs.

Humans learn quickly. If a substance relieves pain or helps you get some sleep, taking the substance is reinforced, and the substance will be used repeatedly to obtain the rewards. Your ability to learn is getting you in deeper with addictive difficulties.

The focus of treatment is on finding healthier alternatives for meeting these needs that replace addictive behaviors. The following list presents some functions an addictive behavior may be serving:

- Relaxation
- More relaxed socialization
- Mood enhancement
- Feeling powerful and in control
- Feeling in love and being loved
- Sleep
- Increased energy
- Reduced pain
- Reduced boredom

IN THIS CHAPTER

- Understanding interventions
- Comparing outpatient treatments
- Getting into inpatient treatments
- Working to prevent relapse

Chapter 9

Reviewing Inpatient and Outpatient Treatment Options

"Getting away and leaving the mess behind." "Starting over fresh." These are some thoughts that motivate inpatient treatment. Typically, your search for the right kind of inpatient or outpatient help involves finding a trusted advisor (your doctor, teacher, insurance agent, pastor, or someone else). Although addiction is a familiar topic, you may need to expand your support network to include those who can provide expert treatment advice informed by current developments. Finding good advice can be surprisingly difficult. Beware of people acting like they know more than they actually do. Keep searching — treatment is an important decision. A life-saving and life-giving decision.

While the search is partly external, the most important obstacles are internal. The *stigma* (shame) you feel (about addiction) can stop a thorough search. Stigma is a powerful and can influence even the hardiest of people. It can make one feel defeated, defensive, and ashamed. The pain of admitting the need for help may feel worse than the pain of staying addicted.

But rather than letting shame and fear dominate, remember that you have an illness. It's a somewhat infectious illness. Someone was persuasive in getting you started. They were responsible, to some degree, in infecting you. No one intends to develop addiction. No one wants the pain. Other people have other illnesses; you have this one. No one goes through life without some pain and illness and it's hard to say, ultimately, whose hardships are worse as they're all bad. Epidemiological studies can give us crude averages, but at the individual level, it's hard to say how much an illness hurts. We just know it hurts. In this case, there's a healthy way to relieve the pain.

REMEMBER

The bottom line of illness is that our bodies and minds are (temporarily) beyond control. The only thing that helps is getting more control. If you need help, the strongest and most dignified thing to do is to get the help you need.

Another simple reason for the difficulties in finding the best care is that addiction services aren't very well-publicized. To help you get started with some addiction services, I've listed most of the easy-access entries to care in Chapter 20. A tremendous network of recovering people welcome questions, and are available to offer advice through twelve-step and other programs. In addition, the American Society of Addiction Medicine is dedicated to educating physicians and improving treatment. Although there's progress, professional knowledge about addiction is too often lacking because addiction, as we've seen, is complex, and even clinicians need specialized training to treat and understand such complexities.

In this chapter, I discuss how to obtain professional services (including intervention services) and outpatient care, and I help you decide what to do if inpatient care is necessary.

Interventions: Breaking Through Denial and Fear

Your family and those who care often don't know what to do. Their lives are turned upside down and they are worried sick (often). Every waking moment can seem weighed down with serious concerns. You may have promised many times to end your addiction and get help. As they look back, the truths of the hours lost, the money lost, and emotional trauma are now clearer and undeniable. These losses provoke the very sad moments of addiction. If you're not ready to stop, you may be offering empty promises and guilt-ridden apologies. What can they do with these exchanges? What can *you* do?

When you seek professional help, your fears and those of your family and loved ones peak. You may find yourself even more frightened than before. It's hard to look down into the apparent abyss. It's embarrassing and shaming when carefully protected secrets are exposed. When getting help becomes a realistic option, you may find yourself willing to do anything to avoid it or minimize exposure. Lying (with a straight face and even indignantly) can happen. You may promise anything to take the pressure off. If that doesn't work, you may righteously push back: "What right do *you* have to tell *me* what to do? If you don't stop this questioning, our relationship is over." The fear and hostility can be palpable, even to you. You can be amazed at how fast it escalates.

The situation can become more and more intolerable until something has to give. Your family may consider the services of a professional interventionist at this point.

WARNING

Sometimes your loved ones may find no apparent way to guide you into care. When trapped in a cycle of denial and fear, fueled by shame, resentment, and inner pain, you can feel so alone that you become hardened and evasive about the emotions and anger of loved ones. Professional help is strongly recommended if you're at this point.

CASE STUDY

MOLLY IS AFRAID TO GET HELP

Molly was desperate for help. She had grown up in a small town with a loving, middle-class family. She wanted to be a high school teacher. Still, at 23 years of age, she was filled with self-doubt and confusion. In high school, she had been very sociable. She loved to dance and party. She experimented with alcohol and smoking. One night after a dance, she got involved sexually with her date. One thing led to another, and she "got a bad rep as one of the school sluts." She couldn't wait to move out of town to attend teachers' college to get a fresh start. Then the unbelievable happened: She went to a party at college, got loaded, and got casually involved in sex. The cycle started all over again. Boys asked her out, but they only wanted "one thing." No one took her seriously. She was so ashamed. She felt too ashamed to talk to girlfriends or her family. She "knew" that she was "bad" and flawed. How could such a rotten person ever be a teacher? She hated herself and saw no hope for change.

When she did go out socially, she felt unworthy. To dull the emotional pain, she drank. Drinking seemed to help. She could forget her insecurities. Alcohol became a way of dulling the pain.

Molly was caught up in a vicious cycle. She felt too ashamed to ask for help. She felt alone and empty. Drinking became her solution and her problem. She couldn't bring herself to ask for the kind of help that she really needed.

How an intervention works

An *intervention* is an objective, caring, nonjudgmental process whereby family members and/or those who care gather together to motivate within you an acceptance of help. You're confronted with the reality of your actions by those adversely affected. You're invited to a meeting without being told much about the purpose of the meeting. At the meeting, which is carefully planned and structured, people express love and caring while describing, in behavioral terms (usually written and read), how they're being affected by your addiction. They express their wishes and needs for you to enter treatment.

REMEMBER

Although loved ones are involved, a professional interventionist guides the process. Interventionists are trained to communicate supportively, helping you accept a need for help while educating you and your family about addiction. They provide a link to treatment, ensuring that the right treatment center is found and contacted, and that the background preparation for entry is completed.

Initially, many interventions followed the Johnson method, developed by a priest (Vernon Johnson). It started as a challenge to the idea that you couldn't be helped until you hit rock bottom. The purpose of any intervention method is to help you confront denial and fear of change, and to help you get into effective care.

TIP

Concerned persons must state concerns clearly, without lapsing into accusations and anger. One simple skill is to communicate with an "I" message versus a "you" message. For example, "I feel sad" versus "You make me feel sad." Describing behavior versus voicing feelings, opinions, and judgments is a learned skill. It is based on referring to the actions that are clearly observable, like those that would be captured on video or audiotape, for example.

During the intervention, the realistic consequences of not entering treatment are described matter-of-factly. They may include separation or divorce, the refusal of adult children to attend family functions or maintain contact, job loss, and loss of friendships. Other people can't control *your* decisions and behavior. They can only control *their* responses to your decisions and behavior.

The intervention process often exposes weaknesses in the family system. Families who have long suffered from a member's addictive behavior may be angry and punitive. Or they're numbed into temporary or chronic states of no longer caring what happens. Conversely, they may fear reprisals for breaking the codes of silence that have helped enable your addiction. The denial of problems and disbelief in the potential for change often add up to turning a blind eye to your addictive

behavior. The interventionist has to balance the goal of getting you into treatment with the complex communications of family members who likely have old and new issues to settle.

REMEMBER

An intervention isn't the time for a complete course of family therapy. Family therapy meetings can and should occur *after* the addicted person is established in treatment.

Most interventionists and experienced clinicians are specialists in helping you get past your denial and increase your motivation. To achieve this goal, they use a tactic known as *motivational interviewing*, an evidence-based treatment approach. Such interviewing is designed to help you go beyond guilt, fear, and anger to engage in healthy decision-making. The interventionist helps you consider decisions practically, in terms of what you stand to gain and lose by changing and what you stand to gain and lose by not changing. The goal is to help you make an informed decision about treatment.

AN INTERVENTIONIST'S EXPERIENCE

A colleague of mine is a licensed alcohol and drug addiction counselor and an experienced interventionist. He sent this description of a recent case:

I received a call from a father who told me that his daughter, April, age 20, spent most of her time in a drug haze hanging out with people who "don't give a damn about her." He didn't know what to do but he wanted to do something. Her mother was a wreck, and her brother and sister couldn't understand her. The father wanted to arrange for treatment, but hadn't spoken to his daughter in three weeks. He deeply regretted the last contact where he called her "every name I could think of" while pleading with her to stop. Her phone call was a desperate call for help.

My approach: The first job was to ensure the safety of the patient and the participants. April was in danger. She was in a situation where she was at risk for assaults, including rape. Her father's first inclination was to charge in, but that approach rarely works and generally increases the risk because April would likely rebel against her father's take-charge attitude. I decided to go in gradually, using contacts in the area and make a direct approach to April. After ensuring the addicted person's safety, protecting their dignity is uppermost in my mind. I give people a chance to refocus their lives. April was in "escape mode." She didn't really care what happened to her, but she reacted when I spoke about her brother's worry. Actually, she started to cry and said she missed him. This was an opening — the motivation for change.

(continued)

(continued)

I use my experience (which spans the entertainment and sports businesses), my understanding of the resources available in communities and nationally, and my openness to the process. April was willing to go to a small (six-bed) treatment facility where she would get intensive therapy along with twelve-step work. Every intervention is different, because every person is different. The commonality is the addiction, which doesn't get better with time. I care deeply about my clients and their families and stay in touch with them through the early stages of treatment.

Intervention principles

These nine principles often influence the decision to intervene and guide the intervention process:

- Because your behavior is causing significant damage, you need to change it now.
- Your denial prevents you from fully appreciating the damage your addiction is causing.
- Your denial and addiction makes it unlikely for you to seek help on your own.
- The people involved with you will eventually refuse to enable your ongoing addiction — which increases the likelihood you will seek and accept help.
- The genuine concern and understanding conveyed by an interventionist is a very important factor in motivating you to seek and accept help.
- Anger and punitive measures have no place in interventions; they raise defenses, making it less likely you'll seek and accept adequate help when it's needed.
- You may require an initial period of intensive treatment such as a 28-day residential program or an intensive outpatient program to address your denial.
- An intervention may be useful even if you don't respond by entering treatment.
- The intervention isn't a confrontation. Rather, it's a well-organized expression of genuine concern for you, after a chronic and serious addiction problem is identified.

Choosing an interventionist

The standards guiding the choice of an interventionist are clear. Following the Johnson Institute guidelines, I recommend the following. Choose an interventionist who:

- Uses acceptable criteria and procedures for assessing problems of dependency and addiction.
- Demonstrates the necessary abilities (knowledge, skill, and attitude) for assessing the physical, emotional, motivational, and mental capacities of concerned persons to carry out an intervention.
- Commits to the principle that the goal of the intervention, first and foremost, is to secure help for the addicted person.
- Commits to the principle that pre-intervention counseling is short-term and time-limited, and shouldn't be prolonged to the degree where help for the addicted person is postponed.
- Ensures that during the intervention, statements by concerned persons to the addicted person are not shaming or demeaning but caring and respectful, and based on specific facts, behaviors, and feelings.
- Treats all people in the intervention process with care and concern, and works to preserve the dignity and self-respect of the addicted person.
- Commits to helping families by directing all family members involved in the intervention into their own process of recovery, when warranted and desired.

Interventionists may not even need to bring all the concerned persons together within a single gathering. Sometimes, the interventionist just meets with you privately and informs you about family concerns and family members' interest in ending enabling processes.

Residential Versus Outpatient Care: Deciding What's Best for You

Intensive outpatient care may be attractive because you don't have to leave job, family, and friends. On the other hand, residential care provides a secure environment that helps you solely focus on recovery. The challenge is to match your needs with the treatment setting.

TIP

Getting help for problems in other areas of your life, aside from reduction of use or abstinence, makes it more likely you'll successfully solve the addiction problem.

REMEMBER

It is particularly important to get treatment for three specific problem areas: employment, family relations, and internal psychological conflicts. If you treat problems in these three areas, you're more likely to stay in addiction treatment long enough to complete it and recover.

Outpatient Treatment

There are many types of outpatient care, ranging from group therapy to brief individual counseling to long-term individual psychotherapy. These types are aided by behavioral self-control training and psychopharmacological interventions. Because more people seek help for mental health treatment than for addiction treatment, mental health professionals are learning to effectively treat addictive behavior. (Review the section in Chapter 6 on *dual diagnoses,* where two or more conditions must be taken into account in your addiction treatment. Dual diagnoses also influence the types of care needed.)

TECHNICAL STUFF

Disrespect of a person because they have a particular illness erects barriers that prevent the person from getting needed help. The stigmas of mental illness and addictions, however, are gradually decreasing as new treatments are developed and the media is becoming more truthful and sophisticated about covering addiction problems. The main issue is to see people as *suffering* from a disorder but not *defined* or *consumed* by it. A sizeable proportion of Americans experience mental health and addictive disorders annually depending on how "disorder" is defined. Even general definitions yield a proportion of one in every five people, meaning that every extended family and most nuclear families experience at least one person suffering mentally and emotionally.

Psychotherapy

Psychotherapy is a formal, confidential, professional relationship within which you explore difficult, painful emotions and experiences. These include guilt, anxieties, and depression, and experiences of trauma and loss. Psychotherapy is a process that allows you to gain an increased capacity for choice, through which you become more autonomous, effective, and self-determined. There are many different types of psychotherapy (see Chapter 8). The key consideration for you is the therapist who must have considerable experience with addictions no matter which method is emphasized.

There is also the critical factor of *therapeutic alliance*, which boils down to your experience of a reliable and meaningful connection with the therapist. In many studies, therapeutic alliance has been identified as a more important factor than theoretical orientation in treatment effectiveness — and in every well-conducted study, it has been identified as an important factor.

TIP

Ask your potential therapist explicitly "How much experience do you have in treating people with addiction? What methods do you use for assisting addiction recovery? Is there scientific evidence supporting the treatment you employ for *my* type of addiction? What are the risks, if any, of the treatments you carry out and recommend?"

Controlled drinking

Many addiction treatments aim for abstinence or total avoidance of the addictive behavior. Other addiction treatments, however, aim for controlled use. Controlled drinking, for example, is an approach that aims for moderate, problem-free drinking. What exactly is moderate drinking? It's drinking *below* the levels that cause dangerous and significant health risks. These levels are based on medical guidelines and vary depending on your health status. The controlled drinking approach involves relearning how to manage consumption. This approach can be applied to any substance or behavior.

How controlled drinking works

Many different outpatient treatments encourage moderate or controlled drinking, but here I focus on the example of behavioral self-control training. What follows are the most relevant strategies:

- **Self-monitoring** of your drinking so that you map (in advance) when, where, and with whom you will drink.
- **Functional analysis** of your drinking so that you can determine all the ways alcohol serves and influences you (for example, "Helps me relax. Helps me dull pain. Helps me fluently socialize.")
- **Goal setting** so that you know and set your limits and stay within them.
- **Learning alternative** ways of meeting the needs that alcohol is serving. (Use exercise as a means of relaxing. Find healthier pain management strategies. Alternate alcoholic and nonalcoholic beverages when socializing, or taking smaller sips and fewer sips to make a drink last longer.)

Is controlled drinking for you?

A number of factors determine whether a controlled drinking approach or controlled substance use is the right solution for you. Much depends on the severity of your addiction, how much you're using the substance, your health status, and other health- and addiction-related problems — and what happens when you try it out on a trial-and-error basis.

TECHNICAL STUFF

Definitions of moderate drinking vary, but generally, these definitions classify *moderate* drinking as not exceeding more than 4 to 12 drinks a week, or no more than 1 drink a day for women, or 2 drinks a day for men. Generally, a drink is considered to be 12 ounces of regular beer, 5 ounces of wine, or 1.5 ounces of 80-proof distilled spirits.

REMEMBER

This treatment is an option for you only if your drinking problem is considered mild-to-moderate and not severe.

Risk reduction

Risk reduction is a widely applied term that refers to procedures designed to help people cut down on the risks associated with addiction. Risk reduction is frequently referred to as harm reduction. Risk is increased or decreased by lifestyle choices, or the environments in which you live and work. Risk reduction applies to most diseases such as heart disease, HIV, and diabetes.

TECHNICAL STUFF

Addiction can increase your risk for sexually transmitted and other infectious diseases. When on a "run," your judgment is impaired, and you may get involved with multiple partners and unsafe sex. These kinds of risks are described in Chapter 4.

Some of the most common risk reduction strategies include:

- **Reduction of risk-increasing drug use:** This approach involves the distribution of needles and syringes so that you don't share needles and syringes with others with infectious diseases. Often, supervised injection settings are provided to ensure safe drug use.
- **Reduction of morbidity and mortality:** The focus is on helping you (no matter what your circumstances are) to reduce the health and mortality risks associated with engaging in addictive behavior. This is achieved by the changed attitude of health and social services toward addiction disorders.
- **Opiate maintenance:** This method refers to giving the addicted person an alternative opiate (methadone) under medical conditions (see Chapter 10).

- **Reduction of social harm:** This strategy involves decriminalization and the creation of settings where a drug use lifestyle is tolerated as long as it doesn't influence the surrounding society.

In the United States, the most common risk reduction strategies are opiate maintenance and the reduction of morbidity/mortality risk. But other strategies are more common in Canada and Europe.

Tips on seeking outpatient professional help

You must consider several points when choosing a therapist. The most important consideration is whom you feel confident in. Who do you click with? Who can be a therapeutic ally? Apart from credentials, fee structures, and therapeutic models, the personality characteristics of your therapist affect how confident you feel about them.

TIP

Don't hesitate to seek the therapist with whom you feel confident working with.

Therapist or counselor?

Credentials and experience are important and sometimes complex because counselors come from multiple backgrounds. In the addictions area, many recovering people want to help, want to tell their stories, and want to encourage newcomers. These activities are often best left to the self-help and twelve-step meetings guided by stable structures and long-standing traditions of helping. Professional care requires credentials, experience, and supervision. Make sure your counselor is licensed to provide the treatment they are delivering. If not licensed, the counselor should have an explicit supervisory relationship with a licensed practitioner.

Credentials

Your therapist should have credentials from an established and recognized program and should have special training in addiction. The credentialing authority should have clear procedures so that you can read about how your therapist was registered and how to lodge a complaint, if that ever becomes necessary.

The therapeutic alliance

The therapeutic relationship in individual therapy involves three key aspects:

- **Bond:** The bond is based on your emotional and empathic connection with the therapist. Does the therapist understand you and seem to respond to

your feelings and emotions in ways that truly help? This connection can be based on similarities (gender, cultural background, religious beliefs) but is more basically related to the ability to communicate openly and honestly with each other.

- **Therapeutic goal:** Many therapists work hard to define the goals of therapy early in the relationship. Specific goals are often preferable to general goals. "Feeling better" as a goal, for example, is quite different from "being able to resist urges in specific situations." You may not feel better *while* you're engaged in resisting urges, but you'll probably feel better *after* you've successfully resisted. You can see how important it is to be very specific in how you define goals.
- **Therapeutic tasks:** You may have expectations of the therapist such as how much the therapist communicates and explains, and how much or little structure is provided. Some therapists actively assign homework tasks for you to do. You may be given exercises that enable the practice of developing new skills outside of the therapy office. Other therapists may expect you to free associate and report on recent dreams and fantasies. The tasks focused on differ widely across different types of therapy. All tasks, however, play an important part in how you judge the therapeutic relationship and how comfortable and motivated you are within the therapeutic relationship.

TIP

Typically you'll know if the therapy and your therapist will help you after three to four sessions. By then, your judgment of bond, goal, and therapeutic tasks is more realistic. Although you'll know more about your problems and how they're being addressed over time, you'll also have to take a leap of faith with your therapist. Always try to get personal references from others about the therapist if possible.

Residential or Inpatient Treatment

Given the media attention paid to figures in the entertainment industry, the 28-day rehabilitation (rehab) program is well-known to the public. What isn't well-known is what goes on in these programs. Before entering the rehabilitation setting, you'll probably have to be detoxified of alcohol and drugs and cleared medically. (See Chapter 10 for the procedures of detoxification and the medical risks.) Entering rehab is a big — potentially pivotal — step in your life.

The stages of inpatient treatment

Regardless of the treatment model, when you enter residential treatment for an addiction, you will likely progress through three stages:

- **Stage one represents the induction and early treatment phase.** You learn about the treatment community rules, expectations, and procedures. This is an important phase because you thoroughly learn what you're getting into while building trust with the treatment team and your fellow members. During this time, you assess treatment needs and set goals for what you want to change in order to recover from addiction. You acquire a deeper understanding of the nature of your addiction and, hopefully, make a deeper commitment to the recovery process.
- **Stage two represents the active treatment and rehabilitation phase.** You focus on changing your attitudes and behaviors toward yourself, your addiction, and others. You also focus on taking responsibility for actions and their consequences. During this stage, you may focus on developing new skills — for instance, acquiring further education and vocational training. You may also undergo interventions to help with health, psychological, family, and work problems.
- **Stage three represents the time of re-entry into life outside the treatment community.** Post-residential aftercare interventions may include individual and family counseling and vocational and educational guidance. Often, aftercare includes linking up with self-help groups that support your recovery process.

It's voluntary

Laws across states and countries differ, but in general, most inpatient treatment is provided voluntarily, which means that you're attending because you want to and are free to leave at any time. If you leave before the treatment team recommends discharge, you've left "against medical advice."

The rules of rehab

Every setting has a unique set of expectations for clients and their families. The rules or expectations from several well-known residential centers are listed here. These expectations evolve from the treatment facility's philosophy of human nature and addictions:

- "We consistently ask the patient to take responsibility for whatever is happening in the patient's life."

  This is based on the belief that you must accept the choices (made consciously and unconsciously) made in responding to life events, and that these choices bring about consequences that you have created.

- "You must earn before receiving, whether it's emotional support, financial support, spiritual support, or physical support."

  This expectation is based on the belief that addiction is sustained by the unconscious or conscious fantasy of a life without consequences. Much emphasis is placed on earning your way, or demonstrating merit in your personal rehab process that impacts all others observing you in the program.

- "We ask patients to assume adult responsibilities while in treatment, including working and homemaking for themselves and others."

  This expectation is based on the belief that being addicted is akin to being childlike in that you have limited control and you're dependent. Recovery, on the other hand, means moving away from being childlike to becoming an adult with the usual responsibilities of adulthood.

- "We ask patients to do unto themselves and others as they would have others do unto them."

  This expectation is based on the belief that by helping yourself and others, you can reverse the effects of dysfunctional relationships. You can change the past or how you experience the past, by changing your current behavior to others.

REMEMBER

Although at first you may think the rules or expectations of rehab seem too simple or are demeaning, try to understand the philosophy underlying the rules. The philosophy is intended to guide you towards positions of strength, autonomy, compassion, and control.

How long is long enough?

Professionals believe that you often leave treatment prematurely because of perceived pressures from work and family, or from the structure of the treatment center. Insurance coverage may also be a factor as it may limit the length of treatment that will be approved for payment.

TIP

A period of residential care from 28 days to 90 days is often recommended by addiction treatment providers. Another critical success factor in our experience is the aftercare period that extends to one year of post-residential treatment. Your aftercare plan is an important key to recovery.

Aftercare

The period after you leave rehabilitation is crucial to recovery. This is when your challenge is to apply your new behavior in routine environments. Aftercare has different aspects, but the goal is clear: Return to your life and live without relapsing to addictive behavior — *no matter what happens.*

Fear of the real world

You may have lived so long in the culture supporting your addictive behavior that returning to the real world is very challenging. You may have to face the music at home and/or work. You have questions to answer and routines to establish.

Telephone counseling

Contact with the treatment center is sometimes maintained via telephone sessions. These sessions reinforce lessons about managing urges and avoiding risky situations where the probability of relapse is high. And most important, the sessions teach you how to maintain contact with supportive people. The well-known saying in this regard is "If you don't want to slip, stay away from slippery slopes." Whether you call a counselor, a twelve-step sponsor, or a recovering friend, the key is to make the call rather than suffer the symptoms alone and start to slip.

The Minnesota Model

In the 1940s in the United States, treatment options for alcohol dependence were severely limited. Addiction was viewed as a moral weakness, and the medical community wasn't sure what to do about it. In Center City, Minnesota, the Hazelden therapeutic community was developed out of a guesthouse for men with alcohol addiction.

This historic development had a treatment program based on five simple expectations:

- Behave responsibly
- Attend lectures on the Twelve Steps of Alcoholics Anonymous
- Talk with other patients
- Make your bed
- Stay sober

REMEMBER

The model started with a focus on men, in accord with the social attitudes of the times. Now, women are also active participants in both public life and in treatment programs. Addictive behavior cuts across gender lines. Women's unique health issues are now sensitively considered in addiction treatment.

What was revolutionary was the fact that the treatment of alcoholism moved from custodial care (often in despicable conditions) to a setting where people were treated with dignity and respect. Equally stunning for the time was the observation that by telling your story and listening to others, you could help each other.

The rules, simple as they may seem, addressed the fact that as an addicted person, you can be secretive, self-centered, and resentful. You're often isolated from others and suspicious of attempts to tell you what to do.

The benefits of residential care include: an opportunity to learn life skills from others; a time to focus specifically on getting help; a time to bring your life into order by dealing with medical, financial, employment, legal, family and psychological problems; and an opportunity to break away from dysfunctional behaviors and risky situations.

Relapse Prevention

Addiction is a chronic, relapsing disorder. *Relapse* is defined as a return to addictive behavior after a period of abstinence, given a client goal of abstinence. The revolutionary concept applied to relapse was that relapse was part of recovery. The first step in accepting relapse is to discover what can trigger a relapse (for you) and then work on how to prevent the identified triggers from precipitating the relapse. The statistics on relapse are sobering. About 90 percent of those with alcohol addiction will experience at least one relapse over the four-year period following treatment. Given the likelihood of relapse, treatments have increasingly started to focus on teaching relapse prevention skills. An important part of this training involves identifying triggers for substance use and addictive behavior. These methods are detailed in Chapter 16.

TIP

Bill Moyers, a famous TV interviewer, has said that many people, himself included, have the idea that addicted people consciously choose to light up, shoot up, or drink, so the negative consequences are their own fault. "I hope that people come to a new definition [of addiction], and realize the addicted person may relapse, just as a person in remission with cancer can have a new onslaught," Moyers said. "It's a chronic problem, and people have to stay in therapy." More than 80 percent of those who get treatment will have at least one relapse.

"If your child comes to you for help, get informed, and don't panic. Don't scold or punish," Moyers said. "If your daughter came to you and said she had breast cancer, you would work out a way to have it treated. The same goes for addiction." In our view, Mr. Moyers has made a critically important point: Our culture needs to destigmatize addiction problems in order to improve treatment response.

Therapeutic Communities and Sober Living

Dr. Maxwell Jones developed the therapeutic community concept in the early 1950s. These communities are structured in different ways, but they provide the clean and sober environment and structured living that can be very helpful. Dr. Jones's view was that therapy should be a continuous process. To achieve this goal, he created an atmosphere where you could interact informally with medical and nursing staff. Dr. Jones wrote scripted plays to help clients tell their stories as part of an intensive therapy experience.

In a therapeutic community, people with addiction make a long-term commitment to contribute to the community while they work on their sobriety. Unlike a residential (inpatient) option, the therapeutic community is largely based on self-help. The residential inpatient programs usually last one to three months (typically one month) while the therapeutic community membership lasts for many months (or years).

How therapeutic communities work

Therapeutic communities are drug-free residential settings that are sometimes referred to as *sober-living centers.* They're located in a wide variety of settings, including former rural camps and ranches and within residential communities. They have also been set up in jails, prisons, and shelters. The number of members admitted to a therapeutic community depends upon its residential capacity, but most accommodate between 40 and 80 members.

The treatment model is hierarchical in that you progress through stages that reflect increased levels of personal and social responsibility. A fundamental principle of therapeutic communities is *mutual self-help:* You have a responsibility to contribute to the recovery of your peers, and this responsibility is considered an important aspect of your own treatment. Accordingly, a strong emphasis is placed on learning from each other, so members interact in to restructure the attitudes, perceptions, and behaviors associated with drug use. Fellow members know the ins and outs of the abuse culture and are credible resources for knowledge about change.

Activities in the therapeutic community are structured to help counter your disordered life on the outside. A focus of therapy is teaching life skills — including planning skills, goal setting, and accountability. Therapeutic communities focus

on teaching *right living* (learning to be responsible for yourself and others, and learning to behave toward others as you want them to behave toward you) and *acting as if* (behaving as you aspire to be rather than as you have been).

The providers of treatment come from a variety of backgrounds and have varying credentials. Many are licensed professionals such as physicians, social workers, nurses, and psychologists. Veterans of addiction treatment programs often also form part of the treatment staff. Having struggled with addiction and recovery, they provide an experienced, informed, and compassionate model of recovery.

A focus on rehabilitation

Because of your addiction, you may have developed a poor history of social functioning, poor education or poor vocational skills, and few positive community and family ties. Recovery equates to rehabilitation — you must relearn and re-establish healthy functioning. You may never have had a functional lifestyle, and the therapeutic community may be your first exposure to orderly living. In this case, recovery may involve learning, for the first time, the behavioral skills, attitudes, values, and responsibilities associated with socialized group living.

How effective are therapeutic communities?

The U.S. National Institute on Drug Abuse (NIDA) conducts studies to advance scientific knowledge on the outcomes of drug abuse treatment. These studies collected baseline data from over 65,000 individuals admitted to publicly funded treatment agencies. They included a sample of therapeutic community programs and other types of programs (methadone maintenance, outpatient drug-free, short-term inpatient, and detoxification programs). Data were collected at admission, during treatment, and in a series of follow-ups that focused on outcomes that occurred 12 months and longer after treatment.

Members of therapeutic communities reported several positive outcomes. Those members who successfully completed treatment exhibited lower levels of cocaine, heroin, and alcohol use; less criminal behavior; less unemployment; and fewer symptoms of depression than they had before treatment.

Who obtains treatment from a therapeutic community?

In considering whether a therapeutic community is an appropriate treatment option for you, it may be helpful to know that often members of therapeutic

communities have other severe problems, such as multiple addictions, involvement with the criminal justice system, lack of social support, and mental health difficulties (depression, anxiety, post-traumatic stress disorder, and antisocial and other personality disorders).

REMEMBER

Therapeutic communities are open to you so long as you're willing to follow the specific rules of the community. The rules are there to help you develop self-control and responsibility and, ultimately, to overcome addiction. Personal privileges, disciplinary sanctions, security, and surveillance are enforced to protect you and to ensure that community life remains orderly and productive.

How long should you stay in treatment in a therapeutic community?

Therapeutic communities have no predetermined length of optimal treatment. The optimal length for you depends on your pace of change. The goal of stable, sober living is the key. If you stay long enough to complete treatment, you're most likely to achieve the best outcomes. However, even if you drop out, you'll likely still receive some benefit. Research indicates that, on average, if you complete at least 90 days of treatment, you're likely to achieve significantly better outcomes over the next year than if you'd left earlier.

TIP

If you have other serious problems (multiple addictions, criminal involvement, mental health disorders, and poor employment history), being in treatment for at least 90 days or even longer is especially important for achieving a good outcome.

Unfortunately, many therapeutic communities have a high dropout rate. Research is underway to determine whether certain characteristics of therapeutic communities can be changed to decrease the rates of member drop out.

Some client characteristics influence your chances of sticking it out in a therapeutic community. For example, characteristics associated with dropping out of therapeutic communities prematurely include having family and friends who also abuse substances or are involved in crime. Factors associated with staying *longer* in treatment include being pressured by the courts or legal system to enroll in treatment, having your employer demand that re-employment be conditional on your seeking and sustaining addiction treatment, and your family providing inducements (sanctions or enticements) for you to stay in treatment.

REMEMBER

Probably the most important characteristic about you that will determine whether you stay in treatment is motivation. Other important characteristics are your level of self-respect and your resilience capacities. The more confident you are about yourself, the harder you tend to try to overcome your addiction problem. You can get treatment for strengthening self-respect and for increasing related motivations.

Traditionally, stays in therapeutic communities have varied from 18 to 24 months. Recently, however, funding restrictions have forced many therapeutic communities to significantly reduce stays to 12 months or less or to develop alternatives to the traditional residential model such as work-treatment arrangements.

Andrew's Choice: A True Story of Getting into Treatment and Achieving Success

CASE STUDY

Andrew was on the winning track. He was smart, good looking, and connected. In the financial markets, he was a whiz kid; he could make a deal happen. His employers trusted him. However, Andrew, at age 35, was living a lie. Secretly, he had increased his drug use to the point that every day was a mixture of uppers and downers. His judgments were clouded, and he made decisions on impulse. Andrew knew he was in desperate shape, and he decided to act. He called a friend for help and within a day he was on his way to rehab. The first section is Andrew's story of entering rehab.

The second section follows Andrew's description of one of his days in rehab. Andrew became a person committed to recovery and to helping others. Andrew has been in recovery for two years. As of today, he remains clean and sober.

How things began

It was 11 a.m. as my plane touched down. The hash I had swallowed the night before to calm my nerves was still going strong, but I knew they would be waiting just outside the gate. I grabbed my carry-on and got off the plane. The long tunnel to the terminal didn't appear to have any light at the end of it, but I continued down its path. I was going to make this change; it was time. I emerged through the entryway to see my name in big, black, bold letters held high above a man's head. I quickly looked the other way and decided that it would be easier to make a change after a few quick beers. I walked past the two men and proceeded to the airport bar. It was like any bar I had been to; rows upon rows of liquor neatly placed behind the bar in front of a mirror, with cigarette smoke gently caressing my nostrils and tempting me to light up. At that moment, I felt a tap on my shoulder. "Are you Andrew?" I was asked. By the stunned look on my face, they knew they had their man. Off to the facility I went.

The drive over wasn't too bad. The two guys that picked me up had both been there for ten weeks, and as part of the treatment process they were to show me the ropes just as someone had shown them. I waited into the busy lobby with my

luggage for my intake assessment. A rather enthusiastic staff member called me to her office, as if I were a little kid going to camp for the first time, and proceeded to ask me about my drug and alcohol history. Some time later, after realizing I had had blackouts from my drinking, and acid trips do count as hallucinations, and smoking rock cocaine is the same as crack, I was to go for a blood test. No trick questions there, I thought. The needle didn't hurt; I actually got a rush from it. The nurse drew blood, looked at it, and chuckled. "I always get amused by the color of your blood when you guys check in," she said. What was wrong with the color of my blood I thought? "It's supposed to be red, not black," she said as if she was able to read my thoughts. I hope they all can't read minds here, I thought.

Next I was to meet my House group. These were the other men I would be living with. Sixteen of us. The ones who had been there for some time were obvious, but some had come just days before me. They showed me my room, which I shared with another guy. I can't sleep in a single bed, I thought, and I should have brought my own pillow. Two to a room, two rooms to a unit, four units to a house, I was told as if I was to be given a test tomorrow.

I unpacked and was called for dinner. We cooked our own. Food vouchers were given to each unit, and we were to shop for our own food, too. I had not shopped for food in months. After dinner, we had a house meeting, and everyone introduced himself. We had lawyers, businessmen, students, and the unemployed; all suffering from alcohol or drug abuse. I didn't say much. I was exhausted. I was asleep before my head hit the pillow. Where was my pick-me-up? I hadn't been to bed this early since preschool — a slight change already.

One day in rehab

My alarm goes off at 7:45 a.m. I'm still not used to getting up at this ungodly hour. They suggest I either pray or meditate in the morning, but I still fight this one. I'm going to do it my way for a while longer. I make my bed so I don't get any demerit points, and then I go to the kitchen to make breakfast. The guys who have been here for some time are already up. They've showered, had breakfast, and are reading or chatting outside. I obviously don't fit in yet. I have a banana, a shower, and brush my teeth before heading off to the campus, which is a funny thing to call a licensed mental institution. We are called "clients" not "patients," but we all meander over like students trudging off to class. Everyone gathers in a large circle for roll call. Afterward, a client who will be leaving later this week reflects upon the changes they made during their stay and then plays some music of their choice. It's usually pretty interesting to see what people choose. Next comes a presentation by someone who has been here and has been able to write down their story. How they started using, whom they hurt, how they have tried to stop in the past, the trouble they got in, effects on work, and so on. The more you hear, the

more you start to realize you aren't as unique as you once thought. Some people share their feelings or make comments afterward, but if you're the presenter, a weight is lifted.

Usually, we quickly check the board to see if we have to do a random urine test today. Next, we break into groups of about ten with our primary therapist. Our primary therapist gives each of us feedback on our progress so far. At the beginning, it's usually "Try harder, stop fighting the system," or "You need to share more in this group." From here, we go off to group therapy. This is with a different therapist and a different group of people, made up of men and women. In here, we talk about the way we feel, what is bothering us, or anything else we want to talk about. We're told not to comment on anyone's sharing other than how it makes us feel or how we've had a similar feeling from some other experience. We're not to degrade, make fun of, or try to save any other client. Sometimes, it gets pretty uncomfortable, but a lot of good comes out of this group. After this, we go to lunch.

In the afternoon, we're required to go to an education class where we learn about the effects of drugs and alcohol on our brains. This class is usually pretty fun because we all think we're experts in the field. After that, we sometimes have a spiritual discussion, not from the Bible, but just about spirituality. Or sometimes we're assigned to a special group that deals strictly with a particular issue. Some people have had some pretty traumatic experiences from their using, and they find it easier to talk with only those who have had similar experiences. Some have other issues that need to be discussed, and some just need more time.

Some days, our house group gets together to talk about what's going on in our living area. These meetings can get pretty heated, especially if some guys don't get along. Other days, we're given free time and can do as we please. We have to travel in groups of three at all times, but we're able to go to a gym or for coffee as long as we're back for dinner. Afterward, we're usually required to attend a twelve-step meeting of our choice and then make it back to the Institution by curfew and a nighttime roll call for our house unit. We can stay up as late as we want, watch TV, or call our loved ones — as long as we keep it to one call a day for no longer than 15 minutes. If we do break one of the rules, we're supposed to tell our primary therapist about it. The place has lots of rules. What is even harder is that we're supposed to report on other clients for breaking rules. The idea is that you're helping them to stay the course. This takes some time to buy into. If you don't report on someone and it comes out you knew, you usually end up in more trouble than he does.

Before bed, you're supposed to reflect upon your day and see where you could improve. The longer you're there, the more serious you start taking stuff because what you start to notice is that those who do what is suggested do change. And isn't that why I came here in the first place?

IN THIS CHAPTER

- Finding out how your body uniquely reacts to drugs
- Demystifying the detox process
- Explaining treatment
- Identifying medications that can help
- Considering the advantages of methadone treatment

Chapter 10
Treating Physical Dependence

If there is but one theme emphasized in this chapter, it's to get yourself into treatment with a physician you trust. Of course, the tendency is to want to detox alone, without anyone's help. It can be embarrassing to admit how addicted you are, and getting detox help involves getting past that embarrassment. But it is important to understand that *it's unlikely you know enough to manage your own detox.* Without medical supervision, the complexities are such that you can be in a lethal situation abruptly and before there are warning signs you can heed. Please don't take the discussion in this chapter as indicating that you can handle it on your own. You need a physician you trust involved in your detoxification.

This chapter may be most helpful if you're battling a drug or alcohol addiction. I discuss the detoxification challenges presented by these substances by describing how the body reacts to different drugs and how your body rids itself of them. And while I discuss acute drug and alcohol treatments the most, the principles of detox apply to other toxic substances and behaviors as well.

WARNING

It is extremely important that you work with a physician to detox. It helps to understand the medical aspects of these processes, and you will never know as much as your physician does. The considerable risks related to detoxification are especially related to sedative-hypnotics, where withdrawals can be and often are life-threatening. For example, if you have a severe dependence on alcohol, you must be withdrawn gradually under the close supervision of your doctor to avoid delirium tremens.

TECHNICAL STUFF

Delirium tremens occurs upon abrupt alcohol withdrawal. The symptoms can be life-threatening and require emergency treatment. Symptoms include tremors, irritability, sleep disturbance, nausea, vomiting, hallucinations, confusion, delusions, severe agitation, and seizures. Other physical symptoms include increased heart rate, blood pressure, and temperature. Symptoms can be severe enough to lead to cardiovascular collapse (that is, cardiac arrest).

I should mention that behavioral addictions (such as gambling or sex) don't result in the same changes in brain chemistry as those that cause physical dependence. They cause psychological dependence, as described in Chapter 5. Although changes in brain chemistry (especially in the opiate and neurotransmitter systems of your brain) do occur with behavioral addictions, these changes aren't so severe as to cause a physical dependence requiring medically supervised detox. But dependence reduction may require psychological supervision.

Understanding Your Body's Reactions to Drugs

Drugs alter brain chemistry. Over time, the acute alterations give way to chronically adaptive changes in brain cells, biochemistry, and neural functioning. These changes result in drug tolerance and physical dependence.

For example, alcohol generally reduces anxiety and causes *sedation* (sleepiness). Over time, the brain adapts, requiring more alcohol consumption to get the desired effects (this is *drug tolerance*). With prolonged use, some brain cells adapt such that they don't function normally without a daily alcohol dose (this is *physical dependence*). If you don't consume enough alcohol, your brain cells rebel and produce an array of symptoms that may include anxiety, insomnia, hallucinations, and seizures (this is toxic drug *withdrawal*). Large quantities of alcohol can cause sleep, coma, and even death by a depressing the respiratory system. At these quantities, this is known as *alcohol poisoning.* Your body tries to protect you against poisoning by inducing you to vomit after you've consumed too much alcohol.

Just these descriptions of tolerance, dependence, withdrawal, and poisoning should persuade you to get physician help, as your physician can appreciate the necessary adaptations that keep you out of serious trouble.

TECHNICAL STUFF

The scientific term for the adaptation of cells and neural functioning following the continued exposure to drugs is *neuro-adaptation.*

The signs of withdrawing a drug from your body are different and often opposite to how the drug affects your body. For example, heroin results in euphoria, reduced pain sensitivity, and constipation. Heroin withdrawal oppositely results in depressed mood, increased sensitivity to pain, and diarrhea. Alcohol generally causes sedation, but acute alcohol withdrawal results in hyperarousal, even to the point of potential seizure activity. Because these withdrawal effects can be life-threatening, you need a doctor to monitor you while detoxifying. Detoxification optimally happens inside a specific detoxification program attached to a hospital (if hospitalization is needed) or a residential treatment facility.

The time period between abruptly stopping the substance and experiencing withdrawal symptoms varies substantially. For example, withdrawal symptoms from alcohol may be noticeable within hours of ceasing regular intake. Withdrawal symptoms from diazepam (or other benzodiazepines) can be prolonged for several days and peak five to ten days after the initiation of withdrawal.

Detoxification: What Is It, and How Does It Work?

Detoxification (detox) is the process of becoming non-dependent, physically, on alcohol and/or other drugs. When people are addicted to a combination of alcohol and/or other drugs (*polydrug abuse*), the detox process is more complicated as it involves multiple substances. The complexity is such that this chapter is limited to the medically accepted guidelines for the detoxification from alcohol and other drugs of abuse, including prescription and nonmedical drugs. If you need a physician to assist you with single drug withdrawal, the need is even greater for multiple drug withdrawals.

WARNING

Detoxification isn't a treatment for addiction but rather a method to manage the symptoms of drug withdrawal. Be wary of "treatment plans" (perhaps dictated by third parties) that *only* involve detoxification. Detoxification isn't the treatment — it is just the start.

REMEMBER

Overcoming a drug or alcohol addiction takes more than simply clearing your body of toxins. For a case study that backs this up, read the sidebar "Detoxification Isn't Enough." Addiction has many aspects, and some of the most powerful are the most subtle. Detox doesn't treat these other aspects. For example, you must figure out how to deal with the cues that trigger you to engage in addictive behavior. You need to try one or more of the treatments discussed in the other chapters of Part 3 to get help. Thus, although detoxification is a fundamental component of treatment, it doesn't address the powerful psychological aspects of the addiction.

Coming to the realization that you have a substance addiction is a process. You can read more in Chapter 6 about the process of deciding on when you need treatment. Your experience isn't unique if you find yourself going through several detox treatments before understanding that treating addiction takes more than detoxification. Still, detoxification is usually a fundamental component in a comprehensive treatment strategy.

The goals of detox

In the short term, detox has three immediate goals:

- **To provide a safe withdrawal from the drug(s) of dependence, allowing you to be drug-free.** Detox from a serious addiction must take place under close medical supervision, optimally in a situation where residential treatment is an option. Detox from milder levels of addiction may be treated successfully on an outpatient basis, but always under medical (MD) supervision.

  WARNING

  Once again, acute withdrawal *can be life-threatening*. Withdrawal can be so painful and disturbing that those undergoing detoxification are susceptible to using street drugs to ease the pain. The street drugs, by definition, are unreliable and can interact with the addictive substances already in your system to cause serious problems and even death.

- **To provide a humane withdrawal that protects dignity and confidentiality.** Detox programs are staffed by people familiar with and experienced in helping folks withdraw. Your distress, irritability, and sickness can be treated competently and compassionately.

- **To prepare you for the next phase of treatment.** Just as the staff will talk to you about treatment options after detox, some peers attending detox with you may provide first-hand knowledge of follow-up treatment options that may help.

REMEMBER

You may relapse following the first few attempts at quitting, but every relapse provides important information about what you need to do differently the next time you detox. You can approach each subsequent detox program more realistically and knowledgeably.

Each detoxification will encourage you to get a more complete and effective form of drug dependence treatment. In other words, knowing that you can get free will motivate you to get treatment for the other aspects of addiction that keep you psychologically "hooked."

CASE STUDY

DETOXIFICATION ISN'T ENOUGH

Mary was addicted to cocaine and prescription and nonprescription drugs. She used prescription medication like benzodiazepines to help her sleep and to calm her agitated nerves. She consumed large quantities of Tylenol daily to combat headaches.

She got started using cocaine through her boyfriend and friends. At first, she only used cocaine when she was at parties with her friends, but slowly she began using it in the evenings after work. At these times, she and her boyfriend would snort cocaine to get high. Gradually, she came to use cocaine after work even if alone. Because she started to have trouble sleeping, she went to her doctor to see whether she could get something to help her sleep. She didn't tell her doctor that she was using cocaine. Instead she blamed her sleeping problems on feeling anxious and irritable at work. Her doctor prescribed diazepam (otherwise known as Valium). She began using diazepam every night to help her sleep. At first it seemed to help, but in time she noticed that her sleep problems returned. A glass of wine at night seemed to help, so eventually she had a drink or two of wine every night to help her sleep. She also took the diazepam.

What Mary didn't know was that she had built up a physical tolerance to the diazepam and needed more to achieve the same result. Her poor sleep patterns and her chronic cocaine use were the primary causes of her headaches. Her overuse of Tylenol to treat her headaches followed the same course as the diazepam. Over time, she had to keep increasing how many Tylenol tablets she took daily to help her headaches.

A number of events led Mary to realize that she was physically addicted to cocaine. She believed that all she had to do to overcome her cocaine addiction was to go through detox. She was confident that if she could rid her body of the physical addiction, she would not be tempted to use cocaine again. She went through a detox program for both her cocaine and diazepam addiction. Upon discharge from the detox program, she was sure she had licked the problem. However, within a few months, she was back using cocaine on a recreational basis. Soon it escalated to a daily use pattern. For a second time, Mary went into a detox program to withdraw from cocaine. She still believed that she could resist taking cocaine if she could just overcome the physical dependence. She now thought she was especially vulnerable to the physically addictive properties of cocaine, and as long as she got help with withdrawing from cocaine use and she never used cocaine again on a recreational basis, she would be okay. However, it wasn't long before Mary found herself addicted to cocaine for a third time.

The process: In the body

The detoxification process takes time, but the exact *amount* of time is difficult to predict. Individuals react differently to chemical dependence, especially if there is *polydrug* (multiple-drug) addiction. The medications used to treat withdrawal can mask or suppress withdrawal symptoms. Because these treatment medications can be prescribed for lengthy periods (even for years to reduce relapse vulnerability), spotting exactly *when* the side effects of withdrawal have ceased is difficult. Knowing how to pace the process is difficult.

The process: In the mind

During detoxification, you're likely to experience significant anxiety. And previous withdrawal attempts will likely dominate your thinking. Reassurance from an experienced physician who medically manages your withdrawal symptoms is strongly recommended.

TECHNICAL STUFF

A return to using the drug you have detoxed from reveals that the brain adapts more quickly to drug-use the second (or third) time, and this quicker adaptation means more *tolerance* develops (more drug is needed for similar effects). There is also increased *dependence* (your brain cells react more when there's no drug or "not enough" in the system). When you become physically dependent on a drug, your brain changes, and some of the changes remain stable after detox. These residual changes in brain cells render you more vulnerable to becoming addicted faster after a relapse.

Each addictive substance has a typical set of symptoms experienced for specific periods of time. Table 10-1 provides basic guidelines about what to expect.

TECHNICAL STUFF

Many different types of benzodiazepine medications are available. Some are systematically absorbed faster (fast-acting drugs) and some take longer (long-acting). You experience the drug effects sooner with fast-acting versus long-acting benzodiazepines. You also experience withdrawal symptoms faster with short-acting benzodiazepines versus long-acting ones.

REMEMBER

Different drugs affect different neurotransmitters in the brain producing the high or the calm. These chemicals in the brain cells are responsible for both the drug effect and the withdrawal effects.

TABLE 10-1 **Lengths of Time for Withdrawal Symptoms to Cease Following Cessation of Substance Use**

Substance	Time of Onset of Withdrawal Symptoms after Stopping Substance Intake	Typical Length of Time for Withdrawal Symptoms to Cease
Alcohol	6–24 hours, peaking on the 2nd day	3–5 days
Short-acting benzodiazepine (such as lorazepam and alprazolam)	Within 24 hours, peaking within 1 day	Gradually subside over 2–4 weeks
Long-acting benzodiazepine (such as diazepine and a clonazepam)	Can take as long as 5 days to start, with peaks around day 9 (or later)	Gradually subside over 2–4 weeks
Following a 2–3 day binge on stimulants (cocaine, cocaine crack, amphetamines, methamphetamine and crystal methamphetamine)	24–48 hours	At least 24–48 hours and sometimes considerably longer
Following regular use of stimulants (cocaine, crack cocaine, amphetamines and methamphetamine)	2–4 days	At least 2–4 days and sometimes considerably longer
Opiates (such as heroin and morphine)	8–12 hours	At least 5–7 days and sometimes considerably longer

Knowing What to Expect with Detoxification Treatments

In the following sections, I review what you can expect when you undergo a detox treatment for a specific substance like alcohol or an opiate. In the following list, I cover some of the common principles or pointers that you should consider when thinking about starting a detox program:

- Detoxification alone is rarely enough to treat substance dependencies. The goal of detox is to get you safely withdrawn from the substance; detox isn't a full addiction treatment. I strongly encourage a full course of follow-up treatment to deal with the other aspects of your addiction.
- Get help with detoxification from a medically approved treatment facility.
  - Considerable research has been done on finding the best and most effective treatments for detoxification. A good facility will have the best treatments aligning with the most recent research. The detox treatments

used in these medically approved treatment programs are those that have been proven safe and effective.

- You also can receive promising, newly discovered treatments in medically approved detox programs. Many of the medically approved treatments will alert you to treatment options that although promising, have not yet been fully tested for safety and success. Depending on the facility, you may have the option to try one or more of these new treatments. See Chapter 13 to learn more about alternative treatments.

- Detox is usually very difficult. Your body cries out for the drug you've been using, and you may be tempted to find relief from the withdrawal in unhealthy ways. For this reason, many detox programs try to ensure that you don't have access to unauthorized medications or street drugs.
- Everyone's withdrawal is individualized. The time frame and severity of withdrawal symptoms vary from one person to another.
- Detox programs use every means possible to reduce your withdrawal symptoms safely. Many programs provide both medications and supportive counseling to help you proceed through the acute withdrawal period as quickly and as comfortably as possible.

REMEMBER

Most important, remember that detox aims to get you off drugs and alcohol safely. Detox doesn't treat any of the other aspects of addictions. After detox, you need to get additional treatments for your addiction.

REMEMBER

Hallucinogens such as LSD, DMT (dimethyltryptamine), mescaline, and Ecstasy don't produce physical dependence and aren't associated with physical withdrawal symptoms.

Detox from alcohol and other sedatives/hypnotics

As I discuss in Chapter 2, sedatives are drugs that produce calming and sleep-inductions in the body. Alcohol and benzodiazepines, a type of prescription drug, are the two major drugs in this group. In this section, I go over the details of withdrawal from these two drugs.

Alcohol

In most cases, alcohol withdrawal can be performed on an out-patient basis. The exceptions are when you have a severe dependence on alcohol or a polydrug addiction.

You likely will need the most support on the second day after your last drink of alcohol — the withdrawal symptoms are usually then at their worst. The amount of time it will take for your withdrawal symptoms to subside depends partly on your overall health, and partly on the severity and duration of your addiction. If your health is poor, you will need to undergo a slower and longer detox treatment process.

The range of symptoms you can experience when you stop drinking varies, depending upon how severely dependent you were on alcohol. These symptoms include: restlessness, irritability, anxiety, agitation, loss of appetite, nausea, and vomiting. You will experience increased arousal as evidenced by tremors, elevated heart rate, and increased blood pressure. This *hyperarousal* affects sleep, so you'll have difficulty sleeping, and when you do sleep, you may experience intense dreaming and nightmares. Other symptoms include: difficulty concentrating, poor memory, impaired judgment, increased sensitivity to sounds, and changes in your skin sensations (the creepy-crawly feeling).

All of these symptoms can be bothersome, but none are life-threatening. The more dangerous withdrawal symptoms that can occur following termination of a serious alcohol dependence are delirium, hallucinations, elevated body temperature, and seizures. The latter need to be monitored carefully by a physician. For this reason, detoxification from a serious alcohol dependence problem is often performed on an inpatient basis.

Benzodiazepines

Not surprisingly, the severity of withdrawal symptoms from stopping benzodiazepine medications (such as diazepam) depends on the dose of medication you've been taking, the length of time you've been using, and whether the drug is fast-acting or long-acting. Most medical prescriptions of these sedatives are at low-dose levels and are prescribed for the treatment of anxiety problems. Withdrawal symptoms are milder from low-dose prescription levels.

TECHNICAL STUFF

What is considered a low-dose level varies depending on which benzodiazepine is prescribed. For example, 6 milligrams of alprazolam (Xanax) is equivalent to a 60-milligram dose of diazepam (Valium). The dosage also depends on your age and the purpose for the prescription (for example, treatment for anxiety disorder or a sleep problem).

REMEMBER

Withdrawal symptoms from the benzodiazepines can be confused with a return of anxiety symptoms. You may have a difficult time telling the difference between true withdrawal symptoms and the symptoms of an anxiety disorder. So work to achieve a complete withdrawal before assessing whether further treatment is needed for your anxiety problems.

The range of withdrawal symptoms reported includes nausea, vomiting, irritability, tremor, coordination problems, insomnia, restlessness, blurred vision, sweating, loss of appetite, and anxiety. Withdrawal from benzodiazepines must be medically managed. You will be gradually withdrawn from (tapered off) and may be prescribed another benzodiazepine to lessen the discomfort of the withdrawal symptoms and to prevent serious medical consequences. (For more on this, see the section "Medications for treating benzodiazepine withdrawal" later in this chapter.) Any abrupt discontinuation of high-dose of benzodiazepines may produce severe withdrawal symptoms, including seizures, disorientation, psychosis, and depression.

REMEMBER

Symptoms of withdrawal from short-acting benzodiazepine (lorazepam) are more severe than symptoms from long-acting benzodiazepine (diazepam).

Detox from stimulants such as cocaine and amphetamines

The most common symptoms following a two- to three-day cocaine or amphetamine binge are sadness (*dysphoria*) and irritability. The most common withdrawal symptoms following regular use of stimulants, like cocaine or methamphetamine, are dysphoria, irritability, difficulty sleeping, and intense dreaming.

If you also abuse alcohol, marijuana, or benzodiazepines, you're not alone. Typically, you turned to these others substances to reduce the irritability caused by chronic stimulant abuse. Detox in these cases is complicated, because you must be withdrawn from multiple substances.

Detox from opiates

All *opiates*, which include heroin, morphine, hydromorphone, codeine, and methadone, produce similar withdrawal symptoms. However, they differ as to how quickly withdrawal begins after use has stopped and how long it lasts. In addition to the type of opiate used, the severity of the withdrawal symptoms depends on the total daily dose, the interval between doses, the duration of use, and your overall health.

The symptoms of withdrawal from opiates can be grouped by what parts of the body they affect the most. There are four groups:

- Gastrointestinal distress, including diarrhea and, less frequently, nausea or vomiting

- Pain, typically either joint pain, muscle tenderness, or abdominal cramping
- Anxiety
- Sleep disturbance

Detox from marijuana

There are only minor withdrawal symptoms from marijuana use. You may experience some feelings of irritability and have difficulty sleeping for several days when you discontinue chronic use.

Detox from inhalants/solvents

Detoxification from chronic use of inhalants/solvents is very similar to alcohol detox. The withdrawal symptoms are similar as well. Refer to the section on detox from alcohol if you want to find out more about what to expect with inhalants/solvents withdrawal.

Medications That May Help

Specific medications may help you detoxify from almost all of the serious drug dependence problems. And because this is an area of intense study, new treatments are approved frequently. In the remainder of this chapter, I go over the most effective medications used for drug and alcohol detox.

TIP

A great website for the latest information on drug abuse treatments is `https://nida.nih.gov`.

REMEMBER

The goal of detox is to get you off the addictive substance in as safe and comfortable a manner as possible. All of these detox medications aim to do that. They're only prescribed for a brief time to get you over the withdrawal period.

Medications for alcohol problems

Depending upon the severity of your alcohol dependence, you may be able to be withdrawn from alcohol on an outpatient basis. The detox treatment team can advise you on your best treatment options.

TIP

If you have a choice, a residential detox treatment program is safer than an outpatient program. Although guidelines help the clinical team determine whether your dependence problem can be treated on an outpatient basis, when it comes right down to it, the severity of withdrawal symptoms in a particular person is hard to predict. Therefore, err on the safe side.

The most common medications prescribed for withdrawing from alcohol dependence are sedatives such as the benzodiazepines. Because these medications have a sedating effect on the body similar to alcohol, they're helpful in lessening some of the hyperarousal withdrawal symptoms, such as seizures and tremors. The real advantage of benzodiazepines is that they're a different substance from alcohol, and they can be managed in a more controlled way because the dosages can be titrated.

TECHNICAL STUFF

Some of the commonly prescribed benzodiazepines are chlordiazepoxide (Librium), clonazepam (Klonopin), chlorazepate (Tranxene), and diazepam (Valium).

In some instances, you may be prescribed a medication that specifically controls seizures. One medication is carbamazepine (Tegretol). Beta-blocker medications are also frequently prescribed. These medications help reduce or prevent a rapid heart rate, elevated blood pressure, sweating, and tremors. With severe alcohol dependence, you may experience hallucinations while withdrawing. An antipsychotic medication called haloperidol (the trade name is Haldol) has been found to effectively treat hallucinations.

Medications for treating benzodiazepine withdrawal

Withdrawing from benzodiazepines typically involves a slow and gradual weaning process. Even if you've been taking the benzodiazepine medication for only a month, you should taper off gradually. *Tapering off* means that you will be prescribed a progressively milder dose that helps your body adjust to having less and less drug. In many cases, you will be able to withdraw from these medications on an outpatient basis. The exception is with the last two administrations of the medication.

Depending upon the severity of your withdrawal symptoms, your treatment team may advise that you be admitted to a hospital for the period of time you're withdrawing from the last two administrations of the drug. Even though the last administrations of the medication are usually quite low dosages, your body may have a bigger reaction than in previous reductions. As an inpatient, the severity of your withdrawal symptoms can be monitored more closely.

REMEMBER

As mentioned earlier, the withdrawal symptoms from the short-acting benzodiazepines are more intense than those with the long-acting medications. Thus, although tapering off works well for the long-acting drugs, it may not work so well for the short-acting drugs. Often, your medical team will suggest switching you from a short-acting drug to a long-acting one and then gradually taper you off the long-acting one over a one- to two-week period.

Medications for treating opiate addiction

The approach to detoxification from an opiate addiction involves prescribing medications to help relieve the withdrawal symptoms. Often this involves switching you from heroin to another type of opiate drug associated with fewer side effects, and then gradually tapering you off this alternative opiate. The medication most commonly prescribed to help lessen the intensity of most withdrawal symptoms is clonidine (Catapres). Unfortunately, this medication doesn't help relieve the symptoms of muscle aches or sleep disturbance. Nor does it lessen drug cravings. The latter symptoms of aches, sleep disruption, and cravings are helped by switching you to another opiate drug that is associated with fewer withdrawal symptoms.

The two alternative opiates that you may be switched to are methadone and buprenorphine. Because both drugs are used to help relieve drug cravings and prevent relapse, I discuss them further in the section "Maintenance medications and craving reducers." In most cases, you will be gradually withdrawn from these alternative opiate medications. If you're at very high risk of relapse to a heroin addiction, you may be maintained on methadone for a long period or even for the rest of your life.

Medications for stimulant abuse

Withdrawal symptoms associated with stimulant withdrawal typically subside in two to four days (refer to Table 10-1). No specific medications for stimulant withdrawal exist. However, you may be prescribed a mild medication to help relieve sleep disturbance and distress.

Maintenance medications and craving reducers

Some medications help reduce the cravings for opiates and alcohol. They also help reduce the pleasurable effects so that if you slip and reuse these substances, they produce fewer of the desired effects. These medications are referred to as

maintenance drugs because they can be used on a longer-term basis to reduce the harm of drug addiction by reducing cravings or by blocking the high associated with the drug you previously abused. Because the effects of maintenance drugs are fairly benign or less risky than the illicit drug, they can be tolerated for extended periods of time. I go into further details on some of these drugs in the following sections.

Naltrexone

Naltrexone is a craving-reducer for both alcohol and opiates. It acts on the brain's opiate system by blocking the sensations of pleasure associated with alcohol and opiate intake. Research indicates that you're significantly less likely to relapse and resume drinking alcohol when taking naltrexone. If you do slip and have a drink, Naltrexone also increases the likelihood that you'll recover from the relapse and resume abstinence. The drug is typically prescribed for a three-month period.

If naltrexone increases one's chances of abstinence, why doesn't everyone use it? One reason is that it is associated with some negative side-effects. These include nausea and stomach cramps. Plus, as naltrexone blocks the effects of opiates in the brain, it can worsen opiate withdrawal symptoms. It's best to wait five to ten days after being drug-free from heroin before taking naltrexone and even longer if you have withdrawn from methadone or buprenorphine.

Although naltrexone does reduce cravings for alcohol, it fortunately doesn't interfere with the experience of other kinds of pleasure. Nor does it interfere with non-opioid pain medications such as acetaminophen, aspirin, and ibuprofen.

WARNING

Like detox treatment, naltrexone isn't effective as a sole treatment for alcohol addiction. You need additional treatments for help with the other aspects of addiction.

Antabuse (disulfiram)

Antabuse is used as a treatment for alcohol addiction by producing a highly unpleasant sensitivity to alcohol. The unpleasant symptoms persist until the alcohol is completely excreted from your body. The unpleasant sensations are numerous and include flushing, headache, breathing difficulty, nausea, vomiting, sweating, thirst, chest pain, rapid heart rate, dizziness, blurred vision, and confusion. The symptoms can sometimes be life threatening. They can last up to an hour in the case of mild reactions and several hours for severe reactions.

Campral

Campral (or acamprosate calcium) is a drug that also helps prevent relapse following alcohol withdrawal. It modifies the effects of one of the brain's biochemicals, namely GABA. The result is that it reduces the pleasurable effects of drinking alcohol. Research indicates that people taking Campral as a maintenance medication for the treatment of alcoholism are significantly more likely to remain abstinent as people who aren't taking this medication following alcohol withdrawal.

One big advantage of Campral is that it doesn't have much of an effect on the liver, so it can be used in most people who have liver disease. The exception is with people who have very severe liver disease. Other contraindications for its use are pregnancy, kidney disease, or ongoing drug abuse.

Buprenorphine

Withdrawal from buprenorphine takes longer than from methadone, but the symptoms are less severe and often more easily controlled. It can be prescribed both alone (Subutex) and with naloxone (Suboxone). The combination drug with naloxone is intended to discourage abuse of buprenorphine. If you do attempt to abuse the combination pill by dissolving it and injecting it like heroin, naloxone will block the opiate effects and result in opiate withdrawal symptoms. When combined with buprenorphine in a pill form, naloxone doesn't affect the absorption of buprenorphine.

Methadone Treatment

Methadone is a drug commonly used to help users withdraw from heroin. During the initial detox phase, you will be treated with methadone on an inpatient basis. Furthermore, after you're through the detox phase, you may be kept on a maintenance dose as an outpatient. In either mode of treatment, you may have to undergo mandatory drug testing to verify that you haven't relapsed to heroin use.

REMEMBER

You may also have to qualify for methadone treatment by having your physician verify that your physical dependence warrants it.

What is methadone?

Methadone is a long-acting narcotic (an opiate) that because of its actions on the opioid receptors in your brain, acts as a stabilizing agent. When taking methadone, your physical dependence is managed, allowing you to deal with your drug-seeking behaviors (which typically include illegal acts to get the drug or the money

to pay for it). Methadone does produce a high, but because the effects are less intense than with heroin, users are less likely to abuse it. Nevertheless, because methadone *is* physically addictive, its use is highly regulated. Your doctor will inform you of the particular regulations relevant to you, which depend on where you live and what laws are currently applicable. (The effects of narcotics on the brain are discussed more in Chapter 5.)

Methadone myths

I'd like to dispel a few misconceptions about methadone that you may have heard. I've included a list of various false notions about methadone:

- It is easier to overcome the psychological effects of a heroin addiction when taking methadone.

  FALSE: Although methadone does reduce the physical cravings for heroin, it does *not* help reduce the mental cravings. You still need to work at countering the mental desire to take heroin.

- Methadone is worse for your body than heroin.

  FALSE: Methadone is safer than street drugs, because it is medically regulated and manufactured. Like street drugs, methadone can cause serious health consequences if overdosed. However, because methadone is medically regulated, you're less likely to overdose on it. Furthermore, because it isn't associated with the euphoric rush of heroin, you're unlikely to desire more than the prescribed dose.

- Methadone harms your liver.

  FALSE: Although methadone is cleared from your body by the liver, there is minimal harm to the liver. Even if you have liver damage, you can take methadone.

- Methadone is harmful to the immune system.

  FALSE: It is not harmful to the immune system.

- Methadone causes people to use cocaine.

  FALSE: You may well have progressed from cocaine to heroin use, but no evidence indicates that methadone increases your chances of taking cocaine.

- The lower the dose of methadone, the better.

  FALSE: The best dose of methadone for you is the one that controls your drug craving.

Who should choose methadone treatment?

If your detox efforts in withdrawing from heroin or morphine have been unsuccessful, then you should try methadone treatment.

WARNING

Except in rare cases, methadone treatment in the United States has not been approved for treating heroin addictions in adolescents.

Does it work?

Methadone is the only opiate treatment that has been proven safe and effective for opiate withdrawal and dependence. It is taken once daily and it successfully suppresses opiate cravings for 24 to 36 subsequent hours. It not only reduces the cravings associated with heroin use, it also blocks the euphoric high from heroin. Because methadone isn't associated with the extreme highs and lows of heroin or morphine use, you won't experience the uncontrolled cravings for methadone that you do for these other powerful narcotics.

IN THIS CHAPTER

- Taking a look at the variety of twelve-step programs
- Going over AA's Twelve Steps
- Getting into a program that fits you
- Surveying the negative side of such programs

Chapter 11
Twelve-Step Programs

We're experiencing important changes in how society views mental health. Previously, mental health was seen as inherited or automatic. Now with the evidence-based constructs from health psychology and neuroscience, we know the brain is neuroplastic, continually responding to what we do. A clarification is captured in the statement "mental health is health," which points to mental health being a situational achievement based on decision and discipline. Therefore, we personally vary in mental health based on the efforts and disciplines we commit to — and the adverse conditions we experience.

It is quite clear that we humans (even talented and skillful humans) are far from perfect. As a result, we must deal with failure frequently and resiliently — and need support and another person's understanding to do so.

Twelve-step programs are good examples of caring and understanding in the face of failure and stigma. These programs respond to the ultimate plea for understanding, "If only you knew what it's like. If only you could understand what I'm going through." Twelve-step programs help because participants can genuinely say, "We've been there, we understand." One of the responses to the plea for understanding is for members in the program to share stories — and not avoid the bad and ugly parts.

Types of Twelve-Step Programs

The purpose of twelve-step programs is to teach and support resilience skills. In the beginning of *your* recovery program, the structure and availability of twelve-step meetings can be critical. These meetings provide a refuge and help you overcome your resistance to seeking help. They assist you as you learn to manage the triggers of your addictive behavior and the other compulsive reactions that can plague your lifestyle.

REMEMBER

Compulsive behavior refers to wasteful or self-destructive actions that are repeated because they temporarily reduce anxiety. Addictive behaviors fit this definition. The empty promises to quit made by addicted people happen when in the grip of emotions they can't control or resolve. One can also slide to the other side of the spectrum, adopting a risky, what-the-hell attitude. Finding better and better understandings of what triggers your compulsive-addictive behaviors can be very important in recovery.

Bill Wilson began Alcoholics Anonymous in 1935 and established the AA tradition. Wilson and others codified their approach in the *Big Book*, which guides problem drinkers through the process of recovery. The main criterion when attending a meeting is that members admit to a problem. ("Hi, I'm Jane and I'm an alcoholic.")

Although AA was created for alcoholics, the treatment approach has been applied to many other types of addictions. The focus may differ because the guidance provided depends on the issues the addicted person faces. In many cases, the person has a *polydrug problem* (using several different types of drugs, including alcohol). In addition, people may have other addictive behaviors (sex, gambling, money, overeating, work).

TECHNICAL STUFF

Over two million people worldwide participate in AA.

You can find more than 64,000 twelve-step groups in the United States and over 120,000 worldwide. The following is a partial listing of twelve-step programs that are available in most cities:

- Al-Anon (support for families with an addicted member)
- Alateen (support for teens with addicted family members)
- Alcoholics Anonymous (AA)
- Debtors Anonymous (DA)
- Gamblers Anonymous (GA)
- Marijuana Anonymous (MA)

- Narcotics Anonymous (NA)
- Overeaters Anonymous (OA)
- Sex and Love Addicts Anonymous (SLAA)

In some communities, you may have to cross over and attend a meeting that doesn't address your specific addiction. Nevertheless, the principles are consistent: regular meetings, participation if you're comfortable, and fellowship.

The Actual Twelve Steps

The hardest part of joining AA is walking into a first meeting. You can be assured that you will be welcome. Most people agree that this first experience is positive, and for some, AA is exactly right for them.

TIP

After you've been attending meetings on a regular basis, you may want to ask another experienced member to sponsor you. Find someone at the meetings whom you respect, and ask that person how they achieved recovery. See whether you feel comfortable with and can trust this person. If the person passes your personal tests, ask them to sponsor you. Your sponsor will get you started with respect and caring and guide you through the process known as *the steps.* Working through the steps in AA is the cornerstone of recovery. The preamble that follows is how AA describes its membership.

AA Preamble

Alcoholics Anonymous is a fellowship of people who share their experience, strength, and hope with each other that they may solve their common problem and help others to recover from alcoholism.

The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership; self-support happens through contributions. AA is not allied with any sect, denomination, politics, organization, or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes. The primary purpose is to stay sober and help other alcoholics to achieve sobriety.

What follows are the Twelve Steps of Alcoholics Anonymous, which are adaptive to other addictions. The steps are taken in order, but folks often a need to revisit a step and reinstate some of the commitments and understandings.

1. We admitted we were powerless over alcohol — that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

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Working Your Program

In twelve-step programs, you hear the phrase "working your program" a great deal. Working your program means:

- Accepting guidance and practicing the steps of recovery.
- Replacing the cognitions and behaviors that prolong addiction with the behaviors and thinking that initiate and sustain recovery.
- Actively participating in the fellowship.

What do I mean by recovery? *Recovery* is a major transformation. Your whole life has been yanked out of balance by chemicals and actions that have undermined balances, values, and achievements. *Recovery* refers to recovering the simple but healthy balances that made you feel good when you ate, exercised, loved, and engaged in honest, wholesome friendships. Somewhere along the line, either by relying on the quick fix of a chemically induced buzz or by being overwhelmed by a sudden set of very painful experiences, you began the habit of seeking artificial solutions to life's challenges. Recovery means rediscovering your own natural resources to meet those challenges. In doing so, you feel natural satisfactions and develop a natural sense of confidence in yourself.

Hitting bottom and working toward recovery — one day at a time

You aren't alone if you remember a first drink, hit, or bet with excitement and nostalgia. You may recall the temporarily positive impact of the behavior, when you probably felt your anxiety reduce and a path open to an escape into pleasure and euphoria. This memory trace can be so powerful that it can counteract the more real life experience of spiraling downward. You can get used to the downward slide and numb yourself to it, until you hit bottom. Then you realize that there's no more room to slide. Things can't get any worse. But hitting bottom can also be the beginning of the big turn-around. The bottom can be the start of recovery — where it hurts most is where healing can begin.

Whether you've hit bottom or not, taking one day at a time is extremely important. Psychologically, this state of mind exerts considerable power. You don't want to look back and relive past mistakes, and you don't have to look to the future either. The focus is on living *today* in an addiction-free state of mind and body.

TIP

Keep track of your days in recovery. People who are recovering tend to keep track of their days of sobriety or behavioral control. They celebrate "birthdays" that symbolize their achievements in recovery. They don't take even one day for granted. Live *one day at a time.*

A friend was coming up to a three-year birthday and when asked how long he had been sober he said it had been 1,092 days — not three years. That's what is meant by one day at a time. Don't get ahead of yourself. The process of recovery is consistently hard.

Discovering spirituality

Spirituality can be important in recovery because addiction can become so powerful that it competes with the spiritual power people feel during religious and meditative ritual. After you're addicted, more and more of your life is consumed with looking forward to each addictive fix. Your substance or behavioral addiction takes the same place that religious or spiritual commitment may have once occupied in your life. Rediscovering your spirituality can help you reorder your life and reconnect with your own spiritual power, helping you to put your addiction in perspective. A spiritual view reminds you that you are *more* than your addiction.

TIP

What if you don't feel spiritually oriented? It's a good question because you can't fake spirituality. If you don't feel spiritually oriented or motivated, don't pretend that you do.

Sometimes the difference is one of form rather than degree. Spirituality is a highly personal matter. The form of spirituality right for you may be very different from what's right for someone else. Many people have some idea of a transcendent core that continues after the body dies. Many people also believe in some order to life that can be comprehended and used to guide one's actions. Such beliefs, however, don't necessarily coalesce into a particular religious or spiritual view.

If you feel spiritual in this way, you don't need to force your feelings into a given structure. Instead, follow your own feelings about how your sense of spirituality is strengthened. If some of your feelings are confirmed by your participation in twelve-step programs, great. If some aren't addressed in twelve-step programs, that's fine too. Take what works for you and leave the rest alone.

Using affirmations

The value of slogans or affirmations to the recovering process depends very much on you as an individual. Depending upon what is meaningful to you, keeping a special thought in mind can be motivating. *Affirmations* are basically reminders of the positive sides of the processes of growth and transformation. As much as you may believe that you don't need such reminders, they can actually make a difference as to what thoughts, emotions, and actions are emphasized in your life.

TIP

Check out the Daily Motivation website for free daily affirmations (`www.dailymotivation.site/affirmations`). You can try out affirmations to see if they resonate with you. The one for today is "I feed trust rather than fears."

Deciding Whether a Twelve-Step Program Is Right for You

Only you can decide whether the twelve steps and twelve-step traditions will really be helpful. The basic approach of AA and other twelve-step programs is to identify a problem and then assess your willingness to make a call, go to a meeting, and stay with the program.

REMEMBER

Twelve-step programs work best if you're willing to admit to your addiction and honestly want it to stop. If you have reservations about wanting to stop ("I hope that one day I'll be able to drink again"), then quitting is harder, and the twelve-step is less of a match. The core of the twelve-step approach is the admission that the addicted behavior must stop with no compromises: It must be a *complete* stop.

Most people with addictive disorders want to experiment with a return to addictive behavior. Your desire to return to only a normal state with some 'compromise' is typical of other chronic illness sufferers. The diabetic may experiment with sugar levels and the asthmatic with exposure to allergens. The usual response to experimenting with addictions, however, is that the addictive behavior is re-established. Simply put, experimentation leads to relapse.

The following questions were developed by AA and are used to help you decide whether AA is for you. These questions are similar to our assessments in Chapter 5.

Answer yes or no to the following questions:

- Have you ever decided to stop drinking for a week or so, but only lasted for a couple of days?
- Do you wish people would mind their own business about your drinking — stop telling you what to do?
- Have you ever switched from one kind of drink to another in the hope that this would keep you from getting drunk?
- Have you had to have an eye-opener upon awakening during the past year?
- Do you envy people who can drink without getting into trouble?
- Have you had problems connected with drinking during the past year?
- Has your drinking caused trouble at home?
- Do you ever try to get "extra" drinks at a party because you do not get enough?

- Do you tell yourself you can stop drinking any time you want to, even though you keep getting drunk when you don't mean to?
- Have you missed days of work or school because of drinking?
- Do you have "blackouts"?
- Have you ever felt that your life would be better if you did not drink?

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Problems with Twelve-Step Programs

As twelve-step programs have become more and more common, a number of participants have voiced their dissatisfactions with them. Some of these participants have found it constricting to "accept that one is powerless" against the addiction and therefore submit to the guidance of a "higher power." To some people, the twelve-step program principles conflict with an acceptance of an individual's personal inner strength and resources and power to effect change. In this section, I go over some of the criticisms that have been leveled at twelve-step approaches. In Chapter 12, I describe several groups that provide approaches that are effective alternatives to the twelve-step program.

What the critics say

Critics point out that twelve-step programs don't help everyone, although they're sometimes presented as if they can. The percentage of successful recoveries, when compared to the total number of program participants, is relatively modest. AA's own surveys show that of the people who attend a meeting, nine out of ten drop out within the first year. Similar research hasn't yet been done on Narcotics Anonymous (NA) and other twelve-step programs, but I suspect that dropout rates are similar.

With a 90 percent dropout rate, it's clear that twelve-step programs are far from perfect. However, the prevailing attitude is that people who fail the program are the problem, not the program itself. Members who resist or criticize twelve-step programs are told, "Utilize, don't analyze." Thus, the very process by which people everywhere evolve and mature — by thinking critically and exploring new

ideas, and implementing change — can be treated as a heretical process if directed toward twelve-step programming. This resistance to innovative thinking about the model can lead to blind adherence and an absence of scientific inquiry.

Any comments on the program are labeled as "the addiction talking" rather than being viewed as honest attempts to understand and perhaps modify existing programming. If you're the kind of person who tends to creatively dissent and challenge, twelve-step programs probably will not be functional because they offer little tolerance for incisive, creative questioning.

Is a twelve-step program enough?

The other relevant question is whether twelve-step programs are sufficiently powerful to help you reach a full recovery. The best answer to this question relates to how powerful the approach seems to you. If you don't experience yourself as being especially enthusiastic about or confident in twelve-step programming, the approach will likely not have the power for you that it has for someone who is more committed and enthusiastic.

REMEMBER

Keep in mind that the approach is supposed to have the power to help you make positive transformations of your own thoughts, emotions, and behaviors. The strength of your belief in this transformational power is an important factor in actually helping you to make these transformations.

If you don't feel the power of twelve step, it may just not be for you. If that's your experience, don't waste time feeling rejected or angry. Go where you find the power of healing.

IN THIS CHAPTER

- Discovering SOS
- Getting SMART
- Understanding Women for Sobriety
- Discovering religious organizations that can help you

Chapter 12

Joining Self-Help and Support Groups

One of the most common self-help approaches is the twelve-step program. Because of its widespread popularity, I devoted a whole chapter to it (see Chapter 11). But some people don't find this approach helps. Some are opposed to the spiritual part of the program or to the view that you're powerless at fighting an addiction on your own. Others don't like the expectation of a lifelong commitment to Alcoholics Anonymous (AA).

In this chapter, I emphasize the self-help approaches that have emerged as alternatives to the twelve-step program. Although some of these alternatives may not be directly available in your community, a good number offer support via the Internet or telephone.

Self-help approaches typically involve *moderators* who have personally recovered from addictions. They also actively involve *you* in peer support and counseling. Peers in the group can be powerful role models for you. You may find it reassuring and encouraging to speak with counselors who, like you, have experienced the highs and lows of the recovery process and has developed the means to successfully overcome their own addictions.

REMEMBER

You too serve as a role model for others. This kind of group responsibility and support may be your first step out of the self-absorption of an addiction into a more giving, caring relationship with others.

WARNING

In the early stages of recovery from an addiction problem, you will probably need more than self-help approaches. Research has shown that your chances of recovering and staying recovered are greater when you use a combination of treatment approaches. Self-help approaches can be one helpful tool in this combination. You can read more about combining treatment approaches in Part 3 of this book.

Secular Organizations for Sobriety and Save Our Selves (SOS)

Secular Organizations for Sobriety (SOS), also known as Save Our Selves, was founded in 1985 as an alternative to the AA approach. Although SOS was initially an approach for overcoming alcohol addiction, it now aims to help people overcome all types of addictions, including both substance and behavioral. Like AA, SOS advocates lifetime abstinence from your addictive substance. However, SOS maintains that you can find that power to resist using and abusing within yourself.

The SOS approach

SOS is an independent, worldwide organization. According to SOS, each person must find their own recipe for recovery. SOS doesn't provide a standard approach that everyone must fit into. Rather, they encourage you to try several methods so you can find the set of approaches that work best for you. In keeping with their openness to different methods for different people, SOS has no problem with you simultaneously utilizing other treatment approaches such as AA. And SOS also provides guidance for family and friends.

Although the SOS approach isn't structured, it offers a toolkit of strategies on its website to help you achieve abstinence. SOS lists over 40 tools on its website at `www.sossobriety.org`.

Here are some examples of the SOS tools:

- **Abstinence:** No matter what, there is no valid reason to use again.
- **Determination:** Never turn back, especially if things get rough. You've gotten another chance at life. How many really have that chance? Sobriety doesn't fix everything, but it makes everything possible.

- **Honesty:** Get things into the open. Get rid of the shadows and darkness of the past. Shine light on the dark things, and they lose their power. Even longstanding problems can be dealt with reasonably when they're truthfully reviewed.
- **People:** Human contact is powerful. If you meet people who are in recovery, your interactions with them can fight the old patterns of isolation.

REMEMBER

SOS is most likely to appeal to you if:

- You feel that you have the power within yourself to overcome your addiction.
- You wish to maximize flexibility in your recovery approach.
- Abstinence is your priority.
- You feel you could benefit from group support.

Joining an SOS group

You can visit the SOS website (`www.sossobriety.org`) to find out about meetings in your community. You can also register if you're interested in helping establish a meeting group in your community. The website helps link people from the same communities so they can establish their own local meeting group. It also provides a 24-hour online meeting schedule (over multiple time zones), that allows for flexibility in accessing the support of SOS through an Internet connection.

Self-Management and Recovery Training: SMART

SMART Recovery (`www.smartrecovery.org`) is another approach to addiction recovery that is based more directly on the theories of cognitive-behavioral change supported by scientific evidence. Like SOS, SMART, which stands for Self-Management and Recovery Training, advocates self-management strategies that rely on your inner abilities and motivations. Thus, you need not believe a Higher Power is necessary to help you overcome an addiction.

The SMART approach

SMART offers free face-to-face and online self-help groups. The group believes in the power of social support and the importance of relapse prevention. Thus, it

encourages members to attend group meetings. But the group doesn't insist on a particular set of tools or strategies. Rather, SMART changes its approach over time, based on the outcomes of research studies. They adopt the strategies that have the best track record in research. Their tools and strategies target four key areas of cognitive-behavioral change:

- Enhancing and maintaining the motivation to abstain
- Coping with urges to use
- Problem solving (managing thoughts, feelings, and behaviors and finding practical solutions)
- Lifestyle balance (balancing momentary and enduring satisfactions)

TIP

SMART's recovery tools and strategies are based on psychological principles that can be readily combined with other approaches, including pharmacologic approaches that feature the use of various anti-addictive drugs (see Chapter 10).

REMEMBER

SMART provides members with the support, tools, and strategies to come to decisions about change. It also helps pinpoint the best strategies for effectively changing. SMART recognizes the many needs that underlie addiction problems, and helps you develop strategies for eliminating or managing these needs in healthier ways.

Joining SMART

You can directly access information on SMART from its website (`www.smartrecovery.org`), which states that the group sponsors more than 300 face-to-face meeting groups around the world. SMART also runs multiple online meetings a week, which you can join if you have access to the Internet.

If you're interested in approaches like SMART that focus on the underlying factors in addictions, you can learn more about the psychological approaches to treating addictions in Chapter 8.

REMEMBER

Typically, addictions evolve because the addictive substance or behavior is helping you feel temporarily better in some way, as in more relaxed, less lonely, and more satisfied. Giving up the addiction means finding new ways to enhance well-being, improve your mood, and overcome feelings of isolation or loneliness. Mutual aid and psychotherapy approaches address these underlying issues.

Women for Sobriety (WFS)

Women for Sobriety (WFS) was founded in 1975 by Jean Kirkpatrick, a recovering alcoholic. She founded WFS (`https://womenforsobriety.org`) as a female alternative to AA because she felt that women with addictions already spent too much time in conflict with themselves. She felt that what women needed was a supportive group that would take their special needs into account.

The WFS approach

The WFS program is described in Kirkpatrick's book, *Turning About: New Help for the Woman Alcoholic* and in more recent articles available on the WFS website. The group advocates abstinence. Women with all types of addictions are welcome. The focus is on building self-esteem and empowering women to make life choices that sustain their sobriety. The WFS motto is: "We are capable and competent, caring and compassionate, always willing to help another, bonded together in overcoming our addictions."

REMEMBER

If you're female and looking for a support group that specifically addresses the needs of women with addictions, WFS may be for you. It encourages the use of meditation, diet, exercise, and positive-thinking strategies. It will probably be especially attractive to women interested in a wholistic approach to addiction treatment.

Joining WFS

You can obtain information on WFS groups in your community and on other services of WFS by visiting its website at `womenforsobriety.org`. It offers online chat rooms, newsletters, literature, tapes, videos, conferences, and information on community and group meetings.

CASE STUDY

ANITA'S EXPERIENCE WITH AA

Anita is a mother of three children. Her husband has a successful law practice in a medium-sized town. Anita is an energetic person herself. She's very sociable, involved in all of her children's recreational activities. Her friends would describe her as the life of the party. However, inside she feels worthless. Her mother was an alcoholic, and as a child, Anita adopted the role of caretaking her younger siblings and father. As an adult, she wanted desperately to have what she believed was a normal family. She had always

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imagined herself cooking wonderful meals for her family, being an ideal mother, keeping an immaculate house, having a loving and intimate relationship with her husband, having no problems of her own, and always being there to support her husband and children. She expected her husband would be home most nights for dinner. She also expected that he, too, would participate in their children's recreational activities, and would appreciate and love her deeply.

She felt it was her fault when her family life didn't turn out the way she'd imagined. Instead of having a normal family life, she started experiencing her husband as being distant, working long hours, and having no time for their children's recreational and social activities. He seemed to take her caretaking activities for granted.

Her drinking started as a way to numb her feelings of disappointment and worthlessness. It wasn't long before her drinking got in the way of her mothering activities. She was frequently late to pick her children up from school, and sometimes didn't even get there. She would frequently lose sight of appointment times. Meal preparations deteriorated so badly that their oldest son, who was just 10 years old, started to caretake his younger brother and sister. Her old childhood and family pattern was repeating itself. When the school principal confronted her husband about the neglected children, and when her husband threatened to leave her and take full custody of their children, Anita finally went to her first AA meeting.

Although AA helped her get sober, it did little to help her sense of worthlessness. In fact, AA's focus on humility and recognizing one's flaws only reinforced Anita's feelings of worthlessness. After each AA meeting, she felt squashed down rather than encouraged and bucked up. She learned about Women for Sobriety through another woman in her AA group.

Discovering WFS was a transformational experience for Anita. Here were women like herself who were also struggling with empowering themselves to assert individual rights and regain self-esteem. Women at WFS were learning to no longer subjugate their needs to their family demands. Through WFS, Anita learned to balance her need to take care of herself with taking care of her family. She also learned that both men and women are affected by sex role stereotyping and that her husband's lack of involvement in their family life was not because he didn't love his family. Rather, he believed that the most loving thing he could do for his family was to be a good provider. As Anita learned to validate her own needs she was better able to communicate with her husband. As a result she and her husband have been able to work together in finding ways for Anita to take time to look after herself. Her husband has found more time to share in family activities.

Religious Organizations

A number of religious organizations offer support groups for individuals and families. If you're religious, you may want to ask at your own place of worship about an affiliated support group for addiction problems. Also, the Christian Recovery International (www.christianrecovery.com), the National Association for Christian Recovery (www.nacr.org), and the Jewish Alcoholics, Chemically Dependent People, and Significant Others (www.jacsweb.org) websites offer information on numerous religious support groups for addiction problems.

IN THIS CHAPTER

- Using psychedelic drugs as treatment opportunities
- Discovering acupuncture
- Reviewing nutritional therapies
- Meditating yourself to health
- Reducing harm

Chapter 13

Psychedelic Therapies and Other Alternative Treatments

In the last decade, increasing numbers of people with addictions have sought alternative treatments in North America and Europe. Currently, more people consult alternative treatment professionals than licensed physicians, a statistic reflecting this shift.

Despite the trend, there has been reluctance in investing the funds needed to scientifically assess alternative treatments. As a result, we're in a transition. Some early trial evidence, case studies, and anecdotes about treatment alternatives are available. But in most cases, we know less about the evaluation of alternative treatments than about the evaluation of standard medical procedures.

WARNING

The important consideration in any experimentation with alternative therapies is to ensure your safety by concurrently maintaining conventional treatments and regular contact with trusted physicians. You don't want to ignore the wisdom of centuries of medical science. It makes sense to go for the best combination of treatments available — but be sure some of it includes the best that Western medical science can offer.

Although I don't cover all the alternative treatments that are used in addiction treatment in this chapter, my goal is to describe the most important ones and to provide a framework for you to decide on what to try and how to try it out. The thorough scientific evaluation of these treatments is still in the works, despite the fact that people have voted with their feet to consult alternative health professionals. You need to evaluate the scientific data that exists, critically, while being willing to trust your experience of what works for you.

Psychedelics

It may seem ironic that your history of substance exposure may have caused an addiction or freedom from it. Your experience with psychedelic substances like psilocybin (magic mushrooms) or LSD, which in testing have proven to be *anti*-addictive and useful in helping patients move to abstinence, may have been different than for someone else. Some chemicals, when ingested during experimentally validated protocols, are anti-addictive for some people. What is meant by anti-addictive?

REMEMBER

An anti-addictive substance is a substance used to prevent or treat addiction. It's also unlikely to induce addiction, either to the substance itself, or to other substances.

The current research on the potential benefits of psychedelics in the treatment of addiction supplies a needed correction to the hysteria of the Harvard experiments of the early 1960s. There is much to read about these past errors of judgment that led to systematic research being legally prevented (for decades). Most important, however, is the current availability of anti-addictive experimentation that can suggest a potent pathway to personal recovery.

TECHNICAL STUFF

To properly understand why and how we arrived at the current situation, we must review some of the events that unfolded after psychedelics were discovered experimentally. First, psychedelics were *rediscovered* experimentally, given the documentation of psilocybin mushroom and peyote cactus use for centuries before science was applied. Most of the early scientific experiments occurred in the 1950s in Canada in the province of Saskatchewan. Tommy Douglas, the charismatic leader of the socialist Saskatchewan government, was intent on bringing in innovative researchers to reform the health system. Along with Humphrey Osmond, a British psychiatrist at the Saskatchewan Mental Hospital, another psychiatrist, Abram Hoffer, with biochemical training, was recruited. They, began experiments with the psychedelic most accessible at the time — LSD. They primarily

confronted alcoholism, focusing on single session effects. Whether it was luck or intuition, LSD proved to be anti-addictive with alcoholic disorders.

What did they specifically find?

Because Osmond believed LSD induced symptoms like delirium tremens, he and Hoffer decided to investigate the possible connections (and similarities) between alcohol molecules and LSD molecules. Despite the original observational motivation, they treated 2,000 people with alcohol addiction under carefully controlled conditions. They were astonished that 40 to 45 percent of the LSD–treated patients remained abstinent one year following treatment.

Recent studies undertaken by multiple researchers demonstrate the anti-addictive effects of LSD and other psychedelics for a range of addictions. A meta-analytic review that assessed all study results between 1966 and 1970 involved 536 patients who demonstrated significant benefits in reduced alcohol use at short- (one month), medium- (two to three months), and long-term (six months) follow-ups after LSD administration. Such promising results are now also being observed with psilocybin; although, the studies are in earlier developmental stages.

Clinical trials for nicotine dependence and alcohol dependence have shown significant abstinence outcomes, with additional trials now under way.

TECHNICAL STUFF

A *clinical trial* takes place when individuals agree to undergo an experiment in which they are randomly assigned to receive a particular treatment. The new treatment investigated is called the *experimental* treatment. It's called experimental because the scientists don't yet know enough about how it works. They want to know whether it works as well or better than the standard treatment. Sometimes, the comparison treatment condition is a placebo because the scientists want to test whether the experimental treatment works better than the effects people can actualize themselves through expectations of positive treatment effects.

In the case of psilocybin, it was administered to 15 treatment-*resistant* tobacco/nicotine-dependent smokers, along with cognitive behavioral therapy for smoking cessation. A first dose was administered on the participant's target quit date to quit smoking, with a second and third dose administered two and eight weeks after the target quit date. At the six-month follow up, 12 of 15 participants (80 percent) were biologically verified to be abstinent from tobacco use. At a 12-month follow-up, 10 of 15 participants (67 percent) were biologically verified as abstinent. In a long-term follow-up that averaged two and a half years after the target quit date, 9 of the 12 participants (75 percent) were again biologically verified as abstinent. The results can be described as impressive considering how powerfully addictive tobacco use becomes.

Another study examined psilocybin in the treatment of alcohol dependence with ten alcohol-dependent participants administered psilocybin along with a 12-week program of motivational enhancement therapy. Participants had to abstain from alcohol for 24 hours before their first psilocybin session. A second session occurred four weeks later with therapy sessions conducted between two psilocybin sessions, and after the second psilocybin session. Self-reported alcohol use decreased significantly after the first psilocybin session and remained lower than baseline at 36-week follow-up. Drinking was reported to have occurred on 40 percent of days at baseline, and on less than 20 percent of days at follow-up. Consistent with prior findings from the studies of psychiatric distress, higher mystical-type experience scores in the psilocybin session were related to greater reductions in alcohol consumption. Encouraged by these promising signs, a large, randomized trial of psilocybin in the treatment of alcohol dependence is now underway.

The current work is so innovative that it includes an assessment of whether a participant was having a mystical experience during the psilocybin session, and if so, how powerful the experience was and how much it might have contributed to no longer being susceptible to addiction. The good news of this type of assessment was that some subjects did have mystical experiences that helped them withstand subsequent addictive urges. What were the content of such experiences? They varied quite a lot but the common theme was valuing life a great deal more (than before) with all the difficulties and pain of life involved.

These are early findings, so what relevance might they have for you?

First, you may have already had experiences with psychedelics you're wondering about. (Can your experience with magic mushrooms twenty years ago help with your addiction to nicotine now?) An important message from current experiments is that the benefits occurred within highly controlled experiments that combined psychotherapy with substance intake. Unlike other drugs, generally, the mindset of the participant and the physical environment when psychedelics are ingested appear important to benefits. We have fortunately progressed beyond the "turn on, tune in, drop out" days of Timothy Leary when potent psychedelics were wrongly considered "entertainment" drugs. Now we know, experimentally, that they alter the default brain networks with results that persevere for months and years. It is far from an evening at the theater or concert hall. It is a life-changing experience that you will live with for some time to come, whatever the results are.

Second, you may be a psychedelic responder (a person for whom these drugs are beneficial) and willing to apply for participation in an ongoing study that is happening close to you.

Third, there will be an increasing number of qualified therapists offering psychedelic therapy for addiction recovery in the foreseeable future. Finding the right psychedelic therapist, if motivated to try the therapy, will take some rigorous

searching. With a psychedelic, the "inner you" may become more exposed and subject to influence than in non-psychedelic therapy. It is very important to trust and feel confident in the professionals you are working with.

Acupuncture

What is acupuncture? And why would anyone believe it might help addiction? The practice of medical acupuncture involves inserting needles in the body in various combinations, locations, and patterns. According to traditional acupuncture theory, the choice of needle patterns stimulates the flow of qi (pronounced *chee*), a subtle type of invigorating energy. Different disorders are said to be caused by obstructions in the energies that flow through meridians or channels by which they circulate throughout the body. Treatment involves inserting needles into the channels affecting the disordered organs to stimulate the energy circulation that restores energetic balance and proper organ function.

Many people are convinced of the benefits of acupuncture due to its long history in Asian (especially Chinese) medicine. How could so many people believe they've been helped, over a history that spans several thousands of years, if there were no beneficial effects?

TECHNICAL STUFF

The long history of traditional acupuncture is an important point because it evokes another question. Could a treatment work well in one environment and not in another? It is certainly possible. First, a treatment may work well in one environment simply because of the *placebo effect,* where a person's positive expectations lead to improved outcomes. Second, whenever you take a treatment out of its natural cultural environment and expose it to patients with a different set of cultural norms, you're changing that treatment. When we put acupuncture to the Western scientific test in a Western medical clinic, we're changing the collective expectations of the patients in that clinic and thus treatment effects. You may argue that we're only changing it in a minor way. However, we really don't know just how major or minor the changes are. What we do know is that the acupuncture being tested, in the end, is different from the acupuncture practiced throughout the ages in China and other parts of Asia.

In Western science, evidence about acupuncture varies. In terms of treating drug abuse and addiction, the randomized controlled trial methods and results are still being refined.

Which results do you trust amidst those you might read about? I can't say for sure, but two perspectives are worth considering. The first is that the difficulties involved in conducting a high-quality clinical trial in acupuncture are so extensive

that such a trial has not been done satisfactorily. From this viewpoint, you can trust the correlational evidence more, because this evidence is derived from easier forms of experiments that, because they're easier, have been undertaken more frequently and effectively. The second view is that the clinical trials provide the most exacting evidence of effectiveness, and acupuncture just doesn't measure up under these stringent conditions of testing.

I go over examples of both types of evidence in the following sections, so you can see for yourself what makes sense.

Correlational research

Much animal research in acupuncture is devoted to testing whether the treatment reduces addictive behavior. First, addictive responses are induced (for example, in laboratory rats), then the strengths of the addictive responses are tested following acupuncture treatment. For example, rats induced into a nicotine addiction (the addictive tobacco ingredient) are given acupuncture and then observed. The treated rats show decreases in addictive behaviors consistent with lesser addiction levels. An important aspect of these studies is that the same anti-addictive effects observed externally, in terms of behavior, are also observed internally, in terms of biological responses.

The human research is more varied, although similar. One important question has been whether acupuncture assists patients in withdrawing from addictive states. If it does, its anti-addictive action may be effectively rebalancing the biological processes that become disordered during drug abuse and addiction. If true, the anti-addictive effects of acupuncture may also be effective in preventing relapses.

Clinical trials

In several randomized clinical trials with humans, acupuncture has effectively reduced the addictive withdrawal responses of patients detoxifying from nicotine, alcohol, cocaine, and opiates. However, the picture isn't all clear because other clinical trials, specifically testing nicotine and cocaine addiction, have yielded opposite results — little or no differences between acupuncture effects and the effects of a sham needle treatment. The sham treatment is meant to look like acupuncture, but the needles inserted aren't placed in any of the real acupuncture points. Thus the sham treatment is purposely ineffective. If it turns out to be as effective as acupuncture, then either a new, effective needle treatment has been discovered (highly improbable) or there's some placebo response involved that suggests the action of acupuncture isn't crucial to the benefits derived.

How do you interpret these positive and negative study results? You may conclude that some studies were done more precisely and that the more precise studies showed either positive or negligible results. Or you may conclude that some patients are highly responsive to acupuncture, and others are unresponsive. Whenever results are compared across patient groups, the data of each group is analyzed as a whole. Therefore, there is an overriding of differences in the responses of individual people.

Plainly put, if the most acupuncture-reactive patients were compared with the control groups of these studies, different results may be obtained from the ones reported. In practical terms, it may be that certain sectors of the patient population, or the general population, have a stronger response to acupuncture. Other sectors are less responsive. In most studies, thus far, both responsive and unresponsive sectors are mixed together in evaluating responses. Practically speaking, if you, individually, are a strong responder to acupuncture, you may have more positive responses than those reported in the published studies.

This kind of responder research could be done systematically, but the science in this area hasn't progressed there yet. You may decide, on the basis of current findings, to try out acupuncture as part of a treatment regimen. Then you can evaluate how strong your response is — and see whether you feel you're a responder and, if so, whether you will continue with treatment to derive the benefits.

Ibogaine

Ibogaine, a hallucinogenic substance derived from the root of a West African shrub, is a fascinating, plant-based remedy believed to have anti-addictive properties. As a biochemical, it's referred to as an alkaloid that is used to alleviate opiate dependency and withdrawal. It has been categorized elsewhere as a hallucinogen (like peyote) and was perhaps originally used for its anti-addictive action by the tribes in West Africa that discovered it.

How ibogaine may work

The research on ibogaine is simple to interpret because most of the reliable studies have been done on animals. Most indicate ibogaine reduces opiate withdrawal symptoms and alcohol dependency. For example, in morphine-dependent mice, ibogaine reduced physical withdrawal reactions. In rats that have been preconditioned to be alcohol-preferring, ibogaine reduced the subjects' desire for alcohol intake, with minimal side-effects on food intake.

HISTORICAL BEGINNINGS OF IBOGAINE TREATMENT

Despite the observation that the visions associated with ibogaine can be stressful, it has a history of underground use from the early 1960s onward. At that time, it was transported to North America in sufficient quantities to become known as an anti-addictive substance. One of its discoverers, Howard Lotsof, gave it to seven heroin and cocaine addicts and reported that five of the addicts stopped their use for 18 months, experiencing minimal withdrawal problems. Lotsof pursued efforts to patent the drug, finally succeeding in 1985 with a patent for its use in opioid withdrawal. Addiction treatment with ibogaine began in informal clinics in the Netherlands as early as 1989, and has progressively expanded so that clinics now use it in the U.K., Canada, Slovenia, and Mexico. Although ibogaine is legally used in most countries, it is, unfortunately, outlawed in Belgium and the United States. Although scientists in the United States continue to try to evaluate its effects, at this time there is insufficient research data to warrant FDA approval.

Ibogaine research

With humans, ibogaine research has been controversial, partly because of its hallucinogenic properties. In low doses, ibogaine is a mild stimulant. At high doses, users report emotionally provocative visions, some pleasant and some harrowing. One formerly addicted patient who credits ibogaine with three years of sobriety after 15 years of addiction, stated, "It was like dying and going to hell 1,000 times." Because this described this patient's experience after ingesting ibogaine, you can see why ibogaine wouldn't be addictive in itself. Ibogaine may induce an emotional catharsis that motivates one to never again ingest anything that could be addictive.

WARNING

At this point in time, it's unwise to use ibogaine without the careful supervision of a physician experienced with its use. Although not yet legal in the United States (at the time of printing), some clinics in Mexico, the Caribbean, and Europe administer it. One of ibogaine's investigators, Kenneth Alper of the New York University School of Medicine states that ibogaine seems to work on "every neurotransmitter system we know about." That's a general statement but it leaves a lot of room for how it might have positive or negative effects. Certainly, one of its important actions is as an antidepressant agent that acts on the serotonin levels in the brain. The available data suggests that ibogaine is safe, but careful supervision of patients is also indicated as the safety data is in early stages and may not be as reliable as preferred.

Ketamine

Ketamine is a relatively safe drug that's been used as a general anesthetic in most hospitals (internationally) for decades. Until recently, its antidepressant (psychoactive) effects were unknown and unstudied. These effects are observed only with doses much lower than those used for anesthesia. The lower intake is associated with depersonalization effects that can be so disruptive that ketamine is sometimes casually (and wrongly) referred to as a psychedelic.

But sufficient experimentation has resulted in the current acceptance that ketamine has surprisingly powerful antidepressant effects. Unfortunately, these effects are not stable over time, meaning that they reduce in intensity. Therefore, current experimentation focuses on extending therapeutic effects by using them to enable patients to benefit from talk therapies (such as cognitive behavioral therapy). In addition to antidepressant effects, pain reduction and anti-addictive effects have been observed. The ongoing question is whether some effects (such as antidepressant effects) are leading to other effects, or whether the multiple effects observed are separate and independent.

In terms of addictive disorders, depression and anxiety symptoms can precipitate attempts to self-medicate to reduce distress, or simply escape symptoms through distraction. For ketamine to effectively assist, it's important to identify the extent to which depression and anxiety play a role in one's unhealthy urges. That identification alone can be helpful as there are multiple approaches to reduce anxious-depressive symptoms and by doing so, reduce urges and "slips" that can result in stronger addictive patterns.

WARNING

Ketamine use is not without its own risks of addiction. One can imagine that the antidepressant impacts would be very attractive and, because short-lived, lead to repeated use.

As ketamine therapy becomes better established in psychiatric treatment, ketamine is now available as a nasal spray and in lozenge form, and may also be delivered via infusion therapy. One negative effect that must be considered about ketamine treatment pertains to cardiovascular effects as it can raise blood pressure and act as a cardiovascular stressor.

TECHNICAL STUFF

If we look solely at the effects of ketamine on addiction, I must mention a study that involved 70 detoxified heroin-addicted patients randomly assigned to two groups, both receiving ketamine-based psychotherapy (KPT) while taking higher and lower doses. The patients in the experimental group received existentially oriented psychotherapy in combination with a strong dose of ketamine (2.0 mg/kg) while the controls received the psychotherapy with a much lower dose of ketamine (0.2 mg/kg). The results of this randomized clinical trial showed the higher

dose (2.0 mg/kg) of ketamine elicited a more psychedelic-type experience while the lower dose of ketamine (0.2 mg/kg) elicited "sub-psychedelic" experiences that still assisted guided imagery. The higher dose produced a significantly greater rate of abstinence in heroin addicts within the first two years of follow-up, including a greater and longer-lasting reduction in craving for heroin. This certainly is an encouraging study. But oddly it was done and reported on in 2002 and no further testing by this research group has been done. The most advanced research on ketamine pertains to depression effects.

Nutritional Therapy

If you believe nutrition is important for health, it follows that you'd believe good nutrition is especially important for recovering from an addiction. Furthermore, scientific evidence suggests that nutrition can play a major role.

Addictions and poor nutrition

Recently the first comprehensive examination of the link between substance abuse and eating disorders revealed that over one third of the people who abuse drugs or alcohol have an eating disorder. This statistic contrasts with the 3 percent of the general population with an eating disorder. Furthermore, about one half of people classified as having eating disorders also engage in the abuse of alcohol or drugs. What does this mean?

Simply put, if you have an alcohol or drug abuse problem, you're more likely to additionally have an eating disorder. And if you do have an eating disorder or an eating problem, the result for you is probably poor nutrition, which combines with the chemical imbalances in your body that exist because of your use and abuse. And the reverse is also true — if you have an eating disorder, you're also more likely to have an alcohol or drug abuse problem. Both problems combine in creating chemical imbalances.

TIP

Because an unfortunate side-effect of most addictions is a poor diet, your recovery process will benefit by following a healthy diet. What constitutes a healthy diet? Start with what is recommended by authoritative bodies such as the U.S. and Canadian governments (`https://health.gov` and `www.hc-sc.gc.ca`).

REMEMBER

Pay attention to your diet. A good nutritional approach is important in counteracting your substance abuse and behavioral addiction tendencies.

What is good nutrition?

Even in this era of fad diets and controversies over how much protein you should eat, everyone agrees on fresh fruits and vegetables. Increasing these consumptions is associated with a reduced incidence of cancer and heart disease, as well as other chronic illnesses. You just can't go wrong with these basic staples of good nutrition.

Another valuable dietary change is reducing daily intake of sugars and refined carbohydrates. This is much more difficult. These foods are broken down easily and raise the levels of your blood sugar precipitously. Then they burn out quickly. You naturally produce higher levels of insulin to match blood sugar levels, so when the burnout happens, you're left with too much insulin in your blood, and the result is fatigue and often, a lower mood. If you're going to consume carbohydrates, consume complex carbohydrates — whole grains and cereals. These types of carbohydrates are like the logs that burn longer in your fireplace. They get broken down more slowly and raise your blood sugar levels more gradually and evenly — and your blood sugar levels are maintained at higher (energizing) levels for longer periods. This results in more energy and evener moods.

This point about carbohydrates and nutrition, generally, can be very important and difficult for those who abuse alcohol. Because alcohol intake impairs absorption of nutrients by interfering with two major body organs, namely the liver and the pancreas, following withdrawal, it's important to be on the lookout for imbalances of fluids, calories, and electrolytes as well as vitamin deficiencies involving pyridoxine, thiamine, and vitamin C. Furthermore, because you get accustomed to a good deal of carbohydrate intake in the form of alcohol, you can find yourself experiencing an acute, refined carb deficit after withdrawal. The result is a residual sweet tooth. You may find yourself prone to eating lots of sugars — pastries, ice creams, chocolates, and hard candies. You will probably have to adjust gradually to a lower carb intake or, alternatively, to an intake of the healthier complex carbs. This transition usually requires a good deal of attention and discipline.

Macrobiotic diets

Among the special diets that can help people overcome health problems, this Asian-style vegetarian diet emphasizes low fat intake and eating whole grains, vegetables, and nonprocessed foods. It may prove helpful in dealing with food allergies, chemical sensitivities, and addictive tendencies.

The macrobiotic diet is based on ancient Chinese philosophy. It is a nutritional attempt to balance the *complementary opposites* known as yin and yang — the forces that the Chinese believe must be kept in harmony to achieve good health.

These forces are woven into every aspect of life. Their characteristics are as follows:

- Yin is said to be expansive, cold, wet, slow, passive, sweet, loose, and dark.
- Yang is contractile, hot, dry, fast, aggressive, salty, tight, and light.

REMEMBER

Alcohol and drugs are extremely yin in character.

The macrobiotic dietary regimen strives to bring daily dietary intake into balance. According to the Chinese philosophy, some food substances are neither yin nor yang but rather in-between. It is said the most balanced foods in the yin/yang continuum (though not necessarily in nutritional science) are brown rice and whole grains. Hence, these foods constitute the foundation of the macrobiotic diet.

To this foundation, the macrobiotic regimen adds foods reflecting different degrees of yin and yang, selected in accordance with the individual's dietary needs and temperament. In practice, this usually works out to a diet consisting of:

- **About 50 to 60 percent whole grains, including brown rice, barley, millet, oats, corn, rye, wheat, and buckwheat.** Keep in mind that whole grains are considered the best types of carbs to consume in current Western nutritional circles.
- **About 25 to 30 percent fresh vegetables.** Especially recommended are *cruciferous* vegetables (members of the cabbage family) and other dark green and deep yellow vegetables. They should be grown organically and locally, if possible. Macrobiotic advocates recommend lightly steaming or boiling them, or sautéing them with a small amount of vegetable oil. For purposes of the macrobiotic diet, vegetables fall into three categories:
  - *Eat frequently:* Cruciferous vegetables, including arugula, bok choy, broccoli, cabbage, cauliflower, collards, kale, kohlrabi, mustard greens, radishes, rutabaga, turnip greens, turnips, and watercress; also included are Chinese cabbage, dandelion, onion, daikon, orange squashes, and pumpkin
  - *Eat occasionally:* Celery, iceberg lettuce, mushrooms, snow peas, and string beans
  - *Avoid:* Potatoes, tomatoes, eggplant, peppers, asparagus, spinach, beets, zucchini, and avocado
- **About 5 to 10 percent of your food in the form of beans, soy-based products, and sea vegetables.** In this category, tofu (soy bean curd) is a favorite. Sea vegetables to consider include wakame, hijiki, kombu, nori, arame, agar-agar, and Irish moss.

» **About 5 to 10 percent of your food as soups.** Miso soup, a broth made with soybean paste, is a popular choice. Also permissible are soups made with vegetables, grains, seaweed, or beans.

Macrobiotic diets and substance addiction

From the macrobiotic perspective, an overabundance of substances like drugs and alcohol creates an imbalance of too much yin in your diet. Accordingly, you need to counteract the dominance of yin in your diet with more yang substances. From this perspective, if you establish a balance between yin food items and yang food items, you will reduce your craving for alcohol and drugs.

The research on macrobiotic diets as an aid to substance abuse treatment

WARNING

At this time, no scientific evidence supports the idea that a macrobiotic diet will reduce your urges for alcohol or drugs. Nevertheless, evidence shows that when addictions dominate your life, a healthy diet is often neglected. Moreover, some of these addictions (alcohol abuse/addiction) impair your body's ability to properly process the nutrients in foods. Macrobiotic diets do help ensure a more nutritionally balanced diet than what you are likely achieving when consumed by an addiction.

Meditation

Meditation techniques were once difficult to scientifically evaluate. This has changed radically given the considerable increase in scientific findings over the past decades about meditating offering important benefits.

Underlying this revolution are innovative ways of detecting subtle brain signals within different parts of the brain. By using sophisticated forms of fMRI and electroencephalograph tests, subtle changes in neural signals can now be detected at very high rates (1,000 times per second). With these tests, we've discovered that high levels of neural activity in the left prefrontal cortex are associated with states of happiness, vitality, and alertness. High levels of activity in the right prefrontal cortex, in contrast, are associated with emotional distress, depression, and anxiety. The consistency of these and other findings raise questions as to whether people can be taught the mental disciplines that amplify the brain patterns associated with happiness and vitality.

Can people, for example, be taught to activate the brain regions associated with happiness while deactivating the regions associated with depression? If so, could these disciplines lead to cultivating happiness and alertness, and increased vitality? It is important to consider that Buddhist meditation has a history of 2,500 years — and that use of such a procedure would not be sustained if there were no gratifying outcomes. More simply, Buddhist mindfulness meditation would not have survived if it did not feel good.

TECHNICAL STUFF

Preliminary answers have been derived from studies of Buddhist meditation masters and the general population. During a form of compassion meditation, the advanced meditators demonstrated a remarkable leftward shift in prefrontal brain activity — a shift that stimulated the same brain areas associated with positive emotion, vitality, and alertness. Although this was an important finding, it was possible that it required many years of meditation discipline to accomplish. Can these meditation techniques be useful for regular people unable to devote years to meditating?

To demonstrate that these same shifts were possible for ordinary citizens, a randomized study was conducted on healthy employees from a large company. Half the group was randomly allocated to an eight-week training in mindfulness forms of meditation, and the other half placed on a waiting list group and assessed but not trained. The results indicated significant increases in left-sided activation for the meditators when compared with the nonmeditators.

These and other findings demonstrate that brief trainings in mindfulness meditation generate positive effects on brain function similar to those achieved by advanced meditators. Briefly put, ordinary citizens can learn meditation techniques that assist them in cultivating positive emotional states, vitality, and alertness.

How does this relate to addictions? Addictive states are associated with people becoming dependent on substances or engaging in behaviors that, temporarily, generate excitement and satisfaction. The hardest part of detox and recovery is that after withdrawal, you must find *new* ways to sustain positive states — without the substances or behaviors that once did the trick.

As we have seen in the experimental results, meditation techniques, particularly mindfulness approaches, can be useful in cultivating positive states of mind. Rather than subjective reports of positive changes, we now can observe actual brain signals — the "biology" associated with positive emotional states. With meditation techniques and new methods of observation, we may be ushering in a new era of *seeing* what's healthy and what isn't healthy within the brain — then *engaging* in activities, like meditation, that help us make critical transitions from unhappiness to well-being.

A BRIEF INTRODUCTION TO MINDFULNESS

Mindfulness meditation involves the non-avoidant awareness of the thoughts, emotions, and sensations that arise in one's immediate experience. No particular thoughts are emphasized. All are related to in the same way.

Attention is first directed to breathing sensations until a thought, image, emotion, or sensation is perceived. Then *that* thought, image, emotion, or sensation is noted, and attention is redirected back to breathing sensations. This simple process continues for 10 or 15 or 30 minutes, or for as long as a person wishes. One can be in a seated position (recommended) or lying down. The technique can be summarized in the following way:

- Attention is directed to breathing sensations
- Awareness arises of a thought, image, emotion, or sensation
- Attention is redirected to breathing sensations
- Awareness arises of the next thought, image, emotion, or sensation
- Attention is redirected to breathing sensations

Harm-Reduction Approaches

Harm-reduction strategies aim to reduce the worst dangers of drug and alcohol use without requiring complete abstinence. Instead these approaches focus on reducing use-associated risks. For example, if teens with a drinking problem can't abstain, they can relinquish a driving license and, in doing so, reduce the risks associated with driving under the influence.

Perhaps the most recognizable harm-reduction approaches are those relating to opiate addictions that include needle exchange programs (which ensure reduced use of dirty needles that transmit infectious diseases like HIV/AIDS and hepatitis C) and methadone maintenance programs. These methadone programs provide controlled, midway steps between total abstinence from opiates and the dangers of street use. Methadone programs provide a regular dose of opiates that don't produce a high or a deficiency leading to craving and re-engagement with street use. (See Chapter 10 for more information on methadone treatment.) Although these are concrete examples, the principles of harm reduction are widely applicable.

The other noticeable example of harm-reduction strategies in North America and parts of Europe are the introduction of decriminalized marijuana programs. Such programs don't encourage use but do reduce the legal penalties that are sometimes much more damaging than actual use.

The following principles are important to understanding what harm reduction is:

- Accept for better and worse that licit and illicit drug use is part of our world and work to minimize the harms rather than simply ignoring or condemning them.
- Understand that drug and alcohol use is a complex phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledge that some ways of using drugs and alcohol are clearly safer than others.
- Establish quality of individual and community life and well-being — not necessarily cessation of all drug use — as the criteria for successful interventions and policies.
- Call for provision of services and resources to people who use drugs and to the communities in which they live in order to assist them in reducing attendant harm.
- Ensure that drug users and those with a history of drug use routinely have a voice in the creation of programs and policies designed to serve them.
- Affirm that drug users themselves are the primary agents of reducing the harms of their use, and seek to empower them to share information and support each other in strategies that meet their actual conditions of use.
- Recognize that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other inequalities affect people's vulnerability to and capacity for effectively dealing with drug-related harm.

REMEMBER

What is difficult about harm reduction is deciding where to draw the line between reducing the harm of abuse and making it easier for abusers to keep abusing. This boundary is best understood in terms of each individual's situation and how that person responds to harm-reduction efforts. If you feel that someone's exploiting a harm-reduction program, the situation must be dealt with as effectively and as immediately as possible. Exploitation threatens the harm reduction program and enables the addicted individual to avoid confronting the necessity of limiting or stopping use.

IN THIS CHAPTER

- Looking at the unique experience of teens
- Decision-making when you suspect abuse
- Choosing teen treatment
- Keeping optimistic after slip-ups

Chapter 14
Teen Treatment

You may be a teen or a concerned adult. Either way, you're worried about someone who seems headed toward addiction or is already addicted. You are also dealing with a brain that will not physiologically mature for another six or seven years (it doesn't fully mature until the age of 25). It's a brain that deserves a chance to mature healthfully.

Experimentation with drugs, alcohol, and tobacco is common with teens. Why not explore what adults seem to get excited about? You've also seen an abundance of advertising suggesting that alcohol, tobacco, and drugs are *worth* exploring. And socially speaking, you may think that experimentation helps you "break the ice" and feel connected to others (at first) with whom you want to connect.

But, if you're still reading this, you know it isn't all good. You're aware of an internal signal, a warning signal, that's influencing you to see the other side — the *destructive* side of drugs and alcohol. You don't have to look far to see that the destructive sides created ghosts out of people who had healthy brains and bodies. It's time for a straight, honest look.

Why Alcohol and Drugs Are More Destructive When You're Young

Statistics show the younger you are when using drugs and alcohol, the greater your chances of becoming destructively addicted. If you start using alcohol regularly at age 13 (or younger), you have a 43 percent chance of becoming an alcoholic. By comparison, if you start at age 21, there's a 10 percent chance. In other words, the more mature your brain (and the broader your experience of life), the less likely you are to become addicted.

If you've already started using, what then? All the available statistics in biology and psychology indicate you should stop or reduce your intake. The longer you use and the more you use, the firmer the addictive imprint in your brain and the harder it is to stop. If you're unable to stop or reduce your intake (on your own), it's time to get help.

REMEMBER

The younger the brain and the earlier the use, the more dependent the brain becomes on use (of drugs and alcohol).

It's easier to damage a growing brain

TECHNICAL STUFF

While you grow and develop, your brain decides which biochemicals are required for health. The most important brain chemicals, your *neurotransmitters,* influence your mood, sleep, and appetite. If you take drugs and alcohol during your teen years, your brain becomes accustomed to and dependent on these substances and imbalances in brain chemistry result. The cravings represent your brain's dysfunctional attempts to "right" the balance.

Teens have a tougher time these days

This headline seems strange, given the advantages of today's youth that other generations missed. But we've gone through a technological shift (with smartphones, the Internet, and social media) over the last few decades for ill and for good. We've also gone through a deadly virus pandemic that "shut down" life as usually lived. According to multiple sources of mental health data, teens are more likely to be unhappy (or worse) these days and more likely to use drugs and alcohol in the attempt to feel better.

The one fact that captures current teen problems is the *tripled* rate of teen suicide in the last 60 years. Unfortunately, adult role models are similarly troubled. In the past two decades, deaths of despair from suicide, overdose, and alcoholism have risen dramatically, and now claim hundreds of thousands of American lives

annually. A recent survey indicated nearly 10 percent of college students have seriously considered suicide, and 1.5 percent made actual attempts. If you're a parent or adult reading this, please take this as a warning. Take all talk of suicide very seriously.

TIP

If you can't stop feeling sad, anxious, and overwhelmed, get support and help. These feelings can't be managed on your own. But getting help *will* help.

Working back from the alarming suicide statistics, you can see that teen stress increases the likelihood of mood-anxiety problems. A wanting to believe that a cigarette, drink, or drug will help is understandable. After all, a lot of advertising suggests drinking, smoking, and prescription drugs result in desirable moods. But alcohol and nonprescription drug use makes things worse, not better. The more avoidant you are of problems, the worse the problems become.

TIP

Confront fears and anxieties. One reliable result of current research shows that avoidance fuels anxiety. The more you avoid fears or anxieties, the bigger they grow (in your imagination), and the more burdensome they become.

Another key point is that after transient highs, drugs and alcohol leave you in bad shape to solve any problems. Although alcohol may lower anxieties and inhibitions in the short-term, it ultimately is a depressant. So you're more depressed after drinking than before drinking.

REMEMBER

Today we must also consider the effects of cannabis, which is decriminalized in many places and more available than ever. Once again, if it gets you high, your life gets complicated with dependency and getting high to escape work, school, and relationships. Consider limiting cannabis use despite decriminalization.

What to Do When You Suspect Substance Abuse in a Loved One

In the preceding section, I indicated that young people were more susceptible *to* abuse and more injured *by* it. But young people are also less able to find a way out of the slippery slope of use, abuse, and addiction. If you're a friend or parent and you suspect someone is slipping down the slope, contact a trusted professional or friend to talk over how you can help. That may seem like a scary step, but it's the single most effective step you can take. A modest amount of personal consultation can make a big difference in how persuasive you can be in encouraging troubled friends or offspring to get help.

Depending on where you live and your preferences, the professional you speak with may be a family physician, pediatrician, psychiatrist, or counselor (especially a counselor working within a substance abuse program).

REMEMBER

Professional advice will help to clarify the situation and your feelings. You will be more effective in approaching your friend or child and getting help. Professionals can advise you on how to use your relationship to dispel denial and support solutions.

Advice for parents

If you're a parent, consider what treatment options are immediately available to your child and how you can support your child's treatment by direct financing, through third-party insurance, or via a government-funded program. After you raise the issues of use, abuse, or behavioral addiction with your child, act firmly and decisively to guide your child to appropriate treatment.

TIP

Have as detailed an understanding as possible before an intervention. Also take care of as many details as possible — before intervening about abuse or behavioral addiction. Things move very quickly and emotions escalate once an intervention begins.

CASE STUDY

CASE ONE: PART ATHLETE, PART ADDICT

John was from a large family in a rural area in the Midwest and had the good looks, athletic skills, and charisma to be a sought-after date for the prom. However, other elements about John's life weren't so apparent. He'd been adopted as an infant and had gnawing questions about the circumstances that caused his birth parents to give him up for adoption. He felt an underlying uneasiness and insecurity that didn't seem to go away, no matter how well he performed on the sports field — no matter how much respect he earned with his skills. He fell in with a group of teammates who got together for beers after games and on weekends, and he found something new in the experience of drinking. The background buzz of insecurity that plagued him seemed to go away for a while.

It wasn't long before John wanted the tranquilizing effects of alcohol more frequently — not just after games and on weekends. He began to save beers and have older friends buy extras so he could have some around on weekdays. He began drinking alone — in private. Soon, he found that it was difficult to function as smoothly if he didn't have several beers daily and that few grew in number. Meanwhile, he had to adopt more and more special measures to keep looking normal to peers and his parents, and to hide his drinking.

Oddly enough, his athletic performance didn't drop off at first. Gradually, however, he began to find that he had less endurance, although he continued working out at the same levels. Also, his reflexes and coordination were no longer as reliable, and he began to flub key plays. By then, however, he felt trapped into regular drinking, fearing things would get worse, and his athletic performance would suffer if he stopped drinking suddenly. He felt stuck and trapped in this seemingly private problem — except for the whispering amidst his friends and fans that something wasn't right. For more on what happens to John, see the sidebar "Case One Treatment Success: Athlete Finds Inner Peace" later in this chapter.

Advice for good friends

If you're a friend or concerned peer of a teen who may have an addiction, you need to discuss your concerns with a trusted adult before proceeding. It's not that you don't know what you're doing. You probably know the situation better than anyone else. But you need help in navigating the adult system. It's preferable that the adult be a parent, guidance counselor, or school administrator. Even if you don't get the response you want from the first adult you talk to, persist, because you're doing the right thing. Sooner or later, you'll find a responsible, sensitive adult who can and will help.

Even though some of the actions necessary in starting treatment must be undertaken by an adult, you, as a friend and peer, have an extremely important role. In fact, you may have the *key* role if you've seen your friend get into trouble with excessive use on several occasions. Your recall of those situations can be very important in helping your friend come out of denial.

REMEMBER

The individual you're concerned about and want to help may be afraid to admit to a problem. Part of this anxiety is disclosing the secret that is internally destroying them. This individual may also fear that acknowledging the problem will cause a mass rejection by peers, and disappointment and anger in parents. You can provide immediate proof that someone will be concerned and supportive, and that people care about your friend's whole person, not just the easy, good-times sides. The importance of your role in this respect can't be overstated.

A word about denial

Denial is a huge part of the addictive process. Drugs and alcohol are often used when people are having a hard time but are trying to have a good time. In this situation, you can see denial in action. Although you shouldn't try to shame the person you're concerned about, expect denial, and be prepared to counteract denial when the opportunity presents itself.

WARNING

Don't say a word to someone you see as being on the abuse slippery slope unless you're willing to be firm and direct without being critical. Be especially firm in encouraging your friend to seek and accept help. Also, save your energy and refrain from confrontations unless you're willing to be *empathic* — to make a sustained effort to understand your friend's world and what it's like to be so out-of-control that alcohol and drug use are the only reliable ways to feel good.

CASE STUDY

CASE TWO: GOLDEN GIRL WITH A DIET PILL ADDICTION

Joan was a straight-A student who scored off the charts on every achievement test she took. There was no doubt she'd be one of the smartest kids in whatever school she'd attend. But she didn't see her intelligence as such a great advantage. She felt emotionally at loose ends, unable to comfortably connect with people. She often fell into a pattern of being very entertaining and funny, rather than relaxed and authentic.

She was also attractive but had a tendency to gain weight — nothing very noticeable, but she wanted to be slimmer and to have the body of the celebrities and influencers she sees on social media.

When a friend offered her diet pills to give her the energy she needed to study for final exams, she was interested in whether the pills, taken regularly, would do the trick for weight control. Well, they did the trick for studying. She pulled an all-nighter and had energy to spare the next day to do well on two separate exams. She couldn't seem to find a downside to these little diet pills.

Soon she started taking them regularly. It worked — she lost the pounds she had worried about. However, there *was* a downside. She began to find it hard to sleep — and even when she fell asleep, she'd awaken in the middle of the night. She had to start wearing more makeup to hide the circles under her eyes and she found she was quite jumpy during the day. She frequently felt edgy. She was worried because her heart often raced and she felt that it skipped beats.

She was becoming, step-by-step, an amphetamine addict. She couldn't miss a day for fear of crashing and entering into that awful depression she had just tasted just once — when her supply was temporarily interrupted. She still was the golden girl of academics in her school — except now she had a secret. Even her boyfriend and her parents didn't know. She was in addictive trouble. For more on what happens to Joan, see the sidebar "Case Two Treatment Success: Golden Girl Becomes Successful Artist" later in this chapter.

Be prepared for a long haul to a healthy recovery

Addiction can't be cured like a sore throat. The problems of abuse take a while (months and sometimes years) to resolve. Nonetheless, the first step taken covers the most ground. Then, be prepared to persevere for a couple of reasons:

- **The person you're concerned about may resist taking action.** You may enter a period of impasse where the cat is partially out of the bag — you and the person you're worried about know the issue won't go away. On the other hand, the time is not yet right to get to the bottom of it all. Tolerating this uncertainty and strain and continuing to love the person are what is needed to bring the abuser out of denial and the abuse out of the closet.
- **Getting to the right treatment match may take a while.** A variety of outpatient and residential programs are available for teens — one size doesn't fit all. The first effort at treatment may not be exactly right, and if that's the case, adjustments will be needed. The remaining sections of this chapter help you fine-tune the process of making the best possible choices, guided by the best information available. Try to review the case examples in the sidebars of this chapter because they illustrate a few of the many forms the slippery slope takes in addictive behavior. As you read, try to think about the specific form your friend or child's situation is taking. There is much that you can understand, as long as you think about the details of what you have observed.

Making the investment in teen treatment

On a purely practical level, you need to communicate with an insurance expert to see how much outpatient or residential treatment is covered by your regular health insurance plan. Addicted people rarely resolve their addiction without help. Also the situations of addicted individuals can quickly become very dangerous. Thus, there is a continuum of services that may be critically helpful at different times: These include outpatient treatment, family-based treatment, drug (urine) testing, residential treatment. Often, such programs must be accredited by specific organizations for you to be reimbursed (in part or full), and you need to know what accreditations are necessary before considering different alternatives. In some cases, the only insurance expert you need will be your insurance agent, but in other cases, you'll have to find another skilled individual familiar with your program who can read the fine print of policies and interpret precedents.

Getting Treatment as a Teen

Treatment may be a frightening word at first, but consider the positive side. In your determination to get the very best help, you'll find that the help received will address many of the important questions you have about life and about living in a healthy, meaningful way.

REMEMBER

You may feel confused and low in confidence when you acknowledge unsolved problems. But regardless of how you feel, you're now taking the important step. You now have the humility to know you need to ask the tough questions. Some of the toughest seem very simple: What *is* healthy? How do you really know what's good for you?

Those questions are an important part of your renewed effort to search. The search starts with choosing to change and getting the treatment that helps you to change. In the end, be assured, you must *choose* to change, and treatment will help you through the part you're unable to do on your own. No one can effectively treat you against your will. Your parents may choose a treatment setting, and you may go along with their choice, but you won't really be helped until something clicks — until some inner yes happens, some inner light turns on — and you feel something is learned and understood in the immediate situation. Until you feel you're touching on some wisdom, whatever is happening will go in one ear and out the other.

TIP

You need to do the treatment in a setting where you feel you'll learn something valuable. This starts with you trying to be honest with yourself about what really seems right and what doesn't.

Asking for help: Any time is a good time

You tried to stop on your own, and it didn't work. The feelings and urges return. Your mood swings and your frustrations and anxieties arise all over again.

TIP

If you feel you're slipping, the first step is to bridge your negative feelings with your willingness to deal with the problem. Many famous, highly skilled people have had the same problems, so these are not problems that strike only the weak. In reading these very words, you're showing the strength and courage needed to get to the root of the problem and on the path to recovery. Now, keep going. Just keep taking one step after another; little steps, like reading this section, can be very important. They add up.

The sooner you're in contact with a trusted, competent counseling professional, the more likely you are to use your energy to best advantage. Some of the most

important help this person gives you is when you acknowledge you have a problem but are unclear about how serious it is and what to do about it. A skilled counselor can help you with your feelings and help you to find solutions.

If you're concerned about yourself, you have to take the step of talking with a trusted adult. I'm not saying that finding a trustworthy adult whom you feel comfortable with is easy. For example, you may not feel comfortable talking to either of your parents, or to any of the school counselors. If so, don't give up. In Chapter 20, I list some teen help centers in the United States. Or you can go directly to a clinic or a doctor. There *is* a trustworthy adult out there, somewhere, who will listen nonjudgmentally and guide you. You're doing the right thing even though it may seem the right thing should be easier to do. Keep going.

Finding a counselor

Certainly, one very important part of the program you choose is the counselor. No worthwhile counselor will try to intimidate you into going along with a program. No worthwhile counselor will get you to stop asking honest questions or to stop calling attention to stuff that you feel doesn't make sense. No, the counselor understands what you're going through, knows a fair amount about how you got there, and knows how to get you back into good shape. The good counselors realize that you're going to have to find a match between what you're confused about, what you want, and what they're offering. The good counselors may be tough, but you don't doubt their kindness and their essential interest in you as a separate, living, breathing, thinking, and feeling human being.

REMEMBER

You must take the first step and dial the phone. The good counselors are out there — they can be found. Because you're a unique person, you may have to do some searching to find the right counselor for you. And this person may not come in the packaging you'd expect. They may be shorter or taller, or more or less attractive, than the people you imagine. They may seem smarter and brainier, or less intellectual and more practical, than you imagine. The important thing is that something this person says — something that happens in your mind and your emotions when you're with them — sticks and doesn't go away. You feel that great relief, that sense of trust that this person is showing you something about life that's reliable and useful — and it makes you appreciate life more than you did before. The good news is that you can find this person, and that this person, once found, will help you a lot.

TIP

In selecting a counselor, make sure you ask about their training and experience in counseling youth. Many counselors specialize in treating either youth or adults. Obviously, you want to connect with a counselor trained in counseling youth.

Relating to your counselor

In most cases, your counselor will have an independent practice or will be associated with an established residential or outpatient program. If your counselor has an independent practice, you will probably go to the counselor's office for scheduled sessions that usually last between 45 minutes and 2 hours. The focus will be on talking. Initially, you'll talk about how you began using and why, and how you have continued.

Be aware that your therapist will be doing a lot of listening, and while listening, they may be taking notes that permit a later review of what you've said. This initial stage can make you feel very uncomfortable because the things you're talking about are painful — you will likely be describing periods of insecurity and anxiety, situations where you made bad choices or did stuff you knew was wrong. It may feel strange talking to a virtual stranger about stuff you haven't told your friends or parents. Keep in mind that you're engaged in a process that has been tested and found effective for quite some time. Keep in mind that it's a confidential process so you should feel comfortable to speak freely, without worrying about the consequences of what you say. The only consequences you carry away from a session are those that have to do with changes in how you feel and think and the choices you make.

WARNING

Your counselor should have no other relationship with you aside from being your counselor. This kind of single-focus relationship coordinates with the principle of confidentiality (that your communications with them will be kept secret). In combination, these conditions help you to talk freely without being worried that what you're saying will be communicated to anyone else in your life. In other words, you're able to talk without worrying that what you're saying could cause problems for someone or influence another situation. In order for someone to be that separate from the rest of your life, that person must be a virtual stranger in the beginning.

At the start, there must be distance between you and your counselor, but this distance need not be a difficult barrier for long. You should begin noticing that the quality of your counselor's listening is different from that which you usually expect from other adults — your teachers, parents, and relatives, for example. In fact, the quality of listening should be different from that which happens with your friends as well. You should feel that someone is listening to you *very, very carefully* — that your counselor is somehow picking up on what you're saying with surprising accuracy and understanding. Because your counselor listening to you so well, you begin trusting that something good can come from your conversations.

TECHNICAL STUFF

The experience of understanding and sharing the feelings of another is called *empathy*. When your counselor listens to you with empathy, it helps you to feel heard and that someone is right there with you, understanding what you're saying and feeling (while you're talking).

The other experience that is important is what I call *alliance* or the experience of feeling that this person you're talking to is somehow in your corner, acting as a valuable ally. Counselors are valuable not because they agree with everything you say, but because they show you the utmost respect in how they listen. Furthermore, they're completely honest in their responses to you. You may be motivated to show your best side to your counselor and minimize your difficulties — that's natural. But you'll notice that your counselor isn't fooled when you skate around difficult points and is, instead, patiently waiting for you to get down to more honest and earnest communication. Because the honesty involves you acknowledging more emotional negativity, your counselor is the very opposite to what has been described as a fair weather friend — your counselor wants you to feel free and not judged so you can reveal the best and worst sides of your story. Just disclosing issues that you have previously kept hidden has been shown to be helpful and anxiety reducing.

REMEMBER

Also consider what counseling *isn't* going to be like. For instance, good counselors don't give you answers and tell you what to do. They will listen and help, but you will have to make decisions about what things in your life you want changed.

DOES YOUR COUNSELOR HAVE TO BE A RECOVERED ADDICT IN ORDER TO HELP YOU?

The short answer to this question is no. Just like a cardiologist doesn't have to have heart disease to be a good heart doctor, a counselor doesn't have to have come through the process of recovery from addiction to be a good counselor. Your counselor may be someone who has simply found the counseling process interesting and fulfilling, without having had to confront addictive kinds of problems. Although it can be an advantage for a counselor to have been through recovery, it can also be a disadvantage. Sometimes, the method of recovery has left such an imprint on the counselor that the counselor winds up taking inflexible approaches to counseling. On the other hand, having been there with an addiction can be helpful, because your counselor can refer to personal experience and feelings and recall direct events that parallel those you're dealing with. You will have to judge for yourself how helpful or unhelpful it is that your counselor has or has not had a recovery experience. Personal experience with an addiction is certainly not required to be a successful and effective counselor.

Counseling in group programs

You may choose to work in a *group format*, where people like yourself gather to talk under the direction of the counselor. Sometimes, this format seems to be the least desirable, particularly if you feel automatic negativities about other people who have addiction problems. One typical thought is "It's bad enough dealing with my own problem, why choose to be in a situation where I have to deal with other people's problems as well?"

Although this may be a deciding point for you, it's good to look at the other side of the picture before rejecting group treatment. The other people with addiction issues may be valuable to get to know simply because they *are* like you. They understand. They're going through the same thing. Being in a group may even help you reach some important realizations more quickly than you would in individual treatment. No one is a loser just because they somehow got involved with the slippery slope of use and abuse. The common ground in group treatment isn't the past of abuse but finding a new path for living that deals with today and makes past problems a distant memory.

REMEMBER

One advantage of group treatment is that you're able to give help to others in the group while you receive help — and sometimes that feels like making use of your natural strengths. Also, you learn, from direct example, about the different stages people go through as they experience progress and the inevitable bumps on the road to recovery.

Group and individualized treatment aren't mutually exclusive — you can do both at the same time or you can do them in an alternating pattern: first individual, then group, and so on. The point is the two are *complementary* (they can complete each other), and you don't have to make any decisions in favor of one as opposed to the other.

CASE STUDY

CASE ONE TREATMENT SUCCESS: ATHLETE FINDS INNER PEACE

Although it took trying a number of programs, John eventually found a residential program that took him away from the environments he found so difficult to manage. He has had to stay completely sober and refrain from even the occasional beer to progress with his career and eventually, to begin and sustain his own happy family life. He made contact with his birth-mother and has maintained regular contact with her for several years, including face-to-face visits on Mother's Day during which she gets to play with John's son — who also shows the promise of being a superlative athlete.

Furthermore, family-based treatments (that include other family members) can be an important component of group-based treatments. The more your family truly understands you, the more truly supportive they can be.

Residential treatment: Group and individual treatments

If your circumstances and your old friends make it impossible to stop using, get away from it all and take up a new residence within a program designed to provide intensive and personal therapy in an environment that nurtures positive change.

This approach is particularly important if you feel the temptations of continuing to use are so high that you can't trust yourself to stay clean. Getting into residential treatment ensures that temptations are reduced to a minimum and opportunities and rewards for healthy activity are maximized. Residential treatment is all about replacing old habits with new, positive, healthy habits.

How is this done? First, residential programs place you in an environment that restricts you from situations that are tempting and exposes you to situations where you experiment with (and can establish) a whole new set of healthy habits. Some residential treatment programs for youth, for example, are set on working ranches where a good deal of activity is directed toward tending and riding horses. Other programs focus on adventure learning, involving expeditions to wilderness areas where you experience the beauty and freshness of the great outdoors while learning survival techniques, camping, and navigation skills. You also engage in specific challenges like climbing or rappelling down cliffs or kayaking through different levels of rapids. The idea behind these programs is to experience nature in a full way and, in doing so, to find and appreciate your own healthy, inner nature. Being in a place of natural beauty leads to an ascending mood that is drug-free, and points the way to other natural highs of a healthier lifestyle.

Other residential programs have therapeutic specialties that directly address the particular addictive problem you've been plagued with. For example, if your problem is an addictive behavior like an eating disorder, some residential programs focus solely on that problem, guaranteeing expert help. If you do have an eating problem, these types of programs can be very helpful because they address the problem at all levels, from the meals you're served to the group and individual counselors you meet with.

And some programs are specialized for the type of drug addiction you have (cocaine, opiates), once again ensuring that the people you work with will talk with you in detail about your experiences and the changes you've been going through. They will also help you see what you need to do to free yourself.

CASE TWO TREATMENT SUCCESS: GOLDEN GIRL BECOMES SUCCESSFUL ARTIST

CASE STUDY

Joan eventually found her way to intensive outpatient psychiatric therapy and, after three years of intensive, psychodynamically oriented treatment, left the big city in which she had lived, to attend a university in a rural town in California. It took a good deal of outpatient therapy for her to free herself of the recurrent temptations to use amphetamines, but out of her therapy emerged a new commitment to visual arts. She had always enjoyed being an amateur artist, but had not allowed herself the freedom to consider it a serious vocational choice. However, after she granted herself that freedom, she discovered she had considerable talents, enough to propel her to a very successful career as a freelance artist. Now, as she says, she is positively addicted to working away in her artist's studio, making art in a way that produces a healthy high.

The time that you spend in a residential treatment setting can vary widely although the typical span of time begins with five to seven days and can extend to several weeks or even several months. Some programs add academics so that you can simultaneously keep pace with your grade level courses or get additional tutoring that helps you catch up if you've fallen behind while troubled by addictions.

TIP

For those of you who are religiously oriented, some residential treatments have spiritually based programs that encourage use of scriptures or multicultural spiritual approaches to augment and complete your recovery program. Some of these carry with them the advantage of being supported by church foundations and charities, limiting the costs that will have to be paid while you're in residential treatment.

Harm reduction programs for youth

At any stage of treatment, harm reduction programming is very important. Basically *harm reduction* focuses on reducing the risk of harm associated with any engagement in addictive behaviors and/or any use of substances. Examples include needle exchange programs, substituting methadone for heroin, educating about HIV risk and the importance of safe sex (condom use), implementing driving laws that limit how many passengers a teenage driver can transport, and so on. Harm-reduction programs follow several principles. Read Chapter 13 to learn more about harm-reduction programs.

Remembering That Slips Aren't Freefalls

Slips (temporary lapses back to using) are learning experiences. You see more clearly that a high from using leads to a down that feels bad afterwards. You experience real remorse about the slip and can link your remorse to plans to avoid the triggers that caused your slip.

REMEMBER

Your teens are just one period of seven or so years, and your lifespan will extend much, much longer. On the news are many stories of youth who were once heavy users, abusers, and addicts who then went on to completely reverse these problems and become societal leaders.

Whatever the immediate situation, you are constantly growing and maturing, physically and psychologically. Remember to never give up on yourself: Find what the good life is for you! And remember this if you're a friend concerned about someone who may be heading for addiction. Hanging in for the longer-term is an important idea because things can change in a major way. Don't give up hope or condemn anyone who has recently slipped. Youth is a time of resilience with the capacity for a great deal of change and redirection.

Ultimately, the best way to counteract the slippery slope of abuse and addiction is to take the approach of starting over, knowing you have time and insight to build the right life for you.

4 Life in Recovery

IN THIS PART . . .

Recovery focuses on building a healthier, more naturally satisfying life. It includes practical learning about how to avoid slips and relapses. In this part, I describe barriers to recovery and guide you in overcoming them. Everyone experiences temptations to slip, and many people do slip and relapse. I show you how to get back on track after a slip and how to pull yourself out of a relapse.

I also review how to re-establish sound social, family, and work relationships and how to rebuild a sound financial footing. Invariably, family and friends are also learning how to recover their own balance, especially in how they relate to you. I provide guidance to family members and friends in how to help you in your recovery.

IN THIS CHAPTER

- Developing recovery skills
- Increasing resilience
- Identifying fears about recovery
- Self forgiveness
- Taking the leap and sustaining the gains

Chapter 15

Overcoming Barriers to Recovery

There's a big gap between thinking about ending an addiction and deciding to end it. There's also a big gap between deciding to end it and following up with the necessary discipline to do so. How do you bridge the gap between indecision and decision? How do you bridge the gap between making a decision and the discipline that makes the decision a new reality?

If you're reading this book, you may be thinking about recovery but still conflicted about the commitment. But you know, through your thinking, that you have the potential within you to decide to quit addictive activities. On the other hand, you may be ready to decide to quit *and* commit to it, feeling the inner potential to "go all the way."

In this chapter, I focus on actualizing this desire to end your addiction — on turning positive potential into positive reality. I go over the essential pointers — emphasizing self-acceptance, self-forgiveness, being calm, and being resilient — to overcome the barriers to recovery.

Be Prepared: The First Step

Statistics indicate that successful treatment usually involves at least one relapse back into addiction. (For more on relapse, see Chapter 16.) This is discouraging if relapse is viewed as failure rather than as a necessary stepwise experience. Okay, the experience of relapsing *is* painful. But remember that you are human, and we humans make errors regularly that are painful. We then learn from those mistakes and resiliently do better.

So we take the realistic approach of the "imperfect attempt." Imperfect attempts add up to progress in a recovery process that never ends. Why should it end? When recovery progresses, you become less susceptible and impulsive. The slippery slope becomes less slippery. You have more traction. But you still have to do the work to recover, and whatever is done, whenever it's done, there are flaws and failures. The key is resilient learning. Although you may experience periods of satisfaction and relaxation, you're never completely cured. But you can recover so well that you're better off than before. You become a better person than you might have been, had the addiction never darkened your door.

In simple terms — you *can* do it. You have the resources: the energy, know-how, and motivation. Everything you need is inside you. The more you access your internal healing resources, the more helpful the resources become.

REMEMBER

Recovery is always a challenge — but it's a challenge you can meet with hard work.

Building Your Skills for Recovery

You won't get far on the road to recovery unless you're honest with yourself. Pretending slows you down. So let's acknowledge that you have already experienced high-honesty and high-integrity states of mind-body in your life. That you are your best self, although it's often a humble best.

But being humbly honest is good. Your addiction is a set of behaviors — not part of your basic core experience. You are *more* than your addiction. As you recover, you discover this, and rediscover your real self — your natural self without any addictive imprint.

So what are the critical skills you need to get started? Here are some to start with:

- **Refusal:** Although refusal may seem simple, it's not — it's actually quite difficult. You need to develop the skill of saying, hearing, and accepting "no."

You have to say no to yourself and mean it. You must accept that the addictive behavior is *no longer part of you!* You must take care of yourself without taking care of the addiction. Why this emphasis? Because life has twists and turns. Saying no and accepting it (no matter which situation or the emotion is involved) is the basic skill you need. Your refusal can be courageous, creative, noble, and life-giving. Refusal is a foundational skill in recovery.

- **Surrender:** The best generals throughout history knew when to fight and when to avoid fighting. If you admit you're addicted, the addiction is the sometimes superior force to contend with. Letting go of the belief that you can reduce addiction to a convenient level is key. Accept that your brain and body are vulnerable to addiction and that addiction is a powerful force to contend with. My practice is full of people who are powerful in chosen activities — from elite sports to corporate leadership — but they readily admit their powerlessness over addiction. Twelve-step and other abstinence programs center on this very point. Accepting that you need expert help in beating addiction is what is meant by *surrender* — summoning that humility in the face of addiction requires skill.
- **Commitment:** You have to maintain your commitment and your resolve to change. You must have a plan you're confident in. Recovery isn't a New Year's resolution but a matter of life and death in the brain and the rest of your body. It's choosing life instead of self-harm.
- **Action:** Deciding which actions are necessary and acting decisively are essential. Deciding what's necessary and what isn't and then trusting your decision enables you to vigorously and thoroughly proceed — those are skills you must cultivate in recovery.
- **Healing time:** You need to devote definitive time to healing. With all the change you're undergoing, you need time to just be in the moment with no demands to be a particular way. Relaxing in a mindful way, without distraction or self-indulgence, accelerates healing.

CASE STUDY

CAN YOU HELP HARRIET?

After reading this chapter, put yourself in the shoes of an expert and review Harriet's situation:

Harriet was ready for recovery. She had a 20-year history of alcohol and drug abuse and too many superficial sexual relationships. She had a job and a child whom she loved. But otherwise she hated her life and herself.

(continued)

(continued)

Harriet went to treatment through her company's Employee Assistance Program. She went to Alcoholics Anonymous and worked with her sponsor, and stopped her addictive behavior. She wanted to change, and she wanted a truly loving relationship.

But Harriet hated her life. She was disgusted with the way she had behaved in the past. Harriet had to work on forgiving herself. She had to refuse her impulsive desires to get involved in superficial sexual relationships. She had to heal. She had to learn.

It's time for you to be Harriet's support person. Help Harriet help herself. Give Harriet your best advice.

Hint — focus on Harriet's psychology. Review the section "Building Your Skills for Recovery" in this chapter and advise Harriet on three things that will help her.

1. _____

2. _____

3. _____

Pacing: Taking Things One Step at a Time

Your recovery is a journey, and every journey has a pace. *You* decide the pace. Go too far-too fast, and you get exhausted or injured. Go too slow and too indirect, and you stagnate and lose momentum. Rather than trying to prescribe the right pace for you, I give you pointers about how to tell when you're going too fast or too slow.

If you're going too fast, slow down

Surprisingly, the most common problem is going too fast. You know you're going too fast when ideas and emotions are far ahead of your actual behavior. For example, you may have virtually completed recovery (in your head) and yet in reality, you've barely progressed. You can get ahead of yourself mentally and then get disappointed or demoralized when you can't match your mental momentum with real change and real action.

If this description fits you, slow down. Take things one step at a time — both in how you think and what you do. Remember, you don't want to stumble on your path of recovery. Your balance and traction are best when you focus on the immediate present.

If you're bogged down, pick up the pace

You know you're going too slow when it feels like nothing is *really* moving. You can get bogged down to the point where you start rolling backward. But the only lifegiving, lifesaving direction is forward. If you feel bogged down, you probably *are* bogged down, and you must get moving forward again.

If you feel stuck, straighten up, put your foot on the accelerator, and move forward. You may need to imagine and envision your goals more clearly.

Pacing with time

A routine with structure can be very helpful. The predictability can be comforting and can strengthen your motivation to go forward. In recovery, a good routine involves time spent with daily reflection on addictive behavior. You may do this reflection in different ways: by attending a meeting or a counseling session, or participating in a session of mindfulness meditation.

TIP

In recovery, start with your sleep-wake cycle to build up a workable routine. When you keep regular hours, you form a basis for routine that is comforting in its predictability. If you go into rehabilitation, you'll see a predictable daily schedule that may remind you of school or sports or a boot camp.

REMEMBER

Remain flexible but consistent in routines. You don't want to get too rigid and, therefore, stressed about change. On the other hand, you don't want to be wishy-washy with yourself. You're building strength. Keeping with your life-routine is like keeping with a daily workout. You're going to have to put work in, to get success out.

Pacing with activities

Another key to pacing is to focus on structured activities. Carefully pick the activities you think are most helpful toward your recovery (for example, taking a walk outside or practicing fifteen minutes of mindfulness). Remember that with every minute, hour, or day you spend putting effort into recovery, you're building personal strength and reducing the strength of the addiction.

Pacing with activities means that you pick activities purposefully. Some activities are picked for gratification, some boost you up with an experience of successful progress, and some are difficult and strenuous but must get done anyway. Eliminating the nonessentials and focusing on the must-dos are important in pacing yourself through and past obstacles.

Building Resilience

Although anticipating every obstacle to recovery is impossible, it is important that you build strength and resilience. In this section, I give you pointers on how to do that.

Maintain personal hygiene

It's not surprising that people with addictions neglect themselves. Feeding addictions often involves neglecting needs and personal care. One path to recovery is simple hygiene. Showering, washing, brushing teeth, combing your hair — each act is simple but each is a morale booster. Conversely, when neglected, hygiene deficits drag you down.

Explore your senses

The five senses (sight, touch, hearing, taste, and smell) are connected to parts of your nervous system associated with key brain centers. For example, vision often dominates the brain. In this age of bombardment of visual stimuli (through smartphones and computers), we disregard other senses. Addiction-wise, pornography is an example where vision substitutes for interpersonal, sensory exchanges. Similar impoverishing processes can happen with the other senses, especially when engagement is distorted by drug intake. To appreciate our natural selves, we must re-engage in natural sensory experiences.

In the grip of addiction, you probably lost some of your abilities to richly experience your senses. Many of your natural senses became dulled. Exercises in which you focus on specific senses and specific sensory events rehabilitate your sense awareness. Many drugs target the pleasure centers of the brain, providing an unfortunate shortcut to powerful but artificial gratifications. Sensory exercises can help re-establish the natural pathways to gratification. These are the natural ways to feel good — healthy ways. You can't get yourself into trouble by stopping to smell the roses.

What is your favorite smell? What is your favorite taste? What works of visual art are appealing? What music do you find compelling? What experiences with nature are most enjoyable?

Take some time to appreciate each sense and then write a few phrases that describe what was special about each sensate experience:

Sight: _____

Hearing: _____

Touch: _____

Taste: _____

Smell: _____

TIP

Take time to deeply explore the unique aspects of your experience. Explore each sense separately and in different combinations. Using your senses in this way reinvigorates the neural pathways and enables you to sense more completely.

Exercise

Whether you love to or hate to, you need exercise to build resilience. Why? Because exercise helps you discharge stress, generate energy, reduce fatigue, and increase activity in the endorphin and endocannabinoid systems that are associated with natural gratification and health-enhancing activity. You can also boost these responses through mindfulness and other meditative disciplines.

TECHNICAL STUFF

Aerobic exercise involves muscle movements that raise the heart rate by about 80 percent for periods of 15 minutes or longer. When done consistently, aerobic exercise accelerates metabolism, enabling your body to convert food and oxygen to energy more quickly. Aerobically exercised muscles develop more *mitochondria* — those central cellular structures that, like tiny power plants, produce 90 percent of the energy in the body. The more mitochondria in muscles, the more energy produced, and the more energy at your disposal.

Another important resilience-building aspect of aerobic exercise is that people who work out regularly sleep more deeply and more consistently. Aerobic exercise also helps your muscles relax while sleeping, encouraging better restoration of body and mind.

Still another benefit is that aerobic exercise triggers releases of pain-reducing and gratifying biochemicals. You feel less pain and more physical gratification when exercising regularly. Aerobics and, more recently, milder exercise formats, have been shown to have effective antidepressant effects for people with mild-to-moderate depression. In my practice I have found that walking-based cognitive behavioral therapy (CBT) intervention programs have been effective when people are also severely depressed.

TIP

Everyone can do some form of aerobic exercise, and slow or moderately paced walking is a good place to start. Combine the walk with increases in observational skills. Check out architecture, birds, trees, and flowers. Pace yourself. You don't have to go all out as your body will send signals about when it can use more intensity. It is more important to first get consistent with every day or nearly every day exercise. Breathe and become sensitized to breathing sensations. Focus on taking in more air and oxygen and feeling more alive but also focus on letting go of the air in your lungs, making room for the fresh oxygen.

REMEMBER

Exercise boosts your self-respect and mood — two aspects of yourself that need boosting when you're in recovery. Exercise helps you fight those low, painful moments when you're tempted to give in to your addictive urges.

Handling Your Everyday Fears

Worrying about yourself and your life (including the future) may be a threat to recovery. But worrying may also lead to acting more wisely and conscientiously. You must act to control your worry, however, because worrying about things you can't control is paralyzing.

The work of worry

Thinking of the future is smart. For example, saving money for retirement or for rainy days makes sense. Doing so gives you flexibility and a certain control of your destiny. Worry is part of thinking that allows humans to anticipate future negatives (associated with anxiety and low-level fear). Worry, if tied to a plan of future action, is healthy. But first you have to decide what you can and can't control.

The work of worry is best done in front of a piece of paper (or in today's world, a computer). Write down your biggest worries. Then go further; write down all your worries, working from the bigger ones to those progressively smaller. Opposite each worry, make a note as to what you can do about it. (When honest with yourself, you'll recognize that you can't do anything about certain worries.) Keep a record. Then put the record away until the next day.

TIP

No worry-work session should exceed a maximum of 30 minutes daily. That is all your brain can handle healthfully — with more you're likely to lapse into pathological worrying. Also don't do any worry work within three hours of going to sleep. Don't be afraid to ask for help. And remember that other people have had similar worries. People are not that different.

HOW MILLIE HANDLES A VERY REAL WORRY

CASE STUDY

Millie was worried about getting a job. She had lost three years of life to addiction. She thought that she would be judged as weak and fragile. She knew, though, that as part of her recovery, she needed to manifest high levels of honesty and personal integrity in relation to past actions.

Millie couldn't control how others judged her. However, she could control how she presented herself and her story. For example, at a job interview, if asked to explain a gap in her resume (due to her addiction lapses), she could respond with a positive statement highlighting what skills she can bring to the job. She didn't need to drag herself through the mud. The job interview concerned how well she could do the job.

For instance, the interviewer asked her what happened after she worked in New York (the period during which she struggled with addiction). Millie replied, "I hit a rough spot in my life and had to take time away from work. It's funny, though, during that tough time, I learned how strong I was. In this job, it sounds like I'm going to have to be very persistent. I'm willing to stay focused. I'm motivated and self-reliant."

Death and dying

You may or may not be surprised to discover that many people with addictions aren't particularly concerned about dying. These folks are often more concerned with the problems of living. Rather than a fear of death, they have a hatred of the pain and emptiness that living sometimes brings. Their main need is to learn to live again.

Nevertheless, the fear of death and dying does play a major role in the lives of some who face addictions. The usual expression of this fear is a panic anxiety, a feeling of terror where almost everything feels out of control. At these times, the system producing adrenaline goes into overdrive, producing shakiness, shallow breathing, chest tightening, sweating, dizziness, and dry mouth. This experience may feel a lot like having a heart attack and can lead to a visit to the emergency room.

Fear of death may result in many different reactions — ranging from avoidance of risky activities to frequent visits to the doctor. If you do suffer from these fears, you may find it helpful to learn more about how these fears affect your thinking and behavior. You may also want to learn about the various ways of treating these fears. In Chapter 20, I provide resources that may help with a number of problems — including anxiety. You may also want to speak with your doctor about getting a referral to a mental health professional who can determine whether you have a panic disorder.

Abandonment

The fear of abandonment is fundamental to many if not most people. Most people don't want to be left alone and no one likes to be rejected.

The best ways to handle the fear of being abandoned are to

- **Learn to appreciate your own company.** Learn to enjoy time to yourself where you can get to know yourself and look after your own needs.
- **Take an active interest in others.** In particular, learn to listen actively and truly understand the emotions of others. Isolation can be due to not paying enough empathic attention to the other people in your life.
- **Venture out.** Join groups, participate in activities, and find clubs or events that put you out in the world. We are socially-sensitive primates and have been for quite a long time — it's in our genes to be socially engaged in different forms.

Handling Your Fears about Recovery

Giving up a habit is difficult, and addictions are especially well-engrained habits. You can usually come up with many reasons to not change and to give in to your habits. But that giving in is probably your fear talking. You may need to bring your fears — both short-term and long-term — out into the open where you can clearly confront them.

REMEMBER

Accepting your human qualities — your fallibilities and vulnerabilities — is key to recovery.

Short-term fears: Withdrawal problems

As I detail in Chapter 10, some drugs are relatively easy to quit, but others are increasingly difficult. If you've gone through a withdrawal process, you may have acquired a learned fear of the pain and discomfort related to withdrawal. Thus, if you've relapsed and are contemplating getting back on track with recovery, one fear that may stand in your way is the fear of proceeding through withdrawal again.

The opiates are usually a withdrawal challenge. Some say withdrawal feels like a bad flu; others say it's like an agonizing sickness. Whatever the experience, the

fear of these symptoms, much like fear of dental procedures, has to be confronted and managed. Good medical care helps. But the fear must be brought out into the open and confronted with an experienced counselor or guide.

Long-term fears

Recovery is a marathon, a protracted effort in changing your way of living. In the long run, you must change your basic attitude toward addictive behavior and build up coping skills. You have to confront your emotions or even a curious *lack* of feeling, which is often the cover of emotional suppression.

Boredom

Boredom is a form of emptiness that's sometimes experienced when stressed to a point of exhaustion. It most certainly is a risk factor for relapse because it probably was associated with your initial lapse into addiction. ("I just want some excitement in life.") Boredom can occur when you've experienced not enough or too much stimulation. You may feel bored when life feels humdrum, especially after a period of hard partying that's now suspended. In any case, the fear of boredom can take many forms including a feeling of disgust about boredom — hating the feeling that life is so empty and devoid of vitality. It's hard to recognize that it's an internal problem that you can address with exercise and mindfulness meditation.

Discomfort

Some addictions start with physical pain (as a result of injury or congenital defects). The discomfort that you have to endure, particularly with chronic pain, may result in the dependence on painkillers (opiates, analgesics). If you overcome this dependence, you may be left with having to tolerate the pain all over again, and you may fear this possibility. Fear is usually a powerful motivator, particularly when combined with pain. But fear of pain can be brought out into the open and confronted.

Helplessness

Helplessness is a psychological condition in which you believe that *no matter what you do,* desired outcomes (good job, loving partner, nice kids, nice possessions) will never happen. A state of helplessness follows when you consistently try to avoid negative outcomes, like pain, and yet every effort you make at avoidance fails. Eventually, you just want to stop avoiding. Any state of helplessness or futility, particularly if prolonged, is a risk to your recovery.

Sometimes, the antidote to helplessness is vigorous activity. Sometimes the antidote is *to give in* to simply experiencing the feelings of futility until you discover alternative feelings rising to the surface. Then follow these alternatives — they usually point you in the right direction.

Avoiding Self-Anger: A Slippery Slope to Relapse

You may have heard people talk about the slippery slope to relapse. I have used the term frequently in this book. It refers to the tendency to slide (slowly or quickly) into old behavior patterns. Self-anger is a slippery slope dynamics; it sometimes emerges as self-dislike or even irritation with yourself. If you continue to dislike yourself for past behavior, you become increasingly vulnerable to relapse.

TIP

To challenge negative thinking, start with an inventory of your strengths and weaknesses. Focus on your skills and behavior, not on your personality. Watch for labels (stupid, ugly, unlovable, loser) and reduce or delete these descriptors from your inner language.

Next, engage in activities that boost your self-respect and mood. Do something just for *you* that enables you to feel a sense of achievement, no matter how small it may seem. Effectiveness in any form is an important antidote to feelings of unworthiness.

In addition, perform some service that benefits others. Humans are social beings who benefit from community. When you give, you get feedback from those who received, and you feel good. When feeling good, even a little bit good, let that feeling sink in deeply, enabling more confidence and determination to develop about overcoming any barriers to your recovery.

Good feelings about the self are chemical and psychobiological events. They start with and return to the acceptance of yourself — and that revolves around accepting your imperfections and tendencies to make mistakes. Accept that you must forgive yourself for past mistakes, while at the same time accepting responsibility for them. Seek the advice and opinion of others who give you honest feedback. Forgiveness evolves with honest, open communication among people who care — whether they're professional counselors, friends and loved ones, or caregivers.

REMEMBER

Some people consider payment for treatment or therapy as a kind of paid friendship. But therapy *isn't* friendship. Therapy is honest communication that enables you to examine core beliefs and feelings about the ongoing situations of their lives. Therapy helps you uncover and release the layers of self-anger to find true

self-acceptance. Seeing the lovable bits within yourself can feel at first like a tiny flame, a flickering light that is elusive and fleeting. In time, the light will strengthen and guide you.

Putting judgments on hold

One established technique to challenge self-anger is to temporarily put judgments about yourself and others on hold. Stop the "shoulds" (I *should* have done this; they *shouldn't* have done that). Playing the "should game" wastes time. Instead, look for the root cause of the behavior — the thinking and the feeling behind it. Listen to yourself and try to understand, rather than judge and label.

Recognizing negative moods

Negative moods and feelings are a normal part of life. All people are imperfect, and you are too. If you learn to recognize your feelings, you can navigate negative states better and gain clearer insights about what's important to you. When you feel happy, you know what you're like. When you feel sad, you can understand what's hurting by tracing that hurt to its origins. At any one time, you can describe feelings (in other words, moods, body sensation, emotions). Feelings include happiness, sadness, anger, tension, anxiety, guilt, and many others. Being able to recognize your negative moods is an important skill to learn because negative moods can trigger relapse.

REMEMBER

Try to remember that you are having the inevitable downs and ups of human emotions. And remember also that if you want to understand your feelings, you also need to pay attention to your thinking — that is, to the statements and images that occupy your mind.

Assessing your sadness

Sadness isn't clinical depression but rather an emotional state. You may feel low, down, tearful, and unhappy. The cognitive theme associated with sadness is loss; something important being missed. You know when you're feeling sad because of the empty feeling in the pit of your stomach and the ache in your heart and chest.

Assessing your anxiety

Anxiety is associated with feelings of threat. Something is threatening your world — a danger is perceived. You feel tension, worry, and agitation. You may be sweating or trembling as a result and you may feel your heart beating at an accelerated rate.

Assessing your anger

Anger is a protective reaction toward a perceived or real assault. When feeling angry, you find yourself ready to attack or in a prolonged state of defensiveness. Two primary themes are associated with anger states. The first is frustration, when you're blocked from achieving a goal or deprived of an important need. (Animals get very frustrated when blocked from their food dishes.) The second is resentment, the sense that you're being treated unfairly when something is unjust or not right. Anger feelings may include overall hostility, outrage, and just being mad. Usually you "don't want to talk about it" — but talking about it is good and often necessary.

Assessing your guilt and shame

Guilt and shame mood states are complex. Shame is defined by your morals and social group and is associated with letting yourself and your social group down. Guilt typically occurs when you have violated a standard or an expectation. These expectations may be based on your family's beliefs or the code of a social institution (church, school). With shame, you feel humiliated; with guilt, you feel embarrassed.

Recognizing stressful situations

Stress undermines your commitment to recovery. Your resources to counteract stress aren't unlimited, so having to deal with a lot of stress in your life takes energy away from dealing with overcoming addiction. Thus, dealing with stress as quickly and thoroughly as possible is very important.

Check out the resources in Chapter 20 to assess your stress level.

REMEMBER

Stress is a term used to describe times when events, either internal (expectations and disappointments) or external (job loss or separations), tax or exceed your perceived ability to cope with them. No one can avoid stress, and some stressors may actually provide you with a challenge that you may enjoy (the good stress or *eustress*). For example, crowding can be stressful, especially if you hate being in that situation, but on a crowded dance floor, it may be fun.

If you're under chronic stress, then you're at risk in your recovery, and you have to deal with that risk as soon as possible. Many ways and many teachers can help you deal with stress. In Chapter 20, I provide some links to stress management resources.

CASE STUDY

FELIX AND FELICIA

Felix believed no one cared for him. Since he was a young boy, he had been neglected and had spent most of his time alone. He wanted to be close to his mom, but she was never there for him. Later in his life, Felix was thrilled to meet Felicia. She was incredible. But Felix just couldn't commit to a relationship with Felicia because he couldn't see what his girlfriend saw in him. He wanted to be married but if he married, he knew it wouldn't last.

Felix hated being alone but when Felicia comforted him, he felt "too needy" and asked her to leave. In fact, he kicked her out, often following an argument based on his jealousy. Felix was in conflict. He wanted to commit to Felicia but instead rejected her. A comedian once quipped that he would never want to join a club that would have him as a member. Felix lived like that.

Felicia felt that she needed to end it with Felix. They had been dating for four years, and he backed off whenever she mentioned the future. She spoke with her therapist. She had to move on.

Felix said "Fine, I knew you'd leave me eventually. I never loved you." He was in agony. The only thing that seemed to help was getting loaded. He had to numb the pain. He cried. He was depressed. He developed a serious drug dependency.

The couple attended couples counseling. Felix learned about his pattern of rejecting Felicia because he felt angry (really self-angry) when he was dependent. He learned that at these times he was going against a silent rule that he had given himself as a child ("I'll never depend on anyone but myself"). Felicia learned to give Felix some space and let him work out his conflict rather than getting angry and hurt, which just reinforced his resolve not to commit. On the addiction side, Felix realized that he was using alcohol to cope but also to anger Felicia so she would reject him (in a self-fulfilling prophecy). Felix had to deal with his drinking first and then expose himself to some painful therapy experiences. Felix was successful, and Felicia is proud of him.

Taking Action: Storming the Barricades

There comes a time when you let your actions speak. No more talking, no more excuses, no more delay. The time to take action has arrived.

Taking action to commit to change

To *commit* means to take a stand. You'll encounter many challenges, but there's only one final pathway to change your addictive behavior and your life. If you

waver (and you almost certainly will), recommit to the change and learn from your mistakes — and get back on course.

Taking action against triggers that increase cravings

What are the triggers that increase your cravings? Suppose your worst trigger is that uncomfortable feeling when you're trying to impress a new group, trying to fit in. They want to party, and you know that you would love to join them. But you also know that being with that group will expose you to stimuli — alcohol, drugs — that may make you relapse into past addictive behavior. (For more on triggers, turn to Chapter 7.)

So you need to take action! Can you afford to go to the party as a clean-and-sober person and increase your risk of addictive behavior? The answer to this question is highly personal. One thing is clear — you must counter the *cravings*, those stimuli that set off the urge to engage in addictive behavior.

TIP

Ultimately, you need to discover the ways to counter cravings that work best for you. Here are some tips to get you started:

- Drink water when feeling the acute urge to take a hit or a drink. Cravings are time limited.
- Remind yourself of all the personally meaningful reasons that motivated your course of recovery.
- Remind yourself of all the effort you've made and the success you've had in your recovery.
- Find healthy ways to counteract negative mood states (see information later in this chapter).
- Be prepared to leave the risky situation promptly.

TIP

When in doubt, stay away. If you go, be prepared to leave immediately. If you leave, be prepared to call your support system.

Taking action to build self-confidence

How do you improve self-confidence? Where does it come from? *Self-confidence* refers to your self-perceived ability to handle situations, to achieve goals, and to manage the tough situations in life.

Confidence in life starts with a sense of pleasure, looking after basic needs such as nurturance, achievement, and affection. When you were a baby or a small child, you couldn't control those things. Many factors influenced the nurturance and security you felt as a child, including your parents' skills and abilities in caring for you. Psychological research shows that beyond a basic need for food, a baby's attachment to a mother figure is critical in development. During these early years, you learn many things, including how to comfort and soothe yourself. No one can pick or control their caregivers during the early years. Your parents were what they were; you can't change that now, so consider forgiving them for their errors while forgiving yourself. Forgiveness helps release you to move ahead in your recovery.

TECHNICAL STUFF

Self-confidence as a youth and adult depends on competencies. You want to build skills and competencies so that you can handle the different situations you encounter in life, including caring for others. This learning and skill building is lifelong, so it's always possible to become more self-confident.

TIP

To build self-confidence, quiet your internal critic, because self-criticism and perfectionism are destructive. Then begin building your skills and knowledge in an area and start to feel better (gradually) about who you are.

Taking action against negative moods

Experiencing negative moods isn't bad. In some ways, negative moods make us feel real.

TIP

Use your moods to help understand yourself. Find those cognitive themes (the thinking associated with your negative moods) and determine how true they really are in this situation. If you feel sad, think about a sense of loss or disappointment that you may have experienced to cause this mood. If you're anxious, think of what's threatening and figure out where the danger is, including the danger to your self-esteem. Try to view the mood as a shadow — a momentary darkness to a positive mood when the sun isn't shining. What could that positive mood be? Think deeply and be honest with yourself. Don't accept the idea that you're thinking about nothing.

When feeling a negative mood, ask yourself: What does this say about me, my future, the world? Next, consider how true your responses are. Here are some questions to help you judge the validity of your thoughts:

- What would I think of (insert the name of a good friend) if they had this experience?

- Are there alternative ways of thinking about the situation?
- If (insert name of a good friend) said this to me, what would I say to help them get perspective?
- Am I jumping to a conclusion without much evidence to base it on?
- Am I magnifying the consequences of the event?
- Am I trying to predict the future?

REMEMBER

One in five people who suffer from an addiction also have a mood or anxiety disorder. Don't hesitate to seek professional advice.

IN THIS CHAPTER

- Knowing the difference
- Understanding relapses
- Examining and understanding relapse tendencies
- Preventing relapse by restoring balance in your life

Chapter 16
Handling Slips and Relapse

When relapsing, you cycle back into addictive behavior. Relapse is never rational or logical. It happens when emotions and impulses dominate. You're driven by *conditioned responses* (learned responses triggered by events) and the *residual habit strength* of past addictive reactions (how deeply you were addicted). These conditioned responses can dominate when you drift away from the preparations and precautions that keep them under control.

In this chapter, I differentiate between relapses and slips and focus on what you can learn from both. I also provide pointers on retrieving your balance after a relapse or slip.

Slips Versus Relapse: What's the Difference?

It depends on how far you slip and slide. For example, I usually receive calls right after clients take a first drink (or hit). They *slip* for several minutes and then, quickly, get back on the track toward recovery. A *relapse* is when you slide back to

the same level of addiction where you left off. (For example, if you were addicted to alcohol, your drinking levels are back at the destructive levels experienced before treatment and quit attempts.)

One key to the transition from a slip to relapse is how you experience what is known as the "first use." If you see it as the *start* of a binge or a run, you may be willing to make a call for support. If you don't see the slip as the start of a potential relapse, you tend *not* to reach out for backup. But without backup, the second and third use can lead to the one-hundredth use. You can slide a long time — including for the rest of your life.

Why Relapse Happens

Typically, relapse happens when your thought and attention start to wander away from recovery. Often that's because the vision of your recovery fades and becomes less vital. Urges to behave addictively start to take hold again and become prominent in your thoughts. Sometimes you lose sight of recovery goals. There may not be enough pleasure or satisfaction from your life now, and the stress and stressors may have built up. The everyday work on recovery gets harder and harder to do — and then with a relapse, impossible to do.

You can almost count on it

Relapse is alarmingly common, but not inevitable. The facts are that most people in recovery relapse at least once. Relapse rates for alcohol and drug addiction range from 50 percent for resumption of heavy use to 90 percent for briefer slips.

WARNING

Given how common relapse is, it's best viewed as a learning event that aids recovery. But it's important to realize that you're at considerable risk of dying or becoming severely ill by overdose when relapsing, and you need to manage the event carefully. In a relapse, all the positive factors are reduced and all the negative factors are increased. The habit-strength of addiction increases while the habit-strength of recovery efforts decrease.

On the other hand, during a relapse you may feel (almost as an afterthought) that some progress toward your recovery has been made. Some of the thrill is gone from the addictive engagement. You go through the motions of re-addiction, but you're actually less hooked than before. It's like an echo of the sharp sounds of the original addiction.

How can you quickly limit the relapse and minimize its impact? Ask yourself, "How quickly can I get back on the path to recovery?" As quickly as possible, is

what to aim for. Any partial return and any gesture toward return is better than not trying at all. The less you try to get back on the path, the more likely you are to become dangerously re-addicted.

Triggers for relapse and what to do about them

Early in the process of recovery, many triggers are tied to old associations with friends, environments (bars, parties, casinos), and paraphernalia (a pipe, a racing form, music). The media is a powerful trigger because addictive behaviors are portrayed as desirable. For example, the party scenes in commercials look like fun, with everyone pleasantly having a good time. But remember, that's just 30 seconds of video footage of temporarily-employed actors acting like they're having a good time. That is not applicable to you. If you try it out, you're likely to dangerously relapse.

WARNING

Be aware that a very specific smell, sound, or image can trigger urges. Be aware that urges can be set off suddenly (in a "flash") and powerfully. As fast as information is processed in the brain, a powerful urge can be triggered.

Urges and cravings are linked, for the most part, to *subcortical brain processes* that involve minimal thinking but exert powerful influences on you. Because you aren't aware of these processes, they're difficult to counteract and can dominate you.

To counteract urges, do something that radically alters experience at cortical (thinking levels) and subcortical levels (non-thinking levels). For example, intense physical exercise can counteract the power of the subcortical messages. Other methods to counteract urges include a very cold shower or treating yourself to a pleasurable, nonaddictive experience, like deep massages or excellent meals. The better you are at directing your experience away from the addictive urges, the more you gradually weaken the conditioning underlying urges.

TIP

How do you avoid relapse triggers? For a start, learn to deal with the trigger after the triggering happens. Resolve that when the trigger hits you (for example, the smell of alcohol, seeing a casino ad, being at a party), you will talk about it with a trusted person. Get away from the trigger if you can (yes, leaving the party is better than relapsing). Focus on your recovery goals and think about the changes in your life since you've started recovery. Call a trusted person to talk about your experience. (The sponsors you connect with by joining twelve-step and other support groups for recovery can be very helpful.)

REMEMBER

Some of the most difficult triggers are the most internalized ones, often associated with emotional blind spots and automatic thinking (sometimes known, in Alcoholics Anonymous circles, as *stinking thinking*). In other words, it's the thinking that you haven't really challenged (for one reason or another) that's the most

trouble. Stinking thinking can set off a slip or relapse by creating a certain downward momentum (that feels uncontrollable) in your cognition. If you think it, you have the power to think differently. Take responsibility for that power. It can save your life. It may have already saved your life. Let's use that power.

High-risk situations and their remedies

Most relapses are associated with the following four high-risk situations:

- **Anger and frustration:** Anger, especially when it results from deprivation, drives rebellion and relapse. Some typical thoughts are "I just don't care anymore," or "I deserve better after all I've been through." Resentment and self-pity fall into this category. Thoughts like "Why me? Why can't I control this situation?" arise repeatedly. Ask the why question in reverse: "Why can't you re-exert control?"

  You can't afford to dwell for long on the negative thinking of anger and frustration because it rapidly progresses beyond control. So call someone and talk about your feelings. Remember that you can feel bad without having to relapse. Feelings pass, especially when you can do a meditation session or mild, moderate, or vigorous exercise. The key point is to get the feelings and thoughts *out of your system* rather than letting them build up inside and pressure you into more negative and self-destructive behaviors.

- **Social demands and pressures:** Social demands are more subtle. We're all social beings and respond to the social pack we identify with. Sometimes there are unglamorous stressors that involved returning to the demands of life (and specifically our roles in life — whether it's mother, worker, executive, or rock star). There are tedious things we must do to experience the exciting and enjoyable and joyous things.

  You may need some advice on how to cope with your roles. You may need to explore how other people who've been in the same boat coped. Look for ways to change the stressors that seem beyond control. If you're overwhelmed in your current roles, find alternative roles. Recovery is the primary concern now, not career-building. One step at a time is the best approach with the key steps being internal ways to find calmer states of mind and body.

- **Interpersonal temptations:** Such temptations are very risky. New relationships may bring on recovery challenges, such as when someone says, "Aw, come on, just have one." For someone on a recovery path of abstinence, "just one" can set off a run of many that disrupts recovery for years to come.

  You may want to be a normal drinker, a normal user, and so on, but that is not your fate. For you that normality is impossible. A friend once described his response to the interpersonal pressures I'm talking about. He said, "Yeah, I'd love to have a drink with you. But you know, I wouldn't stop with one, and even if I did, the next day I'd want another one. Pretty soon, I'd be lying

around my house in relapse." In these situations, you have to be blunt and honest. Start with "No, I can't drink, use, gamble, or do any of that anymore."

- **Feeling great:** How, you ask, can feeling good lead to relapse? Many people at risk for relapse admit that feeling great lulls them into a false sense of security. When you're feeling particularly good, you can deceive yourself that you're now strong enough to engage in your addictive behavior just once — for fun.

  Be wary of playing with fire. Few experiences of well-being can withstand the pressure of addictive urges after they're restarted with actual use. Your confidence level when things are going well may be high. But the relapse risk doesn't go away.

The good news: Relapse is preventable

A relapse-prevention approach helps you develop a profile of past use behaviors and current expectations about high-risk situations. The first task is to study your unique risky situations and to understand how certain thoughts and feelings precede the actions that lead you to those risky situation. Exerting control over these thoughts and feelings is very important. Always have a plan to call someone for support. And preferably, have two or three people to call in order to most surely reach one.

TIP

It may be useful to think of a craving for addictive behavior as similar to hunger. The only difference is that hunger is natural, and your entire biology centers on getting adequate nutrition. An addictive craving isn't natural; therefore, it will fade into the background when managed correctly.

Learning from Relapse

To begin to avoid relapse, you must develop an understanding of why you relapse, a willingness to act to quell trigger responses, and an acceptance of both the positive and the negative consequences of all your actions.

Examining your relapse

To learn anything meaningful from a relapse, you have to dig deep into your High-Honesty, High-Integrity (H-H, H-I) states of mind. Put on your detective hat and ask these questions of yourself:

- **Who?** The who is easy. Look in the mirror, but be aware that "you" change under different conditions.

- **What?** What did you actually do? Be very specific. Solely describe the behavior at first. What actually happened? Event by event.
- **When?** When did you do it? Describe the timeline and plot it out just as you would if writing a script.
- **Where?** Where did these behaviors take place? Describe the situation in as much detail as possible. You may miss a detail at first.
- **Why?** This is the toughest one. Be honest and dig deep using your High-Honesty, High-Integrity approach.

Write your responses down. Writing has the effect of slowing your mind, allowing you to think more clearly and with more emotional and rational connections.

When answering these questions, describe your inner thoughts, feelings, and motivations. Great directors of film, sales people, psychologists, and detectives know how to find the person's motivation. *You* have to find your own.

Doing things differently next time

How can you prevent future relapses? Focus on the skills needed to develop or refine a greater sense of self-confidence and self-control in future situations. These skills include figuring out how to limit or abstain from addictive behaviors, how to combat urges and cravings, how to relax when initially tense, and how to effectively deal with the underlying emotional issues that make you vulnerable to relapse. (I discuss these skills more in Chapter 15.)

CASE STUDY

GARY'S RELAPSE STORY

Gary relapsed after six years of being clean and sober. He went on a self-destructive binge that lasted weeks. When he finally contacted me, he was sheepish but quick to react with resentment. Gary hated being controlled. He hated being dependent. He refused to knuckle under. He wasn't going to make an excuse. Gary said, "I relapsed. I don't know why." That was it. What was surprising was the anger that his lack of explanation generated. Everyone who loved him wanted an explanation. "He owes us an explanation! He's so self-centered. He doesn't even care enough to make an excuse."

Gary eventually agreed to examine his relapse. He answered the same questions presented in the "Examining your relapse" section. His responses follow:

- **Who?** Me — I accept responsibility. No one else was to blame. I'm tired of blaming everybody and everything external for my binges.

- **What?** Started out at my old local bar. I don't know why. [Therapist note: Gary leaves the whys for later. They get in the way initially. Just focus on facts.] Left after two drinks. Went to the strip club. Drank heavily. Talked with girls. Met X — very nice, kind. Used cocaine — can't remember any more about what happened after that. Woke up in a seedy motel near the airport. No money.
- **When?** At 3 p.m. started out at my old local bar. Left at 3:30 p.m. after two drinks. At 4 p.m. went to the strip club. Drank heavily. Talked with girls. At 8 p.m. used cocaine. At 10 a.m. woke up in a seedy motel near the airport.
- **Where?** My old local bar — I knew *not* to go there — so stupid. [Therapist note: No labels are necessary — they block the discovery process.]
- **Why?** Why did I go? I was bored, pissed, happy — you pick one! [Therapist note: There's sarcasm but follows the feelings. Start with being pissed and angry.]

Gary had ten or so people whom he could have called when he had the urge to drink. But he didn't make the call. ("I didn't want to bother anyone.") The reality was that Gary refused to make the call. He was angry (the number one reason for relapse is anger), and he didn't want any interference.

Digging into the anger, Gary had been flirting with a young server at a local restaurant for months. On the eventful day, he was feeling great. He had made some money and he went to the restaurant. He finally got up the courage to ask her out, and she turned him down flat. Ouch. Gary went to the bar and started his binge.

To block his tendency to go back to his local bar, Gary went by and spoke to the owner when he was sober (compulsive gamblers also take this step with casinos). He took responsibility for his actions by asking the owner to refuse to serve him the next time. The owner told Gary that he would help. He asked if he could call the police if Gary wouldn't leave, and Gary said yes.

Getting Your Balance Back

Once again, relapse is part of recovery. And relapse prevention is hard work. Slips are easier to manage than relapses — so catch the slip while it's still a slip. Get help as soon as possible. Assume you need help rather than trying to go it alone.

TECHNICAL STUFF

The severity of your addictive behavior is an important factor here. If the past severity of addiction was high, you have a greater need for multiple approaches to relapse prevention — each powerful in its own way.

Medications may help

A few medications may help reduce cravings. Antidepressant drugs are commonly used. Disulfiram or naltrexone can help for alcohol abuse, and methadone for heroin dependence. Contact a physician and talk it over. (See Chapter 10 for more on helpful medications.)

Getting back on track

Okay, you've relapsed. Now what? What's next? What should you do?

- Go to a meeting. Call your support system. Be honest, open to feedback, willing to change. Just do it.
- If you get hopeless (for whatever reason), get help immediately!

What's going to keep you on the straight and narrow?

- A meeting or a call to your support system. Be honestly open and willing to change. Just try it.
- If you get hopeless (for whatever reason), get help immediately!

(The repetition here is intended as this advice is critically important. Get help. I want to emphasize that.)

Deciding whether you need some extra help

How do you know if you need extra help? If you agree with any of the following statements, get added help:

- Your program just isn't working.
- You are starting to white-knuckle your sobriety. In other words, you've recently survived several near misses of relapses or slips.
- You tried to control the behavior but before long, you were right back at it.
- You feel like giving up and packing it in.
- You've just heard some shocking news. Share the shock rather than absorbing it and handling it on your own.

IN THIS CHAPTER

- Dealing with relationship and family relationship problems
- Making sense of work problems
- Coping with financial challenges
- Looking at relapses in relation to work and family

Chapter 17

Handling Work and Family During Recovery

Addiction may have been an escape from responsibility, but now responsibilities beckon you back to resume control. Responsibilities in the familial and work contexts come first, and this chapter offers advice in these areas. I discuss how families are affected by addiction and how your family's recovery relates to your own recovery.

The basic point resonating throughout this chapter is that when you start treatment, relationships begin anew with family and friends. In starting over, it's natural to aim for a higher level of honesty and personal integrity within those relationships.

REMEMBER

Treatment fundamentally reverses the addictive process for you and your family. You trade in the unnatural highs for the natural highs of good relationships. It's the best trade possible — unnatural highs bring you down while natural highs bring discoveries of healthy joys and fulfilling activities.

Dealing with Relationships During Recovery

When you commit yourself to treatment, most everyone around you seems relieved and provides support. But it doesn't remain so simple for long.

For over half a century, psychologists and psychiatrists have studied the details of how families and close relationships evolve. During this time, the interactive principles have become clearer, namely that every member of the family reacts to every other member. It's a dynamic process that can get hyper-reactive and hectic. In this section, I help you prepare for and persist with positive relationship change.

Dealing with positive changes

Although some of the positive changes you aim for are welcomed by others, some changes may be hard for them to accept. Where there's a lack of acceptance, you must look back at how you affected your family in the past.

REMEMBER

When you were in addiction's grip, your family experienced tremendous pressure. When you enter treatment and evoke the promise of better health, the pressure eases. As a result, everyone may seem more lively and happy. If you're away from home (in residential treatment), you may feel your family is better off without you. There's some truth to that. They're better off not exposed to your sliding into deepening addiction. It's very hard to watch the slide happen to someone you care about, and especially hard for a parent to watch a child's deepening addiction — it can be more difficult than for the person doing the actual sliding.

But their vacation from concern about your downward slide is short-lived. Your ongoing and progressive recovery is the only way to liberate them from ongoing grief. Now you can focus on how elevating your health, mood, and sensitivity to *them* can lead to their upward shifts of mood and overall sense of well-being.

TIP

Be aware that loved ones' relieved responses — reactions to not having to worry about you so much — may sometimes kick off feelings of resentment in you. Watch for any behavior on your part that could result in a family downer. Also beware of adopting the attitude of "I'm suffering, so they should suffer." Instead, accept that the effects of your former addiction on the family were bringing them down. Now they, like you, are struggling upward.

REMEMBER

Rarely are your family members and friends better off without you, if you stay clean. When you're under better control, they're happier. When you get healthier, they get healthier. After you see this more calmly and clearly, you realize that positive chain reactions can occur — you can set them off.

Dealing with negative changes

You may be surprised to hear that after you start treatment, the people around you may have difficulty curbing *their* wilder, addictive behaviors. When you get into treatment, there's a reduction in pressure on them that can have negative as well as positive effects. If you lost control in the past, they can lose control and get wild in the present. Instead of doing healthier stuff, they can act out with riskier stuff. It will take time, but every bit of your personal recovery will have a recovery-influencing effect on them.

For instance, if your addictive actions caused your child to curb their wilder actions, they may now feel it's their turn to try out their wilder side. Rather than learning from your positive actions, they may try out a version of your past negative actions and wildness. Remember that this wild behavior is an attempt to find balance. Your child is not trying to mess things up — they're trying to make sense of what feels messed up within.

REMEMBER

No one close to you will become saints just because you've made positive changes. You must be ready to tolerate their bad behavior just like they tolerated your bad behavior. This tolerance requires careful navigation because not expecting family members to be perfect doesn't mean encouraging their bad behavior — or tolerating it.

CASE STUDY

THE MACADEMUS FAMILY

No one could figure out what was going on with the five Macademus children. Joe (16), Angela (14), Christina (13), Lucy (11), and Josephine (7) were all unusual kids. They kept to themselves, never had friends over, and seemed to be seething with resentment much of the time. Even little Josephine got in trouble in first grade. What was up with these kids?

The parents, Chris and Jackie, seemed quite normal. They were frequently at work and weren't home much, but that wasn't that unusual. One day Angela called her teacher an offensive name and stomped out of class. The teacher went to the principal, and they arranged a meeting with Chris and Jackie.

The parents maintained that nothing was wrong. Everything was fine. But just two weeks later, the same meeting was reenacted because each one of the Macademus kids was now acting out — all within the span of one week.

At a second meeting with the principal, under the increased demand for straight answers, the true story came out. Mrs. Macademus had an addiction problem — and she had just completed her first ten-day inpatient program. The kids were having trouble coping with her absence. This important turn in her battle against addiction was difficult for them to tolerate.

Dealing with Family Problems

In dealing with family problems while in treatment, remember the one thing that helps the family most is staying in treatment and progressing with recovery. As you progress with recovery, you get stronger and better able to help members of your family make the changes that are healthy for them.

During all treatment phases, however, you must pace yourself. You can only help yourself and others within a certain limit. That limit is defined by being able to continue staying in and progressing with treatment. Any situation that threatens treatment must be dealt with in a way that deepens your commitment to and involvement in treatment. In recovery and in life, we are subject to "hubris-to-humility" cycles where sometimes we feel we "got it made" only to discover error and fault, and responsibility for correcting and making it better.

Your counseling relationship should help with your family problems. Given your past use and abuse, your family will inevitably have problems. Even if you've taken pride in keeping your addicted life separate from the family, at some level they've felt the addictive effects. Kids and spouses have an intimacy radar that picks up on what's happening, even without understanding any details. They sense that something isn't right — they know enough to become upset, even though they may not know enough to recognize addiction problems.

Furthermore, all families invariably have problems regardless of whether there's an addiction or not. Whatever the cause of family problems, you're liable to get emotionally upset by them. You'll be more sensitive than before to these problems, and you will need to figure out (better than before) how to deal with them effectively.

TIP

In your counseling, you must disclose family problems. Disclosure is the first step toward solutions and to seeing how *your* progress contributes to the progress of each and every one of your family members. If you don't feel you can share family problems with your counselor, think about finding a different counselor or, at least, another person to confide in. Addressing family problems is very, very important to your treatment progress.

Do the right thing: Be a good role model

The most important part of treatment, in family terms, is role modeling. Role modeling sounds technical but can be heart-felt because your love is guiding your family from afar. By doing the right thing, you influence family members to do the right thing. Of course, your treatment and recovery help you better understand what happened when you weren't doing the right thing — when addiction blinded

you to what the right thing was. You were role modeling, then, in a negative direction. Now that you've reversed directions, you'll see the difference. And what a difference it can be each and every day to move further in the right direction — the direction that feels good for healthy reasons.

How families are affected by addiction

Families affected by addiction have several similar problems in dealing with the truth. In summary, families of addicts often have two main problems:

- They spend a lot of energy denying troubling realities.
- They make related attempts to present an ideal family image to the outside world — an image that is much better than how things really are.

Of course some families may be prone to state the addiction problem boldly and directly. In fact, some can overdo it. But regardless of which characteristic dominates more, solutions involve openly disclosing problems while letting go of ideal imaging.

You've taken the lead in admitting your problem and getting treatment. In the course of treatment, your progress depends on admitting more of your problems because you must admit them to solve them. And because admitting your problems takes courage, the process of admitting is easier to agree to (in principle) than following through on the admitting itself. Your self-esteem and self-respect feel compromised when disclosing shortcomings. You cycle from a position of hubris to a position of humility. But remember that feeling ashamed is the worst part of the process. These initial feelings fade, and you eventually have a stronger sense of self-esteem because your self-respect rests on a more solid foundation.

Being in treatment gets you ready to view yourself and your family with eyes fully open. Admitting to problems is tough, but try to focus on the good feeling of building a foundation of truth. The added good feeling is that you're helping to build the same truthful foundation under family members simultaneously.

REMEMBER

An old recovery phrase that may help you keep perspective is *progress not perfection*. When applied to living within a family, it means dropping ideas about being the perfect parent, child, or spouse (which is hubris to begin with) and humbly acting in support of the better way. Moreover, this humility places more emphasis on how *you* behave and less emphasis on what you demand from your family. Whatever you feel you must demand, be sure that you've demanded it from yourself, first.

Making positive changes in family relationships

Family members always react to each other. The degree varies, but reactions and counter-reactions go on continually. They go on so much that we often take them for granted. We develop hard and fast expectations that a particular family member *always* reacts a certain way. What we don't realize is that our expectations influence family members to keep reacting in the same old way.

The important point is that positive changes happen in families when we drop expectations and instead observe realities. Change happens when people do things differently — even small things. If we observe closely, we can rearrange situations to induce and reward the small changes that add up to major, significant changes.

The trickiest part is choosing where to direct your efforts — selecting which behavior you might persuade someone to change. Naturally, the more the behavior change you want matches a behavior the person feels should change, the more your efforts meet their motivations. Clearly identifying where this match will or will not occur makes a difference.

REMEMBER

Families with addicted members tend to deny certain realities (while upholding the ideal family image). Positive change involves reversing this: acknowledging problems, big and small, and addressing them.

Originally, the family denial patterns probably related to your addictive behavior. Efforts were made within the family to deny the addiction — just as you were trying to keep it secret. But these patterns eventually went beyond the addictive abuse and included other situations. Now you can change your family's norms by addressing the problems that were previously avoided.

Solving family problems by changing norms

All people and all families keep track of certain *norms* (the ways things usually happen). These norms exist in every family — some are healthier, some less so. To create positive changes, you need to induce small changes consistently so that new, positive norms get established.

By being in treatment, for example, you establish a new norm that says it's okay to seek and find counseling assistance. The new norm begins with you finding your way to good counseling. Then, your example and your positive experiences provide leverage to suggest help to others.

The same is true for the norm of talking through problems, honestly and thoroughly without pretending that something doesn't bother you (when it does) or that an issue is unimportant (when it's important to you). Your counseling relationship helps you prioritize the issues that are most important for you to address with family members and choose what strategies to use when bringing up issues. These strategies help you communicate in the ways most likely to be positively received. Try to maximize positive responses while minimizing defensiveness.

TIP

Bring up issues at a reasonable pace so that they can be dealt with effectively and with enough accompanying positive regard that each person is reassured of love and respect. Only so many issues can be raised at any given time. If too many are raised, people may become flooded with anxiety or react depressively rather than positively. Remember, you're asking for someone to change, so when you bring up too much, your loved one may experience your comments as a critical rejection.

Making long-term plans for positive change

If the best approach to change involves pacing, then a long-range plan for change is helpful. This plan ensures that you don't try going too far, too fast. It acts as a reminder to not let opportunities for change slip by.

REMEMBER

Meaningful changes within intimate relationships often take years rather than months, although they can require daily and hourly attention. A long-term plan often involves determining what changes you want to make during a six-month or one-year time span. Eventually, the long-term plan takes the place of the ideal family image that members once aspired to protecting. Rather than trying to protect a fantasy, there is systematic movement toward a positive do-able reality.

In your long-term plan, give consideration to the balanced use of family resources. In some families, each spouse may feel they are carrying the greater load of family responsibilities. But a true equalization of responsibilities can take time to arrange because outside factors may be involved — like jobs, work hours, training programs, or a move of the entire family.

In any case, after family members commit themselves to a dynamic model of change in contrast to denial-based stagnation, you need to work together on plans for change that unfold over reasonable periods and progress toward goals understood by all family members.

All these changes involve movement from an imbalanced power structure, where decisions are made by and particularly favor a few members, to a more representative structure where each member is given an opportunity for meaningful personal development.

Dealing with Work Problems

If you're one of the providers for your family, any of your work problems (while in treatment) immediately affect the whole family. This brings work issues to the forefront of the recovery picture.

Scenario one: You were hardworking to begin with

Many extremely hard-working, productive people become addicted. If this reflects you, then addiction problems perhaps began with, or were linked to, work addiction. In other words, chronic overwork may have contributed to wanting to develop another life, one that was easier and had lower expectations — a life that included drug, alcohol, or behavioral patterns that eventually were addictive. For more information on work addiction, turn to Chapter 3.

If this work-addicted or nearly work-addicted profile fits, you may have proved yourself so valuable to employers and colleagues that a job is waiting for you after completion of treatment. Or if you're being treated as an outpatient, your colleagues and employers may remain supportive while you take the time needed to recover. Predictably, your work performance, productivity, and earnings improve considerably after good treatment.

On the other hand, if this profile fits, your work life may need transformation. As valuable as you are, you may have become accustomed to overwork, over-use, and perhaps abuse. When that balance shifts, you may lose a surprising amount of confidence in your ability to produce. You might have previously pulled off enormous energy bursts followed by addictive episodes. You could maintain yourself in highly disciplined states if, afterward, you knew you could let loose by using and abusing. The basic patterns I'm talking about are extremes of work and then extremes of addictive behavior. Both are unhealthy and threatening to your career.

WARNING

If you're in the unfortunate situation where your employer truly expects extreme work habits from you, you probably need another job or prepare for serious negotiation. You may be undervaluing yourself as a worker and, as a result, being exploited by someone who's unfairly reaping benefits from your overwork. Look around to see whether people with equivalent skills are working more reasonable hours and still earning reasonable incomes. Try to do these comparisons as systematically as possible. This may not be easy, because salary information is typically private. However, you can get a pretty good idea of the work hours of peers and their compensation levels after putting your mind to it. Underselling yourself as a worker is most definitely a risk factor for slipping back into the addiction. It's also habit forming — the more you undersell now, the more likely you are to keep underselling in the future.

While in treatment, your confidence may roller-coaster up and down, both at work and with family. Many successful people have surprisingly superstitious ideas about success. And with a shift in behavior, like getting clean, their previous ideas about success are severely challenged. You may seriously wonder about whether you still have what it takes. You may wonder whether your career will nosedive into humiliating failure. The important point to remember is that getting treatment and ridding yourself of addiction will increase productivity as your brain will become a healthier organ.

REMEMBER

Although you may have to seek and find *new* modes of being productive, you increase your potential by getting into treatment and getting freed of addiction. It's a simple psychobiological reality. You're increasing your capacity to perform using the most important organ to perform with.

Scenario two: You lose your job due to your addiction

Your addiction problems may have downgraded your career to the point where you don't have a secure job waiting on the other side of treatment. If this is true, you're going to have to adjust to painting on a whole new canvas. You're restarting a career or initiating a new one — and your family may face periods where your financial support is reduced or nonexistent.

This can be embarrassing and demoralizing. Your self-image, as provider, will be threatened. You may no longer feel the strength that comes from fulfilling this important role. It may be painful to hit this type of bottom. But the fact remains that being in treatment is the most important thing, right now, to ensure and increase future earnings.

Whatever your career was like before, working with it while addicted (in the background) was like pursuing it with one arm tied behind your back. Now, when resuming career building, you'll be working with two good arms. Whatever you once achieved, you may increase or double it when addiction no longer impedes your progress.

Meanwhile, your family may be struggling. Your kids may have to drop out of college or high school and get jobs. Your spouse may have to start working, or work longer hours or get a second job to make ends meet. You may need to sell property or cash in bonds or stocks. The costs may be considerable, but hard work rarely injures anyone unless it's addictive. Your treatment is worth everyone's hard work because you'll be so much better able to give when further along in your recovery. Healing is an investment. The best investment you or your family members ever made.

REMEMBER

Addiction is, to a major degree, the result of valuing external substances over the inner you. In recovery, *you* become the focus: your inner resources, inner truths, inner capacities, and inner needs for harmony — they're all emphasized. And this reversal in experience is appropriate but takes getting used to. The basic message is that the inner you is the most important "you," and after the inner you recovers, everything gets better, including the work you do to support your family and yourself.

Dealing with Financial Problems

While in treatment and when coming out of it, financial resources can be substantially reduced. You may be in considerable debt. All previous denial and excess now adds up to dollar signs tinged in red and preceded by minuses. What to do?

Although downsizing expenditures, expectations, and financial obligations are the basics of solving these problems, try to understand the behavioral side. You're coming to come to terms with depleted finances. The psychological side of debt reduction involves revaluing good, old-fashioned work while reducing reliance on indulgent materialism. You need to get over your feelings of being unable to do *without* something, other than the basic necessities. You may think you need cars, planes, boats, pieces of art, houses, clothes, memberships in clubs, or trips to exotic places around the globe. You may think you need gourmet dinners, jewelry, vintage alcohol, or the status that comes with entertaining lavishly. Whatever material objects you think you need, they don't add up to happiness or well-being.

At some level, you know this. But like many of us, you're susceptible to the advertising that runs like a broken record via the Internet, TV, radio, billboards, and by simple word of mouth. Marketing induces you to want something and buy it whether you can afford it or not. Marketers have no interest in your well-being. They're pursuing figures (market-share, profit-margin) that help *their* careers. If you multiply one marketer by several hundred thousand or million, you have the steady influence in our culture that suggests you buy, buy, buy — and feel guilty or shamed if you don't.

You must step away from this merry-go-round to get back on your feet financially. Bluntly stated, you have to refrain from buying stuff you don't need. You won't be able to do this if you see doing without as impoverishment. Instead, focus inward and discover inner harmony to enable a real change of view to occur. You have to feel good about doing the right thing when reversing the addicted lifestyle. When addicted, you put up with disharmony to get and use a substance that, supposedly, made everything better. Before you knew it, you were putting up with a great deal of conflict for highs that were escapes from a world of mounting troubles.

Now you're transforming your world of trouble into a world that works. The major commitment needed is hard work — the hard work of generating income (however you wind up earning it) and the hard work of saving the income generated. Both add up to the hard work of doing the right thing.

You know it's the right thing when it feels right. With the new skills of inner exploration learned in treatment, you become clearer about what's right. You find that it isn't substances that make life good, but honest connections with people. With each relationship that improves — and each relationship that involves real compassion — you realize different highs (better highs) than ones experienced before.

REMEMBER

The inner wealth that comes from good relationships and personal harmony is what helps you refrain from buying what you don't need.

Relapses, Restarts, and How They Affect Your Family

No plan for change is perfect. All involve slips and relapses. Whether a slip involves you or your family members, the difficult issue of forgiveness inevitably arises.

Technically speaking, relapses are excellent opportunities to understand abuse problems better. In contrast to continual use, where it's difficult to determine what the trigger is, the relapse is a specific event where the anatomy of the abuse problem is laid bare. Your counselor will be extremely helpful in analyzing your relapse with you and, if necessary, with members of your family. I also cover relapses in Chapter 16.

RALPH'S ADDICTION, RECOVERY, AND FINANCIAL RECOVERY

CASE STUDY

Ralph had been addicted to gambling for 15 years. His work record was spotty, but he did work as a skilled laborer when he could. In the years before he quit, he spent more and more time at the racetrack. Ralph no longer had any credit. He was broke. Ralph hadn't paid taxes for ten years. He was nearly certain that he'd be dead soon — why pay the government? He gave at the track!

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Ralph's good friend Johnny (they'd known each other since grade school) talked Ralph into going to treatment. He knew Ralph's family and wanted to help Ralph's kids (who'd given up on Ralph). Jenny, Ralph's ex, had left with the kids years ago. Johnny said, "It's time to change." Ralph agreed and went to treatment — for three months. Thankfully, Ralph's old union helped; they pitched in to support his treatment at a local residential center.

Ralph hasn't engaged in gambling for five years. He pays his taxes and is getting his life back in order. He's intent on repaying all his debts — financial and emotional.

Coming to terms with a relapse

The more willing you are to understand how the relapse occurred, the more able you are to prevent its reoccurrence. The more you can communicate about your relapse with family members, the more able you are able to regain their confidence and trust.

REMEMBER

Often, very little is accomplished immediately after a relapse. Family members are usually in shock. The question of whether the addiction can be beaten resurfaces as a real question. Heavy doubts and powerful fears arise. Family members may find little to talk about sensibly. After a relapse, the specter of the addiction, and all the hurt and pain, is at its most powerful.

If you're the one who has relapsed, simply work with your counselor at first, learning as much as you can about what triggered the event. Often, your own situation is emotionally charged — perhaps an argument or a deep-seated conflict surfaced or you experienced failure at work or with a project you set out to accomplish. Or perhaps it was a party or celebration that got out of hand or a situation where you faced temptations you couldn't resist. Whatever the situation, the better you understand your relapse, the better you're prepared to prevent another one.

WARNING

You must wait until feeling confident that you've learned from the relapse before trying to persuade anyone else that you're back on the path to recovery. If you try to be too persuasive too soon — before you have it together — you'll come across as unconvincing. As a result, you may bring on more distrust, rather than less.

Instead, take your time. The strong emotions that dominate immediately after relapse eventually reduce in intensity. And your family is better able to listen and understand — and forgive — when they're less affected by shock, disappointment, and anger.

REMEMBER

Many people who have proceeded with the treatment of addiction have relapsed at least once. Few have a perfect record. If you relapse, listening to and understanding your family is crucial. Let them ventilate their reactions — it hurts to feel their pain, but it doesn't result in permanent injury. You realize, ultimately, that their hurt is linked to their love. And realizing that can be a strong factor in preventing another relapse.

Restarting with the help of your family

Of course, there is no point dealing with the emotions of your family if you don't get back on the path to recovery. Once again, the single most important thing is to stay in treatment. That means getting back with your program.

After analyzing your relapse, you're better able to see abuse as a reaction to problems and not a desirable situation in itself. The good news of this view is that the more problems you solve, the less susceptible to relapse you are.

When your family sees you re-engage with your program, they're relieved, and their confidence in you increases. And as they come to understand more about how and why you were triggered into a relapse, the more they'll be able to help you avert future relapses.

The successful response to a relapse and a strong restart of your program helps you feel less brittle and more resilient. In place of anticipatory anxiety about the future, you have more knowledge about how to effectively reduce problems in the present. This experience can be communicated to, and adopted by, your family as well.

IN THIS CHAPTER

- Laying the groundwork for change
- Assisting your loved one
- Supporting long-term change
- Looking at ups and downs
- Staying optimistic

Chapter 18

For Families and Friends: Ways to Make a Difference

This chapter is dedicated to the families and friends helping a loved one struggling with addition who want to make a positive difference.

To provide help for *you*, I introduce two terms: *empathic load* and *working alliance*. Empathic load refers to how much help weighs you down (and lowers your mood). Working alliance refers to how effectively your alliance is developing with the person you are helping. The two experiences are related, as sometimes you can tolerate a high empathic load provided you feel you're being a good ally. On the other hand, sometimes you can feel there's an ineffective alliance and then the empathic load will seem heavier — and sometimes too heavy. It's important to be sensitive to how you feel. If you feel a high empathic load along with a reduced working alliance, it may be best to temporarily stop trying and take a rest or do something else (meaningful to you).

The distinction between these two terms helps because recovery is a long climb. It can and will get tiresome and fatiguing and emotionally evocative. You will need to sometimes retreat into some form of aloneness and self-care to find resilience (to try again) and to explore new strategies (to better help).

REMEMBER

While you accept the shared struggle (the empathic position of being there for your loved one while supporting the struggle), you will also need to let go of the struggle and accept that your loved one is captain of their own ship. You might be a first mate, but you can't be captain. When you try to captain, it weakens your loved one's effort to steer to safety, honor, and productivity.

The power of family can make a big difference when properly harnessed. Families and friends can channel concern and love into effective actions while getting healthier themselves in the process. The quality of the help you give gives back, or rebounds, to you.

WARNING

Throughout this book, you may have noticed the theme of helping your friend or loved one get *treatment for addiction*. In this chapter, I emphasize the fine line between getting treated and acknowledging the need for treatment for addiction. Due to the substantial, unfair stigmatization of addictive disorders, many people tend to deny they have an *addiction* and deny needing *addiction* treatment. Try not to become a willing party to such denial. Centuries of medicine have proven that an accurate diagnosis is critical to effective treatment.

REMEMBER

There's also a fine line between supporting your friend and/or relative effectively versus enabling (not discouraging) the addiction. These acts can take the form of financial support (paying bills for them) or other practical supports (offering a place to stay, ensuring healthy eating). Notice that the same actions can be either or both allying and enabling. Much depends on the timing and the context or environment in which the efforts take place. Nonetheless, well-meaning efforts can be enabling if the support given permits the loved one to continue use and prolong addiction. When the person you're aiming to help is in addiction treatment, you can ask for and receive professional advice about how to provide support. If you don't feel you're getting good advice, seek another addiction treatment professional. There is good advice, it just takes seeking it out.

Breaking Through Denial and Codependency

People with addictive difficulties will not get far in recovery without changing their thinking and talking about addiction. Therefore, when having a conversation with your loved one, there's opportunity for these changes to occur. You don't

need to directly talk about addiction because just about everything you might talk about relates to addiction: their current mood, work, all relationships or selective ones, family and personal history, and emotional response patterns. The key to helping your loved one is to listen and remember better than you ever have before.

Everyone wants to be carefully listened to and most everyone feels they're not listened to enough. Keep in mind that addiction functions as a refuge from experiences of rejection and consequent inabilities to communicate. They may have never before sought or received the emotional support they need. These support needs, now near the surface, can be met with consistent and reliable responses from you that are appreciated and effectively contribute to healthy behavior change.

REMEMBER

Your expression of concern invariably involves closer inquiries about what is *actually* happening. Remember that inquiry is not interrogation. Although you may not be getting the whole truth, even the disclosing of a partial truth can help. These inquiries help them examine what's happening more closely. When an addicted person begins to examine their actions closely, it's harder to remain in denial.

One must trust the human instinct for getting down to the truth. Certainly, people reroute thinking and talking to avoid the truth, but it always takes more effort and strain to do so. The avoidance becomes more *un*necessary when you're asking intelligent questions in caring ways. Remember also that it's important to set the stage for your talk. Jumping out with a series of questions may be too far too fast and cause a shut-down rather than an opening up in communication.

While preparing for a talk, you may decide to have the talk over a cup of coffee in the kitchen. In this situation, you may face fewer interruptions and you can sit down and not be rushed or tempted to sandwich this event between others. Have several questions framed in your mind and then surface them, gently, in a kind, non-intrusive way. If you ask about the day, ask for details. Inquire about how work is going and how it's going with managers and peers. Seek more details about the stresses or difficulties that have been passed off as no big deal. Whatever is difficult in your loved one's life, using or abusing or even thinking about the difficulty makes it even more difficult. The more you talk about personal change (including your change when relevant), the more you're addressing the addictive process that's hampering needed change.

REMEMBER

Above all, you want to get your addicted family member or friend to talk. You have to give them a lot of airtime because the first step in persuading someone to think differently is listening. If you listen well, you'll spot conflicts within the person's experience. By continuing to listen, you'll learn how to use your understandings of these personal conflicts and discrepancies to be positively influential.

Overcoming denial

Several decades of research suggest that people go through stages in approaching change. They say yes to some changes and no to others. Denial is a way of saying no to change. And the denial no is almost always accompanied by defensiveness about actually considering the possibility of yes.

When your loved one's addiction is in a destructive phase, their denial can be devastating. You can feel hopeless. But if you want to exert influence over the denial, you must overcome your hopelessness by exploring how the judgment of hopelessness may be ill-founded. You might be aiming for a change that is too far beyond current capacities. You may aim for a pace of change that is too fast. Remember that people's attitudes change at different paces and some change more gradually. There's often a darkest-before-the-dawn pattern, where very strong negative reactions precede a reversal of attitude. People resist more intensively until they finally see the point — then they change rapidly.

REMEMBER

To be influential, you must keep believing that everyone's attitudes can and will change. At times, you must keep trying without even seeing any signs of progress. You may shift strategies, and you may take time off from the struggle, but if you believe there's a true need for change, you can't let efforts lapse. Being helpful, at any given moment, means keeping in view of the long haul — because real change usually takes place during a long haul. Overnight declarations of change may be important, but real changes, sustained for extended periods, are how we evolve into healthier beings.

WARNING

If you feel like you're being a nag, stop now. Nagging fuels resistance. Solely being negative doesn't help — you must offer a positive route. You must act with an unyielding belief in a vision of positive change to be effective. If your vision is hampered by too much discouragement, it's time to take a break from trying. Your resilience will bring you back for another try but for now the empathic load is too great and you're not allying effectively.

Dealing with resistance

Members of families affected by addiction tend to overlook troubles (like abuse) while upholding an artificially positive view of family life. (For more on denial within the family, see Chapter 17.) So when you start talking about what's really going on in your family, get ready to take a stand on what you see to be true.

TIP

Overcoming resistance is a long-haul operation. You may not be successful the first day or first month or the first year. But if counteracting your loved one's addiction is important enough, never let your influence lapse. Ancient Confucian texts refer to the gentle, consistent influence of the wind. Over time, because its influence is continuous, the wind exerts a powerful influence, and over time, every stone is eroded by the wind. Use this approach to exerting your influence — consistency enables effects that are both gentle and powerful.

Fundamentally, you're doing two things that disrupt the status quo. First, you're confronting, rather than avoiding, troubles. And second, you're projecting a realistic, rather than rosy, view of family, self, and individuals. There will likely be resistance to both. Your efforts may not bring rewards initially. The resistance you meet will predictably take several forms and to overcome each one, you will need different resources.

"It's none of your business"

The first type of resistance follows the view that taking a stand (against the addiction you're observing) violates privacy. "Who asked your opinion?" is a question you're likely to be asked when verbalizing concern or validating observations. "It's my business, not yours!" is the defensive phrase you may hear.

In this type of resistance, the addicted person is maintaining that their behavior is contained in a bubble and doesn't affect anyone. Although this is unrealistic, the full defense is that the addiction is a private matter. Although flimsy and flawed, the logic can slow you down to a standstill by making you feel your concerns are illegitimate. This is the point where you need to stick to your guns. Addiction isn't private as it affects family and friends. You have a right to persuade your family member or friend to change their behavior and obtain treatment. You have a responsibility to be concerned and to try to limit the damage.

"You're breaking up the family"

This second form of resistance can come from an addicted family member or other family members. You may hear family members say that the stand you're taking is threatening to break up the family. Consequently, they try to stop your efforts to preserve family harmony.

Here again, persistence is needed. If there's an addiction, it's the addictive process that is breaking up the family. What you're doing in initiating change is the right thing to preserve what is healthy in the family and to possibly extend that healthiness in new directions.

CASE STUDY

JOANNE GETS HELP TO DEAL WITH HER MOTHER'S ALCOHOLISM

Joanne was the eldest of three children whose parents had drinking problems that were allowed to spin out of control. When her father was hospitalized for an unrelated illness, her mother drowned her anxiety and despair in alcohol. Joanne felt abandoned and alone. But she was functioning as the primary caretaker of her younger siblings. She was also no longer able to deny that her mother had a serious problem. Fortunately, she contacted a trusted family friend who referred her to a drug and alcohol counselor. When she confronted her mother with the need to get help, her mother rejected the idea. But she acknowledged that she was not providing enough support for the children during this anxiety-filled period. She agreed to take all the children to see the counselor.

Fortunately, the counselor had extensive experience with the denial problems associated with alcohol abuse. He also had experience counseling families with addicted members. Accordingly, he began counseling the children and relating to their anxieties about what was happening. The younger children and Joanne responded well and began to organize themselves — to caretake each other. Still, their mother was adamant that she neither needed help nor had to stop drinking.

Joanne continued with the counseling, scheduling several personal sessions, and the counselor was willing to advise the family even without obtaining the mother's promise to seek treatment. Gradually Joanne's mother began to respond. A turning point came when Joanne refused to buy her any more liquor. Without an enabler, her mother had to confront the fact that she was drinking heavily, and that her drinking was gravely impairing her capacities as a mother. After several weeks of consistent response, the mother agreed to start treatment.

Preparing for Change

If you're consistent and patient in how you approach your loved one, there will likely come a point when your loved one is ready for change. Sometimes, the signals are indirect and vague. Sometimes, you see a dramatic shift. Sometimes, you feel something shift without being able to put your finger on what it is. Trust your feelings and prepare for change.

What do I mean by "prepare"? No change process is one-directional, as people can move forward, and they can also fall back or relapse to earlier stages. They can

always emerge out of and slip back into denial. So it's important to keep the process meticulously moving forward. You can move slowly and cautiously, while moving ahead.

An important step in preparing your loved one for treatment is to assist the search for the right treatment setting. Any step along the path of change can be a misstep, no matter how positive it starts out or seems. Some people thrive in certain kinds of treatment settings, and others shrivel up in the same ones. As much as possible, work with your friend or loved one to clarify the kind of treatment that is likely to work out the best.

TIP

Carefully review the previous chapters that help you understand the differences in treatment and recovery processes. These include Chapters 7 through 13. If your addicted family member or friend is a teen, be sure to read Chapter 14.

The more you learn, the more able you are to understand the kind of treatment that will produce a positive response in your loved one. You need to especially be there when the whole process feels painful. You will have to supply that extra love and encouragement that often makes the difference between sticking with it versus falling into a relapse.

WARNING

At every step of assistance, you need to consider your own well-being. Make sure you're not getting overwhelmed. Make sure that the empathic load is not weighing you down until you're under water and gasping for air. In efforts to help, you must get enough sleep and rest, and the peace of mind to cultivate a personally healthy life.

Helping Your Loved One Follow Through

Finally, when there's a commitment to enter treatment, and when a choice has been made for the treatment setting, the action begins. Preparation is necessary (as just discussed), but sooner or later, there's a leap into action. There's often a critical period for starting treatment and sustaining treatment. Now the whole family can make a big difference.

Treatment for addiction is a long mountainous climb. There are narrow precipices and slippery surfaces (and beautiful landscapes), and you face important questions about why the climb should persist — and how it should continue. I call it a climb because recovery produces, at times, enormous strains. Healing can be difficult and sometimes it seems like an uphill battle. The hardest part is facing up to and letting go of the negative emotions that frequently arise.

Recognizing negative emotions

Addicted individuals often attempt to escape from emotional difficulties for several years. Most confrontations with emotional upset are delayed or derailed. A process of avoidance builds over time and when treatment is obtained, there are two important departures from previous patterns:

- **Negative emotions are used as signals for problem-solving rather than avoidant navigation.** In treatment, negative emotions are focused on as signals of underlying problems that must be addressed.
- **An accumulated backlog of negative emotion is confronted.** The addicted individual, when in treatment, confronts the bad dealings and angry reactions that accumulated over the entire addiction period. As long as the addictive process continued undisturbed, a precarious balance was maintained that involved the addicted person had a way of communicating that kept negative emotions at bay. Acknowledging an addiction changes that balance. The individual now must relate to negative emotions that are both historical and current, especially when they arise in immediate (present) situations.

WARNING

These changes may have so much impact that treatment can be experienced as just too painful. Your family member may complain that a particular counselor is too hard and too tough or that the whole program is too grim and offers too little hope.

Empathizing: "I feel your pain"

In treatment, your friend or family member must counteract and manage the pain of dealing with all the negative emotions. This may be difficult, but it's crucial to treatment success. The critical tool in your support bucket is *empathy*, an awareness and understanding of the thoughts and feelings of another person. Alliance develops and is fostered when there's authentic empathy.

Perhaps the worst part of emotional pain is that it makes you feel isolated and unworthy. The pain makes you feel you *should* be left alone. Why would anyone want to be in contact with someone so burdened? The pained individual can feel radioactive and toxic.

The addicted person in treatment often feels high levels of pain. You may see the world as promising now that your family member is in treatment, but you're not confronting the same levels of pain and emotional volatility that they are.

When in treatment, life can seem, for the time being, much more painful to your loved one. Your family member can be in so much pain that any chance for a good

life seems impossible — that all that's left is confronting the agony of past mistakes. Under such conditions, the addicted individual can feel unloved and unlovable.

REMEMBER

Although you may feel ready to share your loved one's pain, it's frequently not that simple. Some past bad dealings, under the addictive influence, possibly involved you. You, yourself, carry pain from the effects of past problems. You can't just forget it. You have to deal with it yourself, with or without a counselor. You must get past it, if you truly want to be helpful. Dealing with such pain isn't easy, but it can be incredibly liberating and, ultimately, very healthy.

In other words, empathy begins within you. It begins with the experience of facing and overcoming hurt, and finding good feelings, the feelings of healthy resolution, that exist on the other side of the pain. Once you've started the process, you're ready to be empathic with someone else. You're ready to listen as your family member or friend really tells you what it's like without trying to be polite or have it sound good. You're less likely to turn away or cave in when it gets painful — or when you're having difficulties yourself.

As I've said, you must be ready for the long-term — for the long haul and the long climb upward. It doesn't help to be available just when it's convenient. The important feeling for the person you're trying to help is that you are fundamentally there, in good times and bad. That feeling directly counteracts isolation and unworthiness — and feelings of being unloved and unlovable. *There is magic in empathy and that magic transforms pain.* You also learn from pain when you're empathic and what you learn makes you a more sensitive, responsive, and wholesome person.

REMEMBER

If you need to take time to recoup your energy or resolve an issue for yourself — do it. The point is that empathy, as a resource, starts within and radiates out to others. If you feel empty (which can occur sometimes), focus back on yourself with self-care. Seek the support of others like yourself — family members or friends of people who are similarly struggling with addictive problems.

Supporting Change over the Long-Term

So, it's important to be supportive over the long-term. What does that mean? How long is long-term and how much stress and strain are involved?

The six weeks of helping

I have found in my research that when a family member enters treatment for serious illnesses — like cancer, heart disease, and addiction — most families provide

meaningful support for six weeks. After six weeks, many family members can no longer keep up with the time demands, the emotional demands, and the stressful inconveniences.

After six weeks, the process of addiction treatment is definitely started but nowhere near ended. People involved have an understanding of what full recovery requires. After six weeks of being clean, your family member has had an important taste of what life is like without the plague of addictive behavior.

But this period of six weeks is usually too short a span in relation to how much support is truly needed by a family member suffering from addiction. You often need to support your family member's engagement in treatment for several years — and sometimes for the rest of their life. You have to be realistic about the amount of change involved in recovering thoroughly.

REMEMBER

You don't have to supply all the emotional support yourself. You can find different professionals that provide psychological and social support to individuals in recovery, largely by telephone and sometimes the Internet. These services offer several advantages, the most important one being that services are provided by an excellent counselor who can sustain the relationship for long periods, no matter where the addicted person travels.

Expecting and getting through relapse

The long climb toward life without addiction is often likened to starting a new life. So a series of "firsts" mark progress. The first month, the first return to living in the real world, the first set of temptations to use again that can be resisted, the first six months, and the first year without use. And of course, the first slip and possibly, the first relapse followed by a renewed recovery commitment.

No recovery record is perfect, and most involve, at some time or another, slips and relapses. Whether there's a temporary slip or a turning back to use for significant periods, the difficult processes of acceptance and ultimately, forgiveness, invariably arise.

TIP

I know people who have stopped addictive behaviors and never relapsed (even 20 years later). But I think that if you prepare for a relapse, you do yourself no harm.

From the point of ultimate recovery, relapses are opportunities for personal change. In contrast to consistent addictive behavior (where determining the triggers to use is difficult), the relapse lays bare the anatomy of addiction. Your family member's counselor will be helpful in analyzing the relapse with them and, if necessary, can help you understand it as well.

Even though relapse is part of recovery, relapse is often bitter and upsetting for families. The recovery process is an enormous strain. After all the strain, the added strain of watching a family member or friend slip back into the pit of addiction is nearly unbearable. You can easily feel like washing your hands of the relationship. Relapse can hurt that much.

But this is the difference between immediate support and long-term support. From the perspective of long-term support, your family member's relapse is exactly when they need the most support. Again, the important resource is empathy, which starts with imagining how painful the treatment process must be for the relapse to occur. Although the addicted person often re-engages in denial, you can imagine how difficult things will be when recovery resumes and they come out of denial.

Empathy for your relapsed family member is important, but insistence on the resumption of treatment is essential. Conversations, by necessity, become oriented around several questions:

- When will you re-enter treatment?
- What will it take to convince you to re-enter?
- What is happening now to make you resist getting back into recovery?

Until these questions are properly and thoroughly answered, no additional discussion is of much worth. Empathy, at this stage, must take the form of toughness, with a consistent insistence on solutions being applied as soon as possible. The primary solution is getting back into treatment. There is no other solution.

The Ups and Downs of Change

Up to this point in this chapter, I have discussed how to deal with your addicted family member or friend. Now I focus more broadly on how your family is affected by addiction, and how these effects contribute to ups *and* downs. Not everything in this section will be relevant. But some information will likely fit. When it does, use it to full advantage in helping your loved ones and yourself.

Dropping expectations and falsely positive images

There is one basic idea underlying behavior change in all families: Family members are reacting to each other all the time. As a result, we feel we can take certain

reactions for granted. We develop expectations that a family member always reacts a certain way. What we don't realize is that our expectations influence people to keep reacting the same way.

On the other hand, positive change happens in families when expectations are dropped and realities carefully observed. Change happens when people do things differently — at first, even small things. If you observe the details of how your family operates, you can consistently reinforce small changes until they add up to significant ones.

The process of change is more difficult in families with an addicted member because of the tendencies to deny problems and camouflage them with falsely positive images. In meaningful change, the pattern is reversed. The positive camouflage is lifted, and the underlying personal and family problems are identified and resolved.

Originally, the patterns of denial may have largely related to addictive behaviors. Efforts were directed at denying that the addiction was affecting anyone. Gradually, these patterns progressed to include other situations. Avoiding problems became habitual. The pretense that "everything's fine" became the convenient camouflage.

Turning downs into ups

When interested in change, one deliberately and carefully looks at the downs (the emotional problems) to transform them into ups. It is just the opposite when avoiding change. In these cases, one avoids downs, pretending to see ups without acknowledging that downs are being avoided and edited out of ongoing dialogue.

TIP

If you're going to support positive change in your family, you must be willing to see the downs as opportunities for change. That process begins with yourself and entails mustering the courage to see where your pain is located and to look into your pain until you see and surpass its origins and typical patterns.

One reason you must start with yourself is that when you point out family problems, family members will inevitably point to *your* personal difficulties. You can acknowledge them and then undertake a personal change that models what you want your addicted family member or friend to do.

After the reversal is made and the downs are confronted as transformative opportunities, the pace of change becomes an issue. How much change can occur within a given period? What's too far and too fast and what's too slow? How do the paces of different family members vary? How much time should be devoted to confronting downs versus celebrating the ups?

CASE STUDY

MORE ABOUT JOANNE

Joanne was pleased that both parents entered treatment for alcohol addiction and that her father made a full recovery of his health. She was especially pleased with the results of her own counseling. By trusting her parents to remain in treatment, she was able to direct more attention to her own life. She came to a decision to attend a university in a nearby city and to gradually relax her vigilant observation of her parents, limiting herself to biweekly telephone calls. During these consistent contacts, she was alert for any signs that her parents had resumed drinking and therefore quickly picked up on her father's brief relapse. She joined with her mother in persuading him to resume and intensify his commitment to treatment.

But things were not all positive with Joanne, because she experienced a bout of chronic fatigue halfway through her second semester. It wasn't surprising — she had been through several stressful events. The caretaking of her family had also required a great deal of energy, although there was much less energy expenditure currently. Added to it all were the usual academic demands of student life, and her interest in spending time with the boyfriend she had met during her first semester. For a while, her individual life ran rough, and she had no reserve energy. She also was lacking support from her friends, because most had never had family experiences like those she encountered.

Over time, avoiding the potential codependency trap by making sure that she had a life of her own and with ongoing counseling, she began to return to her natural equilibrium. Her parents continued to progress with treatment, and she was able to trust them to the point where, once again, she asked them for support and guidance.

It had taken 18 months to influence her parents to enter and stay in treatment. She would not have traded the 18 months for anything, but it had been, as she described it, "A long, hard climb with lots of uncertainty."

Sustaining Optimism and Support in Your Family

How do you stay optimistic through it all? How do you keep believing that things will work out for the best? How do you keep believing that treatment will work for your family member, for your family, and yourself?

Leaving fantasy-land to find realistic optimism

Recognize the important difference between optimism propped up by fantasy and optimism that's realistic. Fantasy optimism, in the end, gets you nowhere. It supplies momentum, temporarily, but the momentum fizzles when the grit needed to move forward is denied. It fizzles whenever you put on rose-colored glasses and avoid realities. Realistic optimism, on the other hand, involves envisioning a best-case scenario while continually testing reality. You face all possible disappointments while envisioning positive outcomes.

How does one generate this realistic optimism while dealing with the uncertainties and stresses of addiction?

I believe optimism is a natural human resource. Realistic optimism doesn't need to be propped up by pretense. The more you nourish and understand your strengths and successes, the more resilient your optimism becomes.

Being deserving of victory and success

When I have worked with elite athletes, they generate realistic optimism by training to be "deserving of" victory. In other words, with some guidance, they ingrain in themselves their various strengths and various components of previously exhibited successes. They train and prepare for victory. They may not win, but if they feel deserving of winning in every game or match, they get their share of victories. When they train to deserve victory, their optimism becomes very realistic; after all, their optimism is based on realistic experiences. This optimism proves durable through hard times.

In working with your addicted family member or friend, you must aim to be deserving of success, however success is defined. You must prepare thoroughly, and you must be precise and consistent in whatever you do. You must think every action through and get the best advice for finding the best strategy.

TIP

Above all, while you need to be ready to accept temporary setbacks, you must not personalize them as defeats. After all, it is the addicted loved one who chooses to continue addictive behaviors and not you. Your victory is continuing to believe (based on realistic observations) in the potential for full recovery.

You can develop realistic optimism and, with it, you can positively influence your family member and your family. Your well-directed hard work is needed — and it's all worth it when you experience the victory you deserve.

5 The Part of Tens

IN THIS PART . . .

All *For Dummies* books end with top-ten lists, and this one is no exception. If you are a friend or family member of a loved one who has an addiction, I tell you ten ways you can help your loved one overcome an addiction problem. I also provide a list of resources that offer additional information on overcoming addictions and maintaining recovery.

IN THIS CHAPTER

- Breaking through communication barriers
- Holding back criticisms while sometimes criticizing
- Generating and sustaining optimism
- Focusing on health in mind and body

Chapter 19

Ten Ways to Help a Friend or Loved One

Addiction is so powerful that it often takes a whole family, plus a professional interventionist, to persuade an addicted person to confront the problem that exists. As no addicted person changes unless they *want* to, the addicted person must be persuaded to confront emotions that are largely composed, in the beginning, of suffering.

This chapter focuses on ten key ways you can help a friend or family member recover from an addiction problem. I simultaneously focus on what you can do for *your* mental health while you are helping someone else.

Talk Things Over Truthfully While You Listen Attentively

TIP

Knowing your friend or family member has problems and knowing what the problems *are* involve different levels of understanding. You need to break through communication barriers to find out about the problems so that you become knowledgeable enough to help. There's a natural tendency to make observations and to

make suggestions. It is so important to combine that tendency with very careful listening that enables a creation of words and phrases and bodily gestures that get *through* to and are meaningful to the person you wish to help.

TIP

If you feel something isn't right with your family member or friend, get them to start talking and opening up emotionally. As long as you're listening attentively, you can be certain you'll learn more. The more you listen, the closer they will get to telling you the truths that need to be told. When these truths are shared, you can, as an individual or team member, get them appropriate help.

Recognize the Telltale Signs of Addiction

Does your friend or family member actually have an addiction problem? Here are some signs that they do:

- Forgetting commitments or being frequently, uncharacteristically late
- New illnesses or more frequent illnesses not well explained
- Unexplained work and relationship difficulties
- Increased absences or erratic breaks from established routines
- Spending hours with new friends who keep unusual hours and don't seem to have regular jobs
- Financial troubles
- Memory or concentration problems
- Sleep disturbances or changes in sleep habits
- Surprising secrets whether they are disclosed to you personally or not

If you've noticed one or more of these issues, there's reason for concern. Continue observing more closely. See Chapter 5 for more guidance about the signs that may be of particular concern.

Confront Denial

When confronted about a possible addiction, the most common response from a family member or friend is a sometimes impressive mix of denial and rationalization. Problems that keep occurring are called "temporary" with surprisingly coherent attempts to rationalize them away.

REMEMBER

As frightening as it is to see that a friend or family member is addicted, *acknowledging* it is critical. It is the first step to helping that person onto the road to recovery.

This is where an interventionist can be helpful. An interventionist is a professional who assists family members with their confrontations about the addiction problems observed. The interventionist comes to your home and prepares you and your family to communicate about the suspected addictive patterns. They will lead family meetings where the friend or family member is confronted in a supportive and direct way. The interventionist helps you talk about the addiction and the devastating effects it has been having and will engage everyone concerned. Chapter 9 provides more information on the role of an interventionist.

Help Get Treatment

After your family member or friend acknowledges a needs for treatment, the next step is figuring out what kind(s) of treatment will work best. Sometimes, the best thing you can do is assist in the search for treatment. See Part 3 for information on the variety of treatment methods available. And don't forget to look into alternatives that differ from what's been tested and tried in the mainstream. See Chapter 14 for more information on alternative treatments.

Initially, hospitalization may be necessary to enable safe withdrawal and detoxification. (See Chapter 10 for more information on detoxification.) A residential treatment program may further ensure a good start on the road to recovery with a solid foundation of abstinence. Residential programs can last for 28 days or longer. In some cases, programs may be more brief but still effective. (See Chapter 9.)

Addictions affect every area of a life, and so it may be important to think of a combination of treatments rather than thinking that "this one will do it." Recovery can be lengthy. You have to prepare for the long haul. Self-help approaches may also provide excellent assistance in sustaining progress. Some self-help programs have minor fees, but most operate without any fees. (See Chapter 12 for information on self-help approaches.)

REMEMBER

The addicted person may not be the only one who needs help! You too may need professional assistance. Family members are easily caught up in their loved one's problems, sometimes to the level of codependency.

Codependence can even occur unconsciously when you start behaving in a way that supports your loved one's addiction (by smoothing things over in immediate

situations). Or you can become so enmeshed in your loved one's problems that you forget your own needs. You can pay a high price for too much self-sacrifice. (Refer to Chapter 7 for more information about codependency.)

Let Go of Your Need to Control the Situation

Chapter 18 provides more information on what you can do to *take care of yourself*. Perhaps the hardest lesson is figuring out how to motivate a loved one without trying to become captain of the ship. Also, some of your efforts to support your friend or family member in getting clean may not work until the situation worsens. Why? The addicted person needs to *bottom out,* reaching a point of despair where more use and abuse is no longer optional, and the only alternative left is seeking help and accepting treatment.

Terrifying? Yes, of course. Seeing someone at risk for various harms, prison, and death is terrifying. Dealing with the fall-out of addiction is painful, no matter how strong you are. Here are some pointers on what you can do to take care of your own needs:

- Maintain *your* normal routines.
- Keep up *your* social and recreational activities.
- Find a trusted confidant and talk as much as that person is willing to listen to. Or engage a professional counselor.
- Don't blame yourself for your loved one's problems.
- Acknowledge *your* problems. It may be easier to focus on the problems around you. But you'll feel better and function better after you deal with your own issues.

Hold Criticism at Bay

Criticism often makes addictive problems worse. Criticism provokes greater resistance to change. Your friend or family member knows addictive behavior is unhealthy and dangerous. But the addiction takes hold and is hard or impossible to resist. Your loved one may still be denying they have lost control. Communicate your concern directly without criticism. It may well take more than your voice

alone to motivate this person to get help. But they will listen better if talked to sincerely with minimal criticism. (See Chapter 18 for more about how to communicate directly and supportively.)

Offer Balanced Support

You may hit a wall. You've likely, already been put through a very hard time. Under these circumstances, it may be hard to remain caring and supportive, especially after you've been hurt badly. Sure, deep down, the care is there, but you're only human, and there's also anger and frustration. Don't despair, here are a few tips that may help you continue to give constructive support and care:

- Don't get burnt out from focusing all your efforts on your friend or family member's problems and neglecting your own needs. Balance support for them with self-care. Self-care activities naturally include having fun and being self-nurturing. Self-care also means getting help for your psychological, financial, and physical needs.
- Provide love and support, but be careful not to do things that enable your loved one to continue with the addiction. This is what is meant by *tough love.* For example, you may feel you ought to provide bail money to get your friend or loved one released from jail. But consider whether you're actually prolonging the addiction by softening the penalties. Refer to Chapter 18 for information on the fine line between supporting a loved one and enabling the addiction.

Understand What You're Fighting

This book aims to provide a great deal of information on the nature of addiction and addiction treatment. Take your time in reading it thoroughly. Pace yourself, The more you understand about the nature of addictions, the less overwhelmed you will be by the uncertainties. Knowing about treatment options helps you feel less isolated in the fight against addiction. The various treatment options are described in Part 3 of this book.

TIP

Because of the high prevalence of addictions in this modern age, many communities offer some sort of group therapy and peer support groups for the relatives or loved ones of addicts. Participating in a group session permits you to share experiences with others in your situation and to learn techniques that help you self-nurture and self-sustain despite the addiction.

In Chapter 20, I provide a number of Internet links and reading resources for information on addictions and treatment. You can also find information by going to your favorite Internet search engine and looking for information about treatment.

Remain Optimistic

Optimism is a natural human resource, and a *realistic optimism* won't need to be propped up by pretense or avoidance. The more you grasp and understand your reality and that of your friend or family member, the more resilient your optimism becomes. (See Chapter 18 for more specific guidance on remaining optimistic.)

Because relapse is pretty well a "given," family members should not give up hope and lose optimism about recovery when it happens. Hope and optimism are justified when you remember that many addicted persons eventually overcome addiction. Each positive story you hear teaches you and supports courage *and* optimism. Each relapse is an opportunity for everyone, to learn what to do differently in the next recovery attempt. The addicted person may have to hit bottom (sometimes more than once!) to find the motivation to seriously confront addiction. Treatments that greatly increase the chances of successful recovery are available. The key is matching treatment with individual.

REMEMBER

Part of being realistic is realizing that on the road to recovery, relapse is the norm, not the exception. Most addicted people make several quit attempts before quitting for good. Many continue to slip from time to time even though the slips become fewer with more and more time in-between.

Know What to Do When Treatment Efforts Fail

REMEMBER

Sometimes, the best that you can do for the friend or family member is to reduce the immediate life risk. Chapter 9 discusses various harm-reduction measures. These include strategies such as needle and syringe exchange programs, encouraging safe sex to reduce associated health risks (such as infectious disease), providing drugs like methadone under controlled conditions, and decriminalizing certain substances so the addicted person isn't faced with a lifelong criminal record. The goal of harm-reduction is to reduce the risks of serious health or social consequences associated with addictive behaviors.

IN THIS CHAPTER

- Resources to help you tackle addictions
- Resources for families and friends
- Website links to resources
- Website links to related health problems

Chapter 20

More Than Ten Self-Help Resources

In this chapter, I provide additional resources to help you learn more about addictions and how to overcome them. I also make suggestions for resources to help with problems related to addictions such as anxiety, depression, relationships, and work stress. While these are resources I deem most relevant, you are the final judge of what is relevant to you. You're encouraged to explore other books and websites as you find interesting and worthwhile.

Self-Help Books for Problems Related to Addictions

Beck, Aaron T. *Love Is Never Enough: How Couples Can Overcome Misunderstandings, Resolve Conflicts, and Solve Relationship Problems Through Cognitive Therapy.* New York: HarperPerennial, 1989.

Beck, Aaron T., A. John Rush, Brian F. Shaw, and Gary Emery. *Cognitive Therapy of Depression.* New York: Guilford Press, 1987.

Beck, Aaron T., and Brad A. Alford. *Depression: Causes and Treatment.* Second edition. Philadelphia: University of Pennsylvania Press, 2009.

Bien, Thomas, and Beverly Bien. *Mindful Recovery: A Spiritual Path to Healing from Addiction*. New York: John Wiley & Sons, 2002.

Burns, David D. *The Feeling Good Handbook.* New York: Plume, 1999.

David, Lewis, and Antonia Ryan. *Mindfulness for Alcohol Recovery: Making Peace with Drinking.* Devonshire, England: WinsPress.com, 2021.

Gottman, John M. *Why Marriages Succeed or Fail: And How You Can Make Yours Last.* New York: Simon & Schuster, 1995.

Gottman, John M., and Nan Silver. *The Seven Principles for Making Marriage Work.* New York: Harmony Books, 2015.

Greenberger, Dennis, and Christine A. Padesky. *Mind Over Mood: Change How You Feel by Changing The Way You Think.* New York: Guilford Press, 2016.

Kabat-Zinn, J. and Thich Nhat Hanh. *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness.* New York: Bantam Books, 2013.

Lembke, Anna. *Dopamine Nation: Finding Balance in the Age of Indulgence.* New York: Dutton, 2021.

Morgan, Oliver. *Addiction, Attachment, Trauma and Recovery: The Power of Connection.* New York: W.W. Norton & Company, 2019.

Prochaska, James O., and Janice M. Prochaska. *Changing to Thrive: Using the Stages of Change to Overcome the Top Threats to Your Health and Happiness.* Center City, MN: Hazelden Publishing, 2016.

Segal, Zindel V., J. Mark G. Williams, and John D. Teasdale. *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse*. New York: Guilford Press, 2001.

Straaten, C.W. *The Addiction Recovery Workbook: A 7-Step Master Plan To Take Back Control Of Your Life.* CreateSpace Independent Publishing, 2018.

Williams, Rebecca E., and Julie S. Kraft. *The Mindfulness Workbook for Addiction: A Guide to Coping with the Grief, Stress, and Anger that Trigger Addictive Behaviors*. Oakland, CA: New Harbinger Publications, 2022.

Self-Help Websites for Managing Addictions

The **Secular Organizations for Sobriety (SOS)** has a website (www.sossobriety.org) that provides links to SOS programs worldwide.

You can find information on **Self-Management and Recovery Training (SMART)** at www.smartrecovery.org.

You can obtain information on **Women For Sobriety (WFS)** groups in your community and on other services of WFS at www.womenforsobriety.org.

The **Narconon Network** (www.narconon.org) is an association of over 100 drug rehab and prevention and education centers worldwide.

The **Substance Use Counseling and Education (SUCE) Program** (www.gmhc.org) provides information for gay men who want harm-reduction counseling particularly focused on help with the impact of drug use on sexual behavior.

Christian Recovery International has a website at www.christianrecovery.com.

You can find information on **Jewish Alcoholics, Chemically Dependent People, and Significant Others** at www.jacsweb.org.

Research funded by the **National Institutes of Health** in the United States on treatments for addictions and related topics is provided on the National Institute on Alcohol Abuse and Alcoholism website at www.niaaa.nih.gov.

The **American Society of Addiction Medicine** (www.asam.org) provides information on a wide range of addiction topics as well as links to treatment programs.

Websites for Treatment Models

The U.S. **National Institute on Drug Abuse** (www.drugabuse.gov) is one of the best websites for current research information on drugs and drug treatments. It also offers links for family members and for teens.

Another excellent website for drug and alcohol information for all age groups and for family members is the U.S. **Department of Health and Human Services and SAMHSA Clearinghouse** (www.samhsa.gov/resource-search/ebp).

The **National Alliance for Medication Assisted Recovery** (https://namarecovery.org) provides information on methadone treatments and links to methadone providers across the United States.

The **Drug and Alcohol Prevention Network** (www.drugnet.net) provides links to an extensive array of self-help treatments, treatment centers, research, and other related topics.

Practical Recovery (www.practicalrecovery.com) provides links to non–AA treatment groups and referrals.

The **National Harm Reduction Coalition** website (www.harmreduction.org) provides links to many of the needle exchange programs across the United States.

Alcoholics Anonymous Worldwide (www.aa.org) provides links to AA programs across the world including the United States and Canada.

Oxford House (www.oxfordhouse.org) provides a worldwide directory of Oxford Houses, which are self-managed houses for the twelve-step program.

Cocaine Anonymous (www.ca.org) is a twelve-step program for cocaine addiction.

Marijuana Anonymous (www.marijuana-anonymous.org) is a link to twelve-step programs for overcoming marijuana abuse.

Narcotics Anonymous (https://na.org) is a peer support organization for people recovering from drug addictions. It too is based on the twelve-step program model. Its website provides links to support group meetings held in over 100 countries worldwide.

The **National Council on Problem Gambling** (www.ncpgambling.org) offers information on pathological gambling and provides links to gambling treatment programs.

Peer group support for help with online gaming is offered by **Online Gamers Anonymous** (www.olganon.org).

A group that provides information on recovering from problems with debt is **Debtors Anonymous** (www.debtorsanonymous.org).

Overeaters Anonymous (https://oa.org) offers support based on the twelve-step model.

Greysheeters Anonymous (www.greysheet.org) also offers peer group support for recovering from an overeating problem.

Dealing with emotional problems like depression, anxiety, and compulsive behaviors can feel like a life-long, and possibly lonely, struggle. An organization focused specifically on supporting individuals recovering from emotional problems is **Emotions Anonymous** (www.emotionsanonymous.org).

Several peer support organizations are aimed at helping men and women recover from sex and love addictions. These include **Sexual Addicts Anonymous** (www.sexaa.org); **Sex and Love Addicts Anonymous** (www.slaafws.org); **Sexaholics Anonymous** (www.sa.org); **Sexual Compulsives Anonymous** (www.sca-recovery.org); and **Sexual Recovery Anonymous** (www.sexualrecovery.org).

A twelve-step program-based organization for workaholics is **Workaholics Anonymous** (www.workaholics-anonymous.org).

Websites for Families and Teens

Al-Anon Family Groups (www.al-anon.org) offers twelve-step support for families of alcoholics.

Alateen (www.alateen.com) is a program linked with Al-Anon that provides support to family and children of alcoholics.

Codependents Anonymous (www.coda.org) also offers support and guidance to families and partners of people with addictions. Its specific focus is helping individuals to develop healthy relationships. On its website you can find information on possible meeting groups in your community.

Nar-Anon (www.nar-anon.org) is another peer support group organization for families and partners of people with an addiction that is based on the twelve-step program.

Sexual Recovery Anonymous (www.sexualrecovery.org) provides a link to peer support groups for family members of a sex addict.

Mothers Against Drunk Driving (MADD) is an advocacy group fighting for greater protection against drunk drivers (www.madd.org/home).

Mothers Against Misuse and Abuse (www.mamas.org) is an advocacy and educational group that aims to provide current, scientific education about drug abuse to all ages and that promotes healthier alternatives to drug use.

National Association for Children of Addiction (https://nacoa.org) provides information and links to assistance for children of parents who have alcohol or drug addictions.

Websites for Problems Related to Addictions

The **American Psychiatric Association** (www.psych.org) provides information about mental health problems.

The **American Psychological Association** (www.apa.org) provides information about psychological problems as well as links to related resources.

The **Anxiety Disorders Association of America** (www.adaa.org) provides links to self-help groups for anxiety problems.

The **National Foundation for Depressive Illness** (www.depression.org) provides information on help for depression.

The **National Institutes of Mental Health** (www.nimh.nih.gov) reports research results of studies on mental health issues.

Information on many of the prescription drugs that interact with drinking alcohol is provided at by **Verywell Mind** at http://alcoholism.about.com/library/bldrug_la.htm.

The **American Association for Family and Marriage Therapy** (www.aamft.org) provides information and links to marital and family therapists.

Online Lectures on Addiction-Related Topics

In "All Things Ketamine" (www.youtube.com/watch?v=1igJRZlqy70), Dr. John Krystal, professor of psychiatry, neuroscience, and psychology at Yale University, discusses the use of ketamine in mental and addictive disorders.

In "Pain, Pleasure, and the Addictive Chase for Dopamine" (www.youtube.com/watch?v=lKtX4GC4yOc&t=1176s), Stanford psychiatry professor and author of *Dopamine Nation: Finding Balance in the Age of Indulgence*, Anna Lembke explains why the relentless pursuit of pleasure can lead to pain.

In ""How to Find Balance in the Age of Indulgence" (www.youtube.com/watch?v=aEfkx3DsXjs), Professor Anna Lembke discusses how to moderate compulsive overconsumption in a dopamine-overloaded world.

Treatment Centers

The following are notable treatment centers:

- The Betty Ford Center: www.bettyfordcenter.org
- Hazelden: www.hazelden.org
- ASAP Family: www.asapfamily.com
- Visions Adolescent Treatment Program: www.visionsteen.com
- Caron Foundation: www.caron.org

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About the Author

Dr. Paul Ritvo is a full professor at York University in Toronto, Canada. He is a clinical research psychologist who develops and evaluates online cognitive-behavioral therapies for youth and adults with stress, depression, and addictive disorders.

Dedication

This book is dedicated to families and friends, particularly to my extended family who impart extraordinary lessons each day. It is dedicated to clients who teach with their courage and to the research participants who help us pioneer in mental and physical health recovery.

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