Counselor's Family Education Manual

Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders

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Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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Rockville, MD 20857

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I. Introduction to the Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders Approach and Package

The Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders (IOP) package provides a structured approach for treating adults who abuse or are dependent on stimulant drugs. The approach followed in the treatment package was developed by the Matrix Institute in Los Angeles, California, and was adapted for this treatment package by the Knowledge Application Program of the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration (SAMHSA). The Matrix IOP package comprises five components:

- *Counselor's Treatment Manual*
- ***Counselor's Family Education Manual*** (this document)
- **CD-ROM that accompanies the *Counselor's Family Education Manual***
- *Client's Handbook*
- *Client's Treatment Companion*

The Matrix IOP model and this treatment package based on that model grew from a need for structured, evidence-based treatment for clients who abuse or are dependent on stimulant drugs, particularly methamphetamine and cocaine. This comprehensive package provides substance abuse treatment professionals with a yearlong intensive outpatient treatment model for these clients and their families: 16 weeks of structured programming and 36 weeks of continuing care.

Background

The Matrix IOP method was developed initially in the 1980s in response to the growing numbers of individuals entering the treatment system with cocaine or methamphetamine dependence as their primary substance use disorder. Many traditional treatment models then in use were developed primarily to treat alcohol dependence and were proving to be relatively ineffective in treating cocaine and other stimulant dependence (Obert et al. 2000).

To create effective treatment protocols for clients dependent on stimulant drugs, treatment professionals at the Matrix Institute drew from numerous treatment approaches, incorporating into their model methods that were empirically tested and practical. Their treatment model incorporated elements of relapse prevention, cognitive–behavioral, psychoeducation, and family approaches, as well as 12-Step program support (Obert et al. 2000).

The effectiveness of the Matrix IOP approach has been evaluated numerous times since its inception (Rawson et al. 1995; Shoptaw et al. 1994). SAMHSA found the results of these studies promising enough to warrant further evaluation (e.g., Obert et al. 2000; Rawson et al. 2004).

In 1998, SAMHSA initiated a multisite study of treatments for methamphetamine dependence

and abuse, the Methamphetamine Treatment Project (MTP). The study compared the clinical and cost effectiveness of a comprehensive treatment model that follows a manual developed by the Matrix Institute with the effectiveness of treatment approaches in use at eight community-based treatment programs, including six programs in California, one in Montana, and one in Hawaii. Appendix A provides more information about MTP.

Matrix IOP Approach

Overview

The Matrix IOP approach provides a structured treatment experience for clients with stimulant use disorders. Clients receive information, assistance in structuring a substance-free lifestyle, and support to achieve and maintain abstinence from drugs and alcohol. The program specifically addresses the issues relevant to clients who are dependent on stimulant drugs, particularly methamphetamine and cocaine, and their families.

For 16 weeks, clients attend several intensive outpatient treatment sessions per week. This intensive phase of treatment incorporates various counseling and support sessions:

- Individual/Conjoint family sessions (3 sessions)
- Early Recovery Skills group sessions (8 sessions)
- Relapse Prevention group sessions (32 sessions)
- Family Education group sessions (12 sessions)
- Social Support group sessions (36 sessions)

Clients may begin attending the fifth type of counseling session, continuing care (Social Support groups), once they have completed the 12-session Family Education group but are still attending Relapse Prevention group sessions. Overlapping Social Support group attendance with the intensive phase of treatment helps ensure a smooth transition to continuing care.

The Matrix IOP method also familiarizes clients with 12-Step programs and other support groups, teaches clients time management and scheduling skills, and entails conducting regular drug and breath-alcohol testing. A sample schedule of treatment activities is shown in Figure I-1.

Program Components

This section describes the logistics and philosophy of each of the five types of counseling sessions that are components of the Matrix IOP approach. Detailed agendas and instructions for conducting each type of group and individual session are provided in this manual and in the *Counselor's Treatment Manual.*

The Matrix materials use step-by-step descriptions to explain how sessions should be conducted. The session descriptions are methodical because the treatment model is intricate and detailed. Counselors who use these materials may want additional training in the Matrix approach, but these materials were designed so that counselors could implement the Matrix treatment approach even without training. The Matrix materials do not describe intake procedures, assessments, or treatment planning. Programs should use the procedures they have in place to perform these functions. If the guidelines presented in this manual conflict with the requirements of funders or credentialing or certifying bodies, programs should adapt the guidelines as necessary. (For example, some States require that sessions last a full 60 minutes to be funded by Medicaid.)

Figure I-1. Sample Matrix IOP Schedule

Schedule	Intensive Treatment Weeks 1 through 4*	Intensive Treatment Weeks 5 through 16†	Continuing Care Weeks 13 through 48
Monday	6:00–6:50 p.m. Early Recovery Skills 7:15–8:45 p.m. Relapse Prevention	7:00–8:30 p.m. Relapse Prevention	Nothing scheduled
Tuesday	12-Step/mutual-help group meetings	12-Step/mutual-help group meetings	12-Step/mutual-help group meetings
Wednesday	7:00–8:30 p.m. Family Education	7:00–8:30 p.m. Family Education **or** 7:00–8:30 p.m. Social Support	7:00–8:30 p.m. Social Support
Thursday	12-Step/mutual-help group meetings	12-Step/mutual-help group meetings	12-Step/mutual-help group meetings
Friday	6:00–6:50 p.m. Early Recovery Skills 7:15–8:45 p.m. Relapse Prevention	7:00–8:30 p.m. Relapse Prevention	Nothing scheduled
Saturday and Sunday	12-Step/mutual-help group meetings	12-Step/mutual-help group meetings	12-Step/mutual-help group meetings

* 1 Individual/Conjoint session at week 1

† 2 Individual/Conjoint sessions at week 5 or 6 and at week 16

All Matrix IOP groups are open ended, meaning that clients may begin the group at any point and will leave that group when they have completed the full series. Because the Matrix groups are open ended, the content of sessions is not dependent on that of previous sessions. The counselor will find some repetition of information among the three Individual/Conjoint sessions as well as group sessions. Clients in early recovery often experience varying degrees of cognitive impairment, particularly regarding short-term memory. Repeating information in different ways, in different group contexts, and over the course of clients' treatment helps clients comprehend and retain basic concepts and skills critical to recovery.

Individual/Conjoint Sessions

In the Matrix IOP intervention, the relationship between counselor and client is considered the primary treatment dynamic. Each client is assigned one primary counselor. That counselor meets individually with the client and possibly the client's family members three times during the intensive phase of treatment for three 50-minute sessions and facilitates the Early Recovery Skills and Relapse Prevention groups.

The first and last sessions serve as "bookends" for a client's treatment (i.e., begin and end treatment in a way that facilitates treatment engagement and continuing recovery); the middle session is used to conduct a quick, midtreatment assessment of the client's progress, to address crises, and to coordinate treatment with other community resources when appropriate.

Conjoint sessions that include both the client and family members or other supportive persons are crucial to keeping clients in treatment. The importance of involving people who are in a primary relationship with the client cannot be overestimated; the Matrix IOP approach encourages the inclusion of a client's most significant family member or members in each Individual/Conjoint session in addition to Family Education group sessions. The counselor who tries to facilitate change in client behavior without addressing family relationships ultimately makes the recovery process more difficult. It is critical for the counselor to stay aware of how the recovery process affects the family system and to include a significant family member in part of every Individual/Conjoint session when possible.

Early Recovery Skills Group

Clients attend eight Early Recovery Skills (ERS) group sessions—two per week for the first month of primary treatment. These sessions typically involve small groups (10 people maximum) and are relatively short (50 minutes). Each ERS group is led by a counselor and co-led by a client who is advanced in the program and has a stable recovery (see pages 7–8 in the *Counselor's Treatment Manual* for information about working with client co-leaders). It is important that this group stay structured and on track. The counselor needs to focus on the session's topic and be sure not to contribute to the high-energy, "out-of-control" feelings that may be characteristic of clients in early recovery from stimulant dependence.

The ERS group teaches clients an essential set of skills for establishing abstinence from drugs and alcohol. Two fundamental messages are delivered to clients in these sessions:

1. You can change your behavior in ways that will make it easier to stay abstinent, and the ERS group sessions will provide you with strategies and practice opportunities.

2. Professional treatment can be one source of information and support. However, to benefit fully from treatment, you also need 12-Step or mutual-help groups.

The techniques used in the ERS group sessions are behavioral and have a strong "how to" focus. This group is not a therapy group, nor is it intended to create strong bonds among group members, although some bonding often occurs. It is a forum in which the counselor can work closely with each client to assist the client in establishing an initial recovery program. Each ERS group has a clear, definable structure. The structure and routine of the group are essential to counter the high-energy or out-of-control feelings noted above. With newly admitted clients, the treatment routine is as important as the information discussed.

Relapse Prevention Group

The Relapse Prevention (RP) group is a central component of the Matrix IOP method. This group meets 32 times, at the beginning and end of each week during the 16 weeks of primary treatment. Each RP group session lasts approximately 90 minutes and addresses a specific topic. These sessions are forums in which people with substance use disorders share information about relapse prevention and receive assistance in coping with the issues of recovery and relapse avoidance. The RP group is based on the following premises:

- Relapse is not a random event.
- The process of relapse follows predictable patterns.
- Signs of impending relapse can be identified by staff members and clients.

The RP group setting allows for mutual client assistance within the guiding constraints provided by the counselor. Clients heading toward relapse can be redirected, and those on a sound course to recovery can be encouraged.

The counselor who sees clients for prescribed Individual/Conjoint sessions and a client co-leader facilitate the RP group sessions (see pages 7–8 in the *Counselor's Treatment Manual* for information about working with client co-leaders).

Examples of the 32 session topics covered in the RP group include

- Guilt and shame
- Staying busy
- Motivation for recovery
- Be smart, not strong
- Emotional triggers

Family Education Group

The chances of treatment success increase immensely if significant others become educated about the predictable changes that are likely to occur within relationships as recovery proceeds. The primary counselor educates participants and encourages involvement of significant others, as well as clients, in the 12-session Family Education group. The Family Education group is discussed in depth on page 7.

Social Support Group (Continuing Care)

Clients begin attending the Social Support group at the beginning of their last month of primary treatment and continue attending these group sessions once per week for 36 weeks of continuing care. For 1 month, intensive treatment and continuing care overlap.

Social Support group sessions help clients learn or relearn socialization skills. Persons in recovery who have learned how to stop using substances and how to avoid relapse are ready to develop a substance-free lifestyle that supports their recovery. The Social Support group assists clients in learning how to resocialize with clients who are further along in the program and in their recovery in a familiar, safe environment. This group also is beneficial to the experienced participants who often strengthen their own recovery by serving as role models and staying mindful of the basic tenets of abstinence. These groups are led by a counselor, but occasionally they may be broken into smaller discussion groups led by a client–facilitator, a client with a stable recovery who has served as a co-leader and makes a 6-month commitment to assist the counselor.

Social Support group sessions focus on a combination of discussion of recovery issues being experienced by group members and discussion of specific, one-word recovery topics, such as

- Patience
- Intimacy
- Isolation
- Rejection
- Work

The Role of the Counselor

To implement the Matrix IOP approach the counselor should have several years of experience working with groups and individuals. Although detailed instructions for conducting sessions are included in this manual, a new

counselor may not have acquired the facility or the skills necessary to make the most of the sessions. The counselor who is willing to adapt and learn new treatment approaches is an appropriate Matrix IOP counselor. The counselor who has experience with cognitive–behavioral and motivational approaches and has a familiarity with the neurobiology of addiction will be best prepared to implement Matrix IOP intervention. Appropriate counselor supervision will help ensure fidelity to the Matrix treatment approach.

In addition to conducting the three Individual/Conjoint sessions, a client's primary counselor decides when a client moves from one group to another and is responsible for integrating material from the various group-counseling formats into one coordinated treatment experience.

Each client's primary counselor

- Coordinates with other counselors working with the client in group sessions (e.g., in the Family Education sessions)
- Is familiar with the material to which the client is being exposed in the Family Education sessions
- Encourages, reinforces, and discusses material that is being covered in 12-Step or mutual-help meetings
- Helps the client integrate concepts from treatment with 12-Step and mutual-help material, as well as with psychotherapy or psychiatric treatment (for clients who are in concurrent therapy)
- Coordinates with other treatment or social services professionals who are involved with the client

In short, the counselor coordinates all the pieces of the treatment program. Clients need the security of knowing that the counselor is aware of all aspects of their treatment. Many people who are stimulant dependent enter treatment feeling out of control. They are looking to the program to help them regain control. If the program appears to be a disjointed series of unrelated parts, these clients may not feel that the program will help them regain control, which may lead to unsuccessful treatment outcomes or premature treatment termination. Appendix B provides more notes on the counselor's role in facilitating Family Education groups.

The Matrix IOP Package

In addition to this *Counselor's Family Education Manual* (introduced in detail on page 7), the Matrix IOP package consists of these components:

- *Counselor's Treatment Manual*—The *Counselor's Treatment Manual* contains all the materials necessary for a counselor to conduct the Individual/Conjoint sessions and ERS, RP, and Social Support groups. It is organized by type of group session; each section begins with an overview that includes a discussion of
  - The overall goals for each type of group session
  - The general format and counseling approach of the sessions
  - Special considerations relevant to a particular type of group session
- The overview is followed by instructions for conducting each session. Copies of the handouts that make up the *Client's Handbook* are at the end of each section's instructions for easy reference.
- *Client's Handbook*—This illustrated handbook contains an introduction and welcome and all the handouts that are used in the Matrix IOP program, except

for those used in the Family Education group sessions. Individual handouts are used for Family Education sessions because family members attend this group with clients and do not have the handouts from the *Client's Handbook*.

- *Client's Treatment Companion*—The *Client's Treatment Companion* is for clients to carry with them in a pocket or purse. It contains useful recovery tools and concepts and provides space for clients to record their relapse triggers and cues, write short phrases that help them resist triggers, and otherwise personalize the book. Ideas are included for ways to personalize and make the *Client's Treatment Companion* a useful tool for recovery.

Introduction to the Family Education Group

Overview

People with substance use disorders often find themselves isolated from their families or in ongoing conflict with family members. Family members (including extended family members) and significant others may experience feelings of abandonment, anxiety, fear, anger, concern, embarrassment, or guilt. Family members often do not understand substance use disorders and the changes that have occurred in their family. They also may not understand the dynamics of recovery and the changes that recovery brings. Providing education about substance use disorders and recovery and an opportunity for family members to talk about their concerns is critical to helping them support the person who is in treatment and can alleviate anxiety and other negative feelings they may have.

Education helps families change some behaviors that are common to families coping with people who have a substance use disorder (such as protecting people who are dependent on substances from the consequences of their dependence). These behaviors may be disruptive both to people in treatment and to their family members. In addition, having some idea of what to expect as their loved ones progress in their recovery helps family members adjust to changes that accompany recovery. Treatment is more likely to succeed if significant others become educated about the predictable changes that occur within the relationship as recovery proceeds. In addition to providing specific education, the Family Education group sessions provide the counselor with an opportunity to facilitate involvement of significant others in clients' recovery. Substance abuse can place families in crisis. Counselors should be mindful that violence can erupt in this kind of environment. A concern for the safety of clients and the family members involved in treatment should be foremost in the counselor's mind.

The Family Education group is not family *therapy* and does not attempt direct intervention into individual familial dynamics. Rather, the Family Education component of the Matrix IOP package takes a psychoeducational approach. It provides a relatively nonthreatening environment in which to present information and an opportunity for clients and their families to feel comfortable and welcome in the treatment facility. Information is presented about methamphetamine dependence, other drug and alcohol use, treatment, recovery, the ways in which families are affected by a client's drug use and dependence, and how family members can support a client's recovery.

Matrix treatment experience shows that, if clients are involved closely with significant others, those significant others are part of the recovery process regardless of whether those others are involved in treatment activities. Because the interactions in clients' families

before clients begin treatment often can be negative, clients may be adamant that they need to "do my program alone." The counselor can work with clients to help them understand the importance of involving their families in treatment, but if clients continue to resist family members' participation, the counselor should not insist.

It is common for family members to believe that "it's not my problem." They may be angry and unwilling to involve themselves in the client's treatment. Therefore, the counselor personally invites family members to attend the sessions and carefully explains the potential value of attending.

When deciding who should be included in the Family Education group, programs should use a definition of "family" that accommodates important people in a particular client's life. For example, a long-term romantic partner should be considered family whether the partner is married to the client or not. A client may also consider a close friend or mentor as family. Older adolescents may be appropriate for the program, but the Family Education group cannot accommodate and is not useful for younger children. Programs should consider offering child care during group sessions to facilitate family members' attendance.

All clients attend Family Education group sessions whether their family members or significant others attend. These group sessions provide the structured educational component of treatment for clients. In addition, clients receive information about the dynamics of family relationships as they relate to substance use disorders.

The counselor facilitating Family Education group sessions should be sensitive to cultural and other diversity issues relevant to the specific populations being served. The counselor needs to understand culture in broad terms that include not only obvious markers such as race, ethnicity, and religion, but also socioeconomic status, level of education, and level of acculturation to U.S. society. The counselor should exhibit a willingness to understand clients within the context of their culture. However, it also is important to remember that each client is an individual, not merely an extension of a particular culture. Cultural backgrounds are complex and are not easily reduced to a simple description. Generalizing about a client's culture is a paradoxical practice. An observation that is accurate and helpful when applied to a cultural group may be misleading and harmful when applied to an individual member of that group. The forthcoming Treatment Improvement Protocol *Improving Cultural Competence in Substance Abuse Treatment* (CSAT forthcoming) provides more information on cultural competence.

The Family Education group counselor should be aware of local 12-Step and mutual-help groups that can support family members. These groups include

- Al-Anon and Alateen: http://www.al-anon.alateen.org
- Nar-Anon: http://www.nar-anon.org/naranon
- Codependents Anonymous (CoDA): http://www.coda.org
- Jewish Alcoholics, Chemically Dependent Persons and Significant Others (JACS): http://www.jbfcs.org/programs-services/jewish-community-services-2/jacs/#.Ud8XJawdHcw
- Adult Children of Alcoholics (ACoA): http://www.adultchildren.org

The counselor should, throughout Family Education, encourage family members to attend support group meetings. Meeting attendance can be mentioned, whenever appropriate, in

any session. The counselor also may want to prepare a list of organizations (including Web addresses and other contact information) that offer local meetings and have copies of local meeting schedules available at each session.

The sections below provide the counselor with an overview of the Family Education component of the Matrix IOP package and general guidelines for conducting sessions. The specific presentation instructions for each group session are presented in Section II.

Goals of Family Education Group

- Present accurate information about addiction, recovery, treatment, and the resulting interpersonal dynamics.
- Help clients and family members understand how the recovery process may affect current and future family relationships.
- Provide a forum for families to discuss issues of recovery.
- Present accurate information about the effects of drugs.
- Teach, promote, and encourage clients' family members to care for themselves while supporting clients in their recovery.
- Provide a professional atmosphere in which clients and their families are treated with dignity and respect.
- Encourage participants to get to know other recovering people and their families in a comfortable and nonthreatening environment.

Group Format

The Family Education group meets once per week for 12 weeks. Clients and their families may enter the group at any time and attend for the first 3 months of a client's intensive treatment. Group sessions last for 90 minutes. There is no limit on the number of family members a client can bring to Family Education sessions. Groups can be run with only 2 people or as many as 30 people. The counselor should be aware that groups that are either very small or very large can be unwieldy because they can work against the free flow of discussion.

Group session techniques vary as follows:

- Seven sessions are based on PowerPoint slide presentations.
- Four sessions are multifamily group discussions.
- One session is a panel presentation.

Slide Presentations

Slides for seven sessions are included on the CD-ROM accompanying this manual. They can also be downloaded from http://store.samhsa.gov/product/Matrix-Intensive-Outpatient-Treatment-for-People-with-Stimulant-Use-Disorders-Counselor-s-Family-Education-Manual-w-CD/SMA12-4153. These slides may be used as PowerPoint presentations or printed and copied onto overhead transparencies. Each session is saved as a separate file on the CD-ROM with the session number and title indicated. The instructions in Section II for presenting these sessions include talking points for each slide. Each slide presentation is followed by a focused discussion about the topic. The last part of each session is used as an open discussion period for participants to talk about pressing issues.

Multifamily Group Discussions

Four sessions are organized as discussion groups with handouts. For the first part of each session, participants read information or answer questions on the handouts that prepare participants for group discussion. The counselor may be instructed to provide some background information. The remainder of the session is a facilitated discussion.

Panel Presentation

The panel format includes individual presentations by panel members (clients who have completed the program or their family members or both or members of 12-Step or mutual-help groups in the community). Each brief presentation is followed by a question-and-answer period, and the counselor facilitates a final open discussion.

General Guidelines

The counselor may want to review this section occasionally to be reminded of general points that are common to every session. Appendix B contains notes on group facilitation that the counselor may find useful.

Before Each Session

- Read the instructions for facilitating the session.
- Become familiar with the handouts and slides.
- Set up the group room so that chairs are arranged to allow participants to see the slides and to encourage discussion. For multifamily group discussion sessions, arrange chairs in a circle.
- Arrange for equipment to display the slides that are on the enclosed CD. The slides are also available at http://store.samhsa.gov/product/Matrix-Intensive-Outpatient-Treatment-for-People-with-Stimulant-Use-Disorders-Counselor-s-Family-Education-Manual-w-CD/SMA12-4153.
- Make copies of all handouts for session participants.
- Find out which clients and family members are new to the group, and introduce them at the beginning of their first session.

During Each Session

- Act as host for the group, welcoming clients and families and introducing new participants.
- Take care to refer appropriately to people clients invite to sessions. These people could include spouses, partners, adult children, friends, employers, colleagues, and others. Avoid using limiting terms like "husband" or "wife," and refer to the people invited as family members or friends, unless instructed otherwise by the client.
- Encourage clients and family members to ask questions and make comments that are appropriate to the topic.
- Be prepared to provide sources of information. References are provided at the end of the talking points for sessions 2, 4, 7, and 10. Clients or family members may be curious about the sources of statistics and other information presented during these sessions. The counselor can provide citations as required.
- Close the session by thanking participants for attending and announcing the following week's topic.
- Remain in the room after the session to answer questions and to talk with anyone who is experiencing problems.

The counselor should recognize that discussions about drug and alcohol use may serve as triggers for clients and stimulate cravings. The counselor routinely should encourage anyone experiencing triggers or cravings to stay after the group to talk until he or she feels focused on recovery again. The counselor also may suggest that, if the client is not with a family member, he or she call home and let family members know he or she has started home. This creates accountability for the client and begins to strengthen the family's sense of participation in the client's treatment and recovery.

II. Session Instructions

Family Education Sessions Overview

Session Number	Session Title	Type of Session	Content	Pages
1	Triggers and Cravings	PowerPoint presentation	Participants learn about the chemical basis of pleasure and reward in the brain and how triggers and cravings relate to addiction.	13–20
2	Alcohol and Recovery	PowerPoint presentation	Participants learn about the nature and prevalence of alcohol use, including the dangers it poses to health and recovery.	21–29
3	Recovery	Panel presentation	Participants learn about the benefits and challenges of recovery from others in recovery. Participants also learn about 12-Step programs and mutual-help groups.	30
4	Methamphetamine and Cocaine	PowerPoint presentation	Participants learn about the nature and prevalence of methamphetamine and cocaine, including the dangers they pose to health and recovery.	31–42
5	Roadmap for Recovery	PowerPoint presentation	Participants learn what relapse risks they will face in each of the four stages of recovery.	43–55
6	Coping With the Possibility of a Relapse	Multifamily group discussion	Participants explore feelings and needs of one another with respect to relapse and learn strategies for coping with relapse.	56–57
7	Opioids and Club Drugs	PowerPoint presentation	Participants learn about the nature and prevalence of heroin and club drugs. They also learn about the dangers to health and recovery posed by heroin, GHB, Rohypnol, LSD, and ecstasy.	58–66
8	Families in Recovery	PowerPoint presentation	Participants learn about the process of recovery and how they can work together to avoid relapse.	67–76
9	Rebuilding Trust	Multifamily group discussion	Participants explore the important role that trust plays in recovery and how they can begin to repair damaged relationships.	77

Session Number	Session Title	Type of Session	Content	Pages
10	Marijuana	PowerPoint presentation	Participants learn about the nature and prevalence of marijuana, including the dangers it poses to health and recovery.	78–83
11	Living With an Addiction	Multifamily group discussion	Participants explore the ways in which recovery can affect family life and discuss challenges and strategies.	84
12	Communication Traps	Multifamily group discussion	Participants explore the important role that communication plays in healthy relationships and about the problems that can hamper communication.	85–88

Session 1: Triggers and Cravings (PowerPoint Presentation)

Overview

Goals of Session

- Help participants understand the relationship between the pleasure and reward system in the brain and addiction.
- Help participants identify the process of addiction.
- Help participants understand the development and progression of craving.
- Help participants recognize the relationship of triggers to craving.
- Help participants develop ways to address triggers and cravings.

Handouts

- FE 1A—A Definition of Addiction: American Society of Addiction Medicine
- FE 1B—Thought Stopping

PowerPoint Presentation (40–45 minutes)

The counselor presents the PowerPoint slides, encouraging participants to ask questions at any time. Pages 14 through 20 contain talking points for each slide. The counselor should add examples and explain concepts in a way that is appropriate for the audience.

Focused Discussion (30 minutes)

The counselor facilitates discussion of the material presented and asks open-ended questions such as

- What did you hear that was new information? What surprised you?
- How does the information relate to your experience?
- How will this information affect the way your family copes with recovery?
- What questions do you have about this information?

Open Discussion (15–20 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Presentation

The bulleted points presented below concisely state the information the counselor should cover for each slide. The PowerPoint slides can be downloaded from http://store.samhsa.gov/product/Matrix-Intensive-Outpatient-Treatment-for-People-with-Stimulant-Use-Disorders-Counselor-s-Family-Education-Manual-w-CD/SMA12-4153.

Slide 1-1—Triggers and Cravings

- This presentation begins with an overview of addiction and dependence and then focuses on the development of addiction and cravings and the relationship of environmental and internal triggers for craving.
- Understanding this process allows both clients and families to view substance use disorders in a new, more understandable way and to see what is behind much of the advice given to clients in treatment.
- In short, triggers lead to cravings, and cravings lead to using drugs or drinking alcohol.
- Common sense suggests that being around people, places, or situations that have resulted in past substance use can increase the chances of using or drinking again.
- The influence that triggers have on the brain makes the advice to avoid triggers more than just a good idea; there is no other reliable way to avoid cravings and relapse.

Slide 1-2—Changes in the Brain

- Addiction is a neurobehavioral disorder. To understand what this means, we must look at two important areas of the brain: the prefrontal cortex and the limbic system.
- In a healthy brain, the prefrontal cortex, or outside portion of the brain, is responsible for rational thinking. It is the decisionmaker, the onboard computer of the human being.
- Underneath the cortex is a much older, more primitive part of the brain's anatomy, the limbic system.
- To a greater or lesser degree this lower part of the brain is involved in all forms of addiction. It is where the pleasure and reward system is located and where most, if not all, survival mechanisms originate.
- Pleasure is a powerful biological force for survival. If you do something pleasurable, the brain is wired in such a way that you tend to do it again.
- Unlike the cortex, the limbic system is not under conscious, or voluntary, control. The powerful effects of drugs and alcohol on this and other parts of the brain can lead to addictive use, lessening normal, rational restraints on behavior.
- Prolonged drug use changes the brain in fundamental and long-lasting ways. These changes are a major component of the addiction itself.
- Accepting addiction as a complicated relationship between the brain and behavior is a step toward recovery.

Slide 1-3—Conditioning

- The part of the brain affected by mood-altering substances is the same part of the brain that makes us seek food when we are hungry and water when we are thirsty and is responsible for our sexual drive.

- Hunger, thirst, sexual desire, and the need for nurturing are natural cravings. Satisfying these cravings promotes our survival as individuals and as a species. When a craving is not satisfied (e.g., when a person has not eaten for a long time), satisfying the craving overpowers all other concerns.
- When long-term drug or alcohol use occurs, the brain can become rewired and adapt to these substances as if survival depends on them.
- There is a demonstration that reflects the power of drugs on the brain and behavior:
  - If you release a caged mouse and it has the option to run into a well-lighted area or a dark area, it always will run into the dark.
  - Mice and other small rodents have been conditioned to seek out the dark automatically, because darkness protects them from predators. This ingrained survival mechanism evolved over millions of years in this species.
  - If the mouse is given doses of cocaine in the lighted area, the mouse will go into the lighted area each time it is released from its cage. This classic experiment demonstrates "conditioned place preference," reversing the conditioning that took place over millions of years.

Slide 1-4—Pavlov

- To understand the relationship of triggers to craving, it is important to understand a bit about a process called conditioning.
- I.P. Pavlov, a Russian scientist, received the Nobel Prize for a series of experiments he conducted on the physical processes of digestion.
- These experiments were continued by some of his students, and the conclusions from these experiments became known as the principles of classical conditioning.

Slide 1-5—Pavlov's Dog

- Pavlov would feed the dogs and ring a bell at the same time.
- The dogs saw and smelled the food that then stimulated, or triggered, a part of their brain, causing them to produce saliva and secrete stomach acid in anticipation of eating.
- In a relatively short time, Pavlov and his colleagues rang the bell *without* the presence of food, and the dogs still produced saliva and stomach acid as if food were present.
- The dogs connected the sound of the bell, the **trigger**, with anticipation of eating and responded (involuntarily) physically to the powerful trigger, or stimulus, of the bell.
- Once a dog had been conditioned in this way, no matter how smart or well trained the dog was, it continued to produce fluids at the sound of the bell. It had no choice; the only way that Pavlov's dogs could avoid drooling was by avoiding the bell.
- The dogs had developed a conditioned response to the bell.

- The human brain responds in much the same way to conditioned drug and alcohol triggers that produce cravings.
- Drugs and alcohol produce changes in the brain, which result in feelings of pleasure. Events that people experience or surroundings that people are in when they use are like Pavlov's bell; they cause people to experience cravings (like the dogs' physical response to the bell, salivating) even when they are not using. The brain may even trigger physical reactions that are similar to those initially created by the drug itself.
- For example, if participants were to think about sucking on a lemon, they probably would pucker their lips without even meaning to. This response is based on their experiences of tasting a lemon in the past.
- This sort of response to drug triggers occurs regardless of whether a person intends to use. The dependent person can prevent his or her brain's reaction only by avoiding triggers.
- Triggers and cravings are hallmarks of addiction.

Slide 1-6—A Definition of Addiction

- Handout FE 1A provides a definition of addiction developed by the American Society of Addiction Medicine.
- Primary means that addiction is not just a symptom of another disease or disorder; it is a disease in and of itself.
- Chronic means that the disease continues over time and can be treated but not cured. Examples of other chronic diseases include diabetes and heart disease.
- The definition states that genetic, psychosocial, and environmental factors may influence the development and manifestations (symptoms) of the disease.
- "Genetic" means that some people are born with certain susceptibilities to becoming addicted to drugs or alcohol.
- "Psychosocial and environmental factors" means that a person's emotional, mental, and social life as well as his or her family, peers, living situation, employment or school situation, and other life circumstances can affect whether addiction develops and how it develops.
- These psychosocial and environmental factors are important to consider when looking at a person's triggers for drug or alcohol use.

Slide 1-7—The Addictive Process

- The rest of this session looks at the process of developing addiction over time, focusing on craving and the triggering of craving.
- The process of addiction can be looked at in terms of four phases: the introductory phase, the maintenance phase, the disenchantment phase, and the disaster phase.
- During each phase, people experience increasing levels of obsessive thinking, craving responses, use, and consequences resulting from their substance.

- Although the slides are methamphetamine specific, the process of addiction is virtually the same for other addictive drugs and alcohol.

Slide 1-8—Addictive Process (Introductory Phase)

- Methamphetamine (or another drug or alcohol) use is relatively infrequent during the introductory phase of the process of addiction.
- Use may be limited to a few times a year, by chance, or on special occasions.
- The positives of drug or alcohol use appear to outweigh the negatives.

Slide 1-9—Conditioning Process During Addiction (Introductory Phase)

- Unknowingly, persons who use drugs or alcohol are conditioning their brains every time they use, but they experience only a mild association between people, places, or events and drug or alcohol use.

Slide 1-10—Development of Obsessive Thinking (Introductory Phase)

- During this phase, drug or alcohol use is only one small component of a person's overall thought process.

Slide 1-11—Development of Craving Response (Introductory Phase)

- The craving response is the combined experiences of drug or alcohol triggers activating the limbic system and the continuing thoughts about using drugs or alcohol associated with these triggers.
- During this introductory phase, the limbic system is activated *directly* by drugs or alcohol and, depending on whether the substance is a stimulant or a depressant, physiological arousal either increases or decreases (for example, methamphetamine causes the heart and respiration to speed up, whereas heroin causes the heart and respiration to slow down).

Slide 1-12—Addictive Process (Maintenance Phase)

- During the maintenance phase of the addictive process, the frequency of drug or alcohol use increases to perhaps monthly or weekly.
- The scales begin to lean away from the positives.

Slide 1-13—Conditioning Process During Addiction (Maintenance Phase)

- Conditioning is progressing. The people, places, and things associated with drug and alcohol use have become triggers.
- Exposure to these triggers causes thoughts about drug and alcohol use.
- These thoughts produce moderate physiological reactions leading to a drive to find and use drugs and alcohol.

Slide 1-14—Development of Obsessive Thinking (Maintenance Phase)

- Thoughts of drug and alcohol use occur more frequently.

Slide 1-15—Development of Craving Response (Maintenance Phase)

- A mild physiological *arousal* occurs in situations closely associated with drug and alcohol use.
- As the person encounters drug and alcohol triggers, the limbic system is activated, and drug and alcohol cravings occur.
- When drugs and alcohol finally are ingested, a concurrent physiological state occurs.

Slide 1-16—Addictive Process (Disenchantment Phase)

- During the disenchantment phase, the scales tip from the positive to the negative.
- The consequences of drug and alcohol use are severe, and the person's life becomes unmanageable.
- At this point the rational decision is to stop using, but the cortex part of the brain is no longer in control.
- Thinking, evaluating, and decisionmaking may appear to be happening, but behavior is not always based on rational thinking.
- People may resolve sincerely to quit using yet may find themselves out of control at the first thought of drugs and alcohol, at the first encounter with someone they used with, at the availability of cash, or with other potent triggers.

Slide 1-17—Conditioning Process During Addiction (Disenchantment Phase)

- At this point people usually cross the line into addiction, continuing to use in spite of serious negative physical and social consequences.
- Triggers in this phase produce a strong physiological response that drives people to acquire and use drugs and alcohol.

Slide 1-18—Development of Obsessive Thinking (Disenchantment Phase)

- During the disenchantment phase, the frequency of drug and alcohol thinking increases, crowding out most thoughts about other aspects of life.

Slide 1-19—Development of Craving Response (Disenchantment Phase)

- In this phase, the craving response is powerful.
- People feel an overpowering physical reaction in situations further and further removed from drugs or alcohol.
- The craving response is almost as powerful as the actual physical reaction to drugs and alcohol.

Slide 1-20—Addictive Process (Disaster Phase)

- In the disaster phase, the drug and alcohol use is often automatic.
- People cannot restrain themselves from using drugs or alcohol.

- People's behavior in the phase is much like the behavior of addicted laboratory animals that use drugs until they die.

Slide 1-21—Conditioning Process During Addiction (Disaster Phase)

- In this phase, addicted persons are using either daily or in binges, which most likely are interrupted only by physical collapse, hospitalization, or arrest.
- The constant overpowering craving from the limbic system overwhelms the cortex.

Slide 1-22—Development of Obsessive Thinking (Disaster Phase)

- Thoughts of drug and alcohol use dominate the person's consciousness.

Slide 1-23—Development of Craving Response (Disaster Phase)

- In the disaster phase, cravings can create powerful physiological effects that even can begin to mimic the initial physiological effects of actually ingesting the drug.

Slide 1-24—Trigger–Thought–Craving–Use

- Craving can be activated by external triggers.
- Triggers can cause thoughts, which can turn into cravings and lead to use.

Slide 1-25—Interruption

- The earlier this chain of events is interrupted, the more likely relapse will be avoided.
- An effective technique for coping with triggers and cravings is thought stopping.

Slide 1-26—Thought Stopping

- Simply put, thought stopping interrupts the usual process that culminates in using or drinking.
- The usual reaction to thoughts about using "argue" with the developing thought/craving. The argument usually results in the addiction winning.
- Arguing precedes negotiation, compromise, justification, and, possibly, relapse.
- Thought stopping ends this process before relapse begins, usually stopping cravings in their tracks.
- If thought stopping works, but the thoughts frequently keep coming back, people in recovery may have to change their immediate environments or engage in tasks that require full concentration.
- Thought stopping techniques include
  - Visualization
  - Relaxation
  - Rubberband snap
  - Calling someone

Slide 1-27—Visualization

- When people experience thoughts of using drugs or alcohol, they can visualize a switch or lever and imagine actually moving it from ON to OFF to stop the drug- or alcohol-using thoughts.
- It is important to have another thought ready to replace the drug- or alcohol-using thoughts.
- It should be a pleasurable or meaningful thought and one that does not involve drug or alcohol use.

Slide 1-28—Rubberband Snap

- The rubberband behavioral technique helps people in recovery "snap" their attention away from thoughts of using drugs or alcohol.
- People who are addicted simply put a rubberband loosely around their wrists.
- When a craving or using thought occurs, people snap the rubberband lightly against their wrists and say "NO" (either aloud or not, depending on the situation) to the drug- or alcohol-using thought.
- As with visualization, people need to have another thought ready to replace the drug- and alcohol-using thoughts.
- This technique works best if people leave the rubberband on all the time.

Slide 1-29—Relaxation

- Cravings often create feelings of hollowness, heaviness, and cramping in the stomach.
- These feelings often can be relieved by breathing in deeply (filling the lungs with air) and slowly breathing out three times in a row and by focusing on relaxing the body as much as possible for a few minutes.
- This process can be repeated as often as necessary whenever the feelings return.

Slide 1-30—Calling Someone

- Talking to another person provides an outlet for feelings and allows people to "hear" their own thinking process.
- Recovering people should carry the phone numbers of supportive people with them *always*, so they can call whenever support is needed.
- Handout FE 1B provides a list of thought-stopping suggestions.

Session 2: Alcohol and Recovery (PowerPoint Presentation)

Overview

Goals of Session

- Provide participants with factual information about alcohol.
- Provide participants with information about the risks that alcohol poses to recovery.
- Provide an opportunity for participants to talk about their experiences (or the experiences of their family member) with alcohol and recovery.

Handout

- FE 2—Fact Sheet: Alcohol

PowerPoint Presentation (40–45 minutes)

The counselor presents the PowerPoint slides, encouraging participants to ask questions at any time. Pages 21 through 29 contain talking points for each slide. The counselor should add examples and explain concepts in a way that is appropriate for the audience.

Focused Discussion (30 minutes)

The counselor facilitates discussion of the material presented and asks open-ended questions such as

- What did you hear that was new information? What surprised you?
- How does the information relate to your experience?
- How will this information affect the way your family copes with recovery?
- What questions do you have about this information?

Open Discussion (15–20 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Presentation

The bulleted points presented below concisely state the information the counselor should cover for each slide. The PowerPoint slides can be downloaded from http://store.samhsa.gov/product/Matrix-Intensive-Outpatient-Treatment-for-People-with-Stimulant-Use-Disorders-Counselor-s-Family-Education-Manual-w-CD/SMA12-4153.

Slide 2-1—Alcohol and Recovery

- This session focuses on alcohol.

- Because alcohol is such a significant and pervasive part of U.S. culture, *not* drinking presents a particular challenge for a person recovering from stimulant dependence.
- People in recovery must understand how alcohol can affect their bodies, behaviors, and recoveries.
- Although many people use alcohol occasionally and without problems, alcohol is a powerful substance that can seriously damage people's bodies and lives.

Slide 2-2—Alcohol in the Brain

- Alcohol affects many chemical systems in the brain.
- A delicate balance exists between chemical systems that *stimulate* and chemical systems that *inhibit*, or slow down, functions of the brain and body.
- Alcohol interferes with and changes this delicate balance.

Slide 2-3—Adaptation

- If people drink alcohol frequently and steadily, their brains adapt over time to the presence of alcohol.
- They do this by producing naturally stimulating chemicals in larger quantities than normal.
- As the brain and body adapt, the person can become dependent on alcohol to maintain a chemical balance.
- If a person who is dependent on alcohol stops drinking all at once, the high level of stimulating chemicals can cause withdrawal symptoms because the depressant effect of alcohol is absent.
- Withdrawal symptoms vary depending on how much alcohol and how long a person has been drinking.

Slide 2-4—Withdrawal Symptoms

- Withdrawal symptoms can include
  - Seizures
  - Tremors (shakiness)
  - Nausea
  - Auditory or visual hallucinations (hearing or seeing things that aren't there)
  - Insomnia
  - Agitation (extreme nervousness and irritability)
  - Confusion

Slide 2-5—Delirium Tremens

- Alcohol withdrawal can be life-threatening.
- Delirium tremens (DTs) is a dangerous withdrawal condition.
- Without treatment, as many as 1 out of every 20 people who develop its symptoms dies.[1]

- Symptoms of DTs include
  - Rapid heart rate
  - Increased body temperature
  - Increased blood pressure
  - Abnormally fast breathing
  - Sweating
  - Tremors
  - Loss of ability to control muscle movement
  - Altered mental status
  - Hallucinations
  - Cardiovascular collapse and death

Slide 2-6—Incidence

- Most people older than 21 can drink moderate amounts of alcohol without developing problems.
- The 2003 National Survey on Drug Use and Health reports that about half of Americans ages 12 and older report drinking alcohol.[2]
- The National Institute on Alcohol Abuse and Alcoholism estimates that about 3 in 10 (30 percent) American adults drink at levels that increase their risk for physical, emotional, and social problems.[3]
- Of these heavy drinkers, about one in four currently has an alcohol use or dependence disorder.[4]

Slide 2-7—Incidence by Gender and Age[5]

- In general, more men report being current drinkers than do women: in 2003, 57 percent of men ages 12 and older reported past month alcohol use compared with 43 percent of women.
- The rate of alcohol *dependence* is also lower for women than it is for men.
- Estimates indicate that about one-third of those dependent on alcohol are women.
- The incidence of heavy alcohol use is highest among young adults between ages 21 and 29 and lowest among adults ages 65 and older.

Slide 2-8—Initial Effects of Alcohol

- When people first begin to drink, they experience
  - Feelings of well-being or euphoria
  - Talkativeness and increased sociability
  - Lowered inhibitions (people may do or say things they otherwise would not do or say)

Slide 2-9—Later Effects

- As people continue to drink, they begin to feel sedated and drowsy and may
  - Have trouble with balance
  - Experience impaired peripheral vision (the ability to see to the sides)
  - Vomit
  - Fall asleep

- Experience delayed reaction time
- Slur their words
- Black out and not remember anything that happened for a period while under the influence

Slide 2-10—Long-Term Effects

- Heavy drinking can cause significant damage to organ systems in the body.
- "Heavy" drinking can be defined as binge drinking on five or more occasions in the past month.
- Binge drinking is drinking five or more drinks on one occasion at least once in the past month.
- When alcohol is consumed, it enters the bloodstream and is distributed throughout the body.
- Although heavy drinking is most commonly associated with liver damage, it also can affect the digestive, cardiovascular, immune, endocrine, and nervous systems.

Slide 2-11—Liver

- The liver is the primary site of alcohol metabolism (breaking down the alcohol into other chemicals and eliminating it from the body), yet a number of the chemicals produced by this process are toxic (poisonous) to the liver itself.
- These toxins add up over time, leading to alcohol-induced liver damage.
- This damage can take the form of either inflammation (alcoholic hepatitis) or scarring (cirrhosis).
- Often both types of damage exist in the same person.
- Alcohol dependence is the leading cause of liver-related deaths in the United States.
- It is estimated that more than 2 million people experience some form of alcoholic liver disease.

Slide 2-12—Digestive System

- Alcohol also affects the digestive system.
- Excessive drinking has been shown to cause chronic inflammation of the esophagus (the passageway to the stomach), which can lead to esophageal cancer.
- Enlarged blood vessels in the esophagus (esophageal varices) can be caused by liver disease.
- These blood vessels can rupture; when this happens, it is often fatal.
- Heavy alcohol use has been linked to pancreatitis (inflammation of the pancreas) and cancers in the throat, colon, and rectum.

Slide 2-13—Cardiovascular System

- Although moderate alcohol intake (one drink per day for women; two drinks for men) has been shown in some studies to be heart protective, heavy alcohol use is associated with serious heart disease:
  - It interferes with the pumping action of the heart, causing irregular and/or weak heartbeats.
  - It causes high blood pressure, which can increase the risk of stroke.
- Blood platelets, involved in blood clotting, also are damaged, causing an increased risk of bleeding.

Slide 2-14—Immune System

- Alcohol can seriously affect the body's immune system (the system that protects the body from disease) by damaging white and red blood cells.
- People who drink heavily experience more infectious diseases than do people who drink only moderately.
- Alcohol can damage the immune system to a level where the immune system attacks the body. This can result in, or worsen, alcohol-induced organ damage such as alcoholic liver disease.

Slide 2-15—Endocrine System

- The body's endocrine system (the hormone-controlling system) can be damaged by long-term alcohol use.
- The balance of the hormones insulin and glucagon, which regulate blood sugar levels, is disrupted; diabetes is common among people who drink heavily.
- Drinking alcohol can alter the release of reproductive hormones, growth hormone, and testosterone.
- The effects of alcohol on hormone systems include decreased testicle and ovary size and disrupted sperm and egg production.
- Alcohol-induced changes in hormone concentrations are associated with sexual dysfunction in both men and women.

Slide 2-16—Nervous System

- Heavy use of alcohol may damage the nervous system. This damage may include
  - Peripheral neuropathy, resulting in numbness and tingling in the legs, arms, and/or hands
  - Wernicke's syndrome, resulting in disordered eye movements, very poor balance, and difficulty walking
  - Korsakoff's syndrome, resulting in severely affected memory, preventing new learning from taking place
- In addition to these nervous system disorders, most people who drink heavily have some loss of mental function, reduced brain size, and changes in the function of brain cells.

Slide 2-17—Behavioral Effects

- Drinking can cause behavioral and physical problems.
  - Alcohol use is associated with domestic violence, child abuse, and assault.
  - Use is associated with all types of accidents.
  - The more heavily a person drinks, the greater the potential for problems at home, at work, with friends, and even with strangers. These problems may include
    - Arguments with or separation from spouse and other family members
    - Strained relationships with colleagues
    - Absence from or lateness to work with increasing frequency
    - Loss of employment because of decreased productivity
    - Committing or being the victim of violence
    - Auto crashes and/or arrests for driving under the influence (DUI)

Slide 2-18—Alcohol and Women[6]

- Drinking affects women differently than it affects men:
  - Over the long term, women develop alcohol-related disease more quickly and after drinking less alcohol than men do.
  - Women develop alcoholic liver disease more quickly and after drinking less alcohol than men do. Women are more likely than men to develop alcoholic hepatitis (liver inflammation) and to die from cirrhosis.
  - Women are more vulnerable than men to alcohol-induced brain damage.
  - Among people who drink heavily, men and women have similar rates of alcohol-related heart disease, even though women drink less alcohol over a lifetime than men do.
- For some women, even moderate drinking can slightly raise the risk of breast cancer.

Slide 2-19—Alcohol and Pregnancy

- A woman who drinks when she is pregnant puts her baby at risk of serious problems.
- Babies born to mothers who drank during pregnancy may have mental retardation or other learning and behavioral problems.
- Research has not found *any* amount of alcohol to be safe during pregnancy.

Slide 2-20—Fetal Alcohol Spectrum Disorders

- The most serious risk is fetal alcohol spectrum disorders (FASD).
- FASD is the leading known cause of preventable mental retardation in the United States.[7]

Slide 2-21—Fetal Alcohol Spectrum Disorders (Cognitive and Behavioral Impairments)[8]

- Although the effects of FASD vary, children with the syndrome have cognitive and behavioral impairments.
- Behavioral and neurological problems associated with FASD may lead to poor academic performance and legal and employment difficulties in adolescence and adulthood.

Slide 2-22—Fetal Alcohol Spectrum Disorders (Craniofacial Features)

- Children with severe FASD usually have distinctive facial and head features, such as
  - Skin folds at the corner of the eyes
  - A low nasal bridge
  - A short nose
  - An indistinct philtrum (the groove between the nose and upper lip)
  - A small head circumference
  - A small eye opening
  - A small midface
  - A thin upper lip

Slide 2-23—Total Abstinence

- Heavy alcohol use has obvious damaging effects.
- However, occasional, light drinking can have a damaging effect on a person in recovery, even if the person has never experienced any problems with alcohol.
- Clients in Matrix treatment are asked to stop using all illicit drugs *and* alcohol, no matter what drug or drugs brought them into treatment.

Slide 2-24—Alcohol Triggers Are Everywhere

- A person in recovery who is trying to stop using alcohol faces a difficult struggle.
- External triggers bombard people in recovery; consumption of alcohol may be assumed to be the norm, especially at social functions and celebrations.
- Drinking often accompanies certain activities: wine with dinner, a beer at the game, a drink after work.
- It is hard for a person in recovery to go through a typical day without coming across many reminders—both cultural and personal—of alcohol.
- Advertisements, movies, and TV shows link drinking with being happy, popular, and successful.
- Recovering people encounter colleagues, friends, and family members with whom they used to drink and pass by bars or liquor stores that they used to frequent.
- Alcohol is integral to celebrations such as parties and weddings.
- A person in recovery who is not drinking may feel left out of the fun or less cool.

Slide 2-25—Internal Triggers

- Internal triggers also pose problems:
  - Depression, anxiety, and loneliness are all characteristic of recovery.
  - These emotional states and others, such as stress, anger, and guilt, are cues to drink for many people.
  - Facing the emotional fallout from quitting other substances, people in recovery may feel justified in turning to alcohol to "relieve" their mental state.

Slide 2-26—Relapse Warning

- However, in spite of the difficulty, it is critical that people recovering from stimulant dependence abstain from alcohol.
- One big reason for this is that studies show that people who use stimulants are *eight times* more likely to relapse to stimulant use if they use alcohol than if they don't drink.[9]

Slide 2-27—Relapse

- Drinking lowers a person's inhibitions and makes the person more likely to act impulsively on any using thoughts they may have.
- Because alcohol affects the rational, reasoning part of the brain, people who are drinking are ill equipped to cope with any triggers for stimulant use they encounter.
- In addition, people who are drinking are more likely to encounter triggers than are individuals who are not drinking. For example, drinking may
  - Put people in recovery into contact with other people who use stimulants
  - Put people in recovery into a "party" atmosphere that can trigger the desire to use stimulants
  - Trigger a desire for the stimulant high

Slide 2-28—Other Reasons for Abstaining

- There are other reasons for abstaining from alcohol. When people are learning to handle problems without resorting to stimulants, using alcohol to numb the uncomfortable learning process is counterproductive for two reasons:
  - Drinking alcohol prevents people from directly confronting their stimulant use problem.
  - Drinking puts people in recovery at risk of becoming dependent on alcohol while they are trying to overcome their dependence on stimulants.

Slide 2-29—Plan Not To Drink

- It is important for people in recovery to *plan* not to drink, rather than wait until they are confronted with a trigger or urge to drink. For example, people in recovery can
  - Think about other ways of celebrating
  - Avoid being around others who are drinking

- Think about ways of spending time with friends that don't involve alcohol
- Make friends with others who are in recovery
- Practice saying "no thank you"
- Avoid going to bars and parties
- Ask family members not to drink in their presence or keep alcohol in the house

Slide 2-30—Plan To Cope

- A person in recovery should develop a plan for coping with the uncomfortable feelings that arise during recovery. This plan could include
  - Regularly attending 12-Step or mutual-help group meetings
  - Discussing feelings openly in Matrix group sessions
  - Obtaining a 12-Step sponsor
  - Regularly practicing relaxation techniques
  - Practicing HALT (not becoming too hungry, angry, lonely, or tired)
  - Developing a way to remember that uncomfortable feelings are normal in recovery and will pass
  - Obtaining help from a therapist if feelings become too overwhelming
- Handout FE 2—Fact Sheet: Alcohol summarizes the information presented in this session.

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1 Tevisan, L.; Boutros, N.; Petrakis, I.; and Krystal, J.H. Complications of alcohol withdrawal. *Alcohol Health and Research World 22*(1):61–66, 1998.

2 Substance Abuse and Mental Health Services Administration (SAMHSA). *Results From the 2003 National Survey on Drug Use and Health: National Findings.* NSDUH Series H-25, DHHS Publication No. (SMA) 04-3964. Rockville, MD: Office of Applied Studies, SAMHSA, 2004.

3 National Institute on Alcohol Abuse and Alcoholism. *Helping Patients Who Drink Too Much: A Clinician's Guide,* 2005 Edition. Bethesda, MD: National Institutes of Health, 2005.

4 See note 3.

5 See note 2.

6 National Institute on Alcohol Abuse and Alcoholism. Are women more vulnerable to alcohol's effects? *Alcohol Alert* 46, December 1999 (updated October 2000).

7 National Institute on Alcohol Abuse and Alcoholism. Fetal alcohol exposure and the brain. *Alcohol Alert* 50, December 2000 (updated April 2001).

8 See note 7.

9 Rawson, R.A.; Shoptaw, S.J.; Obert, J.L.; McCann, M.J.; Hasson, A.L.; Marinelli-Casey, P.J.; Brethen, P.R.; and Ling, W. An intensive outpatient approach for cocaine abuse treatment: The Matrix model. *Journal of Substance Abuse Treatment* 12(2):117–127, 1995.

Session 3: Recovery (Panel Presentation)

Goals of Session

- Provide an opportunity for participants to hear stories of successful recovery.
- Provide an opportunity for participants to ask questions of individuals in recovery.
- Provide important information about the recovery process in a personal way that engages participants.

Handouts

- FE 3A—Guidelines for Graduate Panel Participants
- FE 3B—Guidelines for Family Member Panel Participants
- FE 3C—Guidelines for Recovery Panel Participants

Preparation

At least 1 week before the session, the counselor identifies, invites, and orients four or five panel participants. The panel should comprise a mix of program graduates who are stable in their recovery and actively involved in a 12-Step program or mutual-help group and family members of program graduates who are working on their own program of recovery in Al-Anon or a mutual-help group. If the counselor is unable to identify appropriate graduates, he or she should contact the local Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) Intergroup Office's Hospitals and Institutions or Treatment Facilities Committee for help in identifying local individuals who are in recovery and would be willing to participate on the panel.

The counselor ensures that graduate panel participants receive a copy of handout FE 3A—Guidelines for Graduate Panel Participants and that family member panel participants receive a copy of handout FE 3B—Guidelines for Family Member Panel Participants before the session. If the counselor is using AA or NA members, the counselor should give these participants a copy of FE 3C—Guidelines for Recovery Panel Participants as they arrive at the facility.

Just before the session, the counselor should remind panel participants that they will have about 10 minutes to tell their stories, using the guidelines listed on the handouts.

Presentation (45 minutes)

The counselor introduces panel participants and facilitates each presentation to ensure that each participant stays on track and does not take too much time. The counselor may ask a panel member a question from the handouts if he or she seems to be having difficulty staying on topic. The counselor should have extra copies of the handouts available for panel participants to refer to as needed.

Question-and-Answer Period (30 minutes)

The counselor encourages group members to ask questions of panel participants and facilitates discussion. When the discussion winds down, the counselor thanks panel members and dismisses them.

Open Discussion (15 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Session 4: Methamphetamine and Cocaine (PowerPoint Presentation)

Overview

Goals of Session

- Provide factual information about how methamphetamine and cocaine act in the brain.
- Provide factual information about the psychological and physical effects of methamphetamine.
- Provide factual information about the psychological and physical effects of cocaine.
- Provide an opportunity for participants to talk about the effects stimulant drugs have had on them or their family member.

Handouts

- FE 4A—Fact Sheet: Methamphetamine
- FE 4B—Fact Sheet: Cocaine

PowerPoint Presentation (40–45 minutes)

The counselor presents the PowerPoint slides, encouraging participants to ask questions at any time. Pages 32 through 42 contain talking points for each slide. The counselor should add examples and explain concepts in a way that is appropriate for the audience.

Focused Discussion (30 minutes)

The counselor facilitates discussion of the material presented and asks open-ended questions such as

- What did you hear that was new information? What surprised you?
- How does the information relate to your experience?
- How will this information affect the way your family copes with recovery?
- What questions do you have about this information?

The counselor may want to break the discussion into two parts, stopping between the presentation on methamphetamine (slides 4-10–4-28) and the presentation on cocaine (slides 4-29–4-44).

Open Discussion (15–20 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Presentation

The bulleted points presented below concisely state the information the counselor should cover for each slide. The PowerPoint slides can be downloaded from http://store.samhsa.gov/product/Matrix-Intensive-Outpatient-Treatment-for-People-with-Stimulant-Use-Disorders-Counselor-s-Family-Education-Manual-w-CD/SMA12-4153.

Slide 4-1—Methamphetamine and Cocaine

- This session focuses on methamphetamine (meth) and cocaine.
- Both are highly addictive stimulant drugs that are similar in many ways, although there are significant differences as well.

Slide 4-2—Differences Between Cocaine and Methamphetamine

- Cocaine and methamphetamine differ in that cocaine is processed out of the body much faster than is methamphetamine, so the effects, or high, of cocaine don't last as long.
- The effects of cocaine last for only 1 to 2 hours, whereas the effects of methamphetamine last 8 to 12 hours.
- Withdrawal from methamphetamine also can last longer, and the symptoms of withdrawal may be more intense than those of cocaine withdrawal.

Slide 4-3—Dopamine

- The effects of both meth and cocaine are caused by the drugs' effects on *dopamine*, a chemical that is always present in the brain.
- Dopamine plays an important role in
  - Body movement
  - Thinking
  - Motivation and reward
  - Pleasure responses
- Dopamine also plays an important role in addiction to any drug.

Slide 4-4—Example of Dopamine's Effect

- When a person engages in natural activities like eating, drinking, and sex, dopamine is released by cells in the brain and creates immediate (though short-lasting) feelings of pleasure by stimulating other cells in the brain.
- These feelings reward the basic activities of eating, drinking, and sex and motivate people to repeat them, ensuring survival.

Slide 4-5—Dopamine Imbalance

- When the natural balance of dopamine is upset (by a drug, for example), a person can experience negative effects:

- Too *much* dopamine may produce nervousness, irritability, aggressiveness, fears that are not based on reality, and bizarre thoughts.
- Too *little* dopamine is associated with low mood, fatigue, and the tremors and the inability to control movement that are part of Parkinson's disease.

Slide 4-6—Dopamine and Stimulant Drugs

- When a person uses meth or cocaine, too much dopamine becomes available in the brain.
- Although each drug increases the amount of dopamine in the brain in a different way, many of the effects are the same.
- When a person first starts taking meth or cocaine, he or she will experience primarily pleasurable effects but will also experience some negative effects that are caused by too much dopamine.

Slide 4-7—Dopamine and Stimulant Use Over Time

- As a person continues to use meth or cocaine, the brain's dopamine system becomes damaged.
- As the damage increases, the person will continue to experience some pleasurable effects but also will experience substantial negative effects from meth or cocaine.

Slide 4-8—Use–Depression–Craving–Use

- When the stimulant and euphoric effects of meth or cocaine wear off, dopamine levels may decrease to levels that are below normal, and the person experiences an abrupt drop in mood and energy levels.
- Symptoms of fatigue and depression are common.
- These negative feelings often create a strong desire (craving) in the person to take the drug again.
- Over time (often, very little time), this use–depression–craving–use cycle leads to addiction.

Slide 4-9—Route of Administration

- How a drug is taken influences
  - How quickly it produces an effect
  - The strength of the drug's effects, both positive and negative
  - The negative effects a person will experience
- Both meth and cocaine are available in various forms that can be
  - Injected
  - Smoked
  - Snorted

Slide 4-10—Methamphetamine

- The first stimulant drug we will discuss is meth, a synthetic drug that is manufactured from common chemicals.

Slide 4-11—Street Names

- Methamphetamine is known on the street as
  - Meth
  - Ice
  - Glass
  - Crank
  - Crystal
  - Speed
  - Chalk
  - Tweak

Slide 4-12—Popularity of Meth[1]

- The 2004 National Survey on Drug Use and Health (NSDUH) estimated that 12 million people ages 12 and older had used meth at least once in their lifetime.
- Some evidence shows that meth use has stabilized. The number of people using meth and the number of people trying it for the first time remained constant in 2002, 2003, and 2004.
- From 2002 to 2004, the average age of first use increased by more than 3 years, from 18.9 years to 22.1 years.

Slide 4-13—Who Uses Meth?

- Although the overall rate of meth use may not be increasing, use remains a significant problem.[2,3]
- The number of people dependent on meth more than doubled between 2002 and 2004.[4]
- Once confined to certain areas of the country, particularly Hawaii and west coast cities, meth use has spread throughout the country and among different populations.[5]
- People who use meth have traditionally been Caucasian, male, blue-collar workers.
- Meth use spread to the party and club scene (raves, etc.).
- Meth use is increasing among Hispanics and young people who are homeless.
- Use among women has increased.
- More women use meth than use cocaine or heroin; near-equal numbers of men and women now use the drug.
- Meth is used increasingly in the workplace; it has long been used by long-haul truck drivers, but use is spreading on construction sites and in manufacturing.
- People in the entertainment, sales, retail, and legal professions also increasingly are using meth.

Slide 4-14—Immediate Psychological Effects

- The immediate psychological effects of methamphetamine include
  - Euphoria
  - Alertness or wakefulness
  - Feelings of increased strength and renewed energy
  - Feelings of invulnerability (feeling that nothing bad can happen to you)
  - Feelings of increased confidence and competence
  - Intensified feelings of sexual desire
  - Decreased feelings of boredom, loneliness, and shyness

Slide 4-15—Immediate Physical Effects

- The immediate *physical* effects of methamphetamine include
  - Increased
    - Heart rate
    - Pupil size
    - Sensitivity to sound and stimulation
    - Blood pressure
    - Breathing rate
    - Body temperature
  - Decreased
    - Appetite
    - Sleep
    - Reaction time

Slide 4-16—Toxic Effects

- These effects may not sound bad, or they even may sound desirable.
- However, meth can cause serious long-term psychological and physical damage (toxic effects).
- Although many toxic effects go away in time, even after a person stops using meth, some effects can be permanent.
- Most negative effects begin fairly soon with regular meth use.

Slide 4-17—Chronic Psychological Effects

- Chronic *psychological* effects ("chronic" means that these effects may begin later in a person's use cycle and last a long time) of meth use include increased
  - Confusion
  - Loss of ability to concentrate and organize information
  - Mood swings
  - Irritability and anger

- Loss of ability to feel pleasure without the drug
- Paranoia (persistent feelings that one is being watched, is being followed, or is about to be harmed)
- Insomnia and fatigue
- Depression
- Anxiety and panic disorder
- Depression when not using meth, called "crashing"
- Reckless, unprotected sexual behavior

Slide 4-18—Severe Psychological Effects

- Particularly severe *psychological* effects can include
  - *Tactile* hallucinations (the person feels as if things are crawling on him or her) or *auditory* hallucinations (the person hears things that aren't there)
  - Severe depression that can lead to suicidal thoughts or attempts
  - Episodes of sudden, violent behavior
  - Severe memory loss that may be permanent

Slide 4-19—Chronic Physical Effects

- Chronic *physical* effects of use include
  - Tremor (shakiness)
  - Weakness
  - Dry mouth
  - Weight loss and malnutrition
  - Increased sweating
  - Oily skin
  - Sores caused by oily skin and by the person picking at his or her skin, a common effect of meth use
  - Headaches
  - Severe problems with teeth and gums caused by teeth grinding, decreased blood flow to the mouth, and decreased saliva

Slide 4-20—Severe Physical Effects

- Particularly severe *physical* effects can include
  - Seizures
  - Damage to small blood vessels in the brain, which can lead to stroke
  - Damaged brain cells
  - Irregular heartbeat that can cause sudden death
  - Heart attack or chronic heart problems, including the breaking down of the heart muscle
  - Kidney failure
  - Liver failure
  - "Tweaking," movements that a person can't control that are repeated regularly
  - Infected skin sores that can cause severe scarring

Slide 4-21—Meth Is Not Just Meth

- Because meth is manufactured by amateur "cooks," it is often full of impurities, such as lead acetate or mercury, which can lead to heavy metal poisoning, and various acids created in the process.
- In addition, meth is "cut," or diluted, before it is sold to maximize profits.
- The substances used to cut meth can cause problems of their own.
- Meth purity tends to range from 40 to 70 percent, meaning 30 to 60 percent of what a person injects, snorts, or smokes is *not* meth.[6]

Slide 4-22—Injecting Meth

- The ways in which a person can take meth create special problems as well. *Injecting* meth can cause
  - Blood clots
  - Skin abscesses
  - HIV, tuberculosis, or hepatitis C virus exposure from sharing needles and other works or from unprotected sex
  - Heart inflammation
  - Pneumonia
  - Kidney failure

Slide 4-23—Snorting Meth

- *Snorting* meth can cause
  - Sinus infection
  - Holes in the septum, the cartilage between nostrils
  - Hoarseness
  - Nosebleeds

Slide 4-24—Smoking Meth

- *Smoking* meth can cause
  - Throat problems
  - Burned lips
  - Lung congestion
  - Severe coughing with black mucus
  - Chronic lung disease

Slide 4-25—Meth Dose and Effects

- The dose and frequency of meth use affect the level of toxic effects, as well.
- The higher the dose and the more frequent the use, the higher the likelihood of toxic effects.
- People who use meth tend to develop *tolerance* for the drug, meaning that it takes a higher dose to get the desired effect as people continue to use meth.

Slide 4-26—Pregnancy and Meth

- A woman who uses meth while she is pregnant may harm her fetus.
- Fetuses of mothers who use meth are at higher risk of having a stroke or brain hemorrhage, often causing death, before delivery.
- Meth use during pregnancy also can cause premature birth.
- Fetuses also may be exposed to HIV or hepatitis if the mother is infected with these viruses.
- Babies of mothers who used meth during pregnancy may have
  - Abnormal reflexes
  - Extreme irritability
  - Trouble eating and digesting food

Slide 4-27—Other Effects on Children

- Children are affected by meth in other ways:
  - Although increasing amounts of meth are being imported from Mexico, home-based labs for making meth remain common in the United States; often children are in these homes.
  - When children live with parents who manufacture meth, the children are exposed to toxic chemicals used in the process.
  - Meth labs are dangerous places for children and adults.
  - Fires, explosions, chemical spills, and toxic fumes are common.
  - The chemicals used to make meth give off fumes that are strong enough to burn lungs; can damage the brain, kidneys, or liver; and even can be fatal.
  - Children of people who use meth may be neglected or abused.
  - In 2001, 700 children who were present in meth labs that were raided by the Drug Enforcement Administration tested positive for toxic chemicals.[7]

Slide 4-28—Other Problems With Meth Labs

- Labs where meth is made cause serious problems for other people and for the environment:
  - Toxic fumes released from the chemicals used to make meth go into the walls and carpets and remain there for a very long time, putting everyone in the house at risk.
  - Even people moving into a home that once housed a meth lab are at risk.
  - Making meth creates solid waste as well.
  - For every pound of meth produced, 5 to 6 pounds of toxic waste are created.[8]
  - This waste usually is dumped on the ground, dumped into local waterways, or flushed into sewer or septic systems, contaminating the surrounding area.
- Handout FE 4A summarizes these meth facts.

Slide 4-29—Cocaine

- The next stimulant to be discussed is cocaine, a drug that is made from the leaves of the coca plant.

Slide 4-30—Street Names

- Powdered cocaine (cocaine hydrochloride, a salt) is known on the street as
  - Coke
  - Snow
  - Flake
  - Blow

Slide 4-31—Crack Cocaine

- Crack cocaine is cocaine that has been processed from cocaine hydrochloride into a rock crystal form that can be smoked.
- It gets its name from the cracking sound it makes when heated.
- Crack is sometimes called “rock” or “freebase.”
- When people process cocaine hydrochloride themselves and smoke the result, it often is called “free basing.”

Slide 4-32—Popularity of Cocaine[9]

- The 2004 NSDUH survey estimated that nearly 34 million Americans have used cocaine at some time in their lives.
- The same survey estimated the following:
  - About 2 million people in the United States currently use cocaine.
  - Some 2.5 percent of young people ages 12 to 17 reported that they had used cocaine at least one time. Nearly 9 percent of 18 year olds reported using cocaine at least once.
  - Among young adults ages 18 to 25, 16 percent reported using cocaine at least one time.

Slide 4-33—Who Uses Cocaine?[10]

- Adults 18 to 25 years old have a higher rate of current cocaine use in any other age group.
- Overall, men have a higher rate of current cocaine use than do women.

Slide 4-34—Immediate Psychological Effects

- The immediate *psychological* effects of cocaine are similar to those of meth and include
  - Euphoria
  - Increased energy
  - Increased talkativeness
  - Increased sensitivity to sensations of sight, sound, and touch
  - Increased mental alertness
  - Increased confidence
  - Intensified feelings of sexual desire

Slide 4-35—Immediate Physical Effects

- The immediate *physical* effects of cocaine include
  - Constricted blood vessels
  - Dilated pupils
  - Increased heart rate
  - Increased temperature
  - Increased blood pressure
  - Decreased appetite
  - Decreased sleep

Slide 4-36—Warning

- In rare instances, sudden death can occur with cocaine use, even the first time someone uses the drug.
- Drinking alcohol with cocaine increases this risk.
- The liver combines cocaine and alcohol and manufactures a third substance, cocaethylene.
- Cocaethylene intensifies cocaine's euphoric effects, while increasing the risk of sudden death.

Slide 4-37—Chronic Psychological Effects

- Chronic *psychological* effects of cocaine use include
  - Irritability
  - Depression
  - Increasing restlessness
  - Paranoia
  - Auditory hallucinations
  - Possible bizarre and/or violent behavior (with high doses)
  - Damaged ability to feel pleasure without the drug
  - Exposure to HIV or hepatitis C virus through reckless, unprotected sex

Slide 4-38—Chronic Physical Effects

- Chronic *physical* effects of cocaine use include
  - Cardiovascular effects, such as
    - Disturbances in heart rhythm
    - Heart attacks
  - Respiratory effects, such as
    - Chest pain
    - Respiratory failure
    - Bronchitis and pneumonia

- Neurological effects, such as
  - Strokes
  - Loss of appetite over time leading to significant weight loss and malnutrition
  - Seizures
  - Headaches

Slide 4-39—Injecting Cocaine

- Like meth, the way in which cocaine is used may cause particular problems. People who regularly *inject* cocaine may experience
  - Abscesses (infected sores) at injection sites
  - Allergic reactions, either to the drug or to some additive in street cocaine, which can result in death
  - Exposure to HIV and hepatitis C virus

Slide 4-40—Snorting Cocaine

- Regularly *snorting* cocaine can lead to
  - Loss of sense of smell
  - Problems with swallowing
  - Overall irritation of the nasal septum leading to a chronically inflamed, runny nose
  - Nosebleeds
  - Hoarseness
  - Deviated septum

Slide 4-41—Smoking Crack

- *Smoking* crack cocaine can lead to
  - Throat problems
  - Burned lips
  - Lung congestion
  - Severe coughing
  - Chronic lung disease

Slide 4-42—Cocaine Dose and Effects

- As with people who use meth, people who use cocaine regularly develop tolerance for the effects of the drug and use higher and higher doses to get the same euphoric effect.
- Higher doses and more frequent use increase the likelihood of toxic effects.

Slide 4-43—Pregnancy and Cocaine

- Using cocaine during pregnancy may cause serious problems for a woman's fetus.
- The drug passes through the placenta, enters the fetus' bloodstream, and passes through the fetal brain barrier.
- Babies born to mothers who used cocaine during pregnancy may[11]
  - Be born prematurely
  - Have low birth weights
  - Have smaller than normal heads
  - Be shorter than normal
- Babies also may be exposed to HIV or hepatitis virus if the mother is infected.

Slide 4-44—Cocaine-Exposed Children

- Fetal cocaine exposure does not seem to cause as serious and long-lasting problems as was once thought.
- However, as cocaine-exposed children grow up, they may have subtle, yet significant, problems later in life in areas that are important for success in school, such as[12]
  - Paying attention to tasks
  - Thinking things through
  - Learning new information
- Handout FE 4B summarizes these cocaine facts.

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1 Substance Abuse and Mental Health Services Administration (SAMHSA). *The NSDUH Report: Methamphetamine Use, Abuse, and Dependence: 2002, 2003, and 2004.* Rockville, MD: Office of Applied Studies, SAMHSA, September 16, 2005.

2 National Institute on Drug Abuse. *NIDA Community Drug Alert Bulletin: Methamphetamine.* Bethesda, MD: National Institutes of Health, 1998.

3 Office of National Drug Control. *Fact Sheet: Methamphetamine.* Rockville, MD: Drug Policy Information Clearinghouse, November 2003.

4 See note 1.

5 See note 2.

6 See note 3.

7 See note 3.

8 See note 3.

9 Substance Abuse and Mental Health Services Administration (SAMHSA). *Results From the 2004 National Survey on Drug Use and Health: National Findings.* NSDUH Series H-28, DHHS Publication No. (SMA) 05-4062. Rockville, MD: Office of Applied Studies, SAMHSA, 2005.

10 National Institute on Drug Abuse. *Research Report Series: Cocaine Abuse and Addiction.* NIH Publication No. 99-4342. Bethesda, MD: National Institutes of Health, revised November 2004.

11 See note 9.

12 See note 10.

Session 5: Roadmap for Recovery (PowerPoint Presentation)

Overview

Goals of Session

- Help participants understand what to expect as clients recover by describing a four-stage model of recovery.
- Help participants recognize the characteristics of each stage of recovery.
- Help participants recognize particular relapse risks clients may face in each stage of recovery.
- Help participants learn more about triggers for drug craving and ways both clients and their family members can avoid or cope with these triggers.

Handouts

- FE 5A—Daily/Hourly Schedule
- FE 5B—Relapse Justifications

PowerPoint Presentation (40–45 minutes)

The counselor presents the PowerPoint slides, encouraging participants to ask questions at any time. Pages 44 through 55 contain talking points for each slide. The counselor should add examples and explain concepts in a way that is appropriate for the audience.

Focused Discussion (30 minutes)

The counselor facilitates discussion of the material presented and asks open-ended questions such as

- What did you hear that was new information? What surprised you?
- How does the information relate to your experience?
- How will this information affect the way your family copes with recovery?
- What questions do you have about this information?

Open Discussion (15–20 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Presentation

The bulleted points presented below concisely state the information the counselor should cover for each slide. The PowerPoint slides can be downloaded from http://store.samhsa.gov/product/Matrix-Intensive-Outpatient-Treatment-for-People-with-Stimulant-Use-Disorders-Counselor-s-Family-Education-Manual-w-CD/SMA12-4153.

Slide 5-1—Roadmap for Recovery

- This presentation will look at recovery as following a predictable course (like a roadmap) through a series of four recovery stages.
- People in recovery are likely to experience particular physical and emotional changes and symptoms in each stage of recovery, and each stage brings particular relapse risks. Families are likely to witness these changes and symptoms.
- This does not mean that every person or family will experience recovery in exactly the same way; although the general progression is predictable, every person in recovery will follow his or her own roadmap.
- A few people will progress from stage to stage smoothly, many will become "stuck" for a time in one stage, and others will veer off track completely before resuming their progress.
- Even though there will be variability, being aware of the stages of recovery can give people in recovery and their family members a basic idea of what to expect during recovery.
- Knowing what to expect can help people avoid pitfalls and stay on the road to recovery.
- Knowing what to expect also helps family members understand the recovery process and allows them to provide more support for the person in recovery.

Slide 5-2—Recovery Stages

- Recovery stages we will discuss include
  - Stage 1: Withdrawal
  - Stage 2: Early abstinence (sometimes called the "Honeymoon" or "pink cloud" stage)
  - Stage 3: Protracted abstinence (sometimes called "the Wall")
  - Stage 4: Adjustment and resolution

Slide 5-3—Stage 1: Withdrawal

- The withdrawal stage begins when a person first stops using drugs and alcohol.
- This stage lasts from 1 to 2 weeks.
- Typical characteristics of the withdrawal stage (particularly for those who used methamphetamine or other stimulants) include
  - Physical detoxification
  - Intense cravings for the drug
  - Depression or anxiety
  - Low energy
  - Irritability or aggression
  - Exhaustion
  - Insomnia and extended periods of sleep
  - Disordered thinking
  - Paranoia
  - Memory problems and difficulty concentrating
  - Intense hunger

- If people have been using other drugs heavily, such as tranquilizers, barbiturates, or heroin, or have been drinking alcohol heavily, they may experience symptoms of physical withdrawal from those substances, as well.
- The depression, anxiety, and paranoia people experience when first abstaining from stimulants are the direct result of the brain's adjusting to the absence of a stimulant drug and, in most cases, are temporary.
- It is important for both people in this stage of recovery and their family members to understand that these emotions will pass, but such emotions can lead to suicidal thoughts or plans in the short term. If the depression, anxiety, or paranoia persists or is very severe, a psychiatric consultation may be recommended.
- In addition to experiencing the characteristics/symptoms listed, people in recovery may need medical attention for problems resulting from their drug use, such as
  - Seizures
  - Infections at injection or skin popping sites
  - Cardiovascular problems
  - Severe weight loss
  - Vitamin deficiencies
  - Respiratory problems
  - HIV/AIDS
  - Hepatitis C

Slide 5-4—Withdrawal (Relapse Risk Factors)

- During the withdrawal stage, people tend to feel out of control of their lives.
- Symptoms such as paranoia, depression, fear of withdrawal, and disordered sleep patterns contribute to vulnerability to cravings.
- Unstructured time and proximity to triggers increase the risk of relapse.

Slide 5-5—Withdrawal (Structure)

- The concept of *structure* is an important part of Matrix treatment.
- People in outpatient treatment, with the help of their family members, must learn to design their own structure because outpatient treatment does not provide the structure of an inpatient facility.
- Creating structure by scheduling their time can help people in recovery feel more in control of life.
- Self-designed structure
  - Helps eliminate avoidable triggers by providing a *plan* to avoid them
  - Makes the concept of "one day at a time" concrete
  - Reduces anxiety
  - Counters the drug-using lifestyle
  - Provides a basic foundation for ongoing recovery
- Matrix clients learn to schedule their time outside treatment.
- Family members can help by supporting clients' scheduling efforts.

Slide 5-6—Building Blocks of Structure

- With the help of their counselor and family members, people in recovery create structure by organizing and planning their time using schedule sheets.
- Handout FE 5A—Daily/Hourly Schedule provides an example of a form that can be used to help clients structure their time.
- The building blocks of a person's structure should incorporate new drug-free behavioral options, such as
  - Treatment activities
  - Interest in new or long-dormant recreational/leisure activities
  - Attending 12-Step or mutual-help group meetings
  - Work, school, or volunteer activities
  - Physical exercise and sports
  - Activities with friends who are drug free
  - Time scheduling
  - Family-related events
  - Spiritual activities
  - "Island building" (planning specific events or "islands" of rest, relaxation, or fun to look forward to)
- The end result is a daily plan for activities that promotes recovery and reduces the possibility of boredom, impulsive decisionmaking, exposure to triggers, and relapse.

Slide 5-7—Scheduling Pitfalls

- Scheduling should be a positive experience, but sometimes scheduling can become tedious or stressful.
- Some scheduling problems that a person in recovery can encounter include
  - Unrealistic schedules (for example, working 8 hours, taking children to an afterschool activity, attending a Matrix group session, attending a 12-Step meeting, and exercising—all in 1 day)
  - Unbalanced schedules (not enough or too much leisure time, for example)
  - Imposed schedules (allowing others to tell one what to do and when to do it, for example, rather than choosing activities oneself)
  - No support from significant others
  - Holidays, illness, and other changes that can disrupt one's schedule
- It is important that clients in Matrix treatment work closely with their counselor to learn how to schedule appropriately and to plan for coping with unusual events that disrupt the schedule.
- It is equally important that family members support clients' efforts to schedule their time.
- Scheduling and creating structure in one's life is a skill that needs to be practiced.

Slide 5-8—Stage 2: Early Abstinence

- The early abstinence stage is sometimes called the Honeymoon or pink cloud stage because it is the stage in which people often feel much better and start to think that their problems with substances are solved.
- This stage usually lasts for about 4 weeks.
- Typical characteristics of the early abstinence stage (particularly for those who used methamphetamine or other stimulants) include
  - Increased energy and optimism
  - Overconfidence
  - Difficulty concentrating
  - Continued memory problems
  - Concerns about weight gain
  - Intense feelings
  - Mood swings
  - Other substance use
  - Inability to prioritize
  - Mild, continuing paranoia

Slide 5-9—Early Abstinence (Relapse Risk Factors)

- During this stage, people's moods typically improve, they have more energy, cravings diminish, and confidence and optimism increase.
- This increased energy leads some people to become overinvolved with their work; "workaholism," in turn, may lead to relapse as recovering people
  - Neglect self-care
  - Decrease their involvement in treatment and other recovery activities
  - Become overtired and stressed
- Overconfidence also may cause problems; people in recovery may start to believe "I've got this substance problem licked." This belief can lead them to think that they
  - No longer need treatment
  - Can safely be around friends and family members who still are using drugs or go to places where they used drugs
  - Can safely use a drug other than their "problem" drug or drink alcohol
- Exposure to triggers and using secondary drugs or alcohol often may lead to relapse to methamphetamine or other stimulant use.
- People in this stage also may experience
  - Concerns over weight gain
  - An inability to prioritize
  - Anxiety about changes in sexual behavior
  - Resistance to continued behavior change
  - Occasional paranoia

- People in recovery in this stage need to
  - Recognize the risks in this stage of recovery
  - Learn to channel Honeymoon energy toward specific recovery tasks, putting together a solid structure of activities to build momentum that will carry them through subsequent recovery stages
- Family members, too, need to recognize that, although people in recovery appear to be better and more optimistic, they still need support and encouragement to
  - Attend all treatment activities
  - Attend 12-Step or mutual-help group meetings
  - Avoid people and places associated with drug use
  - Abstain from all drugs and alcohol
  - Continue careful scheduling of their time
  - Participate in regular physical exercise

Slide 5-10—Early Abstinence (Triggers and Thought Stopping)

- No matter how carefully people in recovery schedule their time, it is likely that they will encounter a person, place, situation, or emotional state that triggers thoughts about using.
- People in the early abstinence stage of recovery need to understand the concepts of triggers and thought stopping. Family members also need to understand this concept.
- To people in recovery, the trigger–thought–craving–use sequence can feel as if all parts of the sequence happen simultaneously.
- In fact, recovering people can learn to interrupt the sequence at any point.

Slide 5-11—Interruption

- Another way to envision this process is to see the trigger–thought–craving–use sequence as moving down a steep slide.
- The time to use thought stopping is right after one recognizes the first thought of using.
- At that point, the urge to use, as shown by the small circle moving toward the figure, is still relatively small and containable.
- It still is possible to stop this process when it reaches the craving stage, but then it is much more difficult. When a person is in the craving mode, the small circle has become enormous—a huge force that is nearly out of control.
- The person in recovery may not want to use and may attempt to deflect the cravings, but more often than not, the cravings are so powerful that they propel the person into relapse.
- A first step toward learning to interrupt the trigger–thought–craving–use sequence is to understand what constitutes a trigger and to learn to recognize a trigger as quickly as possible.

Slide 5-12—Types of Triggers

- Triggers can relate to
  - People
  - Places
  - Things
  - Times
  - Emotional states

Slide 5-13—Triggers (People)

- Triggers related to *people* may include
  - Friends who use drugs
  - Absence of a significant other (loneliness)
  - Voices of friends who use drugs/dealers (for example, on phone calls)
  - Drug dealers
  - Partners in meth-related sexual activity
  - People discussing drug use in a positive way

Slide 5-14—Triggers (Places)

- Triggers related to *places* may include
  - Drug dealer's home
  - Bars and clubs
  - Drug use neighborhoods
  - Work
  - Some street corners
  - *Anyplace* associated with use

Slide 5-15—Triggers (Things)

- Triggers related to objects or *things* may include
  - Drug paraphernalia
  - Money/ATMs
  - Movies and TV shows about or depicting drug and alcohol use
  - Sexually explicit magazines and movies
  - Certain music associated with using
  - Using a drug other than the identified problem drug or drinking alcohol

Slide 5-16—Triggers (Times)

- Triggers related to particular *times* include
  - Idle time
  - After work
  - Holidays
  - Birthdays, anniversaries, and other special occasions
  - Stressful times
  - Paydays
  - Friday and Saturday nights

Slide 5-17—Triggers (Emotional States)

- The reality for most recovering people is that *any* emotional state, positive or negative, can be a trigger if it has been associated with drug or alcohol use.
- Triggers related to emotional states include
  - Anxiety
  - Depression
  - Boredom
  - Fear
  - Sexual arousal, deprivation, or anxiety about performance
  - Fatigue (or fear of becoming fatigued)
  - Anger
  - Frustration
  - Concern about weight gain

Slide 5-18—Thought Stopping

- Thought-stopping techniques can be used to interrupt the trigger–thought–craving–use cycle.
- The first step in successfully using thought-stopping techniques is to recognize thoughts about using ("using thoughts") as soon as they occur.
- People new to recovery don't always realize when they are having using thoughts, but they can learn to do so by consciously focusing on their thought processes.
- Once people recognize a using thought, they can choose to interrupt the thought by using one of these thought-stopping techniques:
  - Visualization
    - When people experience thoughts of using drugs or alcohol, they can visualize a switch or lever and imagine actually moving it from ON to OFF to stop the drug- or alcohol-using thoughts.
    - It is important to have another thought ready to replace the drug- or alcohol-using thoughts.
    - The thought should be a pleasurable one or one that is meaningful to the person and does not involve drug or alcohol use.
  - Rubberband snap
    - The rubberband technique helps recovering people "snap" their attention away from thoughts of using drugs or alcohol.
    - People simply can put a rubberband loosely around their wrist.
    - When a craving or using thought occurs, people snap the rubberband lightly against their wrist and say "NO" (either aloud or not, depending on the situation) to the drug or alcohol thoughts.
    - As with visualization, people need to have another thought ready to replace the drug- and alcohol-using thoughts.
    - This technique works best if people leave the rubberband on all the time.

- Relaxation
  - Cravings often create feelings of hollowness, heaviness, and cramping in the stomach.
  - These feelings often can be relieved by breathing in deeply (filling the lungs with air) and slowly breathing out, repeating the process three times, and focusing on relaxing the body as much as possible for a few minutes.
  - This process can be repeated as often as the feelings return.
- Calling someone
  - Talking to others provides an outlet for feelings and allows people to "hear" their thought process.
  - People in recovery should carry the phone numbers of supportive people, including family members, with them so they can call someone whenever support is needed.

Slide 5-19—Nontrigger Activities

- If thought stopping works, but the thoughts frequently keep coming back, people in recovery may have to change their immediate environments or engage in tasks that require full concentration.
- A few examples of nontrigger activities include
  - Exercise
  - 12-Step/mutual-help group meetings
  - New recreational activity or hobby
  - Activities in the person's faith-based or spiritual community
  - Meditation or prayer
  - Eating or sleeping
  - Non–drug-oriented movies
  - Structured/monitored periods (time with family or friends who do not use, for example)
- A person in recovery should keep a list of such activities handy for times when they may be needed.

Slide 5-20—Stage 3: Protracted Abstinence

- The protracted abstinence stage typically lasts for about 3 to 4 months.
- This stage (sometimes called the Wall) brings a shift back from the high of the Honeymoon phase to a period of low energy and an emotional state often characterized by apathy, depression, and anhedonia (inability to experience pleasure).
- This shift is likely even though people in recovery are continuing to make positive changes in their lives and are beginning to reap the benefits of recovery.

- Common characteristics of this stage of recovery include
  - Continued lifestyle changes
  - Anger and depression
  - Episodes of paranoia or suspicion
  - Isolation
  - Family adjustment and conflict
  - Concerns about loss of sex drive, difficulties with sexual performance, and reduction in sexual activity
  - Positive benefits from abstinence
  - Emotional swings
  - Unclear thinking
  - Weight gain
  - Return of cravings
  - Return to old behaviors
- It is important for people in recovery and their family members to know that the changes of this stage are the result of a continuing healing process in the brain and that, if people remain abstinent, their brain chemistry will stabilize and the negative emotions and the low energy of this stage will pass.

Slide 5-21—Protracted Abstinence (Relapse Risk Factors)

- Relapse factors common to this stage include
  - Increased emotionality
  - Behavioral "drift"
  - Decreased ability to feel pleasure
  - Concern about weight gain
  - Poor self-care
  - Low energy/fatigue
  - Secondary drug or alcohol use
  - Breakdown of structure
  - Interpersonal conflict
  - Loss of motivation
  - Sexual anxieties
  - Insomnia
  - Paranoia
  - Relapse justification
- The person in recovery is particularly vulnerable to relapse during the protracted abstinence stage because the person often perceives that the negative emotional states and low energy common to this stage will persist indefinitely.
- The person in this stage of recovery may begin to think that if recovery feels this bad, it may not be worth it.
- This thinking, and the low energy and fatigue, can lead to behavioral drift, a gradual letting go of the structure (including treatment activities and 12-Step or mutual-help group meetings) and other behavioral changes the person has worked hard to achieve.
- As structure breaks down, the person may experience more thoughts about using drugs or alcohol and begin to create justifications for use.
- It is critical that the person in recovery anticipate the Wall and understand it is a temporary phase.

- It is critical that a person in recovery remain in treatment and continue the behavioral changes already made to this point to avoid a sequence of inertia, boredom, loss of recovery focus, relapse justification, and, finally, relapse.
- Good self-care, particularly regular exercise, and the understanding and support of family members can greatly help a person negotiate this phase successfully.

Slide 5-22—Secondary Drugs and Alcohol

- It is quite common for people in all stages of recovery to entertain at times the idea of using drugs other than those they consider to be their primary problem drug (called "secondary drugs") or alcohol.
- The use of secondary drugs is a particular relapse risk in the protracted abstinence stage of recovery because of the uncomfortable emotional states common to the stage and the tendency for decreasing supportive structure.
- People in recovery may begin to tell themselves, "My problem is with methamphetamine; I've never had a problem with pot. I just need to relax a little."
- Using a secondary drug or alcohol is a bad idea and may lead quickly to relapse to using one's primary drug in a number of ways:
  - **Cortical disinhibition.** Using a secondary drug or alcohol can cause the prefrontal cortex, the part of the human brain responsible for rational decisionmaking, to become disinhibited (less active), thus paving the way for a return to the primary drug use. This effort is especially likely if secondary drug use exposes people to triggers associated with their use of the primary drug (buying from a dealer, for example).
  - **Stimulant craving induction.** Studies at the Matrix Institute have shown that, if cocaine or amphetamines are the drugs of choice, a return to alcohol use will increase the risk of relapse to stimulants by 800 percent. A return to the use of marijuana will do the same by 300 percent. This result remains true even if the client was not addicted to alcohol or marijuana.
  - **12-Step group philosophy conflict.** If people in recovery use a secondary drug or alcohol, they are unlikely to continue to attend 12-Step groups, groups that are vital to recovery, because using any illicit drug or alcohol is contrary to 12-Step group philosophy and people will be increasingly uncomfortable in meetings.
  - **Abstinence violation effect.** There is a strong tendency for people to begin thinking, "Well, I'm drinking again; I might as well use a little meth, too."
  - **Interference with new behaviors.** Using a secondary drug or alcohol to cope with problems or life stresses will interfere with learning new coping behaviors, which are necessary to ensure long-term recovery.

Slide 5-23—Protracted Abstinence (Relapse Justification)

- Relapse justification occurs when the addicted brain attempts to provide a *seemingly* rational reason (justification) for behavior that moves a person in recovery closer to a slip.
- It is critical that people in recovery and their family members learn to recognize a relapse justification as soon as it arises.
- Most relapse justifications are based on the faulty premise that people in recovery have no choice about whether to use drugs or remain in recovery.
- Although at some point, using does become inevitable (for example, once people are at their dealer's house, they probably no longer have a choice; the craving is then in control), they can choose not to put themselves in risky situations.
- Relapse thoughts gain power when they are not recognized or discussed openly.
- Relapse justifications can take many forms:
  - Other people made me do it.
  - I needed it for a specific purpose.
  - I was testing myself.
  - It wasn't my fault.
  - It was an accident.
  - I felt bad.

Slides 5-24 through 5-29—Relapse Justifications

- Handout FE 5B—Relapse Justifications identifies the excuses for using on slides 5-24 through 5-29 and discusses the process of relapse justification.

Slide 5-30—Stage 4: Adjustment and Resolution

- The adjustment/resolution stage typically lasts for about 4 to 6 months.
- Although a person is well past physical withdrawal and may have mended from many or most of the physical effects of substance use, recovery is far from complete.
- There often is a great feeling of accomplishment at having passed the Wall stage.
- This feeling can result in a false sense that, finally, one's life can return to pretreatment normalcy.
- People in recovery who successfully cope with this stage (and their family members) must recognize that the lifestyle and relationship changes made are now the new definition of "normal."
- Once people have completed treatment, they need to shift from learning new skills to
  - Maintaining a balanced lifestyle
  - Recognizing and accepting that recovering from addiction is a lifelong process
  - Monitoring for relapse signs
  - Developing new areas of interest
- Because of increasing emotional stability in this stage, the person may be ready to address significant, and sometimes volatile, underlying issues that were avoided or had not emerged before.

Slide 5-31—Adjustment and Resolution (Relapse Risk Factors)

- Because cravings occur less often and feel less intense by this stage of recovery, people may
  - Believe that they now can use a secondary drug safely
  - Relax their vigilance for relapse signs
  - Relax the recovery structure they have created, putting themselves in high-risk situations
  - Return to relationships with people who use stimulants
  - Neglect recovery activities, losing the momentum of recovery
  - Neglect exercise and other self-care activities
- People in recovery and their families also may struggle with acceptance of the addiction and the lifelong nature of recovery.
- Emerging or reemerging emotional or relationship issues may cause distress and a desire to use drugs or alcohol; these issues need to be addressed in a counseling or treatment setting to avoid possible relapse.

Slide 5-32—Adjustment and Resolution (Balance)

- A critical task for this stage of recovery (and in the future) is developing balance in one's life.
- This representation of a recovery pie illustrates the lifestyle balance necessary to sustain ongoing abstinence and sobriety.
- Every individual needs to find the optimal balance that works.
- Families can help people in recovery find and maintain this balance in their lives.

Session 6: Coping With the Possibility of a Relapse (Multifamily Group Discussion)

Goals of Session

- Help participants explore their feelings and fears about relapse.
- Help clients and their family members better understand one another's fears and needs.
- Help participants share ideas for coping with relapse.

Handouts

- FE 6A—Coping With the Possibility of Relapse for the Person in Recovery
- FE 6B—Coping With the Possibility of Relapse for Family Members of the Person in Recovery
- FE 6C—Family Members and Recovery

Introduction (2–3 minutes)

The counselor explains that

- Today's session provides an opportunity for clients and their family members to discuss issues and fears related to the possibility of relapse.
- Relapse to drug or alcohol use can occur only after abstinence is achieved.
- Many people experience relapse at some point. Recovery is like learning any difficult skills; most people are not able to acquire the skills of recovery without making mistakes.
- However, relapse is not inevitable. Some people achieve long-term recovery without relapsing.
- Family members can relapse, too; those who have learned new, healthier ways of communicating and behaving can relapse to old behavior and ways of communicating and can stop taking care of themselves when the family member in recovery relapses to drug or alcohol use.
- It is normal for people in recovery and their family members to fear relapse.

Handout Review (10–15 minutes)

The counselor

- Gives clients a copy of handout FE 6A—Coping With the Possibility of Relapse for the Person in Recovery and asks them to read the information and carefully consider and write down their answers to the questions
- Gives family members a copy of handout FE 6B—Coping With the Possibility of Relapse for Family Members of the Person in Recovery and asks them to read the information and carefully consider and write down their answers to the questions

- Tells participants that their answers to the questions are to guide discussion; no one will see their responses

Focused Discussion (50–55 minutes)

The counselor

- Facilitates discussion, using the questions on the handouts to provide structure
- Reinforces good ideas for coping with relapse that are brought up in the discussion

Summary (2–3 minutes)

The counselor

- Summarizes the ideas for effectively coping with relapse that were discussed by the group
- Gives family members handout FE 6C—Family Members and Recovery
- Explains that the handout contains some concepts that are important for family members of a person in recovery to remember and that referring to it from time to time may be helpful

Open Discussion (15 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Session 7: Opioids and Club Drugs (PowerPoint Presentation)

Overview

Goals of Session

- Familiarize participants with the nature and prevalence of two groups of drugs: opioids (e.g., heroin, oxycodone, and morphine) and club drugs (e.g., ketamine, LSD, and ecstasy).
- Familiarize participants with the dangers to health and to recovery posed by opioids and club drugs.

Handouts

- FE 7A—Fact Sheet: Opioids
- FE 7B—Fact Sheet: Club Drugs

PowerPoint Presentation (40–45 minutes)

The counselor presents the PowerPoint slides, encouraging participants to ask questions at any time. Pages 58 through 66 contain talking points for each slide. The counselor should add examples and explain concepts in a way that is appropriate for the audience.

Focused Discussion (30 minutes)

The counselor facilitates discussion of the material presented and asks open-ended questions such as

- What did you hear that was new information? What surprised you?
- How does the information relate to your experience?
- How will this information affect the way your family copes with recovery?
- What questions do you have about this information?

Open Discussion (15–20 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Presentation

The bulleted points presented below concisely state the information the counselor should cover for each slide. The PowerPoint slides can be downloaded from http://store.samhsa.gov/product/Matrix-Intensive-Outpatient-Treatment-for-People-with-Stimulant-Use-Disorders-Counselor-s-Family-Education-Manual-w-CD/SMA12-4153.

Slide 7-1—Opioids and Club Drugs

- This presentation offers an overview of opioids and club drugs, including what they are, who uses them, their effects on the body, and the risks they pose to recovery.

- Handouts FE 7A—Fact Sheet: Opioids and FE 7B—Fact Sheet: Club Drugs summarize the information that is discussed during this session.

Slide 7-2—The Importance of Total Abstinence

- For treatment to work, people in recovery should be totally abstinent. Abstaining from all psychoactive substances greatly increases the chances of a successful recovery.
- If people are in treatment for abusing stimulants, they must give up alcohol and *all* illegal drugs, including drugs such as marijuana that some people believe are harmless, to ensure a successful recovery.

Slide 7-3—What Are Opioids?

- Opioids are a group of drugs that act on the opiate receptors in the brain. Opioids can be made from natural sources (e.g., poppy plants) or synthetically.
- Natural opioids (like morphine and heroin) and synthetic opioids (like meperidine and oxycodone) have similar effects.
- Opioids treat pain effectively because they dull sensation and relieve the anxiety that comes from anticipating pain.
- People abuse opioids because they provide a powerful feeling of euphoria or a “rush.”

Slide 7-4—Physical Effects of Opioids

- Once opioids enter the brain, they take effect in a matter of minutes.
- The physical signs of opioid use are constricted pupils, flushing of the skin, and a heavy feeling in the limbs. People on heroin are described as “nodding” because they look as if they are about to fall asleep.
- The rush of euphoria is followed by a drowsy state. Breathing and heart rate slow during this time. Headaches and dizziness are common. These immediate effects fade a few hours after the drug is taken.

Slide 7-5—Opioids and Tolerance

- As people continue to use opioids, higher and higher doses are required to achieve the same effect. This is called “tolerance.”
- Eventually, a person’s tolerance for opioids means that the drug is taken mainly to stave off withdrawal, not to get high.

Slide 7-6—Dependence Versus Addiction

- Repeated use of opioids can result in dependence and addiction.
- People who take opioids that have been prescribed by their doctors to treat pain rarely become addicted.
- With long-term use, even people who take medication as prescribed can become dependent on opioids.

- These people must stop taking opioid pain medication gradually or they will have withdrawal symptoms.
- Addiction is marked by physical dependence accompanied by a compulsive urge to take the drug, even if negative consequences result.

Slide 7-7—Withdrawal From Opioids

- A person who is dependent or addicted will go through withdrawal if opioids are discontinued suddenly. Symptoms of withdrawal include restlessness, severe muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes, and goose bumps (the origin of the phrase "going cold turkey," used to describe going into withdrawal).
- Withdrawal can take up to a week to run its course. It is rarely fatal to healthy adults, but it can result in early labor or miscarriage in a woman who is pregnant.

Slide 7-8—Abuse of Prescription Opioids

- The main prescription opioids that people abuse are codeine, oxycodone (OxyContin®, Percodan®, Percocet®, Tylox®), hydrocodone (Vicodin®), meperidine (Demerol®), and hydromorphone (Dilaudid®).
- We will focus on oxycodone in the next few slides. OxyContin is the strongest form of oxycodone available.

Slide 7-9—Oxycodone (Use Patterns)

- Oxycodone abuse appears to be increasing.
- According to the 2004 National Survey on Drug Use and Health, more than 10 percent of people in the United States ages 18 to 25 have used oxycodone nonmedically. The number of people abusing oxycodone has increased every year since the drug was introduced in 1995.[1]
- Most of the people who abuse oxycodone are older than 30.[2]
- In 2004, 5 percent of high school seniors reported using oxycodone at least once.[3]

Slide 7-10—Oxycodone (Facts)

- Oxycodone is a timed-release tablet that is prescribed for people with long-lasting pain, such as pain from cancer or back pain.
- People obtain oxycodone illegally by pretending to be in pain, forging prescriptions, and robbing pharmacies.
- To defeat the timed-release action, people who abuse oxycodone crush the tablet and then swallow or snort it or dissolve it in water and inject it.
- When taken in these ways, oxycodone produces a euphoric high like that of heroin.
- Oxycodone's street names include oxy, OC, kickers, killers, blue, and hillbilly heroin.

Slide 7-11—Oxycodone (Dangers)

- OxyContin contains a much larger dose of opioid than do other oxycodone formulations, such as Percodan or Percocet.
- When tablets are crushed before they are taken, the risks of dangerously slow breathing, heart attack, and overdose increase.
- People who dissolve the tablets and inject the solution face diseases such as hepatitis and HIV/AIDS that are linked with dirty needles.
- Like all opioids, oxycodone is highly addictive when abused.

Slide 7-12—Heroin (Use Patterns)

- The main natural opioids that people abuse are heroin and morphine. We will focus on heroin in the next few slides.
- Some 1.6 percent of people 12 years and older have used heroin. More than 3.1 percent of high school students have used heroin.[4]
- As many as 1 million people in the United States may be addicted to heroin.[5]
- Among Caucasians, Hispanics, and all people younger than 26, heroin is linked to more deaths than any other substance except alcohol.[6]
- Heroin is connected with 15 percent of all visits to emergency rooms in the United States.[7]
- Most people who use heroin are Caucasian males older than 30 who live in urban areas.[8] The age at which people start using heroin had dropped from the middle twenties in 1990 to the early twenties in 2000.[9]
- Increasing use among younger people is partly attributable to the purer forms of heroin that have become cheaper and more widely available in recent years. This purer heroin can be smoked or snorted, rather than injected.
- Smoking or snorting heroin has increased in popularity because people mistakenly assume that smoking or snorting heroin will not lead to addiction. Fear of using needles also has contributed to increasing use of these routes of administration.

Slide 7-13—Heroin (Facts)

- Heroin is made from morphine, which is derived from poppy plants. It was used widely as a pain remedy in the late 19th and early 20th centuries. Because it is highly addictive and other painkillers were available, heroin was banned in 1914.
- Pure heroin is a white powder. Heroin purchased on the street varies in color from white to dark brown and usually is mixed with other substances such as sugar, powdered milk, starch, or poisons such as strychnine.
- Heroin is known by many street names, including smack, horse, big H, junk, dope, skag, and poison.

Slide 7-14—Heroin (Dangers)

- People who use heroin often become so focused on obtaining the drug that they neglect most other aspects of their lives.
- Some experience weight loss, dehydration, and malnutrition. Some become impoverished and turn to crime.
- Because the purity of heroin varies, accidental overdose is a prominent danger.

Slide 7-15—Heroin (Disease Risks)

- Most people who use heroin regularly inject it. Those who start out smoking or snorting heroin often progress to injection because it provides a quicker and more intense rush.
- Injection drug use is estimated to be a factor in one-third of all HIV cases and more than one-half of all hepatitis C cases in the United States.
- Injecting heroin can lead to collapsed veins, clogged blood vessels, bacterial infections of the heart and blood vessels, pneumonia, tuberculosis, and liver or kidney disease.

Slide 7-16—What Are Club Drugs?

- Club drugs include a wide variety of substances, many of which are mistakenly thought to be relatively safe. They include gamma hydroxybutyrate (GHB), Rohypnol, ketamine, lysergic acid diethylamide (LSD), and MDMA, or ecstasy.
- Club drugs are used primarily by people younger than 30 who are Caucasian; high school and college students show highest levels of use.
- Club drugs are used at college fraternities, dance clubs, bars, concerts, and all-night dance parties known as raves.

Slide 7-17—GHB (Use Patterns)

- Most people who use GHB are between ages 18 and 30. Most are Caucasian, middle-class males.[10]
- GHB use rose precipitously during the 1990s. There were 56 emergency room reports connected with GHB use in 1994; in 2002 there were nearly 5,000 such reports. That represents a 9,000-percent increase over 8 years.[11] Emergency room reports involving GHB have declined since 2002.[12]
- Approximately 2 percent of high school seniors used GHB at least once in 2004.[13]

Slide 7-18—GHB (Facts)

- GHB is manufactured in illegal labs from inexpensive ingredients. It is a light-colored powder that dissolves easily in liquid. When mixed with liquid, it is clear, odorless, and tasteless.
- At clubs, it often is sold in liquid form from a water or sports drink bottle, by the capful.
- GHB is known by the street names soap, easy lay, vita-G, and Georgia home boy.

Slide 7-19—GHB (Physical Effects)

- GHB produces euphoric and hallucinogenic states, accompanied by loss of control of balance, coordination, and speech. GHB takes effect 15 to 30 minutes after a dose is ingested. The effects last 3 to 6 hours.
- At high doses, dangerously slow breathing, unconsciousness, coma, and overdose can occur. If GHB is mixed with alcohol, death can result.
- Since 1990, there have been nearly 16,000 cases of GHB overdose and 70 deaths from GHB.[14]

Slide 7-20—Rohypnol (Use Patterns)

- Most people who use Rohypnol are 13 to 30 years old and male.[15]
- Rohypnol use seems to be decreasing in most parts of the country.
- Rohypnol is popular with some youth because it is cheaper than other club drugs.
- Some 1.6 percent of high school seniors used Rohypnol at least once in 2004.[16]

Slide 7-21—Rohypnol (Facts)

- Rohypnol is the trade name of a drug that is legal in Mexico and Europe, where it is used to treat insomnia; it has never been legal in the United States.
- Rohypnol tablets often are sold in their original packaging, which can make people think the drug is legal.
- Rohypnol is a depressant like Halcyon, Xanax, and Valium, but it is many times stronger.
- Rohypnol is known by the street names roofies, rophies, roche, rope, and the forget-me pill.

Slide 7-22—Rohypnol (Physical Effects)

- Like GHB, Rohypnol produces euphoria and hallucinations in those who take it.
- The effects of Rohypnol begin 15 to 20 minutes after it is taken and can last more than 12 hours.
- Rohypnol's effects include decreased blood pressure, slurred speech, impaired judgment, and difficulty walking.
- Rohypnol can cause headaches, nightmares, tremors, muscle pain, digestive problems, aggressive behavior, and blackouts that can last 24 hours.

Slide 7-23—Ketamine (Use Patterns)

- Ketamine is popular with students and young adults who go to nightclubs and raves.
- Ketamine use has been slowly but steadily decreasing.
- Some 1.9 percent of high school seniors used ketamine at least once in 2004.[17]

Slide 7-24—Ketamine (Facts)

- Ketamine is an anesthetic first used on battlefields because of its fast action. Today it is used almost exclusively by veterinarians. Veterinary clinics are robbed specifically for ketamine.
- Ketamine is produced as a liquid but usually is dried into a white, odorless, tasteless powder before it is sold illegally. It can be added to drinks, snorted, or smoked with marijuana or tobacco.
- Ketamine has no smell or taste, so it is hard to detect.
- Ketamine is known by the street names special K, vitamin K, kit kat, super acid, and jet.

Slide 7-25—Ketamine (Physical Effects)

- Ketamine produces altered perceptions and hallucinations and can induce amnesia.
- At low doses, altered perceptions include a pleasant feeling of floating or being outside one's body.
- High doses can lead to terrifying feelings of near total sensory deprivation known as the K-hole.
- The effects of ketamine begin a few minutes after it is taken and usually fade within an hour although people report not feeling fully normal again for 24 to 48 hours.
- At high doses, ketamine can cause heart attack, stroke, and oxygen starvation—all of which can lead to coma and death.

Slide 7-26—Club Drugs and Date Rape

- Along with GHB and Rohypnol, ketamine can render people confused and helpless, leaving them vulnerable to crime, especially rape.
- People who take these drugs may be unable to resist sexual acts.
- Rohypnol is tasteless and odorless and can be dissolved easily in drinks at a club.
- Newer Rohypnol tablets turn blue in a drink to increase visibility and decrease its use as a date rape drug.

Slide 7-27—LSD (Use Patterns)

- LSD is used primarily by students and young adults at clubs, raves, and concerts.
- Approximately 10 percent of people 12 and older have tried LSD; 0.2 percent used LSD at least once in 2003.[18]
- Use of LSD by adults has been decreasing in recent years.
- In 2004, 2.2 percent of high school seniors reported using LSD at least once in the previous year.[19]

Slide 7-28—LSD (Facts)

- LSD is one of the most powerful mood- and perception-altering drugs. It has no medical use.
- LSD is sometimes sold in tablet form but most often is dissolved onto blotter paper that is divided into squares. It is odorless but has a slightly bitter taste.
- LSD is known by the street names acid, blotter acid, battery acid, window pane, microdot, sunshine, and zen.

Slide 7-29—LSD (Physical Effects)

- The first effects of LSD are felt 30 to 90 minutes after it's taken. Physical changes include increased heart rate and blood pressure, sweating, nausea, dry mouth, loss of appetite, numbness, and trembling.
- At low doses, LSD produces rapid emotional swings and heightened sensations.
- At high doses, LSD induces distortions of perception: shapes change, time slows down, and sensations seem to blend. These hallucinations are called a trip.
- A bad trip can be a terrifying experience that causes confusion, panic, and fear. People experiencing LSD hallucinations have had fatal accidents.
- A trip can last up to 12 hours and often is followed by fatigue and depression.
- One of the most dangerous aspects of LSD is its unpredictability. Its effects depend on the dose, the mood of the person taking it, and the environment in which it's taken.
- People who use LSD regularly are prone to flashbacks in which they suddenly experience hallucinations without having taken the drug.
- LSD may contribute to long-term depression or schizophrenia.

Slide 7-30—MDMA ("Ecstasy") (Use Patterns)

- The chemical MDMA, ecstasy, is used most heavily by Caucasian and upper middle-class students and young adults.[20]
- Originally used mostly in clubs, ecstasy has spread to other social settings.
- Nearly 5 percent of people 12 and older have tried ecstasy; 1 percent used it at least once in 2003.[21]
- Some 4 percent of high school seniors used ecstasy at least once in 2004; this number appears to be decreasing.[22]

Slide 7-31—Ecstasy (Facts)

- Ecstasy was used in psychotherapy in the 1970s, but it has no medical value and was banned.
- Pure ecstasy is a white powder, but it can be combined with other drugs or substances before it is sold, usually in pill form.
- Ecstasy is the drug's main street name, but it is also known as XTC, X, E, Adam, clarity, hug drug, and love drug.

Slide 7-32—Ecstasy (Physical Effects)

- The physical effects of taking ecstasy include increased heart rate and blood pressure, nausea, loss of appetite, jaw tightness, and compulsive chewing and teeth clenching.
- After getting an initial rush from taking ecstasy, people experience calm, positive feelings that last 3 to 6 hours; this process is called "rolling."
- Ecstasy also produces increased energy, desire for visual stimulation, and heightened awareness of and response to sensory input.

- Because ecstasy increases feelings of well-being and tolerance for others, many people mistakenly consider it a harmless drug.
- Ecstasy can raise the body temperature to dangerous levels (as high as 109 degrees); these high fevers lead to dehydration, which has killed people on ecstasy.
- Because dehydration is a known risk, people who have taken ecstasy sometimes drink too much water, which can lead to a dangerous and potentially fatal condition called hyponatremia.
- Ecstasy is neurotoxic—it kills nerve cells in the brain. Studies in rats and monkeys have shown that even a few doses of ecstasy cause damage that is not repaired 7 years later.

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8 See note 5, p. 2.

9 See note 6, p. 10.

10 Office of National Drug Control Policy. *Fact Sheet: Gamma Hydroxybutyrate (GHB)*. Rockville, MD: Drug Policy Information Clearinghouse, November 2002, p. 2.

11 National Institute on Drug Abuse. *NIDA InfoFacts: Rohypnol and GHB*. Bethesda, MD: National Institutes of Health, March 2005, p. 2.

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13 See note 11.

14 See note 10.

15 Office of National Drug Control Policy. *Fact Sheet: Rohypnol*. Rockville, MD: Drug Policy Information Clearinghouse, February 2003, p. 1.

16 See note 3, p. 43.

17 See note 3, p.43.

18 See note 4.

19 National Institute on Drug Abuse. *NIDA InfoFacts: LSD*. Bethesda, MD: National Institutes of Health, March 2005, p. 2.

20 Center for Substance Abuse Prevention. *Ecstasy: What's All the Rave About?* DHHS Publication No. (SMA) 3710B. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2002, p. 9.

21 See note 4.

22 See note 3, p. 43.

Session 8: Families in Recovery (PowerPoint Presentation)

Overview

Goals of Session

- Help family members and people in recovery better understand substance use and recovery.
- Help family members understand how they can support recovery.

Handouts

- FE 8A—Anticipating and Preventing Relapse
- FE 8B—Relapse Justifications
- FE 8C—Avoiding Relapse Drift

PowerPoint Presentation (40–45 minutes)

The counselor presents the PowerPoint slides, encouraging participants to ask questions at any time. Pages 67 through 76 contain talking points for each slide. The counselor should add examples and explain concepts in a way that is appropriate for the audience.

Focused Discussion (30 minutes)

The counselor facilitates discussion of the material presented and asks open-ended questions such as

- What did you hear that was new information? What surprised you?
- How does the information relate to your experience?
- How will this information affect the way your family copes with recovery?
- What questions do you have about this information?

Open Discussion (15–20 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Presentation

The bulleted points presented below concisely state the information the counselor should cover for each slide. The PowerPoint slides can be downloaded from http://store.samhsa.gov/product/Matrix-Intensive-Outpatient-Treatment-for-People-with-Stimulant-Use-Disorders-Counselor-s-Family-Education-Manual-w-CD/SMA12-4153.

Slide 8-1—Families in Recovery

- In this session, we are going to talk about the people who are most important to you. All attendees are here because they care about a family member.

- People in recovery are here because they care enough about themselves and their families to seek treatment; family members are here because they want to offer encouragement and support.
- When a family is coping with a loved one who abuses stimulants, life can be frustrating and chaotic. The person who is using can behave self-destructively; the family members can resort to desperate measures just to cope.
- Often, it's hard for all involved to understand how they got to this point. How did things get this bad? Evaluating a situation when you are in the middle of it can be difficult.
- In this session we will look at how people become dependent on a substance and how they and their families recover from dependence. The hope is that by better understanding the processes of dependence and recovery, family members will be better able to provide support.

Slide 8-2—Who Makes Up a Family?

- It is important to think of family in the broadest possible terms.
- Family includes immediate family and extended family, friends, mentors, partners, colleagues from work—all of these people are part of your family when it comes to treatment. If someone you are close to is supportive, that person is part of your family.

Slide 8-3—What Is Addiction?

- Addiction is a complicated physical and emotional process that takes place in the brain. As a result of drug use, the brain changes and people engage in behavior that affects themselves and their families.
- Addiction is a medical disorder. It is counterproductive to recovery to think of addiction as representing a personal failing, a lack of willpower, or a moral downfall.

Slide 8-4—Development of Addiction

- The development of addiction involves two different areas of the brain: the prefrontal cortex and the limbic system.
- The prefrontal cortex is the intelligent, rational, thinking part of the brain. It is the decisionmaker, the brain's computer. The prefrontal cortex constantly directs our behavior and evaluates both the positives and negatives of any situation to make a decision.
- The limbic system is made up of smaller parts of the brain below the prefrontal cortex. The limbic system's involvement in emotion and motivation drives addiction. Each dose of a substance—especially stimulants—activates the limbic system. Eventually, the system becomes overactivated to the point where normal, rational restraints on behavior are lost.
- One way to understand the process of addiction is as a struggle between the rational part of the brain (the prefrontal cortex) and the emotional part of the brain (the limbic system).
- For most people who use meth, the rational part of their brain keeps their meth use in check at first. However, with continued use, meth's effects on the parts of the brain that govern emotion and motivation begin to override reason and clear thinking.

Slide 8-5—Development of the Craving Response

- Craving is the physical and emotional desire for a drug.
- Three separate processes converge to create a craving for a drug:
  - The cognitive process
  - The conditioning process
  - Obsessive thinking
- The cognitive process is how the rational part of the brain (the cortex) copes with substance use.
- The conditioning process is the involvement of the emotional part of the brain (the limbic system) in addiction.
- Obsessive thinking is the struggle between the rational and emotional responses to substance use.

Slide 8-6—Cognitive Process (Beginning Stages of Addiction)

- In the beginning stages of addiction, meth use occurs occasionally, often at a party or on a special occasion.
- Use gradually increases, but the rational part of the brain is in control and decides that using meth is justifiable because of the supposed benefits it provides.
- The positives seem to outweigh the negatives. The facts that meth is illegal and extra money is spent to buy it do not carry as much weight.

Slide 8-7—Cognitive Process (Disenchantment)

- The person who continues to use meth eventually becomes disenchanted, as the negative consequences of meth use clearly outweigh the positives.
- Some people are able to stop using when it becomes apparent that meth use is damaging their lives. Those who can't stop are addicted.
- A powerful hunger for meth becomes stronger than the rational part of the brain.
- The rational decision not to use and willpower are not enough to deter the craving for meth that has taken root in the emotional part of the brain. The rational, decisionmaking process is severely impaired, and the addicted brain's demands are imperative.

Slide 8-8—Conditioning Process (Mild Cravings)

- While the cognitive process is taking place in the prefrontal cortex, a parallel progression of events takes place in the limbic system of someone who is using meth. This is the conditioning process.
- Conditioning is a type of learning that occurs by association. Every time people take meth, they strengthen a mental link between the drug and its pleasurable effects. This link conditions the brain to want more meth.
- At first, meth use is so infrequent that there is no automatic response to the people, places, or situations associated with meth.

- Over time, this link becomes stronger and more general, so that not only taking meth, but thinking of things associated with the drug (money, a dealer's house, certain friends) can induce cravings for meth.
- Things that are associated with meth use and that initiate desire for the drug are called triggers.
- Craving is a desire for meth that is intensified by the activation of the brain's emotional center and by obsessive thoughts about meth use.
- Developing a craving for a substance is a process. Repeated uses of meth "build" a craving for the drug in a person's mind.
- At first, purchasing and using the drug activate the brain's emotional and motivational centers in the limbic system. This results in euphoria and physiological arousal: increased breathing and heart rate, adrenaline effects, and increased energy.
- The brain begins to form an association between meth and pleasure.

Slide 8-9—Conditioning Process (Strong Cravings)

- As the mental connection between meth and the pleasure it produces grows stronger, things other than the drug itself increasingly trigger craving, and the craving becomes stronger.
- A person who continues using meth will feel an overpowering physical response to meth in situations further and further removed from the drug itself.
- In the later stages of addiction, thinking about meth will set off powerful cravings. For a person who is dependent on meth, thinking about meth or about using meth produces a powerful arousal similar to actual effects of meth.
- Triggers initiate an automatic craving to use meth, and this feeling drives people to find and take meth.

Slide 8-10—Conditioning Process (Overpowering Cravings)

- Soon, triggers proliferate, and the mental links between the triggers and drug use become overpowering. Addiction—the loss of rational control to the emotional part of the brain—has set in.
- As the addiction becomes severe, people use either daily or in binges that are interrupted only by physical collapse.
- The rational brain is totally overwhelmed by the constant, powerful craving from the addicted brain. People who are addicted cannot be stronger than the conditioned response that has been forged in the brain. They can be only smarter.

Slide 8-11—Development of Obsessive Thinking (Early Use)

- When a person starts using meth, very little time or thought is invested in it. Meth use is just a small part of the person's life.
- If the person keeps using, decisions about whether to use, where to get money to buy drugs, and how to conceal the evidence of using begin to take more time and thought.

- These thoughts of using intrude more and more because the links formed in the emotional part of the brain between meth and enjoyment have begun to exert their influence.

Slide 8-12—Development of Obsessive Thinking (Continued Use)

- With continued use, thoughts about meth crowd out other aspects of life. For the most part, the emotional part of the brain is given over to addiction and meth dominates the person's thoughts.
- People using meth become so obsessed with meth that their relationships may begin to crumble. There is little room in their lives for a relationship with anyone or anything except meth.
- This overwhelming preoccupation does not mean that family members mean less to people than meth does. It means that the brain changes caused by meth make the desire to use meth all but irresistible.

Slide 8-13—Progressive Phases of Addiction

- Now we turn to the family members' responses as they watch the person they care about become dependent on meth. We can trace family members' responses through four progressive stages of addiction:
  - Introductory
  - Maintenance
  - Disenchantment
  - Disaster

Slide 8-14—Family Members' Response to Meth Use (Introductory Phase)

- During the introductory phase of a person's meth use, family members are probably not affected very much. They may be completely unaware of the meth use.
- Family members may see behaviors that stem from occasional meth use but not associate them with a drug problem.
- Family members may wonder why the person occasionally neglects responsibilities and fails to meet obligations.

Slide 8-15—Family Members' Response to Meth Use (Maintenance Phase)

- Often, during the maintenance phase of a person's addiction, family members realize that a problem exists and attempt to solve it.
- Family members may give financial assistance. They may make up excuses for thoughtless behavior that results from meth use. They even may try to take on all the responsibilities for earning money, taking care of the family, keeping up friendships, and maintaining the household.
- These efforts help only temporarily because the real problem is the meth use and its consequences.
- The problems continue to mount as long as the meth use continues. Family members want to help, so they pick up the slack for their loved one who is using.
- This behavior does more harm than good. It helps the person stay addicted by covering up the consequences of meth use. Such activities give the person more time, energy, and money to continue using and cover up the fact that meth use must stop.

Slide 8-16—Family Members' Response to Meth Use (Disenchantment Phase)

- By the time the person reaches the disenchantment phase of addiction, family members often are angry and have given up trying to solve the problem.
- Recognizing that none of the attempted solutions is working, family members try to ignore what is going on.
- When they are unable to avoid being confronted with the consequences of the person's behavior, family members tend to blame either the person who is using or themselves.
- The person's dependence on meth makes all members in the family feel guilty and ashamed of what is happening and of their inability to control the situation.

Slide 8-17—Family Members' Response to Meth Use (Disaster Phase)

- During the disaster phase, family members often end up separating from the person who is using to save themselves. As a result of the emotional and physical separation, family members feel a sense of failure and hopelessness.
- When family members stay with the person, they learn to behave and think in ways that preserve the peace but often are not healthy for individual or family well-being.
- Children in such an environment learn ways of behaving that can interfere with their ability to have healthy relationships later in life.

Slide 8-18—Benefits of Family Involvement

- It is important for family members to be involved in treatment. Studies show that treatment works better when at least one supportive family member is engaged in the treatment.
- Family members who participate in treatment have a better understanding of what the person in recovery is going through. They also learn about the stages of recovery so that they can anticipate the difficulties the person in recovery will face and be aware of problems that may arise.
- The person in recovery is responsible for quitting meth and working on recovery. But family members who have been interacting with the person in recovery during the progression of the drug dependence have been affected by the process and need to make changes of their own to undo the damage that has been done.
- Handout FE 8A—Anticipating and Preventing Relapse discusses family members' roles in recovery.

Slide 8-19—Stages of Recovery

- People who stop taking a substance they are dependent on usually go through predictable stages during their recovery.
- The timetable for recovery varies for each person, but the stages usually don't vary.
- Knowing that there is a pattern to recovery and knowing what to expect in each stage often provide encouragement to family members and help them better support the person in recovery.

Slide 8-20—Withdrawal

- The withdrawal stage usually lasts 1 to 2 weeks.
- During this stage, the most severe symptoms are craving and depression. Many people also experience low energy, difficulty sleeping, increased appetite, and difficulty concentrating.

Slide 8-21—Honeymoon

- The Honeymoon stage lasts about 4 weeks.
- It is characterized by increased energy, enthusiasm, and optimism.
- Many people think this is the end of the recovery process and that things will remain positive from here on. Unfortunately, the hardest part of the recovery is still to come.

Slide 8-22—The Wall

- The Wall is the hardest stage of recovery and one of the longest. It lasts about 12 to 16 weeks.
- The Wall brings with it some troublesome emotional and thinking difficulties. The optimism of the Honeymoon stage gives way to the full realization of the difficulty and sheer effort involved in recovery.
- People in recovery experience depression, irritability, difficulty concentrating, low energy, and a general loss of enthusiasm. Risk of relapse is very high during this stage.
- This stage is almost always a struggle for people in recovery, but with the support of family members and the recovery strategies they learn in treatment, clients get past the Wall.

Slide 8-23—Readjustment

- The readjustment stage is when the individual begins to adjust to an ongoing state of abstinence.
- During this stage, the Wall has been surmounted and the person in recovery and family members begin to return to a more normal lifestyle.
- During the readjustment stage and after, individual and family issues can benefit from psychotherapy and family counseling. Treatment for meth dependence often does not address issues of long-term importance.

Slide 8-24—Goals for Withdrawal

- The main goal for the person in recovery during the withdrawal stage of treatment is stopping meth use.
- In group sessions that focus on early recovery skills, the person in recovery learns specific techniques for reducing cravings and avoiding relapse.
- The person in recovery also begins to learn about the process of addiction and how drugs, such as meth, affect brain chemistry and the rest of the body.
- When the person in recovery is in the withdrawal stage of treatment, family members have one major decision to make: whether they are willing to be part of the recovery process.

- Family members will find it is easier to be involved if they view the meth use, not the person in recovery, as the problem and if the meth use is recognized as a medical condition, regardless of how it began.

Slide 8-25—Goals for the Honeymoon

- During the Honeymoon stage of recovery, people in recovery work on improving their physical health and outlook on recovery by exercising and staying active.
- People in recovery also begin to identify personal triggers and relapse justifications and to use targeted techniques to stay abstinent.
- Often, persons in recovery feel as if they are "cured" during this period. It is important for people in recovery to continue to work on their recovery and to avoid testing themselves by being around drugs.
- Family members can be very helpful during the Honeymoon stage, working with the person in recovery to support the primary goal of abstinence.
- Although family members are not responsible for the loved one's recovery, their behavior and attitudes during this time can significantly increase or decrease the chances of the person in recovery achieving and maintaining abstinence.
- Family members need to recognize and discontinue triggering interactions.

Slide 8-26—Goals for the Wall

- By the time people in recovery reach the stage known as the Wall, they have been abstinent for several months. They continue to work on maintaining abstinence by putting relapse prevention techniques they have learned into practice.
- The person in recovery also focuses on repairing relationships with family members and friends and developing support networks to cope with the problems that arise during recovery.
- The Wall can be a frustrating and difficult part of recovery. The person in recovery needs support and encouragement from many sources. Working on developing new interests and staying active also are important to recovery.
- Also important are recognizing and addressing dangerous emotions.
- While the person in recovery is in the stage known as the Wall, family members need to guard against expressing anger toward the person.
- As much as possible, family members need to move past resentment and work to support the person in recovery. Family members who are committed to this support need to begin trusting the loved one's recovery.
- Family members should relearn how to take care of themselves by beginning to return to the normal routines of life and pursuing activities that are rewarding and self-nourishing.
- It also is important at this stage to explore how family members communicate, how poor communication may have led to problems, and how communication can be improved.

- Handout FE 8B—Relapse Justifications helps family members understand how relapses can start.

Slide 8-27—Goals for Readjustment

- By the time people in recovery reach the readjustment stage of recovery, they know which behaviors they need to engage in to keep their recovery strong and which behaviors place their recovery at risk.
- The task for people in recovery during this stage—and for the rest of their lives—is to monitor their recovery, ensuring that they engage in those behaviors that will help them avoid relapse.
- Because people in recovery often will be confronted with the opportunity and desire to use, they need to be aware of those situations and thoughts that put them at risk of relapse. For this reason, they need to anticipate troublesome situations and have detailed plans for how to address them. The most important aspect of maintaining abstinence is knowing how to avoid relapse.
- During the readjustment stage, the person in recovery works on forming new, healthy relationships and on strengthening existing friendships. The person in recovery also begins to examine long-term life goals.
- When the person in recovery reaches the readjustment stage, the family has been with him or her through about 4 months of recovery. The person in recovery and the family members have learned a lot about what it takes to support the recovery and to make the family function well.
- The readjustment stage is marked by a return to a more predictable, more normal lifestyle for everyone in the family. Family members should be mindful that many of the changes they have made in their lives to offer support for recovery will need to continue and become permanent.
- It is important for family members to accept limitations of living with a person in recovery; maintain a balanced, healthy lifestyle; and avoid relapsing to former behaviors.
- Patience with the process of recovery is crucial.
- Handout FE 8C—Avoiding Relapse Drift helps family members understand how they can support the person in recovery.

Slide 8-28—Key Relapse Issues for People in Recovery

- The person in recovery and the family members need to evaluate which lifestyle and attitude changes are important for each of them individually and as a family. After this point in recovery, the person in recovery will receive less support in the form of treatment.
- Some of the support role will be taken up by 12-Step or mutual-help groups and by friends, but family members will be a major source of support for the person in recovery.
- Families need to decide which adaptations they have made during recovery should become permanent in their lives.
- When making these decisions, families should bear in mind the most common relapse issues for people recovering from meth use. All of the six issues listed on this slide may not be a problem for the person in recovery, but the family needs to find out which issues might be troublesome for the person in recovery.

- Family members should have an open discussion with the person in recovery about how best to support his or her recovery.

Slide 8-29—Key Relapse Issues for Family Members

- Whereas the person in recovery needs to be on the alert for relapse to meth use, family members need to be careful not to return to their former ways of behaving, thinking, and communicating.
- This slide lists common problems that can precede a slip back into old behaviors for family members.
- Just as it helps people in recovery to anticipate situations that might lead to relapse, so it will help family members to be on guard for ways in which they might slip back into behaviors that will destroy recovery and the family.

Session 9: Rebuilding Trust (Multifamily Group Discussion)

Goals of Session

- Provide an opportunity for participants to think about and discuss the role that trust plays in relationships.
- Provide an opportunity for participants to address the loss of trust that can come from stimulant use, including family members' ongoing suspicions of substance use by clients.
- Provide an opportunity for participants to begin to repair damaged relationships.

Handout

- FE 9—Rebuilding Trust

Introduction (2–3 minutes)

The counselor explains that today's session provides an opportunity for participants to discuss the loss of trust that can come with stimulant use and ways to rebuild that trust in family relationships.

Handout Review (15–20 minutes)

The counselor

- Gives participants a copy of handout FE 9—Rebuilding Trust and asks them to read the information and carefully consider and write down their answers to the questions
- Tells participants that their answers to the questions are to guide discussion; no one will see their responses

Focused Discussion (50–55 minutes)

The counselor facilitates discussion, using the questions on the handout to provide structure.

Summary (2–3 minutes)

The counselor summarizes the ideas for rebuilding trust among family members that were discussed by the group.

Open Discussion (15 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Session 10: Marijuana (PowerPoint Presentation)

Overview

Goals of Session

- Familiarize participants with the nature and prevalence of marijuana use.
- Familiarize participants with the dangers to health and to recovery posed by marijuana use.

Handout

- FE 10—Fact Sheet: Marijuana

PowerPoint Presentation (40–45 minutes)

The counselor presents the PowerPoint slides, encouraging participants to ask questions at any time. Pages 78 through 83 contain talking points for each slide. The counselor should add examples and explain concepts in a way that is appropriate for the audience.

Focused Discussion (30 minutes)

The counselor facilitates discussion of the material presented and asks open-ended questions such as

- What did you hear that was new information? What surprised you?
- How does the information relate to your experience?
- How will this information affect the way your family copes with recovery?
- What questions do you have about this information?

Open Discussion (15–20 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Presentation

The bulleted points presented below concisely state the information the counselor should cover for each slide. The PowerPoint slides can be downloaded from http://store.samhsa.gov/product/Matrix-Intensive-Outpatient-Treatment-for-People-with-Stimulant-Use-Disorders-Counselor-s-Family-Education-Manual-w-CD/SMA12-4153.

Slide 10-1—Marijuana

- This presentation offers an overview of marijuana, including what it is, the short- and long-term effects its use has on the mind and body, and the risks it poses to recovery.

Slide 10-2—The Importance of Total Abstinence

- For treatment to work, people in recovery should be totally abstinent. This means that regardless of why people are in treatment, they should abstain from *all* psychoactive substances.
- A person in treatment for abusing stimulants must give up alcohol and all illegal drugs, even drugs such as marijuana that many people believe are harmless, to ensure a successful recovery.
- The use of any substance can jeopardize recovery from stimulant dependence.

Slide 10-3—Is Marijuana Harmless?

- Many people wrongly believe that marijuana is not dangerous, especially when compared with drugs such as heroin, cocaine, crack, meth, or club drugs.
- Marijuana is the most widely used illegal drug, which may contribute to the perception that it is harmless. Each year, about 25 million Americans ages 12 and older use marijuana. That is more than 1 out of every 10 Americans.[1]
- More young people go into treatment for marijuana use than for all other illegal drug use combined.[2]
- Marijuana use poses significant health hazards. It affects nearly every organ system in the body.[3]
- In addition to its physical effects, marijuana can have a profound impact on people's education, employment, and personal life.

Slide 10-4—Marijuana Prevalence

- Each year about 2.6 million people try marijuana for the first time. Two-thirds of those first-time users are younger than 18. The average age when people first try marijuana is 17.[4]
- Two out of every five Americans have tried marijuana. One in ten has used marijuana in the last year. One in a hundred has used marijuana at least 300 days in the last year.[5]

Slide 10-5—What Is Marijuana?

- Marijuana is a greenish gray mixture of dried and shredded parts of the hemp plant, *Cannabis sativa.* The mixture may consist of leaves, stems, flowers, and seeds.
- It is usually smoked in hand-rolled cigarettes or pipes. Sometimes cigars are sliced open, and the tobacco inside is replaced with marijuana.
- Marijuana's more concentrated forms are a resin called hashish and a black liquid called hash oil.

Slide 10-6—Street Names

- Marijuana is known by many street names that vary by region of the United States. Some of the more common names are pot, weed, bud, herb, ganja, hash, grass, Mary Jane, chronic, and cannabis.
- Marijuana cigarettes are known as joints or nails. Pipes are called bongs. Cigars packed with marijuana are called blunts.

Slide 10-7—History

- Marijuana is grown in all 50 States. The main foreign sources for marijuana are Mexico, Canada, Colombia, and Jamaica.
- Marijuana is a Schedule I controlled substance, like heroin and LSD.
- Nonmedical use of marijuana has been illegal in the United States since 1937.

Slide 10-8—Medical Marijuana

- Marijuana has been used to treat
  - Loss of vision due to glaucoma
  - Nausea experienced by patients receiving treatment for HIV/AIDS and cancer
  - Pain associated with multiple sclerosis
- In 1985, the U.S. Food and Drug Administration approved Marinol, an oral capsule that includes marijuana's active ingredient.
- Marinol is available by prescription to treat the nausea and vomiting that can accompany cancer chemotherapy and the weight loss seen in patients with AIDS.
- Other countries, including Canada and the United Kingdom, have approved an aerosol form of marijuana that is delivered with an inhaler to treat pain in patients who have multiple sclerosis.

Slide 10-9—Active Ingredient

- The active ingredient in marijuana is the delta-9-tetrahydrocannabinol (THC).
- THC is responsible for the effects that produce the marijuana high.
- Over the past two decades, THC levels in marijuana have increased. Today's marijuana contains three times as much THC as marijuana from the 1970s and 1980s, making it three times stronger.

Slide 10-10—Short-Term Effects

- When someone smokes marijuana, THC rapidly goes from the lungs to the bloodstream to the brain. THC causes nerve cells in the brain to release the neurotransmitter dopamine.
- The release of dopamine is responsible for the person feeling "high," a relaxed, euphoric feeling.
- THC can also impair short-term memory, disrupt balance and coordination, slow reaction time, increase heart rate, distort perception, and result in disorientation, confusion, and panic.
- The immediate effects of marijuana can last from 1 to 3 hours.
- After the high subsides, a person may feel sleepy or depressed. Feelings of panic, anxiety, and distrust are common.

Slide 10-11—Long-Term Effects

- Marijuana can have long-term effects on memory and learning.
- People who use marijuana regularly have trouble learning and remembering even 30 days after they stop using the drug.[6]
- Students who smoke marijuana regularly get lower grades in high school and college than those who don't.[7]
- Marijuana impairs so many skills that influence learning that people who use it regularly may be functioning at a reduced intellectual level all of the time.
- Workers who use marijuana are more likely than their colleagues to have problems on the job, including accidents, absence, lateness, and job loss.[8]
- People who use marijuana at least 300 days a year are more likely to be unemployed than those who use it less often or not at all.[9]

Slide 10-12—Cancer Risks

- People who smoke marijuana are exposed to lung damage just as people who smoke tobacco.[10]
- Regular use of marijuana can cause frequent chest colds, bronchitis, and emphysema.[11]
- Marijuana smoke has five times more tar and carbon monoxide and up to 70 percent more carcinogens than does tobacco smoke.[12]
- Smoking marijuana may increase the risk of lung cancer more than does smoking tobacco.[13]
- Studies suggest that smoking marijuana increases the chances of developing cancer of the head or neck.[14]

Slide 10-13—Risk of Infection and Disease

- The active ingredient in marijuana, THC, hampers the immune system's ability to fight off infection and disease.
- Studies have shown that immune system cells exposed to marijuana ingredients have a reduced ability to prevent infections and tumors.[15]

Slide 10-14—Marijuana and Driving

- Because it impairs balance, coordination, and decisionmaking, marijuana is associated with all kinds of accidents.
- Studies show that up to 11 percent of fatal accident victims have THC in their bodies.[16]
- Driving under the influence of marijuana is dangerous.
- Even low doses of marijuana significantly reduce drivers' performance on road tests. Combining marijuana with alcohol further impairs drivers' abilities.[17]

- Drivers' coordination and reaction time are impaired for several hours after the high from marijuana use has faded.
- After alcohol, marijuana is the substance most frequently found in drivers involved in fatal car crashes. Seven percent of fatal crashes involve marijuana.[18]
- Studies estimate that more than one in seven high school seniors drive under the influence of marijuana.[19]

Slide 10-15—Marijuana and Pregnancy

- A woman who uses marijuana during pregnancy exposes her fetus to a variety of dangers.
- Low birth weight and problems with neurological development have been linked to marijuana use.
- Later in life, babies exposed to marijuana during pregnancy may have trouble concentrating, learning, and making decisions. These problems are compounded if the mother continues to use marijuana after the child is born.
- Breast-feeding mothers who use marijuana can pass THC to their babies. THC in breast milk is very concentrated and has been linked to problems with motor development in children.

Slide 10-16—Marijuana Addiction

- One of the reasons people think of marijuana as a "safe" drug is that they think it is not addictive.
- Although people may not develop physical dependence on marijuana, they can become psychologically addicted to marijuana. They cannot imagine living without the drug.
- Addiction means using a drug even though it interferes with family, school, work, and other important aspects of life.
- For those who are psychologically addicted, withdrawal from marijuana use can include cravings for the drug, anxiety, irritability, and sleeplessness.

Slide 10-17—Marijuana and Other Drugs

- People who use marijuana at least 300 days a year are more likely to drink heavily and use illicit drugs than people who occasionally use marijuana or those who never use it.[20]
- The younger people are when they start using marijuana, the more likely they are to use heroin and cocaine and become dependent on drugs as adults.[21]
- Because it is so integrally linked with other substance use, marijuana use poses a particular risk to people in recovery from meth use.

Slide 10-18—Marijuana and Relapse

- Research suggests that people recovering from cocaine or meth use who continue to use marijuana have relapse rates two to three times higher than people who abstain from marijuana.[22]

Slide 10-19—Marijuana and Families

- People may use marijuana as a way to cope with boredom, anxiety, and depression.

- Marijuana can be used to escape, rather than address, serious problems in a family.
- In addition to making recovery from meth harder, marijuana use can contribute to the deterioration of personal and family life.
- More than half of adult men who are arrested used marijuana in the past year. Two out of five men who are arrested test positive for marijuana at the time of their arrest.

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1 Substance Abuse and Mental Health Services Administration (SAMHSA). *The NSDUH Report: Daily Marijuana Users.* Rockville, MD: Office of Applied Studies, SAMHSA, November 26, 2004.

2 Office of National Drug Control Policy. *Fact Sheet: Marijuana*. Rockville, MD: Drug Policy Information Clearinghouse, February 2004, p. 6.

3 Khalsa, J.H.; Genser, S.; Francis, H.; and Martin, B. Clinical consequences of marijuana. *Journal of Clinical Pharmacology* 42 (suppl):7S–10S, 2002.

4 See note 2, p. 1.

5 See note 2.

6 Center for Substance Abuse Prevention. *Marijuana: Weeding Out the Hype.* DHHS Publication No. (SMA) 3710D. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2002, p. 13.

7 National Institute on Drug Abuse. *NIDA InfoFacts: Marijuana.* Bethesda, MD: National Institutes of Health, March 2004, p. 4.

8 See note 7.

9 See note 1.

10 See note 2, p. 3.

11 See note 2, p. 3.

12 See note 7, p. 3.

13 See note 7, p. 3.

14 See note 7, p. 3.

15 See note 7, p. 3.

16 National Institute on Drug Abuse. *Research Report Series: Marijuana Abuse.* NIH Publication No. 02-3859. Bethesda, MD: National Institutes of Health, October 2002, p. 4.

17 See note 7, pp. 3, 4.

18 See note 6, p. 19.

19 See note 2, p. 4.

20 See note 1.

21 See note 2, p. 1.

22 Rawson, R.A.; Shoptaw, S.J.; Obert, J.L.; McCann, M.J.; Hasson, A.L.; Marinelli-Casey, P.J.; Brethen, P.R.; and Ling, W. An intensive outpatient approach for cocaine abuse treatment: The Matrix model. *Journal of Substance Abuse Treatment* 12(2):121, 1995.

Session 11: Living With an Addiction (Multifamily Group Discussion)

Goals of Session

- Provide an opportunity for participants to think about and discuss the ways in which recovering from addiction will affect family life.
- Provide an opportunity for participants to share concerns and solutions with others in the group.

Handout

- FE 11—Living With an Addiction

Introduction (2–3 minutes)

The counselor explains that

- Making a commitment to recovery requires recognizing and accepting certain realities.
- Recovery brings all sorts of questions: What happens after the drug and alcohol use stops? Does life eventually go back to normal? Can a person in recovery lead the same lifestyle as a person who has never been addicted?
- Today's session provides an opportunity for participants to discuss issues and concerns related to living with addiction and recovery from the perspectives of both people in recovery and their family members.

Handout Review (10–15 minutes)

The counselor

- Asks participants to read the information on the handout and carefully consider and write down their answers to the questions
- Tells participants that their answers to the questions are to guide discussion; no one will see their responses

Focused Discussion (50–55 minutes)

The counselor facilitates discussion, using the questions on the handout to provide structure.

Summary (2–3 minutes)

The counselor summarizes the issues and ideas for effectively living with addiction and recovery that were discussed by the group.

Open Discussion (15 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Session 12: Communication Traps (Multifamily Group Discussion)

Goals of Session

- Provide information about communication styles, techniques, and traps.
- Provide an opportunity for participants to consider and discuss family communication issues.
- Encourage participants to practice new communication skills.

Handouts

- FE 12A—Communication Traps
- FE 12B—Improving Communication
- FE 12C—Contract: Commitment To Practice Communication Skills

Introduction (2–3 minutes)

The counselor explains that

- People in families coping with substance use disorders often feel guilty, angry, hurt, and defensive.
- These feelings can affect seriously the way family members communicate with one another; negative patterns of interacting often become automatic.
- Understanding that positive communication involves skills that can be *learned* is an important first step in improving family relationships.
- This session focuses on communication traps (communication behaviors that are not productive) and the skills necessary for improving family communication.
- Paying attention to communication issues and learning new skills help families improve their communication.
- Clear, positive interactions allow people to increase self-esteem and confidence and pave the road to committed, trusting relationships.
- Recovery from substance use disorders is a difficult process for both the person in recovery and his or her family.
- Positive and trusting family relationships support *everyone* in the recovery process.

Focused Discussion and Handout Review (55–60 minutes)

The counselor facilitates discussion of communication and recovery by asking participants the following questions:

- In what ways do you think improving communication could improve your family relationships?
- In what ways has communication in your family changed during recovery?

The counselor

- Gives participants a copy of FE 12A—Communication Traps
- Provides examples of each communication trap (one example for each communication trap is provided in Communication Traps: Sample Scenarios on pages 87 and 88; the counselor may want to add examples)
- Facilitates discussion of each communication trap, asking questions such as
  - How do you think the situation in the example could have been avoided?
  - Do you recognize this communication trap from your own family interaction? Would you be willing to share an example?
- Provides examples of positive "fixes" for each communication trap if they were not brought up in discussion (one example for each communication trap is provided in Communication Traps: Sample Scenarios; the counselor may want to add examples)

After discussion of FE 12A—Communication Traps, the counselor

- Gives participants a copy of FE 12B—Improving Communication
- Goes over each point

Summary (15 minutes)

The counselor

- Summarizes the issues and ideas related to communication in recovering families that were discussed by the group
- Gives participants handout FE 12C—Contract: Commitment To Practice Communication Skills and allows about 5 minutes for participants to complete the contract using the techniques listed on FE 12B
- Suggests that participants keep the contract in a place that will remind them to practice these skills regularly

Open Discussion (15 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Communication Traps: Sample Scenarios

1. Are You Assuming?

The scenario

Nancy asked her husband Pete, "Will you be coming home right after work?" Pete exploded, "You don't have to check up on me every 5 minutes! Do you want a urine sample, too?" Nancy responded angrily, "Well, you've sure given me enough reasons to check up on you." The conversation then became a full-fledged fight about the past. Pete assumed that Nancy was suspicious when she asked whether he was coming right home from work and felt frustrated and angry that she wasn't trusting him or noticing the changes he'd made in recovery. What Nancy was really wondering when she asked the question was whether Pete would be able to pick up the dry cleaning before the shop closed or whether she needed to make plans to leave work early.

Example of a communication "fix"

Pete could have avoided the fight by not assuming that he knew what Nancy was thinking. He could have answered, "Yes, why do you ask?" in a neutral tone of voice or answered directly and waited for her response.

2. Are You Hinting?

The scenario

Ricardo, a 17-year-old in recovery, was playing a video game when his mother, Rosa, walked by and said, "Ricardo, the kitchen trash can is getting full." Ricardo responded, "Uh huh," and continued to play his game. Half an hour later, Rosa noticed that Ricardo hadn't emptied the trash. She angrily confronted Ricardo for not taking the trash out right away. Ricardo responded to her anger by loudly saying, "Hey, I'll do it when I'm good and ready!"

Example of a communication "fix"

Instead of hinting that she wanted Ricardo to take out the trash right away, she could have asked him directly by saying, "Ricardo, I need you to take out the trash in the next 15 minutes; I'll be starting dinner soon and will have a lot of vegetable scraps." Ricardo would then have known that she meant "now" and not "sometime."

3. Are You Giving Double Messages?

The scenario

Tanya asked her husband, Andre, "Do you mind if I go fishing with Sharonne Saturday?" Andre had been planning to spend time with Tanya on the weekend and didn't want her to go with Sharonne. However, he replied "Sure, go ahead." As he said this, his arms were stiffly crossed across his chest and he didn't look directly at Tanya. Tanya felt uneasy and said, "You're really OK with it?" Andre responded angrily, "I said I was, didn't I?" The discussion escalated into an argument.

Example of a communication "fix"

Andre could have been honest with Tanya about his feelings, instead of showing them indirectly. He could have said, "Well, I was hoping we could spend some time together Saturday. I've been working

too much and I miss seeing you." Tanya would then have understood clearly what his needs were and either changed her plans or negotiated a way to spend time with him.

4. Can You Admit a Mistake?

The scenario

Bob forgot that it was his and Catherine's fifth wedding anniversary. A coworker invited him to bowl a few frames after work, and he accepted. When he arrived home, he discovered the table set for two and Catherine in tears. She had left their children with her sister and prepared a romantic dinner, now drying out in the oven. When she confronted Bob about being so late, he responded defensively, "You know I have trouble remembering these things; you should have reminded me! How am I supposed to know you were planning a special dinner?" Catherine responded, "How could you forget our anniversary?" Bob was feeling guilty at this point, but not wanting to admit he was wrong, defensively replied, "Listen, Catherine, we've been married 5 years now; what's the big deal?" Catherine locked herself in the bedroom.

Example of a communication "fix"

When Bob realized that he had forgotten their anniversary, he could have simply admitted his mistake and apologized sincerely. Although the ensuing discussion still would have been difficult, it may not have escalated.

5. Do You Use "I" Statements?

The scenario

Pam, a senior in high school, was out on a date. Her curfew was midnight, and she was rarely late. When Pam arrived home at 1 a.m., her mother, Emily, was extremely worried. Emily greeted Pam at the door saying, "You're late! You could have picked up a phone and called; you're always so inconsiderate!" Pam responded angrily, "I am not always inconsiderate!" A fight ensued.

Example of a communication "fix"

Emily could have used an "I" statement, saying something like "I really worry that something has happened when you're late and I don't hear from you. Please give me a quick call if you'll be late." Emily would have directly addressed an important issue in a calm way, and Pam would not have felt the need to defend herself aggressively. Pam also may be more likely to call her mother the next time she is late.

III. Family Education Handouts

Number	Handout Title
FE 1A	A Definition of Addiction: American Society of Addiction Medicine
FE 1B	Thought Stopping
FE 2	Fact Sheet: Alcohol
FE 3A	Guidelines for Graduate Panel Participants
FE 3B	Guidelines for Family Member Panel Participants
FE 3C	Guidelines for Recovery Panel Participants
FE 4A	Fact Sheet: Methamphetamine
FE 4B	Fact Sheet: Cocaine
FE 5A	Daily/Hourly Schedule
FE 5B	Relapse Justifications
FE 6A	Coping With the Possibility of Relapse for the Person in Recovery
FE 6B	Coping With the Possibility of Relapse for Family Members of the Person in Recovery
FE 6C	Family Members and Recovery
FE 7A	Fact Sheet: Opioids
FE 7B	Fact Sheet: Club Drugs
FE 8A	Anticipating and Preventing Relapse
FE 8B	Relapse Justifications
FE 8C	Avoiding Relapse Drift
FE 9	Rebuilding Trust
FE 10	Fact Sheet: Marijuana
FE 11	Living With an Addiction
FE 12A	Communication Traps
FE 12B	Improving Communication
FE 12C	Contract: Commitment To Practice Communication Skills

FE 1A A Definition of Addiction

American Society of Addiction Medicine

Addiction is a primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. Addiction is characterized by behaviors that include one or more of the following:

- Impaired control over drug use
- Continued use despite harm
- Compulsive use
- Cravings

From: Graham, A.W.; Schultz, T.K.; Mayo-Smith, M.F.; Ries, R.K.; and Wilford, B.B., eds. *Principles of Addiction Medicine,* Third Edition. Chevy Chase, MD: American Society of Addiction Medicine, Inc., 2003.

FE 1B

Thought Stopping

Visualization

- Picture a switch or lever in your mind.
- Imagine yourself actually moving it from ON to OFF to stop the drug- or alcohol-using thoughts.
- Have another picture ready to replace the drug- or alcohol-using thoughts.
- Make sure that it is a pleasurable or meaningful thought and does not involve drug or alcohol use.
- If the thought stopping works, but the thought frequently keeps coming back, change your environment or engage in a task that requires your full concentration.

Rubberband Snapping

- “Snap” your attention off thoughts of using drugs or alcohol.
- Simply put a rubberband loosely around your wrist (don’t cut off your circulation!).
- When a craving or using thought occurs, snap the rubberband lightly against your wrist and say “NO” (either aloud or not, depending on the situation) to the drug- or alcohol-using thoughts.
- As with visualization, have another thought ready to replace the drug- and alcohol-using thoughts.
- Keep the rubberband on all the time.

FE 1B

Thought Stopping

Relaxation

- Understand that cravings often create feelings of hollowness, heaviness, and cramping in the stomach. These feelings often can be relieved by breathing in deeply (filling the lungs with air) and slowly breathing out. Do this three times.
- Try to relax your body as much as you can for a few minutes.
- Feel the tightness leave your body.
- Repeat this process whenever the feelings return.

Calling Someone

- Understand that talking to another person provides an outlet for feelings and allows you to “hear” your own thinking process.

FE 2

Fact Sheet: Alcohol

How Does Alcohol Work?

Alcohol affects many chemical systems in the brain. A delicate balance exists between chemical systems that stimulate and chemical systems that inhibit, or slow down, functions of the brain and body. Alcohol interferes with and changes this delicate balance.

How Do People Become Dependent on Alcohol?

If people drink alcohol frequently and steadily, their brains adapt over time to the presence of alcohol. They do this by producing naturally stimulating chemicals in larger quantities than normal.

As their brains adapt, people may become dependent on alcohol to maintain a chemical balance. If a person who is dependent on alcohol stops drinking all at once, this high level of stimulating chemicals can cause withdrawal symptoms.

Withdrawal symptoms vary depending on how much alcohol and how long a person has been drinking.

What Are the Symptoms of Withdrawal?

Withdrawal symptoms can include

- Seizures
- Tremors (shakiness)
- Nausea
- Auditory or visual hallucinations (hearing or seeing things that aren't there)
- Insomnia
- Agitation (extreme nervousness and irritability)
- Confusion

Alcohol withdrawal can be life-threatening. Delirium tremens (DTs) is a dangerous withdrawal condition. Without treatment, as many as 1 out of every 20 people who develop its symptoms die.

Symptoms of DTs include

- Rapid heart rate
- Increased body temperature
- Tremors
- Loss of ability to control muscle movement
- Increased blood pressure
- Abnormally fast breathing
- Sweating
- Altered mental status
- Hallucinations
- Cardiovascular collapse

Who Uses Alcohol?

Most people older than 21 can drink moderate amounts of alcohol without developing problems. Moderate drinking means 1 drink per day for women and 2 drinks per day for men. The 2003 National Survey on Drug Use and Health reports that about half of Americans ages 12 and older report drinking alcohol.

The National Institute on Alcohol Abuse and Alcoholism estimates that about 3 in 10 (30 percent) American adults drink at levels that increase their risk for physical, emotional, and social problems. Of these heavy drinkers, about one in four currently has an alcohol abuse or dependence disorder.

In general, more men report being current drinkers than do women: in 2003, 57 percent of men ages 12 and older reported past month alcohol use compared with 43 percent of women.

The rate of alcohol dependence also is lower for women than it is for men. Estimates indicate that about one-third of those dependent on alcohol are women.

The incidence of heavy alcohol use is highest among young adults between ages 21 and 29 and lowest among adults ages 65 and older.

FE 2

Fact Sheet: Alcohol

What Are the Immediate Effects of Drinking Alcohol?

When people first begin to drink, they may experience

- Feelings of well-being or euphoria
- Talkativeness and increased sociability
- Lowered inhibitions (people may do or say things they otherwise would not do)

What Happens as People Continue To Drink?

They begin to feel sedated and drowsy and may

- Have trouble with balance
- Experience impaired peripheral vision (the ability to see to the sides)
- Experience delayed reaction time
- Slur their words
- Vomit
- Fall asleep
- Black out and not remember anything that happened for a period while under the influence

How Does Heavy Drinking Affect a Person?

"Heavy" drinking can be defined as binge drinking on five or more occasions in the past month. Binge drinking is drinking five or more drinks on one occasion at least once in the past month. Heavy drinking also can be defined as frequent binge drinking (drinking more than five drinks on one occasion for men and more than four drinks on one occasion for women).

FE 2

Fact Sheet: Alcohol

Heavy drinking can cause significant damage to organ systems in the body. When alcohol is consumed, it enters the bloodstream and is distributed throughout the body.

Although heavy drinking is most commonly associated with liver damage, it also can affect the digestive, cardiovascular, immune, endocrine, and nervous systems. Alcohol affects the liver.

- The liver is where alcohol is broken down. A number of the chemicals produced by this process are toxic (poisonous) to the liver itself.
- These poisons add up over time, leading to alcohol-caused liver damage.
- This damage can take the form of either alcoholic hepatitis or cirrhosis (scarring of the liver).
- Often both types of damage exist in the same person.
- Alcohol dependence is the leading cause of liver-related deaths in the United States.
- It is estimated that more than 2 million people experience some form of alcoholic liver disease.

Alcohol affects the digestive system.

- Heavy drinking has been shown to cause chronic inflammation (swelling and irritation) of the esophagus (the passageway to the stomach), which can lead to cancer.
- Enlarged blood vessels in the esophagus (esophageal varices) can be caused by liver disease.
- These blood vessels can rupture; when this happens, it is often fatal.

- Heavy alcohol use also has been linked to pancreatitis (inflammation of the pancreas) and cancers in the throat, colon, and rectum.

Alcohol affects the heart.

- Although moderate alcohol intake has been shown in some studies to be heart protective, heavy alcohol use is associated with serious heart disease because it interferes with the pumping action of the heart, causing irregular and/or weak heartbeats, and causes high blood pressure, which also can increase the risk of stroke.
- Blood platelets, involved in blood clotting, also are damaged, causing an increased risk of bleeding.

Alcohol affects the immune system.

- Alcohol can seriously affect the body's immune system (the system that protects the body from disease) by damaging white and red blood cells.
- People who drink heavily experience more infectious diseases than do people who drink only moderately.
- Alcohol can damage the immune system to a level where it attacks the body. This can result in, or worsen, alcohol-induced organ damage such as liver disease.

Alcohol affects the endocrine system.

- The endocrine system (the hormone-controlling system) can be damaged by long-term alcohol use.

- The balance of the hormones insulin and glucagon, which regulate blood sugar levels, is disrupted; diabetes (high sugar) is common among people who drink heavily.
- Drinking alcohol can alter the release of reproductive hormones, growth hormone, and testosterone.
- The effects of alcohol on hormone systems include decreased testicle and ovary size and disrupted sperm and egg production.
- Alcohol-induced changes in hormones can hurt sexual function in both men and women.

Alcohol damages the nervous system.

- Heavy use of alcohol may damage the nervous system. This damage may include
  - Peripheral neuropathy, resulting in numbness and tingling in the legs, arms, and/or hands
  - Wernicke's syndrome, resulting in disordered eye movements, very poor balance, and difficulty walking
  - Korsakoff's syndrome, resulting in severely affected memory, preventing new learning from taking place
- In addition to these nervous system disorders, most people who drink heavily have some loss of mental function, reduced brain size, and changes in the function of brain cells.

FE 2

Fact Sheet: Alcohol

Drinking can cause behavioral and physical problems.

- Alcohol use is associated with domestic violence, child abuse, and assault.
- Use is associated with all types of accidents.
- The more heavily a person drinks, the greater the potential for problems at home, at work, with friends, and even with strangers. These problems may include
  - Arguments with or separation from spouse and other family members
  - Strained relationships with colleagues
  - Absence from or lateness to work with increasing frequency
  - Loss of employment because of decreased productivity
  - Committing or being the victim of violence
  - Auto crashes and/or arrests for driving under the influence

Does Alcohol Affect Men and Women in the Same Way?

Drinking, even in small amounts, affects women differently than it affects men.

- Women develop alcoholic liver disease more quickly and after drinking less alcohol than men do. Women are more likely than men to develop alcoholic hepatitis (liver inflammation) and to die from cirrhosis.
- Women are more likely than men to get alcohol-induced brain damage.
- Among people who drink heavily, men and women have similar rates of alcohol-related heart disease, even though women drink less alcohol over a lifetime than men do.

Fact Sheet: Alcohol

For some women, as little as one drink per day can slightly raise the risk of breast cancer.

What About Drinking and Pregnancy?

A woman who drinks when she is pregnant puts her baby at risk of serious problems. Babies born to mothers who drank during pregnancy may have mental retardation or other learning and behavioral problems. The most serious risk is fetal alcohol spectrum disorders (FASD). FASD is the leading known cause of preventable mental retardation in the United States.

Although the effects of FASD vary, children with the syndrome can have cognitive and behavioral problems. Behavioral and neurological problems associated with FASD may lead to poor academic performance as well as legal and employment difficulties in adolescence and adulthood.

Children with severe FASD usually have distinctive facial and head features, such as

- Skin folds at the corner of the eyes
- A low nasal bridge
- A short nose
- An indistinct groove between the nose and upper lip
- A small head circumference
- A small eye opening
- A small midface
- A thin upper lip

RESEARCH HAS NOT FOUND *ANY* AMOUNT OF ALCOHOL TO BE SAFE DURING PREGNANCY.

FE 3A Guidelines for Graduate Panel Participants

Congratulations! Being invited to be on the Recovery Panel means that you are making progress in recovery and can help guide others. It is helpful for clients (and their family members) who are in the first months of treatment to hear your success story. This experience also may help you, by giving you an opportunity to tell your story and view your experience from a different perspective. Many people find that being a panel member gives them renewed confidence and assurance about themselves and their recovery.

You and three or four other participants will take turns sharing your treatment and recovery stories at a Family Education group session on _____ at _____ p.m. You will have about 10 minutes to speak. When you have finished sharing, group participants will have an opportunity to ask you questions. Please answer questions as directly as you can. If a question makes you feel uncomfortable, please feel free to tell the person asking the question that you're not comfortable answering.

When thinking about what you want to share with the group, use the questions below to help you organize your thoughts:

- What effects has your substance use disorder had on your life?
- How did you get involved in treatment?
- What feelings do you remember having during the first few weeks and months of treatment?
- What experiences, activities, and behaviors have been most helpful in recovery?
- What do you think you could have done differently?
- What role does AA/NA or other 12-Step or mutual-help group have in your life today?

Guidelines for Graduate Panel Participants

- If you have a 12-Step sponsor, how did you go about selecting that person?
- What do you wish you had known in the first few weeks and months of treatment?

Remember:

- Your story will be more powerful if you are open and honest about your feelings.
- You should avoid telling others what to do. They will learn best from hearing you relate your experiences and emotions.

Thank you for participating!

FE 3B Guidelines for Family Member Panel Participants

Congratulations! Being invited to be on the Recovery Panel means that your family is making good progress in recovery. It is helpful for clients and their family members who are in the first months of treatment to hear your success story. This experience also may help *you*, by giving you an opportunity to tell your story and view your experience from a different perspective. Many people find that being a panel member gives them renewed confidence and assurance about themselves and their recovery.

You and three or four other participants will take turns sharing your treatment and recovery stories at a Family Education group session on _____ at _____ p.m. You will have about 10 minutes to speak. When you have finished sharing, group participants will have an opportunity to ask you questions. Please answer questions as directly as you can. If a question makes you feel uncomfortable, please feel free to tell the person asking the question that you're not comfortable answering.

When thinking about what you want to share with the group, use the questions below to help you organize your thoughts:

- What effects has your family member's substance use disorder had on your life?
- What behaviors did you use to try to cope with your family member's use?
- What appeared to help during this time?
- What do you think you could have done differently?
- What feelings do you remember having during the first few weeks and months of your family member's treatment?

Guidelines for Family Member Panel Participants

- What experiences, activities, and behaviors have been most helpful in recovery?
- What role does Al-Anon/Alateen or other 12-Step or mutual-help group have in your life today?
- If you have a 12-Step sponsor, how did you go about selecting that person?
- What do you wish you had known in the first few weeks and months of your family member's treatment?

Remember:

- Your story will be more powerful if you are open and honest about your feelings.
- You should avoid telling others what to do. They will learn best from hearing you relate your experiences and emotions.

Thank you for participating!

FE 3C Guidelines for Recovery Panel Participants

Thank you for agreeing to participate on this Family Education Group Recovery Panel. It is helpful for our clients (and their significant others) who are in the first months of treatment to hear your success story.

You will have about 10 minutes to speak. When you have finished sharing, group participants will have an opportunity to ask you questions. Please answer questions as directly as you can. If a question makes you feel uncomfortable, please feel free to tell the person asking the question that you're not comfortable answering.

When thinking about what you want to share with the group, use the questions below to help you organize your thoughts:

- What effects has your substance use disorder had on your life?
- How did you get involved in treatment (or in AA/NA)?
- What feelings do you remember having during the first few weeks and months of recovery?
- What experiences, activities, and behaviors have been most helpful in recovery?
- What do you think you could have done differently?
- What role does AA/NA have in your life today?
- If you have a 12-Step sponsor, how did you go about selecting that person?
- What do you wish you had known in the first few weeks and months of your recovery?

Remember:

- Your story will be more powerful if you are open and honest about your feelings.
- You should avoid telling others what to do. They will learn best from hearing you relate your own experiences and emotions.

Thanks again.

FE 4A

Fact Sheet: Methamphetamine

What Is Methamphetamine?

Methamphetamine is a powerful stimulant drug that is manufactured from several chemicals.

Methamphetamine (meth) is known on the street as

- Ice
- Glass
- Crank
- Crystal
- Speed
- Chalk
- Tweak

How Many People Use Methamphetamine?

The number of people using meth more than doubled between 1994 and 2000.

The 2004 National Survey on Drug Use and Health estimated that 12 million people ages 12 and older had used meth at least once in their lifetime.

Some evidence shows that meth use has stabilized. The number of people using meth and the number of people trying it for the first time remained constant in 2002, 2003, and 2004. From 2002 to 2004, the average age of first use increased by more than 3 years, from 18.9 years to 22.1 years.

Who Uses Methamphetamine?

Although the overall rate of meth use may be going down, use remains a big problem and actually is increasing among certain populations. Once confined to certain areas of the country, like Hawaii and west coast cities, meth use has now spread throughout the country.

People who use meth have traditionally been Caucasian, male, blue-collar workers. Meth use soon spread to the party and club scene (raves, etc.).

Fact Sheet: Methamphetamine

Meth use is increasing among Hispanics and young people who are homeless.

Use among women also has increased. More women use meth than use cocaine or heroin; near-equal numbers of men and women now use the drug.

Meth is used increasingly in the workplace; it has long been used by long-haul truck drivers, but use is spreading on construction sites and in manufacturing. There also is more meth use among people in the entertainment, sales, retail, and legal professions.

What Are the Effects of Meth?

The immediate *psychological* effects of methamphetamine include

- Euphoria
- Alertness or wakefulness
- Feelings of increased strength and renewed energy
- Feelings of invulnerability (feeling that nothing bad can happen to you)
- Feelings of increased confidence and competence
- Intensified feelings of sexual desire
- Decreased feelings of boredom, loneliness, and shyness

The immediate *physical* effects of methamphetamine include

- Increased
  - Heart rate
  - Pupil size
  - Sensitivity to sound and stimulation
  - Blood pressure
  - Breathing rate
  - Body temperature

- Decreased
  - Appetite
  - Sleep
  - Reaction time

Chronic *psychological* effects ("chronic" means that these effects may begin later in a person's use cycle and last a long time) of meth use include

- Confusion
- Loss of ability to concentrate and organize information
- Loss of ability to feel pleasure without the drug
- Paranoia
- Insomnia and fatigue
- Mood swings
- Irritability and anger
- Depression
- Anxiety and panic disorder
- Reckless, unprotected sexual behavior
- Tactile hallucinations (the person feels as if things are crawling on him or her) or auditory hallucinations (the person hears things that aren't there)
- Severe depression that can lead to suicidal thoughts or attempts
- Episodes of sudden, violent behavior
- Severe memory loss that may be permanent

Fact Sheet: Methamphetamine

Chronic *physical* effects of use include

- Tremor (shakiness)
- Weakness
- Dry mouth
- Weight loss and malnutrition
- Increased sweating
- Oily skin
- Sores caused by oily skin and by the person picking at his or her skin, a common effect of meth use
- Headaches
- Severe problems with teeth and gums caused by teeth grinding, decreased blood flow to the mouth, and decreased saliva
- Seizures
- Damage to small blood vessels in the brain, which can lead to stroke
- Damaged brain cells
- Irregular heartbeat that can cause sudden death
- Heart attack or chronic heart problems, including the breaking down of the heart muscle
- Kidney failure
- Liver failure
- “Tweaking,” movements that a person can’t control that are repeated regularly
- Infected skin sores that can cause severe scarring

Fact Sheet: Methamphetamine

The ways in which a person can take meth create special problems.

Injecting meth can cause

- Blood clots
- Skin abscesses
- HIV, tuberculosis, or hepatitis C virus exposure from sharing needles and other works or from unprotected sex
- Heart inflammation
- Pneumonia
- Kidney failure

Snorting meth can cause

- Sinus infection
- Holes in the septum, the cartilage between nostrils
- Nosebleeds
- Hoarseness

Smoking meth can cause

- Throat problems
- Burned lips
- Lung congestion
- Severe coughing with black mucus
- Chronic lung disease

What About Using Meth During Pregnancy?

A woman who uses meth while she is pregnant may harm her fetus.

Fetuses of mothers who use meth are at higher risk of having a stroke or brain hemorrhage, often causing death, before delivery. Meth use during pregnancy also can cause premature birth.

Fetuses also may be exposed to HIV or hepatitis if the mother is infected with these viruses.

Babies of mothers who used meth during pregnancy may have

- Abnormal reflexes
- Extreme irritability
- Trouble eating and digesting food

In What Other Ways Can Children Be Affected by Meth?

Meth labs are sometimes located in homes with children. Meth labs are dangerous places for children *and* adults for many reasons:

- Fires, explosions, chemical spills, and toxic fumes are common.
- The chemicals used to make meth give off fumes that are strong enough to burn lungs; can damage the brain, kidneys, or liver; and even can be fatal.

In 2001, 700 children who were present in meth labs tested positive for toxic chemicals.

What Other Problems Do Meth Labs Cause?

Toxic fumes released from the chemicals used to make meth go into the walls and carpets and remain there for a very long time, putting everyone in the house at risk. Even people moving into a home that once housed a meth lab are at risk.

Making meth creates solid waste; for every pound of meth produced, 5 to 6 pounds of toxic waste are created and are usually dumped on the ground, dumped into local waterways, or flushed into sewer or septic systems, contaminating the surrounding area.

FE 4B

Fact Sheet: Cocaine

What Is Cocaine?

Cocaine is a powerful stimulant drug made from the leaves of the coca plant. Powdered cocaine (cocaine hydrochloride, a salt) is known on the street as

- Coke
- Snow
- Flake
- Blow

Crack cocaine is cocaine that has been processed from cocaine hydrochloride into a rock crystal form that can be smoked. It gets its name from the cracking sound it makes when heated.

Crack is sometimes called “rock” or “freebase.”

How Many People Use Cocaine?

The 2004 National Survey on Drug Use and Health estimated that nearly 34 million Americans have used cocaine at some time in their lives.

The same survey estimated the following:

- About 2 million people in the United States currently use cocaine.
- Some 2.5 percent of young people ages 12 to 17 reported that they had used cocaine at least one time.
- Among young adults ages 18 to 25, 16 percent reported using cocaine at least one time.

Who Uses Cocaine?

Adults 18 to 25 years old have a higher rate of current cocaine use than those in any other age group. Overall, men have a higher rate of current cocaine use than do women.

Fact Sheet: Cocaine

What Are the Effects of Cocaine?

The immediate *psychological* effects of cocaine are similar to those of meth and include

- Euphoria
- Increased energy
- Increased talkativeness
- Increased sensitivity to sensations of sight, sound, and touch
- Increased mental alertness
- Increased confidence
- Increased feelings of sexual desire

The immediate *physical* effects of cocaine include

- Constricted blood vessels
- Dilated pupils
- Increased heart rate
- Increased temperature
- Increased blood pressure
- Decreased appetite
- Decreased sleep

In rare instances, sudden death can occur with cocaine use, even the first time someone uses the drug.

Drinking alcohol with cocaine increases this risk. The liver combines cocaine and alcohol and manufactures a third substance, cocaethylene. Cocaethylene intensifies cocaine's euphoric effects while increasing the risk of sudden death.

Chronic *psychological* effects of cocaine use include

- Irritability
- Depression
- Increasing restlessness
- Paranoia
- Paranoid psychosis with auditory hallucinations

Fact Sheet: Cocaine

- Bizarre and/or violent behavior (with high doses)
- Damaged ability to feel pleasure without the drug
- Exposure to HIV or the hepatitis C virus through reckless, unprotected sex

Chronic *physical* effects of cocaine use include

- Disturbances in heart rhythm
- Heart attacks
- Chest pain
- Bronchitis and pneumonia
- Respiratory failure
- Strokes
- Seizures
- Headaches

In addition, loss of appetite over time can lead to significant weight loss and malnutrition. As with meth, the way in which cocaine is used may cause particular problems. People who regularly *inject* cocaine may experience

- Abscesses (infected sores) at injection sites
- Serious allergic reactions
- Exposure to HIV and hepatitis C virus

Regularly *snorting* cocaine can lead to

- Loss of sense of smell
- Problems with swallowing
- Overall irritation of the nasal septum leading to a chronically inflamed, runny nose

- Nosebleeds
- Hoarseness
- Holes in the septum, the cartilage between nostrils

Smoking crack cocaine can lead to the same problems as smoking meth:

- Throat problems
- Burned lips
- Lung congestion
- Severe coughing
- Chronic lung disease

What About Using Cocaine During Pregnancy?

Babies born to mothers who used cocaine during pregnancy may

- Be born prematurely
- Have low birth weights
- Have smaller heads
- Be shorter in length

Babies also may be exposed to HIV or hepatitis if the mother is infected with these viruses.

Fetal cocaine exposure does not seem to cause as serious and long-lasting problems as was once thought.

However, as cocaine-exposed children grow up, they may have subtle, yet significant, problems later in life in areas that are important for success in school, such as

- Paying attention to tasks
- Learning new information
- Thinking things through

FE 5A

Daily/Hourly Schedule

Date:

7:00 AM

8:00 AM

9:00 AM

10:00 AM

11:00 AM

12:00 PM

1:00 PM

2:00 PM

3:00 PM

4:00 PM

5:00 PM

6:00 PM

7:00 PM

8:00 PM

9:00 PM

10:00 PM

11:00 PM

How many hours will you sleep? _____

From _____ To _____

Notes:

Reminders:

FE 5B Relapse Justifications

Once people decide not to use drugs anymore, how do they end up using again? Do relapses happen completely by accident? Or are there warning signs and ways to avoid relapse?

Relapse justification is a process that happens in people's minds. A person may have decided to stop using, but the person's brain is still healing and still feels the need for the substances. The addicted brain invents excuses that allow the person in recovery to edge close enough to relapse situations that accidents can and do happen.

It is important that people in recovery and their family members learn to identify relapse justifications quickly. Review this handout for examples that may help you recognize a justification for what it is.

Other People Made Me Do It

- My wife used so . . .
- I was doing fine until he brought home . . .
- I went to the beach with my sister and . . .
- My brother came over for dinner and brought some . . .
- I wanted to see my friend just once more, and he offered me some . . .

I Needed It for a Specific Purpose

- I was getting fat again and needed to control my weight, so I . . .
- I couldn't get the energy I needed without . . .
- I can't have fun without . . .
- Life is too boring without . . .
- I can't be comfortable in social situations or meet people without . . .

FE 5B Relapse Justifications

I Was Testing Myself

- I wanted to see whether it would “work better” now that I’ve been clean awhile.
- I wanted to see my friends again, and I’m stronger now.
- I needed a little money and thought I could sell a little without using.
- I wanted to see whether I could use just a little and no more.
- I wanted to see whether I could be around it and say no.
- I thought I could drink without using . . .

It Wasn’t My Fault

- It was right before my period, and I was depressed.
- I had an argument with my spouse.
- My parents were bugging me.
- My partner was intimate with another person.
- The weather was gloomy.
- I was only going to take a hit and . . .

It Was an Accident

- I was in a bar, and someone offered me some meth.
- I was at work, and someone offered . . .
- I found some in my car.
- I went to a movie about . . .
- A friend called to see how I was doing. We were talking and decided to get together.

FE 5B Relapse Justifications

I Felt Bad

- Life is so boring I may as well use.
- I was feeling depressed so . . .
- My job wasn’t going well, and I was frustrated so . . .
- I was feeling sorry for myself, so I . . .
- Recovery is just too hard.

FE 6A Coping With the Possibility of Relapse

For the Person in Recovery

The possibility of relapse is a reality of recovery, and it is normal for both people in recovery and family members to fear it. Some people would rather not think about the possibility. However, considering how you and your family would handle a relapse can prepare you to cope with it and can minimize both the duration of the relapse and its effect on your family.

Think about each question below, and answer it as honestly as you can. These questions are to guide the group's discussion; we will not see your answers unless you want us to. However, when group members share their thoughts with one another, all members hear new ideas and insights and feel supported and less alone.

What are your biggest fears about a relapse?

_____

_____

If a relapse occurs, what feelings do you think you might experience?

_____

_____

If you experience a relapse, what could your family members do or say that would help you get back on track quickly?

_____

_____

What steps are you taking to avoid a relapse?

_____

_____

FE 6B Coping With the Possibility of Relapse

For Family Members of the Person in Recovery

The possibility of relapse is a reality of recovery, and it is normal for both people in recovery and family members to fear it. Some people would rather not think about the possibility. However, considering how you and your family would handle a relapse can prepare you to cope with it and can minimize both the duration of the relapse and its effect on your family.

Think about each question below, and answer it as honestly as you can. These questions are to guide the group's discussion; we will not see your answers unless you want us to. However, when group members share their thoughts with one another, all members can hear new ideas and insights and feel supported and less alone.

What are your biggest fears about a relapse?

_____

_____

If a relapse occurs, what feelings do you think you might experience?

_____

_____

If your family member has relapsed in the past, what did you do to try to cope with the situation?

_____

_____

What helped you the most? (If your family member has not experienced a relapse, what do you *think* would help you cope?)

_____

_____

FE 6C Family Members and Recovery

Things to remember:

- You are participating in treatment for **yourself**, not just for the sake of the person who used substances.
- Your loved one's recovery, sobriety, or abstinence does not depend on you.
- Your family's recovery does not depend on the recovery of the person who used substances.
- You did not cause your family member's substance use disorder. It is not your fault.
- Relapse does happen, but people *do* get back into recovery.
- You can support your family member in recovery, but you are not responsible for maintaining his or her recovery. The person in recovery is responsible for recognizing relapse warning signs and making necessary adjustments.
- Although it is important that you support your family member in recovery, it is equally important that you take good care of yourself, emotionally and physically.
- If your family member relapses, it is especially important that you continue to take care of yourself. Listed below are some ways to do this:
  - Continue to attend 12-Step or mutual-help group meetings.
  - Talk to your family member in recovery about your feelings and concerns.
  - Exercise regularly.
  - Eat well.
  - Get enough sleep.
  - Talk to supportive friends and relatives.
  - Visit your church, mosque, synagogue, temple, or other spiritual organization for support.
  - Continue to participate in leisure and social activities or hobbies you enjoy.
  - Seek counseling for yourself if you feel it could help your personal growth.

FE 7A

Fact Sheet: Opioids

What Are Opioids?

- Opioids are a group of drugs that act on the opiate receptors in the brain.
- There are natural opioids that come from poppy plants (e.g., morphine and heroin) and synthetic opioids (e.g., oxycodone and meperidine). Both kinds of opioids have similar effects.

What Effects Do Opioids Have?

- The physical signs of opioid use are constricted pupils, flushed skin, and a heavy feeling in the limbs. People on heroin are said to be “nodding” because they look sleepy.
- After the euphoric rush of opioid use, there is a drowsy state. Breathing and heart rate slow. Headaches and dizziness are common.

What Is Opioid Tolerance?

- As people continue to use opioids, they need larger and larger doses to get high. This is called “tolerance.”
- Eventually, a person’s tolerance for opioids means that the drug is taken mainly to prevent withdrawal, not to get high.

What Is Opioid Dependence? What Is Opioid Addiction?

- People who take opioids that have been prescribed rarely become addicted.
- With long-term use, though, people who take medication as prescribed can become dependent on opioids.

Fact Sheet: Opioids

- People who are dependent on opioid pain medication must stop taking it gradually or they will go through withdrawal.
- Addiction means that a person is physically dependent on opioids but also has a compulsive urge to take the drug, even if it is harmful.

What Is Opioid Withdrawal?

- Withdrawal happens when a person who is physically dependent on or addicted to an opioid stops taking the drug suddenly.
- Symptoms of withdrawal include restlessness, severe muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes, and goose bumps (going "cold turkey").
- Withdrawal can take up to a week to run its course.

What Are Prescription Opioids?

- The main prescription opioids are codeine, oxycodone (OxyContin®, Percodan®, Percocet®, Tylox®), hydrocodone (Vicodin®), meperidine (Demerol®), and hydromorphone (Dilaudid®).

Who Abuses OxyContin?

- In 2003, nearly 3 million people older than 12 years abused OxyContin, the most potent prescription opioid available.
- Most of those who abuse OxyContin are older than 30, but 5 percent of high school seniors say they have used it.
- To obtain OxyContin, people pretend to be in pain, forge prescriptions, and rob pharmacies.

Fact Sheet: Opioids

What Are the Dangers of OxyContin Abuse?

- People crush the tablets and then eat, snort, or inject (after mixing with water) the substance. When OxyContin is taken in this form, the risk of dangerously slow breathing, heart attack, and overdose is increased.
- Injecting a mixture of crushed tablets and water exposes the person to diseases such as hepatitis and HIV/AIDS that are linked with dirty needles.
- OxyContin is highly addictive when it is abused.

What Is Heroin?

- Heroin is powerful narcotic pain reliever made from morphine, which comes from poppy plants.
- Pure heroin is a white powder. Heroin purchased on the street varies in color from white to dark brown and usually is mixed with other substances such as sugar, powdered milk, starch, or poisons such as strychnine.
- Heroin is known by many street names, including smack, horse, big H, junk, dope, skag, and poison.

Fact Sheet: Opioids

Who Uses Heroin?

- Some 1.6 percent of people 12 years and older have used heroin. More than 3.1 percent of high school students have used heroin.
- Most people who use heroin are Caucasian males older than 30 who live in cities or towns. But the age at which people start using heroin dropped from the middle twenties in 1990 to the early twenties in 2000.

What Are the Dangers of Using Heroin?

- Because the purity of heroin varies, accidental overdose is a real danger.
- Heroin is connected with 15 percent of all visits to emergency rooms in the United States.
- Most people who regularly use heroin inject it. Injection drug use is a factor in one-third of all HIV cases and more than one-half of all hepatitis C cases in the United States.
- Injecting heroin can cause collapsed veins, clogged blood vessels, bacterial infections of the heart and blood vessels, pneumonia, tuberculosis, and liver or kidney disease.

FE 7B

Fact Sheet: Club Drugs

What Are Club Drugs and Who Uses Them?

- Club drugs include substances such as GHB, Rohypnol, ketamine, LSD, and ecstasy that are often used at parties or dance clubs. Many people wrongly assume that these drugs are safe.
- Most people who use club drugs are younger than 30 and Caucasian. High school and college students show highest levels of use.

What Is GHB?

- GHB was once used as anesthetic. It produces euphoria and hallucinations.
- Now, GHB is banned and is manufactured in illegal labs.
- At clubs, GHB often is sold in liquid form from a water or sports drink bottle, by the capful.
- GHB is known by the street names liquid ecstasy, soap, easy lay, vita-G, and Georgia home boy.

Who Uses GHB?

- Some 2 percent of high school seniors used GHB at least once in 2004.

What Are the Effects of GHB?

- At low doses, people experience loss of balance and coordination and lowered breathing and heart rate.
- At higher doses, GHB can cause comas. Since 1990, 70 people have died from GHB overdoses.

Fact Sheet: Club Drugs

What Is Rohypnol?

- Rohypnol is the trade name of a drug that is legal in Mexico and Europe, where it is used to treat people who have trouble sleeping. Rohypnol has never been legal in the United States.
- Rohypnol tablets often are sold in their original packaging, which can make people think the drug is legal.
- Rohypnol is a depressant like Halcyon, Xanax, and Valium, but it is many times stronger.
- Rohypnol is known by the street names roofies, rophies, roche, rope, and the forget-me pill.

Who Uses Rohypnol?

- About 1.6 percent of high school seniors used Rohypnol at least once in 2004.
- Rohypnol is popular with youth because it is cheaper than other club drugs.

What Are the Effects of Rohypnol?

- The first effects of Rohypnol are relaxed muscles and drowsiness. Later effects include decreased blood pressure, slurred speech, impaired judgment, and difficulty walking.
- Rohypnol can cause headaches, nightmares, tremors, muscle pain, digestive problems, aggressive behavior, and blackouts that can last 24 hours.

FE 7B

Fact Sheet: Club Drugs

What Is Ketamine?

- Ketamine is an anesthetic first used on battlefields because of its fast action; today it is used almost exclusively by veterinarians. Veterinary clinics are robbed specifically for ketamine.
- Ketamine is known by the street names special K, vitamin K, kit kat, super acid, and jet.

Who Uses Ketamine?

- About 1.9 percent of high school seniors used ketamine at least once in 2004.

What Are the Effects of Ketamine?

- At low doses, ketamine causes slurred speech, increased heart rate and blood pressure, impaired coordination, muscle stiffness, vomiting, and convulsions.
- High doses of ketamine can lead to a near total shutdown of a person's senses. This experience is known as the K-hole.
- At high doses, ketamine can cause heart attack, stroke, coma, and death.

What Are "Date Rape Drugs"?

- Date rape drugs are drugs such as GHB, Rohypnol, and ketamine that can make people confused and helpless, leaving them vulnerable to crime, especially rape.

- Because Rohypnol impairs memory, people may not remember what happens to them after they take it.
- Newer Rohypnol tablets turn blue in a drink to increase visibility and decrease its use as a date rape drug.

What Is LSD?

- LSD is a powerful mood- and perception-altering drug.
- LSD alters people's moods and how they perceive the world; it can cause powerful hallucinations.
- LSD is known by the street names acid, blotter acid, battery acid, window pane, microdot, sunshine, and zen.

Who Uses LSD?

- Some 10 percent of people 12 and older have tried LSD; 0.2 percent used LSD at least once in 2003.
- In 2004, 2.2 percent of high school seniors reported using LSD at least once.

What Are the Effects of LSD?

- At low doses, LSD produces rapid emotional swings and heightened sensations.
- At high doses, LSD induces distortions of perception: shapes change, time slows down, and sensations seem to blend.
- LSD hallucinations can cause confusion, panic, and fear.

Fact Sheet: Club Drugs

- One of the most dangerous aspects of LSD is that it is unpredictable. Its effects depend on the dose, the mood of the person taking it, and the environment in which it's taken.
- People who are experiencing LSD hallucinations have had fatal accidents.
- People who use LSD regularly are prone to flashbacks in which they suddenly experience hallucinations without having taken the drug.
- LSD may contribute to serious mental illness, such as long-term depression or schizophrenia.

What Is Ecstasy (MDMA)?

- Pure ecstasy is a white powder, but it can be combined with other drugs or substances before it is sold, usually in pill form.
- Ecstasy is the drug's main street name, but it is also known as XTC, X, E, Adam, clarity, hug drug, and love drug.
- Because ecstasy increases feelings of well-being and tolerance for others, many people mistakenly consider it a harmless drug.

Who Uses Ecstasy?

- Nearly 5 percent of people 12 and older have tried ecstasy; 1 percent used it at least once in 2003.
- About 4 percent of high school seniors used ecstasy at least once in 2004; this number appears to be decreasing.

Fact Sheet: Club Drugs

What Are the Effects of Ecstasy?

- Ecstasy can raise the body temperature to dangerous levels (as high as 109 degrees); these high fevers lead to dehydration, which has killed people on ecstasy.
- Because dehydration is a known risk, people who have taken ecstasy sometimes drink too much water, which can lead to a dangerous and potentially fatal condition called hyponatremia.
- Ecstasy is neurotoxic—it kills nerve cells in the brain. Studies in rats and monkeys have shown that even a few doses of ecstasy cause damage that is not repaired 7 years later.

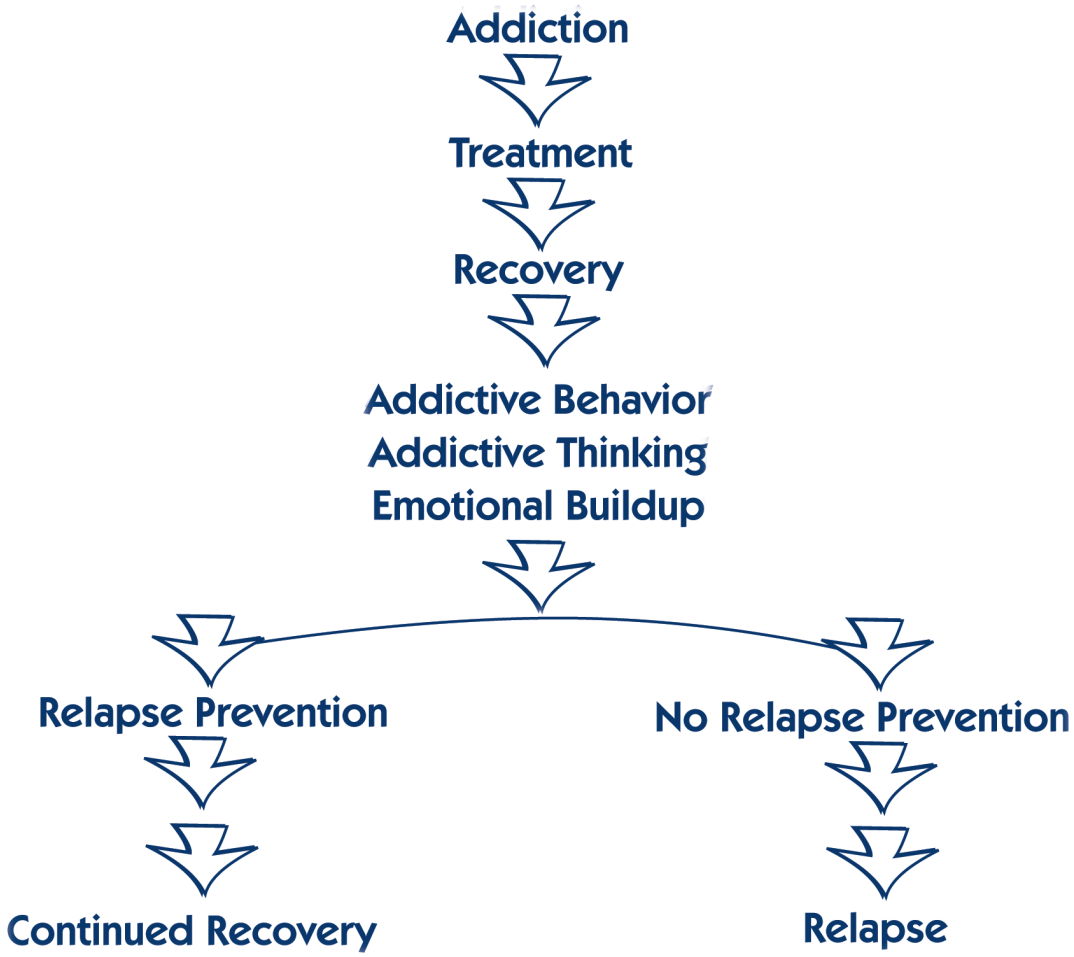
FE 8A Anticipating and Preventing Relapse

Why Is Relapse Prevention Important?

Recovery is more than not using drugs and alcohol. The first step in treatment is stopping drug and alcohol use. The next step is not starting again. This is very important. The process for doing it is called *relapse prevention*.

What Is Relapse?

Relapse means going back to substance use and to all the behaviors that come with it. Often the behaviors return before the substance use. The behaviors can be an early warning of relapse. Learning to recognize the beginning of a relapse can help people in recovery stop the process before they start using again.



FE 8A Anticipating and Preventing Relapse

What Are Addictive Behaviors?

The things people do as part of abusing drugs or alcohol are called addictive behaviors. Often these are things that people who are addicted do to get drugs or alcohol, to cover up substance abuse, or as part of abusing. Lying, stealing, being unreliable, and acting compulsively are types of addictive behaviors. When these behaviors reappear, people in recovery should be alerted that relapse will soon follow if they do not take action.

What Is Addictive Thinking?

Addictive thinking means having thoughts that make substance use seem OK. (In 12-Step programs this is known as "stinking thinking.") Some examples of addictive thinking by a person in recovery are the following:

- I can handle just one drink.
- If they think I'm using, I might as well.
- I have worked hard. I need a break.

What Is Emotional Buildup?

Feelings that don't seem to go away and just keep getting stronger cause emotional buildup. Sometimes the feelings seem unbearable. Some feelings that can build during recovery are boredom, anxiety, sexual frustration, irritability, and depression.

Take Action

The important step is to *take action* as soon as danger signs appear. Families can help the person in recovery in two ways. First, they can look out for danger signs. Second, they can provide support when their loved one takes the following actions:

- Calling a counselor
- Calling a friend

Anticipating and Preventing Relapse

- Going to a 12-Step or mutual-help support meeting
- Contacting a 12-Step sponsor
- Meditating or praying
- Exercising
- Taking a day off
- Talking with the family
- Scheduling time more rigorously
- Taking time to write about feelings during recovery

FE 8B

Relapse Justifications

Once people decide not to use drugs anymore, how do they end up using again? Do relapses happen completely by accident? Or are there warning signs and ways to avoid relapse?

Relapse justification is a process that happens in people's minds. People may have decided to stop using, but their brains are still healing and still feel the need for the substances. Addicted brains invent excuses that allow people in recovery to edge close enough to relapse situations that accidents can happen. Clients may remember times when they intended to stay substance free but invented justifications for using. Then, before they knew it, they had used again. Family members or loved ones can probably recall times when they resolved to change their behavior (e.g., stop eating desserts or stop swearing) but then thought of reasons why it was OK to go back on their resolution.

Looking at the examples below will help family members understand the types of justifications invented by the addicted brain of a person in recovery. If family members notice these justifications, a relapse may not be far behind.

Someone Else's Fault

Addicted brains can convince people in recovery that they have no choice but to use. These justifications might sound like the following:

- An old friend called, and we decided to get together.
- My partner started using again.
- I had friends come for dinner, and they brought me some wine.
- I was in a bar, and someone offered me a beer.

FE 8B Relapse Justifications

Catastrophic Events

Sometimes, people in recovery have one unlikely major event that they feel will give them an excuse to use. This is a kind of safety hatch, reserved for emergencies. These justifications may take the following forms:

- My spouse left me. There's no reason to stay clean.
- I just got injured. It's ruined all of my plans. I might as well use.
- I just lost my job. Why not use?
- There was a death in the family. I can't get through this without using.

For a Specific Purpose

Sometimes people in recovery convince themselves that using drugs or alcohol is the only way to accomplish something. Here are examples of this type of relapse justification:

- I'm gaining weight and need stimulants to control my weight.
- I'm out of energy. I'll function better if I use.
- I need drugs to meet people more easily.
- I can't enjoy sex without using.

Depression, Anger, Loneliness, and Fear

Feeling depressed, angry, lonely, or afraid can make using seem like a good idea. Here are examples of how emotions can be used as justifications for using:

- I'm depressed. What difference does it make whether I use?
- When I get mad enough, I can't control what I do.

Relapse Justifications

- I'm scared. I know if I use, the feeling will go away.
- If my partner thinks I've used, I might as well use.

Substance Dependence Is Cured

People in recovery sometimes convince themselves that they could use just once or use just a little. These justifications might sound like the following:

- I'm back in control. I'll be able to stop when I want to.
- I've learned my lesson. I'll only use small amounts and only once in a while.
- This substance was not my problem—stimulants were. So I can use this and not relapse.

Testing Yourself

It's very easy to forget that being smart, not being strong, is the key to staying abstinent. When people in recovery forget to be smart, they sometimes try to prove that they are stronger than drugs. They justify this decision with the following thoughts:

- I'm strong enough to be around it now.
- I want to see whether I can say "no" to drinking and using.
- I want to see whether I can be around my old friends.
- I want to see how the high feels now that I've stopped using.

FE 8B

Relapse Justifications

Celebrating

On special occasions, people often think it is OK to make an exception to abstinence. They feel that the regular guidelines for recovery can be suspended for a time. Beware of the following relapse justifications:

- I'm feeling pretty good. One time won't hurt.
- We're on vacation. I'll go back to not using when we get home.
- I'm doing so well. Things are going great. I owe myself a reward.
- This is such a special event that I want to celebrate.

As a family member or loved one of a person in recovery, what might you do when you recognize these excuses to use?

FE 8C

Avoiding Relapse Drift

How Relapse Happens

Relapse does not happen without warning, and it does not happen quickly. The gradual movement from abstinence to relapse can be subtle and easily explained away or denied. So a relapse often feels to a person in recovery as if it happens suddenly. This slow movement away from abstinence can be compared to a ship gradually drifting away from where it was moored.

Interrupting Relapse Drift

During recovery people do specific things that keep them abstinent. These activities can be called “mooring lines.” People in recovery and their families and loved ones need to understand what activities support abstinence. People in recovery need to identify these mooring lines in a specific way so they are clear and measurable. These activities are the “ropes” that hold recovery in place and prevent relapse drift from happening without being noticed.

Maintaining Recovery

Following these guidelines will help keep people from drifting out of their recovery and into relapse. Family members and loved ones should understand the process of relapse drift and how the person in recovery can prevent it. The person in recovery should do the following:

- Identify and list four or five *specific* things that help maintain abstinence (e.g., working out for 20 minutes, 3 times a week).
    - Include items such as exercise, writing in a diary, therapist and group appointments, scheduling activities, 12-Step meetings, and eating patterns.
    - Do not list attitudes. They are not as easy to measure as behaviors.

Avoiding Relapse Drift

- Note specific people or places that are known triggers and need to be avoided.
- Inform family members of the activities and behaviors that serve as mooring lines.

Sometimes events interfere with mooring lines. Emergencies and illnesses cannot be controlled. The mooring lines disappear. Many people relapse during these times. The more people know about what keeps their recovery strong, the stronger they will be during difficult times. Family members can help support the person in recovery by being alert to signs of relapse drift. They also can be sure that they are helping the person in recovery keep the mooring lines in place.

FE 9

Rebuilding Trust

Most people who use substances hide their behavior from those they care about. Deceiving family members is part of their substance use. When this deception comes to light, it erodes the family's trust. People who use substances often have difficulty being honest, especially in their most important relationships. They say and do things that destroy trust and damage relationships.

Spouses, family members, and friends who are affected by the substance use can contribute to the problem. Acting out of fear and anger, they can say and do things that erode the trust in the relationship even further. Two things may help family members begin to rebuild trust. First, it may help them to know what the person in recovery is experiencing. Second, it may help them to learn that addiction is a chronic medical condition, like diabetes.

The first step in restoring trust to a relationship is for people in recovery to stop using drugs and stay abstinent. But trust does not immediately return to a relationship because people in recovery are abstinent. Even if all the people involved want the situation to get better, trust is a feeling that cannot be demanded or willed. People in recovery must provide consistent evidence that they deserve the trust of family members again. Trust usually returns. But people in recovery and family members must be willing to talk openly about the hurt that was done and work together to return to a trusting relationship.

Has trust in your relationship been damaged by stimulant use? How?

_____

_____

_____

_____

_____

_____

FE 9

Rebuilding Trust

In addition to staying abstinent, what can the person in recovery do to reestablish trust?

What can family members contribute to the process of rebuilding a trusting relationship?

What steps has your family taken to reestablish trust? What steps have been effective? How can you build on those successful efforts?

Rebuilding trust can be frustrating for both people in recovery and their families. Take a minute to imagine the other person's struggle. Family members, imagine that you have worked hard to quit using drugs and change your life and still do not have the full trust of those closest to you. People in recovery, imagine what it feels like to be deceived and have your trusting relationship damaged.

FE 10

Fact Sheet: Marijuana

Who Uses Marijuana?

- Marijuana is the most widely used illegal drug. Each year more than 1 out of 10 Americans ages 12 and older use marijuana.
- Each year 2.6 million people try marijuana for the first time. Two-thirds of those people are younger than 18.
- More young people get treatment for marijuana use than for all other illegal drugs combined.
- Two out of every five Americans have tried marijuana.

What Is Marijuana?

- Marijuana is dried parts of the Cannabis sativa plant that are usually smoked.
- Marijuana is known as pot, weed, bud, ganja, grass, and chronic, among other names.
- Marijuana cigarettes are called joints.
- Pipes are known as bongs.
- Marijuana cigars are called blunts.
- Marijuana (except for medical uses) has been illegal since 1937.

What Is Medical Marijuana?

- Marijuana has been used to treat pain and nausea, as well as vision loss due to glaucoma.
- In 1985, the U.S. Food and Drug Administration approved Marinol, a medication that contains marijuana's active ingredient.

- Marinol treats the nausea of cancer chemotherapy and the weight loss of AIDS. Marinol is available only by prescription.

What Short-Term Effects Does Marijuana Have?

- THC is the ingredient that produces the marijuana high.
- The high includes a relaxed, euphoric feeling.
- THC can cause
  - Impaired short-term memory
  - Poor coordination
  - Increased heart rate
  - Disorientation
  - Confusion
- The high fades after 1 to 3 hours. Then people may feel sleepy, depressed, or anxious.
- People who use marijuana are more likely to
  - Use heroin and cocaine
  - Become addicted to other drugs
  - Be unemployed
  - Get arrested
  - Develop cancer

What Long-Term Effects Does Marijuana Have?

- Marijuana makes it harder to learn and remember things:
  - Students who use marijuana get lower grades than students who don't use.
  - Workers who use marijuana have more problems at work than those who don't use.

Fact Sheet: Marijuana

- Smoking marijuana damages the lungs and can cause
  - Frequent chest colds, bronchitis, and emphysema
  - Lung cancer
- THC makes it harder for the body's immune system to fight infection and disease.

How Does Marijuana Affect Driving?

- Even low doses of marijuana reduce driving ability. Adding alcohol makes things worse.
- Reaction time and coordination are affected even after people stop feeling high.
- Seven percent of all fatal crashes involve marijuana.

What About Using Marijuana During Pregnancy?

- A pregnant woman who smokes marijuana can have a baby with
  - Low birth weight
  - Brain and nerve problems
- Later in life, children exposed to THC during pregnancy can have
  - Trouble learning
  - Trouble making decisions

Is Marijuana Addictive?

- Long-term marijuana use can lead to addiction.
- People are addicted if they keep using marijuana even though it damages their lives.

- Withdrawal can include
  - Cravings for marijuana
  - Anxiety
  - Crankiness
  - Trouble sleeping

How Does Marijuana Affect Recovery?

- People who are heavy users of marijuana are more likely to drink heavily and use illicit drugs.
- Marijuana use increases the risk of relapse to meth use.
- People often use marijuana to avoid personal or family problems.

FE 11

Living With an Addiction

Making a commitment to recovery requires recognizing and accepting certain realities. Recovery brings all sorts of questions: What happens after the drug and alcohol use stops? Does life eventually go back to normal? Can a person in recovery lead the same lifestyle as a person who has never been addicted? Think about the following principles and how each is relevant to your family relationships, and then answer the questions below:

1. People in recovery need to learn their limits and relapse signals.
2. A person in recovery needs to respond immediately to relapse signals. Family members must understand that avoiding relapse often may take priority over family relationships and plans but that avoiding relapse is in everyone's best interest.
3. A person in recovery has to maintain a balanced lifestyle, more so than if there had been no addiction.
4. Recovery is a process, and all aspects of it, including reestablishing trust, may occur slowly.
5. It is often difficult for family members to live without a guarantee that a relapse will not occur.

In what ways do these principles apply to *your* family situation?

_____

_____

_____

_____

_____

_____

FE 11 Living With an Addiction

Which principles are (or, in your opinion, will be) most difficult for you to accept?

What problems have you experienced so far in your family relationships during recovery?

If you are a family member of a person in recovery, what could help you live with the reality that your family member is in recovery?

If you are a person in recovery, what do you need your spouse, partner, or family member to understand about the limits an addiction puts on your life?

FE 12A

Communication Traps

Why are words so important? What difference does it make how something is said? How is it possible that the listener receives a different message than the speaker intended?

People in families coping with substance use disorders often feel guilty, angry, hurt, and defensive. These feelings can affect seriously the way family members communicate with one another. Negative patterns of interacting often become automatic. Changing these patterns can be difficult for family members. Admitting mistakes, taking responsibility for one's feelings, and being honest with one another can be scary steps to take. However, understanding that positive communication involves skills that can be *learned* is an important first step in improving family relationships.

To learn new ways of talking to other family members and to avoid blaming and arguing, consider the following communication issues. Listen to yourself when you are talking to determine whether you are falling into any of these communication traps.

1. Are You Assuming?

If you believe something to be true without having all the facts, be sure to ask for more information before you react.

2. Are You Hinting?

Ask clearly for what you want or need, and try to accept that your request may not be granted.

3. Are You Giving Double Messages?

Know that facial expressions or body language often convey a message that differs from the speaker's words. Be aware of your own and others' nonverbal cues.

4. Can You Admit a Mistake?

Accept that being understood is more important than being right. Begin to understand each other; do not resort to a power struggle.

Communication Traps

5. Do You Use "I" Statements?

Be aware that the tendency to blame and to argue can be stopped if both parties speak clearly from their own experiences and feelings. Begin sentences with "I," and follow it with descriptions of your own feelings to avoid blaming and arguing with family members.

Paying attention to these issues helps families improve their communication. Clear, positive interactions allow people to increase self-esteem and confidence and pave the road to committed, trusting relationships. Recovery from substance use disorders is a difficult process for both people in recovery and their family members. Positive and trusting family relationships support *everyone* in the recovery process.

FE 12B Improving Communication

When communicating with family members:

Be Polite

Use the same courteous words and tone you would use with a stranger or a coworker. Be aware that “please” and “thank you” can go a long way toward improving family relationships.

Express Positive Feelings

Let other people know what you like about them and the things that they have done. Focus on successes as much as on things that are not going well.

Determine the Importance of an Issue Before Complaining

Ask yourself whether something is worth complaining about. Complain only about things that matter.

Choose an Appropriate Time

Choose settings and times that are conducive to a positive discussion. Don’t bring something up when either of you is angry or doesn’t have the time to discuss it.

Have a Goal in Mind

Ask yourself, “What am I trying to achieve? What am I looking for? Why do I want these changes? Are they reasonable and achievable?”

Be Specific About Your Complaints

Focus on one thing at a time. Have a specific example of the problem. Be prepared to tell family members precisely what you would like them to do differently. Stay focused, avoid saying “You always…,” and don’t bring up other problems.

FE 12B Improving Communication

Request Changes Positively

In a positive way, tell people what is bothering you and what you would like changed. Avoid criticisms, put-downs, and assumptions about motives.

Use "I" Statements

Be aware that saying "I get worried if you don't call when you'll be late" leads to a calmer discussion than the statement "You never call when you're late; you're so inconsiderate."

Compromise

Be prepared to discuss solutions that can work for both of you. Don't declare ultimatums or dismiss the other person's ideas.

Do Something Nice

Work on your family relationships and help improve communication by doing something nice for other family members. Without being asked or without a special reason, do something that a family member would like or find special. Do it without expecting something in return.

FE 12C

Contract:
Commitment To Practice Communication Skills

Making a formal commitment to practice communication skills can help you fulfill your good intentions. To avoid overwhelming yourself, choose only one new skill to work on at this time.

Fill out this contract, sign it, and keep it somewhere handy. You may want to share it with other family members and ask for their support, or you may want to keep it to yourself, at least for a while. Either way, refer back to the contract from time to time to renew your commitment.

I, _____, commit to practicing the following communication skill for 1 week:

_____

Signature: _____ Date: _____

Once you have practiced this new skill for a while and are feeling comfortable with it, you may want to choose a new skill to work on.

Communication Skill: _____

Communication Skill: _____

Appendix A. The Methamphetamine Treatment Project

Overview

Conducted over 18 months between 1999 and 2001, the Methamphetamine Treatment Project (MTP) is (to date) the largest randomized clinical trial of treatment approaches for methamphetamine dependence; 978 individuals participated in the study (Rawson et al. 2004). MTP researchers randomly assigned participants at each treatment site into either the Matrix model treatment or the program's treatment as usual (TAU). The study design did not standardize TAU across sites, so each program offered different outpatient treatment models (including lengths of treatment ranging from 4 to 16 weeks).

All TAU models, along with the Matrix model, either required or recommended that participants attend 12-Step or mutual-help groups during their treatment, and all treatment models encouraged participation in continuing care activities after primary treatment.

The characteristics of a cross-section of participants in MTP (both TAU and Matrix participants) were found to be consistent with those of the clinical populations who participated in similar studies of treatment for methamphetamine abuse (Huber et al. 1997; Rawson et al. 2000). Figure A-1 lists specific client characteristics.

Figure A-1. Characteristics of MTP Participants

Male Female	45% 55%	Average education	12.2 years
Caucasian Hispanic/Latino Asian/Pacific Islander Other*	60% 18% 17% 5%	Employed	69%
Average age	32.8 years	Average lifetime methamphetamine use Average days of methamphetamine use in the past 30 days	7.54 years 11.53 days
Married and not separated	16%	Preferred route of methamphetamine administration Smoking Intravenous Intranasal	 65% 24% 11%

**Two percent of participants in the Other category were African American (personal correspondence with Jeanne Obert, Matrix Institute, November 2004).*

Source: Rawson et al. 2004, p. 711.

Participants' histories indicated multiple substance use. During the study, participant self-reports and drug and breath-alcohol tests confirmed that some clients had used marijuana or alcohol, as well as methamphetamines, but virtually no other substances of abuse were identified.

All MTP participants completed baseline assessments including the methamphetamine-dependence checklist in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (American Psychiatric Association 1994), and the Addiction Severity Index (McLellan et al. 1992). The assessments were repeated at several points during participants' active treatment, at discharge from treatment, and at 6 and 12 months after their dates of discharge from the program. Urine drug testing was conducted weekly throughout active treatment.

Results

No significant differences in substance use and functioning were found between TAU and Matrix groups at discharge and at 6-month followup. However, the MTP study found that the Matrix model participants (Rawson et al. 2004)

- Had consistently better treatment retention rates than did TAU participants
- Were 27 percent more likely than TAU participants to complete treatment
- Were 31 percent more likely than TAU participants to have methamphetamine-free urine test results while in treatment

At 6-month followup, more than 65 percent of both Matrix and TAU participants had negative urine tests for methamphetamine and other drugs (Rawson et al. 2004).

Appendix B.
Notes on Group Facilitation

All clients in a group, even in the highly structured Family Education group, develop individual relationships with their counselor. The degree to which the counselor can instigate positive change in clients' lives and support their family members is related directly to the credibility that he or she establishes. The counselor must be perceived as a highly credible source of information about substance use. Two keys to establishing credibility with clients are the degree to which the counselor engages and maintains control over a group and the counselor's ability to make all participants perceive the group as a safe place.

These two elements are highly interrelated. For a group to feel safe, the members need to view the counselor as competent and in control. Sometimes, group members enter the group with a lot of energy and are talkative and boisterous. Frequently this situation occurs during holidays, particularly if several members have relapsed. The counselor should use verbal and nonverbal methods of calming the group and focusing the group on the session topic. Conversely, there may be times when group members are lethargic, sluggish, and depressed. During these times, the counselor should infuse energy and enthusiasm. He or she needs to be aware of the emotional tone of families and respond accordingly, particularly when working with multifamily groups.

Because of the effects substance use disorders have on family members, negative emotions may be very close to the surface. The counselor must be prepared to handle these emotions appropriately as they arise and not to allow negative discussions or arguments to dominate a group session.

The members of a group need to feel that the counselor is keeping the group moving in a useful and healthful direction. The counselor must be willing to interrupt private conversations in the group, terminate a graphic drug use story, or redirect a lengthy tangential diversion. He or she must be perceived as clearly in control of the time in the group. Each member must be given an opportunity to have input. The counselor should ensure that a few members do not monopolize the group's time.

The counselor needs to be sensitive to emotional and practical issues that arise in group. At times it also may be necessary to be directive and confrontational or to characterize input from group members as a reflection of addictive thinking. In these instances, the counselor should focus on the addiction as opposed to the person. In other words, care should be taken to avoid directing negative feedback toward the client, focusing instead on the addiction-based aspects of the client's behavior or thinking.

The Family Education group counselor may be the professional who sees the clients for prescribed Individual/Conjoint sessions. The advantage of this dual role (group leader and individual counselor) is that the counselor can coordinate more effectively and guide the progressive recovery of each individual. The frequency of contact also strengthens the therapeutic bond that can hold the client in treatment. A potential disadvantage of the dual role is the possible danger that the counselor may inadvertently expose confidential client information to the group before the client chooses to do so. It is a violation of boundaries for the counselor even to imply that

information exists and to attempt to coerce a client into sharing that information if the client has not planned to do so in the group.

Another danger to be avoided is the counselor's being perceived as showing preference to some clients. It is important that the counselor be equally supportive of all group members and not allow them to engage in competition for attention.

The counselor can find discussions of group development, leadership, concepts, techniques, and other helpful information for conducting group therapy in Treatment Improvement Protocol 41, *Substance Abuse Treatment: Group Therapy* (CSAT 2005), a free publication from the Center for Substance Abuse Treatment.

Appendix C.
Acronyms and Abbreviations List

AA	Alcoholics Anonymous
ACoA	Adult Children of Alcoholics
Al-Anon	A support group for families and loved ones of people who are addicted to alcohol
Alateen	A support group for young family members and loved ones of people who are addicted to alcohol
ASI	Addiction Severity Index
CA	Cocaine Anonymous
CAL	Calendar (for worksheets used during scheduling)
CMA	Crystal Meth Anonymous
CoDA	Co-Dependents Anonymous
CSAT	Center for Substance Abuse Treatment
EA	Emotions Anonymous
ERS	Early Recovery Skills
GA	Gamblers Anonymous
HALT	Hungry Angry Lonely Tired
IC	Individual/Conjoint
IOP	Intensive Outpatient Treatment for People With Stimulant Use Disorders
JACS	Jewish Alcoholics, Chemically Dependent Persons and Significant Others
MA	Marijuana Anonymous
meth	Methamphetamine
MTP	Methamphetamine Treatment Project
NA	Narcotics Anonymous
Nar-Anon	A support group for families and loved ones of people who are addicted to narcotics
OA	Overeaters Anonymous
PA	Pills Anonymous
RP	Relapse Prevention
SAMHSA	Substance Abuse and Mental Health Services Administration
SCH	Schedule (for worksheets used during scheduling)
SMART	Self-Management and Recovery Training
SS	Social Support
TAU	Treatment as Usual

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Appendix D.
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Appendix F. Acknowledgments

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