Part II
Learn About the Disease

Seminar # 8

"The disease progresses in stages".

Learning Objectives

1. How is this issue impacting the family members?

2. What response is required?

Introduction

The Addiction Cycle: Addiction can be described as a repeating cycle with **three stages**. Each stage is particularly associated with one of the brain regions described above—basal ganglia, extended amygdala, and prefrontal cortex. But first, it is necessary to explain four behaviors that are central to the addiction cycle: impulsivity, positive reinforcement, negative reinforcement, and compulsivity.

For many people, initial substance use involves an element of impulsivity, or acting without foresight or regard for the consequences. For example, an adolescent may impulsively take a first drink, smoke a cigarette, begin experimenting with marijuana, or succumb to peer pressure to try a party drug. If the experience is pleasurable, this feeling positively reinforces the substance use, making the person more likely to take the substance again. Another person may take a substance to relieve negative feelings such as stress, anxiety, or depression. In this case, the temporary relief the substance brings from the negative feelings negatively reinforces substance use, increasing the likelihood that the person will use again. Importantly, positive, and negative reinforcement need not be driven solely by the effects of the drugs. Many other environmental and social stimuli can reinforce a behavior. For example, the approval of peers positively reinforces substance use for some people. Likewise, if drinking or using drugs with others provides relief from social isolation, substance use behavior could be negatively reinforced.

The positively reinforcing effects of substances tend to diminish with repeated use. This is called tolerance and may lead to use of the substance in greater amounts and/or more frequently to experience the initial level of reinforcement. Eventually, in the absence of the substance, a person may experience negative emotions such as stress, anxiety, or depression, or feel physically ill.

This is called withdrawal, which often leads the person to use the substance again to relieve the withdrawal symptoms. As use becomes an ingrained behavior, impulsivity shifts to compulsivity, and the primary drivers of repeated substance use shift from positive reinforcement (feeling pleasure) to negative reinforcement (feeling relief), as the person seeks to stop the negative feelings and physical illness that accompany withdrawal.15 Eventually, the person begins taking the substance not to get “high,” but rather to escape the “low” feelings to which, ironically, chronic drug use has contributed. Compulsive substance seeking is a key characteristic of addiction, as is the loss of control over use. Compulsivity helps to explain why many people with addiction experience relapses after attempting to abstain from or reduce use.

The three stages:

1. Binge/intoxication,
2. Withdrawal/negative affect,
3. Preoccupation/anticipation

Four Behaviors in the disease progression:

Impulsivity: An inability to resist urges, deficits in delaying gratification, and unreflective decision-making. It is a tendency to act without foresight or regard for consequences and to prioritize immediate rewards over long term goals.

Positive reinforcement: The process by which presentation of a stimulus such as a drug increases the probability of a response like drug taking.

Negative reinforcement: The process by which removal of a stimulus such as negative feelings or emotions increases the probability of a response like drug taking.

Compulsivity: Repetitive behaviors in the face of adverse consequences, and repetitive behaviors that are inappropriate to a particular situation. People suffering from compulsions often recognize that the behaviors are harmful, but they nonetheless feel emotionally compelled to perform them. Doing so reduces tension, stress, or anxiety.

Treatment Stages for Substance Use Disorder

Overview

Adjustments to Make Treatment Appropriate

As clients move through different stages of recovery, treatment must move with them, changing therapeutic strategies and leadership roles with the condition of the clients. These changes are vital since interventions that work well early in treatment may be ineffective, and even harmful, if applied in the same way later in treatment (Flores 2001).

Any discussion of intervention adjustments to make treatment appropriate at each stage, however, necessarily must be oversimplified for three reasons. First, the stages of recovery and stages of treatment will not correspond perfectly for all people. Clients move in and out of recovery stages in a nonlinear process. A client may fall back, but not necessarily back to the beginning. "After a return to substance use, clients usually revert to an earlier change stage—not always to maintenance or action, but more often to some level of contemplation. They may even become pre-contemplators again, temporarily unwilling or unable to try to change . . . [but] a recurrence of symptoms does not necessarily mean that a client has abandoned a commitment to change" (Center for Substance Abuse Treatment 1999b, p. 19). See chapters 2 and 3 for a discussion of the stages of change.

A return to drug use, properly handled, can even be instructive. With guidance, clients can learn to recognize the events and situations that trigger renewed substance use and regression to earlier stages of recovery. This knowledge becomes helpful in subsequent attempts leading to eventual recovery. Client progress-regress-progress waves, however, require the counselor to constantly reevaluate where the client is in the recovery process, irrespective of the stage of treatment.

> Second, adjustments in treatment are needed because progress through the stages of recovery is not timebound. There is no way to calculate how long any individual should require resolving the issues that arise at any stage of recovery. The result is that different group members may achieve and be at different stages of recovery at the same time in the lifecycle of the group. The group leader, therefore, should use interventions that take the group into account.
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> Third, therapeutic interventions, meaning the acts of a clinician intended to promote healing, may not account for all

(or any) of the change in an individual. Some people give up drugs or alcohol without undergoing treatment. Thus, it is an error to assume that an individual is moving through stages of treatment because of assistance at every point from institutions and self-help groups. To stand the best chance for meaningful intervention, a leader should determine where the individual best fits in his level of function, stance toward abstinence, and motivation to change. In short, generalizations about stages of treatment may not apply to every client in every group.

The Early Stage of Treatment

Condition of Clients in Early Treatment

In the early stage of treatment, clients may be in the precontemplation, contemplation, preparation, or early action stage of change, depending on the nature of the group. Regardless of their stage in early recovery, clients tend to be ambivalent about ending substance use. Even those who sincerely intend to remain abstinent may have a tenuous commitment to recovery. Further, cognitive impairment from substances is at its most severe in these early stages of recovery, so clients tend to be rigid in their thinking and limited in their ability to solve problems. To some scientists, it appears that the "addicted brain is abnormally conditioned, so that environmental cues surrounding drug use have become part of the addiction" (Leshner 1996, p. 47).

Typically, people who abuse substances do not enter treatment on their own. Some enter treatment due to health problems, others because they are referred or mandated by the legal system, employers, or family members (Milgram and Rubin 1992). Group members commonly are in extreme emotional turmoil, grappling with intense emotions such as guilt, shame, depression, and anger about entering treatment.

Even if clients have entered treatment voluntarily, they often harbor a desire for substances and a belief that they can return to recreational use once the present crisis subsides. At first, most clients comply with treatment expectations more from fear of consequences than from a sincere desire to stop drinking or using illicit drugs (Flores 1997; Johnson 1973).

Consequently, the group leader faces the challenge of treating resistant clients. In general, resistance presents in one of two ways. Some clients actively resist treatment. Others passively resist. They are outwardly cooperative and go to great lengths to give the impression of willing engagement in the treatment process, but their primary motivation is a desire to be free from external pressure. The group leader has the delicate task of exposing the motives behind the outward compliance.

The art of treating addiction in early treatment is in the defeat of denial and resistance, which almost all clients with addictions carry into treatment. Group therapy is considered an effective modality for …overcoming the resistance that characterizes addicts. A skilled group leader can facilitate members' confronting each other about their resistance. Such confrontation is useful because it is difficult for one addict to deceive another.

Because addicts usually have a history of adversarial relationships with authority figures, they are more likely to accept information from their peers than a group leader. A group can also provide addicts with the opportunity for mutual aid and support; addicts who present for treatment are usually well connected to a dysfunctional subculture but socially isolated from healthy contacts (Milgram and Rubin 1992, p. 96).

Emphasis therefore is placed on acculturating clients into a new culture, the culture of recovery (Kemker et al. 1993).

Therapeutic Strategies in Early Treatment

In 1975, Irvin Yalom elaborated on earlier work and distinguished 11 therapeutic factors that contribute to healing as group

therapy unfolds:

Instilling hope—some group members exemplify progress toward recovery and support others in their efforts, thereby helping to retain clients in therapy.

Universality—groups enable clients to see that they are not alone, that others have similar problems.

Imparting information—leaders shed light on the nature of addiction via direct instruction.

Altruism—group members gain greater self-esteem by helping each other.

Corrective recapitulation of the primary family group—groups provide a family-like context in which long-standing unresolved conflicts can be revisited and constructively resolved.

Developing socializing techniques—groups give feedback; others' impressions reveal how a client's ineffective social habits might undermine relationships.

Imitative behavior—groups permit clients to try out new behavior of others.

Interpersonal learning—groups correct the distorted perceptions of others.

Group cohesiveness—groups provide a safe holding environment within which people feel free to be honest and open with each other.

Catharsis—groups liberate clients as they learn how to express feelings and reveal what is bothering them.

Existential factors—groups aid clients in coming to terms with hard truths, such as (1) life can be unfair; (2) life can be painful and death is inevitable; (3) no matter how close one is to others, life is faced alone; (4) it is important to live honestly and not get caught up in trivial matters; (5) each of us is responsible for the ways in which we live.

In different stages of treatment, some of these therapeutic factors receive more attention than others. For example, in the beginning of the recovery process, it is extremely important for group members to experience the therapeutic factor of universality. Group members should come to recognize that although they differ in some ways, they also share profound connections and similarities, and they are not alone in their struggles.

The therapeutic factor of hope also is particularly important in this stage. For instance, a new member facing the first day without drugs may come into a revolving membership group that includes people who have been abstinent for 2 or 3 weeks. The mere presence of people able to sustain abstinence for days—even weeks—provides the new member with hope that life can be lived without alcohol or illicit drugs. It becomes possible to believe that abstinence is feasible because others are obviously succeeding.

Imparting information often is needed to help clients learn what needs to be done to get through a day without chemicals. Psychoeducation also allows group members to learn about addiction, to judge their practices against this information, and to postpone intense interaction with other group members until they are ready for such highly charged work. Attention to group cohesiveness is important early in treatment because only when group members feel safety and belonging within the

group will they be able to form an attachment to the group and fully experience the effects of new knowledge, universality, and hope.

Therapeutic factors such as catharsis, existential factors, or recapitulation of family groups generally receive little attention in early treatment. These factors often are highly charged with emotional energy and are better left until the group is well established.

During the initial stage of treatment, the therapist helps clients acknowledge and understand how substance abuse has dominated and damaged their lives. Drugs or alcohol, in various ways, can provide a substitute for the give-and-take of relationships and a means of surviving without a healthy adjustment to life. As substances are withdrawn or abandoned, clients give up a major source of support without having anything to put in its place (Brown 1985; Straussner 1997).

In this frightening time, counselors need to ensure that the client has a sense of safety. The group leader's task is to help group members recognize that while alcohol or illicit drugs may have provided a temporary way to cope with problems in the past, the consequences were not worth the price, and new, healthier ways can be found to handle life's problems.

In early-stage treatment, strong challenges to a client's fragile mental and emotional condition can be very harmful. Out of touch with unmedicated feelings, clients already are susceptible to wild emotional fluctuations and are prone to unpredictable responses. Interpersonal relationships are disturbed, and the effects of substances leave the client prone to use "primitive defensive operations such as denial, splitting, projective identification, and grandiosity" (Straussner 1997, p. 68). This vulnerable time, however, is also one of opportunity. In times of crisis, "an individual's attachment system opens up" and the therapist has a chance to change the client's internal dynamics (Flores 2001, p. 72). Support networks that can provide feedback and structure are especially helpful at this stage.

A Note on Attachment Theory and Substance Abuse Treatment

Attachment theory provides a comprehensive meta-theory of addiction that not only integrates diverse mental health models with the disease-concept, but also furnishes guidelines for clinical practice that are compatible with existing addiction treatment strategies including an abstinence basis and alignment with 12-Step treatment philosophy.

Attachment theory (Bowlby 1979) and self-psychology (Kohut 1977b) provided the first compelling theories that offered a practical alternative rationale for the addiction cycle that is not only compatible with the disease concept but expands it by providing a more complete and intellectually satisfying theoretical explanation why Alcoholic Anonymous (AA) works as it does.

According to the theory, attachment is recognized as a primary motivational force with its own dynamics, and these dynamics have far-reaching and complex consequences (Bowlby 1979). In clients with substance use disorders there is an inverse relation between their substance abuse and healthy interpersonal attachments. A person who is actively abusing substances can rarely negotiate the demands of healthy interpersonal relationships successfully.

Using this theoretical model, substance abuse can be viewed as an attachment disorder. Individuals who have difficulty establishing intimate attachments will be more inclined to substitute substances for their deficiency in intimacy. Because of their difficulty maintaining emotional closeness with others, they are more likely to substitute various behaviors (including substance abuse) to distract them from their lack of intimate interpersonal relations.

The use of substances may initially serve a compensatory function, helping those who feel uncomfortable in social situations because of inadequate interpersonal skills. However, substances of abuse will gradually compromise neurophysiological functioning and erode existing interpersonal skills. Managing relationships tends to become increasingly difficult, leading to a heightened reliance on substances, which accelerates deterioration and increases abuse and dependence. Eventually, the individual's relationship with substances of abuse becomes both an obstacle to and a substitute for interpersonal attachments. If problems in attachment are a primary cause of substance abuse, then a therapeutic process that addresses the client's

interpersonal relations will be effective for long-term recovery (Flores 2001; Straussner 1993).

Treatment concentrates on removing stress-inducing stimuli, teaching ways to recognize and quell environmental cues that trigger inappropriate behaviors, providing positive reinforcement and support, cultivating positive habits that endure, and developing secure and positive attachments.

Currently, clients are solidifying their "new identity as an alcoholic with the corresponding belief in loss of control." They develop "a new logical structure" with which to assail their "former logic and behavior." They also can develop a "new story . . . the Alcoholics Anonymous drunkalogue," which recalls their experiences and compares previous events.

Whether information is offered through skills groups, psychoeducational groups, supportive therapy groups, spiritually oriented support groups, or process groups, clients are most likely to use the information and tools provided in an environment alive with supportive human connections. All possible sources of positive forces in a client's life should be marshaled to help the client manage life's challenges instead of turning to substances or other addictive behaviors.

Painful feelings, which clients are not yet prepared to face, can sometimes trigger relapse. If relapses occur in an outpatient setting—as they often do, because relapses occur in all chronic illnesses, including addiction—the group member should be guided through the regression. The leader encourages the client to attend self-help groups, explores the sequence of events leading to relapse, determines what cues led to relapse, and suggests changes that might enable the client to manage cravings better or avoid exposure to strong cues.

For some clients, chiefly those mandated into treatment by courts or employers, grave consequences inevitably ensue because of relapse. As Vannicelli (1992) points out, however, clinicians should view relapse not as failure, but as a clinical opportunity for both group leader and clients to learn from the event, integrate the new knowledge, and strengthen levels of motivation. Discussion of the relapse in group not only helps the individual who relapsed learn how to avoid future use, but it also gives other group members a chance to learn from the mistakes of others and to avoid making the same mistakes themselves.

A Standard for Good Leadership in Early Treatment

Clients usually come to the first session of group in an anxious, apprehensive state of mind, which is intensified by the knowledge that they will soon be revealing personal information and secrets about themselves. The therapist begins by making it clear that clients have some things in common. All have met with the therapist, have acceded to identical agreements, and have set out to resolve important personal issues. Usually, the therapist then suggests that members get to know each other. One technique is to allow the members to decide exactly how they will introduce themselves. The therapist observes silently—but not impassively—watching how interaction develops (Rutan and Stone 2001).

During early treatment, a relatively active leader seeks to engage clients in the treatment process. Clients early on "usually respond more favorably to the group leader who is spontaneous, 'alive,' and engaging than they do to the group leader who adopts the more reserved stance of technical neutrality associated with the more classic approaches to group therapy" (Flores 2001, p. 72). The leader should not be overly charismatic but should be a strong enough presence to meet clients' dependency needs during the early stage of treatment.

During early treatment, the effective leader will focus on immediate, primary concerns: achieving abstinence, preventing relapse, and learning ways to manage cravings. The leader should create an environment that enables clients to acknowledge that (1) their use of addictive substances was harmful and (2) some things they want cannot be obtained while their pattern of substance use continues. As clients take their first steps toward a life centered on healthy sources of satisfaction, they need strong support, a high degree of structure, positive human connections, and active leadership.

In process groups, the leader pays particular attention to feelings in the early stage of treatment. Many people with addiction histories are not sure what they feel and have great difficulty communicating their feelings to others. Leaders begin to help group members move toward affect regulation by labeling and mirroring feelings as they arise in group work. The leader's subtle instruction and empathy enables clients to begin to recognize and own their feelings. This essential step toward managing feelings also leads clients toward empathy with the feelings of others.

The Middle Stage of Treatment

Condition of Clients in Middle-Stage Treatment

Often, in as little as a few months, institutional and reimbursement constraints limit access to ongoing care. People with addiction histories, however, remain vulnerable for much longer and continue to struggle with dependency. They need vigorous assistance maintaining behavioral changes throughout the middle, or action, stage of treatment.

Several studies (Committee on Opportunities in Drug Abuse Research 1996; London et al. 1999; Majewska 1996; Paulus et al. 2002; Strickland et al. 1993; Volkow et al. 1988, 1992) have observed decreased blood flow and metabolic changes rates in the brains of subjects who abused stimulants (cocaine and methamphetamine). The studies also found that deficits persisted for at least 3 to 6 months after cessation of drug use. Whether these deficits predated substance abuse or not, treatment personnel should expect to see clients with impaired decision making and impulse control manifested by difficulties in attending, concentrating, learning new material, remembering things heard or seen, producing words, and integrating visual and motor cues. For the clinician, this finding means that clients may not have the mental structures in place to enable them to make the difficult decisions faced during the action stage of treatment. If clients draw and use support from the group, however, the client's affect will re-emerge, combine with new behaviors and beliefs, and produce an increasingly stable and internalized structure (Brown 1985).

Cognitive capacity usually begins to return to normal in the middle stage of treatment. The frontal lobe activity in a person addicted to cocaine, for example, is dramatically different after approximately 4–6 months of nonuse. Still, the mind can play tricks. Clients distinctly may remember the comfort of their substance past yet forget just how bad the rest of their lives were and the seriousness of the consequences that loomed before they came into treatment. As a result, the temptation to relapse remains a concern.

Therapeutic Strategies in Middle-Stage Treatment

In middle-stage recovery, as the client experiences some stability, the therapeutic factors of self-knowledge and altruism can be emphasized. Universality, identification, cohesion, and hope remain important as well.

Practitioners have stressed the need to work in alliance with the client's motivation for change. The therapist uses whatever leverage exists—such as current job or marriage concerns—to power movement toward change. The goal is to help clients perceive the causal relationship between substance abuse and current problems in their lives. Counselors should recognize and respect the client's position and the difficulty of change. The leader who leaves group members feeling that they are understood is more likely to be able to influence change, while sharp confrontations that arouse strong emotions and appear judgmental may trigger relapse (Flores 1997).

Therapeutic strategies also should consider the important role substance abuse has played in the lives of people with addictions. Often, from the client's perspective, drugs of abuse have become their best friends. They fill hours of boredom and help them cope with difficulties and disappointments. As clients move away from their relationship with their best friend, they may feel vulnerable or emotionally naked, because they have not yet developed coping mechanisms to negotiate life's inevitable problems. It is crucial that clients recognize these feelings as transient and understand that the feeling that something vital is missing can have a positive effect. It may be the impetus that clients need to adopt new behaviors that are adaptive, safe, legal, and rewarding.

As the recovering client's mental, physical, and emotional capacities grow stronger, emotions of anger, sadness, terror, and grief may be expressed more appropriately. Clients need to use the group as a means of exploring their emotional and interpersonal world. They learn to differentiate, identify, name, tolerate, and communicate feelings. Cognitive–behavioral interventions can provide clients with specific tools to help modulate feelings and to become more confident in expressing and exploring them. Interpersonal process groups are particularly helpful in the middle stage of treatment, because the authentic relationships within the group enable clients to experience and integrate a wide range of emotions in a safe environment.

When strong emotions are expressed and discussed in group, the leader needs to modulate the expression of emerging feelings, delicately balancing a tolerable degree of expression and a level so overwhelming that it inhibits positive change or leads to a desire to return to substance use to manage the intensity. It also is especially important for the group leader to "sew the client up" by the end of the session. Clients should not leave feeling as if they are "bleeding" emotions that they cannot cope with or dispel. A plan for the rest of the day should be developed, and the increased likelihood of relapse should be acknowledged so group members see the importance of following the plan.

Leadership in Middle-Stage Treatment

Historically, denial has been the target of most treatment concepts. The role of the leader was primarily to confront the client in denial, thereby presumably provoking change. More recently, clinicians have stressed the fact that "confrontation, if done too punitively or if motivated by a group leader's countertransference issues, can severely damage the therapeutic alliance" (Flores 1997, p. 340). Inappropriate confrontation may even strengthen the client's resistance to change, thereby increasing the rigidity of defenses.

When it is necessary to point out contradictions in clients' statements and interpretations of reality, such confrontations should be well-timed, specific, and indisputably true. For example, author Wojciech Falkowski had a client whose medical records distinctly showed abnormal liver functions. When the client maintained that he had no drinking problem, Falkowski gently suggested that he "convince his liver of this fact." The reply created a ripple of amusement in the group, and "the

client immediately changed his attitude in the desired direction" (Falkowski 1996, p. 212). Such caring confrontations made at the right time and in the right way are helpful, whether they come from group members or the leader.

Another way of understanding confrontation is to see it as an outcome rather than as a style. From this point of view, the leader helps group members see how their continued use of drugs or alcohol interferes with what they want to get out of life. This recognition, supported by the group, motivates individuals to change. It seems that people who abuse substances need someone to tell it like it is "in a realistic fashion without adopting a punitive, moralistic, or superior attitude" (Flores 1997, p. 340).

In the middle stage of treatment, the leader helps clients join a culture of recovery in which they grow and learn. The leader's task is to engage members actively in the treatment and recovery process. To prevent relapse, clients need to learn to monitor their thoughts and feelings, paying special attention to internal cues. Both negative and positive dimensions may be motivational. New or relapsed group members can remind others of how bad their former lives really were, while the group's vision of improvements in the quality of life is a distinct and immediate beam of hope.

The leader can support the process of change by drawing attention to new and positive developments, pointing out how far clients have traveled, and affirming the possibility of increased connection and new sources of satisfaction. Leaders should bear in mind, however, that people with addictions typically choose immediate gratification over long-range goals, so benefits achieved and sought after should be real, tangible, and quickly attainable.

The benefits of recovery yield little satisfaction to some clients, and for them, the task of staying on course can be difficult. Their lives in recovery seem worse, not better. Many experience depression, lassitude, agitation, or anhedonia (that is, a condition in which formerly satisfying activities are no longer pleasurable). Eventually, their lives seem devoid of any meaningful purpose, and they stop caring about recovery.

These clients may move quickly from "I don't care" to relapse, so the group leader should be vigilant and prepared to intervene when a client is doing all that should be done in the recovery process yet continues to feel bleak. Such clients need attention and accurate diagnosis. Do they have an undiagnosed co-occurring disorder? Do they need antidepressants? Do they need more intensive, frequent, adjuncts to therapy, such as more Alcoholics Anonymous or Narcotics Anonymous meetings and additional contacts with a sponsor?

Leaders need to help group members understand and accept that many forms of therapy outside the group can promote recovery. Group members should be encouraged to support each other's efforts to recover, however much their needs and treatment options may differ.

The leader helps individuals assess the degree of structure and connection they need as recovery progresses. Some group members find that participation in religious or faith groups meets their needs for affiliation and support. For long-term, chronically impaired people with addictive histories, highly intensive participation in 12-Step groups is usually essential for an extended period.

The Late Stage of Treatment

Condition of Clients in Late-Stage Treatment

During the late (also referred to as ongoing or maintenance) stage of treatment, clients work to sustain the attainments of the action stage, but also learn to anticipate and avoid tempting situations and triggers that set off renewed substance use. To deter relapse, the systems that once promoted drinking and drug use are sought out and severed.

Despite efforts to forestall relapse, many clients, even those who have reached the late stage of treatment, do return to substance use and an earlier stage of change. In these cases, the efforts to guard against relapse were not all in vain. Clients who return to substance abuse do so with new information. With it, they may be able to discover and

acknowledge that some of the goals they set are unrealistic, certain strategies attempted are ineffective, and environments deemed safe are not at all conducive to successful recovery. With greater insight into the dynamics of their substance abuse, clients are better equipped to make another attempt at recovery, and ultimately, to succeed.

As the substance abuse problem fades into the background, significant underlying issues often emerge, such as poor self-image, relationship problems, the experience of shame, or past trauma. For example, an unusually high percentage of substance and alcohol abuse occurs among men and women who have survived sexual or emotional abuse. Many such cases warrant an exploration of dissociative defenses and evaluation by a knowledgeable mental health professional.

When the internalized pain of the past is resolved, the client will begin to understand and experience healthy mutuality, resolving conflicts without the maladaptive influence of alcohol or drugs. If the underlying conflicts are left unresolved, clients are at increased risk of other compulsive behavior, such as excessive exercise, overeating, or gambling.

Therapeutic Strategies in Late-Stage Treatment

In the early and middle stages of treatment, clients necessarily are so focused on maintaining abstinence that they have little or no capacity to notice or solve other kinds of problems. In late-stage treatment, however, the focus of group interaction broadens. It attends less to the symptoms of drug and alcohol abuse and more to the psychology of relational interaction.

In late-stage treatment, clients begin to learn to engage in life. As they begin to manage their emotional states and cognitive processes more effectively, they can face situations that involve conflict or cause emotion. A process-oriented group may become appropriate for some clients who are finally able to confront painful realities, such as being an abused child or abusive parent. Other clients may need groups to help them build a healthier marriage, communicate more effectively, or become a better parent. Some may want to develop new job skills to increase employability.

Some clients may need to explore existential concerns or issues stemming from their family of origin. These emphases do not deny the continued importance of universality, hope, group cohesion and other therapeutic factors. Instead, it implies that as group members become more and more stable, they can begin to probe deeper into the relational past. The group can be used in the here and now to settle difficult and painful old business.

THE THREE STAGE OF DISEASE PROGRESSION:

The binge/intoxication stage: of the addiction cycle is the stage at which an individual consumes the substance of choice. This stage heavily involves the basal ganglia and its two key brain subregions, the nucleus accumbent and the dorsal striatum. In this stage, substances affect the brain in several ways.

The withdrawal/negative affect stage: of addiction follows the binge/intoxication stage, and, in turn, sets up future rounds of binge/intoxication. During this stage, a person who has been using alcohol or drugs experiences withdrawal symptoms, which include negative emotions and, sometimes, symptoms of physical illness, when they stop taking the substance. Symptoms of withdrawal may occur with all addictive substances, including marijuana, though they vary in intensity and duration depending on both the type of substance and the severity of use. The negative feelings associated with withdrawal are thought to come from two sources: diminished activation in the reward circuitry and activation of the brain's stress systems.

Preoccupation/Anticipation Stage: The preoccupation/anticipation stage of the addiction cycle is the stage in which a

person may begin to seek substances again after a period of abstinence. In people with severe substance use disorders, that period of abstinence may be quite short (hours). In this stage, an addicted person becomes preoccupied with using substances again. This is commonly called "craving." Craving has been difficult to measure in human studies and often does not causally link with relapse. This stage of addiction involves the brain's region that controls executive function: the ability to organize thoughts and activities, prioritize tasks, manage time, make decisions, and regulate one's own actions, emotions, and impulses. Executive function is essential for a person to make appropriate choices about whether to use a substance and to override often strong urges to use, especially when the person experiences triggers, such as stimuli associated with that substance (e.g., being at a party where alcohol is served or where people are smoking) or stressful experiences

The Story

VIDEO ONE

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Matrix Pt III ROADMAP FOR RECOVERY

Educates family members of those in recovery about substance abuse disorders. Three sessions cover triggers and cravings; phases of recovery; and typical family reactions to the stages of addiction and recovery and how they can best support their loved one.

VIDEO TWO

Search Title: Roadmap for Recovery (Part 1): Recovery Begins With Withdrawal

This video presents the four stages of recovery—withdrawal, early abstinence, protracted abstinence, and adjustment and resolution. It explains what people in recovery and their families, friends, and loved ones can do during each stage to make the journey more successful. **Duration: 5:23 min**

The stages of progression to ask

What is the diagnosis?

_____

_____

What assessment tool was use and what were its findings?

_____

_____

What is their current stage? (for each diagnosis, medical, mental health, and addiction)

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_____

What is the current plan of care? (Coordination between the different discipline)

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_____

What is the current plan of treatment? (For each diagnosis, medical, mental health, and addiction)

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Plan of Care and Plan of Treatment are interchangeable. However, we are asking about the plan of care and we want to know what steps are being taken to coordinate the plan between the medical team with what is being done by the Mental Health

team and what is being done with the Addiction treatment team. How well are they collaborating to create a holistic level of care, because all three disciples are involved.

Reference Publications:

NIDA's Special Initiatives for Students, Teachers, and Parents Heads Up: Real News About Drugs and Your Body—A drug education series created by NIDA and SCHOLASTIC INC. for students in grades 6 to 12. www.headsup.scholastic.com

NIDA for Teens: The Science Behind Drug Abuse—An interactive Web site geared specifically to teens, with age-appropriate facts on drugs. www.teens.drugabuse.gov Drug Facts Chat Day— A Web chat between NIDA scientists and teens, held through school computer labs once a year during National Drug Facts Week (below). www.drugabuse.gov/chat

National Drug Facts Week— A week-long observance that encourages community-based events and dialogue between teens and scientists during National Drug Facts Week (below). www.drugfactsweek.drugabuse.gov/

Publications on Prevention and Treatment Principles Preventing Drug Use among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community

Leaders—NIDA's research-based guide for preventing drug abuse among children and adolescents provides 16 principles derived from effective drug-prevention research and includes answers to questions on risk and protective factors as well as on community planning and implementation.

Principles of Drug Addiction Treatment: A Research-Based Guide—This guide summarizes the 13 principles of effective treatment, answers common questions, and describes types of treatment, providing examples of scientifically based and tested treatment components.

The Family Plan of Action

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1. The family members will name which of the three (3) stages of SUD disease progression in the brain is current for their loved one.
2. The family members will identify which of the four behaviors in SUD disease progression their loved one is currently presenting.
3. The family will identify which of the brains thinking skills are being compromised by the disease as seen from their current behavior.