Part III

"The Pathfinder Certificate of Completion Seminar"

Seminar # 19

Issue # Ten of 12 key Issues: Successful Lifelong Recovery

Seminar Objectives:

1. Four main ideas in relapse presentation.
2. Learn the Stages of Recovery
3. How to create a strong support system

Introduction

Substance abuse and addiction can damage family dynamics, erode trust, and weaken communication. Family members who experience a loved one battling with a substance use disorder often endure a host of painful emotions. Equally frustrating is the hopelessness loved ones feel in response to substance abuse. Family members may feel at a loss when seeing a loved one caught in the grips of substance abuse. For example, stumbling upon burnt spoons and used syringes can create a paralyzing feeling of fear and shock.

When individuals are in recovery, they need support and encouragement to strengthen their resolve. The strongest forms of support and nurturing come from those closest to us. Family members often represent our closest connections, and even in instances where there is tension and strife between family members, the bonds often remain very salient.

Maintaining strong family bonds or reinforcing bonds that are stressed or damaged is extremely important for an individual in recovery. Research indicates that strong family support is one of the most important aspects of recovery. Strong family bonds reinforce the notion that the recovering individual is not alone and can rely on others to help them through the rough times.

The relapse process causes the addict to feel pain and discomfort when not using. This pain and discomfort can become so bad that the addict becomes unable to live normally when not using. In Alcoholics Anonymous this is called a dry drunk, but the syndrome is recognized in all areas of addiction and is in essence, abstinence without recovery. The discomfort can become so bad that the addict feels that using cannot be any worse than the pain of staying clean.

PHASE 1: RETURN OF DENIAL.

During this phase, the addict becomes unable to recognize and honestly tell others what s/he is thinking or feeling. The most common symptoms are:

1. Concern about well-being: The addict feels uneasy, afraid, and anxious. At times s/he is afraid of not being able to stay drug-free. This uneasiness comes and goes, and usually lasts only a short time.

2. Denial of the concern: To tolerate these periods of worry, fear and anxiety, the addict ignores or denies these feelings in the same way s/he had at other times denied being addicted. The denial may be so strong that there is no awareness of it while it is happening. Even when there is awareness of the feelings, they are often forgotten as soon as the feelings are gone. It is only when the addict thinks back about the situation later that s/he can recognize the feelings of anxiety and the denial of those feelings.

PHASE 2: AVOIDANCE AND DEFENSIVE BEHAVIOUR.

During this phase, the addict does not want to think about anything that will cause the painful and uncomfortable feelings to come back. As a result, s/he begins to avoid anything or anybody that will force an honest look at self. When asked direct questions about well-being, s/he tends to become defensive. The most common symptoms are:

3. Believing "I'll never use again": The addict convinces self that s/he will never use again and sometimes will tell this to others, but usually keeps it to self. Many are afraid to tell their counsellors or other fellowship members about this belief. When the addict passionately believes s/he will never use again, the need for a daily recovery programmed seems less important.

4. Worrying about others instead of self: The addict becomes more concerned with the recovery of others than with personal recovery. S/he does not talk directly about these concerns, but privately judges the recovery programmed of other recovering persons. In the fellowship this is called "working the other guy's programmed".

5. Defensiveness: The addict tends to defend when talking about personal problems, feelings or his/her recovery programmed even when no defense is necessary.

6. Compulsive behavior: The addict becomes compulsive ("stuck" or "fixed" or "rigid") in the way s/he thinks and behaves. There is a tendency to do the same things repeatedly without a good reason. There is a tendency to control conversations either by talking too much or not talking at all. S/he tends to work more than is needed, becomes involved in many activities and may appear to be the model of recovery because of heavy involvement in Fellowship 12 step work e.g., chairing meetings. S/he is often a leader in counselling groups by "playing therapist." Casual or informal involvement with people however is avoided.

7. Impulsive behavior: Sometimes the rigid behavior is interrupted by actions taken without thought or self-control. This usually happens at times of high stress. Sometimes these impulsive actions cause the addict to make decisions that seriously damage his/her life and recovery programmed.

8. Tendencies towards loneliness: The addict begins to spend more time alone. S/he usually has good reasons and excuses for staying away from other people. These periods of being alone begun to occur more often and the addict begins to feel more and more lonely. Instead of dealing with the loneliness by trying to meet and be around other people, he or she becomes more compulsive and impulsive.

PHASE 3: CRISIS BUILDING

During this phase, the addict begins experiencing a sequence of life problems that are caused by denying personal feelings, isolating self, and neglecting the recovery programmed. Even though S/he wants to solve these problems and works hard at it, two new problems pop up to replace every problem that is solved. The most common symptoms are.

9. Tunnel vision: Tunnel vision is seeing only one small part of life and not being able to see "The big picture." The addict looks at life as being made up of separate, unrelated parts. S/he focuses on one part without looking at other parts or how they are related. Sometimes this creates the mistaken belief that everything is secure and going well. At other times, this results in seeing only what is going wrong. Small problems are blown up out of proportion. When this happens, the addict comes to believe s/he is being treated unfairly and has no power to do anything about it.

10. Minor depression: Symptoms of depression begin to appear and to persist. The person feels down, blue, listless, empty of feelings. Oversleeping becomes common. S/he can distract self from these moods by getting busy with other things and not talking about the depression.

11. Loss of constructive planning: The addict stops planning each day and the future. S/he often mistakes the slogan "One day at a time" to mean that one should not plan or think about what s/he is going to do. Less and less attention is paid to details. S/he becomes listless. Plans are based more on wishful thinking (how the addict wishes things would be) than reality (how things really are)

12. Plans begin to fail: Because s/he makes plans that are not realistic and does not pay attention to details, plans begin to fail. Each failure causes new life problems. Some of these problems are like the problems that had occurred during using. S/he often feels guilty and remorseful when the problems occur.

PHASE 4. IMMOBILISATION

During this phase, the addict is totally unable to initiate action. S/he goes through the motions of living but is controlled by life rather than controlling his/her life. The most common symptoms are.

13. Daydreaming and wishful thinking: It becomes more difficult to concentrate. The "if only" syndrome becomes more common in conversation. The addict begins to have fantasies of escaping or "being rescued from it all" by an event unlikely to happen.

14. Feelings that nothing can be solved: A sense of failure begins to develop. The failure may be real, or it may be imagined. Small failures are exaggerated and blown out of proportion. The belief that "I've tried my best and recovery isn't working" begins to develop.

15. Immature wish to be happy: a vague desire "to be happy" or to have "things work out" develops without the person identifying what is necessary to be happy or have things work out. "Magical thinking" is used: wanting things to get better without doing anything to make them better.

PHASE 5. CONFUSION AND OVERREACTION

During this period, the addict cannot think clearly. S/he becomes upset with self and others, becomes irritable and overacts to small things.

16. Periods of confusion: Periods of confusion become more frequent, last longer and cause more problems. The addict often feels angry with self because of the inability to figure things out.

17. Irritation with friends: Relationships become strained with friends, family, counsellors, and fellowship members. The addict feels threatened when these people talk about the changes in behavior and mood that are becoming apparent. The conflicts continue to increase despite the addict's efforts to resolve them. The addict begins to feel guilty and remorseful about his/her role in these conflicts.

18. Easily angered: The addict experiences episodes of anger, frustration, resentment, and irritability for no real reason. Overreaction to small things becomes more frequent. Stress and anxiety increase because of the fear that overreaction might result in violence. The efforts to control self adds to the stress and tension.

PHASE 6: DEPRESSION

During this period, the addict becomes so depressed that s/he has difficulty keeping to normal routines. At times there may be thoughts of suicide, using or drinking to end the depression. The depression is severe and persistent and cannot be easily ignored or hidden from others. The most common symptoms are.

19. Irregular eating habits: The addict begins overeating or undereating. There is weight gain or loss. S/he stops having meals at regular times and replaces a well-balanced, nourishing diet with "junk food."

20. Lack of desire to act: There are periods when the addict is unable to get started or get anything done. At those times s/he is unable to concentrate, feels anxious, fearful, and uneasy, and often feels trapped with no way out.

21. Irregular sleeping habits: The addict has difficulty sleeping and is restless and fitful when sleep does occur. Sleep is often marked by strange and frightening dreams. Because of exhaustion s/he may sleep for twelve to twenty hours at a time. These "sleeping marathons" may happen as often as every six to fifteen days.

22. Loss of daily structure: Daily routine becomes haphazard. The addict stops getting up and going to bed at regular times. Sometimes s/he is unable to sleep, and this results in oversleeping at other times. Regular mealtimes are discontinued. It becomes more difficult to keep appointments and plan social events. The addict feels rushed and overburdened at times and then has nothing to do at other times. S/he is unable to follow through on plans and decisions and experiences tension, frustration, fear, or anxiety that keep him/her from doing what needs to be done.

23. Periods of deep depression: The addict feels depressed more often. The depression becomes worse, lasts longer, and interferes with living. The depression is so bad that it is noticed by others and cannot be easily denied. The depression is most severe during unplanned or unstructured periods of time. Fatigue,

hunger, and loneliness make the depression worse. When the addict feels depressed, s/he separates from other people, becomes irritable and angry with others, and often complains that nobody cares or understands what s/he is going through.

PHASE 7: BEHAVIOURAL LOSS OF CONTROL

During this phase, the addict becomes unable to control or regulate personal behavior and a daily schedule. There is still heavy denial and no full awareness of being out of control. His/her life becomes chaotic and many problems are created in all areas of life and recovery. The most common symptoms are.

24. Irregular attendance at fellowship and treatment meetings: The addict stops attending fellowship meetings regularly and begins to miss scheduled appointments for counselling or treatment. S/he finds excuses to justify this and does not recognize the importance of fellowship and treatment. S/he develops the attitude that meetings and counselling are not making me feel better, so why should I make it a number one priority? Other things are more important.

25. Development of an "I don't care" attitude: The addict tries to act as if s/he does not care about the problems that are occurring. This is to hide feelings of helplessness and a growing lack of self-respect and self-confidence.

26. Open rejection of help: The addict cuts self-off from people who can help. S/he does this by having fits of anger that drive others away, by criticizing and putting others down, or by quietly withdrawing from others.

27. Dissatisfaction with life: Things seem so bad that the addict begins to think that s/he might as well use because things could not get worse. Life seems to have become unmanageable since using has stopped.

28. Feelings of powerlessness and helplessness: The addict develops difficulty in "getting started;" has trouble thinking clearly, concentrating, and thinking abstractly; and feels that s/he cannot do anything and begins to believe that there is no way out.

PHASE 8: RECOGNITION OF LOSS OF CONTROL

The addict's denial breaks and suddenly s/he recognizes how severe the problems are, how unmanageable life has become, and how little power and control s/he must solve any of the problems. This awareness is extremely painful and frightening. By this time s/he has become so isolated that there is no one to turn to for help. The most common symptoms are.

29. Self-pity: The addict begins to feel sorry for self and often uses self-pity to get attention at Fellowship meetings or from members of family.

30. Thoughts of social using: The addict realizes that drinking or using drugs would help him/her to feel better and begins to hope that s/he can drink/use normally again and be able to control it. Sometimes these thoughts are so strong that they cannot be stopped or put out of mind. There is a feeling that drinking/using is the only alternative to going crazy or commit ting suicide. Drinking/using looks like a sane and rational alternative.

31. Conscious lying: The addict begins to recognize the lying and the denial and the excuses but is unable

to interrupt them.

32. Complete loss of control: The addict feels trapped and overwhelmed by the inability to think clearly and act. This feeling of powerlessness causes the belief that s/he is useless and incompetent. As a result, there is the belief that life is unmanageable.

PHASE 9: OPTION REDUCTION

During this phase, the addict feels trapped by the pain and inability to manage his/her life. There seems to be only three ways out – insanity, suicide, or drug use. S/he no longer believes that anyone or anything can help him/her. The most common symptoms are.

33. Unreasonable resentment: The addict feels angry because of the inability to behave the way s/he wants to. Sometimes the anger is with the world in general, sometimes with someone, and sometimes with self.

34. Discontinuance of fellowship attendance and all treatment: The addict stops attending Fellowship meetings. When a helping person is part of treatment, tension and conflict develop and become so severe that the relationship usually ends. The addict drops out of professional counselling even though s/he needs help and knows it.

35. Overwhelming loneliness, frustration, anger, and tension: The addict feels completely overwhelmed. S/he believes that there is no way out except using, drinking, suicide, or insanity. There are intense fears of insanity and feelings of helplessness and desperation.

PHASE 10: ACUTE RELAPSE PERIOD

During this phase, the addict becomes totally unable to function normally. S/he may use drugs or alcohol or may become disabled with other conditions that make it impossible to function. The most common symptoms are.

36. Loss of behavioral control: The addict experiences more and more difficulty in controlling thoughts, emotions, judgements, and behaviors. This progressive and disabling loss of control begins to cause serious problems in all areas of life. It begins to affect health and well-being. No matter how hard s/he tries to regain control it is impossible to do so.

37. Acute relapse period: The addict experiences periods of time when s/he is totally unable to function normally. These periods become more frequent, last longer, and begin to produce more serious life problems. The relapse cycle is ended by a crisis which causes the person to become totally unable to function for a period due to one or more of the following:

A. DEGENERATION OF ALL LIFE AREAS: The addict may become unable to contribute to the work, social, family, and intimate areas of life. As a result, all life areas suffer due to neglect.

B. DRUG OR ALCOHOL USE: The addict may begin to use drugs or alcohol to escape the pain and desperation. There may be an attempt to control using/drinking by limiting the amount or attempting one short term binge. The ability to control using/drinking is soon lost. This sometimes happens very quickly. Sometimes it occurs after a period of controlled using/drinking. The addict returns to out of control using/drinking with symptoms experienced during the last period of addictive use.

C. EMOTIONAL COLLAPSE: The addict may become emotionally unable to function, may overreact or become emotionally numb, or cry or fly into a rage for no reason at all.

D. PHYSICAL EXHAUSTION: It may become impossible for the addict to continue to function due to physical exhaustion.

E. STRESS RELATED ILLNESS: The addict may become physically sick due to the severe stress that has been occurring for a long period of time.

F. PSYCHIATRIC ILLNESS: The addict develops a severe psychiatric illness such as psychosis, severe anxiety, or severe depression. The psychiatric illness may be so severe that it forces the addict into treatment.

G. SUICIDE: The addict may become suicidal and may attempt or commit suicide.

H. ACCIDENT PRONENESS: The addict may become careless and unable to take normal precautions in acts of living, resulting in a sequence of accidents. These accidents may take the form of car accidents, falls, burns, etc. Often the accidents are life threatening or create serious injury.

I. DISRUPTION OF SOCIAL STRUCTURES: The addict may be unable to maintain involvement in normal life activities, may become socially unable to function

If you notice a warning sign, evaluate your need to seek help.

Practical Exercise One: Families Members part in the "Plan for a Successful Lifelong Recovery"

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1. **Learn the persons plan of care and adjusts to meet their current conditions:**

Q: What can the family members do to support this plan?

_____
_____
_____
_____

2. **Communication Channels that are Two Way, supporting and linked to those who can help maintain recovery.**

    Q: What can the family members do to support this plan?

    _____
    _____
    _____
    _____
    _____

3. Strong Support Systems, flexible to meet day by day issues and challenges.

Q: What can the family members do to support this plan?

_____
_____
_____
_____
_____

4. A family environment that provides a sense of Purpose towards daily life.

Q: What can the family members do to support this plan?

How the Family Participates, Know the signs

VIDEO ONE:

Search 

ASSIGNMENT VIDEO: On www.youtube.com/

Title: Six Skills for Families Affected by Addiction

This brief video provides an overview of six skills to help families and significant others who are affected by a person who has a substance abuse or addiction problem.

Link: **https://www.youtube.com/watch?v=3sBff2khxpo&t=379s** **Duration:** 8:26 min

Successful Lifelong Recovery

Issues the Family Faces

Understand What They Experience.

Search Title: REF: How to Create an Addiction Relapse Prevention Plan

VIEW VIDEO LINK: https://www.youtube.com/watch?v=yd3ESsbtCzY

Duration: 6:13 min

There are four main ideas in relapse prevention. First, relapse is a gradual process with distinct stages. The goal of treatment is to help individuals recognize the early stages, in which the chances of success are greatest. Second, recovery is a process of personal growth with developmental milestones. Each stage of recovery has its own risks of relapse. Third, the main tools of relapse prevention are cognitive therapy and mind-body relaxation, which change negative thinking and develop healthy coping skills. Fourth, most relapses can be explained in terms of a few basic rules.

Educating the family members in these few rules can help them focus on what is important. Consider when a family is documenting the person(s) or organization(s) is now accountable for a particular action, the completion of the action, and how you will measure success. Identifying your past results, allows others to see they too will be measured, and that level of self-administered accountability can go a long way.

The key to relapse prevention is to understand that relapse happens gradually. It begins weeks and sometime months before an individual pick up a drink or drug. The goal of treatment is to help individuals recognize the early warning signs of relapse and to develop coping skills to prevent relapse early in the process when the chances of success are greatest. This has been shown to significantly reduce the risk of relapse. Gorski has broken relapse into 11 phases. This level of detail is helpful to clinicians but can sometimes be overwhelming to clients. I have found it helpful to think in terms of three stages of relapse: emotional, mental, and physical.

The transition between emotional and mental relapse is not meaningless, but the natural consequence of prolonged, poor self-care. When individuals exhibit poor self-care and live-in emotional relapse long enough, eventually they start to feel uncomfortable in their own skin.

Obstacles the family will likely address

Adopting a holistic view of clients in substance abuse treatment is especially important for the family to consider. At the point of referral, there is both an opportunity to address their unmet needs and a potential danger of losing them losing their interest in treatment. Collaboration is crucial for preventing them from "falling through the cracks" among independent and autonomous agencies. Effective collaboration is also the key to serving the client in the broadest possible context, beyond the boundaries of the substance abuse treatment agency and provider.

The traditional referral system from substance abuse treatment programs to outside agencies can create obstacles to effective collaboration.

Goals and Outcomes of Family Members

One main goal of involving families in treatment is to increase family members' understanding of the client's substance use disorder as a chronic disease with related psychosocial components. Edwards (1990) states that family-based services can have the following effects:

- Increase family support for the person's recovery. Family sessions can increase a client's motivation for recovery, especially as the family members realize that the person's substance use disorder is intertwined with problems in the family.
- Identify and support change of family patterns that work against recovery. Relationship patterns among family members can work against recovery by supporting the person's substance use, family conflicts, and inappropriate coalitions.
- Prepare family members for what to expect in early recovery. Family members unrealistically may expect all problems to dissipate quickly, increasing the likelihood of disappointment and decreasing the likelihood of helpful support for the client's recovery.
- Educate the family about relapse warning signs. Family members who understand warning signs can help prevent the person's relapses.
- Help family members understand the causes and effects of substance use disorders from a family perspective. Most family members do not understand how substance use disorders develop or that patterns of behavior and interaction have developed in response to the substance-related behavior of the family member who is in treatment. It is valuable for individuals in the family to gain insight into how they may be maintaining the family's dysfunction. Counselors should help family members address feelings of anger, shame, and guilt and resolve issues relating to trust and intimacy.
- Take advantage of family strengths. Family members who demonstrate positive attitudes and supportive behaviors encourage the client's recovery. It is important to identify and build on strengths to support positive change.
- Encourage family members to obtain long-term support. As the client begins to recover, family members need to take responsibility for their own emotional, physical, and spiritual recovery.

Solutions to Issues & Obstacles

Practical Exercise One: Investigate the Future of What Will Likely Happen

A. What are you seeing?

Possible dysfunctional behaviors include:

B. **Social withdrawal or isolation** – avoiding family and friends; a marked preference to be alone.

Q: What can the family do: _____

C. **Refusal of any concerned efforts – denial of need**; an insistence of doing everything "on your own" with no help from anyone.

Q: What can the family do_____

D. **Sporadic counseling/therapy/12-Step meetings attendance** – Fellowship with other recovering addicts and alcoholics can be a major source of strength and inspiration, but as the saying goes, "it only works if you work it".

Q: What can the family do: _____

E. **Poor eating habits** – responding to stress or emotional pain with food; eating only junk food or fast food; alternately – loss of appetite

Q: What can the family do: _____

F. **Sleep disturbances** – insomnia, wakefulness, poor sleep quality; alternately, excessive sleeping or an inability to get out of bed

Q: What can the family do: _____

Practical Exercise Two: Emotional Relapse

In this earliest stage, the person likely will not even start to think about using or drinking. Rather, they start feeling negative emotions that cause you to act in self-destructive ways. Even when they are sober and abstaining, some of the aspects of their disease can still impact their life.

Emotional relapse precedes physical relapse:

1. **Anxiety** – excessive fear, worry, or uncertainty about your sober new life.

Q: What can the family do: _____

2. **Depression** – overwhelming sadness; loss of appetite; no motivation.

Q: What can the family do: _____

3. **Intolerance** – poor cooperation with others, an uncompromising attitude, or rigid, inflexible opinions

Q: What can the family do: _____

4. **Anger** – resentment or hostility that flares up whenever expectations are not met

Q: What can the family do: _____

5. **Defensiveness** – intensely rejecting any criticism

Q: What can the family do: _____

6. **Mood Swings** – an inability to control one's feelings and reactions, unpredictable emotional volatility

Q: What can the family do: _____

If any of these emotional conditions are left undone with, they can be a factor in the stress factors that can lead to physical relapse.

Practical Exercise Three: How can a family member prepare for what is happening?

1. **Self-Awareness** – Maintaining an active knowledge of your feelings, thoughts, and behaviors. There are several ways to practice self-awareness:

- **Mindfulness meditation** – A 2017 study suggests that practicing mindfulness for as little as 11 minutes

a day can help reduce cravings. Google how to practice mindfulness. www.youtube.com

- **Journaling** - Daily reflection and affirmation.

2. **Self-Care** – Doing the things that are necessary to maintain and improve your physical, emotional, and mental health.

Q: What can the family member do for themselves:

_____

_____

3. **Proper nutrition** – Addiction takes a terrible toll on the body, robbing it of essential nutrients. Eating right gets you healthier by restoring the vitamins and minerals you may have lost. Also, hunger is easy to misinterpret as drug cravings.

Q: What can the family member do for themselves:

Reducing stress – A 2011 study revealed a biological link between chronic stress and addiction. Key benefit: when you are calm, you are far less likely to overreact to the problematic situation.

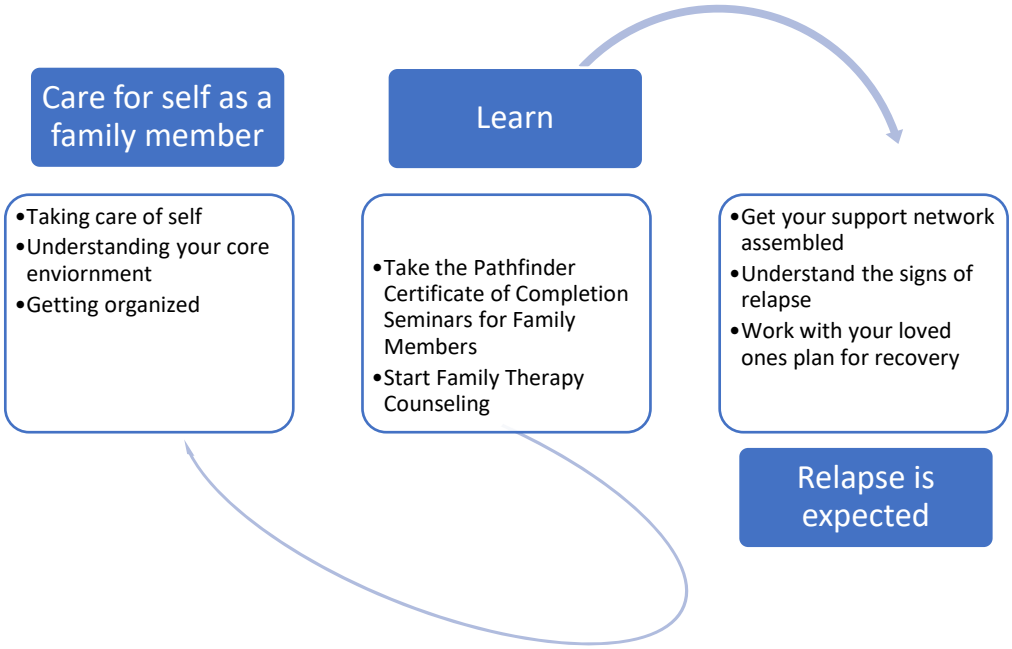
Q: What can the family member do for themselves:

Getting enough quality sleep – Insomnia is the biggest complaint among people in early recovery. Inadequate sleep can lead to irritability, depression, and confusion – each of which can trigger a relapse.

Q: What can the family member do for themselves:

4. **Ask for help when you need it** – The disease of addiction is too large of a problem to try to tackle alone. Asking for and receiving the help you need from supportive, positive people lets you take advantage of new perspectives and additional resources.

Q: What can the family member do for themselves:



Knowing what stage of the journey you are in, helps to determine what services is going to be needed next. The purpose of completing this seminar is to become aware of the family members support services, having the family ready to engage these resources at the right time and knowing what is going to be the possible outcome.

Practical Exercise Four:

Apply the F.T.R. Model for Each Issue
Worksheet
Define the Issue?

Clearly State what happened or will happen.

_____

_____

Identify who is involved or should be involved.

_____

_____

What would you like to have happened, or like to see happen?

_____

_____

How does the issue impact the family?

Who in the family?

_____

_____

In what way?

_____

_____

What is needed to move forward?

_____

_____

What steps can the family take to prepare and then respond to the issue?

What needs to be done, prioritize the list.

_____

_____

Who needs to be involved?

_____

_____

What will it look like when completed?

_____

_____

Who can help and assist the family in their response?

How to search for an organization to help.

_____

_____

What to ask from them?

_____

_____

What to expect?

_____

_____

What should the family expect as their outcome?

Timeline.

_____

_____

The expenses/cost involved in this issue.

_____

_____

Required changes to successful respond to this issue.

_____

_____

You are projecting in this exercise because the actual event has not occurred, updating this for each issue as it happens may be required.

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Relapse Prevention June 2015

Published on Dec 17, 2012

Duration: 1.19 hrs.

"Relapse Prevention" was presented on June 23, 2015; by Erik Anderson LLMSW, CAADC; Dawn Farm Outpatient Therapist. Addiction has been identified as an illness that requires long-term management. Relapse is a process that begins before alcohol/other drug use is resumed and is usually preceded by a pattern of progressive warning signs. Understanding the relapse process assists recovering people to develop an effective plan to identify and prevent relapse. This program will discuss the dynamics of relapse, signs that may forewarn of relapse, how to develop a relapse prevention plan and strategies to handle both every day and high-risk situations. the presentation includes discussion of Marlatt and Gorski's models of the relapse process, the roles played by will power and habit, and ways to use the Six Sources of Influence Inventory for initiating and maintaining behavior change.

This presentation is part of the Dawn Farm Education Series, a FREE, annual workshop series developed to provide accurate, helpful, hopeful, practical, current information about chemical dependency, recovery, family, and related issues. The Education Series is organized by Dawn Farm, a non-profit community of programs providing a continuum of chemical dependency services. For information, please see dawnfarm.org/programs/education-series.

MASTER FAMILY PLAN OF ACTION FOR: "Successful Lifelong Recovery"

Complete answers and move to "Master Family Plan of Action" found in back of workbook.

1. Your family will use the elements of supporting the loved one's plan of care in recovery/
2. A family action plan will be written on how the family will respond in stage of emotion, for potential relapse. Early intervention

3. The family members will use the steps for care for themselves in managing the stress of recovery.

As part of the Master Family Plan of Action the family members will complete the review the needed "points of contact" at the agencies they will possibly need to work with in the future.

REF:

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World Psychiatry. 2009 Jun; 8(2): 67–74. doi: 10.1002/j.2051-5545. 2009.tb00217.x

PMCID: PMC2691160 PMID: 19516922

Grief and bereavement: what psychiatrists need to know

SIDNEY ZISOOK1 and KATHERINE SHEAR

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: When to Treat Grief and Bereavement

TEDx Talks Sidney Zisook, MD, Phd, describes the circumstances when bereaved patients may benefit from treatment. Duration: 5:08 min