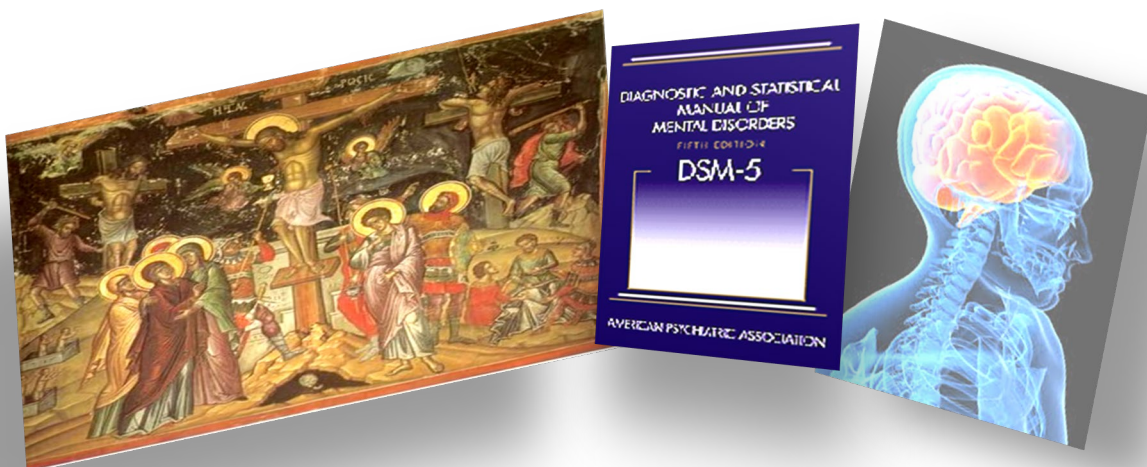


*CADA's
Family Support
and Education Program*



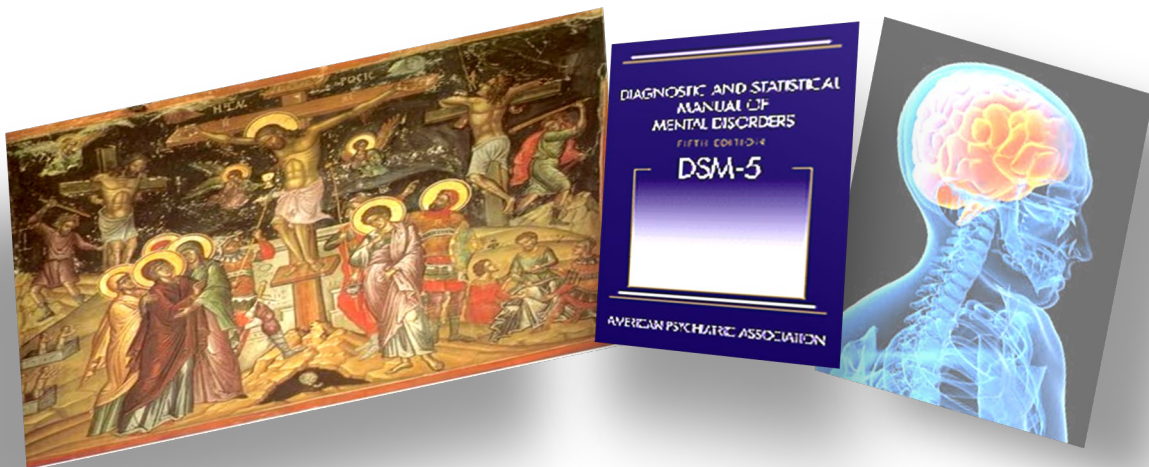
Resource Manual



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Photo: Gene J. Puskar/AP

"When I was a boy, and I would see scary things in the news, my mother would say to me, 'Look for the helpers. You will always find people who are helping.'"

--Rev. Fred Rogers

*CADA's
Family Support and Education Program
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Introduction

Trauma's Children: Changing History

(Family "Roles" Adapted from Polson and Newton)

"Those who cannot remember the past are condemned to repeat it."
--George Santayana

"Whoever fights monsters should see to it that in the process he does not become a monster. For when you look long into an abyss, the abyss also looks into you."
--Friedrich Nietzsche

"When young, circus elephants are attached by heavy chains to large stakes driven deep into the ground. They pull and yank and strain and struggle, but the chain is too strong, the stake too rooted. One day they give up, having learned that they cannot pull free, and from that day forward they can be "chained" with a slender rope. When this enormous animal feels any resistance, though it has the strength to pull the whole circus tent over, it stops trying. Because it believes it cannot, it cannot."
--Gavin de Becker, *The Gift of Fear: Survival Signals That Protect Us from Violence*



People in families affected by addictive disorders (and, for that matter, other mental illnesses) and the attendant traumatic stress find themselves in a downward spiral of makeshift coping with impossible situations.

It's like being raised in a fun house with distorting mirrors. If that's all children see, they never realize that the mirrors are presenting a normal picture of themselves and their world. ("What's normal is what you're used to," as the saying goes.) Only later, in the real world, do they begin to notice the discrepancy between what they've always experienced and how things are outside the "fun house." Out of this improvised coping with events that are, as often as not, traumatic, come inevitable distortions of interaction among family members and others affected by the addiction, such as friends and employers.



These so-called “family roles” (a designation that, perhaps, makes them seem less conscious and deliberate than they may be at the outset) are “played out” daily, just like a script, and not only in the dysfunctional family of origin. Behavior patterns adopted by various family members become their *modus operandi* for life in general, both at the time and, unless they’re revised, for life. This long-term playing out of older, established behaviors is known as “re-enactment,” and it means simply that humans repeat what they’ve learned and practiced through repetition. “Practice makes perfect.” It also makes automatic, even unconscious. Given how people tend to react to threat, i.e., fight or flight, children in disturbed, traumatic situations generally adopt either a defensive, aggressive stance toward the world, or they retreat into fantasy and isolation.



To put it plainly, these family “roles” adopted to enable children to tolerate the intolerable represent a marked stunting of normal childhood psychosocial development, and this impaired ability to relate honestly can plague them in all of their relationships for the rest of their lives. Adopting the roles makes it impossible for the child to have a healthy, normal childhood. Carried into adolescence and adulthood, these behaviors can inhibit the formation of mutually-nourishing relationships.



Original work regarding family roles was conducted by Dr. Virginia Satir, then adapted by Dr. Claudia Black and others to fit families affected by addiction. In *Not My Kid, a Family's Guide to Kids and Drugs**, Beth Polson and Dr. Miller Newton describe predictable roles that children play in families affected by addiction. (Note: In real-world families, a child may assume more than one of these roles, either sequentially or concurrently.) The classic “roles” are:



The “Good Child” (a.k.a. “Hero”): a child who becomes a high achiever or overachiever outside the family to escape the dysfunctional family environment, defining him/herself independently of his/her role in the dysfunctional family, currying favor with parents, and/or shielding him/herself from criticism by family members;



The “Problem Child” (a.k.a. “Scapegoat”): the child who causes most problems related to the family's dysfunction and/or who "acts out" in response to preexisting family dysfunction, in the latter case often in an attempt to divert attention paid to another member who exhibits a pattern of similar misbehavior;



The “Caretaker”: the one who takes responsibility for the emotional well-being of the family, often assuming a parental role (even if unwillingly);



The “Lost Child”: the loner, the inconspicuous, quiet one, whose needs are usually ignored or hidden;



The “Mascot” or “Family Clown”: the comedian, who diverts attention away from the increasingly dysfunctional family system;



The “Mastermind”: the opportunist who capitalizes on the other family members' faults to get whatever he or she wants; often the object of appeasement by grown-ups.

All of this begs the question, why would anyone choose such constricting patterns of relating to others and to the wider world? The simple, stark answer: survival and repetitive training:

At CADA, we hope to offer you and your loved ones the opportunity for enlightenment and hope as you meet together in mutual understanding and support. Now is the time to feel free to break the “rules” and examine the “roles” you’ve perhaps felt you had to play in life. All that matters is the willingness to accept yourself as you are. Any script can be re-written, and, as the author of yours, you have the chance and the invitation to begin doing so. Although you can’t alter the past, you can, indeed, change history.



Welcome!

*Beth Polson and Miller Newton, *Not My Kid: A Family's Guide to Kids and Drugs*, Arbor Books/Kids of North Jersey Nurses, 1984.

Resource:

Grand Opera Is Not for Children

“What an amazing voice for a child so young!” “She’s so tiny; where does all that sound *come from!*?” “Even at his young age, he was born to sing opera!” These and other exclamations of surprise and delight greet the latest wonder-child appearing from time to time on television performance contest shows. The young singers wow audiences with their seemingly-mature, full-throated vocal production. Cause for celebrating their prodigious talent, indeed! Or is it? What if we are, in fact, hearing a disaster, perhaps even a tragedy in the making? That said, how is encouraging youth to over-sing related to juvenile substance abuse?

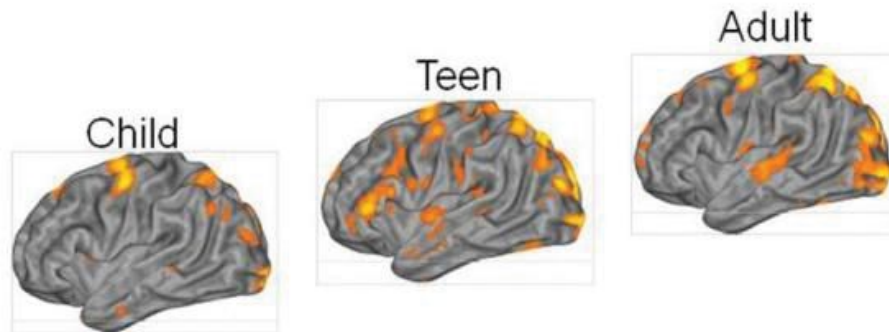


Eduard Magnus: Jenny Lind (1862)

Our concern is for children and adolescents who use any drug, including marijuana or alcohol, whether or not they have a family history of addictive disorders. **In no realm of their functioning are children merely small adults. It is never safe for children to use alcohol or drugs because they have not had time to mature physically, cognitively, or emotionally.**

Youth substance use poses a situation similar to that of a child or adolescent trying to sing grand opera. Their vocal physiognomy is just not developed to the point that such high-impact singing is safe or sustainable. It takes at least 20 years for the larynx, vocal folds and adjoining support structures to finish maturing. (It should be remembered that even trained, adult singers run the risk of vocal problems from time to time when they over-sing.) All the vocal coaching in the world isn't going to change the reality that young people can and do permanently damage their vocal apparatus trying

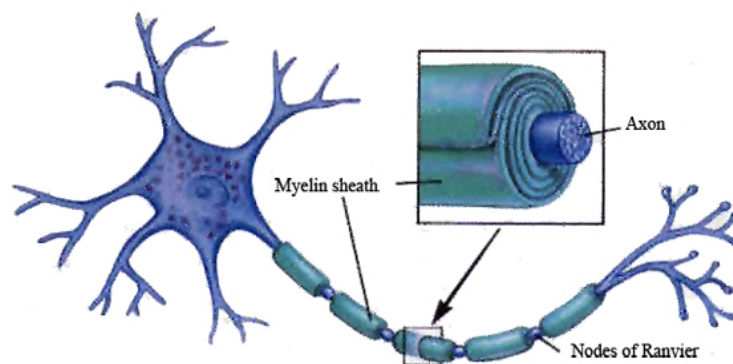
to sing material that is beyond their vocal capacity before they're physically able to do so safely. The vocal folds which produce musical tones are a highly delicate, extremely fragile, easily damaged organ. (An example out of history: Jenny Lind, the “Swedish nightingale,” gave her first performance at 18. Vocal damage forced her to retire by the age of 29.)



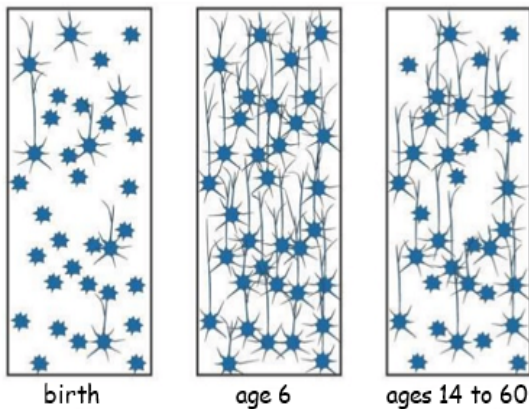
Similarly, other concerns notwithstanding, the reward and cognitive centers in the developing brain are just not matured sufficiently in children and adolescents to accommodate use of any drug, making exposure to chemicals potentially catastrophic. To understand the risk of substance use in children and adolescents, it's necessary to spend a little time covering how the brain matures. From childhood into early adulthood, important events take place that give us the brain we'll have as adults:

From early stages of adolescence into adulthood, the brain experiences major growth and pruning. Initial developments begin near the back of the cortex, and tend to finish in the frontal areas (e.g. prefrontal cortex). There are several key ways by which the brain remodels during various stages of development.

Myelination: Brain nerve fibers are sheathed with a substance called myelin, a lipoprotein providing insulation for nerve cells to transmit electrical signals effectively. During developmental stages, the process of myelination promotes healthy brain functioning and allows for more complex functions.



Synaptic pruning: During maturation, neuronal synapses are eliminated or “pruned” selectively. This process of elimination peaks during the teen years and wanes in late adolescence/early adulthood, extending even into the mid-to-late 20s. Pruning facilitates more efficient brain functioning, a “use-it-or-lose-it” proposition.



- * brain grows rapidly during early years of life;
- * maturing neurons increase the number of axonal and dendritic synapses (age 6);
- * however, synaptic pruning removes weaker synapses (starting in age 14 and throughout life);
- * that is, synapses that are not frequently stimulated;
- * synaptic pruning is an adaptive process;
- * aging, stress, and neurodegeneration can cause synapse loss with or without loss of neurons.

<https://www.slideshare.net/adonissfera/neuroplasticity-and-neurodegeneration>

Increased connectivity: The connections between brain regions that are used regularly appear to be strengthened, thus making communication more efficient. The brain is able to transmit greater amounts of information between regions and becomes better at planning, dealing with emotions, and problem solving.

Executive functions: A majority of the executive functions that we develop are via the prefrontal cortex. This allows us to help assess risk, think ahead, evaluate ourselves, set goals, and regulate our emotions.



A generalization that can be made about the developing brain is its gradual evolution throughout childhood and adolescence into adulthood toward increased emotional and behavioral equilibrium.

Compare the tantrums and “meltdowns” of toddlers when they don’t get their way to the reasoned and emotionally-congruent reaction and restraint of adults—well, at least *mature* adults—who, although disappointed, retain the will and the power to conduct themselves in an age-appropriate manner. This gradual development of self-control is made possible by the growth of reliable connections involving executive function in the frontal cortex. Although, under ideal circumstances, many of these functions are developed during teenage years, they are still under ongoing development and strengthening until our mid-20s.



It's folly to expect the developing brain to be able to cope effectively with the intense reward and emotional and cognitive shifts associated with substance use, even at a low level. The brains of youth are no more able to process such signals effectively than their vocal apparatus can withstand the rigors of high-level singing.

The “rush” of emotional stimulation and pleasurable experience overwhelms the areas of the brain that are meant to moderate that experience with clear thinking. Due to the power of the ecstatic response, the childhood need for instant gratification quickly becomes ingrained, with little or no nuance of the pleasurable impulse. If you also factor in the reality that the child/adolescent may be experiencing a painful, even traumatic home environment (e.g., an abusive parent or the trauma of witnessing violence in the home), which is, in itself, warping the brain's development of executive function behavioral self-control, you have a recipe for disaster. The youth hyper-learns that using alcohol or some other mood alterer soothes the rage and terror they're experiencing on a daily basis.



You cannot over-drive any part of the human body for very long at all without sustaining permanent damage. In juvenile substance use, the immature reward pathways become over-driven and develop a “hair-trigger” response to emotions engendered in the outside world. This over-driving of the reward circuits primes the child to seek solace and comfort in substances or in other addictive behaviors. Just as young singers have to be prevented from over-singing to avoid permanent damage to the vocal apparatus, prevention or early intervention in the traumatic environment and rescue from use of substances is the only known way to prevent the child being set up for catastrophic problems both in childhood and later in life.

WHAT IS ADDICTIVE DISEASE?

PREFACE

Welcome!

We all live in a frenetic world. You have only to observe people going about their daily business to note the speed with which everyone and everything is moving. You can look at almost any movie or television show made recently and compare it with those made a decade or more ago: the editing of these more recent programs makes the "shower scene" in "Psycho" look almost slow in comparison!



Saul Bass, 1959



This pace is not new in itself, and complaints about the speed of modern life aren't new, either. Charlie Chaplin's 1936 film, "Modern Times," was an effective spoof of the fast business of the industrial, the machine age. We have it on the good authority of none other than Simon and Garfunkel in their "59th Street Bridge Song": "Slow down; you move too fast." Words of wisdom, certainly; but, more recently, the overall pace of our daily lives does seem to have sped up.

The problem is, we don't seem to be wired to adapt readily to such a breakneck pace without giving up some important things in the process. People with addiction are especially vulnerable to this bustle, since they are already struggling (some more, some less) with the challenges that accompany abstinence and self-exploration.

We know that an unusually-large percentage of people with addiction have Attention-Deficit Disorder. Those who have not been diagnosed do seem to have specific problems keeping their attention on a task and sustaining that attention long enough to bring the task to some degree of completion.



When you consider that people in recovery are dealing with anxiety and, often, untreated or undertreated depression, it's small wonder that they have trouble centering themselves and achieving reliable stability. Learning to center themselves and maintain stability (serenity) is a primary skill of recovery.



**Ed Koch Queensboro Bridge (59th Street Bridge)
(Gustav Lindenthal, Leffert L. Buck, Henry Hornbostel, 1909)**

Believe it or not, your recovery actually began the moment you detected that you have some sort of problem and decided to do something to make your life better.

Remember: For the rest of your life, you must always reserve the right to

Stop.

Relax.

Refocus.

Slow yourself.

Resume.

Abstinence naturally promotes and encourages you to

Come to yourself.

Focus your self awareness.

Find your voice.

Take your time.

Live your life.



The Paradox of Addiction

Modern humans ("*homo sapiens*," "knowing man") evolved from older primate ancestors and appeared during the middle Paleolithic, about 200,000 years ago. Behaviorally modern humans evolved from these ancestors and appeared about 50,000-100,000 years ago.

Three Principles to Keep in Mind

1. We have a Central Nervous System (CNS) in four parts
Brain stem, Limbic system, Cerebral cortex, Spine
 2. We have an Autonomic Nervous System (ANS) in two parts
Sympathetic Nervous System: Activation ("Arousal")
Parasympathetic Nervous System: Sedation ("Inhibition")
 3. Mammals (including *homo sapiens*) operate according to "The Pleasure Principle"
Moving to and repeating behaviors we find rewarding and safe
Distancing ourselves from and avoiding behaviors we find repellent and dangerous
-

Central Nervous System in Four Parts

Brain Stem (in Primates, Other Mammals and Non-Mammals)

Activation ("Arousal")

Automatic ("involuntary," "avolitional") and typically very rapidly acting
The oldest section of the brain, pre-dating our species, *homo sapiens*

Limbic System (in Primates and Other Mammals)

Mood, threat sense, memory, appetites and satisfaction/reward

Some functions semi-automatic ("semi-voluntary," "semi-volitional")

Some functions automatic

More recent in our evolutionary history, but still pre-dates *homo sapiens*

Cerebral Cortex (in Primates and Other Mammals)

Mostly voluntary ("volitional"); activation on demand

Spine (in All Vertebrate Animals)

Transmits signals from brain to other parts of the body

Autonomic Nervous System in Two Parts

Sympathetic Nervous System: Activation (“Arousal”)

Activated by chemicals, so-called “sympathomimetics,” such as amphetamine, cocaine, nicotine and caffeine, and behaviors which imitate and enhance the action of this nervous system, such as certain forms of gambling, thrill-seeking behaviors, tantrums, violence

Parasympathetic Nervous System Sedation (“Inhibition”)

Activated by chemicals which imitate the action of this nervous system (e.g., alcohol, benzodiazepines and anesthetics and some antihistamines) and by behaviors (e.g., certain forms of gambling, cutting, hair pulling, hypersexuality)

Paradox of Addiction: “If It feels Good, Do It” (?)

Appetites for keeping the individual and/or species alive

Addiction creates appetites for chemicals/activities that threaten well-being under the guise of sustaining wholeness and health

Debriefing Round With Affirmation “H. U. G.”

1. [Name], will you be **H**ere for the next meeting of the conference this morning?

[Regardless of the answer, proceed to Question 2]

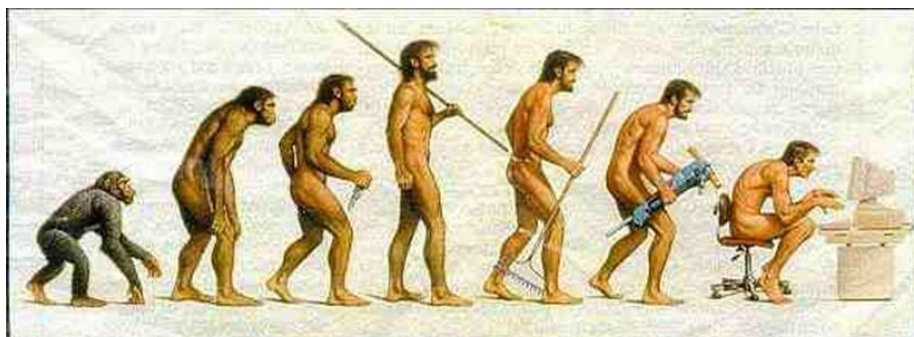
2. [Name], do you have the **U**rge to gamble?

[Regardless of the answer, proceed to Question 3]

3. [Name], are you **G**oing to gamble?

[Regardless of the answer, proceed to the Affirmation]

[Name], you don’t have to gamble, and you’ve been “**HUG**ged”!



If you think about it ...

... substance abuse and gambling don't have very savory reputations!

Observe this early depiction of gambling in Western culture:

Jesus' crucifixion is, seemingly, foretold in the Old Testament:

"They divide my garments among them; for my clothing they cast lots." --Psalm 22:18 ...

... and recorded in this New Testament reference in which Roman soldiers wager to divide Christ's garments while He is still on the cross:

"And they crucified Him and divided up His garments among themselves, casting lots for them to decide what each man should take." --Mark 15:24

Just think of all those hyperventilative sermons delivered by generations of "fire and brimstone" preachers!



Are drug use and gambling *always* deliberate choices?

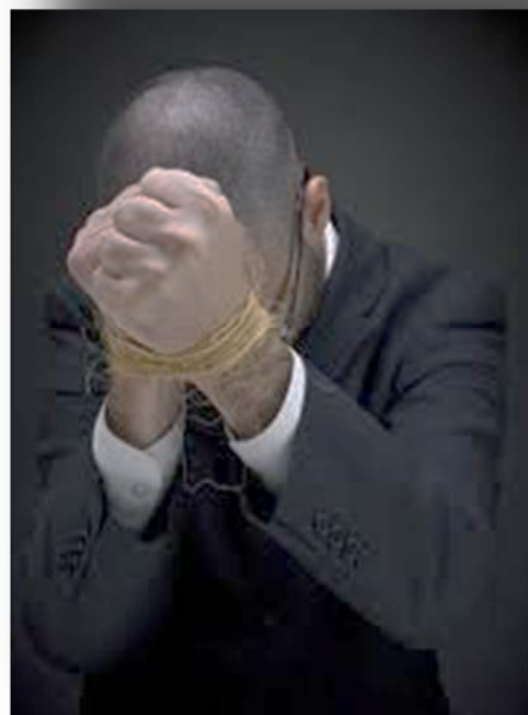
No, they aren't. Not for some people.



People with addictive disorders are, simply put,



HELPLESS.



The DSMs

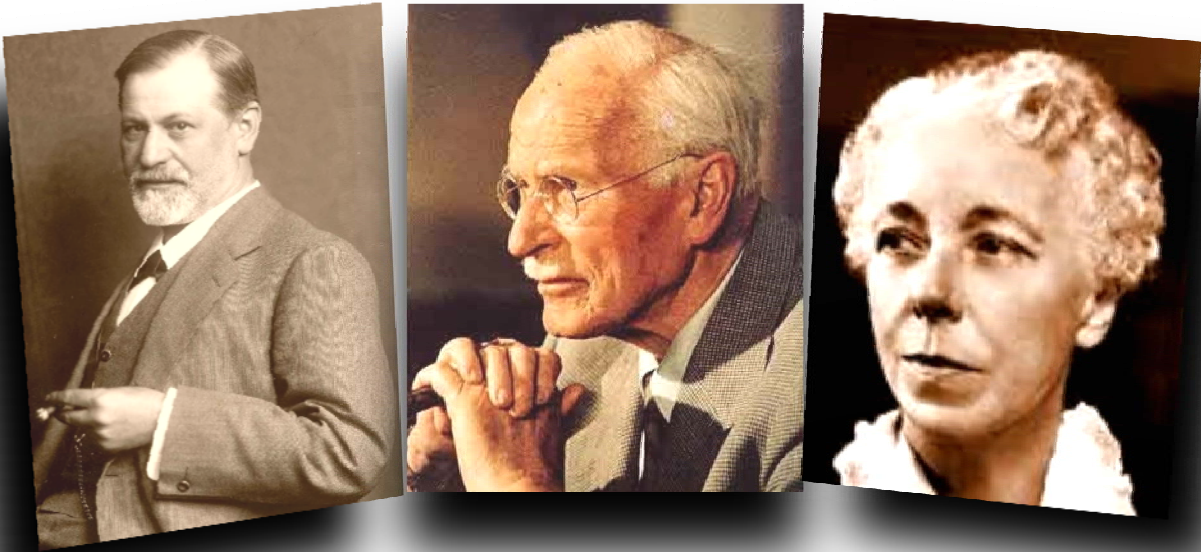
Ancient merchants setting into foreign ports ...

faced an immediate communication problem. For almost a millennium, before English became the *de facto* standard of business, diplomacy and science, the European mercantile community maintained a unique solution to this linguistic dilemma. Their solution was a multinational *patois*: a hodgepodge of French, Italian, Greek, Turkish, Spanish, etc. This “pidgin” language was known as the “*lingua franca*.” The “*lingua franca*” enabled everyone to both communicate and cooperate for the economic betterment of all.



Before the 1950s, people who do science for a living were faced with a similar lack of standardization of the language of psychiatry. There was no “*lingua franca*” that enabled behavioral scientists to understand one another; indeed, such unified language would have been impossible at the time, given the vast range and disparities of theory and clinical practice concerning mental illness. The international language that would make such communication possible was, as yet, still in the future. There were those, however, who were beginning to fashion something of a common language even before the advent of the first Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1952.

There were, among others, Sigmund Freud (1856-1939), Carl Jung (1875-1961), and Karen Horney (1885-1952)



To be sure, they and many others all spoke and wrote with great eloquence, but they were, in effect, speaking different clinical languages.

One of the first classifiers of mental illness ...

and the “father” of psychopharmacology, was psychiatrist Emil Kraepelin (1856-1926), whose work emphasized the biological and genetic factors affecting mental illness.

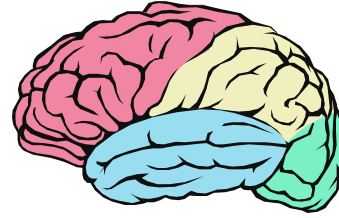


Only now, with the advent of DSM-5 in 2013, are the ramifications of Kraepelin's work toward uncovering etiology of mental disorders being linked to their descriptions. (See the discussion on biomarkers in the DSM-5.)

The American Psychiatric Association's first Diagnostic and Statistical Manual of Mental Disorders was published in January, 1952. DSM-II followed in May of 1968; III in May, 1980; III-R in January, 1987; IV in January, 1994; IV-TR in June, 2000; and DSM-5 in May, 2013.



WHAT IS ADDICTIVE DISEASE?



That question has puzzled everyone who deals with addiction, including therapists, physicians and other scientists, and loved ones. Historically, addictive disease has been blamed on everything from demonic possession to a failure of character or will power.

In the past, the unusual, strange and even dangerous behaviors associated with addiction were seen as a result of a person's having been demon-possessed. Given the erratic and even bizarre nature of these behaviors, it is understandable that people—including those with the disease—might have thought that!

Now we have a more complete answer: Addictive disorders and compulsions to take things, set fires, gamble, etc., result from genetically pre-set “misadjustments” in the middle of the brain.

What creates these “misadjustments” in the limbic system?

- a) faulty coding of the person's genetics at conception;*
- b) exposure to mood altering chemicals or behaviors; and*
- c) the presence of traumatic stress the person wants to “medicate” away.*

Genetically vulnerable people develop crippling dependence on chemicals or other pleasurable behaviors. They then try to maintain a certain level of pleasure in those areas of the brain that regulate pleasure. To fail to do so can create severe emotional pain.

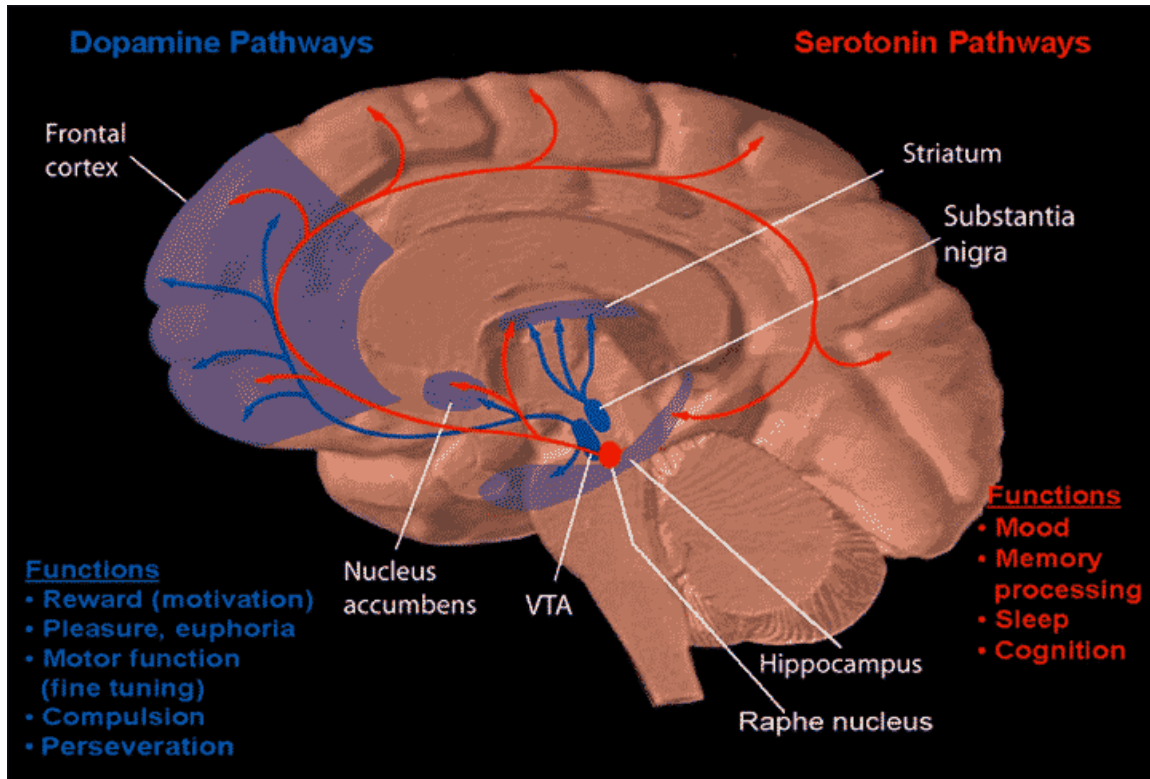
2.

The word “crippling” matters. People in the grip of addiction don't get to choose their behavior. They've lost the ability to resist urges driving them so strongly. (If they did have the ability to resist these urges, they surely would never have allowed the disorder to get so severe that it damages their lives and relationships!)

Which parts of the middle of the brain are involved?

- a) the **lateral hypothalamus**,
- b) the **ventral tegmentum**,
- c) the **medial forebrain bundle**,
- d) the **nucleus accumbens** and, perhaps,
- e) the **insula**

These brain parts normally give us drives and desires and make us satisfied when those drives are met.



drugabuse.gov (Public Domain)

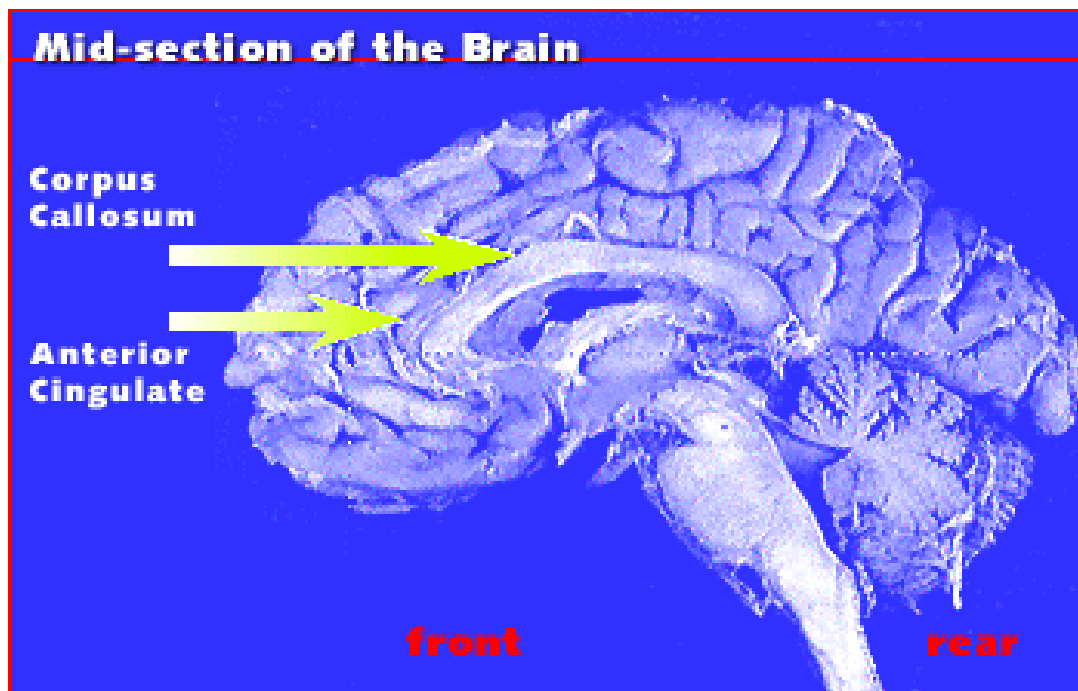
3.

Normally, these brain parts re-set to a “satisfied” state when the person eats, drinks water, has sex, etc. In people with addiction, there seem to be coding errors for at least two brain chemicals,

- a) **serotonin** and*
- b) **dopamine***

These chemicals (neurotransmitters) operate the brain cells (neurons) in these areas, which prevent them from “re-setting” back to that “satisfied” state. People with addiction are creatures of pathological habit, not normal pleasurable habits. It turns out that these regulating neurons are defective from conception (something like a defective thermostat, which registers the wrong temperature when connected to an air conditioner.)

*Another brain area, the **anterior cingulate cortex**, doesn't work properly to tell the difference between safe and dangerous behavior.*

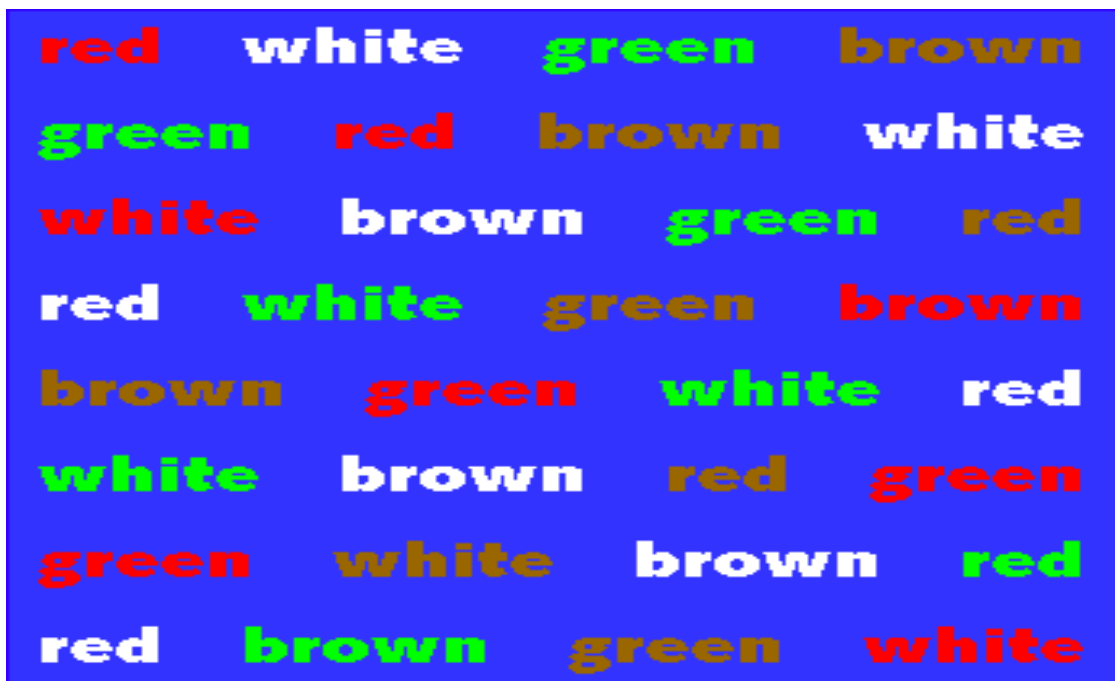


Anterior Cingulate:
Cognitive and Affective Divisions
Wayne State University/Detroit Medical Center

4.

In the exercise below, see how fast you can zip through this series of colors, saying the color of the ink, not necessarily the name of the color as written. Go as fast as you can!

*By the way, as you move through Dr. Ridley Stroop's exercise, you'll almost be able to feel your **anterior cingulate cortex** trying to make out the difference between contradictory signals -- the color of the ink on the page as sometimes opposed to the name of the color as written. People with addiction and compulsion typically have a hard time doing that!*



*John Ridley Stroop (1897-1973):
"Stroop Effect" (1935)*

Treatment helps the person

- a) find healthy ways to deal with everyday stresses.*
- b) accept that he or she has a true illness and*
- c) learn how to function well despite having a brain disorder.*

Technical Appendix

For those who want to know more ...

Here are some of the key areas of your brain that will need to become more active and remain engaged throughout your life as you continue your recovery:

Amygdala (Gr.: almond): *Structure which mediates fear and attack response (“fight or flight”).*

Anterior Cingulate Cortex: *Structure involved in task organization, learning and problem solving (See Prefrontal Cortex).*

Basal Ganglia: *Group of nuclei (neural connection hubs) connected with brainstem, cerebral cortex and thalamus and involved with emotion, motor functions and learning.*

Caudate Nucleus: *An area of the brain involved in voluntary movement and in drug addiction.*

Cerebral Cortex: *The largest part of the brain. It is subdivided into several parts, including the frontal cortex (motor), parietal cortex (sensory), temporal cortex (hearing and speech) and occipital cortex (vision). The sensory cortex receives sensory information coming from the spinal cord, and the motor cortex sends information back down.*

Diencephalon: *Structure in the center of the brain which includes the thalamus and hypothalamus.*

Dopamine: *A neurotransmitter released from neurons in parts of the brain (such as the Reward Pathway) especially involved in drug addiction (and other reward-activation disorders).*

2.

Hippocampus (Gr: hippo = horse + campos = sea animal): An area lying beneath the **cerebral** cortex of the brain. It is involved in learning and memory.

Hypothalamic-Pituitary-Adrenal Axis (HPA Axis): Feedback loop which mediates level of arousal, stress and activity.

Hypothalamus: A portion of the brain lying beneath the thalamus and exerting influence on function of the pituitary and thyroid glands (among others).

Lobes: Specific areas of the brain (left and right hemispheres) performing specific functions:

a. **Frontal Lobe:**

Thought, Reasoning, Judgment, Planning

b. **Temporal Lobe:**

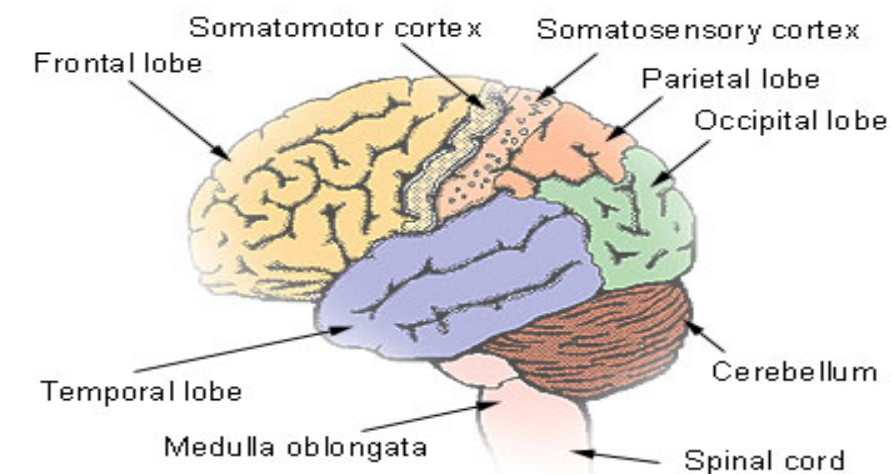
Hearing, Speech

c. **Parietal Lobe:**

Sensory Integration, Spatial Organization, Navigation

d. **Occipital Lobe:**

Vision



Lobes of the cerebrum

United States National Cancer Institute

3.

Locus Ceruleus: Brainstem nucleus mediating physiological response to stressful situations.

Nucleus: A group of specialized nerve cells (neurons), which act as a single unit in the brain and spinal cord.

Nucleus Accumbens (nucleus accumbens septi, "The nucleus leaning against the septum"): Mid-brain (limbic) structure mediating pleasure, reward and satiety. The largest neuronal nucleus in the septal region of the diencephalon (the diencephalon being made up of the thalamus, hypothalamus, subthalamus and epithalamus).

Prefrontal Cortex (PFC)/Anterior Cingulate: Cognitive (Thought-Related) and Affective (Emotion-Related) Divisions: Structures in the mid-front of the brain that both judge and sense emotions and help arrange tasks in critical order (See Anterior Cingulate Cortex).

Receptor: A special protein to which neurotransmitters, hormones and drugs bind. They are found on the membranes of the neuron dendrites, soma and even the terminal. Upon binding, the receptor changes shape to open a channel through which ions (see current) flow, producing a voltage across the membrane.

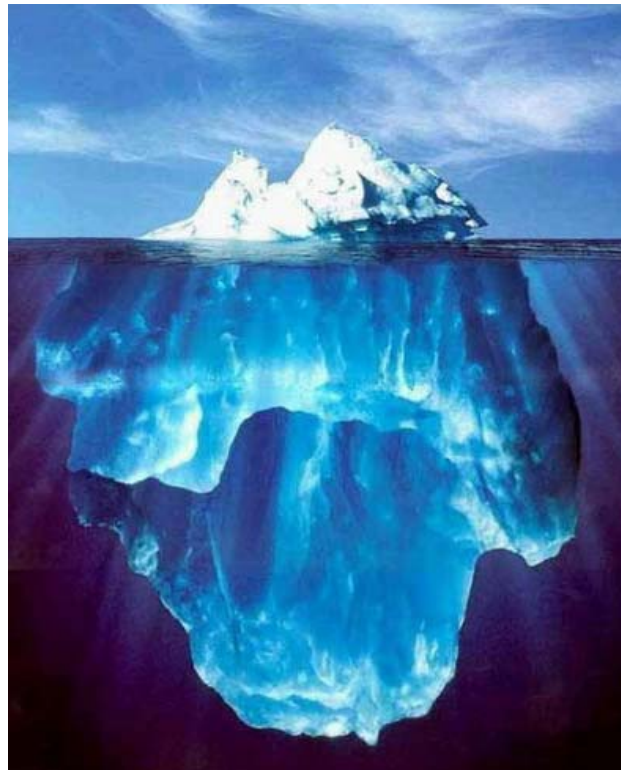
Reticular Activating System (RAS): Structures at the base of the brain mediating alertness and arousal (excitement, panic, surprise, etc.).

Reward Pathway: A specific network of neurons that become activated by pleasurable or rewarding behaviors such as use of cocaine, heroin, nicotine and alcohol, gambling, exercise, sex, eating, thrill-seeking, obsessive attention to detail, etc. Reward-mediated behaviors activate this pathway, which originates in the midbrain and travels through the nucleus accumbens and up to the frontal cortex.

4.

Spinal Cord: *A bundle of long neurons that travel up and down the vertebral column. The neurons form synapses with sensory neurons from the periphery to carry sensory information up to the brain. Neurons leaving the brain travel down the spinal cord and form synapses with neurons that direct muscle movement.*

Thalamus: *A structure of the diencephalon, located in the center of the brain. It functions as a sort of relay for information from the auditory, somatic and visual systems to the frontal cortex and also serves an important function in regulation of sleep, wakefulness, awareness and activity (arousal).*



Resource:

*The Rip Van Winkle Effect:
Recovery Challenges of Regaining Lost Function*

Everything we do as therapists is geared toward one goal: improved functionality for our patients. Part of getting better, of course, is the understanding that substance-related and addictive disorders are chronic conditions necessitating ongoing management, but once people begin achieving the goal of functioning better, how do they learn to tolerate that higher level of functioning without sabotaging it just to feel “normal” (i.e., dysfunctional) again? What if, like Rip Van Winkle, your whole world seems to have undergone a transformation since you’ve been “asleep”?



I just recently got new hearing aids. I'd long been making do with an older pair that were on their last legs, so I finally broke down and sprang for a new set. I hear very much better than I did before. That's a great thing, right?

Absolutely! But ... I'm finding it's a re-learning process in listening in a new, improved way and responding to the expanded world of sound around me. It's certainly a doable thing, but I notice I have to take things a little more slowly and deliberately to track with my surroundings now that I can hear them better.



As an example, I get audible cues that I was missing before, such as the natural echo that comes after a bird call. As someone with a background in audio engineering and psychoacoustics, I understand that what's happening is that I'm having to re-train my brain now that the hearing centers are being supplied with a fuller audio imprint of the world around me.

A more-cogent clinical example of this “Rip Van Winkle Effect” is found in Dr. Oliver Sack’s book, “Awakenings,” which details the life-changing emergence of “sleeping sickness” (*encephalitis lethargica*) patients with doses of dopamine, which brings them out of their stupor and allows a much-more normal functional level. Sadly, many of the patients were not able ultimately to tolerate the side effects of the L-dopa that had brought them out of their stupor, although a lucky (?) few were able to sustain a precarious recovery.



Robin Williams, Robert De Niro in
“Awakenings” (Penny Marshall,
1990) Columbia Pictures

Now we bring our attention to our own patients in recovery in addictive and co-occurring disorders. They, too, have long been “asleep” and are now on the cusp of a new life, i.e., their own kind of awakening. (It is not inconsequential that the 12th Step of Alcoholics Anonymous uses the word “awakening” to describe the transformation in self-awareness that the Steps promote and sustain.) Now that we have invited these patients out of their “sleep,” what will their lives be? And what of their caregivers, who now also have to adjust by providing them “breathing room” to grow and to find their own new identities as a loved one of someone so long asleep?



To appreciate the challenges that people in early recovery face, just look at this list of signs and symptoms appearing in abstinence. Remember that this is only a *partial* catalog of signs and symptoms the counselor is faced with when the patient first walks through the door, and this roster excludes additional symptoms from co-occurring disorders such as depression, anxiety, and personality disorders:

1. Continued craving for chemicals/gambling
2. Frequent exposure to craving triggers in external and internal environments
3. Confusion, including a sense of disorientation with rapid stabilization
4. Memory impairment
5. Emotional lability
6. Clumsiness
7. Fear of the unknown
8. Unresolved grief
9. Unresolved traumatic memories, nightmares, intrusive daytime thoughts, bodily recall of trauma (“body memory”), and “flashbacks”
10. Dissociation (possibly both passive and rageful)
11. Uncertain place in both family of origin and marriage/romantic relationships
12. Sexual/gender orientation confusion and fear
13. Parental challenges borne of their history of addiction-related inadequate parenting
14. Physical fatigue
15. Skewed view of the world as hostile and threatening or as disinterested and indifferent
16. Attachment difficulties
17. Executive function impairment
18. Drug-related medical problems



For survivors of trauma (which includes almost all of the people who come to us for treatment), long-practiced defenses are not relinquished just because someone becomes abstinent; defenses are, in fact, often more-prominently-displayed and seemingly intractable. One of the more-common defenses is fixation, a tendency to strive unconsciously but deliberately to remain at a certain level of development for fear of assuming a more-mature functioning in the world. The fear involved in fixation is of failure when one accepts more responsibility for mature functioning. As a patient once said to me, “What if I can’t hack it? What if I go out there [in the world of sobriety] and just screw it all up?”

I reassured the patient that such a fear is universal in those in early recovery and that there is plenty of support and encouragement “out there.” Besides, I told him, nobody succeeds at everything they try, and there’s no shame in trying something and not succeeding. So-called “failure” is often borne of the attempt to do the impossible, anyway, so it’s expected. (An example would be the “failure” of the child to bring about the recovery of a parent.) “Failure” simply shows us our limits at that particular time. In such cases, “success” may well mean to stop trying to do the impossible!

Unresolved trauma is another challenge of early recovery, and one that, until relatively recently, hasn’t received the emphasis it deserves. No one comes out of a family hobbled by addiction without experiencing some sort of trauma, whether it be physical violence, sexual molestation, abandonment, etc.

All human beings have two basic fears, and they're opposed to one another. One is fear of abandonment. The film, "Home Alone," strikes a nerve because it deals with that basic fear all children have of being left alone by their caretaker. Children are fully aware that they cannot survive without someone to care for them in ways they are not yet able to. Rage and terror are the result.



Macaulay Culkin in Home Alone (Chris Columbus, 1990) 20th Century Fox Film Corporation

The other basic fear is that of engulfment, being smothered or overpowered, with no "breathing room" in which to function. This fear is elicited when a child is molested or otherwise overwhelmed by someone being too close in. Children are fully aware that they lack the ability to defend themselves beyond a rudimentary "safety zone." When that zone is breached, they panic, as we all do. Again, rage and terror are the result.

There are two ways to deal with the legacy of these nightmarish fears and the powerful memories and emotions they engender having come true in the child's life: Detachment from the world (flight) or hostile engagement (fight). Children will dissociate by self-soothing to the point of minimal responsivity to affection and caring; or they'll adopt a hostile stance toward the world to ward off further attacks.



In all cases, it's critical to remember that, in one way or another, survivors of trauma did, in fact, experience everyone's worst nightmare: For them, Chicken Little was right: the sky *did* fall!

Small wonder, then, that many people take refuge in chemicals or behaviors that enhance their ability to "zone out," or dissociate. Abstinence and recovery invites them to forego their "comfort drugs" and engage the real world as it is. (Those in recovery speak of "accepting life on life's terms.") If we are to participate with them in "waking up," they're going to need to be able to address those traumatic memories and the emotions that accompany them and to learn to prevent a re-enactment scenario where they unconsciously but deliberately go "back into the frying pan."



Such therapy does exist, and it is very helpful in lessening the power of traumatic memories and of the cravings to use chemicals that accompany them. With coaching in self-pacing, improvement of executive functioning, and development of a support network that validates and sustains their sense of belonging, stable, abstinent recovery becomes feasible. They can wake up out of their long sleep, take their place in the real world, and—as do all people—“strive to be happy.” They find that their ongoing recovery can be summarized in two words pregnant with meaning:

“Good morning.”



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Resource:

Into Action: How People Change

Recovery in any chronic mental illness is an ongoing, lifetime process, one that is more than merely "getting over" an episode of the illness. Like every other mature adult, people in recovery are always changing, in the process of becoming more mature versions of themselves. The advent of the art and science of promoting those changes was one of the most remarkable innovations in the field of behavioral health of the 20th Century, answering some very basic questions about how people envision and implement change.



Recovery itself begins with admitting there's a problem. The person must give up the thinking that there is nothing wrong (denial) and begin taking stock of how the disease has affected their lives and their loved ones' lives and to become educated on the nature of the disease and its daily management. This courageous step of admission often depends on the help of a professional therapist and a support group. The discipline of recovery can be taught easily enough; the difficulty lies in the acceptance of the need for ongoing, lifetime recovery.

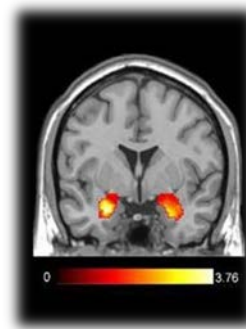
To illustrate how people make changes in their lives, let me tell you an anecdote about something that happened to me several years ago. One beautiful afternoon, I was driving on an interstate to go to a conference. I remember entering the highway noting that the weather is what pilots call "severe clear," the visibility stretching all the way to

the horizon. As the song says, on this clear day, you really *can* see forever. I drive on for several miles with not a care in the world, marveling at the beautiful weather.

At some point, it seems to me that there begins to be something just a little, how to say it ... different ... “off” ... about the horizon. It’s the same as it has been, and yet, it’s *not* the same as it seemed just a few moments ago. Something is different somehow. I think to myself, “If I stop here, turn around, and go in the opposite direction, I might even believe that what I think I’m seeing is just an optical illusion, maybe heat waves bending the light as they rise off the road on a hot day.” Except that it isn’t a hot day; the temperature’s in the low 40s. “So much for that theory,” I remember thinking.

I’m going on about all this at such length because I’m trying to impart to you the gradualness with which my brain is cluing me in as to the situation at hand. Since I don’t turn around and am still moving in the same direction, I come to see that, in fact, there *is* something different about the horizon I’m seeing now. I hadn’t expected to see anything out of the ordinary when I started out this morning, so, for a long time, it’s hard to come to believe that something *is actually amiss*. Now, it’s undeniable: I’m having an “uh oh” moment about this “thing” on the horizon, and I’m now about to embark on a sort of “neurological teleconference” that will ultimately save my life. “What is going on here?” part of my brain is signaling to another part, in the back of my consciousness. (Literally behind my conscious awareness: this preliminary communication is happening between my amygdala, hippocampus, and some other players.)

And now I get a clear, conscious message from my threat center, my two amygdalae: “We have a problem. Danger.”



I query them, “What’s the problem?”

They whisper: “*We have a problem. Danger. We don’t know what’s wrong, but there’s a problem. Danger.*”

I respond, “If you don’t know what the problem is, why should I believe you that there is one?”

I get an answer: “*Danger. There’s a problem. Danger.*”

I respond, “Fine. Ok. There’s a problem, and you don’t know what it is, right?”

“*Danger. There’s a problem. Correct. We don’t know what’s wrong, but there’s a problem. Danger.*”

“Well, what am I supposed to *do* about it?”

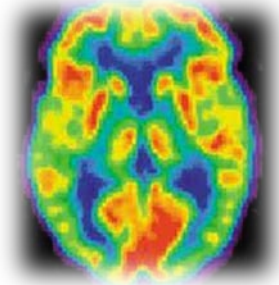
"Danger. There's a problem. We don't know; that's not our job. Danger. There's a problem. We're forwarding this message to your front brain. Danger. There's a problem. Danger."

"Why do you keep telling me there's a problem?"

"Danger. There's a problem. Because it keeps being true. There's a problem. Danger."

"Oh! Well, thanks for letting me know!"

"Danger. There's a problem. Danger." [They will reiterate this single message repeatedly until I'm out of danger later.]



I tune into my front brain (FB), a center of reasoning and judgment, and my anterior cingulate cortex (ACC), which, among other functions, helps me decipher contradictory situations. "FB and ACC, how about you? Got any ideas about what I should do about this 'thing' on the horizon?"

My front brain suggests, "Might want to ease up off the gas a little." My ACC says, "I can't tell yet if it's safe or dangerous. Better assume the worst until we know better."

"Why ease up off the gas?"

It says, "Think this through, Kent. You're traveling 70 miles an hour in a 3500-pound vehicle, and your visual cortex is sending me information that the ... 'thing' on the horizon seems to have gotten a little bit bigger in the last couple of minutes. Although you're going 70, it's not certain that *it's* moving at all."

Well, now I'm literally alarmed, so I do what my FB tells me to: I slow down just enough not to be a hazard to the cars behind me. I still don't know exactly *why* I'm slowing down, except that I believe and feel that I need to. I have the sense of being in potential danger because my brain is alerting me that I am. In my newly-alerted state, I continue to travel toward this ever-so-slowly-growing "thing" on the horizon.

"So then what do I do, FB? Can you come up with a plan?"



“Yes, but I need more information. Let’s get your hippocampus [a center of learning and memory] to pull some information about what you did last time you were in a situation like this. HC? What do you have for us? ... Ok, got it. Thanks! HC’s telling me that the last time you were in a situation like this, an 18-wheeler had blown a tire. That time, you slowed down and carefully went around the tire debris in your lane.”

I press for an answer. “Ok, but I can’t really make out just what’s in the lane just yet. What do I do?”

My front brain reminds me, “I can’t know yet, Kent. We need to consult your visual cortex in the back of your brain. VC, what do you see?”



My VC, a vision-processing sheath of neurons in my occipital lobe, responds, “Scan the scene with your eyes” [FB and ACC chime in: “Look for anything out of the ordinary.”] ... “Ok,” says VC. “I have it. I see a ... some sort of cage-like structure, but I can’t make out what it is ... but I’m beginning to be able to see enough to tell me that it’s really big!”

“Not good, says FB. “How big is it, VC?”

“It seems to be enormous, like it takes up the entire lane we’re in!”

“Um ... you *are* slowing down, aren’t you, Kent?”

“Yes, FB.”

“Good! Thanks, VC! Hey, HC! Quick! Do you have anything on evading a cage-like structure taking up a whole lane of an interstate highway?”

My Hippocampi reply, “Hang on ... Looking ... No ... just a lot of ‘blown-tire’ and ‘disabled vehicle’ stuff. And some police traffic management at an accident where somebody ran off the road. Sorry, that’s all I have to send you at the moment.”

FB says, “Thanks for trying, HC! Kent, we’re going to have to extrapolate a bit from that time you evaded a blown truck-tire. Remind him of that incident, please HC.”

My hippocampi comply, so I recall navigating through an accident a few years back where someone had skidded off the highway.

My front brain continues: “What do you see now, VC?”

“Now it’s pretty clear that our whole lane is blocked by this ‘thing.’ ”

“Ok, Kent. From past experience, I know that we came through safely when you slowed down, got out of the lane you’re in, and—hey, VC, see any police?”

“Yeah. They’re everywhere, and they’re moving their arms and pointing.”

“Great! Thanks, VC! Educated guess, Kent, they’re probably directing traffic. Here’s the plan. We know what’s in your best interests, so, if you can do it safely, get into the other lane *now*. When you get to that ‘thing’ in the highway, follow the directions of the police on the scene *really carefully*. *Do whatever they tell you to*. They’ll get us through this ok. Got that?”

“Got it. Thanks, everyone!”

So that’s what I do. I slow down, get into the other lane, which is open to traffic, and we’re all guided through this obstruction by the police. What is blocking the lane is, indeed, a 15-foot-tall, metal, cage-like structure, the purpose of which I cannot begin to fathom. What *is* very clear to me is that, had I not listened to and heeded this inner conversation, and had I hit this “thing” at cruising speed, I’d’ve have been killed instantly. I received the right kind of help at the right time—from my brain as well as the State Police—and *I was open to accepting and using it*. Why was I open to accepting help? *Because I saw doing so as being in my best interests*. Before I knew it, we were all on our way again, heading down the highway without incident. It could have been a disaster, but it wasn’t. No injuries, no fatalities. *Safe*.



So let’s tie this experience in with how people change. In the late 1970s, two psychologists, James O. Prochaska and Carlo DiClemente (and, later, Wayne Velicer), formulated a progression of awarenesses and behaviors that they called the “Transtheoretical” or “Stages of Change” model. The Stages are: Precontemplation, Contemplation, Preparation, Action, Maintenance, Termination, and, possibly, Relapse, which is no longer considered a specific Stage.

Here's a description of each of the Stages, paraphrasing the authors, along with the tie-in to my experience on the interstate:

Stage 1, Precontemplation: Not intending to take action in the foreseeable future. When I started out that morning, I was unaware there would be an obstruction on the highway. (The vehicle I owned then didn't have GPS-assisted navigation.)

Stage 2, Contemplation: Beginning to recognize that current behavior is problematic, and starting to look at the pros and cons of continued actions. As I traveled, I begin perceiving something different—a little “off”—about the horizon, and it began to dawn on me that I needed to consider doing something different than planned.

Stage 3, Preparation: Intending to take action in the immediate future, and (maybe) beginning to take small steps toward behavior change. I note that a sense of threat, or alarm, was forming in my mind, and I marshalled my mental resources, my front brain, hippocampi and amygdalae, and my vision, to guide me through the impending danger.

Stage 4, Action: Making specific, overt modifications in modifying behavior or in acquiring new healthy behaviors. I heeded what my mind was telling me, and I took specific actions—slowing down, moving into the unobstructed lane, and obeying the State Police—to move safely through the potential danger.

As for Stage 5, Maintenance, I do my best to practice defensive driving skills, including attention to road conditions and looking ahead to possibly dangerous situations further down the road.

Recovery is an entire process of being well, a lifetime collaboration with the illness rather than conflict with it. The threat isn't typically a metal cage in the highway; it's being unexpectedly confronted with a trigger to use or drink or gamble. Cultivating this model of change can guide people with addiction through dangerous situations so they come out the other side. No relapses, no fatalities. Safe.

Resource:

*Living in Fast Forward: Addiction and
Attention-Deficit/Hyperactivity Disorder*

In recent years, there's been something of a quiet revolution in treating addiction. It's becoming clearer that success in recovery beyond mere abstinence involves learning and practicing the skills of sustaining attention, self-pacing, repetitive and sequential behavior, placing a delay on reaction, and declining to react physically, to learn how to "put on the brakes." Even the "Big Book" of Alcoholics Anonymous cites the importance of learning and practicing the art of restraint.



The fear of having somehow damaged one's brain is a common one in early addiction recovery, and many people with addictive disorders will articulate it out loud. Even compulsive gamblers and people with other problems in impulse control who never abused alcohol or other drugs wonder aloud about their apparent lack of mental focus and disorganization. While "brain damage" in the traditional sense is unusual, there are real functional problems that become apparent only after abstinence in addiction begins. These deficits, which "ride along" in people with addiction, involve the abilities to pre-envision, plan, order and carry out tasks. In more technical language, these problems are referred to as difficulties in executive function in the brain.

The exercises, or games, alluded to later have been used with actual inpatients and outpatients. The response has generally been very favorable, as long as the participants understand two points:

First, that there is no intention to make light of these deficits, and, second, That practice brings enhanced skill

Research consensus describes addiction as a chronic neurological disorder, which both involves and worsens specific deficits, including problems in cognition, motivation, and insight; behavioral disinhibition; attention deficits; emotional instability; impulsiveness; aggressiveness; depression; anhedonia; and persistent movement disorders.



Executive functions are those abilities of attention and concentration that allow us to perform and complete tasks and then shift attention to new tasks. Here is a passage from the American Society of Addiction Medicine's Long Definition of Addiction. We're struck by the impression that, if this passage isn't describing true attention-deficit disorder, it's coming very close to delineating a disorder that, as yet, hasn't been named: "In addiction there is a significant impairment in executive functioning, which manifests in problems with perception, learning, impulse control, compulsivity, and judgment. People with addiction often manifest a lower readiness to change their dysfunctional behaviors despite mounting concerns expressed by significant others in their lives; and display an apparent lack of appreciation of the magnitude of cumulative problems and complications." The authors continue, "The still-developing frontal lobes of adolescents may both compound these deficits in executive functioning and predispose youngsters to engage in 'high risk' behaviors, including engaging in alcohol or other drug use. The profound drive or craving to use substances or engage in apparently rewarding behaviors, which is seen in many patients with addiction, underscores the compulsive or avolitional aspect of the disease. This is the connection with 'powerlessness' over addiction and 'unmanageability' of life, as is described in Step 1 of 12 Step programs."

In their paper, "Attention to action: willed and automatic control of behavior," Donald A. Norman and Tim Shallice have outlined specific executive functions:

Those that involve planning or decision making

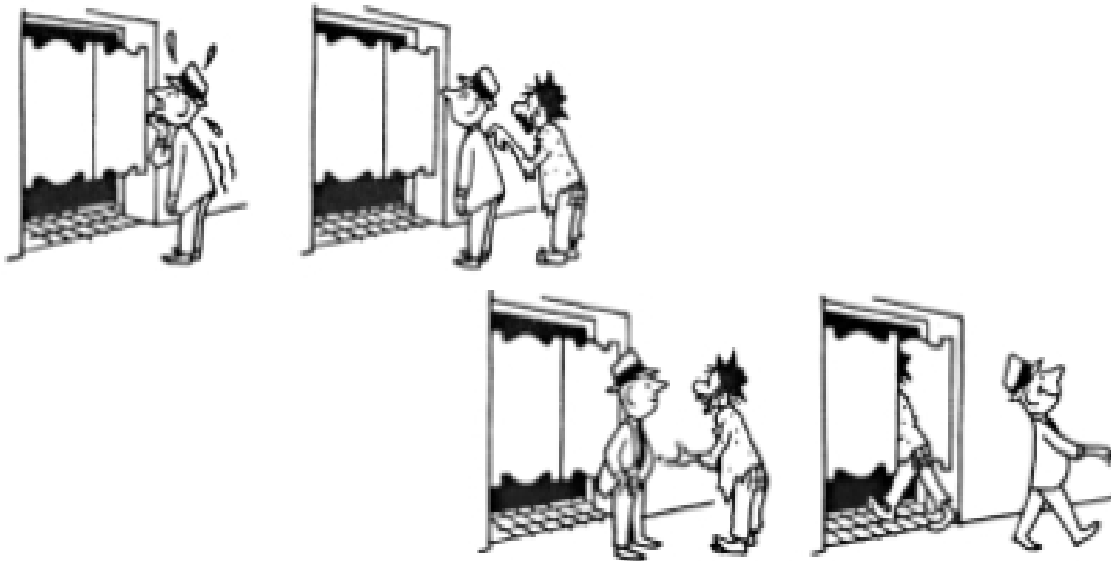
Those that involve error correction or troubleshooting

Situations where responses are not well-rehearsed or contain novel sequences of actions

Dangerous or technically difficult situations

Situations that require the overcoming of a strong habitual response or resisting temptation.

In the abstract to their paper, Norman and Shallice write: “The major theme of the paper is that the primary role of attention is in the control of action. The basic idea is that human action sequences can run themselves off, efficiently, smoothly, without any need for deliberate attention. However, when modifications in a plan must be made, *or when it is desired that some novel alternative action sequence be followed, or when it is desired to prevent some habitual act from occurring* [italics mine], then it is necessary for deliberate attentional intervention into the process.”*



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In other words, the challenges that accompany doing something new or even something that is not well-rehearsed (such as declining the action of drinking, using or gambling, for instance) rather than resorting to “going through the motions,” require that attention be paid to the new task, lest the person find himself reverting to old, previously practiced behavior. As the saying goes, “If you do what you always did, you’ll get what you always got.”

Understanding is important, but *doing* is everything! An early illustration of this truth is found in the Twelve Steps of Alcoholics Anonymous, all of which describe *doing* something. (Interestingly enough, a verb is the first significant word in each of the Twelve Steps, and they’re described in the A.A. Big Book Chapter called “How It Works.”) We know that specific areas of the brain respond to various types of repetition. As these brain areas become more practiced at the skill they’re being taught, the skill becomes more automatic. If practice is lacking, the skill deteriorates.

A.A. also advocates for doing what is necessary to stay in the reality of recovery rather than lapsing into the fantasy of being able to take that first—or next—drink with impunity, without spiraling headlong into yet another alcohol-fueled catastrophe. Meditation (or what we might refer to nowadays as mindfulness) is the perfect antidote to impulsive behavior and bollixed-up emotions. The overarching task is to stay grounded in reality; in the here and now.

Exercises (“games”) have been designed that enhance specific functions of the brain typically *under-practiced* in active addiction and in early recovery. It turns out that one of the most important of these brain skills involves declining to do something, “putting on the brakes.” *Remember: declining to do something is a complete action in itself*, an action which is *different from not* doing something because you haven’t considered doing it. The importance of this skill is obvious to anyone who has struggled with addictive behavior. It’s not about “just saying no;” it’s more accurate to say it’s about saying, “No, not right now. Not this second. Not this moment. Not now. Not here. Not today.”



One of the games involves offering someone a small ball. The sequence goes like this. John and I are within reaching distance of one another. I say to him, “Hi, John.” He responds, “Hi, Kent.” Notice that John and I are now engaged in paying attention to one another. Once that attention has been established, that connection made, I say, “John, please take this ball.” I show him the ball, but I don’t reach out to him to offer it just yet.” John says, “Ok.” Only then do I offer him the ball. He has been instructed to count silently to ten before reaching for the ball and taking it. Once he has reached the count of ten, he reaches over to me and takes the ball. Sounds pretty easy, in fact elementary, doesn’t it? The reality is that addicts have special difficulty doing this, because the parts of the brain that enable someone to decline to act on an invitation are, shall we say, “rusty” at best. The impulse is to take the ball immediately, and declining to do so takes special effort and has to be a specific and much-practiced, single-minded goal for the person to be able to carry it out effectively and reliably.

Here’s what got me thinking along these lines some years ago. I used to teach at a K-12 school. As I was leaving the campus at the end of a school day, I walked past the gymnasium, as I always did, to get to the parking lot. The doors to the gym were open, and as I approached the gym, I could hear a lot of shuffling and laughing. Curious as to what was happening, I looked inside and saw the varsity basketball team in a practice session. What was fascinating to me was that there wasn’t a basketball in sight. The team was running single-file up and down the gym in a more or less straight line as fast as possible. Interestingly enough, they were all running backwards! As you might expect, many of them were falling down on the heavily-padded gym floor, laughing as they lost balance and fell. I thought to myself, “Why in the world would the basketball team be doing something so bizarre? What could running up and down the gym backwards possibly have to do with practicing playing basketball?”



Immediately, of course, it dawned on me why the coach would have the team doing that. When you're playing a real basketball game, you have to do a lot of running more or less backwards, and you have to do it without falling down and without fouling the player next to you. The coach was running them through their paces doing a movement isolated from playing basketball as a whole. He was giving them a tool they could use during a real game, and he introduced it to them and practiced it with them in its simplest form. No dribbling, no throwing, just the single act of running backwards. Taken out of context, it didn't seem to make a lot of sense. Put in the context of a real game, it made all the sense in the world!

Going back to my description of the ball-passing game a moment ago, the real-world utility of that game and its skill set become apparent as John, who happens to be an alcoholic in early recovery, is with friends one evening. One of them—presumably not knowing that John is an alcoholic in early recovery—suggests they all go bar-hopping. John has recent memories of getting drunk and initially enjoying the experience and then also coming to regret having gotten drunk when he had an auto accident and smashed up the family car. The invitation to go bar-hopping incites within him both an anticipation of the pleasure of getting drunk and the dread of what he fears may happen—again—when he does so. *Both the anticipation of drinking and the dread of the likely consequences activate the reward centers, making it especially difficult for an addict to think straight.* Since John can't summon the attentional focus to take himself out of the immediate situation and, perhaps, call his sponsor to discuss the craving and get support, he has yet another relapse.

If, on the other hand, John has systematically cultivated the knack of installing a period of time between the invitation to go bar-hopping and what he does next, he can fall back on that now-practiced response of waiting until his head clears a bit and then getting support from his sponsor, to keep him grounded in reality. This time, in the face of the invitation from his friends, John is able to perform what may seem like a miraculous feat: *he does nothing. For a period long enough to allow him to come back to himself and reorient to reality, he simply stays still and does nothing.*

Again, the overarching task is to stay grounded in reality as a guide for what should be the next move, when the time is right to make it. For now, however, do nothing. Just be.



Harm reduction strategies and activities stem from the desirability of adopting and sustaining practices that mitigate risk and minimize the frequency and severity of harm to our patients (as in a relapse). As important as theory is in psychiatric disease management, its utility is realized only in the doing of behaviors that promote abstinence and recovery. Patients can benefit from contingency planning and from intelligent management of time. Scheduling their day is one very empowering way of helping them stay mentally focused.



The logic of time management in recovery and in relapse-prevention planning goes like this:

There is only one of me.

Since there is only one of me, I have only one brain.

Since I have only one brain, I can pay attention only to one thing at a time.

Since I have only one brain, I can think only one thought at a time.

Since I can think only one thought at a time, I will experience only one emotion at a time.

Since I have only one brain, I can do only one task at a time.

Since there is only one of me, I can be in only one place at a time.

Since it is always today, I can live in only one day at a time.

Therefore: I ask myself the question: "Right here, right now, am I where I'm supposed to be, doing what I'm supposed to be doing?" As long as the answer is "Yes," I can't relapse. If the answer is "No," I reserve the right for the rest of my life to stop and re-set my day as many times a day as necessary to get and stay on track.

*Norman DA and Shallice T: Attention to action: willed and automatic control of behavior. In M Gazzaniga (ed.): Cognitive Neuroscience: A Reader. Blackwell, 2000

Resource: Basic Psychopharmacology
"Frankendrugs": A "Rogue's Gallery" of Synthetics

There's a wise adage in psychopharmacology: "Any drug that has the power to do good has the power to do harm." Some current designer drugs were originally synthesized for study purposes, but they've found their way onto the street, where they're often doing incalculable harm to those seeking to get high. In this article, we're going to examine a "rogue's gallery" of designer drugs that have fallen into the wrong hands across the country as of this writing (2017).

Synthetic Cannabinoids (a.k.a. "Mojo")



Although originally designed for pharmaceutical research in pain management, synthetic cannabinoids are used for recreational drug use. The irony of this situation is that the reason they were synthesized to begin with was legal restriction on using naturally-occurring cannabinoids in research. These synthetics are currently being studied to assess their therapeutic potential.

In illicit use, these synthetics are used for their effects similar to natural cannabis. Synthetic cannabinoids do have their selling points: they're a good deal cheaper than the naturally occurring varieties, and (unfortunately) they're also easy to get through convenience stores, tobacco shops, or head shops. **A typical drug assay won't identify synthetic cannabinoids where natural cannabis would show up.** Legally, it's a slippery slope, since synthetic cannabinoids have been legal in the past, or at least, not illegal to sell or possess.

They can be any of a number of different drugs, each with different effects. There's no way to describe general effects among all the different chemicals because they're all different. Also, **each synthetic cannabinoid will have different effects at different dosages, but because the drugs are crudely manufactured, it isn't possible to know what chemicals the drugs contain or how much of any chemical a user is taking.**

Synthetic cannabinoids are potent drugs capable of causing clinical intoxication and death (probably due to CNS depression and hypothermia) when used. Many compounds have been banned in the U.S., but new examples are always being found. Often, those new versions are different enough to be able to circumvent current bans.^[1]

As is often the case with illegal compounds, no official studies have been conducted on the effects of synthetic cannabinoids on humans. Compared to tetrahydrocannabinol (THC), the adverse effects are often much more severe and can include tachycardia, elevated blood pressure, blurry vision, nausea and hallucinations. Other symptoms include epileptic seizures and acute psychosis.

Current studies indicate correlations between synthetic cannabinoids and episodes of psychosis, so physicians are developing vigilance about investigating possible use of these synthetics in their patients with presenting psychosis, especially when the presentation's cause isn't clear. **Such episodes can continue to occur for a few months after the patient is verified to have stopped using synthetic cannabinoids.**

Kratom (*Mitragyna speciosa*, a.k.a. "ketum")



The kratom is a Southeast Asian tree, the leaves of which have long been used for pain relief. They're typically crushed and brewed as tea or made into pills or capsules. Kratom is a stimulant at lower doses; at higher concentrations, it's a sedative. The DEA says it can trigger psychotic episodes and that it can be addictive. **Kratom targets the brain's opioid receptors.** Some researchers have noted that kratom doesn't produce respiratory depression as do other opioids, and there's work in progress to study it further to see if some of the compounds made from it can be exploited for their medical benefit.

Walter C. Prozialeck, PhD, chairman of the department of pharmacology at Midwestern University in Illinois, has analyzed a number of kratom studies and said he has questions about its addictive nature.

"If it lived up to its billing, some of the compounds in kratom could be useful at least as the basis for the development of better drugs that would treat pain without the addictive benefit of opioids. That would be an amazing advance in pain management, but nobody knows how research will turn out. It could be a dead end. The biggest negative of the DEA ban is it will stifle any research in this area." [2]

Flakka (a.k.a., "gravel")



"Bath salts," a group of related drugs banned in 2012, are making something of a disguised comeback in "flakka," a synthetic producing a cocaine-like high. "Flakka," which can be smoked, snorted, or injected, has the potential to be much more dangerous than cocaine. Even a small overdose can produce methamphetamine-like symptoms: "excited delirium," violent behavior; spikes in core temperature, and paranoia; however, it's most famous—even notorious—for evoking PCP-like super-strength.

"Flakka" (Spanish slang for a beautiful woman, "la flaca") contains a chemical pharmacologically similar to methylenedioxypyrovalerone or MDPV, which is found in so-called "bath salts." **These chemicals' mode of action is similar to cocaine and methamphetamine, i.e., causing dopamine and serotonin surges and then inhibiting the reuptake of those neurotransmitters.** The chemicals in "flakka," however, produce these effects for a far longer period of time. Because the affected neurons can be permanently altered, there is great concern is that the effects of the drug may be permanent. Another possibly-permanent result of its use is its effect on the kidneys; it's frightening to note that people who live through a "flakka" overdose may have to be on dialysis for the rest of their lives.

Although the FDA has placed a temporary ban on "flakka," one way to circumvent the ban is to label the substance "not for human consumption." Nonetheless, a ban might at least serve to discourage potential users.

2C Group (named by their creator, research pharmacologist Alexander Schulgin [1925-2014], from their chemical structure)

When 3, 4-methylenedioxymethamphetamine (MDMA, "Ecstasy") was banned in the US in 1985, 2C drugs became a quick replacement in the club scene. **The main varieties of the 2C group were made illegal in 1994.** Also, like many synthetic drugs, renegade chemists began creating slightly different versions of the drugs so they could claim to sell a legal version of the compound.

The 2C family has historically not been studied as much as some other synthetics because of the number of fatal overdoses. To complicate the picture, it's known that altered versions of the original 2C types can also be significantly more potent, causing tachycardia, among other complications. Not unexpectedly, problems can occur also when 2C drugs are taken with other substances.



MDMA-assisted psychotherapy has shown promise as a treatment for disorders like PTSD and anxiety in clinical studies. Shulgin believed 2C drugs could provide similar benefits. He was horrified that they were being used illicitly without appropriate control. In a 2003 interview, he said, "2C-B is, in my opinion, one of the most graceful, erotic, sensual, introspective compounds I have ever invented. For most people, it is a short-lived and comfortable psychedelic, with neither toxic side effects nor next-day hangover. Its effects are felt very much in the body, as well as in the mind, and thus it has found clinical use as a follow-up to MDMA." [3]

Desomorphine (a.k.a. "Krokodil," possibly related to the similarity to skin, damaged by the drug use, resembling crocodile leather.) Desomorphine was first synthesized in the U.S. in 1932 and patented in 1934. It's a synthetic opioid with powerful, fast-acting effects, such as sedation and analgesia. While it was found to be faster acting and more effective than morphine for the rapid relief of severe pain, its shorter duration of action and the effects of respiratory depression, dangerously lowered blood pressure, and urinary retention appear to override any advantages.



In a manner similar to the production of methamphetamine, "krokodil" can be fashioned from OTC codeine and iodine and phosphorus from matches. It goes without saying that this bootlegging process can easily introduce contaminants with other drugs or substances. Like methamphetamine, desomorphine made this way is often contaminated with various agents.

“Krokodil” has been dubbed the “flesh-eating drug” because of the frequent occurrence of tissue damage among addicts. (The pure form of the drug doesn’t cause tissue damage.) Early medical trials of desomorphine show that even in small doses, there is a high potential for addiction, and tolerance can appear quickly. However, though tolerance to respiratory depression with repeated doses was observed in rats, early clinical trials failed to show any tolerance to these same effects with repeated doses in humans.

25I-NBOMe (2C-I-NBOMe, Cimbi-5, or "25I" (a.k.a. “25i,” “N-Bomb,” “Solaris,” “Smiles,” “Wizard”)



“N-Bomb.” a highly potent serotonin 2A receptor agonist, appeared as a common recreational drug in 2010. **“N-Bomb” is a psychedelic hallucinogen used recreationally and in biochemistry research for mapping the brain’s use of the serotonin 2A receptor.**

25I-NBOMe has effects that are similar to those of LSD. Apparent overdoses have occurred when it is taken by mouth. Other common routes of administration include under the tongue (sublingual), between the gums and cheek (buccal) on blotter paper, and intranasal.

U-47700 (a.k.a. “U4,” “Pink,” “Pinky”)

A research chemical known as U-47700, or “Pink,” has been cited as the cause of dozens of deaths across the U.S. in the last several months—including the overdose death of Prince, caused by a “cocktail” that included Fentanyl and U-47700.



U-47700 was created in a lab by 20th-century pharmaceutical giant Upjohn. In 1976, chemist Jacob Szmuszkowicz patented the drug after a round of animal testing, noting that the new opioid blend was more potent than morphine but with supposedly

less addictive potential. **U-47700 was intended to treat severe pain associated with cancer, surgery, or injury. It was never tested on humans, and it ended up being relegated solely to research.** “Pink” and Fentanyl have been combined and sold on the street as a kind of bootleg Norco, and it causes a euphoric sense of relaxation and sedation. It’s said to be several times as strong as morphine. The downsides are its tendency to create marked respiratory depression and, of course, habituation and dependence.

^[1] <https://www.consumerreports.org/drugs/synthetic-marijuana-real-risks/>

^[2] Prozialeck, Walter C. Interview with Las Vegas Channel 8 KLAS: Now What Is Kratom? Why Does the FDA Want to Ban It? September, 2016

<http://www.lasvegasnow.com/webmd/webmd-addiction-substance-abuse/what-is-kratom-why-does-the-dea-want-to-ban-it/550020438>

^[3] Shulgin, David. Interview with “Brian.” What Is 2C-B? Center for Cognitive Liberty and Ethics (2003)
<http://www.cognitiveliberty.org/shulgin/adsarchive/2cb.htm>

Resource:

How to Sabotage Your Recovery

From looking at the title of this training, you might well ask, “Why in the world would anyone want to sabotage their own recovery?” After all, our patients aren’t explicitly trying to cause themselves harm and frustration. The goal of self-sabotage is to circumvent, to avoid the pain and fear which come inevitably with any profound life change, including the changes that come with a critical illness and its treatment. As such, the motivation of the self-saboteur is defensive rather than self-offensive; it’s a flinch from what’s perceived to be unendurable pain.

Fear and grief and their various disguises mark all attempts to sabotage recovery. There is a process of grieving that everyone in recovery has to pass through. The goal is to make that journey as uneventful and, if not brief, as efficient as possible. Recovery in addiction makes it essential that the person understand and deal effectively with the risks and rewards of living a sober life in the real world.

Such an endeavor as self-sabotage deserves to be taken seriously and dealt with compassionately and with all possible respect for the patient. It can be a life or death struggle.



Here are some common strategies people employ, whether consciously or not, that can serve as barriers to a reliable abstinence and recovery:

1. Self-Pity: “Poor Little Ol’ Me (PLOM)” is a self-assessment guaranteed to

promote a sense of helplessness and futility. How to manage self-pity? The defense mechanism of fixation shows us that self-pity can be an effective strategy for the patient to stay at the current, comfortable level of development rather than take the risk of assuming more personal responsibility and autonomy. Being active in working with other people in early recovery is a proven method for relief from self-obsession and self-pity. Patients benefit by working to help someone still struggling with day-to-day abstinence by being able to compare their current situation with that of someone who may be going through a more-difficult adjustment to early recovery.



Nevertheless, it's important to recognize that what seems like mere self-pity may, in fact, be grief over both the stresses of early recovery but also a dawning awareness of past losses, even trauma. Appropriate therapy to address trauma can be critically important, and the validation and encouragement that come from working with others in mutual support is also invaluable.

2. Negotiation (otherwise known as Bargaining) is a way of holding onto old ideas, situations and emotions that keeps the patient frozen at an introductory stage of recovery. We all know that bargaining is, itself, one of the phases of grieving that people move through as they accept the reality of having a chronic disorder. Trying to find "loopholes" in one's situation is a natural reaction to being confronted with the stark reality of chronic illness. It just takes time to accept the inevitability of illness and the reality that recovery will impose new ways of addressing the vicissitudes of life. Seeing how others are benefiting from adopting a different manner of living can be a powerful inducement for the patient to venture beyond comfortably-predictable behaviors and to try something new.

3. Compliance is manifest in the attitude, "Whatever you say. Just tell me what to do, and I'll do it." Such an outlook prevents any self-ownership of one's recovery, placing responsibility on another person. That can be either an act of passive resistance or simple demoralization. Obviously, neither situation is conducive to self-efficacy. On the other hand, patients' willingness to become somewhat more flexible in accepting help and suggestions can go a long way toward modifying the self-cynicism that goes with early recovery.



4. Deflection is a way of removing the focus from personal self-awareness and responsibility. How individual patients arrive at the stage of their illness where they seek help is one thing, but the responsibility for finding out how to manage a chronic disease and then doing so rests securely on the shoulders of the patient. What's the antidote? Blaming others for behaviors and outcomes that are purely the result of the patient's own misbehaviors or misperceptions clouds the reality that adults have to take responsibility for their actions. As patients make recovery their number one priority, it becomes clearer that every other consideration, including family and work life, now stems from their new-found stability and the integrity that recovery both offers and demands.

5. Elitism says, in effect, "I'm different (meaning better) than those other poor souls." Some people have more empathy than others, but, at some point, most people begin to gain an appreciation of how challenging it can be to reorient one's life. The intent of patients' elitism is attempted isolation from experiencing the pain engendered by a frank assessment of their current situation. Adopting as much as possible a "we're all in this together" outlook will yield the most improvement in their own lives because doing so allows the person to feel less alone as well as to identify with the universal deficits and strengths of people in recovery. (As one of my patients pointed out to me: "Even the Twelve Steps are in the plural.")



6. Keeping secrets says, in effect, "My specific circumstances are no one else's business." Everyone has a right to privacy, but, in the right places and at the right times, it will be important for our patients to learn to confide in someone rather than persist in trying to live life as a "ragged individualist." Remembering that courage is typically accompanied by fear, there's simply no substitute for the focused resolution necessary to work through painful emotions, memories and attitudes. Such self-disclosure is frequently best done not with a layperson, such as a 12-Step sponsor, but with a mental health professional, who can help the person sort through long-suppressed faulty beliefs and traumatic memories.



7. “Hooked on a feeling” is a wonderful fantasy, but attaching to another human being as a way of deriving basic self-esteem can lead to nightmarish consequences, and unhealthy dependence is certainly antithetical to the self-possession and repose necessary to establish and maintain healthy intimate relationships. This being the case, we often caution our patients who are not in a committed relationship to postpone temporarily getting into a close romantic relationship early on. This kind of dependence can be just another addictive pattern. Trying to form a bonded, interdependent relationship at the outset of recovery is often unwise for at least three reasons: at this juncture in their lives, most people don’t really know themselves that well; they tend to have a limited understanding of why they turned to alcohol or other drugs to cope; and they clearly are not yet in any position to be a supportive, reliable partner for someone.



8. Rescuing says, in effect, “I’m fine now. I’ll concentrate on helping others, so I don’t have to accept help from others.” For many people in early recovery, there is a risk of adopting the attitude of a “flight into health,” which would impart to them the belief that they can, somehow, circumvent the necessary, universal stages of transition to a more-balanced way of life with a chronic illness such as addiction. Recovery is, indeed, a two-way street. Helping others is important, but it’s also a wonderful thing to give the gift of appropriate neediness to others in accepting their help as well.

Resource:

*The Rip Van Winkle Effect for Families:
How to Stop Sabotaging Your Own Recovery*

Why would anyone want to sabotage their loved one's recovery? After all, our patients aren't explicitly trying to cause themselves harm and frustration. The goal of self-sabotage is to circumvent, to avoid the pain and fear which come inevitably with any profound life change, including the changes that come with a critical illness and its treatment. As such, the motivation of the self-saboteur is defensive rather than self-offensive; it's a flinch from what's perceived to be unendurable pain. As we'll see, much of the reasoning and behavior of people from dysfunctional families stems from the phenomenon of re-enactment, i.e., repeating what was learned before (or, in the case of trauma, hyper-learned). It is, in fact, the result of unresolved posttraumatic stress disorder.

The following information is summarized from the World Service Organization of Adult Children of Alcoholics (ACA) from material originally from Janet Woititz, EdD, in her seminal book, *Adult Children of Alcoholics* (1983):¹

"The Problem:

"Many of us found that we had several characteristics in common as a result of being brought up in an alcoholic or dysfunctional household. We had come to feel isolated and uneasy with other people, especially authority figures. To protect ourselves, we became people-pleasers, even though we lost our own identities in the process. All the same we would mistake any personal criticism as a threat. We either became alcoholics (or practiced other addictive behavior) ourselves, or married them, or both. Failing that, we found other compulsive personalities, such as a workaholic, to fulfill our sick need for abandonment. "We lived life from the standpoint of victims. Having an overdeveloped sense of responsibility, we preferred to be concerned with others rather than ourselves. We got guilt feelings when we stood up for ourselves rather than giving in to others. Thus, we became reactors, rather than actors, letting others take the initiative. We were dependent personalities, terrified of abandonment, willing to do almost anything to hold on to a relationship in order not to be abandoned emotionally. Yet we kept choosing insecure relationships because they matched our childhood relationship with alcoholic or dysfunctional parents.

"These symptoms of the family disease of alcoholism or other dysfunction made us "co-victims," those who take on the characteristics of the disease without necessarily

ever taking a drink. We learned to keep our feelings down as children and kept them buried as adults. As a result of this conditioning, we confused love with pity, tending to love those we could rescue. Even more self-defeating, we became addicted to excitement in all our affairs, preferring constant upset to workable relationships.

“This is a description, not an indictment.” ²

Characteristics of Adult Children (Woititz et al.):

1. Isolation and fear of people
2. Approval seeking (“people pleasers”)
3. Fear of anger and criticism
4. Addiction to chemicals and/or becoming involved an addict/alcoholic
5. Self-image of “victim”
6. More concern with others rather than with self to a fault
7. Resist self-assertion
8. Addiction to emotional extremes (“hooked on a feeling”)
9. Confusion of love with pity and trauma bonding
10. Tendency to numb painful emotions, possibly to the point of dissociation
11. Low sense of self-esteem
12. Phobia about abandonment, to the point of staying in abusive or neglectful relationships
13. Reacting to life rather than acting on life

Sounds pretty grim, doesn't it? Fortunately, there are new behaviors family members can adopt to help revise or reverse the Problem:

Results of Progress in Our Recovery

1. Move out of isolation to reciprocal friendships
2. Learn the value and safety of “friendly anger”
3. Lose the compulsive need to recreate abandonment
4. Revise self-image of “victim”
5. Feel deserving, not guilty, when we are assertive
6. Avoid emotional extremes (“detox” from drama)
7. Distinguish love from pity and trauma bonding
8. Move from denial to awareness of lifetime trauma
9. Discover a sense of self-worth
10. No longer terrified of abandonment and learn the ability to form mutual relationships
11. Learn to act on life, not react to life

As We Make Progress, We Gain:

1. Empathy
2. Assertiveness
3. Appropriately self-sufficient, aware of our place in the world
4. Truthfulness about our thoughts, feelings, wants and needs
5. Concern with others while maintaining enlightened self-interest

6. Disinterest in emotional extremes and being a “drama junkie”
7. Compassionate rejection of people who trigger feelings of pity and, trauma bonding
8. Awareness of our sufficiency as a going concern as a human being (“cut the umbilical cord”)
9. Skill in avoiding enmeshment and self-loss
10. Appreciativeness of others’ approval
11. Respect for others’ non-demeaning criticism
12. Comfort with our own anger and the non-violent anger of others
13. Ability to “live and let live”

Fear and grief and their various disguises mark all attempts to sabotage recovery. There is a process of grieving that everyone in recovery has to pass through. The goal is to make that journey as uneventful and, if not brief, as efficient as possible. Recovery of family members in the addiction of a loved one makes it essential that they understand and deal effectively with their own risks and rewards of living a relationally-sober life in the real world.

Such an endeavor as self-sabotage deserves to be taken seriously and dealt with compassionately and with all possible respect for family members. It can be a life or death struggle for the family member as well as the addict.



“Hooked on a feeling” is a wonderful fantasy, but attaching to another human being as a way of deriving basic self-esteem can lead to nightmarish consequences, and unhealthy dependence is certainly antithetical to the self-possession and repose necessary to establish and maintain healthy intimate relationships. This being the case, we often caution our patients who are not in a committed relationship to postpone temporarily getting into a close romantic relationship early on but to concentrate on healing themselves and their relationships with loved ones. Interestingly enough, it turns out that AA’s Promises apply just as much to loved ones as they do to identified patients:



"If we are painstaking about this phase of our development, we will be amazed before we are halfway through.
We are going to know a new freedom and a new happiness.
We will not regret the past nor wish to shut the door on it.
We will comprehend the word serenity, and we will know peace.
No matter how far down the scale we have gone, we will see how our experience can benefit others.
That feeling of uselessness and self-pity will disappear.
We will lose interest in selfish things and gain interest in our fellows.
Self-seeking will slip away.
Our whole attitude and outlook upon life will change.
Fear of people and of economic insecurity will leave us.
We will intuitively know how to handle situations which used to baffle us.
We will suddenly realize that God is doing for us what we could not do for ourselves." ³

References

1. Woititz JG: Adult Children of Alcoholics. Deerfield Beach, FL: Health Communications, Incorporated, 1983.
2. <http://www.adultchildren.org/lit-Problem>
3. Wilson W and Smith R: Alcoholics Anonymous. New York: AA World Services, Inc., 1939.

Resource:

*The Rip Van Winkle Effect for Families 2:
"Stockholm Syndrome" and the Trauma Bond*

In August of 1973, a parolee named Jan-Erik Olsson and Clark Olofsson took as hostages four bank employees, three women and one man, during a failed bank robbery at the Kreditbanken in Stockholm, Sweden. The employees were held for six days in one of the bank's vaults. They were systematically threatened with nooses and dynamite. When released, none of the freed hostages would testify against either captor in court, and they actually began fundraising efforts for their legal defense and visiting them in jail.



Kreditbanken, Stockholm

Nils Bejerot, a Swedish psychiatrist, coined the term, "Stockholm syndrome," after the police asked his help in understanding the victims' reactions to the event. The term was originally defined by psychiatrist Frank Ochberg to aid the management of hostage situations.

A famous example of this phenomenon is Patty Hearst, who was taken and held hostage by the Symbionese Liberation Army, "an urban guerilla group," in 1974. She was recorded denouncing her family as well as the police under her new name, "Tania," and was later seen working with the SLA to rob banks in San Francisco. She publicly asserted her sympathetic feelings towards the SLA and their pursuits as well. After her 1975 arrest, "Stockholm syndrome" wasn't admitted as a defense at trial, but her prison sentence was commuted. She was ultimately pardoned by President Bill Clinton, on the operative principle that she was not acting under her own free will.²

You might well say, “This is all very interesting, but what does it have to do with living in a family affected by addiction? No one held us hostage, and we were never threatened or tortured. We coped pretty well, seems to me, and the idea that we’re somehow still affected by his drinking and using is ... well ... just absurd.” But *is* it so absurd? Are family members held hostage, in a sense, and is their day-to-day interaction with the addict one of extreme stress (and maybe worse)? In your family groups, we discuss the effect that living in an addiction family (or other dysfunctional situation) has on children, but what of the adults who have been forced by circumstance to cope with the unpredictability, inconsistency, and—on occasion—violent behavior of an addicted family member?



Patty Hearst 1974



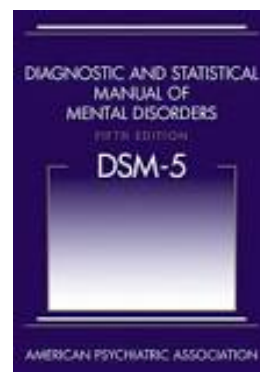
Patty Hearst Today

What of family members, children and adolescents alike, who’ve been abandoned, physically and verbally beaten, or molested by an intoxicated parent or sibling? These adverse childhood events (ACEs) leave permanent scars, and they form a very close parallel to the posttraumatic stress disorder that soldiers suffer in combat.

Physical and Psychological Effects of “Stockholm Syndrome” (a.k.a. “Trauma Bond”):

1. Cognitive: confusion; blurred memory; refusal to accept the reality of events; recurring flashbacks.
2. Emotional: lack of feeling; fear; helplessness; hopelessness; aggression; depression; guilt; dependence on captor; development of posttraumatic stress disorder
3. Social: anxious; irritable; cautious; estrangement
4. Physical: increase in effects of pre-existing conditions; development of health conditions due to possible restriction from food, sleep, or exposure to outdoors¹

Mental health professionals utilize a set of standards, or “criteria,” to make diagnoses of the various mental (i.e., brain-based) disorders that can affect people. The manual describing these signs and symptoms is called the Diagnostic and Statistical Manual of Mental Disorders, or DSM. The DSM is now in its fifth edition, so it’s DSM-5.



Here are the “criteria” for posttraumatic stress disorder. As you go through this list, it’s not necessarily likely that you’ll be able to identity all these symptoms, but the following list will make the point that no one comes out of an addicted family without some problems. (Fortunately, all these problems can be addressed effectively in treatment!)

Criterion A (one required): The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

1. Direct exposure
2. Witnessing the trauma
3. Learning that a relative or close friend was exposed to a trauma
4. Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)



Criterion B (one required): The traumatic event is persistently re-experienced, in the following way(s):

1. Unwanted upsetting memories
2. Nightmares
3. Flashbacks
4. Emotional distress after exposure to traumatic reminders
5. Physical reactivity after exposure to traumatic reminders

Criterion C (one required): Avoidance of trauma-related stimuli after the trauma, in the following way(s):

1. Trauma-related thoughts or feelings
2. Trauma-related reminders



**The Nightmare (1781 version)
Henry Fuseli (1741-1825)**

Criterion D (two required): Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):

1. Inability to recall key features of the trauma
2. Overly negative thoughts and assumptions about oneself or the world
3. Exaggerated blame of self or others for causing the trauma
4. Negative affect
5. Decreased interest in activities
6. Feeling isolated
7. Difficulty experiencing positive affect



Criterion E (two required): Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):

1. Irritability or aggression
2. Risky or destructive behavior
3. Hypervigilance
4. Heightened startle reaction
5. Difficulty concentrating
6. Difficulty sleeping

Criterion F (required): Symptoms last for more than 1 month.

Criterion G (required): Symptoms create distress or functional impairment (e.g., social, occupational).

Criterion H (required): Symptoms are not due to medication, substance use, or other illness.³

Well, that's quite a laundry list of symptoms, isn't it?! We counselors "of a certain age" (ahem!) had been dealing with posttraumatic stress disorder (PTSD) in Viet Nam combat veterans for some time when it began occurring to us that we'd been encountering the same kinds of difficulty in patients who'd never been in combat; namely, in people from families affected by addiction or other mental illnesses. Everybody began "putting two and two together" at more or less the same time, and we soon realized that PTSD is PTSD, regardless of the event(s) that brought it into being.

Posttraumatic stress disorder is, if you will, a "bruise" on the awareness and emotions of someone who's been exposed to (or witnessed) terrible events. It's the mind's way of trying to come to terms with what's happened.



What we want to reinforce again to everyone in the family is that every one of the problems listed here can be effectively dealt with in treatment for those affected by a dysfunctional family! In addition to proper therapy, support groups like Al-Anon can provide a critically important sense of belonging and validation for those learning to rebuild their lives after—or even before—the recovery of the addicted person.



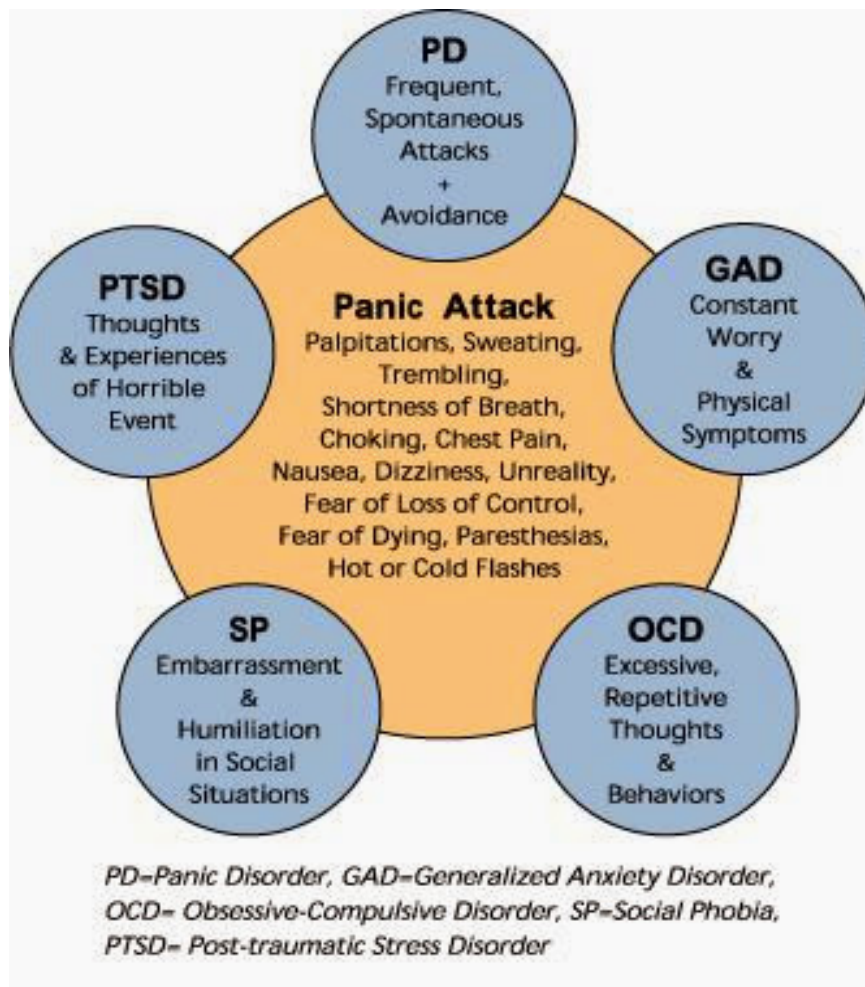
References

- ¹ Alexander DA and Klein S: Kidnapping and hostage-taking: a review of effects, coping, and resilience. London: Journal of the Royal Society of Medicine, 2009.
- ² Adorjan M, Christensen T, Kelly B, Pawluch D: Stockholm Syndrome as vernacular resource. London: The Sociological Quarterly, 2012.
- ³ Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Washington, DC: American Psychiatric Association, 2013.

Resource:

Fear Upon Fear: Addiction and Anxiety

We all know the signs: sweaty palms, rapid breathing, foreboding and a sense of doom, the need to run and hide ... No, we're not talking about income tax day, we're talking about something every one of us experiences from time to time: anxiety. For most of us, those sensations, unpleasant as they may be, can be withstood relatively easily because you know they'll pass with time. But what if they don't? What if they come and go unpredictably, leaving you dreading their return to the point you trigger an episode by worrying that you'll have one? That's an anxiety disorder.



Roughly 20% of Americans present with anxiety problems, which may go along with the addictive disorders or be a separate, coexisting problem; after all, anxiety--the belief that one is in some sort of threat situation, and the emotions that go with it--is a normal part of active addiction, anyway. Finding out whether the person is having trouble with anxiety as part of their disorder or whether they are suffering from separate anxiety problems is challenging because the anxiety will often be so intense that recovery in addiction is impossible unless it is dealt with.

While the common anxiety disorders, panic disorder, social phobia, posttraumatic stress disorder, generalized anxiety disorder and obsessive-compulsive disorder, differ in their symptoms, one commonality is a sense of dread and all the unpleasant—and, often, truly frightening—symptoms accompanying it. Small wonder, then, that early recovery in addiction is made greatly more-challenging by the appearance of these symptoms; so much so that it is often more than the patient can bear without falling back on the tried-and-true (and catastrophic) solution of drinking, using other drugs or gambling, to name a few addictive options. To say to these people, “This, too, shall pass” is not only unfeeling but all-too-often untrue without the right kinds of help.

Until relatively recently, the only effective medications available to treat anxiety were benzodiazepines, drugs such as Valium, Xanax, or Klonopin, etc. While they worked well, they posed the troubling problem of being abusable in people with a history of substance abuse; the very medication that was supposed to be decreasing their anxiety could actually cause more problems than it solved. These difficulties with these medications often led to the attitude of “Leave the anxiety alone, work a solid recovery program, and the anxiety will go away by itself in time.” While this standpoint about anxiety is sometimes true, it is often not true, and people can suffer with untreated anxiety and relapse needlessly into active addiction.

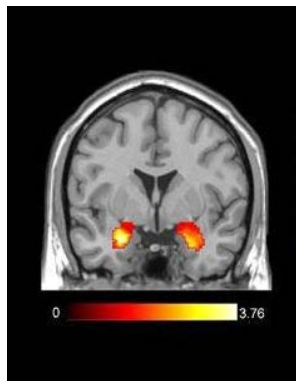


Fortunately, these days, there are options. Medications used to treat depression have been found to be helpful anti-anxiety drugs. These medicines are called SSRIs (from the way they work in the brain, i.e., inhibiting the reuptake of serotonin), and they include Prozac, Paxil, Zoloft and Celexa, among others. Like another drug, buspirone (BuSpar), they're not habit-forming, but they make take several days to be effective. They can be taken for long periods of time with no risk of the person's becoming addicted to them.

Psychotherapy is also essential to help the patient regain a sense of self-confidence, especially if they have been using alcohol or other drugs for a long time. The patient has to learn how to deal with both the symptoms and the causes of anxiety, including past traumatic events which may still be upsetting to them (sometimes years after the trauma). Proper medication and appropriate therapy can help addicts who also suffer with anxiety to achieve a stable, happy recovery.

Let's take a brief look at specific structures implicated in anxiety:

Amygdala: The amygdala is part of the limbic system, a group of structures deep in the brain associated with emotions. It is activated when a person recalls emotionally charged memories, such as a frightening situation. Although it is accurate to state that the amygdala detects threat, it is probably not the case that the amygdala is a “fear center,” per se, since it is only a part of the overall system which causes the individual to detect and then process the meaning of a threat.



MRI of amygdala activation during threat detection

Hippocampus: The hippocampus has a central role in processing learning, long-term memory and recollection. Interplay between the hippocampus and the amygdala might account for the old saying, "once bitten, twice shy." The hippocampus registers fear when, for example, you're confronted by a barking, aggressive dog, and the memory of such an experience may make you wary of dogs you come across later in life:

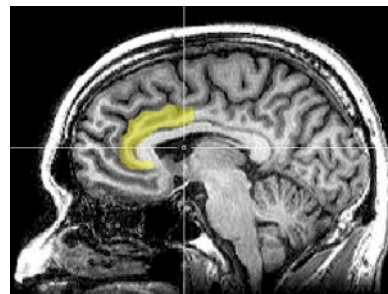
The **angry** dog is growling at me. (Visual sense, hippocampus, working memory)

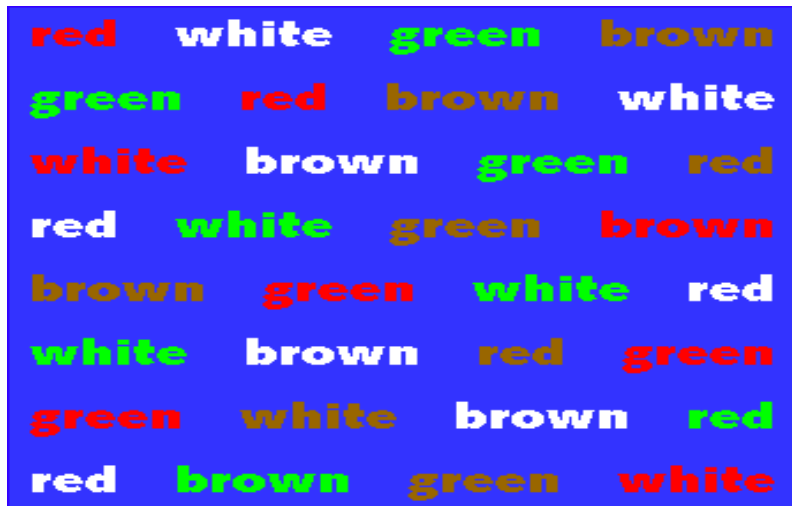
The angry dog is **growling** at me. (Aural sense, hippocampus, working memory)

The angry dog is growling **at me**. (Amygdala, hippocampus, frontal cortex).

The anterior cingulate cortex is particularly involved in appraising and expressing fear and in judgment and anticipation of emotional stimuli. (To self: "The dog is growling, but does that mean I'm in danger?")

MRI of anterior cingulate cortex





Ridley Stroop, PhD (1935)

The insula is involved with perceiving bodily sensations of anxiety. It's an island of the cerebral cortex. Its overall shape is like a pyramid with a triangular base.

One symptom which must not be ignored is thinking (and even planning) to harm one's self to escape the emotional pain of the disorder. If it is determined that someone is having thoughts of hurting themselves, they must be seen as soon as possible by a physician so they can be assessed and, if necessary, treated in a protected environment until they are free of the desire to harm themselves.

It is important to understand and remember that other disorders, including physical problems, such as diabetes or fibromyalgia, for example, can cause many or all of these symptoms in people. Diagnosing a primary anxiety disorder in addicts is frequently challenging, and when the person also has a history of substance abuse, the doctor must first help the person get the chemicals out of their system before an accurate diagnosis can be made. The substance abuse counselor can offer the support and coaching the patient needs to be able to stay free of chemicals long enough for the diagnosis to be made and then for the appropriate treatment to be given. When there is a clear, primary anxiety disorder, the physician may well diagnose and treat it with one or more medications.

Symptoms of anxiety can be masked by addictive behavior, both as a distraction for the person and as a part of the stress and demoralization which normally accompany active addiction.





If anxiety symptoms persist, the patient is likely to benefit from professional help. It's important to remember that, for some people under some circumstances of loss, a normal, anxiety-triggering grieving process can go on for a long time. This protracted grieving is most often caused by attempts to deny or get away from the pain or trying to avoid letting go, either by refusal to address the issues precipitating the grief or by non-compliance in resorting to use of alcohol or other drugs in an attempt to medicate the grief.

Barriers to full recovery in anxiety disorders include: patient noncompliance to taking medication; lying to the doctor about taking the medication; self-discontinuing the medication due to impatience, side effects, or inappropriate fear of becoming dependent.

Seems like an awful lot of bad news, doesn't it? Well, the good news is that anxiety disorders and addiction are both highly responsive to proper treatment. Let's look at some current treatments that have a positive impact on both addictive disorders and on anxiety.

First, for those who need it, detoxification techniques are available to ease the transition from using to drug-free. Medications can be used to treat persisting symptoms, such as depressed mood and emotional instability.

Any therapy that helps the person with socialization and a sense of belonging has direct neurochemical benefits in the very same areas of the brain affected by addiction. Talking therapies have been found useful in helping recovering addicts reorient their self-image and stay abstinent from chemicals. Family networking therapy helps addicts "rejoin the human race" and take their place in their families and other relationships. Peer-support groups can be an important adjunct to treatment in providing a network of encouragement and shared progress in becoming and staying more stable.



Cognitive behavioral therapy (CBT) focuses on the development of personal coping strategies to solve current problems and change unhelpful patterns in thinking, behavior, and emotion. It was originally designed to treat depression and is now used for a number of mental health conditions, including addiction. CBT is based on the understanding that symptoms and associated distress can be reduced by teaching new information-processing skills and coping mechanisms.

Contingency management helps addicts by providing positive consequences when they meet treatment goals and negative consequences when they don't. An example of a positive consequence for abstinence could be receiving vouchers (not cash!) exchangeable for retail goods or progressing in a phased treatment program. A negative consequence could be withholding vouchers or a negative report to a parole officer. Therapists may create written behavioral contracts that detail the desired behavior change and other treatment details.

While they don't cure it, there are medications, such as acamprosate, naltrexone, and some antidepressants, such as bupropion, that can stabilize the ongoing operating balance among the brain structures affected by addiction (specifically the ventral tegmental area, nucleus accumbens and frontal cortex). These medicines help do for the brain what it can't do for itself; they are assistive technology for the brain. In moderating anxiety symptoms, antidepressants also help the reward centers rebalance and stabilize as well.

So ... Here's the short version: Even though neither addiction nor anxiety can be cured, they *can* be stabilized. The good news is that help is available right here in the Shreveport-Bossier area for people and their loved ones. CADA provides the full range of addiction treatment services; everything from medically-supported detox to residential treatment to outpatient and intensive outpatient treatment programs are available. Many insurance plans are accepted, including Medicaid, and payment plans are available for those who need assistance, and no one is turned away due to inability to pay. You can call us confidentially at 318-222-8511 or apply for treatment or additional educational services at our website, www.cadanwla.org.

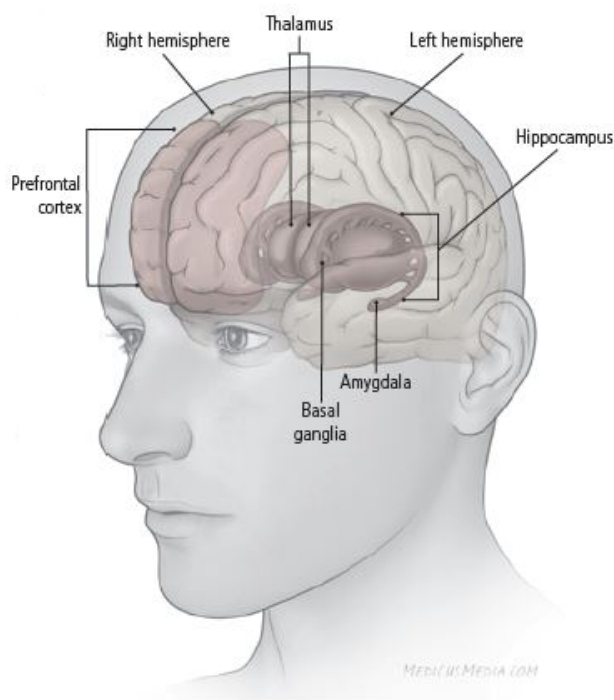


Resource:

Double Trouble: Addiction and Depression

Addictive illness frequently occurs simultaneously with other mental (i.e., brain) disorders. One of the most common conditions which happen in tandem with addiction is depression. It's more than the occasional emotional "let-down" we all have when we aren't feeling well or when confronted with a disappointment or loss (even a major loss, such as the death of a loved one or a divorce, etc.). Depression is a many-sided disorder in the centers of the brain which regulate mood, and it shows itself in a wide variety of symptoms. What's more, depression and addictive disorders often coincide, creating a panoply of symptoms, problems and challenges to recovery.

Areas of the Brain Affected by Depression



The regions shown here are mirrored in both hemispheres of the brain. Also, these structures are interlocking; the illustration suggests location and relative region but not precise location.

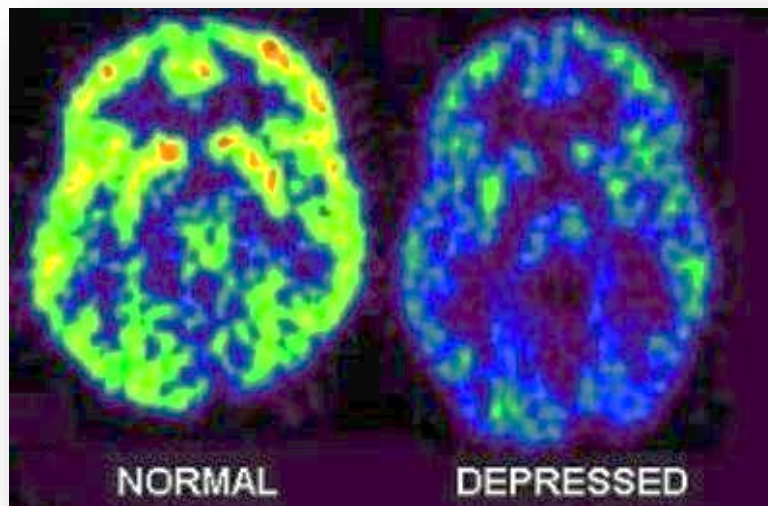
Harvard Medical School

We note specific structures implicated in depression:

Amygdala: The amygdala is part of the limbic system, a group of structures deep in the brain associated with emotions. It is activated when a person recalls emotionally charged memories, such as a frightening situation. Activity in the amygdala is higher when a person is sad or clinically depressed. This increased activity continues even after recovery from depression.

Thalamus: The thalamus receives most sensory information and, similarly to a microwave repeater, relays it to the cerebral cortex, which directs high-level functions such as speech, behavioral reactions, movement, thinking, and learning. Some research suggests that bipolar disorder may result from problems in the thalamus, which helps link sensory input to pleasant and unpleasant feelings.

Hippocampus: The hippocampus has a central role in processing learning, long-term memory and recollection. Interplay between the hippocampus and the amygdala might account for the adage "once bitten, twice shy." It is this part of the brain that registers fear when you are confronted by a barking, aggressive dog, and the memory of such an experience may make you wary of dogs you come across later in life. The hippocampus is smaller in some depressed people, and research suggests that ongoing exposure to stress hormone impairs the growth of nerve cells in this part of the brain.



Crystal Pirner

Naturally, the most-common symptom of depression is the obvious one of a generally-depressed and sad mood even though life in general may be free of situations which one would normally find depressing. Other symptoms of depression can include loss of interest, fatigue, fretting about things, loss of (or increase in) appetite, irritability, rumination on real or perceived negatives in one's life, difficulty in sleeping and in concentrating, unreliable memory, aches and pains, difficulty in carrying out even the simplest of tasks, and feelings of guilt, hopelessness and unworthiness.

One symptom which must not be ignored is thinking (and even planning) to harm one's self to escape the emotional pain of the disorder. If it is determined that someone is having thoughts of hurting themselves, they must be seen as soon as possible by a physician so they can be assessed and, if necessary, treated in a protected environment until they are free of the desire to harm themselves. The greatest cause of suicide in adults and adolescents alike is untreated depression.

It is important to understand and remember that many other disorders (including physical problems, such as diabetes or fibromyalgia, for example) can cause many or all of these symptoms in people. Diagnosing depression can sometimes be challenging, but when the person also has a history of substance abuse, the doctor must first help the person get the chemicals out of their system before an accurate diagnosis can be made. The substance abuse counselor can offer the needed support and coaching for the patient to be able to stay abstinent long enough for the diagnosis to be made and then for the appropriate treatment to be given. When there is a family history, the physician may well diagnose depression and treat it with one or more remarkable medications, which can actually assist the mood centers in the brain in adjusting the person's mood back to normal.

A major loss can trigger depression, and this trigger is now recognized as a common evoking agent to incipient depression. It is common for people to have sadness, pain, anger, bouts of crying, and a depressed mood after a loved one dies. It is important to know about normal grief responses so that you can know if the bereaved person might be getting worse -- going into a major depression. Symptoms of depression can be masked by addictive behavior, both as a distraction for the person and as subsumed into the predictable stress and demoralization which normally accompany active addiction.



About 1 in 5 grieving people develop major depression. People at highest risk for clinical depression include those who have been depressed before, those with no support system, those who have had problems with alcohol or drug abuse, or those who have other major life stresses. People with addictive disorders experiencing the

stress accompanying their illness will find it difficult or impossible to withstand the emotional pain of bereavement. Addicts' ability to adapt and heal in their grief is impaired by the effect on slowing of maturation brought about by their illness and by constant triggering of the reward centers in the brain trying to feel better, causing a desire to self-medicate the pain of the loss with chemicals.

To be clear: symptoms of major depression that are not explained by normal bereavement may include:

1. Constant thoughts of being worthless or hopeless. ("See? I told you I was no good. Just look at me, here, all alone, drinking and using and losing everything important to me.")
2. Ongoing thoughts of death or suicide (other than thoughts that they would be better off dead or should have died with their loved one) These thoughts or statements are always to be taken seriously.
3. Being unable to perform day-to-day activities ("I'm so far behind in everything I'm supposed to do, I may as well just stay here and keep on drinking.")



4. Intense guilt over things done or not done at the time of the loved one's death ("Where was I when he died? Right here, getting high, instead of being there when he needed me.")
5. Delusions (beliefs that are not true) "If I had been there, she wouldn't have died.")
6. Slower body responses and reactions ("I just want to disappear into this slot machine.")
7. Uncharacteristic weight loss or gain

If depressive symptoms last more than 2 months after the loss, the bereaved person is likely to benefit from professional help. It's important to remember that, for some people under some circumstances of loss, the grieving

process can go on for a long time, perhaps even years. This protracted grief can appear frequently in those who were very close to the deceased. It is most often caused by attempts to deny or get away from the pain or trying to avoid letting go.

Also receiving more study is *undertreated* depression, sometimes referred to as residual depression. The term, "undertreated depression" describes a stall in initial, marked improvement after beginning antidepressant therapy. The depressed person begins a good, responsive recovery but does not attain the full measure of symptom relief and normal functioning that can be possible today.

Barriers to full recovery in depression and other mood disorders include: patient noncompliance to taking medication; lying to the doctor about taking the medication; self-discontinuing the medication due to impatience, side effects, or inappropriate fear of becoming dependent.

Treatment success can also be hampered occasionally by lack of physician expertise in prescribing optimally (such as using recognized augmentation strategies as a SSRI in combination with a dual action agent such as bupropion or with buspirone) and giving the medication(s) enough time to be effective, increasing the dose when appropriate rather than moving to a different agent.

So-called "double depression" dysthymia (a type of less-severe but still troubling depression), coexisting with major depressive disorder) responds well to CBT and appropriate medication. Decisive treatment of dysthymia is often overlooked in double depression because the patient has improved when the major depressive episodes are stopped, and the tendency is to "settle for less." This lapse in care leaves the person vulnerable to all the problems of dysthymia plus an increased risk of relapse into major depressive episodes, substance abuse and (in some cases) suicide.

Well, that's the bad news. Seems like an awful lot of bad news, doesn't it? So, what's the good news? The good news is that depression and addiction are both highly responsive to proper treatment. These days, there is a strong likelihood that an addict with depression can go on to lead a happy, productive life. Let's look at some current treatments that have a positive impact on both addictive disorders and on depression.

First, for those who need it, detoxification techniques are available to ease the transition from using to drug-free. Medications can be used to treat persisting symptoms, such as depressed mood and emotional instability. (Example: just as alcohol or other drugs interfere with the brain's ability to conserve the transmitter supplies needed to remain stable, antidepressant and anti-craving medications actually help reverse that deficit to some extent by helping the brain more-effectively store up what transmitter it can now make.)

Any therapy that helps the person with socialization and a sense of belonging has direct neurochemical benefits in the very same areas of the brain

affected by addiction. Talking therapies have been found useful in helping recovering addicts reorient their self-image and stay abstinent from chemicals. Family networking therapy helps addicts “rejoin the human race” and take their place in their families and other relationships. Peer-support groups can be an important adjunct to treatment in providing a network of encouragement and shared progress in becoming and staying more stable.



Cognitive behavioral therapy (CBT) focuses on the development of personal coping strategies to solve current problems and change unhelpful patterns in thinking, behavior, and emotion. It was originally designed to treat depression and is now used for a number of mental health conditions, including addiction. CBT is based on the belief that symptoms and associated distress can be reduced by teaching new information-processing skills and coping mechanisms.

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So ... Here's the short version: Even though neither addiction nor depression can be cured, they can be stabilized. The good news is that help is available right here in the Shreveport-Bossier area for people and their loved ones. CADA provides the full range of addiction treatment services; everything from medically-supported detox to

residential treatment to outpatient and intensive outpatient treatment programs are available. Many insurance plans are accepted, including Medicaid, and payment plans are available for those who need assistance. You can call us confidentially at 318-222-8511 or apply for treatment or additional educational services at our website, www.cadanwla.org.



Resource:

Deadly Despair: Getting Perspective on Suicide

Suicide. The word conjures up all sorts of emotional responses in everyone, and mental health professionals are no exception. How do you feel when you know someone is contemplating ending their life? Fear? Panic? Maybe even anger at them? Most people know of at least one person who has killed themselves, and no one is immune from the feelings around the possibility of suicide or from the obligation to do everything humanly possible to keep it from happening.

By far, the most-common cause of suicide is untreated or under-treated depression or other psychiatric disorder. Prevention begins with understanding what a suicidal episode is like, how it is experienced by the patient. To aid in understanding, here's a scenario:

As a demonstration, imagine you've been asked to fully extend your right arm out to your side parallel to the floor. With no additional support and no help from anyone, your task is to hold an extraordinarily expensive and somewhat heavy vase in your right hand for as long as you can without setting it down, resting it on the floor, or dropping it.



Going into this demonstration, basic common sense tells you that there's only a limited amount of time you'll be able to extend your arm and hold up the vase. You know that, at some point, you're going to lose the ability to support the vase in this way. Never forget, the vase is priceless, a one-of-a-kind treasure, so you don't want to let it fall and shatter on the floor. If you drop it, you fail the test. If you set it down, you also fail the test, because the test is one of endurance.

For a few moments, perhaps, you'll find this demonstration only mildly difficult and not very strenuous. More time passes, and you're continuing to stand there supporting the weighty vase. You're quickly finding that the exertion of holding out your arm and supporting the vase is becoming slightly more strenuous. You're noting the first inkling of weakness. For the moment, you're still holding up the vase. Although you were fully rested when you began this demonstration, the strain is becoming more intense as the seconds go by. It's becoming pretty clear to you that your ability to hold this vase up without help will soon be coming to an end.

A time of decision is drawing near for you, and quickly: you're going to have to do something to avoid setting the vase down or dropping it to the floor and letting it shatter. The options are few. The primary need to not let the vase fall is being replaced by another, more-pressing urge: to get relief from the pain and fatigue of exertion that is now spreading up and down your arm. As your arm muscles continue to contract, they create **lactose**, which causes a burning sensation. This burning feeling is only getting worse; it's beginning to really hurt, and you're getting more fatigued as the seconds pass by. What started out as a minor ache has quickly become an excruciating fire-like sensation, and you're not sure how much longer you can stand it.

Unless help is extended to you by another human being, the outcome is certain. Pain and fatigue will overtake your arm's ability to remain horizontal. You'll ultimately have to let go of the vase one way or the other. You'll fail the test. You're now at the point that you desperately want help, but if you let someone help you, you fail the test.



You drop the vase. Pain and fatigue have overtaken you. You held out as long as you could. You just couldn't hold on forever.

You might think this scenario is a metaphor for a suicidal episode. It isn't. This scenario is a metaphor for a normal, healthy human being who's challenged to exhaustion by some major task. Everyone has vases to hold, or, to use the famous metaphor, "crosses to bear." Here's the suicidal metaphor: At just the point that you drop the vase and feel completely exhausted, having given it your all for as long as you

could, you're instructed to pick up the vase and do it all again, with no time to rest. You may be able to summon some degree of resolve and pick up and hold the vase again, but you're not going to be able to do it for very long at all. When you started, you were fully rested, but now, you're taking up the challenge from the position of exhaustion. *Maybe it's time to change the rules of the test and let someone help you hold the vase.* (Just remember, even Christ had help, and someone who's suicidal has very likely already done more than enough "dying for someone else's sins.")

The most basic human urge is to survive. Everything we do, think, and feel guides us to one imperative: survival. Depression and many other situations can sap people of their will to survive. It isn't that they don't care about staying alive; it's that they're so physically, emotionally and spiritually exhausted that they can't care.

One crucial symptom of suicidality is thinking (and even planning) to harm one's self to escape excruciating emotional or physical pain. If it is determined that someone is having thoughts of hurting themselves, they must be seen as soon as possible by a physician so they can be assessed and, if necessary, treated in a protected environment until they are free of the desire to harm themselves. The most-common triggers to suicide are untreated (or undertreated) depression, bipolar disorder and substance-related disorders.



Also receiving more study is *undertreated* depression, sometimes referred to as residual depression. The term, "undertreated depression," describes a stall in initial, marked improvement after beginning antidepressant therapy. The depressed person begins a good, responsive recovery but does not attain the full measure of symptom relief and normal functioning that can be possible today.

The American Foundation for Suicide Prevention notes several risk factors of concern for possible suicide attempt, some of which are the following:[‡]

Talk

- Being a burden to others
- Feeling trapped
- Having no reason to live
- Killing themselves

Behavior

- Looking for ways to kill themselves, such as searching online

- Acting recklessly
- Withdrawing from activities
- Isolating from family and friends
- Sleeping too much or too little
- Visiting or calling people to say goodbye
- Giving away prized possessions
- Aggression

Mood

- Depression
- Loss of interest
- Rage
- Irritability
- Humiliation
- Anxiety

Psychiatric Disorders

- Depression (including dysphoria from a serious or chronic health condition)
- Bipolar disorder
- Schizophrenia
- Borderline or antisocial personality disorder
- Anxiety disorders
- Substance-related disorders

Environmental Factors

- Stressful life events which may include a death, divorce, or job loss
- Prolonged stress factors which may include harassment, bullying, relationship problems, and unemployment
- Access to lethal means including firearms and drugs
- Exposure to another person's suicide, or to graphic accounts of suicide

Historical Factors

- Previous suicide attempts
- Family history of suicide attempts

Any therapy that helps the person with socialization and a sense of belonging has direct neurochemical benefits in the very same areas of the brain affected by addiction. Talking therapies have been found useful in helping recovering addicts reorient their self-image and stay abstinent from chemicals. Family networking therapy helps addicts "rejoin the human race" and take their place in their families and other relationships. Peer-support groups can be an important adjunct to treatment in providing a network of encouragement and shared progress.



Cognitive behavioral therapy (CBT) focuses on the development of personal coping strategies to solve current problems and change unhelpful patterns in thinking, behavior, and emotion. It was originally designed to treat depression and is now used for a number of mental health conditions, including addiction. CBT is based on the belief that symptoms and associated distress can be reduced by teaching new information-processing skills and coping mechanisms.

Dialectical behavior therapy focuses on building a meaningful life rather than merely remaining abstinent. It has been found helpful both for people who are suicidal and for those with addictive disorders. The goal is to balance the patients' desire to avoid pain while at the same time helping them to learn how to tolerate the normal pain that goes with living "life on life's terms." The addiction counselor helps patients bring about change as they discover new meanings from examining differing perspectives around a subject.

Interpersonal Therapy (IP) incorporates several other theories: object relation, attachment and family systems: Three assumptions central to IP are:

- 1) Human beings are relational creatures, so many problems are interpersonal in nature;
- 2) Family experience is the central source of learning about ourselves and others;
- 3) The therapist-patient relationship can help solve problems.††

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‡American Society for Suicide Prevention, <https://afsp.org/>

‡‡ Teyber E: Interpersonal Process in Psychotherapy. Pacific Grove: Brooks/Cole, 1997.

Resource:

*"The Dimming of the Light":
Addiction and Dementia*

Dementia is the deterioration of cognitive ability in a person who showed no earlier impairment. It may be steady-state, as, for example, the result of traumatic brain injury. Some types of dementia are progressive, and they lead to general, gradual decline from damage or disease in the body. Although dementia is more common in older people, it can occur at any stage of adulthood, but it isn't a normal accompaniment to aging. Some dementias are even reversible.



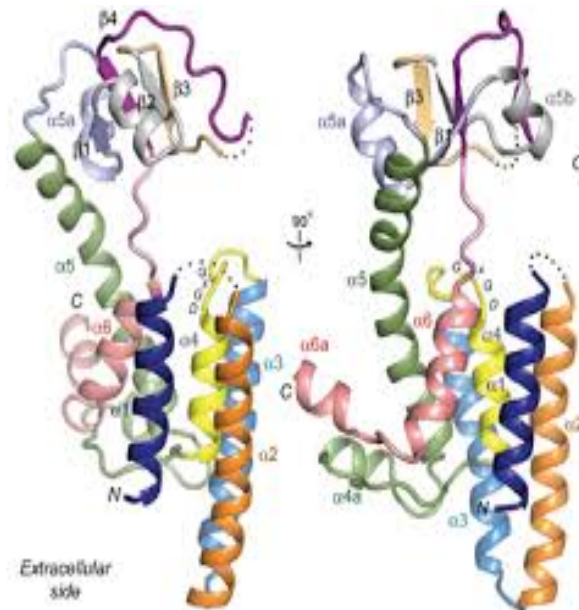
Dementia isn't merely a problem of memory. It also affects attention, language and ability to solve problems. Higher mental functions are affected first in the process. Especially in the later stages of the condition, those affected may not know what day of the week, month or year it is. They may have difficulty knowing where they are and may even not know who they are or who others around them are (even family members).

Other mental and behavioral problems often affect people with dementia, and those problems may influence quality of life. Depression affects 20–30% of people who have dementia, and about 20% have anxiety. Psychoses (often including delusions of persecution) and agitation/aggression also often accompany dementia; they need to be assessed and treated independent of the dementia.

Dementia beginning gradually and worsening progressively over several years is

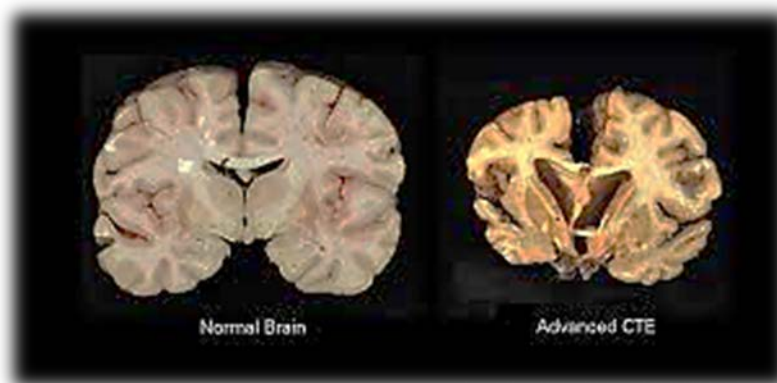
usually caused by neurodegenerative disease, which causes gradual but irreversible loss of function of the affected neurons. Less commonly, a non-degenerative condition may have secondary effects on neurons.

A primary factor coming from genetic studies of central nervous system neurodegenerative conditions involves anomalies in protein handling. Without careful assessment, delirium (often lasting days to weeks) can easily be confused with dementia, because they have symptoms in common, except duration. Mental illnesses such as psychosis and depression can produce symptoms that mimic the dementias.



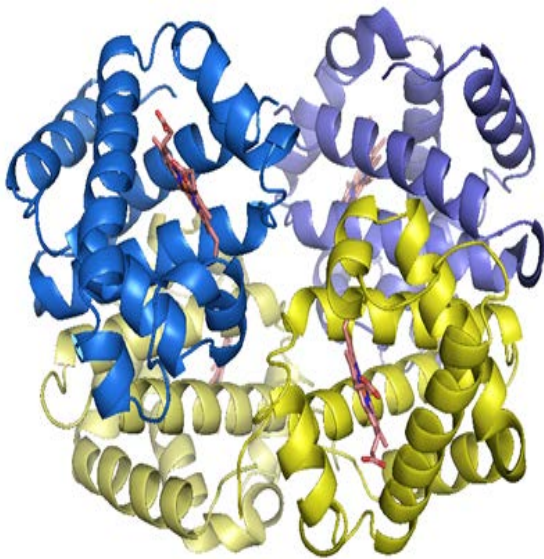
Excessive alcohol use over time can cause alcohol dementia, Wernicke's encephalopathy, which if left untreated can devolve to Korsakoff's psychosis. Some other drugs of abuse can cause substance-induced persisting dementia; and, upon abstinence, cognitive impairment remains in place but does not get worse. Preventing damage in the first place is yet another reason why drug abuse prevention efforts are so important. It's necessary to rule out the presence of intoxication and/or withdrawal, because these states can mimic convincingly the dementia symptoms of confusion, irritability memory problems and other cognitive, mood and even movement impairments also consistent with dementia. Vitamin deficiencies from substance abuse can also undermine effective functioning, as can HIV-related dementia.

Traumatic brain injury (TBI), including chronic traumatic encephalopathy (CTE), seen in many football players, can bring about generalized or more-local damage. Strokes or brain infections, prolonged epileptic seizures and acute hydrocephalus may also have long-term effects on thinking, reasoning and judgement.



In people over 65, a large majority of cases of dementia are caused by Alzheimer's disease or vascular dementia (related, for example, to cardiac insufficiency). Hypothyroidism can be a culprit in gradual cognitive decline, but this issue is sometimes able to be reversed with proper treatment.

In people under 65, it appears that Alzheimer's disease is still the most common cause of dementia, and inherited forms of the disease account for a higher proportion of cases in this age group. In adults up to age 40 of previously normal intelligence, dementia rarely appears without additional neurological symptoms. Most cases of progressive cognitive disturbance in this age group are caused by active psychiatric disorders, alcohol or other drugs, or they're caused by some metabolic disturbance. However, certain genetic disorders can cause true neurodegenerative dementia at this age, such as Gaucher's disease; Niemann-Pick disease; and Tay-Sachs disease.



An emerging theory which contradicts current conventional wisdom in the etiology of Alzheimer's is that, instead of plaque, free-floating bits of amyloid beta may be destroying neurons. If the theory is correct, then drugs that target plaque may be aiming at the wrong target. For almost twenty years, the prevailing plan of attack for researchers and pharmaceutical laboratories had been to find a way to remove amyloid beta, but several recent studies in mice and rats now suggest that floating pieces of amyloid beta called oligomers are the real bad actors in Alzheimer's disease. Some researchers think that plaques may constitute a defense against oligomers.

Proper differential diagnosis between the types of dementia requires referral to a specialist, e.g., a geriatric internist, geriatric psychiatrist, or neurologist. In most cases, duration of symptoms must normally exceed six months for a diagnosis of dementia to be made. Routine blood tests are also usually performed to rule out treatable causes. These tests include vitamin B12, folic acid, thyroid-stimulating hormone (TSH), C-reactive protein count, full blood count, electrolytes, calcium, and kidney and liver function.



CT or MRI scanning may suggest normal pressure hydrocephalus, a reversible contributor to development of dementia, and it can provide information about other types of dementia (e.g. stroke) that would indicate vascular dementia. SPECT and PET scans can detect longer-standing cognitive dysfunction. SPECT can differentiate the vascular cause from the Alzheimer's disease cause of dementias.

It is understood that, in general, people have more health problems as they get older, and many older adults have to contend with chronic pain, whether or not they develop dementia. Beyond the issue of treating pain humanely, chronic pain is, of course, a quality of life matter. Persistent pain can lead to a generally lower and less balanced activity level (often leading to falls), depressed mood, sleep disturbances, substance abuse, impaired appetite and cognitive impairment.

Cholinesterase inhibitors are a type of medication that has been used in an attempt to stabilize or reverse dementia. Medications such as Donepezil (Aricept), galantamine (Razadyne), and rivastigmine (Exelon) are approved by the FDA for Alzheimer's dementia. Their efficacy has been found disappointing. They might have a place in treating other dementing conditions like Parkinsons or vascular dementia. N-methyl-D-aspartate blockers such as memantine (Namenda) can be used simultaneously with acetylcholinesterase inhibitors.

Interestingly enough, some antibiotics may help reduce deposits of amyloid in Alzheimer's patients' brains. Antidepressant drugs may provide some palliative relief, since depression is frequently associated with dementia, worsening cognitive and behavioral impairment. Benzodiazepines such as diazepam have been used for treating co-occurring anxiety in dementia. They are often avoided because they may increase agitation in persons with dementia and are likely to worsen cognitive problems or are too sedating, adding to the risk of falls. Buspirone is often initially tried for mild-to-moderate anxiety.



Adult daycare centers and special nursing home units offer supervision, meals, recreational activities, meals, and limited health care to participants, as well as allowing caregivers to have a much-needed break in their responsibilities. While some preliminary studies have found that music and art therapy may be useful in helping patients with dementia, the quality of the studies has not been the best, so it's been difficult to make sound conclusions based on them.

Resource:

Buried Treasures:

Liberating People from Dysfunctional Families

Have you ever dreamed that your arms and legs weigh several hundred pounds and that it requires a supreme effort even to move very sluggishly? You know how it feels: there's little-to-no freedom of movement, and every exertion has to be painstakingly planned and fought through. For most people, such a dream is just an infrequent and mildly-disturbing nightmare, but for those reared in families affected by addiction and other mental illness, such a sensation is part and parcel of their waking, day-to-day existence. For them, the belongingness and validation most people take for granted are absent, buried under the weighty imperatives of secrecy and "keeping up appearances."



It's long been known that people reared in family systems affected by the chaos and, often, violence engendered by mental illness (including addictive disorders) undergo predictable alterations from normal psychosocial development. The basic task of survival is too often at a premium in these dysfunctional systems. Early on, children find themselves enmeshed in traumas of verbal and physical abuse, sexual abuse and abandonment; profoundly chaotic and unpredictable situations, which ill-equip them to live effectively in the real world of adult responsibility. The so-called "Three Ds" apply here: Dependency, Debility, and Dread. Little wonder, then, that these children grow to become rootless, constricted, ragefully-fearful and emotionally stunted adults.

The working premise is that *everyone*, identified patient and loved ones alike, develops dysfunction in families affected by mental illness (including addiction).

Stage I: Survival in the Family. Special rules seem to apply in families affected by addiction and other mental illness. They are,

1. Don't talk. Don't name the problem, or, for that matter, even think consciously about the problem. Ignore it, not only in conversation but also in your own, private thoughts. Banish it from your personal awareness.



2. Don't trust. Since frightening things happen unexpectedly, and since you can never know when another frightening event will take place, always be on the lookout for "the other shoe to drop." The only thing you *can* trust is the inevitable shock when the next bad thing happens.

3. Don't feel. Keep your emotions in constant check so they don't lead you astray. Don't ever let anyone know what you're feeling because, if you do, they will know, and they will retaliate against you and hurt you. Who can say, they may even kill you if you let the wrong emotion show at the wrong time.



4. Don't make waves. Be steadfastly loyal at all times. Never say or do anything that would alert anyone in or out of the family that you know what is happening. If you accidentally make it public, there will be catastrophic repercussions to the whole family. Your entire family will be broken apart, and it will be all your fault.

5. Be self-negating. Focus rigidly on others all the time. Never take the time away from being other-focused to attend to your own needs. Your needs don't matter. All that matters is that you take care of others.



6. Always remember that you're: crazy, guilty, evil, responsible, different, bad, and, above all, alone.

Striving to live by these rules yields a crisis in the life of the patient. They have only two options: getting help or suicide because they're telling themselves, "I have to be superhuman, and anything less is not good enough."

If people reared in dysfunction get help, they can then move to Stage 2: Awareness of Family Issues. Break the rules in a controlled, constructive way:

1. Do talk. Name the problem. Think consciously about the problem. Don't ignore it. Make it present, not only in your own, private thoughts but also in conversation with select other people. There may well be people in and out of your family who would prefer you keep secrets. Remember, though, that some secrets keep people imprisoned and buried under shame, and you're working to unbury yourself.



2. Do trust. Although frightening things do happen unexpectedly, and although you never know when another frightening event will take place, always be aware that the "other shoe" doesn't have to fall on you. The only thing you need to trust is your personal ability to withstand whatever happens and your ability to free yourself from situation that could harm you. With knowledge comes responsibility, and you no longer have to retreat behind a wall of powerlessness.

3. Do feel. Keep your emotions in constant awareness, but don't allow them to guide your behavior unless the proposed action is also in line with what your reasoning ability dictates it should be. You have to take responsibility for your feelings as well as your behavior. Other people don't make you feel an emotion; that's an inside job.

4. Do make waves. Dare to be disloyal to those who would harm or neglect you; they don't deserve your loyalty in any event. Summon the courage to say or do anything that would alert caring people in or out of the family that you know what is happening. If what you say it is made public, there may be repercussions to the family, but the repercussions are not your fault, and they can bring about healing. Remember: you didn't create the problem, and you don't have to live in it or take responsibility for it.

5. Be self-enlightened. Focus flexibly on yourself when you need to and on others when appropriate. Take time away from being other-focused to attend to your own needs. (Your needs matter, too, after all.) It also matters that you care for others when appropriate. There's a world of difference between being truly selfish and acting in one's own best interest. Enlightened self-interest is one of the hallmarks of a mature personality, as you remind yourself, "I'm only human, and that's good enough."



Always know that you're not: crazy, guilty, evil, responsible, different, bad, or alone. Remember that guilt says, "My behavior is bad." False guilt claims that. "My behavior is bad" even when you haven't done anything wrong. (Remember, just because someone is angry with you doesn't necessarily mean you've done anything wrong.) Shame says, "I'm bad," which is, typically, throwing the baby out with the bathwater.

Stage 3: Dealing with Family Issues

1. Liberate the child while cultivating the adult. When you're an adult, it's too late to have a happy childhood, but it's never too late to grow into an appreciation of the beauty of life.



2. Feel your emotions. All of them.

3. Express all your emotions appropriately at the appropriate time.

4.

4. Dare to be silly sometimes, knowing that a sense of fun is often just the right corrective for many tense situations and temporary bad moods.



5. Tolerate, then accept love. Like salve on a wound, love can be uncomfortable at first

6. Love others.

7. Behave responsibly, not over-responsibly or under-responsibly.

8. Learn to trust your perception of reality. Just because you grew up in a “not-so-funhouse” full of distorting mirrors doesn’t mean that’s how things look in the real world.

Finally, remember: Courage can feel like fear. Hope can feel like despair. Faith can feel like doubt. Love doesn’t feel like anything because it’s not a feeling; it’s self-sacrificial (but not self-destructive) behavior directed toward the welfare of another.

Distortions of personality arising from the “not-so-funhouse” environment of a dysfunctional family can include a deep dependency on others for self-validation and autonomy. As an example of this strong tendency to remain dependent, let me share with you an anecdote about a patient of mine some years ago (and the circumstances have been altered to protect the privacy of the patient):

I once had a patient who was very dependent emotionally, and he said that his greatest fear was of making a mistake and being condemned for it. He said he needed a new blazer to wear for work, and I asked him if he had gotten one yet. “Oh, no,” he said. “I’ve thought about getting one, but I haven’t gotten around to it yet.



Since one of his foibles was a tendency to procrastinate, I made a behavioral agreement with him that he’d go purchase a blazer before our next session in a week

and wear it to the session. He agreed to do that.

When he appeared the next week, he wasn't wearing a blazer. I asked him if he'd remembered that he'd wear it to the session. "To tell you the truth," he admitted, "I didn't pick one out." I asked him if he'd gone to the clothier to carry out his purchase. "I did," he said. "Well ... ?" I asked him. "Honestly, I just couldn't figure out what I like. I didn't know which of all the coats there was one that I liked. He hesitated a bit and then confided, "You see, I don't know what I like. I don't want to make a mistake."

I immediately congratulated him vociferously on just having gone to the store in the first place, and I made a suggestion: "What if you go back to the store and pick out a blazer that you think someone else would like? Just make sure that, if you get it home and decide you really don't like it, you can take it back for a replacement or a refund? Could you do that?" He agreed to do so.

I'd love to say he next appeared proudly decked out in a fine, new blazer of his choosing, but he didn't. He'd gone back to the store, all right, but he was still hobbled by this fear of getting the "wrong" blazer. I praised his persistence and asked him if he'd seen any blazers there that he was certain that he *didn't* like. "Yeah, there were some I thought just 'weren't me.' " "Great!" I said. "Go back and get one of the ones that's in the group that you *didn't dislike*, and be sure and wear it to the session; will you do that?" He agreed. I reinforced to him that I wanted to see the blazer not to pass judgment on it but to allude to it to praise his having made an autonomous choice.

The next week, he came wearing his new blazer (which he had to have for work, anyway). I congratulated him heartily on this accomplishment, being careful not to indicate whether or not I thought the blazer was becoming to him. I made it clear to him that his choice was his alone to make, and no one—including me—had the right to contradict his sense of taste in choosing this particular blazer. My intuition is that he knew all along that this blazer was the one he wanted but that he had to permit himself to come to that conclusion in his own time and at his own pace, not mine (or anyone else's).



School of Addiction and Behavioral Health