

Substance Use Disorder

ADDICTION
a disease of the brain

The role of **12 STEP GROUPS**

Commonly abused drugs & their effects

Help for FAMILY MEMBERS

RECOVERY IS POSSIBLE
with treatment

INSIGHTS magazine is a publication of Pine Rest Christian Mental Health Services and is reviewed by Pine Rest clinical and medical staff. INSIGHTS is produced by the Pine Rest Marketing and Communications Department.

To learn more about substance use disorder, addiction and other mental health topics, visit pinerest.org/insights.

Pine Rest Services

Pine Rest provides a full continuum of addiction services, including outpatient counseling and therapy, intensive outpatient, day programs, integrated substance use/psychiatric inpatient services, residential detoxification, residential programs, relapse prevention groups and intervention and family services. With one call, we can guide you to the most appropriate level of care: 866.852.4001

For more information, visit pinerest.org/addiction

Counseling, Psychiatry and Psychological Assessment & Testing [Iowa and Michigan]
866.852.4001

Inpatient Hospitalization [Michigan]
616.455.9200
800.678.5500
TTY 616.281.6446

Pregnancy & Postpartum HOPEline [Michigan]
844.MOM.HOPE (844.666.4673)
[Iowa]
844.PMD.HOPE (844.763.4673)

Pine Rest is one of the largest free-standing behavioral health providers in the United States. A nonprofit founded in 1910, it has a comprehensive behavioral health center located in Grand Rapids, Michigan and a network of 18 outpatient offices throughout Michigan and Iowa.

Mailing Address

Pine Rest Christian Mental Health Services
300 68th Street SE
Grand Rapids, MI 49548

CONTENTS

Substance Use Disorder 3

Addiction: A Physician’s Perspective..... 4

Age of First Illicit Drug Use 4

Definitions 5

What Happens at Various Levels of Blood Alcohol Content? 7

Treatment for Substance Use Disorders 9

Alcohol and Other Drug Classifications and Effects 12

Substance Use Disorders Most Often Treated by Age 13

Tips for Family Members..... 16

The Role of Twelve Step Groups in Recovery..... 18

Treatment is Effective Back Cover

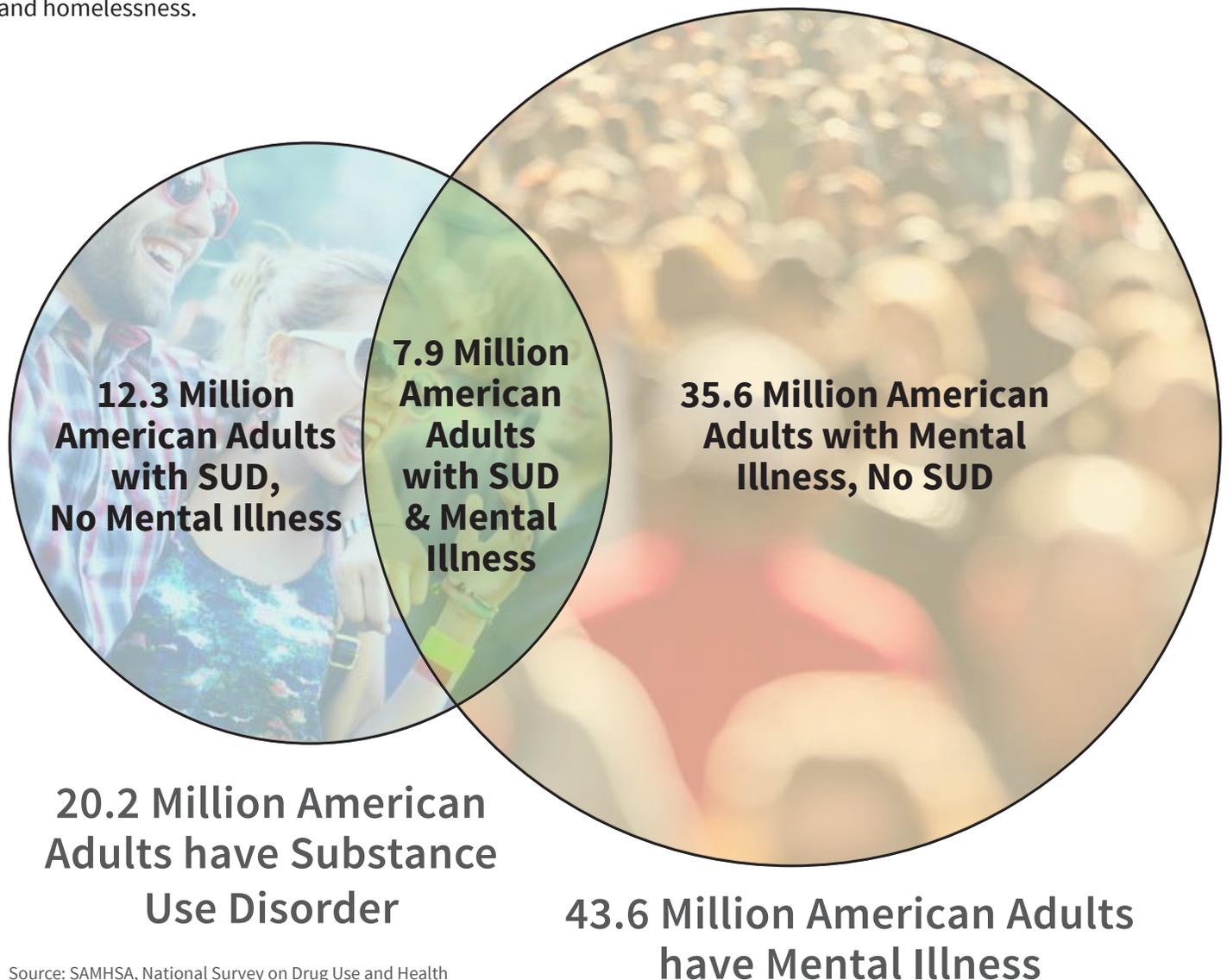
Substance Use Disorder

There are more deaths, illness and disabilities due to alcohol and drug use than any other preventable health condition. Nearly one in four deaths can be attributed to alcohol, tobacco or illicit drug use, and substance use disorder is linked to a variety of health problems including cancer, cardiovascular disease, cirrhosis, dementia, depression, gout, infectious diseases, pancreatitis and seizures.

Substance use is also linked to poorer performance on the job or at school, difficulty in keeping a job and relationship problems. As usage increases, so does the likelihood of being involved in a traffic or workplace accident, legal and financial troubles, violence, crime and homelessness.

One in four Americans will have an alcohol or other drug problem at some point in their lives.

The number of persons with a substance use disorder in the United States holds steady at about 15 to 20 million. In 2014, an estimated 20.2 million American adults needed treatment for substance use, and among those, 39.1% (or 7.9 million) had a co-occurring mental illness. (SAMHSA)



Source: SAMHSA, National Survey on Drug Use and Health

Addiction: A Physician's Perspective

By Bruce Springer, MD

Most health care professionals would agree that addiction is a disease. Like high blood pressure, diabetes mellitus, heart failure and cancer, it shares many disease-defining characteristics and if left untreated, is often fatal.

Unfortunately addiction, whether to drugs or alcohol, is also a relapsing disease that is all too common. Nearly 120,000 of our friends, neighbors and family will die of this disease within the next year. If one considers addiction to nicotine, that number swells to well over one-half million. Addiction finds its home in some of the deepest parts of the human brain and yet reaches outward to affect all of health, family life, law and even history.

Terms used to describe and differentiate people's relationship to potentially addictive substances are important to understand (please see definitions on page 5). Frequently, these terms are used interchangeably, perhaps adding confusion to an already confounding illness. Most people using opiates for severe pain relief may develop tolerance and require higher doses for continued pain relief. Some of these same patients may become dependent and experience uncomfortable withdrawal symptoms if the opiates were stopped abruptly. The majority of these patients will not develop the disease of addiction.

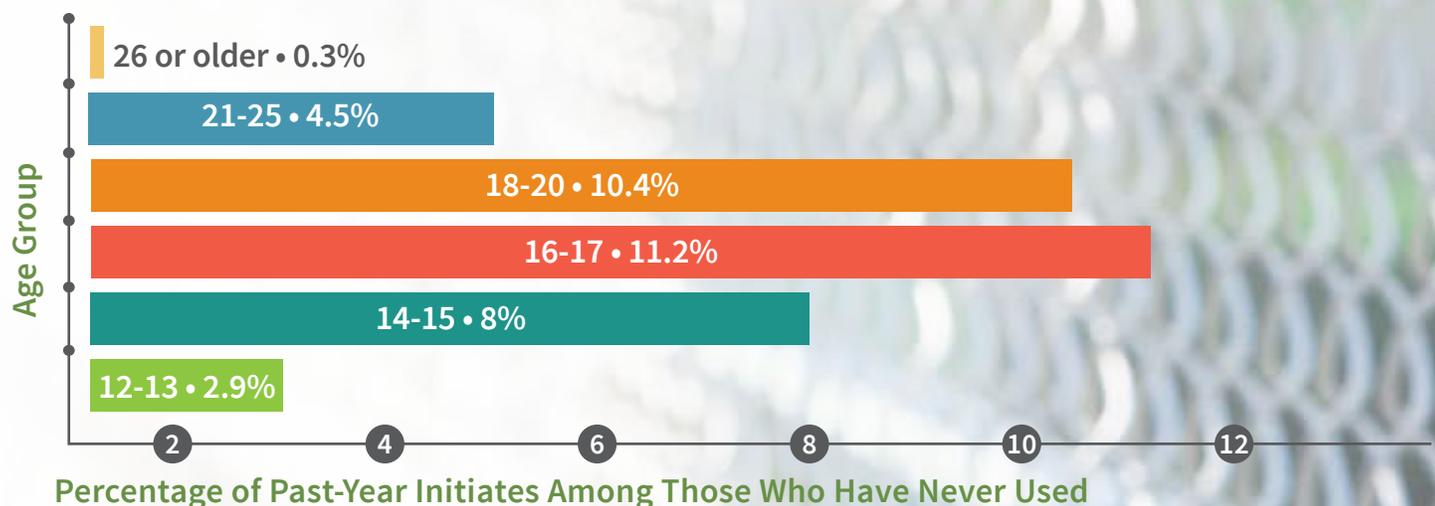
A college freshman may abuse alcohol and drink to intoxication frequently throughout his early college experience, but after failing an important exam, losing his driver's license or frequent morning "hangovers," will decide that moderation and responsibility are important to his health and future success. His best friend, however, may lose control over alcohol consumption and develop addiction to alcohol, drinking despite losing his family, friends, job, health and perhaps his life.

How Common is Substance Use and Abuse?

In 2013, an estimated 2.8 million persons aged 12 and older used an illicit drug for the first time within the past 12 months, or an average of 7,800 new users per day.

In 2014, an estimated 21.5 million persons, or 8.1 percent of the population aged 12 or older, were classified with substance dependence or abuse in the past year based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV). The number of illegal drug users reached 24.6 million. Half of college students binge drink and/or use other drugs and almost a quarter meet medical criteria for alcohol or drug addiction. Each year, approximately 5,000 youth under the age of 21 die as a result of drinking alcohol.

Age at First Illicit Drug Use



SOURCE: SAMHSA, National Survey on Drug Use and Health



Definitions

Tolerance: A state in which an increased dosage of a psychoactive substance is needed to produce a desired effect.

Abuse: The harmful use of a specific psychoactive substance. Abuse may take place without the full syndrome of addiction.

Dependence: A physiological state of adaptation to a specific psychoactive substance characterized by the emergence of a withdrawal syndrome during abstinence, which may be relieved in total or in part by re-administration of the substance.

Addiction: A disease process characterized by the continued use of a specific psychoactive substance despite physical, psychological, or social harm. This may or may not include tolerance and dependence and is identified by certain other behaviors such as:

- The drug is used more than intended;
- There is inability to control drug use;
- Effort is expended to obtain the drug;
- Important activities are replaced by drug use.

Source: American Society of Addiction Medicine

Girls and women become addicted to alcohol, nicotine, and illegal and prescription drugs, and develop substance-related diseases at lower levels of use and in shorter periods of time than their male counterparts.

Among persons aged 12 and older who used prescription pain relievers non-medically in the past 12 months, 55 percent got them from a friend or relative for free.

Who Becomes Addicted?

The media announces, almost daily, the stories of famous people who have entered treatment for their addiction to various substances. For a long time our culture relegated addicts to city streets, back alleys and homelessness. Just the opposite is true, however. The face of the addicted person is one of a mother, father, teacher, athlete, minister, doctor, lawyer or politician.

The Addicted Person Can Be Anyone From Anywhere

Just as there are risk factors for heart disease and lung cancer, there are several characteristics that predict a greater chance for development of addiction. One of the most important of these lies within our DNA. Researchers have found that children of alcoholics (especially sons of alcoholic fathers) are much more likely to become alcoholics themselves. Studies of twins have shown a vastly greater chance of one developing alcoholism if the other has the disease, even if they were raised in different homes. There is a great deal of work the world over to find biochemical and molecular processes that might contribute to this propensity in one person and not in another. There are several other risk factors including: growing up in a dysfunctional family, having a history of certain psychiatric disorders such as antisocial personality disorder and panic disorder, and having peers and friends with heavy drinking behaviors.

Some of the defining characteristics of an addicted person are a loss of control over when and how much of a substance is used, plus spending an inordinate amount of time thinking about and obtaining the substance. Another telling trait in identifying addiction is when use of the substance is more important than engaging in relationships, going to work or living up to life's responsibilities and commitments. The addicted person will use the substance despite physical, emotional, spiritual and social harm. A very frustrating component of addiction is denial. Very often an individual with a serious drug or alcohol dependency problem is unable to recognize it.

A great human tragedy is a person losing everything he or she has and continuing the abuse blaming everything and everyone else instead of facing and recovering from their disease.

Addiction Is a Disease Located in the Brain

For most of time, addiction has been viewed as moral weaknesses or diseases of the will or the spirit. We are now learning addiction begins when significant changes take place deep within the human brain. The brain is made up of billions of individual nerve cells that must be able to communicate with each other. They do this with tiny appendages called axons. These cellular appendages send chemical messages to each other via neuro-transmitters such as serotonin, dopamine and norepinephrine. Many medications and all substances to which human beings become addicted affect the quantities of these chemicals and how they interact with nerve cells.



Deep within the brain lie clusters of nerve cells which allow us to feel joy, happiness and satisfaction. This “pleasure center” is known as the mesolimbic dopamine system (MDS), a nerve pathway running near the bottom of the brain between the right and left hemispheres. It is understood that people susceptible to addiction may experience changes in the interaction of neurotransmitters, such as dopamine, and their receptors in the MDS. Perhaps there is too much or too little dopamine or an abnormality in the production or breakdown of this and other neurotransmitters. There could also be changes in the receptors and alterations in how they interact with these neurotransmitter molecules.

For persons having a predisposition to addiction, the introduction of a substance bringing a pleasurable feeling may begin to disrupt the receptor/neurotransmitter function of the nerve cells in the MDS when used again and again. What once was a source of pleasure becomes a desperate need for the substance bringing pleasure. The disease of addiction may bring with it distinct molecular and biochemical changes in the human brain. It is now felt that addiction to many substances and behaviors such as gambling, sexual behaviors and even eating originate in this region of the brain.

The Price to Be Paid

Addiction takes a toll on the person. Any drug or behavior of choice eventually begins to destroy the physical, psychological, relational and financial health of its victim. Alcohol, as an example, is toxic to almost every organ in the human body. During an episode of intoxication, the brain may be affected by an acute loss of memory (blackouts), and with chronic use, injury may be more dramatic and long lasting.

Many chronic alcoholics coming to treatment have significant difficulty with problem-solving and memory. Brain scans on many show noticeable shrinkage of the brain, indicating loss of neural tissue. A direct

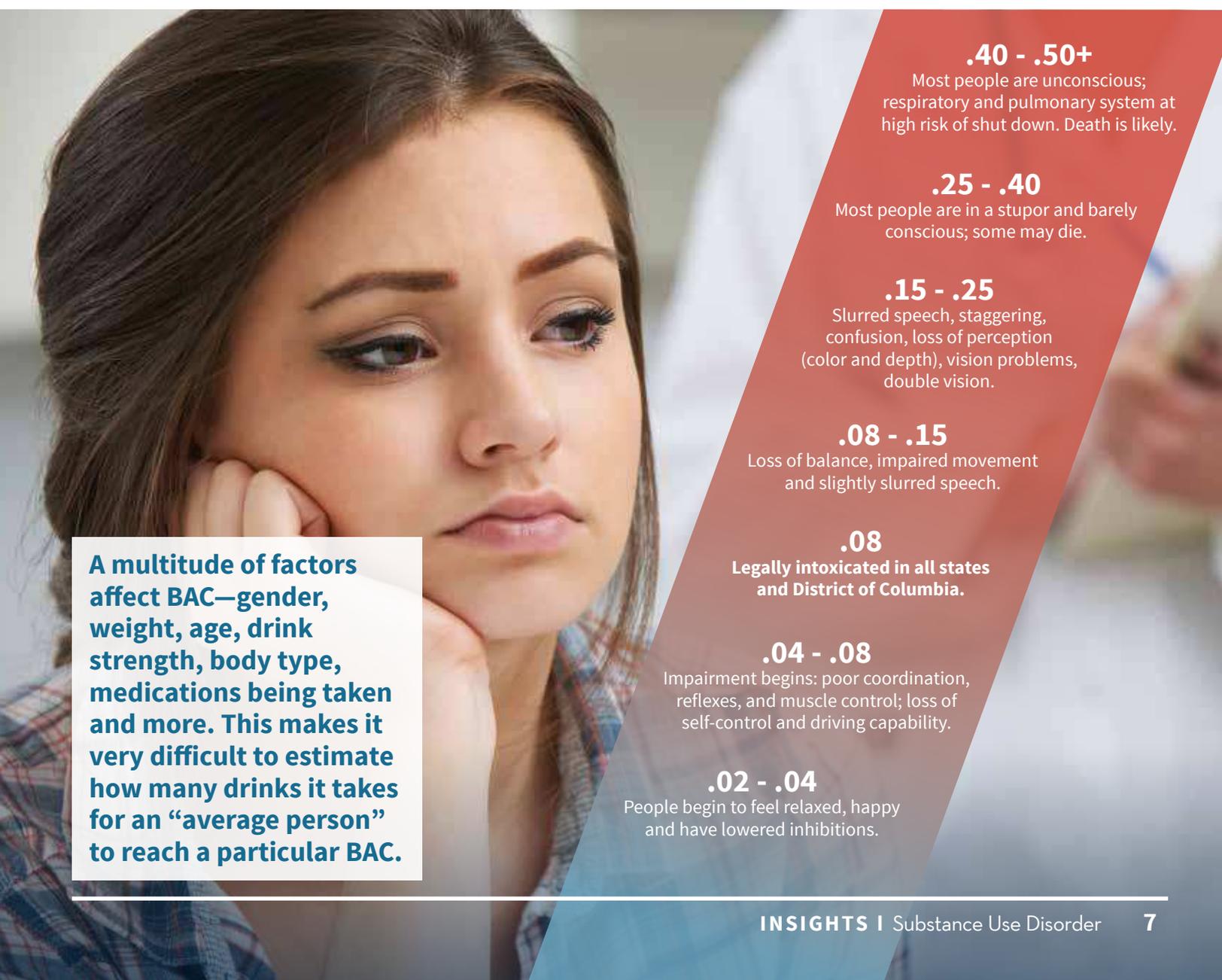
neurotoxin to the balance centers of the brain (cerebellar degeneration) frequently leaves the person addicted to alcohol unable to walk or perform the simplest tasks.

Other neurologic complications of alcoholism include seizures, injury to peripheral nerves, trauma to the brain in accidents and falls, plus damage secondary to lack of essential nutrients such as thiamine. The latter can occur very rapidly when a malnourished alcoholic is given nutrients lacking thiamine.

Other serious effects involve the destruction of the heart and impairment of its pumping function, chronic liver inflammation with cirrhosis and liver failure, pancreatitis,

What happens at various levels of Blood Alcohol Content (BAC)?

Compiled by Jon Weeldreyer, MA, CAADC, CCS-M



A multitude of factors affect BAC—gender, weight, age, drink strength, body type, medications being taken and more. This makes it very difficult to estimate how many drinks it takes for an “average person” to reach a particular BAC.

.40 - .50+

Most people are unconscious; respiratory and pulmonary system at high risk of shut down. Death is likely.

.25 - .40

Most people are in a stupor and barely conscious; some may die.

.15 - .25

Slurred speech, staggering, confusion, loss of perception (color and depth), vision problems, double vision.

.08 - .15

Loss of balance, impaired movement and slightly slurred speech.

.08

Legally intoxicated in all states and District of Columbia.

.04 - .08

Impairment begins: poor coordination, reflexes, and muscle control; loss of self-control and driving capability.

.02 - .04

People begin to feel relaxed, happy and have lowered inhibitions.

and life threatening bleeding from the esophagus, stomach, and duodenum. The blood forming tissues in the bone marrow are not immune to alcohol's toxic nature. Anemia is common as is a diminished ability to fight infection. Sleep apnea, osteoporosis, muscle destruction and several types of cancer afflict the alcoholic more commonly.

Narcotic overdose can cause depression of respiration leading rapidly to death by asphyxiation. A few can even cause seizures. Cocaine use can bring about severe hypertension, heart attacks, strokes, and muscle destruction. It can also cause sudden death in a previously healthy person. Marijuana, which is often abused by youngsters, has been found to cause dependence and quickly impairs memory and learning. Addicts frequently experience psychiatric complications as well.

Most alcoholics and addicts are depressed during the early days of their abstinence, but this is usually self-limited. Cocaine, amphetamines and phencyclidine can

cause psychosis, paranoia and even violent or homicidal behavior. Repeated cocaine use can so deplete the pleasure centers of neurotransmitters that any joyful feelings are almost biologically impossible until cocaine abstinence and time allow the brain to restore dopamine levels. Some addicts begin use of drugs and alcohol in response to a pre-existing psychiatric condition and care must be given in evaluating which came first.

Conclusion

It is not difficult to see that if we are not ourselves victims of addiction, we may well care about someone who is. The disease is all too common in our society. Because it is felt by many to be our number one health problem, it is important for health providers and the public alike to become more familiar with addiction as a disease and not a moral weakness. People with addiction are in great pain and their suffering can be lessened and even eliminated through treatment. We must do what we can to help people with addiction get the care and treatment they need.





The Continuum of Care for Patients with Substance Use Disorders in the New Millennium

By Jon Weeldreyer, MA, CAADC, CCS-M

A Brief History of Treatment

Treatment for mental health and substance use disorder (SUD) patients had very different beginnings. The medical community initiated most mental health treatment, while most SUD treatment was originated by recovering people who, out of gratitude for their own recovery, wanted to help others in need. For many years, persons who were chronically addicted to alcohol or other drugs were often placed in state hospitals, where they were treated for what appeared to be symptoms of psychosis. Many were placed on medications for mental health disorders once they were developed.

After the beginning of the fellowship of Alcoholics Anonymous (AA) in 1935, groups of recovering men and women set up homes to aid persons wanting to quit their drinking. Doctors were consulted, and as the treatment for SUD became more professionally led, detoxification protocols became more specialized and sophisticated. As addiction was increasingly understood to be a biological brain disorder, insurances began to support treatment for SUD.

In time, a 28-day inpatient program became the treatment of choice, where patients were detoxified and led through the initial steps of the 12-step AA program.

With the inception of managed care and its desire to cut costs and improve the efficiency of treatment, the “one size fits all” 28-day program has been modified to the present day “treatment continuum” available to the SUD patient.

Today, the environment calls for treatment programs to be capable of providing treatment for patients with co-occurring substance use and mental health disorders. Therapists need skills to treat patients whose dual conditions trigger and sabotage each other. On-site medication management by psychiatrists is in high demand.

Today’s treatment has graduated steps designed to meet the differing needs of each patient and each phase of addiction or recovery. This treatment continuum allows patients to “step-up” or “step-down” to match treatment intensity with their recovery needs. At the initial evaluation, American Society of Addictions Medicine (ASAM) criteria are used for patient placement into the varied treatment options (pages 10-11). Patients can continue to see their therapist or case manager one-on-one while involved in the specific medical or group services that meet their individual needs.



Treatment Modalities Available Today

Detoxification: Initially, many patients need medical monitoring or management to complete a medical detoxification. Each category of addictive chemical has its own detoxification symptoms and dangers. A broad variety of medications are available from doctors to increase safety and comfort during the process. Most acute detoxification lasts from two to five days.

Inpatient/Residential: Often a controlled environment is necessary to establish initial abstinence. Inpatient (hospital-based) or residential (free-standing facility) treatment length of stay varies greatly. Stays ranging from two to 14 days are typical, and are based on patient need, insurance coverage, and ability to pay. Treatment includes intensive group therapy, lectures, videos, experiential activities, and on-site community support groups such as AA or NA (Narcotics Anonymous). Inpatient care is focused on stabilization and preparation for return to the environment that supported the addiction in the past, but with increased awareness of relapse triggers and behavioral changes needed to maintain abstinence.

Partial Hospitalization/Intensive Outpatient Program (IOP): IOP is designed for those persons not needing residential care, but who are likely to relapse without close assistance and monitoring.

Simply put, IOP is for SUD patients unable to maintain abstinence in traditional outpatient care. IOP has become the focus of most intensive treatment today. In some locations, “domiciliary IOP” is available, with an insurance carrier picking up the cost of treatment, and the patient paying a nominal room and board fee. This allows for intensive services and the safety of a controlled environment when residential treatment may otherwise be unavailable.

Traditional Outpatient and Outpatient Group: This includes individual and/or group therapy for persons who need guidance in early recovery, or to prevent or halt relapse. Traditional outpatient therapy uses the one-on-one session as the basis for treatment, augmented by group experiences. The best programs have a seamless system where group members can “step up or down” between weekly or multiple visits per week in group sessions, without changing group peers or therapists. Group therapy can also increase a patient’s comfort in groups, paving the way to the community support groups. Outpatient care is highly individualized and frequently addresses underlying issues that can trigger relapse.

Research has found group therapy to be the most effective form of treatment for persons with SUD. At the beginning of each group session, patients participate

in setting the agenda for the day. This format allows the therapy to be delivered at “teachable moments” as the clients deal with how recovery interfaces with their real world issues. The therapist’s role is to ensure that each patient is focused on, and addresses, his/her identified problem areas. Didactic presentations and videos are provided as necessary according to each group’s needs and each patient’s individualized treatment plan. The primary goal in therapy is to build an active recovery plan that can assist the patient in maintaining long-term recovery.

Community Support Groups: Fellowships AA and NA are strongly encouraged throughout treatment. For over 75 years, recovering persons have shared their strength, hope, and experience with others in the AA and NA programs. Treatment frequently uses the principles and language of the AA and NA programs to prepare the patient for success in the recovering community. While spiritually-based, these fellowships are not religious organizations and are very accepting to persons regardless of spiritual orientation. AA and NA meetings are often available on the Pine Rest campus.

Long Term Residential: For patients with the most progressed forms of SUD, long-term, therapeutic communities are sometimes necessary. These programs run from three to 12 months. While having less intensive therapy, long-term care provides a controlled environment with continuous access to others in recovery throughout the day. Patients are often allowed to work and have home visitation as they progress through the program.

Opioid Maintenance: The use of methadone has been found to aid some opiate-addicted persons to lead a more manageable life. Methadone is a long-lasting opiate that can minimize the “loss of control” behaviors in many persons previously addicted to illegal or illegally obtained opiate drugs such as heroin. Daily dosing of methadone is required, often at significant cost to the patient.

Medications: The idea of giving medications to someone with a SUD problem seems conflicting at first glance. However, as we grow in our understanding of addiction as a biological brain disorder, it makes a great deal of sense to medically address the chemical imbalances within the body.

Antabuse (*Disulfiram*) is a medication that has been used for many years, causing a variety of negative physical symptoms if a person drinks alcohol while taking the medication. This is often enough to prevent taking the first drink. Other drugs such as *Wellbutrin*, *Naltrexone* and *Suboxone* act on brain circuitry to reduce the desire to use tobacco, alcohol or other drugs. Other non-addictive medications are available to reduce anxiety or depression that are often triggers for relapse.

Substance Use vs. Addiction

Many people who use substances access care before developing the disease of addiction. These persons also need specialized treatment, often focusing on the decision-making processes leading them to abuse alcohol or other drugs. Many times legal, occupational, relational, or medical complications arise, and other persons in their life recommend therapy to the patient. This “external motivation” for treatment can cause resentment and resistance. The therapist must be able to balance the needs of the patient and the needs of the referrer.

A Final Word

Today, therapy for the person with a substance use disorder is multifaceted and patient specific. Specialized training is required for both therapy and medical staff. Research continues to yield new information on biological predisposition, brain chemistry and behaviors. Treatment will need to continue to change and improve. Treatment providers must create trusting, open and caring relationships with the person struggling with substance use disorder.





Alcohol and Other Drug Classifications and Effects

Compiled by Jon Weeldreyer, MA, CAADC, CCS-M

Below is a list of the most commonly abused substances and their general classifications. Common effects are listed; however experiences may vary depending upon the individual's biological makeup, potency of the drug, dose of the drug and frequency of use.

Alcohol: Alcohol is a nervous system depressant and is the most commonly used and abused drug in the United States.

Effects: Loss of inhibitions, relaxation, loss of judgment, loss of coordination, increased aggression, decreased heart rate, slower respiration, sleep interference, damage to the brain, liver, and other internal organs, depression, tolerance, withdrawal and addiction.

Amphetamines: Amphetamines are addictive central nervous system stimulants, similar to the body's natural stimulant adrenaline. They are only legal when prescribed by a doctor.

Effects: Increased heart rate/blood pressure, breathing and energy. Loss of appetite, aggression, blockage of blood vessels, irregular heart beat, stroke/heart failure, tolerance and addiction.

Cocaine: Cocaine comes from the leaves of the South American coca plant. The leaves are ground into a white powder or paste. Cocaine is inhaled (powder breathed in

through the nasal passages), injected (mixed with water and injected into the bloodstream), or smoked (rolled with tobacco or marijuana or in a pipe in "crack" form).

Effects: Brief feeling of euphoria, relief of depression and anxiety, constricted blood vessels, increased heart rate, respiratory problems, high body temperature, stroke or heart attack, immediate depression at the end of the high, nasal irritation and degeneration (holes in your nose), mental changes, violent behavior, tolerance and psychological addiction.

Hallucinogens: Hallucinogens are substances that cause people to experience hallucinations. Some hallucinogens are found naturally in plants (mostly mushroom or cactus plants), but most are man-made substances created in drug labs such as LSD, Ecstasy and PCP.

Effects: Mild euphoria, dangerous increase in blood pressure, hallucinations, dilated pupils, higher body temperature, depression, violent behavior, flashbacks that involve panic, confusion, loss of control and tolerance.

Heroin: Heroin is an opiate and a highly addictive drug. It's produced from morphine, a naturally occurring substance that comes from the seedpod of the Asian poppy plant. People use heroin by injecting, snorting or smoking it. With each use, more is needed to get high. One of the greatest risks with this drug is how extremely easy it is to become dependent. It's estimated that almost one-fourth of the people who try heroin become addicted.

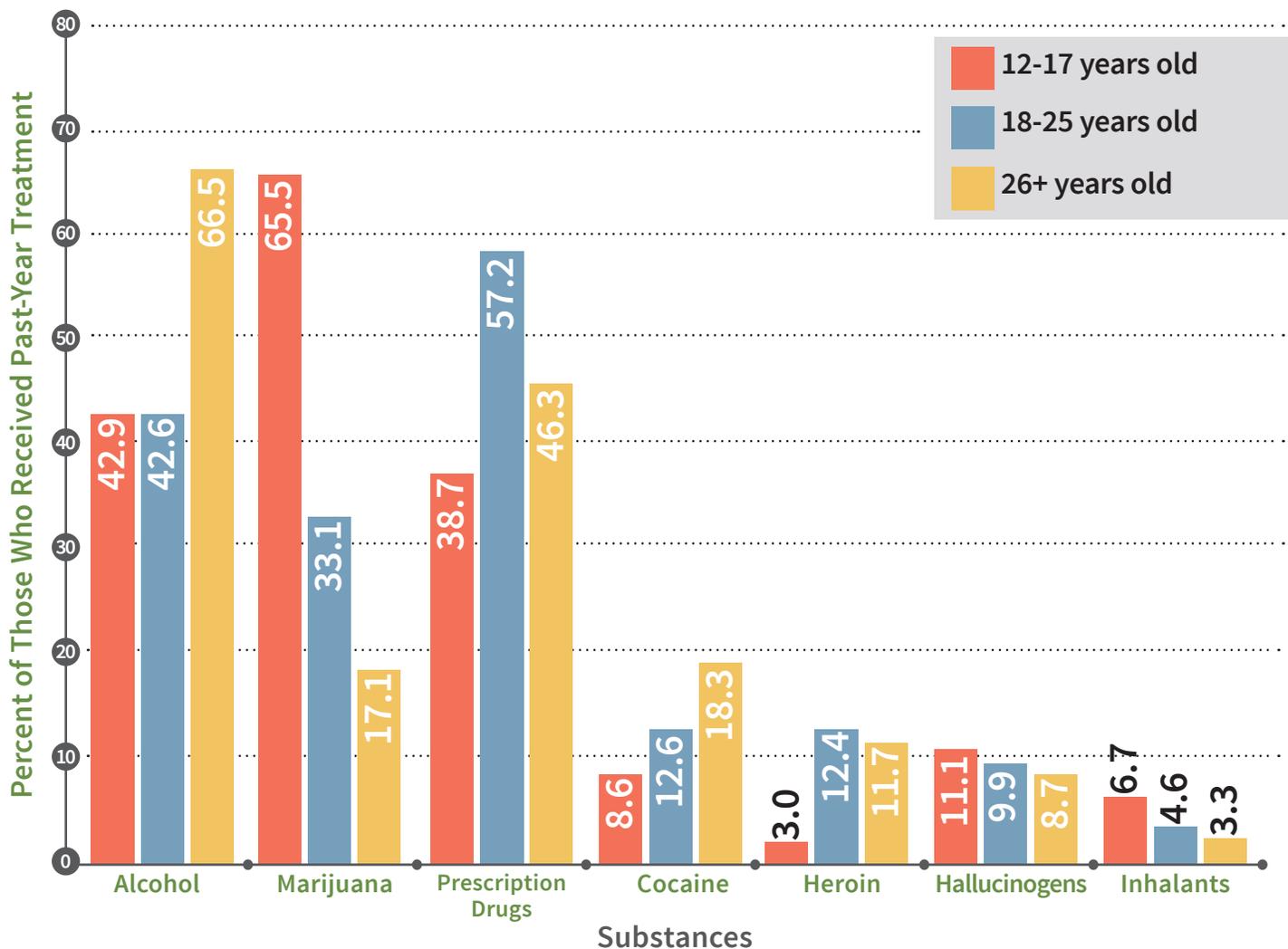
Effects: In the short term, heroin can cause euphoria, dry mouth, severe itching, dizziness, nausea, vomiting, slowed mental function and reduced physical pain. Long-term effects include infectious diseases, collapsed veins, infection of the heart lining and valves, pulmonary complications, abscesses, liver disease, kidney disease and spontaneous abortion.

Inhalants: Inhalants are ordinary household products like glue, whiteout, nail polish remover, paint, aerosol spray cans and the Freon found in air conditioners. Most of these substances can be legally purchased, but it is ILLEGAL to use them in an inappropriate way. Inhalants rank fourth in popularity for use and are the most widely used drug by adolescents age seven to 17. Inhalants cause the most body damage when compared to all other drugs.

Effects: Irregular heart beat, suffocation, brain damage, organ damage, hallucination, mental impairment and tolerance.

Marijuana/Hashish: Marijuana comes from the Hemp plant known as Cannabis Sativa. The main active, mind-altering chemical in marijuana is THC, which targets the central nervous system. Today's marijuana is said to

Substance Use Disorders Most Often Treated by Age



Source: SAMHSA, National Survey on Drug Use and Health

be seven to 10 times more potent than marijuana used in the 1960s. Marijuana tends to be the first illegal and illicit drug used by teenagers (after tobacco and alcohol) and is considered a “gateway drug” as well as a primary addictive substance. Marijuana differs from all other common drugs of abuse in that it stays in the body far longer (up to 150 times as long as alcohol!) due to being fat-based instead of water-based. This long “half-life” causes many of the negative effects listed below.

Effects: Feelings of calm and relaxation, elevation of heart and pulse rate, drowsiness/sleepiness, bloodshot eyes, paranoia, decrease in memory and coordination, Amotivational Syndrome (loss of motivation and interest in life), risk of lung cancer, bronchitis, emphysema, infertility (for both men and women), decrease in school and work performance, tolerance, withdrawal and addiction.

Methamphetamines: Methamphetamines are powerful man-made amphetamines (central nervous system stimulants) that are illegal in all forms. They are usually made in home laboratories. The main ingredient is ephedrine, but they also include toxic ingredients such as hydrochloric acid, drain cleaner, battery acid, fuel and anti-freeze. They have no medicinal value.

Effects: Intense high, hallucinations, twitching/jerking, confusion, dangerous rise in body temperature, rise in blood pressure and heart-rate, malnutrition, heart and respiratory troubles, tolerance and addiction.

Narcotics: Narcotics are drugs that act as pain relievers and sleep inducers (downers). Opiates are narcotics extracted from the poppy flower, while other narcotics are man-made. Narcotics generally cause relaxation with an immediate “rush.” Narcotics are most often injected with intravenous needles or taken orally through misuse of cold medicines and prescribed pills.

Effects: Euphoria, drowsiness, loss of pain sensations, constipation, inflammation of the veins, hepatitis, skin abscesses or other growths, rapid tolerance, withdrawal and addiction.

Tobacco and Nicotine: Tobacco is a leafy plant containing nicotine, a powerful central nervous system stimulant. Nicotine is delivered into the body through smoking a tobacco product (cigars, cigarettes, hookah tobacco), using smokeless tobacco products (snuff, dip, twist, dry tobacco and sachets) or vaping (electronic cigarettes).

Effects: Tobacco use is the leading cause of preventable illness and death in the United States. Short term, nicotine provides a feeling of calm followed by sudden depression, fatigue and craving. Long term effects of tobacco/nicotine include loss of taste and smell, chronic respiratory problems (colds, bronchitis), heart disease, lung disease, emphysema, stroke, cancer (lung, mouth, throat, esophagus, and other internal organs), wrinkling (numerous and premature), tolerance and physical and psychological dependence.

Because electronic cigarettes have been introduced only recently, the long-term health effects of long-term use of e-cigarettes is unknown. Nicotine use in any form can lead to increased blood pressure and heart rate as well as nausea, sweating, vomiting, diarrhea and eye irritation, according to the National Institutes of Health. E-cigarettes may contain ingredients that are known to be toxic to humans.

Poisoning from e-cigarettes is on the rise according to the Center for Disease Control because the liquid used for vaping can be ingested, inhaled or absorbed through the skin and eyes. These products are not required to be childproof and come in candy and fruit flavors that are appealing to children.

Tranquilizers and Sedatives: Tranquilizers are depressant drugs that can be used to treat anxiety or insomnia. Sedatives are used as a sleep aid or relaxant. Tranquilizers are used to gain a sense of well-being or to reduce feelings of panic or tension. Like alcohol, tranquilizers work to depress brain functions. Some common tranquilizers are Xanax, Valium, Klonopin, Ativan and Librium.

Effects: Relief of anxiety or tension, impairment of memory, drowsiness, confusion, stupor, decreased motivation, irritability and impaired sexual functioning.

Source: George Washington University



Girls and women become addicted to alcohol, nicotine and illegal and prescription drugs, and develop substance-related diseases at lower levels of use and in shorter periods of time than their male counterparts.



To the Family Members...

Compiled by Jon Weeldreyer, MA, CAADC, CCS-M

Substance use disorders have enormous impact on the family members and loved ones. It is easy for those outside the family to give what seems to be simple common sense advice. Often this comes in the form of “You don’t have to take that... just move out!” or “I’d ground him if he were my son.” In almost every case, these solutions have been attempted long before the family member was even willing to talk about the problem.

The family structure is often compared to a mobile — an art medium in which a number of objects, balanced on sticks and strings, is hung from the ceiling. When one part of the mobile (in this case a family member) is moved, all parts of the structure are affected. In a family where use of substances has caused problems, members

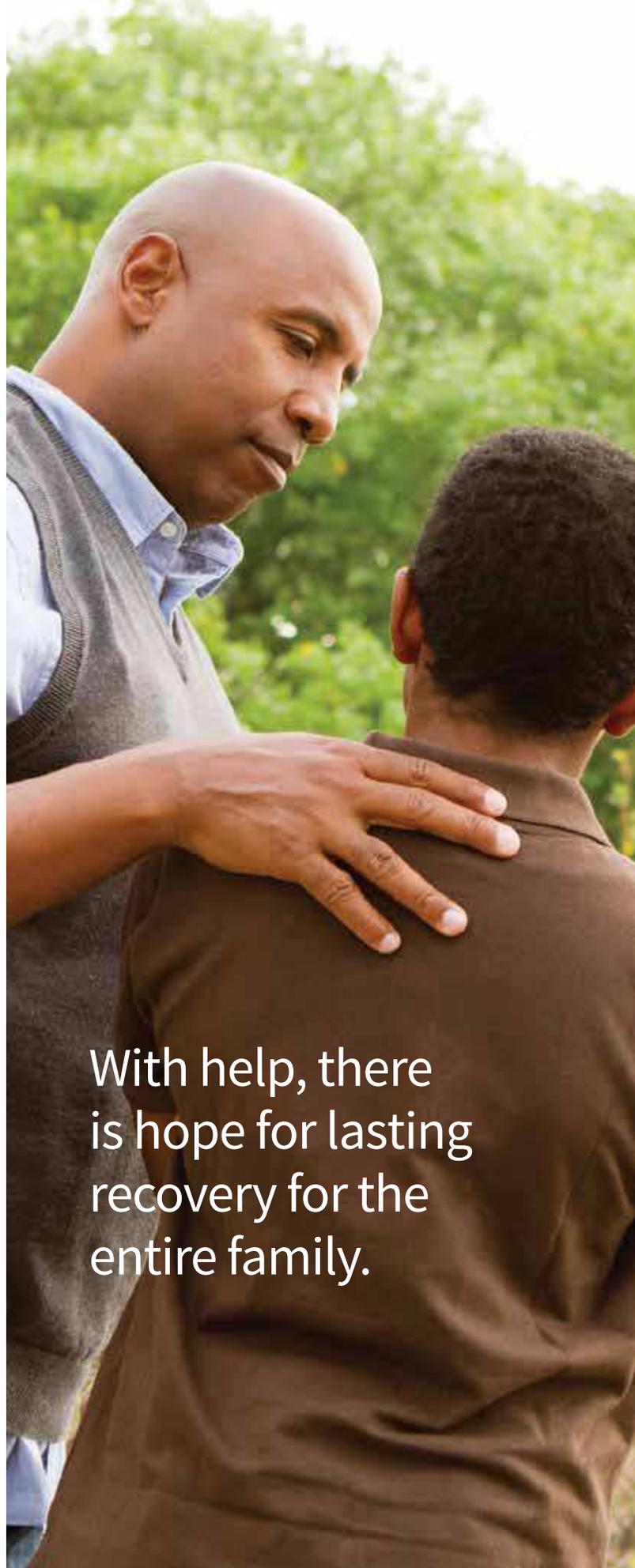
of the family learn roles to cope with the constant instability of life. The reaction to the harmful use of a family member is called co-dependency.

Once a significant pattern of use has started, it is common that the user becomes unable or unwilling to change his/her use patterns. If this is true for the person using the chemical, imagine the near-impossibility of another person to impact that pattern. There are few things family members can do, and many, even when done well, don’t end up with the results desired. With help, there is hope for lasting recovery for the entire family.

Here are some actions family members can take that are often helpful:

- **Separate the behavior from the person.** Your loved one is not defined by their use. The person you care about exists and can return if the using stops.
- **Take care of yourself.** Make sure you are not sucked into unhealthy relational patterns or even into using the substance yourself.
- **Talk about it.** It is easy to be held hostage by silence. As often as possible, be honest, open and willing to accept help from others. Talk openly within the family, with friends and at support groups such as Al-Anon Family Groups (a companion to the AA/NA fellowships, set up as support for loved ones of those with drinking or other drug use problems). Many therapists specialize in treatment for the family members.
- **Set boundaries.** With the input of others, make a decision about how much you are willing to accept, and have a consequence if the substance user disrespects that boundary. For children, this can include restriction of privileges. For marriages or committed relationships, this can range from making the home an alcohol-free zone to separation or police involvement.
- **Let the substance user feel the consequences.** This is perhaps the most difficult and most important. It is painful for other family members if the drinker/user loses a job, gets arrested or has to find somewhere else to sleep. However, the wisdom from recovering people is that “when there is enough pain, change will come.”

The most important thing to do is to have contact with a therapist or others who have been through this disease with their loved ones. Fears of judgment and shame disappear quickly once the veil of secrecy is lifted. Those persons know the pain and frustration involved, and wisdom is often yours for the asking. There is hope and help for persons with addiction and the family. Recovery is possible!



With help, there is hope for lasting recovery for the entire family.

The Role of Twelve Step Support Groups in Recovery

By Larry Vander Plaats, LMSW, CAADC



When asked to write an article on whether there is still a place for Alcoholics Anonymous (AA) in the treatment of substance use disorders, I became a bit anxious. As a therapist who is also a recovering person, however, I feel qualified to address this subject. I do know that some professionals in the mental health field and sometimes those in the general community have a bias against AA. The organization and its principles have been viewed as an unsophisticated, simplistic intervention where religion (disguised as the Twelve Steps) is forced on the unsuspecting client. From my perspective, the Twelve Steps of AA are the true foundation of recovery and are absolutely critical in maintaining long-term abstinence. Therefore, treatment facilities that do not incorporate them into their treatment programs are remiss.

The Steps to Recovery

There are 12 steps to recovery. They start with the admission of powerlessness over alcohol and other drugs—acknowledging that life has become unmanageable. They end with the realization of having had a spiritual awakening and the recommendation to help others who are still suffering. In other words, a self-focused, out-of-control individual who is geared toward short-term, immediate gratification does a complete, 180-degree flip-flop in worldview and becomes concerned with others rather than self. A miracle? Those recovering in AA would say “Yes.” My sobriety, my serenity are indeed miracles.

The person struggling with addiction is filled with a deep sense of guilt and shame resulting from the huge gap between his or her values and behavior that invariably develops from living a life based solely on self-will. He or she attempts to hide these feelings from self and others with a highly developed denial system. Efforts to break this denial system are usually met with an array of defense mechanisms, including rationalization, self-righteousness and minimization. Only when the internal pain of guilt and shame becomes greater than the pain caused by external consequences (“hitting bottom”) will the addict abandon his or her alibi system and seek help. Therapy, in its initial stages, must assist the person in reaching the conclusion that any life managed by self-will is doomed to failure, and there is an alternative that provides hope for the future.

Every person who has honestly inventoried his or her life can only come to one conclusion. “We could wish to be moral. We could wish to be philosophically comforted. In fact, we could will these things with all our might, but the needed power wasn’t there. Our human resources, as marshaled by the will, were not sufficient. They failed utterly.” (Alcoholics Anonymous, 1976, p. 45) Therefore, a power greater than ourselves must exist if there is to be hope for the future. The Second Step of Alcoholics Anonymous suggests we come to believe this very fact. We do so through observation. We listen to the strengths, hopes and weaknesses of others who have gone before

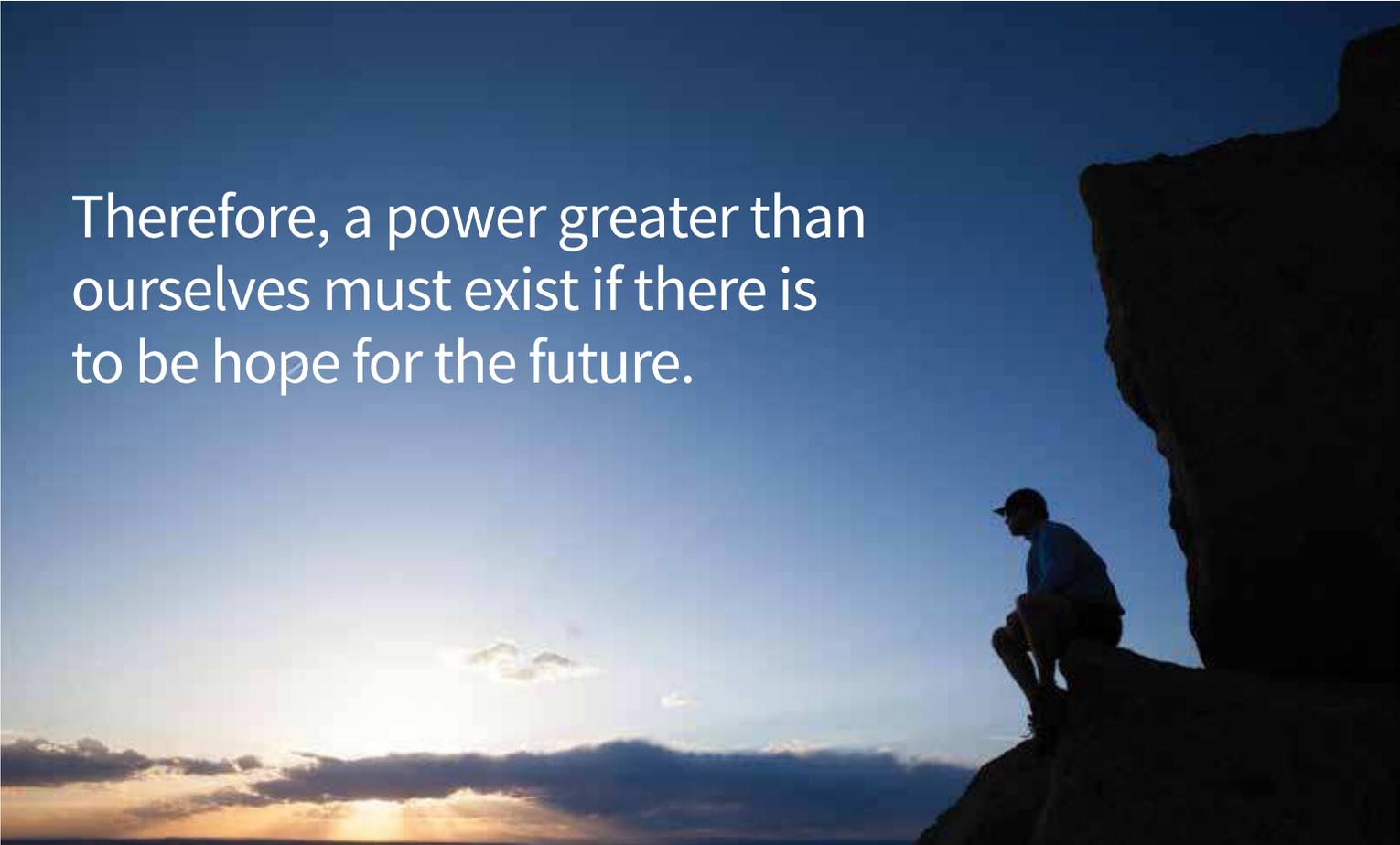
us. Because of their compassion, acceptance, and desire to help us, we start to realize we are not so unique, and they are not so powerless anymore. In fact, we see they are not drinking or using and they are peaceful. Suddenly we find a glimmer of hope that we, too, may be able to find peace. We also get our first awakenings about how wonderful it can feel to make a connection with another human spirit where there are no strings attached. This connection to fellowship, in many cases, is the first positive contact with a higher power and the beginnings of hope.

In Step Three, it is suggested we make a decision to turn our will and life over to the care of this Higher Power. When we do so, we find our sanity returns. Many of us—in fact, all of us who diligently work this program find that after making this step, it is next to impossible to drink. This truly is a miracle of healing. I, who could not say ‘no’ to a drink, now cannot say ‘yes.’ Entrusting your sobriety to the covenantal relationship with God and others is like putting your money in the bank. It is only in jeopardy if taken out of the bank. Our sobriety and peace of mind are secure and protected when in the care of our Higher Power and those in the program. They are only in jeopardy if we take them out of that care.

Who Is Right?

The testimony of countless persons support what a 1999 study by the Stanford University School of Medicine suggested: Twelve Step programs work. People who use them are more likely to remain sober regardless of their religion. Yet the use of the program in formal treatment settings is being challenged. It has been reported that a 59-year-old agnostic ordered to attend AA after a drunk driving conviction, instead took 30 days in jail. He then filed suit against the judge and a treatment center, claiming they violated his First Amendment rights. His complaint was that they were suggesting he could not depend on himself and were asking him to put faith over science. He was unwilling to do that.

Treatment programs employ many other interventions besides AA. Rational Emotive Behavioral Therapy (REBT), Reality Therapy, Dialectical Behavioral Therapy (DBT), Systems Theory, and Cognitive Behavioral approaches are also a large part of both residential and outpatient treatment. However, if I tell the truth, when I walk out of my office at the end of the day, I think of those who participated in treatment with me that day, and I’m praying for the miracle that they may find in the Twelve Step program.



Therefore, a power greater than ourselves must exist if there is to be hope for the future.



Treatment is Effective

Research shows that treatment can help patients stop using, avoid relapse and successfully recover their lives. Of individuals with chronic dependence who achieved sustained recovery, the majority did so after participating in treatment.

Source: SAMHSA

92%
heroin

81%
alcohol

61%
cocaine

43%
marijuana