Social Interpersonal Growth Psychotherapy for Addiction

A QUICK GUIDE TO:
Intensive Outpatient Therapy (IOP)
Structured Outpatient Addictions Therapy (SOAP)

Veronica Emilia Nuzzolo, M.Ed., Ph.D.

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Our prime purpose in this life is to help others, and if you can’t help them, at least don’t hurt them.

-Tenzin Gyatso
The 14th Dalai Lama (b. 1935)
Preface

To understand how to better support those who suffer from addiction, one must develop a foundation of scientific, educational, and communication skills that will allow clinicians to understand, treat, and not blame those struggling in recovery. Understanding key factors of addiction is critical to achieving long-term sobriety.

My area of expertise is in addictions and I have worked with addictive disorders for many years in direct treatment, teaching, and curriculum development of addiction-related training materials and resources. Areas of expertise include the treatment of addictive personality disorders and behaviors, opioid dependence, and the social perception of addiction as a disease. My work focuses on clinical and educational research associated with identifying risks and intervention methods for addiction and addiction treatment outcomes. In addition to active clinical practice, I continue to research extensively psychological complications associated with traumatic experience incurred during active disease that can impede treatment progress and create inevitable interpersonal phenomenon of unique perceptions and distortions.

My goal is to improve the understanding of addiction as a disease and further long-term continuum of care resources by strengthening community support, engagement, and information exchange for dealing with patients who demonstrate addictive behavior. This quick guide was motivated by my desire to further the evolution of treating addiction as a disease and is the result of many years of facilitating Intensive Outpatient Programs (IOP) and Structured Outpatient Addiction Programs (SOAP). It is my hope that the work compiled in this quick guide will enhance the individual/group experience and allow clinicians to connect meaningfully with those persons served.

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Social Interpersonal Growth Psychotherapy for Addiction

This intensive outpatient process introduces a very specific concentrated approach to Interpersonal Psychotherapy as an addictions recovery treatment method with additional focus on behaviorism (learned behaviors and the environment). This psychodynamic therapy focuses on the interaction between interpersonal dysfunction and psychological symptoms. Humans are social beings that react to environmental causation. The basic principles of learning and the concept of behaviorism suggest all behavior is in response to environmental stimuli and the responses to various stimuli are learned from past experiences and are dictated by present circumstance (Bandura, 1999). Social Interpersonal Growth Psychotherapy when used for addiction focuses on these one or two specific problems, the interpersonal conflict experienced at the inception of the addiction (psychological/social/environmental factors), and taking ownership of the addictive behaviors. This form of therapy assumes that the person served is motivated to change. For Social Interpersonal Growth Psychotherapy to be effective, the person served must be open to suggestion and must accept and examine his or her own role in the problem. This methodology is a time sensitive psychotherapy that focuses on interpersonal issues, which are understood to be a factor in the genesis of the psychological distress that has activated the addiction. The targets of this type of therapy are symptom resolution, improved interpersonal functioning, and increased social support (Weissman, Markowitz, and Keerman, 2007). Interpersonal Therapy is recognized by the American Psychological Association (APA) and the National Institute of Health (NIH) as an effective mode of treatment.

The immediate goal of this psychodynamic therapy is symptom relief and improving interpersonal functioning. Understanding the social and interpersonal context of the development of the addiction may help to determine the immediate reasons for the symptoms i.e.; depression and continued substance use/abuse. Helping the person served understand addiction as an illness will assist in developing new healthy coping skills to deal with people and situations. Developing these new social skills can help treat the current addiction and reduce future urges and episodes of relapse. To achieve these goals, the initial method of treatment is meant to be direct, short-term addiction focused treatment, 12-16-20 sessions, or full time, approximately 30 days, that is
geared to make one think, identify the problem, and learn how to improve interpersonal conflict by defining how serious the issue has become and understand why it is so difficult to move forward.

This form of therapy is an appropriate option for IOP/SOAP groups whereas this short-term therapeutic model reduces the likelihood that the person served will drop out of treatment. This fast-paced treatment begins with a specific termination date in mind. To make this determination the assessment phase (intake) of treatment (biopsychosocial) determines if the patient is suitable for intensive group psychotherapy, motivation for change, strengths based identification, interpersonal focus for distress, and adequate social support systems. The focus is the addiction and the reason/choice at the onset or inception of the addiction.

Moving forward into the initial phases of therapy, one must be very cautious when interviewing the person served whereas anxiety and depression are common denominators for those suffering from addiction and this dynamic form of psychotherapy can provoke anxious responses and trigger an event. Daily morning check-in allows the opportunity to assess additional needs by using Motivational Interviewing (MI). An individual client-centered approach is taken during check-in that allows the opportunity to engage each person through MI. MI is a critical component for individual and group success. MI draws out those negative interpersonal feelings that may induce urges and the person’s substance use/abuse. MI allows the Addiction Recovery Clinician to assess the person’s current attitude and readiness to change. MI is also used daily by asking the group to self-reflect and to think about why they first used and to be honest in their recovery when they contemplate why they continued to want to use.

The middle sessions or weeks in IOP/SOAP should involve identifying specific problems i.e., triggers, urges, people, places, things, and the development of solutions to the problems; setting boundaries, assertiveness, modifying behavior, and implementing community supports. This time should include the investigation of the interrelationship between the individual, the environment, and the addictive behavior. Specifically, the examination of learned social behaviors, attitude-relevant behavior, that allows one to resist, adjust, and find meaning from adverse situations and social influence.
The conclusion of treatment, unlike traditional psychoanalytical models of “termination,” will end per contract that had been previously mutually negotiated between clinician and person served. However, this is not the end of therapy. The specific goals at the end of treatment should be geared toward the patient's independent functioning, such as a step down to a day treatment program, incorporating community support groups into a daily routine, and continued individual therapy as long term maintenance strategies. Ideally, this should be a two-treatment process, the intense acute phase of treatment which focuses on the resolution of immediate symptoms, i.e.; substance use/abuse, depression, and anxiety, and a subsequent maintenance plan consisting of relapse prevention and maintaining productive interpersonal functioning.

To achieve positive results, it is imperative that one has a basic understanding of the issues that are most commonly addressed by these humanistic therapies such as addictions, disorders, and mental illness. Depression and anxiety are outcomes of substance use/abuse and result in continued negative thoughts. These negative thoughts may lead to avoidant behavior and isolation. One must identify the specific interpersonal focus for the distress, use/abuse, and then positive support systems must be implemented and maintained. If long-term maintenance is necessary, such as day treatment and future individual therapy, the methodology of Social Interpersonal Growth Psychotherapy can continue to help individuals cope with emotional, gender specific, relationship, and social issues by continuing to learn change strategies, developing coping mechanisms, and the communication skills necessary to create positive change and eradicate addictive self-defeating behaviors.

In this structured group environment, addiction should be viewed as a learning experience. The lifestyle during active addiction teaches and reinforces complex negative behaviors, thought processes, and new found knowledge regarding the effects of drugs and alcohol. People do not intuitively know how to be an addict; this is learned behavior influenced by many factors. The focus must remain on both the positive and negative influences that are within a person’s control such as life changes that will decrease urges and increase the probability of maintaining one’s sobriety. Addiction has only temporarily changed how a person thinks and
behaves. Dysfunctional thinking patterns will continue to put the person served at high risk for continued use if new thought processes are not activated.

Humanistic approaches with an emphasis and focus on moral reasoning and positive qualities can assist and help reduce and overcome anxiety, self-defeating, and self-destructive addictive behaviors. One will strive for self-acceptance gaining better insight into themselves, their behaviors, and their environment. Social Interpersonal Growth focuses on the person’s moral reasoning and positive qualities that enable the whole person to attain inner peace, create and maintain positive relationships, and live a healthy lifestyle. Social Interpersonal Growth Psychotherapy can assist in changing problematic interpersonal behavior patterns that play an important role in substance use/abuse and influences irrational thinking. This process is designed to be repetitive so continued cognitive processing of specific information is constant. Rehearsal is necessary for the group to assess progress and continued to be challenged to think. Cognitive Behavioral Therapy (CBT) and Rational Emotive Therapy (REBT) are recommended therapies that assist in the therapeutic process to allow the person served the opportunity to learn how to recognize self-defeating negative/irrational thoughts. Negative thoughts often lead to painful emotions, anxiety, and depression validating these irrational thoughts. These negative thoughts and feelings reinforce the irrational belief system that allows this person to justify bad behaviors. CBT and REBT teach one how to think more rationally which will help stop the negative and distorted thought process.

To assist in enforcing cognitive processing methodologies, this curriculum has been designed to allow a new member to enter the group conversation at different points of discussion without feeling anxious, lost, or behind. Every week specific questions are asked and every week there should be a significant change in behavior and in the answers to these questions:

*Why are you here? Who are you, and who do you want to be?* This is important to measure interpersonal conflict, current levels of self-esteem, and long-term goals. Most men equate who they want to be with their perception of success. Men typically measure success with house, car, money, material possessions.
This attitude should change by the end of the month; their measure of success should be that they want to be healthy, sober, a good person, etc. Women usually answer good mother, girlfriend, wife, etc., always geared toward others. By the end of the month, their measure of success should be more self-centered, and they should be answering with more confidence and independence, they should also be answering, healthy, sober, good person, etc.

**What was good about your addiction?** In the first stages of recovery, individuals find themselves in a state of cognitive dissonance, an internal state of conflict or anxiety that results from these inconsistencies between one’s beliefs, one’s actions, and the reality of the situation. When accountability is replaced with denial the addicts mind constructs an existence where active addiction was pleasurable and they continue to fall victim to the false sense of security they have created. The addict will attempt to justify the bad behaviors. The person served will glamorize the addiction and will find reasons why the addiction was pleasurable such as; I feel good, I am creative, I am more social, or I had fun. By weeks three and four this answer should change and the response should be there is “nothing” good about my addiction.

There are several advantages when Social Interpersonal Growth Psychotherapy is applied in a group setting. New members of the group learn first through observation what the other members in the group have learned and are currently learning. Participants will model the behavior of current group members, and a structured group setting allows the person served the opportunity to witness different types of social interactions and associations. These interactions can assist new group members how to better understand various approaches when learning to make interpersonal adjustments especially during the creation of his or her relapse prevention plan. Dealing with traumas incurred before or during the addiction is secondary during this initial treatment phase and should be addressed in individual sessions after group and again during the step down process to day treatment which should also include individual therapy, but, whereas this therapy is designed to be in the here and now, a humanistic approach is always taken, if someone is in crisis, experienced a lapse, or does recall a
traumatic event, the structure/formalities of the program stop and the group will assist and give the time and attention necessary to the person in need.

Co-occurring disorders such as heroin abuse and depression can have a profound effect on quality of life and one’s ability to function. Addiction Recovery Clinicians can assist and help the person served set attainable short-term goals as they work to maintain their sobriety. During sobriety, the individual understands that they must accept full responsibility for their actions and then they can move forward, develop new skills, and begin to explore new coping strategies that will allow the person served to begin to set long-term goals that may include rebuilding damaged relationships. Additional responsibilities of the Addiction Recovery Clinician include assessing the person served for a higher/lower level of care when deemed appropriate, creating an individualized action plan, creating a treatment plan, and communicating with collaterals such as; Department of Children and Families, Parole or Probation Officers, and any other persons identified by the person served.

Lastly, emphasize that this is a non-judgmental treatment and that the role of Addiction Recovery Clinician is to make one think, assist, and support everyone in reaching their own lifestyle goals, but more importantly, that their success depends primarily on their own effort, motivation, commitment, and follow through. An individual’s long-term success has nothing to do with the Clinician and everything to do with persons’ desire to succeed. It is a myth that a person with the experience of addiction lacks control over their own actions. Weekly discussion includes topics such as stigma, acceptance/accountability, and the importance of ownership. The creation of the relapse prevention plan includes researching community supports such as AA, NA, Smart Recovery, and Parenting Support Groups, etc. Relapse prevention planning should be discussed daily and during the individual’s one-on-one therapy sessions so that the plan is complete by the termination date.

Following are examples of the structured weeks educational sessions should include. Addiction Recovery Clinicians may incorporate any additional material they are comfortable with that relates to the topic matter presented in curriculum.
Understanding Addiction as a Disease

Substance Use Disorder (SUD) is a chronic illness. The definition of a SUD is a primary, chronic brain disorder characterized by compulsive substance use despite harmful and negative consequences. Chronic severe SUD is commonly referred to as addiction. The goal of treatment for SUD is remission, meaning someone no longer meets the criteria for SUD except for experiencing urges/cravings. Whereas recovery processes may involve cycles of active illness or relapse, effective treatment is patient-centered, humanistic, and can include medication and behavioral interventions.

There is a distinct gap between the science of addiction and current practice. This could inevitably be because of the stigma of addiction and decades of marginalizing addiction as a social problem rather than treating addiction as a disease or medical condition. Current treatment of addictions bears little resemblance of the treatment of other health conditions whereas care focuses on behavior often without considering physiological brain changes.
Physiological and Psychological Effects of SUD

Our brains are designed to recognize pleasure, so when we experience a pleasurable event, we naturally want to experience the sensation again. This is what motivates and drives one to do things to help us survive for example, eating, drinking, and meeting basic needs. Virtually all substances that are used/abused are drugs that change the natural chemicals of the brain's pleasure center. Often, the changes in brain chemistry can cause serious long-term problems, including withdrawal symptoms and brain damage. The area of the brain containing the “reward circuit” or “pleasure principle” has strong connections to the nucleus accumbens or the part of your brain that is responsible for basic emotions and the part of your brain that regulates basic body functions (the ventral tegmental area). One of the reasons that drugs may have such a strong effect is that the substance will act on the part of the brain that oversees very basic survival instincts. When urges/craving are strong and intense the reward/salience areas of the brain will override the pre-frontal cortex, the area of the brain in charge of reasoning and planning. When the pre-frontal cortex is effected one becomes impulsive, fixated, and inevitably continues to use/abuse substances. Because of the way drugs work on the brain, individuals who suffer from SUD only focus on the one or two positive effects of substance use without any consideration for the long-term effects of substance use/abuse. Substance use/abuse can potentially cause permanent damage to the brain and body. Substances such as alcohol, cocaine, and opioids have been shown to have long-term health effects that include liver damage, an increased risk for getting cancer, heart disease and brain damage.

Substance use becomes an addiction when a person goes from social use to needing a drug. People with SUD may also need to continue to use to prevent physical symptoms of withdrawal. Substance use/abuse conditions the brain into needing substances for survival. People who are addicted truly believe that they need the drug, or alcohol, to feel well emotionally and physically. Psychologically the need and feelings associated with addiction will continue to be very strong long after the physical need for the substance has passed. A
person suffering from a SUD must learn to deal with the emotions and feelings that make them want to engage in continued substance use.

**Effective Treatments**
The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient, (NIDA, 2012)

Nearly 80 percent of individuals with an opioid use disorder do not receive treatment. In the 2014 National Survey on Drug Use and Health (NSDUH), 435,000 respondents ages 12 or older reported current use of heroin. Nonmedical use of pain relievers continues to be more widespread than heroin use—4.3 million NSDUH respondents reported nonmedical use of pain relievers in the past month. Medication-assisted treatment (MAT) is an effective response to opioid use disorder. It is the use of medications, in combination with behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Individuals receiving MAT often demonstrate dramatic improvement in addiction-related behaviors and psychosocial functioning. The first barrier to accessing treatment is failure to recognize substance use disorder. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an approach in which screening is followed up as appropriate with brief intervention to promote healthy behavior change and with referral to treatment for those needing more extensive care (www.samhsa.gov/sbirt).

There are several combined effective treatments used in the treatment of SUD. MAT’s such as naltrexone, acamprosate, disulfiram, and topiramate that may be used in the treatment of alcohol use disorder. Methadone, buprenorphine, and naltrexone for use with opioid use disorder. MAT is very effective when used in conjunction with psychosocial/behavioral levels of care such as; partial hospitalization, intensive outpatient, and/or residential treatment. Per the World Health Organization (2017), “In most cases, treatment will be required in the long term or even throughout life. The aim of treatment services is not only to reduce or stop opioid use, but also to improve health and social function, and to help patients avoid some of the more serious consequences of drug use. Such long-term treatment is common for many medical conditions and should not be seen as treatment failure but rather as a cost-effective way of prolonging life and improving quality of life that supports the natural and long-term process of change and recovery.”
Treating SUD Like a Chronic Disease Such as Diabetes

Comparing Medical Management of Diabetes and SUD

<table>
<thead>
<tr>
<th>Diabetes</th>
<th>SUD</th>
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</thead>
<tbody>
<tr>
<td>Disease is chronic, goal is remission</td>
<td>Illness is chronic, goal is remission</td>
</tr>
<tr>
<td>Remission defined by euglycemia and prevention of acute and chronic complications</td>
<td>Remission defined by reduction or cessation of substance use and prevention of complications</td>
</tr>
<tr>
<td>Individualized treatment plans and targets</td>
<td>Individualized treatment plans and targets</td>
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<td>Treatment includes:</td>
<td>Treatment includes:</td>
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<tr>
<td>• Medication</td>
<td>• Medication</td>
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<tr>
<td>• Lifestyle changes</td>
<td>• Lifestyle changes</td>
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<tr>
<td>• Regular monitoring for symptoms and complications</td>
<td>• Regular monitoring for symptoms and complications</td>
</tr>
<tr>
<td>• Behavioral support</td>
<td>• Behavioral support</td>
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*SUD is like other chronic diseases; treatment outcomes can be as favorable whereas we can now apply lessons from other chronic disease care to the current epidemic of opioid use disorder and death.*
Getting Started: Preparing for Change – Stages of Change Model

**PRECONTEMPLATION:** The person is unaware or barely aware that there is a problem, the cons of giving up outweigh the pros, and there is no intent to change drug using in the foreseeable future.

**CONTEMPLATION:** The person acknowledges that there is a problem, are open to information and education, are considering change but are not quite ready, and are considering the pros and cons of giving up.

**PREPARATION:** There is an intention to give up the drugs, the person is beginning to set goals and plans, and strategies are developed.

**ACTION:** Significant action is made to stop using drugs.

**RELAPSE:** The person uses drugs again. This is a learning opportunity, a chance to learn what strategies did not work, and what part of the plan did not work.

**MAINTENANCE:** The person continues to abstain from drugs. The person can more clearly identify situations and self-defeating behaviors that encourage relapse. The person continues to work to prevent relapse.

*Here are some signs that it might be time to ask for help.*

*Do any of these signs apply to you?*

- You have tried to cut back or stop using substances on your own but somehow you keep on using, you begin to worry about your use of alcohol or drugs
- Someone around you is very worried about your use of alcohol or drugs
- You have had legal, financial or relationship problems that are related to your use of alcohol or drugs
WEEK 1

- Why are you here? Who are you and who do you want to be?
- What was good about your addiction?
- Understanding the Addiction Cycle
- Understanding Emotion and Addiction:
  - Anger, Guilt, Shame, and the fear of never using again
- Anxiety and Depression
- Realistic Goals - Remember your top 5 reasons for change
- Recovery must be a priority.

YOUR ADDICTION

What’s good about it:  What’s not good about it:

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I want to change because:

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### Coping with Strong Feelings:

Are there feelings you are struggling with? What are they? Fill in the following and it will help you understand which situations give you strong feelings and how you can handle them.

**Example:**

<table>
<thead>
<tr>
<th>What I was feeling</th>
<th>When does this happen?</th>
<th>How can I think differently about it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angry</td>
<td>Talking to my mother. I hate it when she tells me what to do.</td>
<td>Whatever happens, it’s my choice. She’s just trying to help.</td>
</tr>
</tbody>
</table>

**What can I do?**
- Keep conversations brief.
- Don’t argue. Change the subject.
- Say goodbye, hang up or leave.

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<thead>
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<th>What I was feeling</th>
<th>When does this happen?</th>
<th>How can I think differently about it?</th>
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</thead>
<tbody>
<tr>
<td>Sad</td>
<td>Thinking about my failures, usually when I see how well my sister is doing.</td>
<td>I am making good progress.</td>
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</table>

**What can I do?**
- Make a list of things I’m doing well.

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<tr>
<th>What I was feeling</th>
<th>When does this happen?</th>
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**What can I do?**

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**What can I do?**
Weekly Action Plan I:

This week, I will manage my triggers by:

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This week, I will take care of myself by:

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This week, I will take care of my emotional health by:

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This week, I will work on my communication skills by:

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WEEK 2

- Why are you here? Who are you and who do you want to be?
- What was good about your addiction?
- Coping with Triggers and Cravings
- Tools to use during recovery:
  - Mindfulness/Here and Now/Awareness
    - Journaling
    - Relapse Prevention
    - Coping Skills
    - Anger Management
- Realistic Goals - Remember your top 5 reasons for change
- Recovery must be a priority.

YOUR ADDICTION

What's good about it: ____________________________

What's not good about it: ____________________________

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I want to change because:

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Understanding Triggers:

Triggers are external events or circumstances that may produce very uncomfortable emotional symptoms, such as anxiety, panic, discouragement, despair, or negative self-talk. Having a reaction to these feelings is normal, but is not a reason to respond in a negative way. If we don’t recognize these feelings and respond in a healthy appropriate way, these feelings can result in backsliding and make us feel worse. Becoming aware of your triggers and to develop plans to avoid or deal with triggering events will increase your ability to cope and maintain your sobriety. Here are some common triggers. Check any that might apply to you.

<table>
<thead>
<tr>
<th>Having strong uncomfortable emotions</th>
<th>Dealing with physical discomfort</th>
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<tbody>
<tr>
<td>❑ Sadness</td>
<td>❑ Pain</td>
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<tr>
<td>❑ Anger</td>
<td>❑ Symptoms of withdrawal</td>
</tr>
<tr>
<td>❑ Loneliness</td>
<td>❑ Fatigue</td>
</tr>
<tr>
<td>❑ Frustration</td>
<td>❑ Illness/nausea</td>
</tr>
<tr>
<td>❑ Anxiety</td>
<td>❑ Boredom</td>
</tr>
</tbody>
</table>

Having an urge or a craving

❑ Thinking about the alcohol or drug
❑ Seeing the alcohol or drug
❑ When I’m with others who are drinking or using drugs
❑ When others ask me or pressure me to drink or use drugs
❑ When I want to test my ability to control my use (I think I know when to stop)

To make a good time feel better

❑ To enjoy a special event more
❑ To enjoy being with my friends
❑ While I’m relaxing
❑ To reward myself

When I have problems in my relationships

❑ With my parents
❑ With my loved ones
❑ With my neighbors
❑ With my co-workers

If you stop to think about your patterns of behavior, you might notice that there are some situations in which you are more likely to use drugs or alcohol. Here are some common examples.

Check off any that apply to you:
❑ Getting paid (having money with me)
❑ Being in a certain neighborhood
❑ After work or an appointment
❑ At the end of the day
❑ On weekends
❑ On days I don’t go to work/therapy
❑ Seeing or using paraphernalia (pipes, spoons, needles, bottles/glasses)
❑ Seeing friends and associates who use
❑ Intimate relationships (going on dates)

Other situations:
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Weekly Action Plan II:

This week, I will manage my triggers by:

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This week, I will take care of myself by:

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This week, I will take care of my emotional health by:

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This week, I will work on my communication skills by:

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WEEK 3

- Why are you here? Who are you and who do you want to be?
- What was good about your addiction?
- Coping with Triggers and Cravings – What skills are you using?
  - Interpersonal Conflict/Relationships
    - Ownership and Accountability
    - Self-Esteem
    - Acceptance
- Realistic Goals - Remember your top 5 reasons for change
- Recovery must be a priority.

YOUR ADDICTION

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Self-Esteem - Self-assessment

People who feel good about themselves generally have more success. To do well in recovery, it is important for you to work on building your self-esteem. Use the self-assessment checklist below to understand more about what self-esteem is and then plan for building yours. These are ways of building good self-esteem. Which do you do?

❑ Feel and think about myself in a positive way
❑ Have a sense of well-being and respect for myself
❑ Take care of myself physically and emotionally
❑ Spend time with people whom I respect and who respect me
❑ See my accomplishments as worthwhile
❑ Express my feelings in a way that is respectful of others
❑ Let myself be, without pushing or judging myself
❑ Let others be, without pushing or judging them
❑ Accept and thank others for positive comments
❑ Balance my needs with those of others
❑ Admit mistakes and move on
❑ Make self-talk my best friend

These are ways to reduce your self-esteem. Which do you do?

❑ Not stand up for myself
❑ Have critical self-talk about not being good enough (smart enough, fast enough, etc.)
❑ Not ask others for what I need in a direct, healthy way
❑ Not ask for help when I need it
❑ Stay trapped in old negative ways of thinking and behaving
❑ Don’t believe — not believing in myself
❑ Try to please others and put myself last

Work on Your Self-Esteem:

List Examples on how you can boost your self-esteem:

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Weekly Action Plan III:

This week, I will manage my triggers by:
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This week, I will take care of myself by:
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This week, I will take care of my emotional health by:
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This week, I will work on my communication skills by:
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WEEK 4

• Why are you here? Who are you and who do you want to be?

• What was good about your addiction?

• Coping Strategies for Life:

• Learning from lapses and understanding the potential for lapses:

  • Assertiveness/Boundaries
    o Understanding and coping with emotions
    o Problem Solving
    o Building a strong support network

• Realistic Goals - Remember your top 5 reasons for change

• Recovery must be a priority.

YOUR ADDICTION

What’s good about it:  What’s not good about it:

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I want to change because:

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Self-assessment:

Do you show any of these signs of collapsed, or poor, interpersonal boundaries?

Check off any that apply to you:

- I tell all before I know I can trust someone
- I talk to someone as if we are best friends the first time we meet
- I go against my own values to please someone else
- I don’t notice when someone else is showing poor boundaries
- I take whatever I can for the sake of getting whatever I can
- I let others tell me how I should think or feel
- I let someone hurt my feelings or abuse me
- I let others tell me what is important
- I expect other people to fill my needs without asking
- I get weak or fall apart so that someone will take care of me
- I do things to hurt myself (self-abuse)

Do you show any of these signs of rigid boundaries?

- I don’t tell anyone how I feel
- I don’t trust, even after I have had time to get to know someone
- I feel that others are likely to hurt me — that I am all alone
- I expect others to do things my way, or go away
- I don’t ask for help
- I don’t offer help or support
- I stop/close relationships before they get started

How do you demonstrate healthy boundaries?

- I can say no to requests in a nice way
- I am okay when others say no to me
- I have a lot of self-respect
- I expect give and take in a relationship — what I would do for them, they would do for me
- I share responsibility and control
- I share personal information as I get to know someone, and they share information with me the same way
- I don’t tolerate being abused
- I know what I need and want and express myself assertively
- I value my own opinions and are open to and value others’ opinions
- I ask for help when I need it
- I don’t push my own values aside to avoid being rejected
Weekly Action Plan IV:

This week, I will manage my triggers by:

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This week, I will take care of myself by:

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This week, I will take care of my emotional health by:

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This week, I will work on my communication skills by:

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My Plan for Relapse Prevention:

These are the things that I will do if I start to have difficulty maintaining my recovery:
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These are the things that I will do to stay on track:
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I have the following strengths I can use to maintain my sobriety and live a healthy life:
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Long-Term Treatment Plan Strategies:

- Abstinence: Obtain and maintain sobriety, live a chemical-free life, cope with life without chemicals.

- Controlled drinking: Follow patterns of use that reduce harm.

- Stabilize one's health, finances, vocation/school, employment, living arrangements.

- Resolve and avoid legal problems.

- Develop sober leisure skills. Stabilize one's intimate relationships, marriage, family.

- Include significant others such as spouse/partner, children, relatives, friends, etc., in the recovery program as prescribed.

- Improve social skills, assertiveness, emotional expression, communication. Improve social support, friendships, social pursuits. Deal/cope with/resolve emotional problems/feelings such as rejection, depression, unresolved grief/mourning, shame, guilt, abandonment.

- Improve coping skills, stress management skills, relaxation abilities, self-control.

- Enhance self-esteem, confidence, and self-acceptance. Accept responsibility for the consequences of one's behavior. Improve problem-solving ability, setting of priorities, persistence, frustration tolerance.

- Be an active participant in the treatment program by attending/participating in: Scheduled education classes about chemical dependency and the process of recovery. Scheduled counseling, psychotherapy, and educational groups (e.g. spirituality groups, men's and women's groups, etc.).

- Alcoholics Anonymous/Narcotics Anonymous/etc, groups to develop a sober support fellowship in the community.

- Give Back: Become a sponsor, substance educator, role model.

- Identify high-risk situations, warning signs, and triggers; rehearse coping responses;

- Avoid high-risk situations. Learn and utilize harm reduction approaches
Celebrating Any Positive Change

“If our goal is to promote health and reclaim lives, then we must understand the direct and sometimes circuitous paths through which individuals and families achieve and sustain such health. We must meet each individual and family with fresh eyes in every encounter with a belief that each encounter is an opportunity for movement, no matter how small, towards health and wholeness.” – Arthur C. Evans Jr., 2013
References


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Appendix A

Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2015